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Chapter 3. The Emergency Medical Treatment and Labor Act

Insert at the end of Chapter 3, page 113, a new section 13:

13. Religious Conscience and EMTALA.

For decades, federal law has allowed individuals or organizations to withhold care in situations involving abortion, sterilization, assisted suicide and advance directives, even though such refusals would otherwise violate dozens of laws prohibiting discrimination in the provision of care. In recent years, an increasingly conservative Supreme Court, along with the George W. Bush and Trump Administrations, have broadened these exemptions. For example, in Burwell v Hobby Lobby Stores, 573 U.S. 682 (2014), covered later in this book, the Court, for the first time, extended the Religious Freedom Restoration Act, 42 U.S.C. § 2000bb et seq., to closely-held private corporations and their owners, exempting them from regulations implementing the Affordable Care Act’s (ACA) requirement that employers include all FDA-approved contraceptives, without cost-sharing, in their employee health benefit plans. The Bush Administration issued regulations in 2008 (later rescinded for the most part by the Obama Administration) broadly interpreting laws that allow an individual to forbear from acts that violate his or her religious conscience. As we describe immediately below, in 2019 the Trump Administration issued rules pushing the protection of religious conscience much further.

This trend of broadening the protection of religious conscience raises profound issues. Among other questions, one can ask whether the First Amendment’s Establishment Clause limits the power of the federal government to create exemptions from federal laws in order to accommodate religious freedom. See Adam K. Hersh, Daniel in the Lion’s Den: A Structural Reconsideration of Religious Exemptions from Nondiscrimination Laws Since Obergefell, 70 Stanford L. Rev. 265 (January 2018).

Beyond important legal and philosophical questions is a much more practical one—at what point do exemptions literally compromise public health, deprive others of benefits to which they are entitled, and most potently, perhaps, endanger the lives and health of patients? Do basic concepts of due process in fact tolerate such government policies? Where should the line be drawn? Did we already cross it with the first religious conscience laws following the Supreme Court’s decision in Roe v Wade? What does government have the power to excuse? Withholding contraceptive coverage in the name of religion? Refusing on religious grounds to treat patients because of the color of their skin or the language they speak? Withholding care because of the sexual orientation or gender identity of patients? Where does this end?

On May 21 2019, the Trump administration published a final rule entitled “Protecting Statutory Conscience Rights in Health Care: Delegations of Authority.” 84
Fed. Reg. 23170. This rule grants sweeping religious and moral exemptions for health care workers, effectively taking religious freedom into territory first explored in the rescinded 2008 Bush Administration rule. Arguably the Trump rule goes further than the Bush rule did in terms of the scope of the exemption, which appears to extend beyond certain enumerated health care services such as abortion and contraception.

The 2019 rule establishes the authority of the United States Department of Health and Human Services Office for Civil Rights to interpret and enforce religious conscience laws in health care. The rule moves beyond the outer limits of its 2008 predecessor rule, in that it grants exemptions not just to health care providers but also to insurers and employer plans. The rule also makes clear that its sweep encompasses employees who do not even directly furnish health care, such as people who register patients, clean rooms, or prepare bills. Katie Keith, Trump Administration Finalizes Broad Religious And Moral Exemptions For Health Care Workers, Health Affairs Blog, May 3, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190503.960127/full/ (Accessed July 17, 2019).

The Trump Administration rule also is partially a response to regulations, issued by the Obama administration in 2016 (discussed later in the book), that implement section 1557 of the ACA, a major reformulation of U.S. civil rights policy in health care. Before the ink was dry on the 2016 rule, opponents sued to block enforcement of its provisions governing cases involving pregnancy termination as well as provisions that interpreted 1557’s prohibition against discrimination based on sex (a civil rights landmark, as you will see) to include gender identity. A federal court enjoined enforcement of these provisions on a nationwide basis. See Franciscan Alliance v. Burwell, 227 F. Supp. 3d 660 (N.D. Tex. 2016).

The Trump Administration’s 2019 rule first appeared in proposed form in 2018 as a rule that would build on and expand the rescinded 2008 rule. (Discussed below is the Administration’s proposal to restructure the 1557 rules more generally; the conscience protections discussed here effectively were separated out and put on a faster track.) Nearly a quarter million comments later, the conscience rule was finalized in May, 2019. According to the Administration, the rule is necessary because of the growing number of complaints that individuals are being forced to violate their religious beliefs and the increased litigation around state laws alleged to violate religious freedom. (One such example of this litigation is National Institute of Family and Life Advocates v Becerra, 138 S. Ct. 2361 (2018), in which the Court invalidated on First Amendment free-speech grounds California’s state licensing rules regulating information furnished to clients by so-called pregnancy crisis centers.)

The final conscience rule raises a blizzard of issues related to the extent to which religious freedom may impede access to health care. It also puts front and center the question of whether the Administration even has the legal authority to extend existing

* Note that for some reason the Federal Register misprinted the running header showing the date as May 21, 2018. One of us had to stare at the page a zillion times to make sure this error was not a mirage.
religious conscience laws protecting health care providers to insurers and employer-sponsored health plans. (Ironically, in its proposed rule narrowing 1557 civil rights regulations, the Administration proposes to exempt insurers from the meaning of health care entity except in limited circumstances. Consistency is the hobgoblin of small minds.)

In describing the types of discrimination covered by its provisions, the final rule contains the following paragraph:

§ 88.3 Applicable requirements and prohibitions

... 

(a)(2)(v) Pursuant to 42 U.S.C. 300a–7(c)(2) [the Church Amendment establishing religious conscience protections in the case of sterilization and abortion] entities to which this paragraph (a)(2)(v) applies shall not discriminate against any physician or other health care personnel in employment, promotion, termination of employment, or extension of staff or other privileges because such physician or other health care personnel performed or assisted in the performance of any lawful health service or research activity, because he refused to perform or assist in the performance of any such service or activity on the grounds that his performance or assistance in the performance of such service or activity would be contrary to his religious beliefs or moral convictions, or because of his religious beliefs or moral convictions respecting any such service or activity.

[emphasis added].

The Church Amendment, more than 40 years old, pertains only to religious objections to abortion and sterilization. Is it lawful for the Trump Administration to extend its scope beyond those services?

With respect to how the new rule will interact with EMTALA, the final rule provides as follows:

§ 88.8 Relationship to other laws.

Nothing in this part shall be construed to preempt any Federal, State, or local law that is equally or more protective of religious freedom and moral convictions. Nothing in this part shall be construed to narrow the meaning or application of any State or Federal law protecting free exercise of religious beliefs or moral convictions.

The final rule goes on to provide a “rule of construction”: 
§ 88.9 Rule of construction.

This part shall be construed in favor of a broad protection of the free exercise of religious beliefs and moral convictions, to the maximum extent permitted by the Constitution and the terms of the Federal conscience and anti-discrimination laws.

So in fact, nothing in either the conflict of laws or rule of construction provisions explains how the new rules relate to EMTALA (or other federal laws for that matter that require health care providers to serve everyone in the service area, including community health centers (discussed in Chapter 5)).

Not surprisingly, commenters raised the EMTALA issue along with concerns about how the conscience rule would interact with section 1557’s civil rights provisions. Here is the Administration’s answer:

Comment: The Department received many comments expressing confusion or concern as to how the proposed rule would interact with or be in conflict with other Federal laws, such as the Emergency Medical Treatment and Active Labor Act (EMTALA) and Federal anti-discrimination statutes (such as section 1557 of the ACA).

Response: This final rule provides the Department with the means to enforce Federal conscience and antidiscrimination laws in accordance with their terms and to the extent permitted under the laws of the United States and the Constitution. This final rule, like the 2008 Rule and the 2011 Rule, does not go into detail as to how its provisions may or may not interact with other statutes or in all scenarios, but [the Office of Civil Rights] intends to read every law passed by Congress in harmony to the fullest extent possible so that there is maximum compliance with the terms of each law. With respect to EMTALA, the Department generally agrees with its explanation in the preamble to the 2008 Rule that the requirement under EMTALA that certain hospitals treat and stabilize patients who present in an emergency does not conflict with Federal conscience and antidiscrimination laws. The Department intends to give all laws their fullest possible effect.

84 Fed. Reg. 23182-23183 [emphasis added].

What could this possibly mean? What does “generally agrees” mean? How can the Trump Administration rule, with its sweeping right of refusal of care, not be read as being in direct conflict with EMTALA’s screening and stabilization duties? What happens when a woman experiencing a medical emergency arising from a spontaneous miscarriage arrives at a hospital, but the emergency staff believe (sincerely) that the emergency actually is the result of a failed abortion and refuse to screen or stabilize her? What happens when a transgender man is brought to the emergency department
experiencing what appears to be a stroke and personnel will not screen or stabilize him? How does this rule possibly “not conflict” with EMTALA?

Here is what the current Administration “generally agrees with,” that is, what the Bush Administration said in 2008 (73 Fed. Reg. 78072, 78087-78088)—itself a model of legal dissembling:

Comment: Several Comments raised the question of how this regulation may conflict with rules governing other Department programs. Some expressed concerns that the rule was inconsistent with . . . the treatment requirements under the Emergency Medical Training and Active Labor Act (EMTALA) [sic]. Specifically, Comments assert that this regulation is inconsistent with the requirement that institutions provide care in an emergency, a requirement that includes no exception for religious or moral objections to the needed service . . . .

Response: The Department does not operate its programs in conflict with the existing federal protections being further implemented by this rule. The Department believes that many Commenters are confused as to the programmatic requirements of various Departmental programs, and suggests that concerned parties seek clarification from individual program offices as appropriate. Similarly, the Department believes that Commenters mistakenly confuse certain legal requirements on institutions or health care entities as requirements on individual providers. With respect to emergency treatment, the obligations of EMTALA are imposed on hospitals under 1867 of the Social Security Act only if they elect to operate an emergency room and are also limited to the capabilities of the particular hospital. The requirement under EMTALA that such hospitals treat and stabilize patients who present in an emergency is not in conflict with the Church Amendments’ requirement that certain recipients of Department funds not force any individual to participate in a health service program that they object to based on a religious belief or moral conviction. While this and other hypothetical situations were raised in the Comments, the Department is not aware of any instance where a facility required to provide emergency care under EMTALA was unable to do so because its entire staff objected to the service on religious or moral grounds . . . .

(So the fact that the Department is “not aware” of instances where an entire staff withholds care is enough to rectify what would be a clear violation of federal anti-discrimination law? How about a rural hospital—suppose it is the only one around—where only skeletal staff is available to perform screening and stabilization duties? What happens then in terms of the hospital’s obligations under EMTALA?)

And then this from the 2008 rule:

* Note the agency’s error on EMTALA’s name—not a basis for a vote of confidence.
Comment: Multiple Comments questioned the balance between provisions in the Department’s proposed rule and requested clarification on EMTALA requirements and how they will be upheld if the Department’s proposed rule is promulgated.

Response: The Department notes that this Comment would only be relevant where a hospital, as opposed to an individual, has an objection to performing abortions that are necessary to stabilize the mother, as that term has been interpreted in the context of EMTALA. The Department is unaware of any hospital that has such a policy. Furthermore, the laws this regulation supports have existed alongside EMTALA for many years. Thus, we do not anticipate any actual conflict between EMTALA and this regulation.

Seriously?? Again, the “we are not aware” justification!

Shortly after the 2019 rule was published, but before it took effect, a coalition of local governments and health care providers filed suit to halt its implementation. See County of Santa Clara et al. v. Azar (Case No. 5:19-cv-2916, N.D. California, May 28, 2019). Not surprisingly, plaintiffs argue that the rule contravenes numerous federal laws including EMTALA, and they provide vivid examples of the extent to which the rule would disrupt health care services and operations if existing “nuanced” conscience protections are expanded to swallow the entire health care system and if employees of hospitals, nursing homes, insurers, pharmacies, etc. are allowed to raise religious freedom claims virtually unchecked. At the end of June, unable to meet the briefing schedule set by the court, the Administration agreed to delay the July 22, 2019 enforcement date until at least late November. https://www.courthousenews.com/wp-content/uploads/2019/06/Stipulation_and_Proposed_Order.pdf (Accessed July 17, 2019); Mary Anne Pazanowski, Government Denied More Time for Conscience Rule Case Filings (Bloomberg Law News June 28, 2019).

On a final note, in the middle of the confusion over how the conscience rule affects hospitals’ EMTALA obligations, the Centers for Medicare and Medicaid Services, which enforces EMTALA, issued a notice on July 3—actually it reissued an earlier notice—to remind hospitals that EMTALA protects infants born alive at “any stage of development.” CMS, Interaction of the Emergency Medical Treatment and Labor Act (EMTALA) and the Born-Alive Infants Protection Act of 2002, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/QSO-05-26.pdf (Accessed July 17, 2019). What exactly would happen if hospital staff refused, on religious or moral grounds, to provide emergency care in such situations is, to put it mildly, not clear. The reissuance does not add any further explanation regarding the interaction between EMTALA on the one hand and the Born-Alive Protection Act, and the conscience rule on the other.
Chapter 4 Civil Rights Law and Access to Health Care

Insert at textbook, p. 139 at the very bottom:

Whole Women’s Health v Hellerstedt
136 S. Ct. 2292 (2016)

BREYER, J., delivered the opinion of the Court, in which KENNEDY, GINSBURG, SOTOMAYOR, and KAGAN JJ., joined. GINSBURG, J., filed a concurring opinion. THOMAS, J., filed a dissenting opinion. ALITO, J., filed a dissenting opinion, in which ROBERTS, C.J., and THOMAS, J., joined.

In Planned Parenthood of Southeastern Pa. v. Casey[, ] a plurality of the Court concluded that there “exists” an “undue burden” on a woman’s right to decide to have an abortion, and consequently a provision of law is constitutionally invalid, if the “purpose or effect” of the provision “is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability.” [ ] The plurality added that “[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.”

We must here decide whether two provisions of Texas’ House Bill 2 violate the Federal Constitution as interpreted in Casey. The first provision, which we shall call the “admitting-privileges requirement,” says that

“[a] physician performing or inducing an abortion . . . must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that . . . is located not further than 30 miles from the location at which the abortion is performed or induced.”

This provision amended Texas law that had previously required an abortion facility to maintain a written protocol “for managing medical emergencies and the transfer of patients requiring further emergency care to a hospital.”

The second provision, which we shall call the “surgical-center requirement,” says that

“the minimum standards for an abortion facility must be equivalent to the minimum standards adopted under [the Texas Health and Safety Code section] for ambulatory surgical

We conclude that neither of these provisions confers medical benefits sufficient to justify the burdens upon access that each imposes. Each places a substantial obstacle in the path of women seeking a previability abortion, each constitutes an undue burden on abortion access, and each violates the Federal Constitution.
I

A

In July 2013, the Texas Legislature enacted House Bill 2 (H.B. 2 or Act). In September (before the new law took effect), a group of Texas abortion providers filed an action in Federal District Court seeking facial invalidation of the law’s admitting-privileges provision. In late October, the District Court granted the injunction. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 951 F.Supp.2d 891, 901 (W.D.Tex.2013). But three days later, the Fifth Circuit vacated the injunction, thereby permitting the provision to take effect. *Planned Parenthood of Greater Tex. Surgical Health Servs. v. Abbott*, 734 F.3d 406, 419 (2013).

The Fifth Circuit subsequently upheld the provision, and set forth its reasons in an opinion released late the following March. In that opinion, the Fifth Circuit pointed to evidence introduced in the District Court the previous October. It noted that Texas had offered evidence designed to show that the admitting-privileges requirement “will reduce the delay in treatment and decrease health risk for abortion patients with critical complications,” and that it would “‘screen out’ untrained or incompetent abortion providers.” The opinion also explained that the plaintiffs had not provided sufficient evidence “that abortion practitioners will likely be unable to comply with the privileges requirement.” The court said that all “of the major Texas cities, including Austin, Corpus Christi, Dallas, El Paso, Houston, and San Antonio,” would “continue to have multiple clinics where many physicians will have or obtain hospital admitting privileges.” The *Abbott* plaintiffs did not file a petition for certiorari in this Court.

B

On April 6, one week after the Fifth Circuit’s decision, petitioners, a group of abortion providers (many of whom were plaintiffs in the previous lawsuit), filed the present lawsuit in Federal District Court. They sought an injunction preventing enforcement of the admitting-privileges provision as applied to physicians at two abortion facilities, one operated by Whole Woman’s Health in McAllen and the other operated by Nova Health Systems in El Paso. They also sought an injunction prohibiting enforcement of the surgical-center provision anywhere in Texas. They claimed that the admitting-privileges provision and the surgical-center provision violated the Constitution’s Fourteenth Amendment, as interpreted in *Casey*.

The District Court subsequently received stipulations from the parties and depositions from the parties’ experts. The court conducted a 4–day bench trial. It heard, among other testimony, the opinions from expert witnesses for both sides. On the basis of the stipulations, depositions, and testimony, that court reached the following conclusions:

1. Of Texas’ population of more than 25 million people, “approximately 5.4 million” are “women” of “reproductive age,” living within a geographical area of “nearly 280,000 square miles.”
2. “In recent years, the number of abortions reported in Texas has stayed fairly consistent at approximately 15–16% of the reported pregnancy rate, for a total number of approximately 60,000–72,000 legal abortions performed annually.”

3. Prior to the enactment of H.B. 2, there were more than 40 licensed abortion facilities in Texas, which “number dropped by almost half leading up to and in the wake of enforcement of the admitting-privileges requirement that went into effect in late-October 2013.”

4. If the surgical-center provision were allowed to take effect, the number of abortion facilities, after September 1, 2014, would be reduced further, so that “only seven facilities and a potential eighth will exist in Texas.”

5. Abortion facilities “will remain only in Houston, Austin, San Antonio, and the Dallas/Fort Worth metropolitan region.” These include “one facility in Austin, two in Dallas, one in Fort Worth, two in Houston, and either one or two in San Antonio.”

6. “Based on historical data pertaining to Texas’s average number of abortions, and assuming perfectly equal distribution among the remaining seven or eight providers, this would result in each facility serving between 7,500 and 10,000 patients per year. Accounting for the seasonal variations in pregnancy rates and a slightly unequal distribution of patients at each clinic, it is foreseeable that over 1,200 women per month could be vying for counseling, appointments, and follow-up visits at some of these facilities.”

7. The suggestion “that these seven or eight providers could meet the demand of the entire state stretches credulity.”

8. “Between November 1, 2012 and May 1, 2014,” that is, before and after enforcement of the admitting-privileges requirement, “the decrease in geographical distribution of abortion facilities” has meant that the number of women of reproductive age living more than 50 miles from a clinic has doubled (from 800,000 to over 1.6 million); those living more than 100 miles has increased by 150% (from 400,000 to 1 million); those living more than 150 miles has increased by more than 350% (from 86,000 to 400,000); and those living more than 200 miles has increased by about 2,800% (from 10,000 to 290,000). After September 2014, should the surgical-center requirement go into effect, the number of women of reproductive age living significant distances from an abortion provider will increase as follows: 2 million women of reproductive age will live more than 50 miles from an abortion provider; 1.3 million will live more than 100 miles from an abortion provider; 900,000 will live more than 150 miles from an abortion provider; and 750,000 more than 200 miles from an abortion provider.

9. The “two requirements erect a particularly high barrier for poor, rural, or disadvantaged women.”
10. “The great weight of evidence demonstrates that, before the act’s passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure.”

11. “Abortion, as regulated by the State before the enactment of House Bill 2, has been shown to be much safer, in terms of minor and serious complications, than many common medical procedures not subject to such intense regulation and scrutiny.” see, e.g., App. 223–224 (describing risks in colonoscopies), 254 (discussing risks in vasectomy and endometrial biopsy, among others), 275–277 (discussing complication rate in plastic surgery).

12. “Additionally, risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities.”

13. “[W]omen will not obtain better care or experience more frequent positive outcomes at an ambulatory surgical center as compared to a previously licensed facility.”

14. “[T]here are 433 licensed ambulatory surgical centers in Texas,” of which “336 . . . are apparently either ‘grandfathered’ or enjo[y] the benefit of a waiver of some or all” of the surgical-center “requirements.”

15. The “cost of coming into compliance” with the surgical-center requirement “for existing clinics is significant,” “undisputedly approach[ing] 1 million dollars,” and “most likely exceed[ing] 1.5 million dollars,” with “[s]ome . . . clinics” unable to “comply due to physical size limitations of their sites.” The “cost of acquiring land and constructing a new compliant clinic will likely exceed three million dollars.”

On the basis of these and other related findings, the District Court determined that the surgical-center requirement “imposes an undue burden on the right of women throughout Texas to seek a previability abortion,” and that the “admitting-privileges requirement, . . . in conjunction with the ambulatory-surgical-center requirement, imposes an undue burden on the right of women in the Rio Grande Valley, El Paso, and West Texas to seek a previability abortion.” The District Court concluded that the “two provisions” would cause “the closing of almost all abortion clinics in Texas that were operating legally in the fall of 2013,” and thereby create a constitutionally “impermissible obstacle as applied to all women seeking a previability abortion” by “restricting access to previously available legal facilities.” On August 29, 2014, the court enjoined the enforcement of the two provisions. Gold & Nash.

C

On October 2, 2014, at Texas’ request, the Court of Appeals stayed the District Court’s injunction. Within the next two weeks, this Court vacated the Court of Appeals’ stay (in substantial part) thereby leaving in effect the District Court’s injunction against enforcement of the surgical-center provision and its injunction against enforcement of the
admitting-privileges requirement as applied to the McAllen and El Paso clinics. The Court of Appeals then heard Texas’ appeal.

On June 9, 2015, the Court of Appeals reversed the District Court on the merits. With minor exceptions, it found both provisions constitutional and allowed them to take effect. *Whole Women’s Health v. Cole*, 790 F.3d 563, 567 (*per curiam*), modified, 790 F.3d 598 (C.A.5 2015). Because the Court of Appeals’ decision rests upon alternative grounds and fact-related considerations, we set forth its basic reasoning in some detail. The Court of Appeals concluded:

- The District Court was wrong to hold the admitting-privileges requirement unconstitutional because (except for the clinics in McAllen and El Paso) the providers had not asked them to do so, and principles of res judicata barred relief.
- Because the providers could have brought their constitutional challenge to the surgical-center provision in their earlier lawsuit, principles of res judicata also barred that claim.
- In any event, a state law “regulating previability abortion is constitutional if: (1) it does not have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus; and (2) it is reasonably related to (or designed to further) a legitimate state interest.”
- “[B]oth the admitting privileges requirement and” the surgical-center requirement “were rationally related to a legitimate state interest,” namely, “raise[ing] the standard and quality of care for women seeking abortions and . . . protect[ing] the health and welfare of women seeking abortions.”
- The “[p]laintiffs” failed “to proffer competent evidence contradicting the legislature’s statement of a legitimate purpose.”
- “[T]he district court erred by substituting its own judgment [as to the provisions’ effects] for that of the legislature, albeit . . . in the name of the undue burden inquiry.”
- Holding the provisions unconstitutional on their face is improper because the plaintiffs had failed to show that either of the provisions “imposes an undue burden on a large fraction of women.”
- The District Court erred in finding that, if the surgical-center requirement takes effect, there will be too few abortion providers in Texas to meet the demand. That factual determination was based upon the finding of one of plaintiffs’ expert witnesses (Dr. Grossman) that abortion providers in Texas “will not be able to go from providing approximately 14,000 abortions annually, as they currently are, to providing the 60,000 to 70,000 abortions that are done each year in Texas once all” of the clinics failing to meet the surgical-center requirement “are forced to close.” But Dr. Grossman’s opinion is (in the Court of Appeals’ view) “*ipse dixit*”; the “record lacks any actual evidence regarding the current or future capacity of the eight clinics”; and there is no “evidence
in the record that” the providers that currently meet the surgical-center requirement “are operating at full capacity or that they cannot increase capacity.”

For these and related reasons, the Court of Appeals reversed the District Court’s holding that the admitting-privileges requirement is unconstitutional and its holding that the surgical-center requirement is unconstitutional. The Court of Appeals upheld in part the District Court’s more specific holding that the requirements are unconstitutional as applied to the McAllen facility and Dr. Lynn (a doctor at that facility), but it reversed the District Court’s holding that the surgical-center requirement is unconstitutional as applied to the facility in El Paso. In respect to this last claim, the Court of Appeals said that women in El Paso wishing to have an abortion could use abortion providers in nearby New Mexico.

[Justice Breyer’s extended discussion of why the claims were not precluded under the principle of res judicata, along with Justice Alito’s dissent on the ground of claim preclusion, are omitted]

III

Undue Burden—Legal Standard

We begin with the standard, as described in Casey. We recognize that the “State has a legitimate interest in seeing to it that abortion, like any other medical procedure, is performed under circumstances that insure maximum safety for the patient.” Roe v. Wade, (1973). But, we added, “a statute which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman’s choice cannot be considered a permissible means of serving its legitimate ends.” Casey, 505 U.S., at 877. Moreover, “[u]nnecessary health regulations that have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion impose an undue burden on the right.”

The Court of Appeals wrote that a state law is “constitutional if: (1) it does not have the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus; and (2) it is reasonably related to (or designed to further) a legitimate state interest.” The Court of Appeals went on to hold that “the district court erred by substituting its own judgment for that of the legislature” when it conducted its “undue burden inquiry,” in part because “medical uncertainty underlying a statute is for resolution by legislatures, not the courts.”

The Court of Appeals’ articulation of the relevant standard is incorrect. The first part of the Court of Appeals’ test may be read to imply that a district court should not consider the existence or nonexistence of medical benefits when considering whether a regulation of abortion constitutes an undue burden. The rule announced in Casey, however, requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer. And the second part of the test is wrong to
equate the judicial review applicable to the regulation of a constitutionally protected personal liberty with the less strict review applicable where, for example, economic legislation is at issue. The Court of Appeals’ approach simply does not match the standard that this Court laid out in *Casey*, which asks courts to consider whether any burden imposed on abortion access is “undue.”

The statement that legislatures, and not courts, must resolve questions of medical uncertainty is also inconsistent with this Court’s case law. Instead, the Court, when determining the constitutionality of laws regulating abortion procedures, has placed considerable weight upon evidence and argument presented in judicial proceedings. In *Casey*, for example, we relied heavily on the District Court’s factual findings and the research-based submissions of *amicis* in declaring a portion of the law at issue unconstitutional. And, in [*Gonzales v. Carhart*, 550 U.S. 124 (2007)] the Court, while pointing out that we must review legislative “factfinding under a deferential standard,” added that we must not “place dispositive weight” on those “findings.” *Gonzales* went on to point out that the “Court retains an independent constitutional duty to review factual findings where constitutional rights are at stake.” Although there we upheld a statute regulating abortion, we did not do so solely on the basis of legislative findings explicitly set forth in the statute, noting that “evidence presented in the District Courts contradicts” some of the legislative findings. In these circumstances, we said, “[u]ncritical deference to Congress’ factual findings . . . is inappropriate.” *Gold & Nash*.

Unlike in *Gonzales*, the relevant statute here does not set forth any legislative findings. Rather, one is left to infer that the legislature sought to further a constitutionally acceptable objective (namely, protecting women’s health). For a district court to give significant weight to evidence in the judicial record in these circumstances is consistent with this Court’s case law. As we shall describe, the District Court did so here. It did not simply substitute its own judgment for that of the legislature. It considered the evidence in the record—including expert evidence, presented in stipulations, depositions, and testimony. It then weighed the asserted benefits against the burdens. We hold that, in so doing, the District Court applied the correct legal standard.

**IV**

**Undue Burden—Admitting–Privileges Requirement**

Turning to the lower courts’ evaluation of the evidence, we first consider the admitting-privileges requirement. Before the enactment of H.B. 2, doctors who provided abortions were required to “have admitting privileges or have a working arrangement with a physician(s) who has admitting privileges at a local hospital in order to ensure the necessary back up for medical complications.” The new law changed this requirement by requiring that a “physician performing or inducing an abortion . . . must, on the date the abortion is performed or induced, have active admitting privileges at a hospital that . . . is located not further than 30 miles from the location at which the abortion is performed or induced.” The District Court held that the legislative change imposed an “undue burden”
on a woman’s right to have an abortion. We conclude that there is adequate legal and factual support for the District Court’s conclusion.

The purpose of the admitting-privileges requirement is to help ensure that women have easy access to a hospital should complications arise during an abortion procedure. But the District Court found that it brought about no such health-related benefit. The court found that “[t]he great weight of evidence demonstrates that, before the act’s passage, abortion in Texas was extremely safe with particularly low rates of serious complications and virtually no deaths occurring on account of the procedure.” Thus, there was no significant health-related problem that the new law helped to cure.

[The Court’s summary of the evidence upon which the District Court relied is omitted.]

At the same time, the record evidence indicates that the admitting-privileges requirement places a “substantial obstacle in the path of a woman’s choice.” The District Court found, as of the time the admitting-privileges requirement began to be enforced, the number of facilities providing abortions dropped in half, from about 40 to about 20. Eleven more closed on the day the admitting-privileges requirement took effect.

Other evidence helps to explain why the new requirement led to the closure of clinics. [For example] it would be difficult for doctors regularly performing abortions at the El Paso clinic to obtain admitting privileges at nearby hospitals because “[d]uring the past 10 years, over 17,000 abortion procedures were performed at the El Paso clinic and not a single one of those patients had to be transferred to a hospital for emergency treatment, much less admitted to the hospital.” In a word, doctors would be unable to maintain admitting privileges or obtain those privileges for the future, because the fact that abortions are so safe meant that providers were unlikely to have any patients to admit.

[There are many] other common prerequisites to obtaining admitting privileges that have nothing to do with ability to perform medical procedures. See Brief for Medical Staff Professionals as Amici Curiae (listing, for example, requirements that an applicant has treated a high number of patients in the hospital setting in the past year, clinical data requirements, residency requirements, and other discretionary factors); see also Brief for American College of Obstetricians and Gynecologists et al. as Amici Curiae 16 (ACOG Brief) (“[S]ome academic hospitals will only allow medical staff membership for clinicians who also . . . accept faculty appointments”). Again, returning to the District Court record, we note that Dr. Lynn of the McAllen clinic, a veteran obstetrics and gynecology doctor who estimates that he has delivered over 15,000 babies in his 38 years in practice was unable to get admitting privileges at any of the seven hospitals within 30 miles of his clinic. He was refused admitting privileges at a nearby hospital for reasons, as the hospital wrote, “not based on clinical competence considerations.” The admitting-privileges requirement does not serve any relevant credentialing function.

In our view, the record contains sufficient evidence that the admitting-privileges requirement led to the closure of half of Texas’ clinics, or thereabouts. Those closures
meant fewer doctors, longer waiting times, and increased crowding. Record evidence also supports the finding that after the admitting-privileges provision went into effect, the “number of women of reproductive age living in a county . . . more than 150 miles from a provider increased from approximately 86,000 to 400,000 . . . and the number of women living in a county more than 200 miles from a provider from approximately 10,000 to 290,000.” We recognize that increased driving distances do not always constitute an “undue burden.” But here, those increases are but one additional burden, which, when taken together with others that the closings brought about, and when viewed in light of the virtual absence of any health benefit, lead us to conclude that the record adequately supports the District Court’s “undue burden” conclusion (finding burden “undue” when requirement places “substantial obstacle to a woman’s choice” in “a large fraction of the cases in which” it “is relevant”).

The [] dissent suggests that one benefit of H.B. 2’s requirements would be that they might “force unsafe facilities to shut down.” To support that assertion, the dissent points to the Kermit Gosnell scandal. Gosnell, a physician in Pennsylvania, was convicted of first-degree murder and manslaughter. [ ] Gosnell’s behavior was terribly wrong. But there is no reason to believe that an extra layer of regulation would have affected that behavior. Determined wrongdoers, already ignoring existing statutes and safety measures, are unlikely to be convinced to adopt safe practices by a new overlay of regulations. Regardless, Gosnell’s deplorable crimes could escape detection only because his facility went uninspected for more than 15 years. Pre-existing Texas law already contained numerous detailed regulations covering abortion facilities, including a requirement that facilities be inspected at least annually. The record contains nothing to suggest that H.B. 2 would be more effective than pre-existing Texas law at deterring wrongdoers like Gosnell from criminal behavior.

V

Undue Burden—Surgical–Center Requirement

The second challenged provision of Texas’ new law sets forth the surgical-center requirement. Prior to enactment of the new requirement, Texas law required abortion facilities to meet a host of health and safety requirements. These requirements are policed by random and announced inspections, at least annually, as well as administrative penalties, injunctions, civil penalties, and criminal penalties for certain violations.

H.B. 2 added the requirement that an “abortion facility” meet the “minimum standards . . . for ambulatory surgical centers” under Texas law. [The Court described the many requirements imposed on surgical centers.]

There is considerable evidence in the record supporting the District Court’s findings indicating that the statutory provision requiring all abortion facilities to meet all surgical-center standards does not benefit patients and is not necessary. The District Court found that “risks are not appreciably lowered for patients who undergo abortions at ambulatory surgical centers as compared to nonsurgical-center facilities.” The court
added that women “will not obtain better care or experience more frequent positive outcomes at an ambulatory surgical center as compared to a previously licensed facility.” And these findings are well supported.

The record makes clear that the surgical-center requirement provides no benefit when complications arise in the context of an abortion produced through medication. That is because, in such a case, complications would almost always arise only after the patient has left the facility. The record also contains evidence indicating that abortions taking place in an abortion facility are safe—indeed, safer than numerous procedures that take place outside hospitals and to which Texas does not apply its surgical-center requirements. The total number of deaths in Texas from abortions was five in the period from 2001 to 2012, or about one every two years (that is to say, one out of about 120,000 to 144,000 abortions). Nationwide, childbirth is 14 times more likely than abortion to result in death, but Texas law allows a midwife to oversee childbirth in the patient’s own home. Colonoscopy, a procedure that typically takes place outside a hospital (or surgical center) setting, has a mortality rate 10 times higher than an abortion. ([T]he mortality rate for liposuction, another outpatient procedure, is 28 times higher than the mortality rate for abortion). Medical treatment after an incomplete miscarriage often involves a procedure identical to that involved in a nonmedical abortion, but it often takes place outside a hospital or surgical center. And Texas partly or wholly grandfathers (or waives in whole or in part the surgical-center requirement for) about two-thirds of the facilities to which the surgical-center standards apply. But it neither grandfathers nor provides waivers for any of the facilities that perform abortions. These facts indicate that the surgical-center provision imposes “a requirement that simply is not based on differences” between abortion and other surgical procedures “that are reasonably related to” preserving women’s health, the asserted “[purpose] of the Act in which it is found.” [ ]

The upshot is that this record evidence, along with the absence of any evidence to the contrary, provides ample support for the District Court’s conclusion that “[m]any of the building standards mandated by the act and its implementing rules have such a tangential relationship to patient safety in the context of abortion as to be nearly arbitrary.” That conclusion, along with the supporting evidence, provides sufficient support for the more general conclusion that the surgical-center requirement “will not [provide] better care or . . . more frequent positive outcomes.” The record evidence thus supports the ultimate legal conclusion that the surgical-center requirement is not necessary.

More fundamentally, in the face of no threat to women’s health, Texas seeks to force women to travel long distances to get abortions in crammed-to-capacity superfacilities. Patients seeking these services are less likely to get the kind of individualized attention, serious conversation, and emotional support that doctors at less taxed facilities may have offered. Healthcare facilities and medical professionals are not fungible commodities. Surgical centers attempting to accommodate sudden, vastly increased demand, may find that quality of care declines. Another commonsense inference that the District Court made is that these effects would be harmful to, not supportive of, women’s health.
Finally, the District Court found that the costs that a currently licensed abortion facility would have to incur to meet the surgical-center requirements were considerable, ranging from $1 million per facility (for facilities with adequate space) to $3 million per facility (where additional land must be purchased). This evidence supports the conclusion that more surgical centers will not soon fill the gap when licensed facilities are forced to close.

We agree with the District Court that the surgical-center requirement, like the admitting-privileges requirement, provides few, if any, health benefits for women, poses a substantial obstacle to women seeking abortions, and constitutes an “undue burden” on their constitutional right to do so.

[Discussion of why the severability clause of the Texas Act is of no assistance to the state is omitted.]

Justice GINSBURG, concurring.

The Texas law called H.B. 2 inevitably will reduce the number of clinics and doctors allowed to provide abortion services. Texas argues that H.B. 2’s restrictions are constitutional because they protect the health of women who experience complications from abortions. In truth, “complications from an abortion are both rare and rarely dangerous.” Brief for American College of Obstetricians and Gynecologists et al. as Amici Curiae 6–10 (collecting studies and concluding “[a]bortion is one of the safest medical procedures performed in the United States”); Brief for Social Science Researchers as Amici Curiae 5–9 (compiling studies that show “[c]omplication rates from abortion are very low”). Many medical procedures, including childbirth, are far more dangerous to patients, yet are not subject to ambulatory-surgical-center or hospital admitting-privileges requirements. See Brief for Social Science Researchers 9–11 (comparing statistics on risks for abortion with tonsillectomy, colonoscopy, and in-office dental surgery); Brief for American Civil Liberties Union et al. as Amici Curiae 7 (all District Courts to consider admitting-privileges requirements found abortion “is at least as safe as other medical procedures routinely performed in outpatient settings”). Given those realities, it is beyond rational belief that H.B. 2 could genuinely protect the health of women, and certain that the law “would simply make it more difficult for them to obtain abortions.” When a State severely limits access to safe and legal procedures, women in desperate circumstances may resort to unlicensed rogue practitioners, faute de mieux, at great risk to their health and safety. Targeted Regulation of Abortion Providers laws like H.B. 2 that “do little or nothing for health, but rather strew impediments to abortion,” cannot survive judicial inspection.

Justice THOMAS, dissenting.

Today the Court strikes down two state statutory provisions in all of their applications, at the behest of abortion clinics and doctors. That decision exemplifies the Court’s troubling tendency to bend the rules when any effort to limit abortion, or even to
The very existence of this suit is a jurisprudential oddity. Ordinarily, plaintiffs cannot file suits to vindicate the constitutional rights of others. But the Court employs a different approach to rights that it favors. So in this case and many others, the Court has erroneously allowed doctors and clinics to vicariously vindicate the putative constitutional right of women seeking abortions.

This case also underscores the Court’s increasingly common practice of invoking a given level of scrutiny—here, the abortion-specific undue burden standard—while applying a different standard of review entirely. Whatever scrutiny the majority applies to Texas’ law, it bears little resemblance to the undue-burden test the Court articulated in Planned Parenthood of Southeastern Pa. v. Casey and its successors. Instead, the majority eviscerates important features of that test to return to a regime like the one that Casey repudiated.

Ultimately, this case shows why the Court never should have bent the rules for favored rights in the first place. Our law is now so riddled with special exceptions for special rights that our decisions deliver neither predictability nor the promise of a judiciary bound by the rule of law.

I

This suit is possible only because the Court has allowed abortion clinics and physicians to invoke a putative constitutional right that does not belong to them—a woman’s right to abortion. [Justice Thomas explains why the medical plaintiff do not have standing to raise claims of women seeking abortions. Standing discussion omitted.]

II

Today’s opinion also reimagines the undue-burden standard used to assess the constitutionality of abortion restrictions. Nearly 25 years ago, in Planned Parenthood of Southeastern Pa. v. Casey a plurality of this Court invented the “undue burden” standard as a special test for gauging the permissibility of abortion restrictions. Casey held that a law is unconstitutional if it imposes an “undue burden” on a woman’s ability to choose to have an abortion, meaning that it “has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus.” Casey thus instructed courts to look to whether a law substantially impedes women’s access to abortion, and whether it is reasonably related to legitimate state interests. As the Court explained, “[w]here it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power” to regulate aspects of abortion procedures, “all in
furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn.” *Gonzales v. Carhart* (2007).

I remain fundamentally opposed to the Court’s abortion jurisprudence. Even taking *Casey* as the baseline, however, the majority radically rewrites the undue-burden test in three ways. First, today’s decision requires courts to “consider the burdens a law imposes on abortion access together with the benefits those laws confer.” Second, today’s opinion tells the courts that, when the law’s justifications are medically uncertain, they need not defer to the legislature, and must instead assess medical justifications for abortion restrictions by scrutinizing the record themselves. Finally, even if a law imposes no “substantial obstacle” to women’s access to abortions, the law now must have more than a “reasonable[ ] relation[ ] to . . . a legitimate state interest.” These precepts are nowhere to be found in *Casey* or its successors, and transform the undue-burden test to something much more akin to strict scrutiny.

First, the majority’s free-form balancing test is contrary to *Casey*. When assessing Pennsylvania’s recordkeeping requirements for abortion providers, for instance, *Casey* did not weigh its benefits and burdens. [Omit *Casey’s* discussion of record-keeping.] Contrary to the majority’s statements, *Casey* did not balance the benefits and burdens of Pennsylvania’s spousal and parental notification provisions, either. Pennsylvania’s spousal notification requirement, the plurality said, imposed an undue burden because findings established that the requirement would “likely . . . prevent a significant number of women from obtaining an abortion”—not because these burdens outweighed its benefits. And *Casey* summarily upheld parental notification provisions because even pre-*Casey* decisions had done so.

Second, by rejecting the notion that “legislatures, and not courts, must resolve questions of medical uncertainty,” the majority discards another core element of the *Casey* framework. Before today, this Court had “given state and federal legislatures wide discretion to pass legislation in areas where there is medical and scientific uncertainty.” [ ].

Today, however, the majority refuses to leave disputed medical science to the legislature because past cases “placed considerable weight upon the evidence and argument presented in judicial proceedings.” * * *

Finally, the majority overrules another central aspect of *Casey* by requiring laws to have more than a rational basis even if they do not substantially impede access to abortion. “Where [the State] has a rational basis to act and it does not impose an undue burden,” this Court previously held, “the State may use its regulatory power” to impose regulations “in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn.” The State’s burden has been ratcheted to a level that has not applied for a quarter century.

Today’s opinion does resemble *Casey* in one respect: After disregarding significant aspects of the Court’s prior jurisprudence, the majority applies the undue-
burden standard in a way that will surely mystify lower courts for years to come. As in
*Casey*, today’s opinion “simply . . . highlight[s] certain facts in the record that apparently
strike the . . . Justices as particularly significant in establishing (or refuting) the existence
of an undue burden.” All we know is that an undue burden now has little to do with
whether the law, in a “real sense, deprive[s] women of the ultimate decision,” and more
to do with the loss of “individualized attention, serious conversation, and emotional
support[.]

The majority’s undue-burden test looks far less like our post-*Casey* precedents
and far more like the strict-scrutiny standard that *Casey* rejected, under which only the
most compelling rationales justified restrictions on abortion. One searches the majority
opinion in vain for any acknowledgment of the “premise central” to *Casey*’s rejection of
strict scrutiny: “that the government has a legitimate and substantial interest in preserving
and promoting fetal life” from conception, not just in regulating medical procedures.
Moreover, by second-guessing medical evidence and making its own assessments of “quality of care” issues, the
majority reappoints this Court as “the country’s ex officio medical board with powers to
disapprove medical and operative practices and standards throughout the United States.”
[quoting Gonzales]. And the majority seriously burdens States, which must guess at how
much more compelling their interests must be to pass muster and what “commonsense
inferences” of an undue burden this Court will identify next.

III

The majority’s furtive reconfiguration of the standard of scrutiny applicable to
abortion restrictions also points to a deeper problem. The undue-burden standard is just
one variant of the Court’s tiers-of-scrutiny approach to constitutional adjudication. And
the label the Court affixes to its level of scrutiny in assessing whether the government can
restrict a given right—be it “rational basis,” intermediate, strict, or something else—is
increasingly a meaningless formalism. As the Court applies whatever standard it likes to
any given case, nothing but empty words separates our constitutional decisions from
judicial fiat. ***

The Court should abandon the pretense that anything other than policy
preferences underlies its balancing of constitutional rights and interests in any given case.

IV

It is tempting to identify the Court’s invention of a constitutional right to abortion
in *Roe v. Wade* as the tipping point that transformed third-party standing doctrine and the
tiers of scrutiny into an unworkable morass of special exceptions and arbitrary
applications. But those roots run deeper, to the very notion that some constitutional rights
demand preferential treatment. During the *Lochner* era, the Court considered the right to
contract and other economic liberties to be fundamental requirements of due process of
law. The Court in 1937 repudiated *Lochner*’s foundations. But the Court then created a
The Court has simultaneously transformed judicially created rights like the right to abortion into preferred constitutional rights, while disfavoring many of the rights actually enumerated in the Constitution. But our Constitution renounces the notion that some constitutional rights are more equal than others. A plaintiff either possesses the constitutional right he is asserting, or not—and if not, the judiciary has no business creating ad hoc exceptions so that others can assert rights that seem especially important to vindicate. A law either infringes a constitutional right, or not; there is no room for the judiciary to invent tolerable degrees of encroachment. Unless the Court abides by one set of rules to adjudicate constitutional rights, it will continue reducing constitutional law to policy-driven value judgments until the last shreds of its legitimacy disappear.

JUSTICE ALITO, joined by THE CHIEF JUSTICE AND JUSTICE THOMAS dissented on technical grounds, including res judicata, standing, i.e. doctors can only assert economic interests and not the liberty claims of their patients, and severability.

Notes

1. The legal heart of the matter. As has been true with every abortion case considered since Casey, there lies a core issue that operates as a legal fault line between the majority and the minority: what is the role of the courts in deciding cases involving laws regulating access to abortion?

Legislatures regulate medical practice extensively. And typically, when confronted with challenges to medical regulations, courts defer to legislative judgment regarding the need for regulation and the extent and scope of the regulation that has been imposed. In routine cases, the rationality of medical practice regulation—what standards an outpatient clinic should meet; whether physicians who perform certain procedures in outpatient settings must have active admitting privileges—the question is whether a legislative body has a legitimate interest in a subject and whether there is any rational basis for its actions. See, e.g., Williamson v Lee Optical Co. 348 U.S. 483 (1955).

Regarding abortion, however, a substantive constitutional right is involved, one that has been the target of literally thousands of state regulatory efforts since the right was first recognized in Roe v Wade. And the very existence of the right raises profound issues for those opposed to it on religious and moral grounds. This comes through clearly in Justice Thomas’ characterization of the dispute as involving the “right of a woman to abort her unborn child,” a very different way of characterizing the issues at stake from those who passionately characterize the issue as one involving the right of women to make choices about their bodies without government interference. Note that in his cool analytic approach to the evidence, Justice Breyer never directly frames the underlying constitutional right, as does Justice Thomas. For Justice Breyer, the case is about whether the trial court applied the proper standard of review under Casey v Planned Parenthood Association of Southeastern Pennsylvania and whether its conclusions are supported by the evidence.
Because legal battles over abortion regulation involve such a profound issue—one so deeply reflective of personal belief—can it ever truly be said that the standard “rational basis” deference test is what should be applied when legislatures enact far-reaching legislation that singles out abortions among all possible medical procedures for special constraints? By their terms, laws that restrict abortions are likely to be influenced by deeply held personal beliefs rather than safety; they are designed to single out one specific type of extremely safe and low risk medical procedure for extinction. This reality comes through in Justice Breyer’s masterful review of the trial record. What is involved is not common-sense regulation of outpatient surgery generally, where a court can (and should) reasonably assume that a legislature is responding in some sensible fashion to a specific public health risk. The facts in Whole Woman’s Health show that not only does justification for the restrictions appear to be lacking, but the restrictions appear to endanger the very people they ostensibly are supposed to protect, by eradicating access to safe, licensed facilities already subject to extensive regulation. Against evidence of the actual impact of admitting privileges and surgical center licensure on access to care, the state could offer only speculation that the remaining facilities could be re-designed and staffed up to accommodate a deluge of patients.

It is because laws such as those enacted in Texas, when held up for careful scrutiny, have an impact that is the opposite of improving safety, that such scrutiny becomes necessary. Laws aimed explicitly at abortion rest on deeply held philosophical and religious beliefs. The very essence of the rational basis test—that legislatures act based on evidence and a record—is absent in abortion, where the core purpose of law at issue, according to supporters, is to stop the killing of unborn children. What courts can presume in medical regulation generally, insofar as rational conduct is concerned, is not even remotely present in the case of abortion laws.

This state of affairs was particularly true in the case of Texas H.B. 2, whose culminating debates made national headlines when Texas State Senator Wendy Davis staged an all-night filibuster to stop the law, whose purpose was to close abortion facilities. The nationally televised scenes outside the state capitol, which involved a huge protest by abortion rights advocates, presented about as wild a legislative protest scene as one can get; for 11 hours Senator Davis’ filbuster precluded final enactment. Alexa Ura, Abortion Ruling a Vindication for Alexa Davis and ‘Unruly Mob’, Texas Tribune (June 27, 2016), https://www.texastribune.org/2016/06/27/abortion-ruling-vindication-wendy-davis-and-unruly/ (Accessed July 21, 2017); Texas Observer, Interview: Wendy Davis on the Abortion Fight and the Future of Women’s Health in Texas, (July 12, 2013), https://www.texasobserver.org/wendy-davis-talks-on-the-abortion-fight-and-the-future-of-womens-health-in-texas/ (Accessed July 21, 2017).

The Texas spectacle leading up to legislative enactment of H.B. 2 provides insight into why the Casey standard of review exists. That standard is a significant relaxation of Roe (as the textbook points out); nonetheless it is a standard that requires courts to scrutinize legislative action, and independently create a record that can be weighed in order to determine whether the law at issue improves safety without placing a substantial burden on rights. In this sense, the Fifth Circuit was correct in protesting that the trial
court had substituted its judgment for that of the legislature. But what the trial court actually was substituting was reasonable legislative practice which, had it been carried out, never would have concluded that preventing physicians from performing abortions and closing down licensed clinics represented improvements in health and safety without unduly burdening women’s rights. In other words, the trial court substituted reasonable legislative conduct more than reasonable judgment.

2. The state of play in the wake of Whole Women’s Health. Immediately following the Whole Woman’s Health decision, the Court denied review in cases in which the fifth and the seventh circuits had held that restrictions in Mississippi and Wisconsin, similar to those in Texas, imposed an unconstitutional, undue burden on abortion. But, in 2017 “at least ten major categories of abortion restrictions, including measures based on claims of protecting a woman’s health, lack a foundation in scientific evidence.” Rachel Benson Gold & Elizabeth Nash, Flouting the Facts: State Abortion Restrictions Flying in the Face of Science, 20 Guttmacher Pol’y Rev. 1 (2017) [hereinafter, Gold & Nash].

Eighteen states had adopted laws applying ambulatory surgical center requirements to facilities that provide abortion and ten of those statutes have been enjoined following Whole Woman’s Health. Gold & Nash. See e.g. Comprehensive Health of Planned Parenthood Great Plains v. Williams, 2017 WL 1407658 (W.D. Missouri), appeal filed to 8th Cir., May 8, 1017. Eleven states have admitting privileges requirements and eight of those have been enjoined. Gold & Nash. See e.g. June Medical Services LLC v. Kliebert, 2017 WL 1505596, appeal filed to the 5th Cir., May 12, 2017. Twenty states exclude medication abortion from authorized use of telemedicine and two of those statutes have been enjoined. Gold & Nash. See e.g. Planned Parenthood of the Heartland, Inc. v. Iowa Board of Medicine (Iowa Supreme Court, June 19, 2015).

3. Eroding access to abortion by imposing restrictions on who may perform abortion procedures. The most popular restriction conflicting with empirical evidence about women’s health are rules prohibiting qualified and licensed health professionals, such as physician assistants and nurse practitioners, from providing abortion. Ada Kozicz, Repealing Physician-Only Laws: Undoing the Burden of Gestational Age Limits, 42 Hofstra L. Rev. 1263, 1292 (2015). As of November 1, 2016, 38 states require an abortion to be performed by a licensed physician,18 states require an abortion to be performed in a hospital after a specified point in the pregnancy, and 18 states require the involvement of a second physician after a specified point. An Overview of Abortion Laws, Guttmacher Inst. (Nov. 1, 2016), available at https://www.guttmacher.org/state-policy/explore/overview-abortion-laws (Accessed July 21, 2017). Two states do not limit the performance of abortions to physicians, but non-physician clinicians “have never tried to provide abortion care.” Tracy Weitz et. al., Safety of Aspiration Abortion Performed by Nurse Practitioners, Certified Nurse Midwives, and Physician Assistants Under a California Legal Waiver, 103 Am. J. Pub. Health 454 (2013). In 2013, only four states—Vermont, New Hampshire, Montana, and Oregon—allowed nurses to perform medication and early-term aspiration abortions. Jennifer Templeton Dunn & Lindsay Parham, After the Choice: Challenging California’s Physician-Only Abortion Restriction under the

When performed early in pregnancy, abortion is a relatively simple procedure involving low risks, regardless of whether the provider is a physician or other health professional such as a physician’s assistant or nurse practitioner. Dunn & Parham. Medication abortion, which involves the provision of a pill, can even be safely induced by the woman herself, without the participation of a licensed healthcare professional altogether, as long as she follows the proper instructions; the World Health Organization (WHO) has issued guidance on how individuals can use misoprostol—a drug that treats stomach ulcers but also produces contractions. See Clinical Practice Handbook for Safe Abortion, World Health Organization 22, 29-30 (2014), available at http://apps.who.int/iris/bitstream/10665/97415/1/9789241548717_eng.pdf (Accessed July 21, 2017). If a woman can safely self-induce medication abortion on her own, it is difficult to see the health justification for a law preventing a licensed physician assistant or nurse practitioner from safely providing it.

As noted in the Book at pages 133-35, from a practical perspective, physician-only rules may be the most serious obstacle to women seeking abortions, because of a shortage of physician providers. These restrictions may also be the most difficult to challenge under Whole Women’s Health. In 1977, applying Casey, the Court held that a state is permitted to bar medical professionals other than physicians from providing abortion services. Mazurek v. Armstrong, 520 U.S. 968, 974-75 (1997). The case concerned the only physician assistant in Montana who had been performing first trimester abortions under the supervision of a licensed physician. The term “licensed physician” in the statute had previously been construed to include physician assistants. The challenged Montana law was drafted by an anti-choice group. The Mazurek Court relied on the district court finding that there was insufficient evidence that the law created a substantial obstacle to abortion. Id. at 971-72.

4. Abortion restrictions resting on grounds other than protecting women’s health. Even though Whole Women’s Health only addressed laws defended as protecting women’s health, it has been used to challenge abortion restrictions promoting other interests. For example, 17 states have laws prohibiting abortions after 20 weeks, defended on grounds that they cause fetal pain, and 13 states require counseling on fetal pain, even though scientific evidence does not support these concerns. Gold & Nash. Planned Parenthood v. Commissioner, 194 F. Supp. 3d 818 (S.D. Ind.2016), enjoined a law prohibiting abortions on grounds of the fetus’s race, sex or disability and requiring that fetuses be disposed in a manner similar to human remains. The case is on appeal to the Seventh Circuit. Whole Women’s Health v. Hellerstedt, 2017 WL 462400 (W.D. Texas, 2017), enjoined a law governing disposal of fetal tissue as vague and burdensome to women’s health. Reproductive Health Services v. Strange, 204 F. Supp.3d 1300 (D. Ala. 2016), considered a broad challenge to Alabama’s judicial bypass system for girls seeking to avoid compliance with parental consent rules. The court denied the defendants’ motion to dismiss. West Alabama Women’s Center v. Miller, 217 F. Supp.3d
enjoined a law prohibiting facilities that provide abortion from locating in proximity to a school. The State has appealed to the 5th Circuit.

5. How far does Whole Woman’s Health reach? The crucial issue in Whole Woman’s Health was the Court’s approach to weighing the evidence under the Casey standard: does the state law affect “a large fraction of the cases in which the law is relevant” by operating “as a substantial obstacle to a woman’s choice to undergo an abortion”? In weighing the evidence, what is the starting point? Is it all women? Or the specific group of women to whom a specific state law would be relevant? What is a large fraction of all women? More than 10%? 25%? In assessing the question of substantial burden, how much does a court peer into the evidence on which the law is based? Does the court consider new evidence?

All of these questions are vital. But in the end the standard has its limits because it makes the analysis very specific to the law at issue in terms of how this law affects these women under these circumstances. The more particular the target group, the less transferrable the decision to other state laws, since the decision is all about a particular law and its impact on a particular group of women under particular conditions and at a particular point in time.

This uncertainty regarding how to apply Whole Woman’s Health shows up in the litigation over anti-abortion statutes unfolding in its wake. There are many of these cases, and with the expected confirmation of Judge Brett Kavanaugh as the newest Associate Justice of the United States Supreme Court, replacing Justice Anthony Kennedy (a crucial vote to uphold abortion rights) the number may explode still further. See Guttmacher Institute, Policy Trends in 2017, examining 63 new restrictions on abortion in 2017 alone, adopted by 19 states in the wake of Whole Woman’s Health. Available at https://www.guttmacher.org/article/2018/01/policy-trends-states-2017.

Recent litigation involving medication-assisted abortions is instructive in showing how the Court could cut back on access to abortions while purporting to leave the underlying right intact. In Planned Parenthood of Arkansas and Eastern Oklahoma v. Jegley, 864 F. 3d 953 (8th Cir. 2017), reh. & reh. en banc den. (2017), cert. den. ____ U.S. ____ (2018), the 8th Circuit vacated an injunction and remanded for further consideration a case involving an Arkansas law aimed at curtailing access to early-pregnancy medication abortions. In a move strikingly similar to that taken by Texas in Whole Women’s Health, Arkansas required clinics performing medication abortions (which must be done early in pregnancy) to have written contracts with physicians who have hospital admitting privileges to manage complications requiring hospitalization and arising from the abortion, despite the fact that medication-assisted abortions are safe and effective and used worldwide. Additionally, among other findings, the trial court concluded that the evidence showed that executing a contract with a physician willing to provide back-up services to the clinics was a futile exercise. The admitting privilege law thus effectively closed all of the medication abortion clinics, forcing women into surgical abortions later in pregnancy in the state’s one overwhelmed surgical abortion clinic, a 380-mile round trip from the Fayetteville medication abortion clinic that brought the case.
In vacating the injunction, the 8th Circuit ruled that the trial court’s findings were not supported by the record that, supposedly, lacked sufficient specificity. With respect to the evidence regarding Planned Parenthood’s failure to secure a contract, the appeals court pointed out that there was no evidence of efforts to include “any offer of financial compensation. It is unclear whether the district court considered this fact in its assessment.” 864 F. 3d at 956. The appeals court further concluded that the record failed to show exactly how many women would be affected by increased travel distance from Fayetteville to Little Rock. Nor was the court persuaded that increased travel time alone was enough to sink the law. According to the court of appeals, the record was also deficient because it failed to offer estimates of how many women would forgo abortions entirely, nor did it show how many women would delay their abortions. “As a result we are left with no concrete district court findings estimating the number of women who would be unduly burdened by the contract-physician requirements—either because they would forgo the procedure or postpone it—and whether they constitute a large fraction of women seeking medication abortions in Arkansas such that Planned Parenthood could prevail.” Once certiorari was denied, the judgment was vacated and the injunction dissolved. Planned Parenthood then scrambled back to court.

On remand, the trial court reopened the record for additional factual presentation; on the basis of these new facts, it reinstated a temporary restraining order. Planned Parenthood of Arkansas and Eastern Oklahoma v. Jegley, 2018 WL 3029104 (E.D. Ark., June 18, 2018). The expanded factual record showed, among other matters: (1) plaintiffs’ futile efforts (which included an offer of payment) to find a backup physician (after contacting virtually all of the state’s 60 ob/gyn practices) with admitting privileges who would enter into a written contract with compensation. The record showed a specific finding that “in response to [Planned Parenthood’s] outreach, “the front desk staff was so hostile . . . that they would not let [PPAEO staff] even speak to the physicians and refused to take messages” [Slip. Op. p. 6]; (2) the number of medication abortions—approaching 900—at Planned Parenthood’s Fayetteville clinic that would be affected; (3) a specific estimate of the percentage of women who were extremely low income and who experienced severe transportation-associated problems; (4) specific evidence regarding the inability of the Planned Parenthood Fayetteville clinic to set up a surgical abortion practice because of cost and resource matters, meaning that Fayetteville women losing access to medication abortions would need to travel to Little Rock for a surgical abortion; (5) specific evidence regarding the problems with forcing women to forgo an early medication abortion in favor of a later surgical abortion that could only be secured via a 400-mile roundtrip; (6) the problems associated with surgical abortion as an alternative to an early medication abortion; and (7) estimates of the resulting expected drop in abortions.

Given the problems that emerged on appeal, trial court Judge Baker then spent even more time than the first go-around [Planned Parenthood, Slip op. pp. 9-10] articulating the legal standard emanating from Casey and its multiple descendants:

Although PPAEO and Dr. Ho’s complaint does not specify whether this action is brought as a “facial” constitutional challenge to the
Act or as an “as-applied” challenge, at the prior preliminary injunction stage, this Court reviewed plaintiffs’ claim as one for facial relief. The Eighth Circuit also implicitly treated this case as a facial challenge. Since the Eighth Circuit entered its mandate in this case, neither party has argued that this case should be treated as anything other than a facial challenge. Accordingly, this Court will review this request for a temporary restraining order as a facial challenge.

The Eighth Circuit has recognized that [under Planned Parenthood of Southeastern Pennsylvania v. Casey] facial challenges to abortion statutes can succeed only if a plaintiff can show that “in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman’s choice to undergo an abortion.” Casey teaches that the court need not find that a law imposes an undue burden on a precise percentage of impacted women in order [to] find that facial relief is warranted.

In Casey, a plurality of the Supreme Court determined that, if a government regulation has “the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus,” the regulation is an undue burden on a woman’s right to have an abortion and is unconstitutional. In Gonzales v. Carhart, the Supreme Court then simplified Casey’s description, settling on the effects test. [In Whole Women’s Health], [t]he Supreme Court recently reiterated the undue burden standard that “a statute which, while furthering [a] valid state interest, has the effect of placing a substantial obstacle in the path of a woman’s choice cannot be considered a permissible means of serving its legitimate ends.”

The Supreme Court in Gonzales stated as follows: “[T]he State, from the inception of the pregnancy, maintains its own regulatory interest in protecting the life of the fetus that may become a child, [and this premise] cannot be set at naught by interpreting Casey’s requirement of a health exception so it becomes tantamount to allowing a doctor to choose the abortion method he or she might prefer. Where it has a rational basis to act, and it does not impose an undue burden, the State may use its regulatory power to bar certain procedures and substitute others, all in furtherance of its legitimate interests in regulating the medical profession in order to promote respect for life, including life of the unborn.” The Court acknowledges that the state may, in a valid exercise of its police power, regulate abortion. The state’s police power is, however, limited where a protected liberty interest is at stake. “The State’s interest in regulating abortion previability is considerably weaker than postviability.” Stenberg v. Carhart, 530 U.S. 914, 930 (2000). Therefore, while the Court acknowledges that [Arkansas’ medication abortion law] may be a valid exercise of the state’s police power, the Court is obligated to examine
whether it unduly burdens the constitutional right of Arkansas women to a pre-viability abortion.

To show an undue burden, [plaintiffs] must show that in a large fraction of the cases in which [the law] is relevant, it will operate as a substantial obstacle to a woman’s choice to undergo an abortion. A court limits its inquiry to the group for whom the law is a restriction, not the group for whom the law is irrelevant. An undue burden is an unconstitutional burden. [internal quotation marks omitted]

The undue burden analysis requires this Court to consider the burdens a law imposes on abortion access together with the benefits those laws confer. There must be a constitutionally acceptable reason for regulating abortion, and the abortion regulation must also actually advance that goal in a permissible way. The regulation will not be upheld unless the benefits it advances outweigh the burdens it imposes. [T]he means chosen by the State to further the interest in potential life must be calculated to inform the woman’s free choice, not hinder it. [internal quotation marks omitted]

Further, under the applicable undue burden standard, although the Court must review legislative fact finding under a deferential standard, the court retains an independent constitutional duty to review [a legislature’s] factual findings where constitutional rights are at stake. . . . Uncritical deference to [the legislature’s] factual findings in these cases is inappropriate. [internal quotation marks omitted]

Generally, the state has the burden of demonstrating a link between the legislation it enacts and what it contends are the state’s interests. As a part of the Court’s inquiry, the Court may take into account the degree to which the restriction is over-inclusive or under-inclusive, and the existence of alternative, less burdensome means to achieve the state’s goal, including whether the law more effectively advances the state’s interest compared to prior law. PPAEO and Dr. Ho, who challenge Section 1504(d), retain the ultimate burden of proving the statute’s unconstitutionality.

Under this standard, plaintiffs once again prevailed on the merits, since the state could demonstrate no interest in curtailing medication abortions even remotely sufficient to justify its decision to do so, while plaintiffs were more than able to demonstrate just what impact the curtailment would cause, not only for access to early abortion, but for access to abortion generally.

From this decision—an appeal from which probably will be set in motion—it is possible to appreciate how, regardless of Roe’s core holding regarding the right to an abortion, the question remains open regarding whether, in any particular state, there will
be any means by which some select subgroup of women who seek an abortion actually will be able to meaningfully to exercise their right to obtain one. Indeed, it may be possible for a future Supreme Court, in the wake of Justice Kennedy’s June 2018 retirement, to effectively leave the right in Roe facially intact while making its effectuation a virtual impossibility in large swaths of the country—simply by curtailing the role of the courts in reviewing state laws regulating abortion access, eliminating the power of independent review and falling back to the more simple rational basis test.


In 2011, in an effort to block Planned Parenthood as a family planning provider, Texas terminated its special expanded Medicaid family planning eligibility benefit, which is a state option under the Affordable Care Act, and instead instituted a much smaller state-funded program that excluded Planned Parenthood and seriously reduced access to family planning. The rollback took effect in 2013 and had a dramatic impact on access to services for the poorest women. Following implementation of the reduction, the state experienced a 9 percent decrease in Medicaid enrollees, a 26 percent decline in Medicaid family planning claims and a 54 percent decline in contraceptive claims. Kelsey Hasstedt, How Texas Lawmakers Continue to Undermine Women’s Health (Health Affairs Blog, 2015), [http://healthaffairs.org/blog/2015/05/20/how-texas-lawmakers-continue-to-undermine-womens-health/](http://healthaffairs.org/blog/2015/05/20/how-texas-lawmakers-continue-to-undermine-womens-health/) (Accessed July 22, 2017). Given the importance of Planned Parenthood in rural and lower income communities, this action was associated with diminished access to the most effective forms of contraception among lower income women and an increase in the number of Medicaid births. Amanda J. Stevenson et al., Effect of Removal of Planned Parenthood from the Texas Women’s Health Program, 374 New Eng. J. Med. 853 (2016), [http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=articleResults](http://www.nejm.org/doi/full/10.1056/NEJMsa1511902#t=articleResults) (Accessed July 22, 2017). The remaining clinics—most notably the state’s federally funded community health centers, which by law must offer family planning services but which also must give full primary care services to all low income patients in their communities—were left to pick up the slack, placing immense pressure on the clinics and leaving entire communities without necessary access. Sara Rosenbaum, Family Planning, Community
As of June 2017, in the more politically and philosophically friendly environment of the Trump Administration, Texas has sought to reinstate its expanded Medicaid family planning program in order to reclaim Medicaid’s special 90 percent federal matching rate for Medicaid-funded family planning services. About 700,000 women of childbearing age would regain coverage for at least partial Medicaid benefits such as well-women’s exams, birth control, breast and cervical cancer screening, and certain other preventive screening and counseling services.

Texas being Texas, the request for reinstatement comes with a catch: The state has sought permission—under Section 1115 of the Social Security Act, which permits the HHS Secretary to conduct Medicaid demonstration programs that alter otherwise-applicable legal requirements—to bar Planned Parenthood as a participating Medicaid provider. If the state’s request is granted, the federal government would effectively permit the state receive massive federal funding to promote access to preventive women’s health care while simultaneously excluding its single largest provider of publicly supported family planning services; in 2015, Planned Parenthood clinics served over 1 in 4 Texas women who depend on publicly-supported family planning services. See memo from Jennifer Frost to Senator Patty Murray (Guttmacher Institute, 2017), available at https://www.guttmacher.org/article/2017/05/guttmacher-murray-memo-2017 (Accessed July 22, 2017).

As discussed in Chapter 10 (Medicaid), the core purpose of § 1115 is to empower the Secretary of Health and Human Services to authorize demonstrations that further federal Medicaid objectives. Medicaid’s core objective is to assist needy people gain access to health care. It is a legal mystery, therefore, how a state’s plan to exclude its single largest provider of preventive women’s health care from Medicaid—even as it reinstates eligibility for 700,000 women—could possibly further a Medicaid objective and thus be a minimally rational, lawful use of the Secretary special administrative powers. See, public comments to the state of Texas regarding its proposed 1115 Medicaid family planning demonstration submitted by the Geiger Gibson Program in Community Health Policy, Milken Institute School of Public Health, George Washington University (filed June 9, 2017), https://hhs.texas.gov/laws-regulations/policies-rules/waivers/healthy-texas-women-1115-waiver (Accessed July 22, 2017). As the Geiger Gibson Program comments point out, the state’s community health centers—often cited by Planned Parenthood opponents as an alternative to Planned Parenthood clinics—would need another 20 years, at their current growth rate, to add enough capacity simply to replace the care that women risk losing if the federal government allows Texas to exclude Planned Parenthood.

Of course, should Texas’ 1115 request be approved, one can expect that numerous other states that have sought to eliminate Planned Parenthood from Medicaid to file
comparable requests in order to operate their programs under such an exclusion on a “demonstration” basis.

7. The nationwide assault on family planning. With such a massive effort to suppress access to abortion, one would think that opponents would place special emphasis on enhancing access to family planning. This is not the case.

As noted, Texas was a trailblazer in the effort by some states to move beyond abortion and use their spending and regulatory powers to reach family planning. Much, but by no means all, of this effort was to use funding restriction to drive out of business Planned Parenthood, the nation’s most prominent full-spectrum provider of women’s reproductive health services.

But Planned Parenthood was by no means the only target. State initiatives have also sought to prevent women from receiving appropriate information about pregnancy options. They were also designed to affect family planning services themselves, specifically, as in Texas, the use of grants to local providers to drive individuals away from contraceptives—hailed as one of the 10 most important public health advances of the 20th century—and toward “natural” methods such as abstinence.

At the same time—and paradoxically—a number of states, including states with long-standing animus toward family planning and abortion, simultaneously mounted efforts to expand Medicaid financing of labor and delivery services to include insertion of long-acting reversible contraception (the most effective form of contraceptives) prior to a woman’s hospital discharge. Veronica Vela et al., “Rethinking Medicaid Coverage and Payment Policy to Promote High Value Care: The Case of Long-Acting Reversible Contraception,” 28 Women’s Health Issues 137-143 (March-April 2018).

State efforts to eliminate Planned Parenthood from Medicaid as a participating provider. A number of states have sought to bar Planned Parenthood from Medicaid participation, declaring the organization to be unqualified to furnish covered services. Federal Medicaid law, 42 U.S.C. § 1396a(a)(23), guarantees beneficiaries a free choice of qualified providers, with special protections for family planning services. The law also requires states to set Medicaid provider qualification standards. Although federal law gives states considerable latitude over the standards they set, according to federal agency policies interpreting the statute under the Obama administration, this latitude does not give a state the power to exclude a provider simply because it furnishes services unrelated to those that Medicaid covers and pays for, in this case, abortion services that extend beyond the very narrow classes of abortions that Medicaid will pay for (life of the mother, rape, and incest).

To date, this policy has been adopted by four appellate courts. See, Planned Parenthood of Indiana v. Commissioner of the Indiana State Department of Health, 699 F. 3d 962 (7th Cir. 2012); Planned Parenthood of Gulf Coast v. Gee, 862 F. 3d 445 (5th Cir. 2017); Planned Parenthood of Arizona v. Betlach, 727 F. 3d 962 (9th Cir. 2013), and Planned Parenthood of Kansas v. Anderson, 882 F. 3d 1205 (10th Cir. 2018). However, a fifth appeals court has rejected an attempt to enforce it. Rather than reach the merits, the 8th Circuit Court of Appeals ruled in 2017 that the Medicaid free choice of provider guarantee does not create privately enforceable rights, thereby preventing beneficiaries and providers from bringing an action under 42 U.S.C. § 1983 to enjoin potentially unlawful state actions that exclude Planned Parenthood. Does v. Gillespie, 867 F. 3d 1034 (2017) (See discussion of Medicaid and 1983 enforcement in Textbook Ch. 11). Sara Rosenbaum, Medicaid Coverage for Family Planning—Can the Courts Stop the States from Excluding Planned Parenthood?, 377 New Eng. Jour. Med. 2205-2207 (2017).

With the 8th Circuit decision, the stage is now set for possible Supreme Court resolution of the crucial threshold question in all Medicaid cases brought by private litigants—whether the provision of federal Medicaid law at issue creates rights that can be considered privately enforceable under 1983 or whether enforcement lies exclusively with the HHS Secretary, something addressed in the main text at pp. 524-32. Louisiana and Kansas have appealed the 5th and 10th Circuit decisions in plaintiffs’ favor; Kansas has been joined by 14 state amici in a brief filed in support of Kansas’ petition by Georgia, Idaho, Louisiana, Michigan, Nebraska, Ohio, Oklahoma, South Carolina, South Dakota, Texas, Utah, West Virginia, Wisconsin, and Wyoming. 2018 WL 1920635. As of early June 2018, whether the Trump administration will weigh in on the question of whether the Court will hear a challenge to private enforcement of Medicaid’s free choice of provider guarantee as yet unknown.

As for insight into how the Trump administration might answer the underlying question of whether states can, in fact, use their provider free-choice powers to exclude qualified providers that also furnish services for which Medicaid does not pay, in January 2018 federal officials notified states that the administration was withdrawing the prior agency ruling, communicating their intentions through an informal “Dear State Medicaid Directors” letter, thereby presumably setting the stage for new policies that permit this

State attacks on federal grant funding for Planned Parenthood. The challenges to Planned Parenthood’s funding have not stopped with Medicaid. States also have attempted to derail Planned Parenthood from receiving funding under federal grant programs that provide the state with funds to, among other activities, fund family planning and other preventive services for women. While Title X is the biggest family planning program, other federal grant programs also allow states to fund family planning and other preventive health purposes; some of these programs are the Violence Against Women’s Act; the Breast and Cervical Cancer Mortality Prevention Act; Infertility prevention project grants; a Minority HIV/AIDS initiative; and a personal responsibility education program. These funds go to state health agencies; in turn these agencies allocate funds to local clinics to furnish care, disproportionately to low-income patients.

In Planned Parenthood of Greater Ohio v. Himes, 888 F. 3d 224 (6th Cir. 2018), a federal appeals court permanently enjoined an Ohio statute that barred the state health agency from using the grant funding from these programs from using funds to finance care at any entity that performs abortions or that “contract[s] with any entity that performs or promotes nontherapeutic abortions.” Under the law, the term “promotes” means “advocate for, assist with, encourage, or popularize [abortion] through advertising or publicity.” The term “non-therapeutic” abortions means all abortions other than those performed in connection with rape or incest, or to save a mother’s life.

Suing to prevent the law’s enforcement, plaintiffs argued that the Ohio law, by targeting advocacy, violated their First Amendment free-speech rights. Trying to avoid the First Amendment claim, Ohio argued that its law simply barred certain types of conduct by entities receiving program grants. Rather than deciding the issue on First Amendment grounds, a unanimous court held that Planned Parenthood’s due process rights were violated because the law contravened the “unconstitutional conditions” doctrine. Under this doctrine, while government may impose conditions on benefit grants, it may not “deny a benefit to a person on a basis that infringes his constitutionally protected interests—especially his interest in freedom of speech,” since this would allow government to do directly what it cannot do indirectly, namely, adopt a specific, governmentally-sanctioned viewpoint about a particular issue. 888 F. 3d. at 231. Unlike the law at issue in Rust v. Sullivan, 500 U.S. 173 (1971) (discussed below), in which the Supreme Court upheld wide-ranging funding restrictions on Title X program recipients, the Ohio law, according to the appeals court, did not restrict uses of funds but instead, the types of entities that could qualify for funds:

ODH characterizes Plaintiffs' claims as resting on an asserted entitlement to government funding. ODH mischaracterizes Plaintiffs' argument.
Plaintiffs do not claim an entitlement to government funds. They acknowledge the government's right to define the parameters of its own programs, and have complied with all program requirements. What they do claim is a right not to be penalized in the administration of government programs based on protected activity outside the programs. [Ohio’s law] is unnecessary to accomplish Ohio's choices to favor childbirth and refrain from subsidizing abortions; the program funds here have nothing to do with abortion and for decades both federal and Ohio law have prohibited the use of government funds to pay for abortions.

888 F. 3d at 232-233.

The court also rejected Ohio’s argument that the unconstitutional conditions doctrine bars only those conditions “when they actually operate to impose an undue burden”—in other words, an as-applied test rather than a broader challenge. 888 F. 3d 233. This “undue burden” position was adopted by the 7th Circuit in Planned Parenthood of Indiana v. Commissioner of Indiana State Department of Health 699 F. 3d 962 (7th Cir. 2012), which held that government can favor grants to entities that do not furnish abortions as long as the difference does not unduly burden a woman’s right to obtain an abortion. But according to the 6th Circuit, this position essentially ignored the unconstitutional conditions doctrine, which distinguishes between conditions placed on program grant funding and barriers preventing certain types of entities from qualifying for grants because of the views they hold. The Sixth Circuit’s position placed its ruling in line with Planned Parenthood Association of Utah v. Herbert, 828 F. 3d 1245 (10th Cir. 2016), another case involving efforts by the state of Utah to bar Planned Parenthood from participating in certain state grant programs because of the views it held. For good measure, however, the Sixth Circuit also performed the balancing test required by the undue burden standard and found that the Ohio law did not advance the interest the state purported to assert—promoting life and preventing taxpayer funds from directly or indirectly supporting abortion—because the grant programs addressed by Ohio’s law had nothing to do with abortion, and the law “does little to promote these interests.” 833 F. 3d at 243.

It remains to be seen whether the Supreme Court ultimately weighs in on how the unconstitutional conditions doctrine relates to laws aimed at excluding organizations that furnish abortion from participating in public family planning programs. Are such laws unconstitutional on their face? Or, as the 7th Circuit ruled, are such exclusionary efforts unlawful only if a challenger can show undue burden under particular factual situations? The 2018 proposed Title X family planning rule. The effort to restrict access to comprehensive publicly funded family planning services has culminated in a proposed federal rule that would make sweeping changes in the conditions of funding that would apply to grantees under Title X of the Public Health Service Act, 42 U.S.C. § 300 et seq—the nation’s only federal grant program devoted exclusively to family planning and related services. Enacted in 1970, three years before Roe v. Wade, 410 U.S. 113 (1973) Title X provides funding to state agencies and community clinics to deliver preventive care and primary family planning services. [Link to more information]
From its inception, the Title X statute has expressly prohibited the use of grant funding to finance abortions.

Planned Parenthood is the single largest Title X grant recipient, and Planned Parenthood clinics separate their Title X grant funding to ensure that it is not used to subsidize the abortion services many Planned Parenthood clinics also offer. But for opponents of abortion and states that seek to curb women’s access to abortion, segregation of funding is not enough. Their theory is that Title X funding, even if not used for abortion, represents a crucial source of revenue that helps Planned Parenthood stay afloat financially.

In June 2018, the Trump Administration took the expected step of a soup-to-nuts revamping of the Title X regulations. 83 Fed. Reg. 25502 (June 1). If ultimately adopted in their proposed form, the rules would effectively bar organizations such as Planned Parenthood from the program because they offer both family planning and abortion. The rules would also bar Title X-funded projects from “advocating” for abortion, which, in the case of the proposed rule, seems to consist of a bar against informing women of their full treatment options, including abortion, if pregnant.

The proposed rule is virtually identical to one adopted thirty years ago by the Reagan Administration and upheld by the United States Supreme Court in Rust v. Sullivan, 500 U.S. 173 (1991), as a permissible exercise of federal power to set funding conditions that favor a point of view. Unlike the unconstitutional conditions doctrine discussed in Ohio v. Grimes, above, a closely divided Supreme Court in Rust concluded that the rule simply reflected a permissible decision by government to use its own funds to focus on entities that will advance its point of view. Rust involved a facial challenge to the rule.

The Reagan Administration’s “gag rule,” the name by which it became known, represented a 180 degree departure from prior policy. According to the Administration, the rule was necessary in order to preserve Title X’s funding integrity. Enacted three years before abortion became legal in the country, Title X contains a provision (42 U.S.C. § 1008) that—unchanged to this day—provides that “[n]one of the funds appropriated under this subchapter shall be used in programs where abortion is a method of family planning.” Using this language as the basis for its action, the Reagan Administration’s rule made two enormous shifts in policy. First, it imposed a “wall of separation” between abortion and family planning services; this meant that clinics and organizations providing abortions—Planned Parenthood, hospitals, or other women’s health clinics—would, as a condition of Title X funding, be required to completely separate their abortion services: different buildings; different clinical staff; different administrative staff; different business operations; different financial management or information technology systems, etc. etc. In other words, grantees would need to show that they maintained two entirely separate businesses, each operating completely on its own. Because clinical providers—the organizations that receive Title X project grant funding—necessarily must operate integrated enterprises to achieve some level of cost efficiency, the wall of separation rule effectively meant that no abortion provider also could participate in Title X.
Second, the rule challenged in *Rust* prohibited “all discussion about abortion as a lawful option—including counseling, referral, and the provision of neutral and accurate information about ending a pregnancy.” Clinicians and counselors would be compelled under the rule to limit their counseling to “information that promotes continuing a pregnancy to term.” *Rust* pp. 500 U.S. at 189-190.

Adopting a deferential approach to the Reagan Administration’s power to redefine the meaning of § 1008, the Court concluded that the rule was a reasonable interpretation of the prohibition and did not violate the First or Fifth Amendments or women’s right to privacy:

There is no question but that the statutory prohibition contained in § 1008 is constitutional. In *Maher v. Roe*, 432 U.S. 464 (1977), we upheld a state welfare regulation under which Medicaid recipients received payments for services related to childbirth, but not for nontherapeutic abortions. The Court rejected the claim that this unequal subsidization worked a violation of the Constitution. We held that the government may “make a value judgment favoring childbirth over abortion, and . . . implement that judgment by the allocation of public funds.” Here the Government is exercising the authority it possesses under *Maher* and *Harris v. McRae*, 448 U.S. 297 (1980), to subsidize family planning services which will lead to conception and childbirth, and declining to “promote or encourage abortion.” The Government can, without violating the Constitution, selectively fund a program to encourage certain activities it believes to be in the public interest, without at the same time funding an alternative program which seeks to deal with the problem in another way. In so doing, the Government has not discriminated on the basis of viewpoint; it has merely chosen to fund one activity to the exclusion of the other . . . .

The challenged regulations implement the statutory prohibition by prohibiting counseling, referral, and the provision of information regarding abortion as a method of family planning. They are designed to ensure that the limits of the federal program are observed. The Title X program is designed not for prenatal care, but to encourage family planning. A doctor who wished to offer prenatal care to a project patient who became pregnant could properly be prohibited from doing so because such service is outside the scope of the federally funded program. The regulations prohibiting abortion counseling and referral are of the same ilk; “no funds appropriated for the project may be used in programs where abortion is a method of family planning,” and a doctor employed by the project may be prohibited in the course of his project duties from counseling abortion or referring for abortion. This is not a case of the Government “suppressing a dangerous idea,” but of a prohibition on a project grantee or its employees from engaging in activities outside of the project’s scope.
To hold that the Government unconstitutionally discriminates on the basis of viewpoint when it chooses to fund a program dedicated to advance certain permissible goals, because the program in advancing those goals necessarily discourages alternative goals, would render numerous Government programs constitutionally suspect. When Congress established a National Endowment for Democracy to encourage other countries to adopt democratic principles. It was not constitutionally required to fund a program to encourage competing lines of political philosophy such as communism and fascism. Petitioners' assertions ultimately boil down to the position that if the government chooses to subsidize one protected right, it must subsidize analogous counterpart rights. But the Court has soundly rejected that proposition. *Maher v. Roe,* supra; *Harris v. McRae,* supra. Within far broader limits than petitioners are willing to concede, when the Government appropriates public funds to establish a program it is entitled to define the limits of that program.

But what we have here not the case of a general law singling out a disfavored group on the basis of speech content, but a case of the Government refusing to fund activities, including speech, which are specifically excluded from the scope of the project funded. Petitioners rely heavily on their claim that the regulations would not, in the circumstance of a medical emergency, permit a Title X project to refer a woman whose pregnancy places her life in imminent peril to a provider of abortions or abortion-related services. These cases, of course, involve only a facial challenge to the regulations, and we do not have before us any application by the Secretary to a specific fact situation. On their face, we do not read the regulations to bar abortion referral or counseling in such circumstances. Abortion counseling as a “method of family planning” is prohibited, and it does not seem that a medically necessitated abortion in such circumstances would be the equivalent of its use as a “method of family planning.” Neither § 1008 nor the specific restrictions of the regulations would apply. . . .

Petitioners also contend that the restrictions on the subsidization of abortion-related speech contained in the regulations are impermissible because they condition the receipt of a benefit, in these cases Title X funding, on the relinquishment of a constitutional right, the right to engage in abortion advocacy and counseling. . . . Here the Government is not denying a benefit to anyone, but is instead simply insisting that public funds be spent for the purposes for which they were authorized. The Secretary's regulations do not force the Title X grantee to give up abortion-related speech; they merely require that the grantee keep such activities separate and distinct from Title X activities. Title X expressly distinguishes between a Title X grantee and a Title X project. The grantee, which normally is a health-care organization, may receive funds from a variety of sources for a variety of purposes. The grantee receives Title X
funds, however, for the specific and limited purpose of establishing and operating a Title X project. The regulations govern the scope of the Title X project's activities, and leave the grantee unfettered in its other activities. The Title X grantee can continue to perform abortions, provide abortion-related services, and engage in abortion advocacy; it simply is required to conduct those activities through programs that are separate and independent from the project that receives Title X funds.

In contrast, our “unconstitutional conditions” cases involve situations in which the Government has placed a condition on the recipient of the subsidy rather than on a particular program or service, thus effectively prohibiting the recipient from engaging in the protected conduct outside the scope of the federally funded program.

By requiring that the Title X grantee engage in abortion-related activity separately from activity receiving federal funding, Congress has not denied it the right to engage in abortion-related activities. Congress has merely refused to fund such activities out of the public fisc, and the Secretary has simply required a certain degree of separation from the Title X project in order to ensure the integrity of the federally funded program.

The same principles apply to petitioners' claim that the regulations abridge the free speech rights of the grantee's staff. Individuals who are voluntarily employed for a Title X project must perform their duties in accordance with the regulation's restrictions on abortion counseling and referral. The employees remain free, however, to pursue abortion-related activities when they are not acting under the auspices of the Title X project. The regulations, which govern solely the scope of the Title X project's activities, do not in any way restrict the activities of those persons acting as private individuals. The employees' freedom of expression is limited during the time that they actually work for the project; but this limitation is a consequence of their decision to accept employment in a project, the scope of which is permissibly restricted by the funding authority.

This is not to suggest that funding by the Government, even when coupled with the freedom of the fund recipients to speak outside the scope of the Government-funded project, is invariably sufficient to justify Government control over the content of expression. It could be argued . . . that traditional relationships such as that between doctor and patient should enjoy protection under the First Amendment from Government regulation, even when subsidized by the Government. We need not resolve that question here, however, because the Title X program regulations do not significantly impinge upon the doctor-patient relationship. Nothing in them requires a doctor to represent as his own any opinion that he does not in fact hold. Nor is the doctor-patient relationship established by the Title
X program sufficiently all-encompassing so as to justify an expectation on the part of the patient of comprehensive medical advice. The program does not provide post conception medical care, and therefore a doctor's silence with regard to abortion cannot reasonably be thought to mislead a client into thinking that the doctor does not consider abortion an appropriate option for her. The doctor is always free to make clear that advice regarding abortion is simply beyond the scope of the program. In these circumstances, the general rule that the Government may choose not to subsidize speech applies with full force. . . .

We turn now to petitioners' argument that the regulations violate a woman's Fifth Amendment right to choose whether to terminate her pregnancy. The Government has no constitutional duty to subsidize an activity merely because the activity is constitutionally protected and may validly choose to fund childbirth over abortion and “implement that judgment by the allocation of public funds” for medical services relating to childbirth but not to those relating to abortion. . . . That the regulations do not impermissibly burden a woman's Fifth Amendment rights is evident from the line of cases beginning with *Maher* and *McRae* and culminating in our most recent decision in *Webster v. Reproductive Health Services*, 492 U.S. 490 (1989). Just as Congress' refusal to fund abortions in *McRae* left an indigent woman with at least the same range of choice in deciding whether to obtain a medically necessary abortion as she would have had if Congress had chosen to subsidize no health care costs at all, and Missouri's refusal [in *Webster*] to allow public employees to perform abortions in public hospitals leaves a pregnant woman with the same choices as if the State had chosen not to operate any public hospitals, Congress' refusal to fund abortion counseling and advocacy leaves a pregnant woman with the same choices as if the Government had chosen not to fund family-planning services at all. The difficulty that a woman encounters when a Title X project does not provide abortion counseling or referral leaves her in no different position than she would have been if the Government had not enacted Title X.


Following *Rust*, the George H.W. Bush administration never implemented the Reagan Administration’s regulations. The Clinton administration suspended the rule, and subsequent administrations returned to a policy of non-directive counseling that lays out all options and strict adherence to the prohibition on using Title X funds to pay for abortion. This clearly did not satisfy abortion opponents.

The proposed rule is a virtual reprise of its predecessor. With some minor modifications, it dredges up its same logic relied on previously, namely, the need to preserve Title X’s integrity. The preamble provides no evidence of anything that happened between 1993 and 2018, suggesting the use of Title X funds for prohibited
abortions or abortion “advocacy” other than non-directive counseling. In releasing the rule, which President Trump did formally during a speech presented by the White House press office as “President Trump is Defending American Values,” https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-defending-american-values/, officials argued that the proposal is a more liberal version of its predecessor because counseling is permitted. This is what non-directive counseling looks like under the proposed rule:

If asked, a medical doctor may provide a list of licensed, qualified, comprehensive health service providers (some but not all of which also provide abortion, in addition to comprehensive prenatal care), but only if a woman who is currently pregnant clearly states that she has already decided to have an abortion. This list is only to be provided to a woman who, of her own accord, makes such a request. The list shall not identify the providers who perform abortion as such.


In other words, physicians may “counsel” but only when asked for specific information by specific women. They cannot offer considered, affirmative medical advice but must remain passive. No staff other than physicians apparently can counsel, although in family planning programs, counseling typically is performed by trained health educators. Furthermore, whatever “counseling” is permitted, the content of permissible information is defined and is limited to providing women with highly restricted lists that exclude clinics specializing in abortion. Should the rules become final, testers intent on making sure that family planning clinics do not stray from the information requirements under which they must operate undoubtedly will be out in force to police Title X-funded family planning clinics’ counseling activities. With a long tradition in sting operations aimed at women’s health clinics (especially Planned Parenthood), testers can be expected to be aggressive about identifying clinics engaged in “illegal” counseling by using trained counselors, giving information to the “wrong” women, and handing out lists of “forbidden” providers that actually specialize in abortion.

Presumably the rules will be challenged once finalized. This time the plaintiffs may try to rely on National Institute of Family and Life Advocates v. Becerra ___ U.S. ___ , 138 S. Ct. 2361 (2018), which struck down California’s FACT Act. Plaintiffs—pregnancy crisis centers at whom the law was aimed and which seek to promote birth and curb abortion—sought but were denied a preliminary injunction against enforcement. The denial of the preliminary injunction was appealed to the Ninth Circuit and then the Supreme Court.

The purpose of the Act was to ensure that pregnancy crisis centers offering medical care and operated as licensed medical clinics disclosed all relevant pregnancy-related information to patients, including the availability of publicly-funded abortion services and how to obtain them. FACT also required centers not operating as medical clinics but merely counseling, as well as referral agencies, to disclose the fact that they were not licensed to provide medical care (and presumably, therefore, unqualified to
engage in medical treatment counseling). California argued that its law was a classic case of state regulation of medical care, subject to broad deference. A closely divided Court rejected this argument; in his majority opinion, Justice Thomas concluded that FACT amounted to an unconstitutional effort to regulate the actual content of what he termed “professional speech,” thereby subjecting it to heightened scrutiny as a burden on plaintiffs’ First Amendment rights. Justice Thomas then proceeded to find that the law served no compelling interest, principally because it applied only to selected clinics and broadly exempted most clinics (which, the evidence showed, fully inform patients of their treatment options). A concurrence by Justice Kennedy made clear—lest anyone might view this case as confined to the California’s decision to selectively apply the law—that as far as he was concerned (along with Justices Gorsuch and Alito), nothing California could do in terms of broadening the reach of the law could cure its unconstitutional deficiencies.

In a powerful dissent, Justice Breyer, writing on behalf of himself and Justices Kagan, Sotomayor, and Ginsberg, decried the Court’s attempt to elevate standard professional regulatory law to the First Amendment stratosphere, thereby subjecting states to having to prove their compelling interest in regulating professional speech, that is, professional conduct that simply involves speech.

Could Becerra help plaintiffs in a new challenge to a Title X gag rule? Probably not, since the Rust principle still stands—the federal government can impose speech content constraints that otherwise would be unconstitutional on health care providers as long as the conditions are attached to funding. In other words, people who depend on publicly funded clinics can be subjected to incomplete and downright misleading and dangerous medical advice while those affluent enough to receive entirely private sector care are protected.

More to the point, perhaps, might be the Court’s 2001 decision—subsequent to Rust—Legal Services Corporation v. Velasquez, 531 U.S. 533 (2001). In Velasquez, the Court overturned a condition of funding imposed on local legal services offices by the Corporation that barred lawyers from bringing challenges to the legality of state welfare restrictions under federal law. Here, unlike Rust, the Court concluded that the grant restriction acted as an unconstitutional condition on private lawyers’ free speech, because the services purchased were from private nonprofit entities and thus the restrictions amounted to an attempt to force private speakers to deliver a government message. In the decision, Justice Kennedy, writing for a 5-member majority, characterized the facts in Rust as involving the delivery of government services by government clinics. In fact, family planning clinics that receive Title X funding are nothing of the sort; with the exception of state and local public health agencies, perhaps, family planning clinics are overwhelmingly private nonprofit corporations employing private physicians, counselors, and others and supported by a range of funding sources, both public and private. In other words, they are not “government clinics.”

Whether this critical fact is developed in a challenge to the new version of the rules challenged in Rust remains to be seen.
Insert at the end of Chapter 4, page 167, a new section 5:

5. Section 1557 of the Affordable Care Act—Expanding the Scope of Health Care and Civil Rights; the Trump Administration’s Assault

This chapter considers civil rights laws in a health care context with a focus on sex, disability, and gender. Section 1557 of the Affordable Care Act was designed to expand and strengthen the scope and application of these laws.

The text of section 1557, codified at 42 U.S.C. § 18116, is as follows [emphasis added]:

(a) In general

Except as otherwise provided for in this title (or an amendment made by this title), an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), the Age Discrimination Act of 1975 (42 U.S.C. 6101 et seq.), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title (or amendments). The enforcement mechanisms provided for and available under such title VI, title IX, section 794, or such Age Discrimination Act shall apply for purposes of violations of this subsection.

(b) Continued application of laws

Nothing in this title (or an amendment made by this title) shall be construed to invalidate or limit the rights, remedies, procedures, or legal standards available to individuals aggrieved under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d et seq.), title VII of the Civil Rights Act of 1964 (42 U.S.C. 2000e et seq.), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 et seq.), section 794 of title 29, or the Age Discrimination Act of 1975 [42 U.S.C. 6101 et seq.], or to supersede State laws that provide additional protections against discrimination on any basis described in subsection (a).

(c) Regulations

The Secretary may promulgate regulations to implement this section.
This provision introduces several notable reforms. First, it adds sex as a prohibited basis of discrimination by federally-assisted entities in the context of federal health programs. Previously, discrimination on the basis of sex by entities receiving federal financial assistance was confined to educational settings under Title IX. Second, the provision, in keeping with established civil rights law principles, extends its prohibitions to federally-assisted entities in their entirety, not merely those activities that directly receive federal financial assistance.

Third, the provision applies to any “health program or activity . . . administered by an Executive Agency or any entity established under this title,” thereby reaching all programs administered by any federal agency that is part of the executive branch as well as “entities established under Title I of the Act. This clause was intended as a reference to health insurance Exchanges but would apply to other entities established pursuant to Title I.

Fourth, the provision reaches “subsidies, credits, and contracts of insurance,” meaning that federal premium tax credits, cost sharing subsidies, along with the contracts of insurance purchased with such credits and subsidies, are subject to the non-discrimination provisions.

Finally, the amendment extends all of the enforcement mechanisms made available under Title VI, Section 504, Title IX, or the age discrimination act are available to enforce this section. Because the law specifies “all enforcement mechanisms” in relation to “this subsection,” read in its plainest terms, the law states that any of the enforcement mechanisms available under any of the existing civil rights laws incorporated by reference into section 1557 is available to enforce the protections granted by 1557. Thus, if any of the underlying laws on which section 1557 rest create a private right of action, a private remedy would be available under 1557. (Recall in Alexander v Sandoval (main text) that the United States Supreme Court permitted private enforcement actions under Title VI in cases involving intentional discrimination.) Sidney D. Watson, Section 1557 of the Affordable Care Act: Civil Rights, Health Reform, Race, and Equity, 55 Howard L.J. 855 (Spring 2012).

Following a lengthy regulatory development process beginning in 2013 with a Request for Information (78 Fed. Reg. 46558, August 1), the Obama Administration issued a final rule in 2016 (81 Fed. Reg. 31376, May 18). The rule was notable in several respects. First, the rule extended protections on the basis of sex to cases involving abortion, even as it retained a religious conscience exemption. Second, the rule defined discrimination on the basis of sex to include both sex and gender identity.

Third, the rule established an industry-wide application for health insurance, meaning that it interpreted the phrase “any part of which” consistent with its use in other health settings, thus reaching the entity that participated in the federal program, not merely that part of the entity that received federal assistance. This meant that issuers selling Exchange policies qualifying for tax subsidies and cost-sharing assistance also
were bound by section 1557 across all health plans and products (individual policies, group insurance policies, and administered plans for self-insuring public and private employers). As a result, conduct that would violate section 1557 were it to be present in a tax-subsidized exchange plan would also be prohibited under non-subsidized policies and employer plans. (An example might be placing all HIV drugs, including generics, in the highest cost-sharing tier while providing more generous coverage for other conditions for which ongoing drug therapies are needed).

Fourth, the rule clarified that private rights of action available under any civil rights law incorporated into section 1557 such as Title VI would apply to any 1557 claim of discrimination, thereby creating a private right of action for intentional discrimination based on age, gender identity, sex, disability, or race.

Fifth, the rule established extensive language access protections in the case of people whose primary language spoken was not English, and on the basis of the law’s entity-wide standard, required that these protections be in place on an entity-wide basis.

The Obama Administration’s definition of what constitutes sex discrimination reflected a general trend in the courts through decisions extending the meaning of sex discrimination in federal health programs to cases in which the plaintiff claimed gender bias. See, e.g., Rumble v. Fairview Health Services, 2015 Westlaw 1197415 (D. Minn. 2015) (challenging a hospital’s treatment of a transgender patient); Boyden v Conlin, 341 F. Supp. 3d 979 (W.D. Wis. 2018) (challenging the denial of gender reassignment under state employee health benefit plan coverage).

Although Rumble and Boyden were decided in the plaintiffs’ favor, in 2016 a federal trial court in Texas—the same court that also held that the entire ACA is unconstitutional in Texas v Azar, discussed in this Update at the end of Part II—issued a nationwide preliminary injunction against enforcement by the Obama Administration of section 1557’s abortion and transgender protections. Franciscan Alliance v Burwell 227 F. Supp. 3d 660 (N.D. TX 2016). In a not-particularly-shocking move, the Trump Administration asked the court to stay further proceedings while it considered whether to revise the section 1557 rule. In an equally-not-shocking move, the Administration ultimately notified the court that it agreed with plaintiffs (a group of state and religious institutions) regarding the illegality of the Obama Administration’s 2016 rules. In June 2019, the Trump Administration proposed major modifications of the 1557 regulations, 84 Fed. Reg. 27846 (June 14, 2019). Katie Keith, HHS Proposes to Strip Gender Identity, Language Access Protections from ACA Anti-Discrimination Rule, Health Affairs Blog (May 25, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190525.831858/full/ (Accessed July 16, 2019).

As expected, the Trump Administration rules would make sweeping changes in the Obama regulations’ governing federally-assisted health entities. These changes include: eliminating the definition of sex discrimination that encompasses discrimination based on gender identity; eliminating protections in abortion-related cases (consistent with the Trump Administration’s efforts to eliminate EMTALA protections in cases
involving abortion under its religious conscience rule, also discussed in this Part); and eliminating the rule’s expanded language access obligations. Furthermore, the proposed rule would also exempt insurers from the entity-wide test that applies under normal civil rights principles, meaning that section 1557 would apply only to directly federally subsidized plans sold in the Medicare, Medicaid, or tax-subsidized Exchange markets. As a result, in their non-federally subsidized markets, issuers could continue to follow discriminatory design and coverage determination practices such as tiered cost sharing, in contravention of disability non-discrimination protections or exclusion of gender reassignment treatment. Sara Rosenbaum, Rolling Back Civil Rights Protections in Health Insurance: The Proposed 1557 Rule (Commonwealth Fund, June 12, 2019), https://www.commonwealthfund.org/blog/2019/rolling-back-civil-rights-protections-health-insurance-proposed-1557-rule (Accessed July 16, 2019). Finally the Trump Administration’s proposed rule would reverse the consolidated remedy approach, codified in the law and implemented under the Obama rule, that extends to any 1557 claim all remedies under the civil rights laws incorporated into 1557, including a private right of action even if such a private right of action is not available in the underlying stand-alone civil rights statute, as incorporated.

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Chapter 8 The Employer Retirement Income Security Act (ERISA)

Insert at textbook, p. 285 the following at the end of Note 2, which discussed Kenseth v. Dean Health Plan:

In between the trial court’s denial of relief to Ms. Kenseth and the appeals court’s consideration of her appeal from the denial of relief, the United States Supreme Court decided Cigna v Amara, discussed in Note 3, which follows. In the wake of Amara, the United States Court of Appeals for the Seventh Circuit concluded in its re-visitation of her case, Kenseth v. Dean Health Plan, 2013 WL 2991466 (2013), that Amara changed everything for the plaintiff and that where a breach of fiduciary duty was shown, in the form of giving incorrect advice about her coverage, she could, in fact, seek make-whole money damages as a form of equitable relief.

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Insert at page 425 at the end of Chapter 8:

Note on “Surprise Medical Billing”

In the summer of 2019 one of the hottest areas in health law and policy concerns the issues surrounding so-called “surprise medical billing.” Earlier in this Chapter, in note 4 on page 304, we touched on one species of this phenomenon when we explicated the
ACA’s requirements that all health insurance provide coverage of out-of-network care furnished in emergency departments. As we described there, federal law requires insurers and self-insured plans to provide coverage under a “prudent layperson” standard and requires issuers and plans to pay providers the greatest of in-network rates, out-of-network rates or Medicare’s payment. Plan members’ coinsurance or copayments are limited to what they would have been had they obtained services at an in-network facility. However, their potential out-of-pocket costs could still run into an additional tens of thousands of dollars because the ACA does not ban balanced-billing by out-of-network hospitals for the difference between the federally established minimum payment from the insurer to the out-of-network provider and what the provider actually bills the patient. This is one form of “surprise billing.”

The problem of balance billing, however, is not limited to unplanned care obtained at out-of-network facilities but can also occur when plan members obtain unplanned or even planned care in-network because some specialists, e.g., emergency room physicians, radiologists, anesthesiologists, pathologists or even assisting surgeons, are out of network despite the fact that the setting of care is in-network. In such cases plan members may have done their homework and ensured that they receive care at an in-network provider but they are then quite surprised, again possibly to the tune of tens of thousands of dollars, when they are billed for services furnished by a physician who is out of network although working at an in-network facility. A very recent study, using data from 2017, found that approximately one in six patients insured by employers receive surprise bills of one sort or the other. See Karen Pollitz et al., An Examination of Surprise Medical Bills and Proposals to Protect Consumers from Them, Kaiser Family Foundation (June 20, 2019), \texttt{https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them/} (Accessed July 4, 2019). The problem is thus huge. *

Surprise billing arises because of the very nature of networks. See generally Simon F. Haeder, David L. Weimer & Dana B. Mukamel, Surprise Billing: No Surprise in View of Network Complexity, Health Affairs Blog (June 5, 2019), \texttt{https://www.healthaffairs.org/do/10.1377/hblog20190603.704918/full/} (Accessed July 4, 2019). As discussed much more fully in Chapter 12 below, if the United States had a universal insurance system with a single payer or coordinated payers, then networks would be irrelevant for purposes of paying providers. However, in the absence of such a universal system of payment networks exist because payment in advance of treatment must be arranged between a payer and a network of providers. Networks, by necessity, are therefore limited; so long as care is or must sometimes be obtained out of network some extra-contractual means of deriving payment must exist.

As we have seen in Parts One and Two, the default common law rule is that providers and insurers get to do whatever they want. If a patient engages a provider for services, then the patient has only the “protection” of the market and the patient is stuck

* Due to space limitations we push together the different situations that can create “surprise” billing from the provision out-of-network care, although we realize that each might be treated distinctly.
with the provider’s bill. If the patient contracts with an insurer that refuses to pay for out-of-network care or pays less than that billed by a provider, then it is the patient’s problem and again the patient is stuck with the provider’s bill. That is the meaning of freedom in America—it is the freedom to contract."

States can, and as discussed immediately below, sometimes have intervened with positive law to protect patients, but as discussed in this Chapter, they have power to regulate the individual insurance market but their power to intervene in the employer-sponsored insurance market runs right into the buzz saw of ERISA preemption. They can regulate insurance or providers but they cannot regulate self-insured plans, which cover approximately forty percent of all privately insured persons.

Suppose that in an attempt to avoid ERISA preemption states directly regulate providers by, say, prohibiting providers from balance-billing patients**—something that, by the way, Medicare managed to do decades ago.*** That might protect patients but what about providers? How are they to be paid since it leaves them to duke it out with insurers with which they have no contractual relationship. Then what? At least patients are held harmless, but do we just leave it to providers and insurers to bargain? And if that fails, is litigation the only recourse? And what is there to guide the courts if negotiations have failed?

These problems are why some states, e.g., New York as the leading example, have imposed dispute resolution mechanisms like mediation or arbitration if providers and insurers cannot resolve their differences by negotiation. Other states, e.g., California, Colorado, New Mexico, have imposed some form of benchmark pricing that specifies what an insurer must pay in these situations, for example some percentage of its median in-network rate or some percentage of what Medicare pays. But state regulation of insurer-provider relationships runs headlong into the fact that, as you have learned, ERISA precludes the states from imposing laws that “relate to” ERISA plans and that cannot be saved as laws that regulate insurers. This means, of course, that balance billing laws (which presumably could be saved under the Miller test) nonetheless do not apply to self-insured plans. And what about the fact that some states provide no protection at all and some provide very limited protection? Even among those offering some protection, one finds great variation among them with regard to the type of facilities covered (e.g.,

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** Well, at least we would see it that way, as we write in Chapter 8. By acting on providers, states are not regulating plans but the products they buy and therefore state law should fall outside of the relate-to clause. However, the prevailing view, as Kentucky HMO Association illustrates, is that such laws are saved as regulating insurers but, because of the deemer clause, do not apply to self-insured plans’ contracts with providers.


for Emergency Care in the United States (March 2018), https://isps.yale.edu/sites/default/files/publication/2018/03/20180305_oon_paper2_tables_appendices.pdf (Accessed July 4, 2019). Enamored of the market, these commentators see the use of benchmark pricing—that is, setting the maximum amount that out-of-network providers can charge as some percentage of Medicare payment or what the insurer pays for in-network care—as too regulatory. We examine these arguments much more fully in the material on payment in Chapter 12 but do not pursue them here because, although there was serious legislative consideration of this policy option, at this point it appears to be dead in the water. It seems that forcing all providers effectively into a single network in order to protect patients is opposed by virtually all stakeholders. The only point on which they all seem to agree is that they uniformly wish to preserve their freedom to design networks as they please.

Still, if patients are to be protected, then some form of payment has to be imposed as a substitute for network-derived bargains. Simply requiring providers and hospitals to negotiate a resolution basically creates a vast sea of uncertainty. On the question of how payment should be derived for out-of-network care, stakeholders generally line up on one of two sides. Most hospital and doctor groups oppose any form of benchmark pricing, because they wish to preserve their power to obtain higher payments from insurers; they particularly dread the possibility that federal Medicare rates would be used, payments that, as we explain in Chapter 12, are now much lower than those prevailing in the private sector. Providers generally would prefer that more open-ended processes like arbitration and mediation be used, in part because conflict-resolution systems may allow them to gain leverage because such a system may use provider charges at least as a starting point for determining proper resolutions. See Loren Adler et al., Rep. Ruiz’s Arbitration Proposal for Surprise Billing (H.R. 3502) Would Lead to Much Higher Costs and Deficits, Health Affairs Blog, July 16, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190716.355260/full/?utm_source=Newsletter&utm_medium=email&utm_content=An+Outcomes-Driven+Maternity+Payment+Model%3B+Arbitration+Proposal+For+Surprise+Billing%3B+Court+Blocks+Contraceptive+Rules%3B+Time+Estimates+And+The+Physician+Fee+Schedule&utm_campaign=HAT+7-16-19 (Accessed July 16, 2019); Kevin A. Schulman, Arnold Milstein & Barak D. Richman, Resolving Surprise Medical Bills, Health Affairs Blog, https://www.healthaffairs.org/do/10.1377/hblog20190628.873493/full/?utm_source=Newsletter&utm_medium=email&utm_content=Texas+v++United+States%3B+Surprise+Medical+Bills%3B+Nurses+With+Baccalaureate+Degrees+Associated+With+Better+Outcomes+For+Patients&utm_campaign=HAT+7-10-19 (Accessed July 11, 2019). By contrast, employer groups and insurers are hopeful that they can piggyback on the power of the federal government in its imposition of Medicare rates or at least be able to impose their own in-network rates.*

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*Necessarily there are complicated considerations involved in setting benchmark rates such as what to use as a benchmark, how to handle geographic differences, whether rural providers deserve separate treatment and how to gather relevant data. Likewise, there are questions regarding the parameters of imposed dispute resolution. See, e.g., Loren Adler et al., State Approaches to Mitigating Surprise Out-of-Network Billing; Sabrina Corlette, Jack Hoadley & Kevin Lucia, Successfully Splitting the Baby: Design Considerations for...
Quite simply, the fight is about money. Some commentators are enamored of the “bipartisanship” and “comity” that supposedly exists around the need to protect patients. See, e.g., Abby Goodnough, With Rare Comity, Senate Panel Advances Bills to Lower Health Care Costs, New York Times (June 26, 2019), https://www.nytimes.com/2019/06/26/us/politics/health-costs-prescription-drugs.html (Accessed July 4, 2019); Margot Sanger-Katz, Surprise Medical Bills Give Both Parties an Unexpected Opportunity to Agree, New York Times, May 24, 2019, https://www.nytimes.com/2019/05/24/upshot/surprise-medical-bills-bipartisan-lawmaking.html (Accessed July 5, 2019). But your authors have seen many “good causes” defeated by the fact that, perhaps, money still makes the world go round, even in health care—the general subject of Part Four. We hope to be proven wrong, at least in this context. The one in six members of employer-sponsored insurance hit with surprise bills really need a break.

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Chapter 10 Medicare

Insert at textbook, p. 495 the following material after the Note following Papciak v. Sebelius:

Note: The Final Demise of the Improvement Standard

In Jimmo v. Sebelius, 2011 WL 5104355 (Vt. 2011), a federal court cleared the way for a major examination of whether the Secretary had deliberately and covertly introduced an “Improvement Standard” into Medicare claims by beneficiaries who needed nursing, home health, or therapy services to maintain their health or avert the loss of function. The plaintiffs, several beneficiaries and numerous organizations representing Medicare beneficiaries, alleged that contrary to the federal Medicare statute and implementing regulations, HHS had developed what they termed the “Improvement Standard” as part of their local coverage determination manuals. The Standard, adopted and used in violation of the Medicare program, and without the rulemaking process required under the Administrative Procedures Act, had the effect of denying coverage to thousands of beneficiaries who could demonstrate that treatment would help them from a health preservation perspective, but not that they would “improve.” (Sound familiar? Recall Bedrick, discussed earlier in Part Two).

After rejecting the Secretary’s numerous arguments to dismiss the case on jurisdictional grounds (see Ringer and accompanying materials earlier in this Chapter),* the trial court went on to consider the Secretary’s motion to dismiss the merits of the plaintiffs’ claims based on a lack of evidence that such a standard existed:

. . . [I]n seeking dismissal, the Secretary relies heavily on regulations and policies which forbid the application of anything resembling the Improvement Standard. See 42 C.F.R. § 409.44(a) (explaining that, under the home health benefit, Medicare coverage of skilled services is based on the “unique medical condition of the individual beneficiary”); . . . 42 C.F.R. § 409.44(b)(3)(iii) (providing that the determination of whether a skilled service is reasonable and necessary “must be based solely upon the beneficiary’s unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time”); 42 C.F.R. § 409.32(c) (“Even if full recovery or medical improvement is not possible, a patient may need skilled services to prevent further deterioration or preserve current capabilities.”); Home Health Prospective Payment System Rate Update for Calendar Year 2011, 75 Fed. Reg. 70372, 70395 (Nov. 17, 2010) (“‘Rules of thumb’ in the Medicare medical review process are prohibited.... Medical denial decisions must be based on a detailed and thorough analysis of the beneficiary's total condition and individual need for care.”). Plaintiffs acknowledge the existence of those regulations and policies and do not question their validity, but argue that the Improvement Standard demonstrates they are being ignored. The facts they cite in support of the Improvement Standard’s existence are decidedly scant.

For example, Plaintiffs cite [the Local Coverage Decision manual] as evidence of the Improvement Standard because, under the heading “Indications,” it notes that “[t]here must be an expectation that the condition ... will improve significantly within a reasonable and generally predictable period of time[,]” and under “Limitations” it states that “[p]hysical therapy is not covered when the documentation indicates that a

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* The court’s jurisdictional analysis was lengthy given that various individual and group plaintiffs presented diverse situations. Several are of interest in light of Ringer. One plaintiff sued directly because the home health agency whose care she sought knew that treatment would be denied. As in Ringer, her claims were dismissed on the ground that “presentment” had not happened, that is, that she had failed to present her claim and therefore was barred from proceeding directly to court. Several other plaintiffs, whose claims were in the appeals process, sought judicial waiver of full administrative review on the ground that by using secret and unlawful standards codified in neither the statute nor the regulations, the Secretary had introduced such procedural regulations as to make further appeals futile. Even had they prevailed at their hearings, the “thrust of their complaints” could not have been addressed, given the fact that the complaints focused squarely on the unlawful review standards applied to their claims. 2011 WL 5104355, at pp. 7-8. In the case of Ms. Jimmo, the lead plaintiff, the Secretary attempted to argue that even if there were no Improvement Standard, Jimmo would have lost the case. The court was having none of it and allowed Jimmo's case to proceed on the ground that the allegation of an unlawful standard so tainted the entire administrative review process that it was impossible to say what the outcome might have been.
patient has attained the therapy goals or has reached the point where no further significant practical improvement can be expected.” Id. The Secretary, however, points out that this same LCD also states that the “design of a maintenance regimen/[home exercise plan] required to delay or minimize muscular and functional deterioration in patients suffering from a chronic disease may be considered reasonable and necessary.”

Further, under “Maintenance Therapy,” the LCD states that “[w]here repetitive services that are required to maintain function involve the use of complex and sophisticated procedures, the judgment and skill of a physical therapist might be required for the safe and effective rendition of such services. If the judgment and skill of a physical therapist is required to safely and effectively treat the illness or injury, the services may be covered as physical therapy services.” Id. Thus, [the LCD manual] does not, alone, establish an Improvement Standard.

Plaintiffs cite [a separate LCD manual provision] as evidence of the Improvement Standard because it provides for coverage when the “documentation supports the expectation that the beneficiary’s condition will improve significantly in a reasonable and generally predictable period of time.” Id. In the same paragraph, however, the LCD explains that coverage also applies when the services are “necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.” Id.; see also 42 C.F.R. § 409.44(c)(2)(iii)(A)-(C).

On balance, the LCDs and MBPMs, regarded in the light most favorable to Plaintiffs, do not provide sufficient factual support for Plaintiffs’ allegations that an Improvement Standard is being used for the denial of Medicare coverage. This is hardly surprising, as Plaintiffs further allege that the Secretary’s tacit endorsement of the Improvement Standard is both “covert” and “clandestine.” Plaintiffs further claim that the Improvement Standard “is apparent from the district court decisions that have repeatedly rejected the Improvement Standard over the years.” Papciak v. Sebelius, 742 F. Supp.2d 765 (W.D.Pa.2010). At best, these cases support Plaintiffs’ argument that their allegation of an Improvement Standard is neither fanciful, fantastic, nor delusional. See Gallop v. Cheney, 642 F.3d 364, 368 (2d Cir. 2011) (dismissal of complaint was appropriate where “sufficiently well-pleaded facts are clearly baseless—that is, if they are fanciful, fantastic, or delusional.”). In any event, the court rejects Plaintiffs’ invitation to look elsewhere for evidence of the Improvement Standard and focuses instead on the allegations of the Amended Complaint. With regard to each Individual Plaintiff, the

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11 . . . Plaintiffs cite two additional LCDs [related to occupational therapy] [but these] fare no better. They do not establish an Improvement Standard and qualify any statement that appears to deny coverage merely because a condition is chronic or stable.
Amended Complaint cites Agency decisions that are arguably consistent with the imposition of an Improvement Standard because adjudicators denied coverage based upon, inter alia, a conclusion that the beneficiary’s condition would not improve.

The Secretary counters that the similarities between these Agency decisions are more obviously explained as legal errors in the application of valid regulations than the product of a nationwide covert policy to deny Medicare coverage on an unlawful basis. The Secretary argues that the court must consider this obvious alternative basis and find Plaintiffs’ claim implausible in the face of more likely and reasonable explanations.

The court cannot conclude as a matter of law that Plaintiffs’ Improvement Standard theory is factually implausible when it is supported by at least some evidence in each of the Individual Plaintiffs’ cases and where other plaintiffs have successfully demonstrated the use of illegal presumptions and rules of thumb much like Plaintiffs allege here. “Asking for plausible grounds to infer [application of the Improvement Standard] does not impose a probability requirement at the pleading stage; it simply calls for enough fact to raise a reasonable expectation that discovery will reveal evidence of [the Improvement Standard’s existence].” Bell Atl. Corp. v. Twombly, 550 U.S. 544, at 556 (2007). The Amended Complaint contains factual allegations beyond mere “labels and conclusions” coupled with a “formulaic recitation of the elements of a cause of action[,]” Twombly, 550 U.S. at 555, and “more than an unadorned, the-defendant-unlawfully-harmed-me accusation.” Ashcroft v. Iqbal, 129 S.Ct. 1937, 1949 (2009). The Secretary’s motion to dismiss for failure to allege a plausible claim of relief is therefore denied.


Under the settlement, HHS promised to revise major portions of the Medicare Benefit Policy Manual to specify the use of a “maintenance coverage standard” rather than an “Improvement Standard” as cited in the claims, in the case of skilled nursing, home health, inpatient rehabilitation, and outpatient therapy services. In the case of skilled nursing care, for example, the settlement states that the revisions will clarify that . . . coverage does not turn on the presence or absence of an individual’s potential for improvement from . . . care, but rather on the beneficiary’s need for . . . care. The manual revisions will clarify that . . . services are covered when an individualized assessment of the patient’s clinical condition demonstrates that the specialized, judgment, knowledge, and skills of a registered nurse . . . are necessary.

Settlement Agreement, (filed 10/16/2012) p. 12-13. Similar changes were promised in the case of the other covered services addressed in the Settlement Agreement. In addition, HHS promised to undertake an “educational campaign” aimed at contractors, adjudicators, and providers and suppliers to explain the agency’s shift in policy. (Agreement, p. 14). A CMS fact sheet explaining the scope and breadth of the settlement was posted at the website of the Center for Medicare Advocacy, one of the lead plaintiffs in the case. http://www.medicareadvocacy.org/jimmo-v-sebelius-the-improvement-standard-case-faqs/ (Accessed online, July 13, 2013). No study has yet been conducted to evaluate the financial or health impact of the agreement or the course of compliance with its terms.

Note the similarities between Jimmo and the earlier cases in Part Two that deal with the use of concealed criteria, including Mondry and Bedrick. But unlike Jimmo, in Mondry and Bedrick there was nothing inherently unlawful about an insurer’s decision to exclude treatments that do not improve health, as long as, in applying such standards, the plan administrator was faithful to the terms of the plan and made information about coverage limitations available to plan participants and beneficiaries. In the case of Medicare, however, Congress actually established a substantive standard of coverage that does not take the ability to improve into account. Note, by contrast, that in defining “essential health benefits” for purposes of the coverage standards that will regulate the individual and small group insurance markets beginning in 2014 (PPACA §1302), Congress chose to simply list 10 classes of benefits, devoid of any definitions whatsoever either for individual benefits or for the general medical necessity standard under which coverage determinations will be made.

What would your assumption be, going forward, about the use of improvement as a standard of coverage under health plans subject to the essential health benefit coverage rules, and why?

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Chapter 11 Medicaid

On page 532 just before (c) add the following new paragraph:

With regard to the right to use section 1983 to enforce provisions of the Medicaid Act, see the previous discussion in this Update regarding litigation under the free-choice of provider and family planning services provisions and the split among the circuits, possibly setting the stage for the Supreme Court to address the issue of private rights of action in the next Term.

Delete the material beginning on page 532 at (c) and running through page 552, up to “8.,” and insert the following material:


(1) Introduction

Medicaid creates an enforceable right in eligible individuals to “medical assistance” as defined under federal law. 42 U.S.C. §§1396a(a)(10) and 1396d. But as discussed in the previous subsection, the scope of Medicaid “rights” enforceable under §1983 is narrow, particularly in relation to the vast array of provisions in the Medicaid statute that impose obligations on states as a condition of federal funding.

Among the many duties that states must agree to perform are numerous requirements that obligate them to ensure that health care is accessible. Medicaid’s access provisions are important because of the vulnerabilities of Medicaid beneficiaries; and they are provisions that have no counterpart in private health insurance. For example, states must act “promptly” not only to determine eligibility for benefits but also to actually furnish covered health care services. 42 U.S.C. §1396a(a)(8). States also must use reasonable standards in determining eligibility and the extent of medical assistance, 42 U.S.C. §1396a(17)(A), and must permit beneficiaries to choose among “qualified providers” of covered services. 42 U.S.C. §1396a(a)(23).

Additionally, as explored below in Armstrong v Exceptional Child Center Inc., 135 S. Ct. 1378 (2015), states must pay providers at a rate that is sufficient to ensure that “care services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” 42 U.S.C. §1396a(a)(30)(A). Despite this requirement, which is commonly referred to as the “equal access” statute, Medicaid provider payment rates are very low compared with those paid by Medicare and private plans, and the federal government has done virtually nothing over the years to force states to raise them. The relatively low payments are considered a key (although by no means the only) factor in reduced provider participation in Medicaid. Sara Rosenbaum, Medicaid Payments and Access to Care, 371 NEW ENG. J. MED. 2345 (Dec. 24, 2014).
As we have seen in the previous subsection, these federal obligations may or may not constitute federally enforceable “rights” under 42 U.S.C. §1983. (The courts have varied in the answer to this question as enforcement cases have arisen). See National Health Law Program, THE ADVOCATE’S GUIDE TO THE MEDICAID PROGRAM (2011); Rochelle Bobroff, Section 1983 and Preemption: Alternative Means of Court Access for Safety Net Statutes, 10 LOYOLA J. PUB. INTEREST L. 28 (2008). But together, the access requirements go to the heart of Medicaid’s original and enduring purpose, namely, to help promote beneficiaries’ access to “mainstream” health care. Robert & Rosemary Stevens, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID (1974); Sara Rosenbaum, Medicaid and Access to Health Care: A Proposal for Continued Inaction?, 365 NEW ENG. J. MED. 102 (2011). Nonetheless, federal administrative enforcement of these obligations is seriously limited. In briefs filed with the United States Supreme Court in Armstrong, both Members of Congress and former HHS officials acknowledged that Congress never has appropriated the funding necessary to put in place the personnel and technology to assure effective oversight by HHS. Members of Congress further argued that lawmakers always have assumed that, unless they are explicitly displaced, the equity powers of the courts are available to private litigants as an additional, non-administrative remedy for state violations of federal law. See, Armstrong, Brief of Former HHS Officials as Amici Curiae in Support of Respondents (December 23, 2014); Brief of Members of Congress as Amici Curiae in Favor of Respondents (December 24, 2014).

The question thus becomes whether beneficiaries or providers, faced with what they believe is an ongoing violation of the law by a state, can take matters into their own hands and seek judicial relief in the form of an injunction against continued unlawful conduct while the merits of their claims are resolved. The question is particularly important in the case of Medicaid, since the statute gives neither providers nor beneficiaries a means of putting their claims before the HHS Secretary through an administrative hearing process. Nor does the HHS Secretary have the power to grant an injunction against an unlawful state Medicaid practice pending a final ruling. The Secretary might be able to threaten the state with an enforcement action of her own, but she cannot compel a state to act or to cease unlawful actions while she decides the underlying issues.

Even if providers and beneficiaries have the right to seek a preliminary injunction, they will not necessarily prevail. For a court to grant an injunction against an alleged ongoing violation, it must find not only continuing harm to plaintiffs, but also a likelihood of success on the merits, i.e., that the plaintiffs’ claim is a credible one. Furthermore the court must find that, after balancing the potential for harm to the plaintiffs against that facing the defendants if an injunction is issued, equity cuts in the plaintiff’s direction. Only when these findings are made will a court issue a preliminary injunction against a defendant while the underlying merits are litigated. Indeed, as Justice Sotomayor noted in her Armstrong dissent, state Medicaid officials have prevailed in many “equal access” cases, but this fact should not distract from the initial inquiry as to the jurisdiction of the courts to begin with.
Often simply maintaining the status quo for a while may be all that is needed. For example, in *Douglas v Independent Living Center of Southern California*, 132 S. Ct. 1204 (2012) (the predecessor “equal access” case to *Armstrong*), severe budget constraints caused California to deeply cut its Medicaid provider payment rates. What the successful providers and beneficiaries sought (and got) in *Douglas* was an injunction that essentially amounted to a holding pattern (payment at the old Medicaid payment rates) until the worst of the crisis passed. What California wanted was the freedom to realize some immediate budget savings in the face of a fiscal crisis. (The trial court concluded that the plaintiffs had the potential to win on the merits given the standard for reviewing equal access claims previously established by the Ninth Circuit Court of Appeals in *Orthopaedic Hospital v. Belshe*, 103 F.3d 1491 (1997). It further concluded that the possible dangers to the health of beneficiaries—severely disabled state residents—from cutting payment rates to their institutional providers outweighed the risks to the state, which obviously had a range of budgetary and revenue choices that did not involve the possibility of threats to health facing the state’s most vulnerable residents). By the time the *Douglas* litigation was completed—years later—the crisis had passed.

The question of whether courts can hear private claims involving ongoing state violations of federal law clearly is not unique to Medicaid. Indeed, it is one of the most important constitutional questions in U.S. law, one that concerns the nature of the federal union itself. Dozens of landmark cases have begun as efforts by private actors to halt state action that is alleged to violate federal law. The most notable, perhaps, is *Ex parte Young*, 209 U.S. 123 (1908), which is best remembered as the case that raises the question of whether state officers can be sued in their official capacity without violating the Eleventh Amendment to the U.S. Constitution. But *Young* also deals with an underlying question, namely, whether courts can use their equity powers to intervene in cases in which private parties claim that state actions violate federal laws (in this case, whether Minnesota’s railroad tariffs allegedly violated the U.S. Constitution).

In the context of modern social welfare litigation, this question takes the form of whether federal courts can intervene in private actions brought to enforce federal conditions of participation for states that seek federal funding under programs established by Congress pursuant to the Spending Clause. For years the presumed answer was “yes,” courts could employ their equity powers to protect a Spending Clause program’s intended beneficiaries. One would have thought that this presumption was nullified by *Alexander v Sandoval*, 532 U.S. 275 (2001), discussed in Part One, in which the Supreme Court made clear that in cases involving federal “rights,” private actions were impermissible without an express right of action, such as one under 42 U.S.C. §1983. Yet cases continued despite the lack of clear Congressional authorization, on the theory that where the claim is that official state conduct violates federal law, a private right of action arises directly under the Supremacy Clause to the U.S. Constitution.

For example in *Pharmaceutical Research and Manufacturers of America v. Walsh*, 538 U.S. 644 (2003), decided only two years after *Sandoval*, drug manufacturers claimed, among other things, that Maine’s use of the Medicaid prior authorization requirement to obtain discounts on drugs violated federal Medicaid requirements governing coverage of
prescribed drugs. (They lost). Without commenting on whether the companies had the right to go to court to enjoin Maine’s actions to begin with, the Court upheld Maine’s law. But in his lone concurrence, Justice Thomas raised this question:

I make one final observation with respect to petitioner’s pre-emption claim. The Court has stated that Spending Clause legislation is much in the nature of a contract. This contract analogy raises serious questions as to whether third parties may sue to enforce Spending Clause legislation—through pre-emption or otherwise. In contract law, a third party to the contract (as petitioner is here) may only sue for breach if he is the “intended beneficiary” of the contract. When Congress wishes to allow private parties to sue to enforce federal law, it must clearly express this intent. Under this Court’s precedents, private parties may employ 42 U.S.C. §1983 or an implied private right of action only if they demonstrate an unambiguously conferred right. Respondents quite obviously cannot satisfy this requirement and therefore arguably [are] not entitled to bring a pre-emption lawsuit as a third-party beneficiary to the Medicaid contract. [W]ere the issue to be raised, I would give careful consideration to whether Spending Clause legislation can be enforced by third parties in the absence of a private right of action.

Pharmaceutical Research and Manufacturers Association v Walsh, 538 U.S. at 682-83. Justice Thomas made no mention of Ex parte Young.

In Douglas v Independent Living Center of Southern California, which the Court agreed to hear in the fall of 2011 in the face of dozens of Medicaid rate challenges brought by providers across the country, the issue of whether plaintiffs could seek equitable relief from the courts appeared to be squarely presented. But only a few weeks after oral argument, the HHS Centers for Medicare and Medicaid Services (CMS) (which administers Medicaid and Medicare), approved some of the rate reductions and disapproved others. As a result, the Court sought the views of the parties as to whether this CMS’ administrative enforcement stance changed anything. The answer was a resounding “no” since the question before the Court was the right of private parties to seek injunctive relief in advance of, rather than following, federal agency action.

Against this backdrop, the Court issued its decision. In a seeming judicial sleight of hand and without dismissing the claim as moot, Justice Breyer, writing for a five-member majority that included Justice Kennedy, ruled that circumstances had changed. As a result, the Court would no longer decide the very issue that formed the basis of its decision to hear the case to begin with, namely, “whether the Ninth Circuit properly recognized a Supremacy Clause action to enforce this federal statute before the agency took final action.” In Justice Breyer’s words, the “posture” of the case had shifted when CMS decided on the acceptability of the state rates because that decision constituted final agency action, which plaintiffs needed to challenge the administrative decision under the Administrative Procedure Act (“APA). Hence, according to the majority the plaintiffs could sue under the APA, not the Supremacy Clause. The Court opted to remand the case
back to the Ninth Circuit to allow the parties to argue their new theories of the case. In other words, the majority left open the question of whether the courts’ equitable powers could be invoked in the face of state Medicaid rate cuts that arguably violated federal law, despite the fact that the Medicaid statute itself created no right of action to bring such a case.

On the remand of Douglas from the Supreme Court, the Ninth Circuit got the message. In Managed Pharmacy Care v Sebelius, 716 F.3d 1235 (2013), the court, sitting en banc, permitted the California cuts to proceed on the ground that the broad and ambiguous language of the Medicaid statute’s equal access requirement called for the expertise of agency personnel to determine whether the state’s reductions in fact satisfied federal Medicaid requirements. In this case, HHS had done just that. Applying the deference standard established by the Court in Chevron v Natural Resources Defense Council, 468 U.S. 1227 (1984), the Ninth Circuit refused to substitute its judgment for that of the agency, concluded that the agency’s actions deserved deference (in marked contrast to the trial court, which found no evidence in the record of careful agency review) and denied further injunctive relief. The court left to another day the question of whether, pending federal agency review, private parties could seek injunctive relief.

(2) Armstrong v Exceptional Child Center

This, then, was the backdrop to Armstrong, which reached the Court only three years after Douglas, as the Court once again agreed to decide the question of whether plaintiffs can get to court when the claim involves state violation of the Medicaid equal access statute. Armstrong involved payments to Idaho institutions serving severely disabled children. CMS had approved a specific payment formula for these nursing facilities, but the Idaho legislature never appropriated the funds necessary to increase payments to the CMS-approved level. Without this increase, of course, the state plan was in violation of federal law, thereby exposing the state to the denial of federal Medicaid funding. As usual, however, the federal government took no action. Unlike Douglas, in which the power of a state to reduce payments was the precipitating event for the action, Armstrong involved a state’s failure to pay at the approved federal rate. Indeed, children continued to receive care; unlike the situation in Douglas, there was no allegation of imminent harm to patients.

Armstrong v Exceptional Child Center, Inc.

135 S.Ct. 1378 (2015)

Justice SCALIA delivered the opinion of the Court, except as to Part IV.

We consider whether Medicaid providers can sue to enforce §(30)(A) of the Medicaid Act. 42 U.S.C. §1396a(a)(30)(A).
I

Medicaid is a federal program that subsidizes the States’ provision of medical services to “families with dependent children and of aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services.” Like other Spending Clause legislation, Medicaid offers the States a bargain: Congress provides federal funds in exchange for the States’ agreement to spend them in accordance with congressionally imposed conditions.

In order to qualify for Medicaid funding, the State of Idaho adopted, and the Federal Government approved, a Medicaid “plan,” which Idaho administers through its Department of Health and Welfare. Idaho’s plan includes “habilitation services”—in-home care for individuals who, “but for the provision of such services . . . would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan,” [42 U.S.C.] §1396n(c) and (c)(1). Providers of these services are reimbursed by the Department of Health and Welfare.

Section 30(A) of the Medicaid Act requires Idaho’s plan to:

provide such methods and procedures relating to the utilization of, and the payment for, care and services available under the plan . . . as may be necessary to safeguard against unnecessary utilization of such care and services and to assure that payments are consistent with efficiency, economy, and quality of care and are sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area....”

Respondents are providers of habilitation services to persons covered by Idaho’s Medicaid plan. They sued petitioners in the United States District Court for the District of Idaho, claiming that Idaho violates §30(A) by reimbursing providers of habilitation services at rates lower than §30(A) permits. They asked the court to enjoin petitioners to increase these rates.

The District Court entered summary judgment for the providers, holding that Idaho had not set rates in a manner consistent with §30(A). The Ninth Circuit affirmed. It said that the providers had an implied right of action under the Supremacy Clause to seek injunctive relief against the enforcement or implementation of state legislation. We granted certiorari.

II

The Supremacy Clause reads:
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.

It is apparent that this Clause creates a rule of decision: Courts “shall” regard the “Constitution,” and all laws “made in Pursuance thereof,” as “the supreme Law of the Land.” They must not give effect to state laws that conflict with federal laws. It is equally apparent that the Supremacy Clause is not the source of any federal rights, and certainly does not create a cause of action. It instructs courts what to do when state and federal law clash, but is silent regarding who may enforce federal laws in court, and in what circumstances they may do so.

Additionally, it is important to read the Supremacy Clause in the context of the Constitution as a whole. Article I vests Congress with broad discretion over the manner of implementing its enumerated powers, giving it authority to “make all Laws which shall be necessary and proper for carrying [them] into Execution.” It is unlikely that the Constitution gave Congress such broad discretion with regard to the enactment of laws, while simultaneously limiting Congress’s power over the manner of their implementation, making it impossible to leave the enforcement of federal law to federal actors. If the Supremacy Clause includes a private right of action, then the Constitution requires Congress to permit the enforcement of its laws by private actors, significantly curtailing its ability to guide the implementation of federal law. It would be strange indeed to give a clause that makes federal law supreme a reading that limits Congress’s power to enforce that law, by imposing mandatory private enforcement—a limitation unheard-of with regard to state legislatures.

To say that the Supremacy Clause does not confer a right of action is not to diminish the significant role that courts play in assuring the supremacy of federal law. For once a case or controversy properly comes before a court, judges are bound by federal law. And, as we have long recognized, if an individual claims federal law immunizes him from state regulation, the court may issue an injunction upon finding the state regulatory actions preempted. Ex parte Young, 209 U.S. 123, 155–156 (1908).

Respondents contend that our preemption jurisprudence—specifically, the fact that we have regularly considered whether to enjoin the enforcement of state laws that are alleged to violate federal law—demonstrates that the Supremacy Clause creates a cause of action for its violation. They are incorrect. It is true enough that we have long held that federal courts may in some circumstances grant injunctive relief against state officers who are violating, or planning to violate, federal law. But that has been true not only with respect to violations of federal law by state officials, but also with respect to violations of federal law by federal officials. Thus, the Supremacy Clause need not be (and in light of our textual analysis above, cannot be) the explanation. What our cases demonstrate is that, in a proper case, relief may be given in a court of equity to prevent an injurious act by a public officer.
The ability to sue to enjoin unconstitutional actions by state and federal officers is the creation of courts of equity, and reflects a long history of judicial review of illegal executive action, tracing back to England. It is a judge-made remedy, and we have never held or even suggested that, in its application to state officers, it rests upon an implied right of action contained in the Supremacy Clause. That is because, as even the dissent implicitly acknowledges it does not. The Ninth Circuit erred in holding otherwise.

III
A

We turn next to respondents’ contention that, quite apart from any cause of action conferred by the Supremacy Clause, this suit can proceed against Idaho in equity. The power of federal courts of equity to enjoin unlawful executive action is subject to express and implied statutory limitations. Seminole Tribe of Fla. v. Florida, 517 U.S. 44, 74 (1996). In our view the Medicaid Act implicitly precludes private enforcement of §30(A), and respondents cannot, by invoking our equitable powers, circumvent Congress’s exclusion of private enforcement.

Two aspects of §30(A) establish Congress’s “intent to foreclose” equitable relief. First, the sole remedy Congress provided for a State’s failure to comply with Medicaid’s requirements—for the State’s “breach” of the Spending Clause contract—is the withholding of Medicaid funds by the Secretary of Health and Human Services. 42 U.S.C. § 1396c. [T]he express provision of one method of enforcing a substantive rule suggests that Congress intended to preclude others.

The provision for the Secretary’s enforcement by withholding funds might not, by itself, preclude the availability of equitable relief. But it does so when combined with the judicially unadministrable nature of §30(A)’s text. It is difficult to imagine a requirement broader and less specific than §30(A)’s mandate that state plans provide for payments that are “consistent with efficiency, economy, and quality of care,” all the while “safeguard[ing] against unnecessary utilization of . . . care and services.” Explicitly conferring enforcement of this judgment-laden standard upon the Secretary alone establishes, we think, that Congress wanted to make the agency remedy that it provided exclusive,” thereby achieving “the expertise, uniformity, widespread consultation, and resulting administrative guidance that can accompany agency decisionmaking,” and avoiding “the comparative risk of inconsistent interpretations and misincentives that can arise out of an occasional inappropriate application of the statute in a private action.” The sheer complexity associated with enforcing §30(A), coupled with the express provision of an administrative remedy, §1396c, shows that the Medicaid Act precludes private enforcement of §30(A) in the courts.

B

The dissent agrees with us that the Supremacy Clause does not provide an implied right of action, and that Congress may displace the equitable relief that is traditionally
available to enforce federal law. It disagrees only with our conclusion that such displacement has occurred here.

The dissent insists that, “because Congress is undoubtedly aware of the federal courts’ long-established practice of enjoining preempted state action, it should generally be presumed to contemplate such enforcement unless it affirmatively manifests a contrary intent.” But a “long-established practice” does not justify a rule that denies statutory text its fairest reading. Section 30(A), fairly read in the context of the Medicaid Act, displays an intent to foreclose the availability of equitable relief. We have no warrant to revise Congress’s scheme simply because it did not “affirmatively” preclude the availability of a judge-made action at equity.

Equally unavailing is the dissent’s reliance on §30(A)’s history. Section 30(A) was amended, on December 19, 1989, to include what the dissent calls the “equal access mandate,” the requirement that reimbursement rates be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” There existed at the time another provision, known as the “Boren Amendment,” that likewise imposed broad requirements on state Medicaid plans. 42 U.S.C. §1396a(a)(13)(A). Lower courts had interpreted the Boren Amendment to be privately enforceable under §1983. From this, the dissent infers that, when Congress amended §30(A), it could not “have failed to anticipate” that §30(A)’s broad language—or at least that of the equal access mandate—would be interpreted as enforceable in a private action. Thus, concludes the dissent, Congress’s failure to expressly preclude the private enforcement of §30(A) suggests it intended not to preclude private enforcement.

This argument appears to rely on the prior-construction canon; the rule that, when “judicial interpretations have settled the meaning of an existing statutory provision, repetition of the same language in a new statute” is presumed to incorporate that interpretation. But that canon has no application here. The language of the two provisions is nowhere near identical; and even if it had been, the question whether the Boren Amendment permitted private actions was far from “settled.” When Congress amended §30(A) in 1989, this Court had already granted certiorari to decide, but had not yet decided, whether the Boren Amendment could be enforced through a §1983 suit. Our decision permitting a §1983 action did not issue until June 14, 1990—almost six months after the amendment to §30(A). Wilder v Virginia Hospital Association, 496 U.S. 498. The existence of a granted petition for certiorari demonstrates quite clearly that the question whether the Boren Amendment could be privately enforced was unsettled at the time of §30(A)’s 1989 amendment—so that if Congress was aware of the parallel (which is highly doubtful) the course that awareness would have prompted (if any) would not have been legislative silence but rather express specification of the availability of private enforcement (if that was what Congress intended).

Finally, the dissent speaks as though we leave these plaintiffs with no resort. That is not the case. Their relief must be sought initially through the Secretary rather than through the courts. The dissent’s complaint that the sanction available to the Secretary
(the cut-off of funding) is too massive to be a realistic source of relief seems to us mistaken. We doubt that the Secretary’s notice to a State that its compensation scheme is inadequate will be ignored.

IV

The last possible source of a cause of action for respondents is the Medicaid Act itself. They do not claim that, and rightly so. Section 30(A) lacks the sort of rights-creating language needed to imply a private right of action. It is phrased as a directive to the federal agency charged with approving state Medicaid plans, not as a conferral of the right to sue upon the beneficiaries of the State’s decision to participate in Medicaid. [T]he explicitly conferred means of enforcing compliance with §30(A) by the Secretary’s withholding funding, §1396c, suggests that other means of enforcement are precluded.

Spending Clause legislation like Medicaid “is much in the nature of a contract.” Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17 (1981). The notion that respondents have a right to sue derives, perhaps, from the fact that they are beneficiaries of the federal-state Medicaid agreement, and that intended beneficiaries, in modern times at least, can sue to enforce the obligations of private contracting parties. We doubt, to begin with, that providers are intended beneficiaries (as opposed to mere incidental beneficiaries) of the Medicaid agreement, which was concluded for the benefit of the infirm whom the providers were to serve, rather than for the benefit of the providers themselves. More fundamentally, however, the modern jurisprudence permitting intended beneficiaries to sue does not generally apply to contracts between a private party and the government. Our precedents establish that a private right of action under federal law is not created by mere implication, but must be unambiguously conferred. Nothing in the Medicaid Act suggests that Congress meant to change that for the commitments made under §30(A).

Justice BREYER, concurring in part and concurring in the judgment.

I join Parts I, II, and III of the Court’s opinion.

Like all other Members of the Court, I would not characterize the question before us in terms of a Supremacy Clause “cause of action.” Rather, I would ask whether federal courts may in [these] circumstances grant injunctive relief against state officers who are violating, or planning to violate, federal law. I believe the answer to this question is no.

That answer does not follow from the application of a simple, fixed legal formula separating federal statutes that may underlie this kind of injunctive action from those that may not. “[T]he statute books are too many, the laws too diverse, and their purposes too complex, for any single legal formula to offer” courts more than general guidance. Rather, I believe that several characteristics of the federal statute before us, when taken together, make clear that Congress intended to foreclose respondents from bringing this particular action for injunctive relief.
For one thing, as the majority points out, §30(A) of the Medicaid Act sets forth a federal mandate that is broad and nonspecific. But, more than that, §30(A) applies its broad standards to the setting of rates. The history of ratemaking demonstrates that administrative agencies are far better suited to this task than judges.

Reading §30(A) underscores the complexity and nonjudicial nature of the rate-setting task. The methods that a state agency, such as Idaho’s Department of Health and Welfare, uses to make this kind of determination may involve subsidiary determinations of, for example, the actual cost of providing quality services, including personnel and total operating expenses; changes in public expectations with respect to delivery of services; inflation; a comparison of rates paid in neighboring States for comparable services; and a comparison of any rates paid for comparable services in other public or private capacities.

At the same time, §30(A) applies broadly, covering reimbursements provided to approximately 1.36 million doctors, serving over 69 million patients across the Nation. And States engage in time-consuming efforts to obtain public input on proposed plan amendments. I recognize that federal courts have long become accustomed to reviewing for reasonableness or constitutionality the rate-setting determinations made by agencies. But this is not such an action. Instead, the lower courts here required the State to set rates that approximate the cost of quality care provided efficiently and economically. To find in the law a basis for courts to engage in such direct rate-setting could set a precedent for allowing other similar actions, potentially resulting in rates set by federal judges (of whom there are several hundred) outside the ordinary channel of federal judicial review of agency decisionmaking. The consequence, I fear, would be increased litigation, inconsistent results, and disorderly administration of highly complex federal programs that demand public consultation, administrative guidance and coherence for their success. I do not believe Congress intended to allow a statute-based injunctive action that poses such risks (and that has the other features I mention).

I recognize that courts might in particular instances be able to resolve rate-related requests for injunctive relief quite easily. But I see no easy way to separate in advance the potentially simple sheep from the more harmful rate-making goats. In any event, this case, I fear, belongs in the latter category. For another thing, like the majority, I would ask why, in the complex rate-setting area, other forms of relief are inadequate. If the Secretary of Health and Human Services concludes that a State is failing to follow legally required federal rules, the Secretary can withhold federal funds. If withholding funds does not work, the federal agency may be able to sue a State to compel compliance with federal rules.

Moreover, why could respondents not ask the federal agency to interpret its rules to respondents’ satisfaction, to modify those rules, to promulgate new rules or to enforce old ones? See 5 U.S.C. §553(e). Normally, when such requests are denied, an injured party can seek judicial review of the agency’s refusal on the grounds that it is “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” And an
injured party can ask the court to compel agency action unlawfully withheld or unreasonably delayed.

I recognize that the law may give the federal agency broad discretionary authority to decide when and how to exercise or to enforce statutes and rules. As a result, it may be difficult for respondents to prevail on an APA claim unless it stems from an agency’s particularly egregious failure to act. But, if that is so, it is because Congress decided to vest broad discretion in the agency to interpret and to enforce §30(A). I see no reason for this Court to circumvent that congressional determination by allowing this action to proceed.

Justice SOTOMAYOR, with whom Justice KENNEDY, Justice GINSBURG, and Justice KAGAN join, dissenting.

Suits in federal court to restrain state officials from executing laws that assertedly conflict with the Constitution or with a federal statute are not novel. To the contrary, this Court has adjudicated such requests for equitable relief since the early days of the Republic. Nevertheless, today the Court holds that Congress has foreclosed private parties from invoking the equitable powers of the federal courts to require States to comply with §30(A) of the Medicaid Act. It does so without pointing to the sort of detailed remedial scheme we have previously deemed necessary to establish congressional intent to preclude resort to equity. Instead, the Court relies on Congress’ provision for agency enforcement of §30(A)—an enforcement mechanism of the sort we have already definitively determined not to foreclose private actions—and on the mere fact that §30(A) contains relatively broad language. As I cannot agree that these statutory provisions demonstrate the requisite congressional intent to restrict the equitable authority of the federal courts, I respectfully dissent.

That parties may call upon the federal courts to enjoin unconstitutional government action is not subject to serious dispute. Perhaps the most famous exposition of this principle is our decision in Ex parte Young, from which the doctrine derives its usual name. There, we held that the shareholders of a railroad could seek an injunction preventing the Minnesota attorney general from enforcing a state law setting maximum railroad rates because the Eleventh Amendment did not provide the officials with immunity from such an action and the federal court had the “power” in equity to grant a temporary injunction. This Court had earlier recognized similar equitable authority in Osborn v. Bank of United States in which a federal court issued an injunction prohibiting an Ohio official from executing a state law taxing the Bank of the United States. We affirmed in relevant part, concluding that the case was “cognizable in a Court of equity,” and holding it to be “proper” to grant equitable relief insofar as the state tax was “repugnant” to the federal law creating the national bank.
A suit, like this one, that seeks relief against state officials acting pursuant to a state law allegedly preempted by a federal statute falls comfortably within this doctrine. A claim that a state law contravenes a federal statute is basically constitutional in nature, deriving its force from the operation of the Supremacy Clause, and the application of preempted state law is therefore unconstitutional. McCulloch v. Maryland, 4 Wheat. 316, 436, (1819) (States have “no power” to enact laws interfering with “the operations of the constitutional laws enacted by Congress” is the “unavoidable consequence of that supremacy which the constitution has declared”; such a state law “is unconstitutional and void.” We have thus long entertained suits in which a party seeks prospective equitable protection from an injurious and preempted state law without regard to whether the federal statute at issue itself provided a right to bring an action. See [e.g.] Shaw v. Delta Air Lines, Inc., 463 U.S. 85, (1983) (state law preempted in part by the federal Employee Retirement Income Security Act of 1974) [numerous additional citations omitted]. Indeed, for this reason, we have characterized the availability of prospective relief of the sort awarded in Ex parte Young as giving life to the Supremacy Clause.

Thus, even though the Court is correct that it is somewhat misleading to speak of “an implied right of action contained in the Supremacy Clause,” that does not mean that parties may not enforce the Supremacy Clause by bringing suit to enjoin preempted state action. As the Court also recognizes, we have long held that federal courts may in some circumstances grant injunctive relief against state officers who are violating, or planning to violate, federal law.

B

Most important for purposes of this case is not the mere existence of this equitable authority, but the fact that it is exceedingly well established—supported, as the Court puts it, by a “long history.” Congress may, if it so chooses, either expressly or implicitly preclude Ex parte Young enforcement actions with respect to a particular statute or category of lawsuit. See, e.g., 28 U.S.C. § 1341 (prohibiting federal judicial restraints on the collection of state taxes); Seminole Tribe of Fla. v. Florida, 517 U.S. 44, 75–76, (1996) (comprehensive alternative remedial scheme can establish Congress’ intent to foreclose Ex parte Young actions). But because Congress is undoubtedly aware of the federal courts’ long-established practice of enjoining preempted state action, it should generally be presumed to contemplate such enforcement unless it affirmatively manifests a contrary intent. Unless a statute in so many words, or by a necessary and inescapable inference, restricts the court’s jurisdiction in equity, the full scope of that jurisdiction is to be recognized and applied.

In this respect, equitable preemption actions differ from suits brought by plaintiffs invoking 42 U.S.C. §1983 or an implied right of action to enforce a federal statute. Suits for “redress designed to halt or prevent the constitutional violation rather than the award of money damages” seek traditional forms of relief. By contrast, a plaintiff invoking §1983 or an implied statutory cause of action may seek a variety of remedies—including damages—from a potentially broad range of parties. Rather than simply pointing to background equitable principles authorizing the action that Congress presumably has not
overridden, such a plaintiff must demonstrate specific congressional intent to create a statutory right to these remedies. See Gonzaga Univ. v. Doe, 536 U.S. 273 (2002); Alexander v. Sandoval, 532 U.S. 275, 286 (2001); see also Golden State Transit Corp. v. Los Angeles, 493 U.S. 103, 114 (1989) (KENNEDY, J., dissenting) (Because a preemption claim does not seek to enforce a statutory right, “[t]he injured party does not need §1983 to vest in him a right to assert that an attempted exercise of jurisdiction or control violates the proper distribution of powers within the federal system”). For these reasons, the principles that we have developed to determine whether a statute creates an implied right of action, or is enforceable through §1983, are not transferable to the Ex parte Young context.

II

In concluding that Congress has “implicitly preclude[d] private enforcement of §30(A),” the Court ignores this critical distinction and threatens the vitality of our Ex parte Young jurisprudence. The Court identifies only a single prior decision—Seminole Tribe—in which we have ever discerned such congressional intent to foreclose equitable enforcement of a statutory mandate. Even the most cursory review of that decision reveals how far afield it is from this case.

In Seminole Tribe, the plaintiff Indian Tribe had invoked Ex parte Young in seeking to compel the State of Florida to “negotiate in good faith with [the] tribe toward the formation of a compact” governing certain gaming activities, as required by a provision of the Indian Gaming Regulatory Act. We rejected this effort, observing that “Congress passed [and had created within the Act a] carefully crafted and intricate remedial scheme. We concluded that Congress must have intended this procedural route to be the exclusive means of enforcing [the Act’s requirement that tribes and states negotiate gaming standards].

What is the equivalent “carefully crafted and intricate remedial scheme” for enforcement of §30(A)? The Court relies on two aspects of the Medicaid Act, but, whether considered separately or in combination, neither suffices.

First, the Court cites 42 U.S.C. §1396c, which authorizes the Secretary of Health and Human Services (HHS) to withhold federal Medicaid payments to a State in whole or in part if the Secretary determines that the State has failed to comply with the obligations set out in §1396a, including §30(A). But in striking contrast to the remedial provision set out in the Indian Gaming Regulatory Act, §1396c provides no specific procedure that parties actually affected by a State’s violation of its statutory obligations may invoke in lieu of Ex parte Young—leaving them without any other avenue for seeking relief from the State. Nor will §1396c always provide a particularly effective means for redressing a State’s violations: If the State has violated §30(A) by refusing to reimburse medical providers at a level “sufficient to enlist enough providers so that care and services are available” to Medicaid beneficiaries to the same extent as they are available to “the general population,” agency action resulting in a reduced flow of federal funds to that State will often be self-defeating. Far from rendering § 1396c “superfluous,” then, Ex
**parte Young** actions would seem to be an anticipated and possibly necessary supplement to this limited agency-enforcement mechanism. Indeed, presumably for these reasons, we recently rejected the very contention the Court now accepts, holding that “[t]he fact that the Federal Government can exercise oversight of a federal spending program and even withhold or withdraw funds . . . does not demonstrate that Congress has displayed an intent not to provide the more complete and more immediate relief that would otherwise be available under *Ex parte Young.*” Virginia Office for Protection and Advocacy v. Stewart, 563 U.S. 247 (2011).

Section 1396c also parallels other provisions scattered throughout the Social Security Act that likewise authorize the withholding of federal funds to States that fail to fulfill their obligations. See Maine v. Thiboutot, 448 U.S. 1, 6 (1980). Rosado v. Wyman, 397 U.S. 397 (1970) provides a fitting illustration. There, we considered a provision of the Social Security Act mandating that, in calculating benefits for participants in the Aid to Families with Dependent Children Program, States make adjustments to reflect fully changes in living costs. We expressed no hesitation in concluding that federal courts could require compliance with this obligation, explaining: “It is ... peculiarly part of the duty of this tribunal, no less in the welfare field than in other areas of the law, to resolve disputes as to whether federal funds allocated to the States are being expended in consonance with the conditions that Congress has attached to their use.” Id., at 422–423. We so held notwithstanding the existence of an enforcement provision permitting a federal agency to make a total or partial cutoff of federal funds.

Second, perhaps attempting to reconcile its treatment of §1396c with this longstanding precedent, the Court focuses on the particular language of §30(A), contending that this provision, at least, is so “judicially unadministrable” that Congress must have intended to preclude its enforcement in private suits. Ante, at 1385. Admittedly, the standard set out in §30(A) is fairly broad[. But mere breadth of statutory language does not require the Court to give up all hope of judicial enforcement—or, more important, to infer that Congress must have done so.

In fact, the contention that §30(A)’s language was intended to foreclose private enforcement actions entirely is difficult to square with the provision’s history. The specific equal access mandate invoked by the plaintiffs in this case—that reimbursement rates be “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area”—was added to §30(A) in 1989. At that time, multiple Federal Courts of Appeals had held that the so-called Boren Amendment to the Medicaid Act was enforceable pursuant to §1983—as we soon thereafter concluded it was. See *Wilder v. Virginia Hospital Assn.*, 496 U.S. 498 (1990). The Boren Amendment employed language quite similar to that used in §30(A), requiring that a state plan:

provide . . . for payment . . . of the hospital services, nursing facility services, and services in an intermediate care facility for the mentally retarded provided under the plan through the use of rates . . . which the State finds, and makes assurances satisfactory to the Secretary, are
reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care and services in conformity with applicable State and Federal laws, regulations, and quality and safety standards and to assure that individuals eligible for medical assistance have reasonable access ... to inpatient hospital services of adequate quality.” §1396a(a)(13)(A).

It is hard to believe that the Congress that enacted the operative version of §30(A) could have failed to anticipate that it might be similarly enforceable. Even if, as the Court observes, the question whether the Boren Amendment was enforceable under §1983 was “unsettled at the time,” surely Congress would have spoken with far more clarity had it actually intended to preclude private enforcement of §30(A) through not just §1983 but also Ex parte Young.

Of course, the broad scope of § 30(A)’s language is not irrelevant. But rather than compelling the conclusion that the provision is wholly unenforceable by private parties, its breadth counsels in favor of interpreting §30(A) to provide substantial leeway to States, so that only in rare and extreme circumstances could a State actually be held to violate its mandate. The provision’s scope may also often require a court to rely on HHS, which is “comparatively expert in the statute’s subject matter.” Douglas v. Independent Living Center of Southern Cal., Inc., 565 U.S. —— (2012). When the agency has made a determination with respect to what legal standard should apply, or the validity of a State’s procedures for implementing its Medicaid plan, that determination should be accorded the appropriate deference. Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984); Skidmore v. Swift & Co., 323 U.S. 134 (1944). And if faced with a question that presents a special demand for agency expertise, a court might call for the views of the agency, or refer the question to the agency under the doctrine of primary jurisdiction. See Rosado, 397 U.S., at 406–407; Pharmaceutical Research and Mfrs. of America v. Walsh, 538 U.S. 644, 673 (2003) (BREYER, J., concurring in part and concurring in judgment). Finally, because the authority invoked for enforcing § 30(A) is equitable in nature, a plaintiff is not entitled to relief as of right, but only in the sound discretion of the court. Given the courts’ ability to both respect States’ legitimate choices and defer to the federal agency when necessary, I see no basis for presuming that Congress believed the Judiciary to be completely incapable of enforcing §30(A).

* [Footnote in Justice Sotomayor’s opinion] That is not to say that the Court of Appeals in this case necessarily applied §30(A) correctly. Indeed, there are good reasons to think the court construed §30(A) to impose an overly stringent obligation on the States. While the Ninth Circuit has understood § 30(A) to compel States to “rely on responsible cost studies,” and to reimburse for services at rates that “approximate the cost of quality care provided efficiently and economically,” Orthopaedic Hospital v. Belshe, 103 F.3d 1491, 1496 (1997), other courts have read § 30(A) to require only that rates be high enough to ensure that services are available to Medicaid participants. See Pennsylvania Pharmacists Assn. v. Houstoun, 283 F.3d 531, 538 (C.A.3 2002); Evergreen Presbyterian Ministries, Inc. v. Hood, 235 F.3d 908, 928–929 (C.A.5 2000); Methodist Hospitals, Inc. v. Sullivan, 91 F.3d 1026, 1030 (C.A.7 1996). This Court declined to grant certiorari to address whether the Ninth Circuit’s reading of § 30(A) is correct. But Justice BREYER, in his concurrence, appears to mistake that question about the merits of the Ninth Circuit’s standard for the question this Court actually granted certiorari to address—that is, whether §30 is judicially enforceable at all. To answer that question, one need only recognize, as Justice BREYER does, that “federal courts have
In sum, far from identifying a “carefully crafted ... remedial scheme” demonstrating that Congress intended to foreclose Ex parte Young enforcement of §30(A), the Court points only to two provisions. The first is § 1396c, an agency-enforcement provision that, given our precedent, cannot preclude private actions. The second is §30(A) itself, which, while perhaps broad, cannot be understood to manifest congressional intent to preclude judicial involvement.

The Court’s error today has very real consequences. Previously, a State that set reimbursement rates so low that providers were unwilling to furnish a covered service for those who need it could be compelled by those affected to respect the obligation imposed by §30(A). Now, it must suffice that a federal agency, with many programs to oversee, has authority to address such violations through the drastic and often counterproductive measure of withholding the funds that pay for such services. Because a faithful application of our precedents would have led to a contrary result, I respectfully dissent.

Notes

1. What exactly did the Court hold? To answer this question, see how Justice Scalia, writing for the Court with the exception of his part IV, phrased the issue before the Court in part II. What does it tell you that Justice Breyer, providing the fifth vote, concurred in part II? On the other hand, what did Justice Breyer, to repeat, providing the fifth vote, say in his concurring opinion about phrasing the issue broadly to be the question whether the Supremacy Clause creates a private remedy? How could he write that and concur in part II of Justice Scalia’s opinion? Sometimes the Court seems to move in mysterious ways.

Justice Breyer also concurred in part III of the Court’s opinion. To what issue did that part pertain? Read very carefully Justice Breyer’s rationale for holding that no private right of action exists to invoke federal courts’ equitable powers to review state payment rates; and think back to his opinion in Douglas, discussed above. What would be the result if no review under the APA were available? Is it significant that Justice Breyer used the word “moreover” in the second to last paragraph of his opinion? Is Justice Breyer right that the APA affords complete relief analogous to a federal court’s equitable remedies? What actually happens on the ground when CMS approves state rates that are inadequate to pay providers to furnish services to Medicaid beneficiaries? How often, do you think, courts issue preliminary injunctions to enjoin federal agencies’ final actions? Is your answer affected by the Chevron doctrine of according deference to administrative decisions involving the exercise of discretion committed to the agencies? On the other hand, how extensive, do you think, is the typical record on which CMS reviews state rates and how detailed, do you think, typically is their analysis? See also notes 3 and 4 below.

long become accustomed to reviewing for reasonableness or constitutionality the rate-setting determinations made by agencies.” A private party who invokes the jurisdiction of the federal courts in order to enjoin a state agency’s implementation of rates that are so unreasonably low as to violate §30(A) seeks a determination of exactly this sort.
Finally, what was the point of Justice Scalia’s part IV? How many members of the Court are currently willing to deny the existence of any private remedy to enforce the requirements of a program created under the Spending Clause if the statutory provision, allegedly disobeyed by a state, doesn’t expressly provide both an enforceable right and a private cause of action for express remedies?

2. Separating the merits from the right of action. It is true that Armstrong involved the threshold question of whether plaintiffs had a right to bring their case at all, and the dissent does an admirable job of separating the right to sue from the merits of the claims themselves. But does the majority have a point that in a world in which the need for an express right of action (at least in Spending Clause cases) is now assumed, the very nature of a particular statute might tip the balance away from recognizing a claim? Here the issue is setting provider rates for an insurance program administered by 51 separate jurisdictions (more if the territories are included) and involving a massive array of health care for 70 million people.

Should we expect that if Congress wants to enable litigation against states in such cases it will expressly say so? But on the other hand, should we assume that, in a law of such magnitude—70 million people!!—and with so much at stake—the health of some of the nation’s most vulnerable residents—Congress really would expect state accountability to rest exclusively on an underfinanced, politically emasculated federal agency that simply sat there while Idaho underpaid providers of care for some of the state’s most medically complex children? Indeed, HHS officials opposed the position taken by the Solicitor General in Douglas, arguing that private lawsuits actually helped them identify noncompliant states. Nicole Huberfeld, The Supreme Court Ruling that Blocked Providers From Seeking Higher Medicaid Payments Also Undercut the Entire Program, 34 HEALTH AFFAIRS 1156 (July 2015). The question is especially compelling given (a) the underlying legal entitlement to coverage among the children; (b) the Congressional member brief in Armstrong pointing out that they relied on judicial doctrine of equitable relief in shaping the 1989 amendments; and (c) the former HHS officials brief pointing out that they had no means of enforcing the law in an effective situation.

Think more about this question in light of current doctrine regarding implied private remedies. As we discussed above, in Gonzaga the court unequivocally held that the lack of an express right of action was fatal to use of §1983 as a remedy. Notice that the dissenters use the complete absence of such a remedy as a sword for the plaintiff’s attempt to invoke federal courts’ power in equity to enforce federal law. Does it make doctrinal sense to use the paucity of an express statutory cause of action to defeat an implied cause of action under §1983, while simultaneously using that lacuna to divine the existence of a private cause of action derived from some other source? Notice how hard the dissenters worked to distinguish between §1983 as a remedy and invoking the federal courts’ equitable powers as a remedy. In drawing that distinction, is it relevant that §1983 allows for damages while damages were not traditionally an equitable remedy? Notice, in any event, that the dissenters only had four votes.
Nonetheless, return to the second paragraph of the previous note. All opinions did discuss the possibility of a private cause of action based on federal courts’ powers in equity, and no one had the audacity to call into question Ex parte Young. Does the holding then boil down to the question of when Ex parte Young applies and when it does not? See the rest of these notes!

3. An “unadministrable” statute. Is Justice Scalia correct? This is, after all, simply a rate-setting case, and rate-setting cases have long been a feature of Medicaid. See Jane Perkins, “Armstrong v. Exceptional Child—The Supreme Court’s “Fairest Reading” Really Isn’t Fair, Georgetown University Health Policy Institute (April 17, 2015), http://ccf.georgetown.edu/all/armstrong-v-exceptional-child-supreme-courts-fairest-reading-really-isnt-fair/ (accessed July 7, 2015). No matter whether the case is brought prior or after the rate problem arises, it is still a rate-setting case.

Think about it. According to the Court, the post-Armstrong litigation strategy in a Medicaid rate-setting case would appear to be an Administrative Procedure Act against the HHS Secretary in the event that she approves payment rates that violate the statute’s broad, two-pronged test: payments that are “consistent with efficiency, economy, and quality of care”; and are “sufficient to enlist enough providers so that care and services are available under the plan at least to the extent that such care and services are available to the general population in the geographic area.” To mount such a case would require extensive expert testimony of the type needed in all types of rate-setting cases, that is, expert testimony on long-term care ratesetting, as well as, perhaps, testimony regarding the health and social impact of rates that are too low, as well as testimony on the market behavior of the long term care industry generally. Long-term care ratesetting experts presumably would opine on the methodology needed to set a long term care rate for severely disabled beneficiaries. Experts who specialize in the sub-field of long term care services might testify to the additional costs that arise when such patients are children. Experts would testify on the potential health and health care impact of rates that are too low, and on the expected market response to deficient rates and the closures that might ensue.

In other words, we are describing a piece of complex litigation involving the sufficiency of a payment rate. True, such a lawsuit would be a difficult one. But is it “unadministrable”? Isn’t the only question whether the status quo is maintained while the litigation is going on? Sara Rosenbaum and Timothy Westmoreland, The Armstrong v Exceptional Child, Inc. Payment Case: Now What? HEALTH AFFAIRS (blog) http://healthaffairs.org/blog/2015/04/30/the-armstrong-v-exceptional-child-inc-medicaid-payment-case-now-what/

4. What if patients had brought the case? Armstrong involved a provider challenge, but Justice Breyer’s reasoning (to reiterate, he was, of course, the crucial fifth vote) does not seem to distinguish between patients and providers. He just seems unable to wrap his mind around a legal interpretation of the Medicaid equal access statute that allows what he fears will be unending private challenges to low state payment rates of all kinds. For this reason, he is not opposed to any judicial remedy, but like Justices Scalia,
Alito, Thomas and the Chief Justice, he opposes preliminary injunctive relief, at least when plaintiffs have recourse to obtaining judicial review of final administrative actions under the APA. In this context, think about *Illinois Council on Long Term Care v Shalala* (Textbook pp. 483-84). It is the case that the Medicare statute’s explicit federal jurisdictional bar typically would prevent either beneficiaries or providers from seeking an injunction against Medicare nursing home payment cutoffs on the grounds that forcing them to litigate the legality of the Secretary’s action after the fact would cause irreparable injury. Is there a reason why from a policy or jurisprudential perspective, a bar against federal jurisdiction should be acceptable in the case of Medicare, but courts should retain the flexibility to intercede in Medicaid rate cases at an early point? Does Medicare’s status as a universal legal entitlement—as opposed to Medicaid’s status as a program targeted to the poorest and most vulnerable patients—have any relevance?

5. What does it take to foreclose a judicial remedy? In Medicare payment cases, Congress has been explicit about its desire to avoid judicial interference early in the process; by contrast, in the Medicaid statute Congress is silent regarding the power of the courts to intervene. As Justice Sotomayor notes, lawmakers in their brief stressed their reliance on the law as it stood in 1989, prior to the Court’s aggressive efforts to curtail access to equitable relief in Spending Clause cases. Justice Sotomayor further drew the key distinction between the legal theory advanced by Justice Scalia—a sort of sneak attack on courts’ equity powers by means of a complex statute that takes real work to interpret and apply—and a situation such as that found in *Seminole Tribe*, in which Congress laid out a detailed remedial scheme to be followed. In Medicaid, of course, there is no such detailed remedial scheme indeed, there is nothing except for the Secretary’s own enforcement powers, accompanied by silence. This silence was enough for the majority, and it was also enough for the Solicitor General, who sided with the states.

6. How far will the Armstrong principle extend? Is Armstrong *sui generis*, explained simply by the fact that Breyer was willing to go down this path in the context of a rate-setting case but perhaps not again? From beneficiaries’ perspective, many crucial aspects of federal Medicaid law are expressed as commands on states rather than as rights in individuals. Examples are states’ obligations to accept applications from all individuals wishing to apply and to determine eligibility with reasonable promptness, (42 U.S.C. §1396a(a)(8)), states’ obligations to furnish fair hearings to individuals adversely affected by a state decision, 42 U.S.C. §1396a(a)(4), and states’ obligations to operate their programs on a statewide basis and to offer “comparable” coverage for all categorically needy beneficiary groups. 42 U.S.C. §1396a(a)(10). Any of these commands can—and have been—violated. Resolving legal disputes arising around their violation can be complex. Would a state now be able to cease accepting Medicaid applications with impunity, safe in the knowledge that beneficiaries will not be able to even seek an injunction against such lawless conduct, much less obtain one? Do you think that such a situation causes the federal government to more energetically enforce the law, especially if HHS officials are continuously deluged by Congressional staff furious over the administrative burdens that Medicaid is causing their state?
7. So, what is the holding of the Court, i.e., when does Ex parte Young apply and when does it not? Make a list of the factors mentioned in the reasoning of each opinion. Did they disagree on the relevance of Congress’s intent to preclude plaintiffs’ invocation of federal court’s power in equity, i.e., Ex parte Young? Do they disagree on the factors that go into ascertaining that intent? Does each opinion discuss the existence and adequacy of federal enforcement in the statute, the withholding federal funds? Does each discuss legislative history and the existence, or lack thereof, of adequate alternative recourse, such as lobbying CMS or using the APA? Does each opinion discuss whether Congress provided a comprehensive remedial scheme? (Does Justice Breyer claim that such a remedial scheme exists in this case?). Does each opinion discuss judicial competence to determine whether federal law is being violated by state action?

Chapter 12 Paying for Health Care

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Insert at textbook, p. 623 the following two Notes before heading #3:

Note on Observation Status, the Two-Midnight Rule, and Other Medicare Policies:
Fragmentation and Murphy’s Law

The recent legal and policy collisions flowing from the ambiguity of what is an “inpatient stay” for purposes of payment and various Medicare policies amply illustrates the complications caused by, and the consequences of, the fragmentation that exists among providers and different payment systems for different sites of care. The collisions also illustrate how hard it is to create payment reforms within a fractured health care system in which each segment essentially plays by its own set of rules.

The case in point concerns the recent increase in the practice by hospitals of classifying patients as being on “observation status.” In attempting to address the serious health and financial problems flowing from this practice—which itself is the result of payment reforms—the problem is a mash-up of several underlying factors: the different payment systems for Medicare’s Part A and Part B; the 3-day inpatient stay requirement for nursing home care; the audits conducted by Medicare contractors to ensure that an inpatient stay was reasonable and necessary; and the new penalties for readmissions. This strange brew has created substantial problems for providers, patients and regulators.
1. The definition of “observation status.”

Let’s begin with the definition of an “inpatient stay,” which is supposed to be distinct from “observation status.” A patient is an inpatient “if formally admitted as inpatient with the expectation that he or she will remain at least overnight and occupy a bed . . . ,” CMS, Medicare Benefit Policy Manual: Chapter 1—Inpatient Hospital Services Covered under Part A, at §10, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c01.pdf (Accessed July 17, 2015). Because the definition turns on an “expectation,” professional judgment comes into play, and it is the admitting physician’s expectation that counts (and must be appropriately documented to obtain payment). To understate, the admitting physician has a great deal of discretion:

Physicians should use a 24-hour period as a benchmark, i.e., they should order admission for patients who are expected to need hospital care for 24 hours or more, and treat other patients on an outpatient basis. However, the decision to admit a patient is a complex medical judgment which can be made only after the physician has considered a number of factors, including the patient’s medical history and current medical needs, the types of facilities available to inpatients and to outpatients, the hospital’s by-laws and admissions policies, and the relative appropriateness of treatment in each setting. Factors to be considered when making the decision to admit include such things as:

- The severity of the signs and symptoms exhibited by the patient;
- The medical predictability of something adverse happening to the patient;
- The need for diagnostic studies that appropriately are outpatient services (i.e., their performance does not ordinarily require the patient to remain at the hospital for 24 hours or more) to assist in assessing whether the patient should be admitted; and
- The availability of diagnostic procedures at the time when and at the location where the patient presents.

Id. As you know from Chapters 10 (Medicare) and 12 (Payment), inpatient stays are paid under Medicare Part A.

By contrast observation status, during which services furnished are considered to be outpatient and paid under Medicare Part B, is defined by CMS as “a well-defined set of specific, clinically appropriate services, which include ongoing short term treatment, assessment, and reassessment before a decision can be made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital.” An observation stay is supposed to be short:
In the majority of cases, the decision whether to discharge a patient from the hospital following resolution of the reason for the observation care or to admit the patient as an inpatient can be made in less than 48 hours, usually in less than 24 hours. In only rare and exceptional cases do reasonable and necessary outpatient observation services span more than 48 hours.


Observational care makes perfect sense when clinically appropriate to decide whether or not a patient should be admitted as an inpatient. See generally Jason D. Napolitano & Inderpreet Saini, Observation Units: Definition, History, Data, Financial Considerations, and Metrics, 2 CURRENT EMERGENCY & HOSP. REP. 1 (2014). However, problems arise when clinical factors interact with Medicare payment policies.

2. Clinical uncertainty, hospital incentives, the regulatory response and the provider countermove.

As you know already from your reading of Chapter 12, clinical uncertainty often gives rise to squishiness in a payment system. This inherent squishiness increased when, given a set of incentives, providers have the opportunity to game the system by misclassifying patients. Take the following as an example of clinical uncertainty, and for now assume that only clinical judgment is at work. Suppose that a patient is admitted on observation status because, applying the factors listed above, the patient’s physician does not believe that an inpatient admission is warranted. The patient stays one day, which in the Manual is defined as a stay of 24 hours but is now defined as a stay that crosses either one or zero midnights, e.g., respectively, either 11:59 P.M. through 12:01 A.M. July 1st-2nd, or 11:59 P.M. through 11:59 P.M. on July 1st. In our example, let’s say that the patient is admitted to observation status and the stay crosses one midnight. The next day the physician certifies that another midnight is needed, still believing that an inpatient admission is not warranted. The patient remains on observation status. Patients can and have sometimes remained on observation status—“observation purgatory”—for substantial numbers of day, some as long as ten days or more. See, e.g., June McKoy, The Latest Health Issue for the Elderly: “Observation Purgatory” in Hospitals, THE GUARDIAN (Nov. 29, 2013), http://www.theguardian.com/commentisfree/2013/nov/29/observation-purgatory-killing-elderly-patients (Accessed July 20, 2015); Cheryl Clark, Senators Hear How Two-Midnight Rule Harms Patients, Hospitals, HEALTH LEADERS MEDIA (July 31, 2014), http://healthleadersmedia.com/print/QUA-306944/Senators-Hear-How-TwoMidnight-Rule-Harms-Patients-Hospitals (Accessed July 20, 2015).
Make sure you understand that patients on observation status aren’t just lying around all day watching television while nothing is being done to them. To the contrary, services are being performed, just as if they had been admitted as inpatients. Indeed, imagine the following situation, which is completely realistic. See, e.g., Napolitano & Saini, Observation Units; Michael A. Ross et al., Protocol-Driven Emergency Department Observation Units Offer Savings, Shorter Stays, and Reduced Readmissions, 32(12) HEALTH AFFAIRS 2149 (2013); Christopher W. Baugh & Jeremiah D. Schuur, Observation Care—High-Value Care or a Cost-Shifting Loophole, 369 NEW ENG. J. MED. 302 (2013). One side of a hospital floor is dedicated to patients admitted for an inpatient stay, while the other side is dedicated to patients on observation status. Two patients have presented at the emergency room with chest pain and they are now in rooms and beds across from each other, separated only by the hallway; and they receive the exact same services. How can their status be different? One reason might be clinical uncertainty. A physician may be more sure that the patient on the inpatient side of the hallway requires a stay long enough to fit within the “inpatient stay” category of the payment system but less sure that the patient on the other side requires such a stay—we’re still assuming that nothing but clinical judgment is at play.

Let’s now drop that assumption and consider hospitals’ financial incentives. For now, let’s not differentiate the hospital into component parts, most saliently physicians and administrators (categories themselves that cross) but just go with an aggregate, the “hospital.” We can start with the fact that relatively short inpatient stays are often extremely lucrative. From Chapter 12 you have learned that like all payment systems, the DRG-based Inpatient Prospective Payment System (“IPPS”) is derived from averages but, given that all patients within a DRG are not homogeneous, the actual length of stay can and does vary significantly among them. The evidence clearly shows that short inpatient stays, particularly those not crossing two midnights, are highly lucrative, especially compared to patients who are treated as outpatients, with payment coming from Part B of the Medicare program, which covers outpatient hospital treatment.

Using data from 2012, MedPAC found that “short stays are common and profitable for hospitals relative to inpatient stays,” with a payment-to-cost ratio of 1.55 for one-day stays across all DRGs and a higher ratio of 2.04 for just the medical ones (and 1.17 for the surgical MS-DRGs because costs for the surgical DRGs are front-loaded, at the time of surgery). Medical Payment Advisory Commission, Report to the Congress: Medicare and the Health Care Delivery System 178-79 (June 2015) (“MedPAC 2015 June Report”). Among the twelve medical DRGs with the highest rate of one-day stays, payment-to-cost ratios ran between 1.32 and 2.99. Moreover, as shown below in MedPAC’s Table 7-3, among the six DRGs that are most common to one-day inpatient stays and observation status, “Medicare paid roughly two to three times more for a one-day inpatient stay than for a comparable outpatient observation stay.” Id. at 179 (footnotes omitted).
Thus, hospitals have strong incentives to admit relatively short-stay patients as inpatients, as opposed to treating them as outpatients on observation status. As discussed below, there is strong evidence that a substantial number of patients have been admitted as inpatients despite the fact that they could have been served just as well as Part B outpatients. See id. at ch. 7.

As described in Chapter 12, such moves by providers to enhance their payments by taking advantage of flexibility in the payment system are often matched by a regulatory response, which, in this case was the creation in 2010 of the Recovery Audit Contractor (“RAC”) program, now known simply as the Recovery Audit Program, the mandate of which is to identify and correct over and underpayments. Put simply, with regard to Part A, the job of the RACs, as stated in their contracts with CMS, is to review part A claims to determine “patient status,” whether inpatients should have been treated as outpatients and therefore the hospital should not have been paid under Part A. When a RAC makes such a finding, the hospital has been overpaid and its obligation is to return the money (we discuss the possibility of rebilling under Part B a couple of paragraphs down).

Necessarily, RACs, like all actors in a payment enterprise, have their own incentives, in this case shaped in particular by the fact that their pay is contingent on the number of overpayments they discover and disallow and whether their decisions are upheld through the administrative and judicial appeals process (assuming that hospitals appeal RAC decisions).* So, now put yourselves in the position of a RAC. Do you go

* There are five levels of appeals for hospitals from an adverse determination from a RAC: (1) a redetermination by the relevant Medicare Administrative Contractor (“MAC”); (2) a reconsideration by the relevant Qualified Independent Contractor; (3) a hearing before an Administrative Law Judge (“ALJ”); (4) a review of an ALJ’s decision by the Medicare Appeals Council; and (5) an appeal to federal district court. See generally CMS, Medicare Part A & B Appeals Process (Feb. 2015), http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/MedicareAppealsProcess.pdf
after the low-hanging fruit for which you are more likely to get payment, do you go after
the fruit at the top of the tree for which you are less likely to be paid, or do you comb
through the entire tree? Duh! Given that the RACs are paid on a contingent basis and
given that the easiest instances in which to find an overpayment are the shortest of short
inpatient stays—those only crossing one or zero midnights—the RACs have focused
most heavily on those one-day inpatient stays. MedPAC 2015 June Report at 181-82.

Now return to the hospitals’ incentives. RAC audits are expensive and time-
consuming, requiring higher levels of staff and staff hours, and therefore worth avoiding
if another, less costly alternative exists. In that calculus, on the positive side of the ledger
we have the gains from the higher payments obtained from categorizing patients as
inpatients under Part A, rather than categorizing them as observation stays paid under
Part B, a gain discounted of course by the possibility of losing an audit. On the negative
side of the ledger, we have the likely cost of an audit, which is the expense, including
possible appeals, of prevailing. On this side of the ledger there is also the alternative of
making a substantial investment in policies and procedures to reduce the risk of audits.
However, for hospitals—now think of them as very complex organizations with multiple
actors who often possess conflicting agendas—the path of least resistance is to
manipulate the payment system and, in the process as we discuss below, to shift costs and
risks to patients, rather than make the large investments necessary to improve care, such
as ensuring that inpatient admissions are appropriate. See, e.g., Christopher W. Baugh &
Jeremiah D. Schuur, Observation Care—High-Value Care or a Cost-Shifting Loophole,
369 NEW ENG. J. MED. 302 (2013); Mary D. Naylor et al., Unintended Consequences of
Steps To Cut Readmissions and Reform Payment May Threaten Care of Vulnerable
Older Adults, 31 HEALTH AFFAIRS 1623 (2012). At the margin, therefore, hospitals are
better off classifying patients as outpatients and avoiding audits (but there are incentives
going the other way too, as we discuss below).

An additional feature of the payment system has also played a strong role in
shaping hospitals’ incentives. Hospitals are given a grace period of one year from the
date of service to audit their own claims and, if they deem warranted, to rebill under Part
B some services that had originally been billed under Part A. See CMS, Medicare Benefit
Policy Manual: Chapter 6—Hospital Service Covered under Part B, at §10.2 Likewise,
such rebilling can occur, again only within the one-year window from date of service,
when a claim filed under part A is denied.* See id. §10.2. By contrast, the RACs are
allowed to review claims going back as many as three years—actually as many as four by
the statutory authorization but only three in the implementing regulations. Given the
length of this “look-back” period, hospitals face the strong possibility that the RACs will

*(Accessed July 20, 2015). Chapter 10 (Medicare) describes the appeals process and the different entities
involved.
* You will see below that the American Hospital Association (AHA) and a number of hospitals have filed a
multitude of related lawsuits, some of which have been consolidated, with regard to much of what we
discuss, to-wit, the two-midnight rule, the 0.2% offset, the RAC program, and the one-year time limit for
refiling under Part B a rejected Part A claim. One such lawsuit sought relief from the time limit when the
timing of a RAC audit precludes refiling, but the case was dismissed. See American Hospital Association v.
deny Part A payments for dates of service past the time by which hospital can rebill under Part B, a problem enhanced considerably by the fact that the formal deadlines in the appeals process can extend to as much as just over two years. Thus, part of the risk of a RAC audit is that the RAC will deny Part A payment and the hospital is left with nothing because it no longer can rebill even part of the claim under Part B.

The provider countermove was thus fairly predictable. Facing the time and expense of audits to begin with, compounded by the fact that an adverse result might mean no payment at all, and the potentially high investment needed to “get it right” the first time to avoid audits altogether, hospitals began admitting more patients to observational status—and potentially very long periods of observation at that—instead of taking the risk of losing all payment for those patients because of the adverse of results of an audit.

The evidence that this countermove has occurred is fairly stunning. The literature documents an increased use of observation status over the last five to six years and that hospitals are putting patients into that holding pattern to avoid both the potential untoward consequences of audits and the penalties for readmissions. See, e.g., Giffin W. Daughtridge et al., Quality of Care Transitions and the Trend of Composite Hospital Care, 311 JAMA 1013 (2014); Zhanlian Feng et al., Sharp Rise in Medicare Enrollees Being Held in Hospitals for Observation Raises Concerns About Causes and Consequences, 31 HEALTH AFFAIRS 1251 (2012). For example, using data from 2013, Daughtridge and colleagues found some evidence of substitution, writing that “[h]ospitalizations per 1000 beneficiaries decreased from 313.7 in 2009-2010 to 283.6 in 2012-2013. In that time, observation stays per 1000 beneficiaries increased from 38.7 to 49.0.” Daughtridge et al., at 1013. Analogously, the Office of Inspector General found great variation among hospitals in how stays are coded. Analyzing common complaints—e.g., “chest pain”—the OIG found that hospitals sometimes code outpatient stays extending over one midnight as long outpatient stays, but other hospitals code long outpatient stays as observation status or inpatient stays. Stays that some hospitals code as short inpatient stays—one midnight—others code as observational or outpatient care. Letter to Marilyn Tavenner, Administrator, CMS from Stuart Wright, Deputy Inspector General for Evaluation and Inspections at 15 (July 29, 2003), [hereinafter “OIG Memorandum Report on Hospitals’ Use of Observation Stays and Short Inpatient Stays”],

* This problem has been exacerbated by the fact that, in recent years, both the volume and length of appeals have increased dramatically. The result has been a huge backlog, over 800,000 cases at the ALJ level, driving the actual processing time of an appeal (in fiscal year 2014) to a whopping 547 days. See MedPAC June 2015 Report at 181. To resolve this problem, in August 2014 CMS made a one-time offer to hospitals to pay 68 percent of amounts denied in return for hospital’s dropping all appeals. As of June 1, 2015, CMS had executed settlements with more than 1,900 hospitals, representing approximately 300,000 claims, and it has paid approximately $1.3 billion to providers. See Hospital Settlement Updated 6/11/15, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Medical-Review/InpatientHospitalReviews.html (Accessed July 20, 2015). Meanwhile, the suit brought by the AHA and a number of hospitals to obtain equitable relief to force the Secretary to waive the one-year refiling rule was dismissed, see American Hospital Association v. Burwell, 2014 WL 7205335 (D.D.C.), but is now on appeal. See American Hospital Association v. Burwell, No. 15-505 (D.C. Cir., filed Jan. 21, 2015).
To be sure, other factors have been at work, see Daughtridge et al., *Quality of Care Transitions and the Trend of Composite Hospital Care*. However, MedPACs 2015 June Report provides convincing evidence and analysis that the incentives explicated above are responsible for very much or substantially all of the substitution of observation stays for inpatient ones and for the substantial increase in the length of the observation stays.

### 3. Deleterious impact on Medicare beneficiaries.

This shift is hardly benign because of three significant deleterious financial impacts on Medicare beneficiaries (for a list of many more, see Baugh & Schuur, *Observation Care* at 304). First, as indicated above, care classified as observational falls under Medicare Part B, while care classified as inpatient care falls under Part A. Although the care so classified can be identical, and the distinction invisible to patients—and in fact to providers—patients’ out-of-pocket expenses are significantly higher under Part B. Consider, for example, that a one-day stay in an intensive care unit can be classified as observational care; the patient’s copay will be a whopping 20% of that extraordinarily expensive care compared to a Part A deductible of $1216 in 2014. See, e.g., Jason M. Hockenberry et al., *Factors Associated with Prolonged Observation Services Stays and the Impact of Long Stays on Patient Cost*, 49 HEALTH SERVS. RES. 893 (2014).

Second, Patients are also responsible for certain items not bundled into the outpatient prospective payment system, most importantly, self-administered prescription drugs, the cost of which can really add up, particularly since patients are charged the manufacturers’ list prices, not the discounted prices hospitals pay. Moreover, observation status does not count toward the three-day inpatient stay—i.e., a stay crossing three midnights—required for a beneficiary to be eligible for nursing home care. A patient may have little idea that he or she is on observation status and can end up with an unexpected and huge bill for both a Part B copay and the expenses of a nursing home stay. It is quite a problem. See, e.g., Paula Span, In the Hospital, But Not Really a Patient, **NEW YORK TIMES**, June 22, 2012, [http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?_php=true&_type=blogs&_r=0](http://newoldage.blogs.nytimes.com/2012/06/22/in-the-hospital-but-not-really-a-patient/?_php=true&_type=blogs&_r=0) (Accessed July 18, 2015) (83-year-old patient with a degenerative brain disorder arrives in an ambulance after breaking her neck in a fall, spends four days at the hospital on observation status and ends up with a $35,000 nursing-home bill). * Two advocacy groups, the Center for Medicare Advocacy and the National Senior Citizens Law Center, filed a class action, claiming on multiple grounds that Medicare’s treatment of observation status is illegal. They sought an injunction that would, among other things, direct the Secretary to provide written notice of observation status and the potential consequences for SNF coverage, and to establish an expedited review process to challenge that status. The district court dismissed all claims but the Second Circuit reversed, allowing a due process claim to continue. See Barrows v. Burwell, 777 F.3d 106 (2015). The court held that “[i]f plaintiffs are able to prove their allegation that CMS ‘meaningfully channels’ the discretion of doctors by providing fixed or objective criteria for when patients should be admitted, then they could arguably show that qualifying Medicare beneficiaries have a protected property interest in being treated as ‘inpatients.’ However, if the Secretary is correct and, in fact, admission decisions are vested in the medical
substitution as follows: “When observation is used as a billing status in inpatient areas without changes in care delivery, it’s largely a cost-shifting exercise—relieving the hospital of the risk of adverse action by the RAC but increasing the patient’s financial burden.” *Baugh & Schuur, Observation Care* at 303.

Recent findings also provide evidence that the quality of patient care is potentially diminished. Approximately only one-third of hospitals have created dedicated observation units, although the evidence is clear that patient care is improved when those units exist, are properly managed and are part of physician education. See, e.g., Napolitano & Saini, *Observation Units; Baugh & Schuur, Observation Care*; Christopher W. Baugh et al., Making Greater Use of Dedicated Hospital Observation Units for Many Short-Stay Patients Could Save $3.1 Billion a Year, 31(10) *HEALTH AFFAIRS* 2314 (2012). The reasons for this lacuna are complex and one could certainly lay the blame partly on hospitals’ own decisions. Nonetheless, creating incentives for a greater number of and longer observation stays can have perverse effects, as described above, and solutions to this problem lie in more direct policies to encourage the creation of dedicated, well-run observation units. See, e.g., Emily Carrier et al., Association Between Emergency Department Length of Stay and Rates of Admission to Inpatient and Observation Services, 174(11) *JAMA INTERNAL MED.* 1843 (2014); Ross et al., *Protocol-Driven Emergency Department Observation Units; Baugh & Schuur, Observation Care*; Baugh et al., *Making Greater Use of Dedicated Hospital Observation Units*.

4. The “two-midnight rule,” proposed, criticized, delayed and tweaked again and again, and now greatly reformulated and newly proposed.

In 2013, reacting to the incentives and perverse effects just described, CMS first promulgated its “two-midnight rule.” See CMS, Hospital Inpatient Prospective Systems for Acute Care Hospitals and Fiscal Year 2014 Rates; Payment Policies Related to Patient Status, Final Rule, 78 Fed. Reg. 50,496, 50,746, 50,939-55 (Aug. 19, 2013) [hereinafter, “FY 2014 Inpatient Rates Final Rule”]. The rule is really a benchmark for physicians and hospitals to use in coding claims; and it creates a presumption of reasonable and necessary care for the RACs to use in their claims reviews and audits. The rule uses two midnights as the tipping point: “CMS contractors would presume that inpatient hospital stays lasting 2 nights or longer were reasonable and necessary and would qualify for payment as inpatient stays. Conversely, CMS contractors would presume that stays lasting less than 2 nights would not qualify for payment as inpatient stays and instead would be paid for as outpatient stays.” *OIG Memorandum Report on Hospitals’ Use of Observation Stays and Short Inpatient Stays.* If services are provided for fewer than 2 midnights, a stay could still be classified as inpatient, with justification for overcoming the presumption turning on the attending physician’s reasonable judgment of treating physicians, then Medicare beneficiaries would lack any such property interest.” Id. at 115.

* For a recent attempt to sort out the magnitude of these financial impacts, a subject that is enormously complicated, see Zhanlian Feng et al., The Origin and Disposition of Medicare Observation Stays, 52 *MED. CARE* 796 (2014); see also MedPAC June 2015 Report at 189-90.
expectations concerning the duration over which services will be furnished, as documented in the patient’s record. CMS explained:

[W]e are proposing a new benchmark for purposes of medical review of hospital inpatient admissions, based on how long the beneficiary is in the hospital. Under our proposal, Medicare’s external review contractors would presume that hospital inpatient admissions are reasonable and necessary for beneficiaries who require more than 1 Medicare utilization day (defined by encounters crossing 2 “midnights”) in the hospital receiving medically necessary services. If a hospital is found to be abusing this 2-midnight presumption for nonmedically necessary inpatient hospital admissions and payment (in other words, the hospital is systematically delaying the provision of care to surpass the 2-midnight timeframe), CMS review contractors would disregard the 2-midnight presumption when conducting review of that hospital. Similarly, we would presume that hospital services spanning less than 2 midnights should have been provided on an outpatient basis, unless there is clear documentation in the medical record supporting the physician’s order and expectation that the beneficiary would require care spanning more than 2 midnights or the beneficiary is receiving a service or procedure designated by CMS as inpatient-only.


The rule is supposed to eliminate or reduce the number of long observational stays by allowing hospitals to rely on the presumption that a stay extending through two midnights constitutes reasonable and necessary inpatient care. Hospitals would be

* In the proposed rule, CMS stated that the period of the two midnights would start “when the beneficiary is moved from any outpatient area to a bed in the hospital in which additional hospital services would be provided.” Id. at 27,648. However, for a variety of reasons, such as the unavailability of an inpatient bed for a patient stuck in observation status as a result, in the final rule this definition was eliminated. CMS stated, “we specify that the ordering physician may consider time the beneficiary spent receiving outpatient services (including observation services, treatments in the emergency department, and procedures provided in the operating room or other treatment area) for purposes of determining whether the 2-midnight benchmark is expected to be met and therefore inpatient admission is generally appropriate.” FY 2014 Inpatient Rates Proposed Rule at 50,950; see also CMS, FAQs on 2 Midnight Rule, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-Review/Downloads/QAsforWebsitePosting_110413-v2-CLEAN.pdf (Accessed July 19, 2015). While this change helped hospitals, it did little for beneficiaries primarily because the days spent in observation status still don’t count as part of the three-day stay required to obtain payment for a subsequent nursing home stay. CMS, Medicare Benefit Policy Manual: Chapter 8—Coverage of Extended Care (SNF) Services under Hospital Insurance §20.1 (March 3, 2015). However, in its contracts with some Accountable Care Organizations and Medicare Part C managed care organizations, CMS is experimenting with waiver of the three-day requirement. See, e.g., Susan Jaffe, Medicare Testing Payment Options That Could End Observation Care Penalties, KAISER HEALTH NEWS, July 22, 2014, http://khn.org/news/medicare-testing-payment-options-that-could-end-observation-care-penalties/ (Accessed July 20, 2015).
protected against the risk that auditors would classify inpatient stays extending over two
midnights as inappropriate. The expected effect, then, is that more stays would be
classified as inpatient. Additionally, Medicare patients supposedly would be protected
against those nasty surprises like the unanticipated $35,000 nursing home stays.
Conversely, the rule is supposed to shift short inpatient stays—those crossing only one
midnight—into the category of outpatient or observation status, under the presumption
that short inpatient stays, unless otherwise shown by documentation, should have been
outpatient. This shift would protect the financial integrity of the Medicare program.*

However, despite CMS’s goals, the effects of the rule are uncertain. As discussed
above, much turns on the certification of physicians that an inpatient stay is warranted.
However, hospitals and physicians are simply reluctant to become “soothsayers.”
Suppose a patient has spent one midnight on observation status but the physician is not
sure that the patient will then need another night. The physician will not certify that
inpatient admission is necessary. One midnight passes and the patient is still on
observation status. The physician is then still unsure that another midnight is warranted
and again will not certify that inpatient admission is necessary. Another midnight passes
and the patient is still on observation status; and so on. The long and short of it is that
particularly for medical patients, who comprise the majority of patients on observation
status, there remains too much uncertainty what services many patients will need and for
how long they will need hospitalization. The manner in which observation status is
actually used in practice vastly differs from the manner presupposed by the regulatory
regime. See Ann M. Sheehy et al., Hospitalized but Not Admitted: Characteristics of
Patients with “Observation Status” at an Academic Medical Center, 173 JAMA
INTERNAL MED. 1991 (2013). The two-midnight rule may not alter that fact.

Furthermore, it is still possible for hospitals to manipulate the billing and coding
system, because the rule does not end the fact of overlapping categories, and it is not
clear how physicians’ certifications and hospitals’ coding practices will be changed in
response to the rule. Physicians and hospitals could, for example, simply lengthen stays
or, as another example, manipulate the time of admissions, e.g., admit on 11:59 P.M.
rather than 12:01 A.M., to be sure to fall within the two-midnight presumption. As
mentioned above, the Office of Inspector General found great variation among hospitals
in how stays are coded. It therefore concluded that the effect of the two-midnight rule is
not clear:

* CMS actuaries predicted that this shift away from one-day inpatient stays would save Part A $220 million.
As a result, CMS used that amount as an offset, reducing the IPPS standardized payment amount by $220
million, which translated to 0.2%. See CMS, Hospital Inpatient Prospective Payment Systems for Acute
Claiming that this decision is unsupported by sufficient evidence and that the lack of details prevented
meaningful comments from being filed in the notice-and-comment rulemaking, the AHA and numerous
individual hospitals have filed suit to restore the offset. See American Hospital Association v. Burwell, No.
15-cv-747 (D.D.C., filed May 19, 2015); American Hospital Association v. Sebelius, No. 14-cv-607
(D.D.C., filed April 4, 2014); Shands Jacksonville Medical Center v. Sebelius, No. 14-cv-263 (D.D.C.,
filed Feb. 20, 2014).
Our results indicate that, under the policies proposed in the [rule], some hospitals would likely follow the provisions and continue to bill these as outpatient stays; other hospitals—given strong financial incentives and few barriers—would likely not follow the provisions and would admit beneficiaries as inpatients as soon as possible to meet the 2-night presumption.

OIG Memorandum Report on Hospitals’ Use of Observation Stays and Short Inpatient Stays at 15.

In fact, a recent study contradicts the assumption that implementation of the two-midnight rule would reduce the number of observational stays. Analyzing inpatient and observation encounters in a teaching hospital over a one-year period, the authors found (1) that under the new rule more short inpatient stays would be shifted to observation status than observational stays would be shifted to inpatient stays; (2) that short inpatient stays did not share, for the most part, diagnostic codes with observational stays, meaning that the two categories are clinically distinct; (3) that reliance on length of stay does not sort patients into clinically meaningful categories; and (4) that the time of admission (a non-clinical factor)—e.g., 8 A.M. versus 8 P.M.—or day of admission (another non-clinical factor)—e.g., weekday versus weekend—had a significant effect on whether the stay did or did not cross two midnights. The implications are that (1) under the two-midnight rule many more inpatients would be reclassified as outpatient and lose their eligibility for nursing home care and have to pay higher part B cost sharing even though they are clinically distinct from other patients on observation status, and (2) hospitals, under financial pressure from the loss of part A revenue, would have incentives to manipulate length of stay—e.g., admit more patients during the weekend—to cross two midnights. See Ann M. Sheehy, Observation and Inpatient Status Impact of the 2-Midnight Rule, 9 J. HOSP. MED. 203 (2014). Given these findings, it is possible that the two-midnight rule would increase the amount of harm to Medicare patients and hospitals, as well as create new inefficiencies (consider also how CMS could have promulgated this rule without evidence like that in this study and how crucial it is that regulators have evidence concerning what will actually happen under their rules).

For all these reasons, neither patient nor provider groups were happy with the rule’s initial formulation. Both characterized it as arbitrary, confusing, difficult to implement, clinically meaningless, etc.” As a result of considerable resistance, CMS has on multiple occasions delayed its implementation, as has Congress, including the latest delay until September 30, 2015.”“ There have been Congressional hearings, legislation

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* One of the AHA’s lawsuits presents a frontal challenge to the two-midnight rule itself, claiming that the rule is arbitrary and capricious. See American Hospital Association v. Sebelius, No. 14-cv-609 (D.D.C., filed April 4, 2014).

** Much of this history is recounted in the preamble to the proposed reformulation of the rule, issued on July 1, 2015, see CMS, Fact Sheet: Two-Midnight Rule, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-07-01-2.html (Accessed July 20, 2015), and appearing in the Federal Register on July 8, 2015. See CMS, Hospital Outpatient Prospective Payment and Ambulatory Surgical Center Payment Systems; Short Inpatient
has been introduced to alter or replace the rule, and individual hospitals and multiple hospital groups have filed suit to enjoin its implementation. See, e.g., Health Policy Brief: The Two-Midnight Rule, HEALTH AFFAIRS, Jan. 22, 2015, http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=133 (Accessed July 19, 2015).

Some have speculated that the strongest spur to the latest proposed reformulation of the rule, discussed below, was MedPAC’s June 2015 Report, discussed above. See, e.g., Squire Patton Boggs, CMS Surreptitiously Proposes to Amend the Two-Midnight Rule Before the Fourth of July Weekend, http://www.squirepattonboggs.com/insights/publications/2015/07/cms-surreptitiously-proposes-to-amend-the-two-midnight-rule (Accessed July 19, 2015). Regardless, MedPAC’s report is thorough and tight. After demonstrating the incentives and effects discussed above, MedPAC turned to criticism of the rule itself and alternative policy options. Various changes in payment were among the policy options considered: reduce or eliminate the differential between payments for short inpatient stays and similar outpatient stays through the creation in the IPPS of one-day-stay DRGs; and make payment “site-neutral” for one-day stays regardless of whether that stay is inpatient or outpatient, even going so far as creating a new and different payment system for certain types of services. The Commission did not recommend any of these payment options because each could introduce problems elsewhere in Medicare payment.

Instead, what the Commission did recommend were that (1) the Secretary evaluate creating a penalty for hospitals with excess rates of short inpatient stays; (2) the Secretary allow two days of observation status to count toward the three-inpatient-day requirement for SNF eligibility; (3) Congress require hospitals to notify patients of the fact that they are on observation status; (4) for patients on observation status, bundling self-administered drugs within the outpatient prospective payment system, thereby eliminating those beneficiaries’ separate liability for the drugs; and (5) the Secretary make significant changes to the RAC program, including, categorically, that the two-day rule be withdrawn:


* MedPAC had indicated, before the 2015 June Report, its concerns with the two-midnight rule, criticizing it along much of the ground covered here: “The Commission shares CMS’ concerns about the three issues that CMS said motivated the 2-Midnight policy—growth in observation cases, the financial implications for beneficiaries’ out-of-pocket costs and potential for beneficiary confusion, and ambiguity in Medicare’s inpatient admission criteria. However, the 2-Midnight policy may not address these issues as effectively as possible. We have several additional concerns with the current framework: the 2-Midnight threshold, transparency for beneficiaries, administrative burden on hospitals, and inequity in payment between similar cases treated as short inpatient stays versus outpatient observation stays.” Letter to Marilyn Tavenner, Administrator, CMS from Glenn M. Hackbarth, Chairman, MedPAC at 2 (June 13, 2014), http://www.medpac.gov/documents/comment-letters/medpac-comment-on-cms's-acute-and-long-term-care-hospitals-proposed-rule.pdf?sfvrsn=0 (Accessed July 19, 2015); see id. at 12-15.
The Secretary should:

• direct recovery audit contractors (RACs) to focus reviews of short inpatient stays on hospitals with the highest rates of this type of stay,

• modify each RACs’ contingency fees to be based, in part, on its claim denial overturn rate,

• ensure that the RAC look-back period is shorter than the Medicare rebilling period for short inpatient stays, and

• withdraw the “two-midnight” rule.

MedPAC June 2015 Report at 194. The reasoning for withdrawing the two-midnight rule was, quite simply, “The Commission recommends changes to the RAC program that could alleviate some of the problems that led CMS to implement the two-midnight rule. In particular, reforming the RAC program in these three areas could make RACs more judicious in auditing claims and could mitigate the need for the two-midnight rule’s safe harbor from RAC audits.” Id. The “creation of a penalty for hospitals with excess rates of short inpatient stays to substitute, in whole or in part, for recovery audit contractor review of short inpatient stays,” id. at 196, was part of this reasoning.*

Regardless of whether CMS reacted to MedPAC’s report, on July 1, 2015, it issued a proposed reformulated two-midnight rule, which, to tell the truth, is a pale version of the initial rule. Three elements are particularly noteworthy (for a useful summary, see CMS, Fact Sheet: Two-Midnight Rule).

First, CMS greatly expanded exceptions from the two-midnight rule’s presumption that one-day inpatient stays are generally not eligible for Part A payment. In the rule’s initial formulation the agency had recognized that “certain procedures may have intrinsic risks, recovery impacts, or complexities that would cause them to be appropriate for inpatient coverage under Medicare Part A regardless of the length of

* MedPAC may be right that changing focus from a general formulation of payment policy, like the initial formulation of the two-midnight rule, is warranted and that more attention should be placed on improving the audit process. However, its findings should be approached with sensitivity to the limitations of the aggregate data upon which they are based. As we’ve indicated above, observation status can occur in different settings—dedicated units versus non-dedicated, any-where-theres-room, places in the hospital—and within those varied settings observation services can be delivered under rigorous protocols, at one extreme, or in an ad hoc fashion at the other extreme, varying by the unstructured ordering of attending physicians (and guess what predominates?). See, e.g., Ross et al., Protocol-Driven Emergency Department Observation Units. Additionally, as Sheehy’s work in particular has demonstrated, see Sheehy et al., Hospitalized but Not Admitted; Sheehy, Observation and Inpatient Status Impact of the 2-Midnight Rule, reasons for particular practices at different hospitals are extremely varied. The aggregate data used by MedPAC cannot account for these details and quite arguably both research and policy must be way more granular. See Arjun K. Venkatesh & Lisa G. Suter, Observation “Services” and Observation “Care”—One Word Can Mean a World of Difference, 49 HEALTH SERVICES RESEARCH 1083 (2014).
hospital time the admitting physician expects a particular patient to require.” CMS, Proposed Rule for Short Inpatient Stays at 39,349. One exception existed as a de facto, but not formal matter because some procedures are payable only under Medicare Part A, not eligible for Part B payment, and therefore outside of the two-midnight rule’s presumption. The second exception, by contrast, was subsequently created. After CMS had indicated that additional procedures might present “rare and unusual” circumstances, necessitating further exceptions, CMS “identified medically necessary, newly initiated mechanical ventilation (excluding anticipated intubations related to minor surgical procedures or other treatment) as the first such rare and unusual exception to the 2-midnight benchmark.” Id. at 39,350. Then, in the proposed reformulated two-midnight rule, CMS proposes to revise its regulations as follows:

Existing §412.3(d)(1) specifies, in relevant part, that if the physician expects to keep the patient in the hospital for only a limited period of time that does not cross 2 midnights, the services are generally inappropriate for inpatient admission and inpatient payment under Medicare Part A, regardless of the hour that the patient came to the hospital or whether the patient used a bed. We are proposing to revise §412.3(d) to state that when the admitting physician expects a hospital patient to require hospital care for only a limited period of time that does not cross 2 midnights, the services may be appropriate for payment under Medicare Part A if the physician determines and documents in the patient’s medical record that the patient requires a reasonable and necessary admission to the hospital as an inpatient. In general, we would expect that with most inpatient admissions where the stay is expected to last less than the 2-midnight benchmark, the patient will remain in the hospital at least overnight . . . .

Id. at 39,351. Because this new exception will be monitored only on a “case-by-case basis,” id. at 39,350, much of the presumption in the initial two-midnight rule that one-day inpatient stays are ineligible for Part A payment is about to vanish. Moreover, while the presumption against inpatient payment for one-day inpatient stays has been vitiated, the presumption in the opposite direction remains the same: “inpatient stays for which the patient remained in the hospital at least 2 midnights following formal admission to the hospital will continue to be presumed appropriate for inpatient hospital payment under Medicare Part A and will generally not be selected for medical review of patient status.” Id. at 39,353. Hospitals, therefore, are to get their cake and eat it too because two-midnight inpatient stays will not, absent evidence of systematic abuse, be subject to review, while one-day inpatient stays will no longer be presumed to be ineligible for Part A payment.

* CMS did indicate that “we would expect it to be rare and unusual for a beneficiary to require inpatient hospital admission after having a minor surgical procedure or other treatment in the hospital that is expected to keep him or her in the hospital for only a few hours and not at least overnight. We will monitor the number of these types of admissions and plan to prioritize these types of cases for medical review.” Id. at 39,352. This stated “expectation” does not create anything like the initial rule’s presumption against Part A payment for one-day stays. It’s more in the nature of a heads-up to providers, “We’ll be watching.”
Second, for the most part, CMS has shifted responsibility for the rule’s oversight of one-day inpatient stays to Medicare’s Quality Improvement Organizations (“QIOs”). Described more fully in Chapter 20 (Payers and Health Care Quality), these Medicare contractors provide medical review functions and their mission, unlike the RACs, is not to search for overpayments and deny payment, but instead largely to educate and otherwise work with providers to improve the quality of care. This change is, to some extent, part of a trend. As the delays in implementing the two-day rule continued, CMS turned increasingly to what it calls “probe and educate,” a process by which in the absence of evidence of systematic gaming or abuse, the MACs review a very limited sample of a hospital’s one-day inpatient stays to see if violations are occurring—the “probe” part. If no violation appears in the sample, the hospital is done. The MACs also engage in numerous efforts to educate the sector about the rule—the “educate” part. See, e.g., CMS, FAQs on 2 Midnight Rule; see also CMS, Proposed Rule for Short Inpatient Stays at 39,350.

Nonetheless, the proposed reformulated rule represents a clear shift of emphasis from enforcing payment policies to improving quality. CMS stated, “Regardless of whether we finalize the policy proposals [to expand the exceptions to the two-midnight rule], we are announcing that, no later than October 1, 2015, we are changing the medical review strategy and plan to have Quality Improvement Organization (QIO) contractors conduct these reviews of short inpatient stays rather than the MACs.” Id. at 39,352. More fully,

Under the new medical review shortstay inpatient review process that we will adopt by October 1, 2015, QIOs will review a sample of post-payment claims and make a determination of the medical appropriateness of the admission as an inpatient.

QIOs will refer claim denials to the MACs for payment adjustments. Providers’ appeals of denied claims will be addressed under the provisions of section 1869 of the Act. QIOs will educate hospitals about claims denied under the 2-midnight policy and collaborate with these hospitals in their development of a quality improvement framework to improve organizational processes and/or systems. Under the QIO short-stay inpatient review process, those hospitals that are found to exhibit a pattern of practices, including, but not limited to: having high denial rates and consistently failing to adhere to the 2-midnight rule (including having frequent inpatient hospital admissions for stays that do not span one midnight), or failing to improve their performance after QIO educational intervention, will be referred to the recovery auditors for further payment audit.

* As we describe in Chapter 20 (Payers and Health Care Quality), the appeals process from QIO determinations differs substantially from those made by the RACs. In brief, the initial determinations by the QIOs rely on peer review and therefore reviews from those determinations are focused on the nature and quality of the peer-review process. Further, compared with reviews taken from RACs’ decisions, review of QIO determinations is greatly expedited.
Id. 39,353. Crucially, then, the QIOs will stand between providers and the RACs and only recidivists will be referred to the RACs for audits: “the recovery auditors will conduct patient status reviews focused on those providers that are referred from the QIOs and have high denial rates. The number of claims that a recovery auditor will be allowed to review for patient status will be based on the claim volume of the hospital and the denial rate identified by the QIO. We will adopt this new medical review strategy regardless of whether the 2-midnight rule remains unchanged or is modified.” Id.

Third, CMS recommitted itself to the course of changes in the RAC program to which it had already committed on December 30, 2014. See CMS, Recovery Audit Program Improvements, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Downloads/RAC-Program-Improvements.pdf (Accessed July 20, 2015). These changes include, among other things: (1) reducing the look-back period to six months from the date of service so long as the hospital has submitted a claim within three months from that date; (2) linking the documents that RACs can request in the audit process to a hospital’s denial rates; (3) requiring that RACs complete even complex audits within thirty days or lose their contingency fee; (4) delaying payment of the RAC’s contingency fee from the time of the RAC’s denial to the completion of the second level of appeal; (5) promising corrective action if 10 percent or greater of the RAC’s decisions are overturned at the first level of appeal; and (6) stipulating that the RACs cannot send a finding of overpayment to the MACs, which provide the first level of review above the RACs, thereby ensuring the opportunity for a “discussion period,” during which hospitals can try to sort things out with the RACs, without putting at risk hospitals’ right to file for MAC redetermination. See CMS Recovery Audit Program Improvements; CMS, Proposed Rule for Short Inpatient Stays at 39,350.

Given that the reformulated rule gives hospitals a great deal of relief, the industry’s reactions, as of July 20, 2015, have been positive. See, e.g., Proposed Changes to Two-Midnight Rule Generates Optimism, Praise, iPROTEAN BLOG (July 8, 2015), http://www.iprotean.com/blog/proposed-changes-to-two-midnight-rule-generate-optimism-praise/ (Accessed July 19, 2015); AHA, Statement on Proposed CY 2016 OPPS Rule (July 1, 2105), http://www.aha.org/presscenter/pressrel/2015/150701-pr-


Still, beneficiaries wait.

5. What’s it all about, Alfie?*

How could this *Sturm und Drang* be avoided? Medicine is the exemplar of a set of incredibly complicated transactions, clouded in uncertainty. When uncertainty reigns, payment approaches that try to break up into pieces what is really a continuum of decisions—in response to (potentially) ever-changing factual situations involving real,

live humans with constantly evolving medical conditions—are bound to fail, especially if they are combined with green eyeshade audit procedures focused on isolated moments in time. Medicine cannot know everything there is to know, from the time a patient first enters care until she leaves it. Therefore, ambiguity is the name of the game. What is needed is a more cohesive response to the dilemma of paying for medical care that ensures that well-trained clinicians have a reasonable budget in which to work, well-crafted decision supports to monitor patient changes and make judgments about resource needs, the ability to modify treatment approaches as conditions warrant, and incentives to make efficient decisions that promote the welfare of patients.

In this regard, imagine a health care world in which the division of Medicare into Parts A and B—to simplify we’ll leave out Parts C and D although they’re relevant too—did not exist. In other words, imagine a payment system in which identical services could not be coded as payment under either Part A or Part B because there are no such artificial divisions, with their attendant payment and patient cost-sharing effects. Imagine a system in which there was meaningful integration across the continuum of care such that the sharp demarcation between acute care and everything else—really, that’s how it is, a distinction between acute care and everything else—did not exist. Imagine a system in which payment were bundled so that one part of the one episode on the continuum of care would not be paid under one payment system, with another part paid under a different system, and so on—and really on and on and on. Although as discussed in the book, through innovations such as ACOs and bundled payment, parts of the Affordable Care Act try to make portions of this imaginary world a reality, for the most part such a system remains imaginary and the mess described in this Note—a mess that can be multiplied many, many times over—persists in our fragmented (non)system of providing and paying for care.

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**Note on Price Transparency and Gobeille v. Liberty Mutual**

As summarized in the main text, one of the advantages of a coordinated or single-payer system typically is price transparency and standardization of the method of payment. The advantages of transparency and standardization of prices are many: lower administrative costs, ease of comparing prices and finding variation among providers, and easier comparison of the value of services—the price/quality/cost mix.

By contrast, the situation in the United States has been bedlam, with the result that prices have been largely invisible and widely variable. Writing in 2006, Professor Uwe Reinhardt aptly characterized hospital charges as “chaos behind a veil of secrecy.” See Uwe E. Reinhardt, The Pricing of U.S. Hospital Services: Chaos Behind a Veil of Secrecy, 25 HEALTH AFFAIRS 57 (2006). Different hospitals use different methods to create their schedule of insurer charges (known as “chargemasters”), and charges bear little or no relationship to actual resource use. They are simply a means to price discriminate, to charge higher prices to relatively weaker payers and lower prices to stronger ones. Other producers of health care goods and services, such as are drug
manufacturers, medical device manufacturers, manufacturers of medical supplies, engage in similar price discrimination.

This price discrimination occurs through negotiations between insurers and providers. Therefore, what a private payer actually pays hospitals—and physicians too—is based on its bargaining power, and a payer's strength or weakness is reflected in the extent to which it gets a discount from charges. Actual prices thus vary widely. Moreover, payments remain secret. Providers and insurers are loathe to release meaningful price data because doing so would put them at a competitive disadvantage (or eliminate a competitive advantage). Making price invisible is a strategic use of information and it is part of the dog-eat-dog culture we describe in this Chapter. See generally Uwe E. Reinhardt, Health Care Price Transparency and Economic Theory, 312 JAMA 1642 (2014).

Of course, the unit prices Medicare pays through its administered pricing systems are visible. However, the full amounts Medicare pays to different providers too have been largely invisible and variable—the necessary data have been largely unavailable to the public. Prices in the United States have been mysterious.

However, recently CMS, many states and some private parties have begun to breach “the secure walls of a fortress that kept information on the prices charged for health care and the quality of that care opaque from public view.” Uwe W. Reinhardt, The Disruptive Innovation of Price Transparency in Health Care, 310 JAMA 1927 (2013). This breach has been driven in part by a seminal shift in how the law—statutory law, regulatory law, and judicial decisions—addresses the transparency of pricing.

1. Price and utilization data.

Price and utilization data are becoming more publicly available. With regard to Medicare, for three years CMS has released annual inpatient and outpatient hospital utilization and charge data, and for two years it has released physician claims data, which show utilization. See, e.g., CMS, New Medicare Data Available to Increase Transparency on Hospital and Physician Utilization, http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2015-Press-releases-items/2015-06-01.html (Accessed June 29, 2016). Additionally, 2015 regulations governing Medicare’s inpatient prospective payment system (IPPS) implemented the ACA requirement (42 U.S.C. §300gg-18) that hospitals publish their charge lists (albeit in a fairly weak fashion):

Our guidelines for implementing section 2718(e) of the Public Health Service Act are that hospitals either make public a list of their standard charges (whether that be the chargemaster itself or in another form of their choice), or their policies for allowing the public to view a list of those charges in response to an inquiry. We encourage hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their potential financial liability might be
for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals. We expect that hospitals will update the information at least annually, or more often as appropriate, to reflect current charges.


The Medicare physician-data release, three decades in the making, has been particularly interesting because of the firestorm it has caused. The Medicare story also illustrates some of the problems and controversies associated with price transparency.

In 1977, the predecessor to HHS, the U.S. Department of Health, Education and Welfare ("HEW"), published a list of physicians and physician groups who had received Medicare payments of $100,000 or more for the prior year. Subsequently, citing the Privacy Act of 1974 and an exemption from the federal Freedom of Information Act, a Florida district court issued a permanent injunction that enjoined HEW from disclosing a list of Medicare payments that identified individual physicians. The government did not appeal. This status quo prevailed until Dow Jones & Company, the parent of the Wall Street Journal, convinced the Florida district court some thirty years later that the prior ruling no longer constituted good law. What followed was a CMS request for public comment in August 2013 concerning whether and how to release physician payment data, and subsequently, as noted above, the release of the data, which include information on utilization, payment, and submitted charges, organized by provider number, procedure code and place of service.

To understate, the release of these data has been controversial. The data released were raw and unvarnished. They simply listed charges submitted for payment. The data were unverified and unadjusted for quality or severity of illness. They also failed to take cost into account—the data only represent gross revenue, not net income—nor did they provide a full picture of a physician’s practice apart from the Medicare charges.

Critics, of course, focus on the fact that the data are raw. Although “the data release should spark conversations between health care providers and patients about their shared responsibility for using resources in ways that maximize value,” critics claim that the data potentially are misleading to patients and others, which might “create[] an aura of suspicious or inflated payments when none existed.” The lack of information regarding cost is significant particularly in hospital settings because of the high overhead. Overall, the data “are rooted in a volume-centric approach to health care delivery that has been rapidly losing relevance in today’s changing health care environment,” in which “increasing emphasis is now placed on value, expressed conceptually as the ratio of quality to cost.” In toto, “[e]fforts to make cost considerations transparent are both welcome and laudable; this data release is a small but somewhat flawed step in that direction.” Patrick T. O’Gara, Caution Advised: Medicare’s Physician-Payment Data Release, http://www.nejm.org/doi/full/10.1056/NEJMp1405322 (May 28, 2014) (Accessed June 29, 2016).

Proponents of the release, including officials at CMS, believe that the benefits of releasing the physician data outweigh the costs of misplaced meaning attributed to them. In their view, prior release of the hospital charge data “sparked a national conversation

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* This history and background is drawn from an unpublished paper, Jane Hyatt Thorpe & Elizabeth Gray, Heralding in a New Era of Transparency: The Release of Physician Medicare Claims Data (Milken Institute School of Public Health, George Washington University, 2014).
about the appropriateness of hospital charges and about the large variation in charges for the same service, often in the same geographic area.” Recognizing in particular that patients may assume that the data reflect quality—analogously, patients’ usual assumption about higher prices is that they reflect higher quality—officials wrote that they “view this data release as an important first step in building greater understanding, on the part of a diverse community of policymakers, data entrepreneurs, and consumers, about the way in which Medicare pays physicians and other providers.” Stating a commitment to increase the availability of data on quality, proponents’ bottom line is that the “physician data release is part of a broader strategy of data transparency, and we plan to continue to release additional data in the future. We believe that transparency will drive health system improvement.” Niall Brennan et al., The Medicare Physician-Data Release – Context and Rationale,” http://www.nejm.org/doi/full/10.1056/NEJMp1405026 (May 28, 2014) (Accessed June 29, 2016).

Regardless of who has the better of this argument, release of the data certainly has captured the media’s attention.* The release of the hospital data contributed to the now-famous exposé of price variation and rapacious behavior by Steven Brill in Time. See Bitter Pill: Why Medical Bills Are Killing Us (March 4, 2013), http://time.com/198/bitter-pill-why-medical-bills-are-killing-us/ (Accessed June 29, 2016). It also contributed to a series of stunning articles, under the title Paying Till It Hurts, by Elisabeth Rosenthal in The New York Times about the high, variable and invisible price of health care. Dr. Rosenthal reported on numerous aspects of medical and hospital care pricing and how prices are so variable—to the point of appearing to be random—and how those prices by far exceed prices internationally. See After Surgery, Surprise $117,000 Medical Bill from Doctor He Didn’t Know (September 20, 2014); The Price for a Hip Replacement? Many Hospitals Are Stumped, Research Slows (Feb. 12, 2013); The $27 Trillion Medical Bill: Colonoscopies Explain Why U.S. Leads the World in Health Expenditures (June 2, 2013); American Way of Birth, Costliest in the World (July 1, 2013); For Medical Tourism, Simple Math: U.S. Estimate for a New Hip: Over $78,000. The Belgian Bill: $13,000 (Aug. 4, 2013); As Hospital Prices Soar, A Single Stitch Tops $500: Huge Emergency Bills Shock Patients, and Reflect System with Few Controls (Dec. 3, 2013); Health Care’s Road to Ruin (Dec. 22, 2013).

WALL ST. J. (June 19, 2015); Christopher Weaver et al., Small Group of Doctors Are Biggest Medicare Billers, WALL ST. J. (June 1, 2015); Reed Abelson & Sarah Cohen, Medicare Opens Its Books on Doctors and Payments, N.Y. TIMES (April 9, 2014); Denise Grady & Sheri Fink, The Medicare Data’s Pitfall: Many Favor Spending Report, But Fear Picture Is Misleading, N.Y. TIMES (April 10, 2014); Andrew Pollack & Reed Abelson, The Medicare Data’s Pitfall: Many Favor Spending Report, Eye Doctors Say Their Profits Are Smaller Than They Look, N.Y. TIMES, April 10, 2014. There certainly has been national attention, although reasonable minds can differ whether this focus qualifies as “a national conversation” or is instead, for the most part, simply dueling sound bites.

2. Claims paid data.

As noted, the release of charge data—whether by government or private coalitions—has very limited utility. Not only do charges bear no relationship to what is paid, but typically care is fragmented across a multitude of separate charges. Even worse, care is fractured across a multitude of different actors providing care at one time and at one site of care, and even worse still, across a multitude of different providers across the continuum of care. Even with price data available for discrete services, it is nonetheless extremely difficult to learn the price for any particular episode of care for any particular condition.

As a result, numerous steps must be taken to make the data useful. First, the data must be shifted to what is actually paid—claims data—rather than a bunch of list prices. Second, the manner in which those data are created and reported must be standardized in order to compare apples to apples. Third, systems must be in place to ensure accuracy of the data. Fourth, data have to aggregated into some clinically meaningful whole that is also meaningful to users, particularly patients. If one wants to know what is paid for a hip replacement, it is of little or no use to know what was paid to the surgeons without knowing what was paid to the anesthesiologist, what the hospital charged for its services (and not in a monster itemization down to the number of ibuprofen pills), what was paid for the drugs and so on, and so on, and so on.

Fifth, to report what was paid to anyone one generally needs an adequate sample size, unless there is just one uniform price for every hip replacement, as an example, which there isn’t. Ideally the sample size would be large enough (huge actually) to permit adjustment of the data to reflect the presence of multiple diagnoses so that health risk status can be taken into account. Sixth, unless there is one big mambo payer—that’s why what Medicare pays is often the benchmark for all other payers—the data must come from multiple payers, rather than from some payer that probably pays something different than every other payer, of which there are ordinarily many. Seventh, ideally one collects the data from a number of different providers, across the continuum of care, so that it becomes possible to know the total cost of treating a condition including the medical and surgical costs, hospitalization, rehabilitation stays and accompanying inpatient and outpatient therapy, home health care, etc.

In our system of fragmented services, fragmented providers, fragmented units of payment, and fragmented payers, this task is absolutely daunting. However, some steps are being taken, although without much success yet. In a report from October 2014, the General Accounting Office reported that eleven states already had, and six were planning to create, all-payers claims databases. See GAO 2014 Transparency Report at 11 n.21; see also National Conference of State Legislatures, All-Payer Claims Databases (April 2016), http://www.ncsl.org/research/health/collection-health-data-all-payer-claims-database.aspx (Accessed online, June 29, 2016) (18 states as of January 2016). There even now exists a report card on how well states are promoting price transparency (as of 2015, for two years in a row, all but five states flunked). See Catalyst for Payment Reform, Report Card on State Price Transparency Laws (July 2015), http://www.catalyze-payment-reform.org/images/documents/2015_Report_PriceTransLaws_s_06.pdf (Accessed June 29, 2016). Maine, New Hampshire and particularly Massachusetts are considered to among the leading states because of the quality of their web-based information. See, e.g., id.; Anna D. Sinaiko et al., The Role of States in Improving Price Transparency in Health Care, 175(6) JAMA INTERNAL MED. 886 (2015); see also Jeffrey T. Kullgren et al., A Census of State Health Care Price Transparency Websites, 309(23) JAMA 2437 (2013).

However, even Massachusetts, as shown in a recent report from the Pioneer Institute, still has a long way to go. Pioneer Institute Center for Health Care Solutions, Mass Hospitals Weak on Transparency (June 24, 2015), http://pioneerinstitute.org/healthcare/survey-price-information-difficult-to-obtain-from-massachusetts-hospitals/ (Accessed June 29, 2016). As we note, in order to begin to create a database, one needs standardized and accurate information about prices. The Pioneer Institute researchers had a very tough time just getting the price of an MRI of the
left knee without contrast—about as discrete a service as one could find—from 22 hospitals and clinics in Massachusetts. *It took them seven days to accomplish even this simple task.* Their understated conclusion: “In general, our survey showed that Massachusetts hospitals seem to lack a culture of price transparency.” Id. 2. Nor did the hospitals have the necessary systems and procedures to generate any kind of necessary information: “With few exceptions, hospitals seem to have no systems or procedures in place to direct consumers who are looking for price information.” Id. While insurers are and will be much better sources of data for all-payers claims databases, one still needs information from providers for, as examples, out-of-network prices, prices for the uninsured, and copayments and coinsurance.

Beyond the practical problems, potential legal barriers appear to be hampering the effort to create all-payer claims databases. Private parties are calling for greater state intervention to prohibit contractual enforcement of insurers’ gag clauses, which are often used as the rationale for failure to report price data. See, e.g., Pacific Business Group on Health (“PBGH), Policy Brief: Price Transparency (Aug. 1, 2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407306 (Accessed June 29, 2016). Insurers and providers often claim that the prices they negotiate are proprietary and they claim protection of those data as trade secrets. At least one advocacy organization believes that the providers and hospitals are wrong. See Catalyst for Payment Reform, An Analysis of Popular Legal Arguments Against Transparency (July 2015), http://www.catalyzepaymentreform.org/images/documents/Price_Transparency_Legal_Brief.pdf (Accessed June 29, 2016).*

Moreover, a very recent case, decided by the Supreme Court this term, has thrown a monkey wrench into this (not-so) well-oiled machine.

**Gobelle v. Liberty Mutual Insurance Co.**
136 S.Ct. 936 (2016)

KENNEDY, J., delivered the opinion of the Court, in which ROBERTS, C.J., and THOMAS, BREYER, ALITO, and KAGAN, JJ., joined. THOMAS, J., and BREYER, J., filed concurring opinions. GINSBURG, J., filed a dissenting opinion, in which SOTOMAYOR, J., joined.

Justice KENNEDY delivered the opinion of the Court.

This case presents a challenge to the applicability of a state law requiring disclosure of payments relating to health care claims and other information relating to health care services. Vermont enacted the statute so it could maintain an all-inclusive health care database. The state law, by its terms, applies to health plans established by employers and regulated by the Employee Retirement Income Security Act of 1974

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* This “brief” was prepared by “The Source for Competitive Healthcare,” http://sourceonhealthcare.org/ (Accessed June 29, 2016), which is a project of UC Hastings College of Law.
(ERISA). The question before the Court is whether ERISA pre-empts the Vermont statute as it applies to ERISA plans.

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A

Vermont requires certain public and private entities that provide and pay for health care services to report information to a state agency. The reported information is compiled into a database reflecting “all health care utilization, costs, and resources in [Vermont], and health care utilization and costs for services provided to Vermont residents in another state.” A database of this kind is sometimes called an all-payer claims database, for it requires submission of data from all health insurers and other entities that pay for health care services. Almost 20 States have or are implementing similar databases.

Vermont’s law requires health insurers, health care providers, health care facilities, and governmental agencies to report any “information relating to health care costs, prices, quality, utilization, or resources required” by the state agency, including data relating to health insurance claims and enrollment. Health insurers must submit claims data on members, subscribers, and policyholders. The Vermont law defines health insurer to include a “self-insured . . . health care benefit plan,” as well as “any third party administrator” and any “similar entity with claims data, eligibility data, provider files, and other information relating to health care provided to a Vermont resident.” The database must be made “available as a resource for insurers, employers, providers, purchasers of health care, and State agencies to continuously review health care utilization, expenditures, and performance in Vermont.”

Vermont law leaves to a state agency the responsibility to “establish the types of information to be filed under this section, and the time and place and the manner in which such information shall be filed.” The law has been implemented by a regulation creating the Vermont Healthcare Claims Uniform Reporting and Evaluation System. The regulation requires the submission of “medical claims data, pharmacy claims data, member eligibility data, provider data, and other information,” in accordance with specific formatting, coding, and other requirements. Under the regulation, health insurers must report data about the health care services provided to Vermonters regardless of whether they are treated in Vermont or out-of-state and about non-Vermonters who are treated in Vermont. The agency at present does not collect data on denied claims, but the statute would allow it to do so.

Covered entities (reporters) must register with the State and must submit data monthly, quarterly, or annually, depending on the number of individuals that an entity serves. The more people served, the more frequently the reports must be filed. Entities with fewer than 200 members need not report at all, and are termed “voluntary” reporters as distinct from “mandated” reporters. Reporters can be fined for not complying with the statute or the regulation.
Respondent Liberty Mutual Insurance Company maintains a health plan (Plan) that provides benefits in all 50 States to over 80,000 individuals, comprising respondent’s employees, their families, and former employees. The Plan is self-insured and self-funded, which means that Plan benefits are paid by respondent. The Plan, which qualifies as an “employee welfare benefit plan” under ERISA is subject to “ERISA’s comprehensive regulation[.]” Respondent, as the Plan sponsor, is both a fiduciary and plan administrator.

The Plan uses Blue Cross Blue Shield of Massachusetts, Inc. (Blue Cross) as a third-party administrator. Blue Cross manages the “processing, review, and payment” of claims for respondent. In its contract with Blue Cross, respondent agreed to “hold [Blue Cross] harmless for any charges, including legal fees, judgments, administrative expenses and benefit payment requirements, . . . arising from or in connection with [the Plan] or due to [respondent’s] failure to comply with any laws or regulations.” The Plan is a voluntary reporter under the Vermont regulation because it covers some 137 Vermonters, which is fewer than the 200–person cutoff for mandated reporting. Blue Cross, however, serves several thousand Vermonters, and so it is a mandated reporter. Blue Cross, therefore, must report the information it possesses about the Plan’s members in Vermont.

In August 2011, Vermont issued a subpoena ordering Blue Cross to transmit to a state-appointed contractor all the files it possessed on member eligibility, medical claims, and pharmacy claims for Vermont members. (For clarity, the Court uses “Vermont” to refer not only to the State but also to state officials acting in their official capacity.) The penalty for noncompliance, Vermont threatened, would be a fine of up to $2,000 a day and a suspension of Blue Cross’ authorization to operate in Vermont for as long as six months. Respondent, concerned in part that the disclosure of confidential information regarding its members might violate its fiduciary duties under the Plan, instructed Blue Cross not to comply. Respondent then filed this action in the United States District Court for the District of Vermont. It sought a declaration that ERISA pre-empts application of Vermont’s statute and regulation to the Plan and an injunction forbidding Vermont from trying to acquire data about the Plan or its members.

Vermont filed a motion to dismiss, which the District Court treated as one for summary judgment, and respondent filed a cross-motion for summary judgment. The District Court granted summary judgment to Vermont. It first held that respondent, despite being a mere voluntary reporter, had standing to sue because it was faced with either allegedly violating its “fiduciary and administrative responsibilities to the Plan” or assuming liability for Blue Cross’ withholding of the data from Vermont. The District Court then concluded that the State’s reporting scheme was not pre-empted. Although that scheme “may have some indirect effect on health benefit plans,” the court reasoned that the “effect is so peripheral that the regulation cannot be considered an attempt to interfere with the administration or structure of a welfare benefit plan.”

The Court of Appeals for the Second Circuit reversed. The panel was unanimous in concluding that respondent had standing, but it divided on the merits of the pre-
emption challenge. The panel majority explained that “one of ERISA’s core functions—reporting—[cannot] be laden with burdens, subject to incompatible, multiple and variable demands, and freighted with risk of fines, breach of duty, and legal expense.” The Vermont regime, the court held, does just that.

This Court granted certiorari to address the important issue of ERISA pre-emption.

II

The text of ERISA’s express pre-emption clause is the necessary starting point. It is terse but comprehensive. ERISA pre-empts “any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”

The Court has addressed the potential reach of this clause before. In Travelers, the Court observed that “[i]f ‘relate to’ were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes pre-emption would never run its course.” That is a result “no sensible person could have intended.” So the need for workable standards has led the Court to reject “uncritical literalism” in applying the clause.

Implementing these principles, the Court’s case law to date has described two categories of state laws that ERISA pre-empts. First, ERISA pre-empts a state law if it has a “reference to” ERISA plans. To be more precise, “[w]here a State’s law acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law’s operation . . . , that ‘reference’ will result in pre-emption.”. Second, ERISA pre-empts a state law that has an impermissible “connection with” ERISA plans, meaning a state law that “governs . . . a central matter of plan administration” or “interferes with nationally uniform plan administration.” A state law also might have an impermissible connection with ERISA plans if “acute, albeit indirect, economic effects” of the state law “force an ERISA plan to adopt a certain scheme of substantive coverage or effectively restrict its choice of insurers.” When considered together, these formulations ensure that ERISA’s express pre-emption clause receives the broad scope Congress intended while avoiding the clause’s susceptibility to limitless application.

III

Respondent contends that Vermont’s law falls in the second category of state laws that are pre-empted by ERISA: laws that govern, or interfere with the uniformity of, plan administration and so have an impermissible “connection with” ERISA plans. When presented with these contentions in earlier cases, the Court has considered “the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,” and “the nature of the effect of the state law on ERISA plans[.]” Here, those considerations lead the Court to conclude that Vermont’s regime, as applied to ERISA plans, is pre-empted.
A

ERISA does not guarantee substantive benefits. The statute, instead, seeks to make the benefits promised by an employer more secure by mandating certain oversight systems and other standard procedures. Those systems and procedures are intended to be uniform (ERISA’s pre-emption clause “indicates Congress’s intent to establish the regulation of employee welfare benefit plans ‘as exclusively a federal concern’”). “Requiring ERISA administrators to master the relevant laws of 50 States and to contend with litigation would undermine the congressional goal of ‘minimiz[ing] the administrative and financial burden[s]’ on plan administrators—burdens ultimately borne by the beneficiaries.”

ERISA’s reporting, disclosure, and recordkeeping requirements for welfare benefit plans are extensive. ERISA plans must present participants with a plan description explaining, among other things, the plan’s eligibility requirements and claims-processing procedures. Plans must notify participants when a claim is denied and state the basis for the denial. Most important for the pre-emption question presented here, welfare benefit plans governed by ERISA must file an annual report with the Secretary of Labor. The report must include a financial statement listing assets and liabilities for the previous year and, further, receipts and disbursements of funds. The information on assets and liabilities as well as receipts and disbursements must be provided to plan participants on an annual basis as well. Because welfare benefit plans are in the business of providing benefits to plan participants, a plan’s reporting of data on disbursements by definition incorporates paid claims. See Dept. of Labor, Schedule H (Form 5500) Financial Information (2015) (requiring reporting of “[b]enefit claims payable” and “[b]enefit payment and payments to provide benefits[.]”)

The Secretary of Labor has authority to establish additional reporting and disclosure requirements for ERISA plans. ERISA permits the Secretary to use the data disclosed by plans “for statistical and research purposes, and [to] compile and publish such studies, analyses, reports, and surveys based thereon as he may deem appropriate.” The Secretary also may, “in connection” with any research, “collect, compile, analyze, and publish data, information, and statistics relating to” plans (approving “other studies relating to employee benefit plans, the matters regulated by this subchapter, and the enforcement procedures provided for under this subchapter”).

ERISA further permits the Secretary of Labor to “requir[e] any information or data from any [plan] where he finds such data or information is necessary to carry out the purposes of” the statute, and, when investigating a possible statutory violation, “to require the submission of reports, books, and records, and the filing of data” related to other requisite filings, The Secretary has the general power to promulgate regulations “necessary or appropriate” to administer the statute, and to provide exemptions from any reporting obligations.

It should come as no surprise, then, that plans must keep detailed records so compliance with ERISA’s reporting and disclosure requirements may be “verified,
explained, or clarified, and checked for accuracy and completeness.” The records to be retained must “include vouchers, worksheets, receipts, and applicable resolutions.”

These various requirements are not mere formalities. Violation of any one of them may result in both civil and criminal liability.

As all this makes plain, reporting, disclosure, and recordkeeping are central to, and an essential part of, the uniform system of plan administration contemplated by ERISA. The Court, in fact, has noted often that these requirements are integral aspects of ERISA.

Vermont’s reporting regime, which compels plans to report detailed information about claims and plan members, both intrudes upon “a central matter of plan administration” and “interferes with nationally uniform plan administration.” The State’s law and regulation govern plan reporting, disclosure, and—by necessary implication—recordkeeping. These matters are fundamental components of ERISA’s regulation of plan administration. Differing, or even parallel, regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability. Pre-emption is necessary to prevent the States from imposing novel, inconsistent, and burdensome reporting requirements on plans.

The Secretary of Labor, not the States, is authorized to administer the reporting requirements of plans governed by ERISA. He may exempt plans from ERISA reporting requirements altogether. And, he may be authorized to require ERISA plans to report data similar to that which Vermont seeks, though that question is not presented here. Either way, the uniform rule design of ERISA makes it clear that these decisions are for federal authorities, not for the separate States.

B

Vermont disputes the pre-emption of its reporting regime on several fronts. The State argues that respondent has not demonstrated that the reporting regime in fact has caused it to suffer economic costs. But respondent’s challenge is not based on the theory that the State’s law must be pre-empted solely because of economic burdens caused by the state law. Respondent argues, rather, that Vermont’s scheme regulates a central aspect of plan administration and, if the scheme is not pre-empted, plans will face the possibility of a body of disuniform state reporting laws and, even if uniform, the necessity to accommodate multiple governmental agencies. A plan need not wait to bring a pre-emption claim until confronted with numerous inconsistent obligations and encumbered with any ensuing costs.

Vermont contends, furthermore, that ERISA does not pre-empt the state statute and regulation because the state reporting scheme has different objectives. This Court has recognized that “[t]he principal object of [ERISA] is to protect plan participants and beneficiaries.” And “[i]n enacting ERISA, Congress’ primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay
employees benefits from accumulated funds.” The State maintains that its program has nothing to do with the financial solvency of plans or the prudent behavior of fiduciaries. This does not suffice to avoid federal pre-emption.

“[P]re-emption claims turn on Congress’s intent.” The purpose of a state law, then, is relevant only as it may relate to the “scope of the state law that Congress understood would survive,” or “the nature of the effect of the state law on ERISA plans[.]” In Travelers, for example, the Court noted that “[b]oth the purpose and the effects of” the state law at issue “distinguish[ed] it from” laws that “function as a regulation of an ERISA plan itself.” The perceived difference here in the objectives of the Vermont law and ERISA does not shield Vermont’s reporting regime from pre-emption. Vermont orders health insurers, including ERISA plans, to report detailed information about the administration of benefits in a systematic manner. This is a direct regulation of a fundamental ERISA function. Any difference in purpose does not transform this direct regulation of “a central matter of plan administration” into an innocuous and peripheral set of additional rules.

The Vermont regime cannot be saved by invoking the State’s traditional power to regulate in the area of public health. The Court in the past has “addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law,” in particular state laws regulating a subject of traditional state power. ERISA, however, “certainly contemplated the pre-emption of substantial areas of traditional state regulation.” ERISA pre-empts a state law that regulates a key facet of plan administration even if the state law exercises a traditional state power. The fact that reporting is a principal and essential feature of ERISA demonstrates that Congress intended to pre-empt state reporting laws like Vermont’s, including those that operate with the purpose of furthering public health. The analysis may be different when applied to a state law, such as a tax on hospitals, the enforcement of which necessitates incidental reporting by ERISA plans; but that is not the law before the Court. Any presumption against pre-emption, whatever its force in other instances, cannot validate a state law that enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does.

IV

Respondent suggests that the Patient Protection and Affordable Care Act (ACA), which created new reporting obligations for employer-sponsored health plans and incorporated those requirements into the body of ERISA, further demonstrates that ERISA pre-empts Vermont’s reporting regime. The ACA, however, specified that it shall not “be construed to preempt any State law that does not prevent the application of the provisions” of the ACA. This anti-pre-emption provision might prevent any new ACA-created reporting obligations from pre-empting state reporting regimes like Vermont’s, notwithstanding the incorporation of these requirements in the heart of ERISA. But see 29 U.S.C. § 1191(a)(2) (providing that the new ACA provisions shall not be construed to affect or modify the ERISA pre-emption clause as applied to group health plans); 42 U.S.C. § 300gg–23(a)(2) (same).
The Court has no need to resolve this issue. ERISA’s pre-existing reporting, disclosure, and recordkeeping provisions—upon which the Court’s conclusion rests—maintain their pre-emptive force whether or not the new ACA reporting obligations also pre-empt state law.

* * *

ERISA’s express pre-emption clause requires invalidation of the Vermont reporting statute as applied to ERISA plans. The state statute imposes duties that are inconsistent with the central design of ERISA, which is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements.

Justice BREYER, concurring.

I write separately to emphasize that a failure to find pre-emption here would subject self-insured health plans under the Employee Retirement Income Security Act of 1974 (ERISA) to 50 or more potentially conflicting information reporting requirements. Doing so is likely to create serious administrative problems. The Court points out that the respondent’s plan provides benefits to over 80,000 individuals living in 50 different States. In addition, amici curiae tell us that self-insured, ERISA-based health plans provide benefits to 93 million Americans. If each State is free to go its own way, each independently determining what information each plan must provide about benefits, the result could well be unnecessary, duplicative, and conflicting reporting requirements, any of which can mean increased confusion and increased cost. Private standard setting can of course help alleviate these problems, but given the large number of different possible regulations, I do not believe that is sufficient.

I would also emphasize that pre-emption does not necessarily prevent Vermont or other States from obtaining the self-insured, ERISA-based health-plan information that they need. States wishing to obtain information can ask the Federal Government for appropriate approval. As the majority points out, the “Secretary of Labor has authority to establish additional reporting and disclosure requirements for ERISA plans.” Moreover, the Secretary “is authorized to undertake research and surveys and in connection therewith to collect, compile, analyze and publish data, information, and statistics relating to employee benefit plans, including retirement, deferred compensation, and welfare plans.” At least one other important statute provides the Secretary of Health and Human Services with similar authority. See 42 U.S.C. § 300gg–17(a) (part of the Patient Protection and Affordable Care Act that is applicable to group health insurance plans including ERISA plans); Brief for United States as Amicus Curiae 4 (the Department of Labor, the Department of Health and Human Services, and the Department of Treasury are “currently considering a rulemaking to require health plans to report more detailed information about various aspects of plan administration, such as enrollment, claims processing, and benefit offerings”).
I see no reason why the Secretary of Labor could not develop reporting requirements that satisfy the States’ needs, including some State-specific requirements, as appropriate. Nor do I see why the Department could not delegate to a particular State the authority to obtain data related to that State, while also providing the data to the Federal Secretary for use by other States or at the federal level.

Although the need for federal approval or authorization limits to some degree the States’ power to obtain information, requiring that approval has considerable advantages. The federal agencies are more likely to be informed about, and to understand, ERISA-related consequences and health-care needs from a national perspective. Their involvement may consequently secure for the States necessary information without unnecessarily creating costly conflicts—particularly when compared with such alternatives as giving each State free rein to go its own way or asking nonexpert federal courts to try to iron out, regulation by regulation, such conflicts.

For these reasons, and others that the majority sets forth, I agree that Vermont’s statute is pre-empted because it “interferes with nationally uniform plan administration.”

Justice GINSBURG, with whom Justice SOTOMAYOR joins, dissenting.

To better control health care outcomes and costs, Vermont requires all public and private entities that pay for health care services provided to Vermont residents to supply data to the State’s all-payer claims database. Many States have similar databases in place or in development. The question presented in this case is whether Vermont’s health care data-collection law is preempted by the Employer Retirement Income Security Act of 1974 (ERISA), the federal law regulating employee benefit plans. I would hold that Vermont’s effort to track health care services provided to its residents and the cost of those services does not impermissibly intrude on ERISA’s dominion over employee benefit plans.

In 2005, the Vermont Legislature established the Vermont Health Care Uniform Reporting and Evaluation System, a database populated by information on health care claims paid by insurers and other coverage providers (directing insurers and other coverage providers to “submit medical claims data, pharmacy claims data, member eligibility data, provider data, and other information related to health care provided to Vermont residents and health care provided by Vermont health care providers and facilities”). Health insurers and other coverage providers must report the required data if they cover at least 200 Vermont residents.
Seventeen other States have enacted similar database systems, called “all-payer claims databases.” These States, like Vermont, collect health-claims data to serve compelling interests, including identification of reforms effective to drive down health care costs, evaluation of relative utility of different treatment options, and detection of instances of discrimination in the provision of care. See Brief for National Governors Association et al. as Amici Curiae 11–14; Brief for Harvard Law School Center for Health Law and Policy Innovation et al. as Amici Curiae 11–18; Brief for State of New York et al. as Amici Curiae 12–20. See also Vt. Stat. Ann., Tit. 18, § 9410(a)(1) (Vermont’s data-collection law is designed to help “identify[y] health care needs and inform[m] health care policy,” “evaluate the effectiveness of intervention programs on improving patient outcomes,” “compare [e] costs between various treatment settings and approaches,” “determine the capacity and distribution of existing resources,” and “provide[e] information to ... purchasers of health care”).

Respondent Liberty Mutual Insurance Company (Liberty), in common with legions of employers, provides health care to its employees through a self-insured plan, administered by Blue Cross/Blue Shield (Blue Cross). Because Blue Cross administers thousands of health care policies in Vermont, the State requires it to report data for all of the plans it administers, and Blue Cross has complied with this mandate. In 2010, for example, Blue Cross reported data on over 7,000 Vermont health care-plan beneficiaries. Roughly half of the beneficiaries received coverage through self-insured employer policies. In 2011, at Liberty’s request, Blue Cross did not submit data on Vermont residents who received coverage through Liberty’s plan. Vermont ordered Blue Cross to provide the claims data. Liberty instructed Blue Cross not to comply and, shortly thereafter, filed the instant suit, seeking to block Vermont from obtaining the data.

In defense of its resistance to Vermont’s data-collection law, Liberty relies on its plan’s status as an ERISA-covered “employee welfare benefit plan,” defined as “any plan, fund, or program ... established or maintained by an employer ... for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, medical, surgical, or hospital care or benefits, or benefits in the event of sickness.” Because ERISA directs plan fiduciaries to conserve plan assets for the purpose of “providing benefits to participants,” Liberty maintains that ERISA preempts diverse state health-claims reporting laws. If there is to be mandatory health-claims reporting by ERISA plans, Liberty urges, the source of the mandate should be a uniform national reporting regime.

Opposing ERISA-grounded preemption of its data-collection law, Vermont points out that the efficacy of the State’s law depends on comprehensive reporting, i.e., collecting

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1 States, in addition to Vermont, so far maintaining all-payer claims databases are: Arkansas, Colorado, Connecticut, Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, New York, Oregon, Rhode Island, Tennessee, Utah, Virginia, Washington, and West Virginia.

2 Illustrative of the utility of all-payer claims databases, Minnesota evaluated data on emergency-room visits and concluded that the condition causing two of every three visits could have been treated more efficiently, and as effectively, in a nonhospital setting. Brief for State of New York et al. as Amici Curiae 12–13.
data on numerous beneficiaries from each of several major segments of the health care market. About half of Americans with health insurance receive coverage from their employers, and 61% of such persons are covered by an employer’s self-insured plan. In Vermont, about 20% of the database’s total content originates from employer self-insured plans. Stopping States from collecting claims data from self-insured employer health care plans would thus hugely undermine the reporting regimes on which Vermont and other States depend to maintain and improve the quality, and hold down the cost, of health care services.

The United States District Court for the District of Vermont rejected Liberty’s plea for preemption. Vermont’s data-collection law, that court determined, served the State’s undoubted interest in regulating health care markets, and did not substantially interfere with the operation of Liberty’s ERISA plans. The Court of Appeals for the Second Circuit reversed, two to one. The majority acknowledged that the Supreme Court’s ERISA-preemption decisions of the 1990’s “marked something of a pivot” in starting with a presumption “’that Congress does not intend to supplant state law,’ especially if the ‘state action [occurs] in fields of traditional state regulation,’ like health care.” Nonetheless, the majority concluded that ERISA preempted the application of Vermont’s data-collection law to Liberty’s plan. The reporting of information about plan benefits, the majority reasoned, qualifies as a “core ERISA function” and, therefore, must be “subject to a uniform federal standard.” Judge Straub dissented, offering a concise critique of the majority’s opinion:

“The majority finds that the burden imposed by the Vermont reporting requirement warrants preemption of the [data-collection] statute. This conclusion falters for two primary reasons. First, the reporting requirement imposed by the Vermont statute differs in kind from the ‘reporting’ that is required by ERISA and therefore was not the kind of state law Congress intended to preempt. Second, Liberty Mutual has failed to show any actual burden, much less a burden that triggers ERISA preemption. Rather, the Vermont statute ... does not interfere with an ERISA plan’s administration of benefits.”

II

Essentially for the reasons Judge Straub identified, I would hold that ERISA does not preempt Vermont’s data-collection statute. That law and ERISA serve different purposes. ERISA’s domain is the design and administration of employee benefit plans: notably, prescriptions on the vesting of benefits, claims processing, and the designation of beneficiaries. Its reporting requirements, geared to those functions, ensure that the plans in fact provide covered benefits. Vermont’s data-collection statute, in contrast, aims to improve the quality and utilization, and reduce the cost, of health care in Vermont by

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4 The Federal Government supplies Medicare claims data to Vermont and other States that maintain similar databases. See 42 U.S.C. § 1395kk(e) (requiring the Department of Health and Human Services (HHS) to make Medicare data available to state health-claims databases). And HHS has authorized the States to include Medicaid claims data in their databases.
providing consumers, government officials, and researchers with comprehensive data about the health care delivery system. Nor does Vermont’s law impose burdens on ERISA plans of the kind this Court has found sufficient to warrant preemption.

ERISA’s preemption clause provides that the Act “shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.” Lacking clear direction from the clause’s “opaque” text, the Court has sought to honor Congress’ evident call for an expansive preemption principle without invalidating state regulations falling outside ERISA’s domain.5

Seeking to bring some measure of determinacy to ERISA preemption, the Court has stated: “[A] law ‘relates to’ an employee benefit plan . . . if it has a connection with or reference to such a plan.” In this case, the Court of Appeals found, and the parties do not here contest, that Vermont’s data-collection law lacks “reference to” ERISA plans because the law applies to all health care payers and does not home in on ERISA plans. The question, therefore, is whether the law has an impermissible “connection with” ERISA plans. Because the term “‘connection with’ is scarcely more restrictive than ‘relate to,’” the Court has “cautioned against . . . uncritical literalism,” and has set out this further formulation: “[T]o determine whether a state law has the forbidden connection, we look both to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive, as well as to the nature of the effect of the state law on ERISA plans.”

In framing preemption doctrine, the Court does not “assum[e] lightly that Congress has derogated state regulation, but instead . . . addresse[s] claims of pre-emption with the starting presumption that Congress does not intend to supplant state law,” especially where the State’s regulation deals with “matters of health and safety[.]” In Travelers and subsequent decisions upholding state laws against preemption challenges, this Court made clear that this presumption plays an important role in ERISA cases. Vermont’s data-collection law is a vital part of the State’s control of its own health care market. The presumption against preemption should thus apply full strength, and Liberty has not rebutted it, i.e., it has not shown that ERISA demands the preemption of Vermont’s data-collection law. To the contrary, the Court’s ERISA preemption precedent points against preemption in this case.

A

To determine whether Vermont’s data-collection law, as applied to Liberty’s plan, has an impermissible “connection with” ERISA plans, I look first to the “objectives of the ERISA statute as a guide” (emphasizing “the importance of considering the target at which the state law aims” in applying ordinary field-preemption principles). Because

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5 I have joined opinions proposing that the Court acknowledge that the “‘relate to’ clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary field pre-emption applies—namely, the field of laws regulating” employee-benefit plans. Whether measured against ordinary preemption principles or this Court’s ERISA-specific precedent, Vermont’s data-collection law should survive inspection.
ERISA’s reporting requirements and the Vermont law elicit different information and serve distinct purposes, there is no sensible reason to find the Vermont data-collection law preempted.

ERISA-covered benefit plans must, absent exemption, file annual reports containing financial and actuarial data to enable the Secretary of Labor to evaluate plans’ management and solvency. (Congress “established extensive reporting . . . requirements” to protect against “the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees’ benefits from accumulated funds.”

Beyond debate, Vermont’s data-collection law does not seek to regulate the management and solvency of ERISA-covered welfare plans. Vermont requests no information on plan finances. The State collects data on paid health care claims, not denied claims. Vermont seeks a better understanding of how its residents obtain health care and how effective that care is. Unlike ERISA superintendence, Vermont’s interest does not lie in reviewing whether a self-insured provider is keeping its bargain to covered employees. Nor does Vermont’s statute even arguably regulate relationships among the prime ERISA entities: beneficiaries, participants, administrators, employees, trustees and other fiduciaries, and the plan itself.

Despite these significant differences between ERISA’s reporting requirements and Vermont’s data-collection regime, Liberty contends that Congress intended to spare ERISA plans from benefit-related reporting requirements unless those requirements are nationally uniform. In support of this contention, Liberty points to dicta from this Court’s opinions and selections from ERISA’s legislative history. Far from unambiguously endorsing Liberty’s sweeping view of ERISA’s preemptive scope, these statements can be read at least as reasonably for the unremarkable principle that ERISA preempts state reporting rules designed to serve the same purposes as ERISA’s reporting requirements. This more limited understanding is consistent with the Court’s admonition to pay close attention to the “objectives of the ERISA statute as a guide.”

B

Satisfied that ERISA’s objectives do not require preemption of Vermont’s data-collection law, I turn to the “nature of the effect of the state law on ERISA plans.” The imposition of some burdens on the administration of ERISA plans, the Court has held, does not suffice to require preemption. While a law imposing costs so acute as to effectively dictate how a plan is designed or administered could trigger preemption, no

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6 The Court suggests that the Department of Labor collects, pursuant to ERISA’s reporting rules, similar information to the data that Vermont’s regime elicits. But these reporting obligations are not remotely similar. As one of Liberty’s amici curiae explains, the Department of Labor reporting form cited by the Court requires reporting of the “total amount of claims paid annually by the plan,” not the “granular claim-by-claim” information (including data about the “location of services rendered”) that Vermont collects. The data entries cited by the Court require a plan to enter, in merely a handful of boxes on a four-page form, the aggregate sums of all claims paid annually. See Dept. of Labor, Schedule H (Form 5500) Financial Information (2015).
such extreme effects are present here. Moreover, no “central matter of plan administration” is touched by Vermont’s data-collection law. That law prescribes no vesting requirements, benefit levels, beneficiary designations, or rules on how claims should be processed or paid. Indeed, Vermont’s law does not require Liberty to do anything. The burden of compliance falls on Blue Cross, which apparently provides the data without protest on behalf of other self-funded plans.

Reporting and disclosure are no doubt required of ERISA plans, but those requirements are ancillary to the areas ERISA governs. Reporting and recordkeeping incident to state laws of general applicability have been upheld as they bear on ERISA plans. In De Buono, for example, the Court held that a gross-receipts tax on patient services provided by a hospital operated by an ERISA plan was not preempted, even though administration of the tax required filing quarterly reports. And in Dillingham, the Court held that California’s prevailing-wage law was not preempted as applied to apprenticeship programs established by ERISA plans. Prevailing-wage laws typically require employees to keep records of the wages paid to employees and make them available for review by state authorities. The Second Circuit erred, then, in holding that ERISA preempts any state-law reporting obligation that is more than “slight.”

The Vermont data-collection statute keeps company with the laws considered in De Buono and Dillingham: It is generally applicable and does not involve “a central matter of plan administration.” And, as Judge Straub emphasized in his dissent, Liberty “failed to provide any details or showing of the alleged burden,” instead “arguing only that ‘all regulations have their costs.’”

As the United States explains, the supposition indulged by the Second Circuit that Vermont’s law imposed a substantial burden “is not obvious, or even particularly plausible, without any factual support.” The data-collection law “essentially requires Blue Cross [Liberty’s third-party administrator] to take information generated in the ordinary course of its claims-payment operations and report that information in a prescribed format to the [State].” The Court of Appeals majority accentuated the sheer number of data entries that must be reported to Vermont. Entirely overlooked in that enumeration is the technological capacity for efficient computer-based data storage, formatting, and submission. See Brief for National Association of Health Data Organizations et al. as Amici Curiae 7–9, 13 (describing three-step electronic path data take from health provider, to insurer or health care plan, and ultimately to the State’s database). Where regulatory compliance depends upon the use of evolving technologies, it should be incumbent on the objector to show concretely what the alleged regulatory burden in fact entails.

7 Amici supporting Liberty point to several allegedly burdensome features of compliance with Vermont’s law, but they appear to be no more than everyday facets of modern regulatory compliance: installing and maintaining a software system to collect and remit data to the State, seeking variances from state regulators when health providers do not submit required information to the plan or its administrator, and reformatting data to comply with state-database formatting and encryption standards.

8 Liberty contends that it need not quantify the precise cost of compliance with Vermont’s law to prove that the law is burdensome. But Liberty should at least introduce concrete evidence of the alleged burdens. A
Because data-collection laws like Vermont’s are not uniform from State to State, compliance is inevitably burdensome, Liberty successfully argued in the Court of Appeals. The Court replays this reasoning in today’s opinion. But state-law diversity is a hallmark of our political system and has been lauded in this Court’s opinions. Something more than an inherent characteristic of our federal system, therefore, must underpin the ERISA-grounded preemption Liberty urges.\textsuperscript{99}

Liberty points to \textit{Egelhoff} as exemplary. In \textit{Egelhoff}, a deceased ERISA-plan participant’s ex-spouse challenged a state law that revoked her beneficiary status automatically upon her divorce, even though the ERISA plan’s terms did not. The Court held that ERISA preempted the law because it “binds ERISA plan administrators to a particular choice of rules for determining beneficiary status.” In that context, the Court said: “Requiring ERISA administrators to master the relevant laws of 50 States . . . would undermine the congressional goal of minimizing the administrative and financial burdens on plan administrators—burdens ultimately borne by the beneficiaries.”

The Court took care, however, to confine \textit{Egelhoff} to issues implicating “a central matter of plan administration,” in other words, “a core ERISA concern.” What does that category comprise? As earlier described, prescriptions on benefit levels, beneficiary designations, vesting requirements, and rules on processing and payment of claims would rank under the central or core ERISA subject-matter rubric.\textsuperscript{10} So, too, would reporting and disclosure obligations, but of what kind? Those that further regulation of the design and administration of employee benefit plans, \textit{i.e.}, reporting and disclosures tied to the areas ERISA governs. ERISA’s reporting and disclosure requirements are thus concerned with mismanagement of funds, failure to pay employee benefits, plan assets or allocations, all information bearing on the financial integrity of the plan. Vermont’s data-collection law, eliciting information on medical claims, services provided to beneficiaries, charges and payment for those services, and demographic makeup of those receiving benefits,

\begin{footnotesize}
\textsuperscript{9} Concurring in the Court’s opinion, Justice BREYER worries that “[i]f each State is free to go its own way, . . . the result could well be unnecessary, duplicative, and conflicting reporting requirements.” In support, Justice BREYER cites a 2011 report. In fact, the organizations that published this report inform us, in a brief supporting Vermont, that “submitting claims data to [all-payer claims databases] . . . is a routine, straightforward process” and that States and private organizations have worked in recent years to standardize data-reporting requirements.

\textsuperscript{10} The “core ERISA concern” (or “central matter of plan administration”) inquiry is not meaningfully different from the examination whether a state law is inconsistent with the “objectives of the ERISA statute.” \textit{Egelhoff}, 532 U.S., at 1475. The Court appears to disagree, stating that “[a]ny difference in purpose” between ERISA and Vermont’s reporting requirements “does not transform [Vermont’s] direct regulation of a ‘central matter of plan administration’ into an innocuous and peripheral set of additional rules.” In other words, the Court assumes that a state law that is not inconsistent with ERISA’s purposes can nonetheless burden a “central matter of plan administration” or implicate a “core ERISA concern.” Missing from the Court’s opinion is any definition of these terms. What meaning can “central matter of plan administration” and “core ERISA concern” have if they are divorced from ERISA’s purposes?
\end{footnotesize}
does not fit the bill any more than reporting relating to a plan’s taxes or wage payments does.

Numerous States have informed the Court of their urgent need for information yielded by their health care data-collection laws. Wait until the Federal Government acts is the Court’s response. The Department of Labor’s capacious grant of statutory authority, the Court observes, might allow it to collect the same data Vermont and other States seek about ERISA plan health-benefit payments. Once the information is collected, the Court conjectures, the Department could pass the data on to the States. It is unsettling, however, to leave the States dependent on a federal agency’s grace, i.e., the Department of Labor’s willingness to take on a chore divorced from ERISA’s objectives.11

* * *

Declaring “reporting,” unmodified, a central or core ERISA function, as the Second Circuit did, passes the line this Court drew in Travelers, De Buono, and Dillingham when it reined in § 1144(a) so that it would no longer operate as a “super-preemption” provision. I dissent from the Court’s retrieval of preemption doctrine that belongs in the discard bin.

[End of Opinion]

The Court’s decision raises many questions.

Is the preemption analysis under the “relate-to” clause unique? There is a fundamental question swirling around in the various opinions in Gobeille that is only obliquely referenced in note five of Justice Ginsburg’s opinion: “I have joined opinions proposing that the Court acknowledge that the ‘‘relate to’ clause of the pre-emption provision is meant, not to set forth a test for pre-emption, but rather to identify the field in which ordinary field pre-emption applies—namely, the field of laws regulating” employee-benefit plans. Whether measured against ordinary preemption principles or this Court’s ERISA-specific precedent, Vermont’s data-collection law should survive inspection.” What does this mean?

Perhaps the most recent explicit debate about this issue occurred in Egelhoff v. Egelhoff, 121 S.Ct. 1322 (2001). We discuss the substance of this case below but for now our focus is on Egelhoff’s concurring opinions. In his opinion, joined by Justice Ginsburg, Justice Scalia pointed to the indeterminate reach of the relate-to clause, writing that it “has no discernible content that would not pick up every ripple in the pond, producing a result ‘that no sensible person could have intended.’” He continued, “I persist in the view that we can bring some coherence to this area, and can give the statute both a plausible

11 The Court’s analysis may hamper States’ abilities to require reporting, not just of plan benefits, but of plan assets as well. For example, the Department of Labor collects information about real property held in trust by a pension plan so that it can assess the plan’s financial well-being. States may need to collect the same information for a very different purpose, such as assessing a property tax.
and precise content, only by interpreting the ‘relate to’ clause as a reference to our ordinary pre-emption jurisprudence.” Justice Breyer, joined by Justice Stevens, agreed with this point, writing, “Like Justice SCALIA, I believe that we should apply normal conflict pre-emption and field pre-emption principles where, as here, a state statute covers ERISA and non-ERISA documents alike.” Given the opinions in Gobeille, the Court has yet to adopt this position.

What is the structure of this unique (and mysterious) analysis of the “relate-to” clause?

Let’s go back to Travelers. Writing for the Court, Justice Souter observed that Congress did extend preemption beyond “all state laws dealing with the subject matters covered by ERISA [such as] reporting, disclosure, fiduciary responsibility, and the like . . . .” Much of the battle in Gobeille concerned, of course, whether the “reporting” required by Vermont fell within ERISA’s core concern with “reporting.” Let’s try to discern the structure of the preemption analysis for core concerns.

At one extreme, which might be implied by Justice Ginsburg’s footnote five—and we write “might” because she did not elaborate—would be the conclusion that with regard to core concerns, by enacting ERISA Congress has occupied the field. If that is the correct conclusion, of what relevance would be the existence or lack thereof of a state law’s impact on national uniformity? Must there be a factual showing in that regard and if so, which party would bear the burden of proof? Would it matter whether the state law stems from its traditional authority to regulate health care? Would the law’s direct or indirect impact on ERISA plans be relevant, and if so, which party would bear the burden of proof in that regard? Is anything relevant other than the conclusion that Congress has occupied the field?

At the other extreme would be the indeterminate interpretation of the “relate-to” clause as “pick[ing] up every ripple on the pond.” Nothing indicates that any Justice wished to return to that mess, although in his dissent, not reprinted here, Justice Thomas expressed the view that no interpretation of the relate-to clause could be coherent.

So, what’s in the middle? Balancing of course! What factors would be relevant in the balancing? Might those be some combination of the degree of overlap between the state law and a core concern, the extent to which the state law is a traditional exercise of its police power to regulate health care, the degree to which the state law actually does interfere with ERISA’s interest in national uniformity, particularly—or is this the sole relevant factor?—with regard to core concerns, and the degree of burden, economic or otherwise, direct or indirect, imposed on ERISA plans?

One can truly wonder how such an analysis could be structured to produce consistent results—or if that is possible at all. Regardless, where does the Court’s opinion fall in this range of alternatives? Can you tell?
The Court’s substantive analysis of Vermont’s reporting requirements appears in part III of its opinion. Part III.A. is an ode to the “extensive” nature of “ERISA’s reporting, disclosure, and recordkeeping requirements for welfare benefit plans” and a discussion of how “Vermont’s reporting regime, which compels plans to report detailed information about claims and plan members, both intrudes upon ‘a central matter of plan administration’ and ‘interferes with nationally uniform plan administration.’” The State’s law and regulation govern plan reporting, disclosure, and—by necessary implication—recordkeeping. These matters are fundamental components of ERISA’s regulation of plan administration. Differing, or even parallel regulations from multiple jurisdictions could create wasteful administrative costs and threaten to subject plans to wide-ranging liability.” Ok, we’ve got a core concern, but how do we know that? Does the Court simply take judicial notice that Vermont’s law “intrudes,” “interferes,” and “could create” the list of horribles precluded only by ERISA preemption? What facts in the record show that these impacts exist? What does the use of the word “could,” always a telltale sign, indicate?

Justice Breyer’s concurrence is similar. “I write separately to emphasize that a failure to find pre-emption here would subject self-insured health plans under [ERISA] to 50 or more potentially conflicting information reporting requirements.” How does he know that? What does the word “potentially” tell you? “Doing so is likely to create serious administrative problems.” How does he know this? What does the word “likely” indicate to you? “If each State is free to go its own way, each independently determining what information each plan must provide about benefits, the result could well be unnecessary, duplicative, and conflicting reporting requirements, any of which can mean increased confusion and increased cost.” How does he know this? What do the words “if” and “could” tell you? The core ERISA concern at issue is “reporting.” Vermont’s law requires “reporting.” Do the intrusion, compulsion, interference and waste stem simply from the overlapping word, “reporting”?

If Vermont’s reporting law overlaps with ERISA’s “reporting” requirement, surely there must be federal authority to require the same “reporting,” right? The Court wrote, “The Secretary of Labor, not the States, is authorized to administer the reporting requirements of plans governed by ERISA. He may exempt plans from ERISA reporting requirements altogether. See §1024(a)(3); 29 CFR §2520.104–44 (2005) (exempting self-insured health plans from the annual financial reporting requirement). And, he may be authorized to require ERISA plans to report data similar to that which Vermont seeks, though that question is not presented here.” “May be authorized”?? The “question is not presented here”?? Can preemption—whether field or conflict—have any meaning at all if federal authority does not exist? Imagine that the Secretary of Labor now moves to establish a nationally uniform reporting system containing claims payment data, to which all ERISA plans must submit annually in accordance with federal standards. Imagine further that the Secretary enters into data use agreements with states so that they can examine and make use of the data. Could employers and insurers successfully sue to halt
such a step, claiming that such data collection exceeds the Secretary’s authority?" If you think that such an possibility is absurd, then why did the Court not say explicitly that federal authority exists if it necessarily is a predicate for the existence of preemption of state authority?** "Either way, the uniform rule design of ERISA makes it clear that these decisions are for federal authorities, not for the separate States." Is that a step in the reasoning or a conclusion?

Again Justice Breyer’s concurrence is similar. He writes that states like Vermont can get the information they need by “ask[ing] the Federal Government for appropriate approval.” Justice Breyer “see[s] no reason why the Secretary of Labor could not develop reporting requirements that satisfy the States’ needs, including some State-specific requirements, as appropriate. Nor do I see why the Department could not delegate to a particular State the authority to obtain data related to that State, while also providing the data to the Federal Secretary for use by other States or at the federal level.” Is this the same as writing, “the Secretary of Labor has the authority to develop reporting requirements that satisfy the States’ need, and he has the authority to delegate that authority to the states to act for the federal government”? Again, can the Court logically hold that Vermont’s law is preempted while not concluding definitively that ERISA provides the Secretary with these powers?***

In Part III.B. of its opinion, the Court rejects Vermont’s efforts to overcome the conclusion—supposition?—that Vermont’s law overlaps with federal power. The Court first rejects Vermont’s argument that Liberty Mutual has failed to demonstrate that its law has imposed economic burdens. “But respondent’s challenge is not based on the theory that the State’s law must be pre-empted solely because of economic burdens caused by the state law. Respondent argues, rather, that Vermont’s scheme regulates a central aspect of plan administration and, if the scheme is not pre-empted, plans will face the possibility of a body of disuniform state reporting laws and, even if uniform, the necessity to accommodate multiple governmental agencies. A plan need not wait to bring a pre-emption claim until confronted with numerous inconsistent obligations and encumbered with any ensuing costs.” Is there anything new here or is this merely a repetition of the conclusion—supposition?—that Vermont’s “reporting” overlaps with ERISA’s “reporting”?

* In Part Three we will see that some courts hold that ERISA’s Section 514 does not preempt malpractice actions brought against plans under state law because those laws regulate quality not health insurance coverage, i.e., regulation of quality falls outside of ERISA’s domain. It would follow, then, that ERISA fiduciaries have no duty to collect, much less report, data on quality. If that is the case, then how can the Secretary of Labor require them to do so? Further, how can Vermont’s reporting requirements, pertaining to quality, be preempted?

** It is no answer to write that the failure of DOL to act simply creates an “ERISA vacuum,” something we will address in Part Three, in which states have no authority but the federal government fails to exercise the authority it possesses. Our point is that if state law is preempted by a law passed by Congress, then there must be federal power. How else could Congress purport to preempt anything?

*** Justice Scalia participated in oral argument although he had passed away before the Court rendered its decision. In the argument he expressed doubt whether a federal agency has the authority to “waive preemption.” DOL’s action along the lines suggested by Justice Breyer, or the Court, is clearly an invitation to litigation.
The Court then rejects Vermont’s contention that “reporting” under ERISA is designed to ensure that beneficiaries receive the benefits to which they are entitled, while its “reporting” is structured to control costs, ensure quality and to achieve population health. The Court answers, “The perceived difference here in the objectives of the Vermont law and ERISA does not shield Vermont’s reporting regime from pre-emption. Vermont orders health insurers, including ERISA plans, to report detailed information about the administration of benefits in a systematic manner. This is a direct regulation of a fundamental ERISA function. Any difference in purpose does not transform this direct regulation of ‘a central matter of plan administration’ into an innocuous and peripheral set of additional rules.” Reporting is reporting is reporting, just as a rose is a rose by any other name—if we simply assume the rose.

Finally, in response to Vermont’s argument that its law stems from a traditional exercise of state power, the Court wrote, “The fact that reporting is a principal and essential feature of ERISA demonstrates that Congress intended to pre-empt state reporting laws like Vermont’s, including those that operate with the purpose of furthering public health. The analysis may be different when applied to a state law, such as a tax on hospitals, the enforcement of which necessitates incidental reporting by ERISA plans; but that is not the law before the Court. Any presumption against pre-emption, whatever its force in other instances, cannot validate a state law that enters a fundamental area of ERISA regulation and thereby counters the federal purpose in the way this state law does.” Are these conclusions or reasons that support conclusions?

So, does this analysis amount to use of field preemption for ERISA’s core concerns? One might suppose so since no facts have been proven nor seem to be relevant. But without such facts how does one know that Vermont’s law overlaps with ERISA’s core concerns? Put differently, isn’t some factual predicate necessary to conclude that a core concern is even implicated? If not, where is the stopping point? Is there a stopping point? Aren’t we then right back at Shaw? Consider Justice Ginsburg’s example in note eleven of her opinion: “The Court’s analysis may hamper States’ abilities to require reporting, not just of plan benefits, but of plan assets as well. For example, the Department of Labor collects information about real property held in trust by a pension plan so that it can assess the plan’s financial wellbeing. States may need to collect the same information for a very different purpose, such as assessing a property tax.”

*Lest this worry seem fanciful, consider that the Supreme Court vacated and remanded a decision by the Sixth Circuit that Michigan’s insurance tax on all payers’ claims, designed to help fund its Medicaid program, does not fall within the scope of the relate-to clause. See Self-Insurance Institute of America v. Snyder, 761 F.3d 631 (2014), vacated and remanded, 136 S.Ct. 1355 (2016). The Court ordered the court of appeals to reconsider its decision in light of Gobeille. While the tax in Snyder imposes recordkeeping and reporting requirements, one would think that it falls within Supreme Court precedent holding that such incidental burdens do not trigger preemption, see, e.g., Dillingham Construction and DuBono, discussed in the main text at pages 381-823, which is the recent conclusion of the Sixth Circuit on remand from the Supreme Court. See Self-Insurance Institute of America v. Snyder, 2016 WL 3606849 (July 1, 2016). However, nothing is guaranteed. Many states rely on similar assessments to fund many types of programs. See, e.g., National Academy for State Health Policy, States with Assessments on Self-Funded Plans and/or Third Party Administrators, April 2016, http://nashp.org/wp-content/uploads/2016/04/State-Assessments-on-SF_TPA-Plans-Updated-4.41.pdf (Accessed June 29, 2016). See also Trish Riley, Are States Losing
To understand how requirement of a factual predicate to categorize a state law as affecting a core ERISA concern might provide some stopping points, let’s examine the subjects canvassed by Justice Ginsburg in her opinion.

a. *Is all reporting created equal?* From the main text, you are already familiar with some required disclosures to plan participants and beneficiaries: summary of benefits, documents that constitute the plan, information about coverage, reasons for an adverse medical determination, rights of appeal and the like. There are many other items, such as notification of COBRA rights, the parameters of wellness programs, the right to a 48-hour hospital stay after giving birth, etc. See, e.g., Department of Labor, Reporting and Disclosure Guide for Employee Benefit Plans (Sept. 2014), [https://www.dol.gov/ebsa/pdf/rdguide.pdf](https://www.dol.gov/ebsa/pdf/rdguide.pdf) (Accessed June 29, 2016). We have not covered much of the reporting to DOL. It includes, as examples, the number of plan beneficiaries, the identity of insurers, listing of plan assets and liabilities, etc. See, e.g., DOL, Form 5500 Series, [http://www.dol.gov/ebsa/5500main.html](http://www.dol.gov/ebsa/5500main.html) (Accessed June 29, 2016). The disclosures to plan members and beneficiaries exist to apprise them of their rights and benefits; the disclosures to DOL pertain to those rights and benefits too but also largely to plan solvency.

Compare the data reported to the Department of Labor (DOL) with those reported to Vermont. Is it relevant, as Justice Ginsburg says it is, that the data reported to DOL are the aggregate of claims, while the data reported to Vermont are details of each claim? If a regulator is ensuring matters like plan solvency and that plan money is going to benefits, as opposed to vacations in the Bahamas, is it necessary to obtain disaggregated data regarding claims? If a regulator is trying to find out the various prices paid by insurers for a given service, say a hip replacement, does the regulator need aggregated or disaggregated data? The major fields on DOL’s Schedule H, which plans must use to report “financial information” are: Part I, Asset and Liability Statement; Part II, Income and Expense Statement; Part III, Accountant’s Opinion; and Part IV, Compliance Questions. Do you think that this “reporting” in any way resembles that required by Vermont to create its all-payers claims database? Moreover, don’t you think that “reporting” under ERISA is a term of art, rather than a plain-meaning term? ERISA is quite detailed about what must be reported and the requirements are stated at great length in multiple sections. See 29 U.S.C. §§1021-24. Section 1021 lists as items to be reported, among other things, an annual report, terminal and supplementary reports, failure to meet minimum funding standards, and much, much more in great specificity. Section 1022 contains a very large laundry list of items to be reported in the summary plan description. Section 1023 enumerates in great detail the contents of the annual report, of financial statements, actuarial statements and more. Sections 1024 and 1024 delineate, again in great detail, the required reporting to DOL. Given this great specificity, how can it be maintained that “reporting” under ERISA is the same as “reporting” under Vermont’s law simply because one uses the same word to encompass both?

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b. Did Vermont’s required reporting burden plans? Do you think that a plan administrator like Blue Cross Blue Shield, or the plan itself if self-administered, already possesses the data sought by Vermont? What does Justice Ginsburg say about the cost of manipulating those data so that they are reported in the format Vermont required? How does she know the costs she describes? Does it matter that no facts have been proved? Should a state have to disprove that its law burdens ERISA plans or should a plaintiff erecting ERISA preemption to shield itself from state law have to prove that it is burdened? Recall above the crying need to establish all-payer claims databases. Recall also that these databases must be current and, to enable meaningful comparisons, the data must be standardized. Do you think that Vermont’s requirements regarding formatting data already possessed by plans or their administrators fall within the purpose of traditional state regulation? How do you think the balance of the burden imposed on plans against the strength of the state interest would come out—if we were actually to have any facts at all with regard to that burden? Doesn’t Liberty Mutual at least have to prove something, anything?

c. Did Vermont’s reporting law pose a serious threat to national uniformity of plan structure and uniformity? Exactly how did Vermont’s reporting law affect plan administration or structure? Did it hinder the DOL’s job of enforcing the reporting requirement? Did it affect the amount or disposition of plan assets in any way? Did it affect plan liability in any way? Did it affect the design of plan benefits in any way? Did it affect the categories of services covered by the plan? Did it affect medical necessity determinations in any way? Why is it relevant, as Justice Ginsburg points out, that inconsistent state law is an inexorable fact of life in federalism? Is the relevance of inconsistent state law linked in any way to the degree to which state law burdens plans? Ask again, doesn’t Liberty Mutual at least have to prove something, anything?

In this regard consider carefully the precedent, Eglehoff v. Eglehoff, cited by the majority and by Justice Ginsburg. In that case the Court held that ERISA preempted a Washington statute that provided upon divorce automatic revocation of the designation of a spouse as the beneficiary of a nonprobate asset. The Court concluded that the “statute binds ERISA plan administrators to a particular choice of rules for determining beneficiary status. The administrators must pay benefits to the beneficiaries chosen by state law, rather than to those identified in the plan documents. The statute thus implicates an area of core ERISA concern.” 121 S.Ct. at 1327. The Court continued that “unlike generally applicable laws regulating ‘areas where ERISA has nothing to say,’ which we have upheld notwithstanding their incidental effect on ERISA plans, this statute governs the payment of benefits, a central matter of plan administration.” Id. According to the Court, national uniformity in disbursement of benefits was disrupted by such a law because, to determine entitlement to benefits, not only must plan administrators become familiar with the laws of different states but must also ascertain such extra-legal facts as marital status and domicile. Given that the plan, a plan participant, and the former spouse could be domiciled in different states, “[i]n such a
situation, administrators might find that plan payments are subject to conflicting legal obligations.” Id. at 1328."

What extra-legal facts are relevant to plan administrators’ understanding of and compliance with reporting statutes like Vermont’s?

d. **Who has the authority to create all-payers claims databases?** As noted, and criticized above, the Court and Justice Breyer simply assume that DOL has the authority to collect data to create all-payers claims databases for the states or to delegate the job to them. As also noted above, the reporting needed to create an all-payers claims database differs vastly from that needed to enforce ERISA’s requirements. Given that, what do you think, does ERISA grant DOL authority to require plans to report those data? Also, any statement in *Gobeille* that DOL might have that authority is dictum, pure and simple. Given that, what might plans do if DOL were to require them to report those data? Does ERISA really sweep away the authority of the states to gather these data in order to regulate health care costs and quality?

In thinking about the answer to that question, consider the importance of the issue to the states. As recounted by Justice Ginsburg, “Seventeen other States have enacted similar database systems. These States, like Vermont, collect health-claims data to serve compelling interests, including identification of reforms effective to drive down health care costs, evaluation of relative utility of different treatment options, and detection of instances of discrimination in the provision of care. See also Vt. Stat. Ann., Tit. 18, §9410(a)(1) (Vermont’s data-collection law is designed to help ‘identify health care needs and inform health care policy,’ ‘evaluate the effectiveness of intervention programs on improving patient outcomes,’ ‘compare costs between various treatment settings and approaches,’ ‘determine the capacity and distribution of existing resources,’ and ‘provide information to . . . purchasers of health care’”). These purposes all fall within the domain of state regulation of the availability, quality, and cost of health care, all areas that have been traditionally within the states’ province. *Travelers* mandated that the relate-to clause must be construed under a presumption that Congress did not intend to displace this authority. Does it make sense to apply this presumption just to an assessment of a state law’s indirect effects, as the majority appears to have it, while not applying it to delineate what constitutes a “core” ERISA functions? Can one seriously assess the contours of federal authority without considering the nature of the exercise of state police power?

Consider also the impact of ERISA preemption of these reporting laws. Assuming that the laws are saved with regard to insured plans, the loss of claims generated by self-insured plans significantly impairs, if not eliminates, the laws’ efficacy.” As Justice

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* In his concurring opinion joined by Justice Ginsburg, mentioned above, Justice Scalia found that the Washington law directly conflicted with ERISA.
** In the interest of space and because our focus is on self-insured plans, as was the case in *Gobeille*, we do not fully rehearse the saving clause analysis. State laws aimed at insurers are probably saved. See, e.g., All-Payer Claims Database Council & National Academy for State Health Policy, Key Regulatory Issues Facing APCD States Post *Gobeille v. Liberty Mutual* (April 2016),
Ginsburg recounts loss of data from self-insured plans renders state databases incomplete because approximately 60% of the non-elderly population is insured by employer-sponsored plans and about 63% of these plans are self-insured. In Vermont alone, the result is that the state can no longer compel the submission of claims data for 20% of its population. Without these data, states cannot obtain full information regarding variation in prices and quality, among other things. With regard to prices, as we discuss below, the primary beneficiaries of this opacity are those who can obtain the largest discounts or charge the highest prices, those with market power. See, e.g., Erin Fuse Brown & Jaime King, The Consequences of *Gobeille v. Liberty Mutual* for Health Care Cost Control, Health Affairs Blog, March 10, 2016, [http://healthaffairs.org/blog/2016/03/10/the-consequences-of-gobeille-v-liberty-mutual-for-health-care-cost-control/](http://healthaffairs.org/blog/2016/03/10/the-consequences-of-gobeille-v-liberty-mutual-for-health-care-cost-control/) (Accessed June 29, 2016).

Consider whether the states, or DOL for that matter, have plausible alternatives. States could rely on self-insured plans to submit the necessary data voluntarily, as have many states for their voluntary all-payers claims databases, but, as discussed above, gag clauses and trade secret protection, possibly as well as HIPAA, state privacy laws and ERISA’s duties imposed on fiduciaries, may preclude such submissions. Moreover, relying on voluntary submission might still leave the databases significantly incomplete. See, e.g., Brown & King, supra. Within about a month of the decision in *Gobeille*, self-insured plans stopped sending claims data in at least five states. See Erin Meshon, Health Insurers Stop Providing Cost Data to States, CQ News, April 12, 2016, [http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2016/apr/april-18-2016/health-insurers-stop-providing-cost-data-to-states](http://www.commonwealthfund.org/publications/newsletters/washington-health-policy-in-review/2016/apr/april-18-2016/health-insurers-stop-providing-cost-data-to-states) (Accessed June 29, 2016). States might attempt to obtain data from providers, which stand outside of ERISA’s preemption shield, but duplication of the information contained in plans’ claims data is highly unlikely because data would have to be obtain


* States and other researchers are using the databases for varied purposes, such as studies of price transparency and competition for maternity services and knee replacements in Colorado; variations in subscriptions for psychotropic medications given to children in New England states; and studies of prescribing patterns for opioids in Maine to develop a predicative model regarding potential addiction. After *Gobeille* some researches may not be able to conduct such studies because the loss of data from self-insured plans may rob the studies of the necessary statistical power. Loss of these data may also bias the results because of the loss of a discrete population, workers of self-insured firms, who tend to be younger and healthier than those reflected in public datasets for Medicare and Medicaid, as well as employed in certain sectors of the economy in which self-insurance predominates. See, e.g., Carmel Shachar, Potential Roadblocks in Healthcare Big Data Collection: *Gobeille v. Liberty Mutual*, ERISA, and All-Payer Claims Databases, presented at Conference, Big Data, Health Law, and Bioethics, Center for Health Law & Policy Innovation, Harvard Law School, May 6, 2016, [https://vimeo.com/166555663#t=43m59s](https://vimeo.com/166555663#t=43m59s) (Accessed June 29, 2016).

** To sidestep *Gobeille*, Governor Rick Scott of Florida recently signed a law requiring insurers or third-party administrators contracting with the state’s Medicaid program or state employee health benefits program to submit data for the creation of a web-based database enabling consumers to research provider prices, i.e., actual prices, not charges, obtained from actual claims. See, e.g., New Price Transparency Law Puts Florida in the Consumer Vanguard, Modern Healthcare, April 19, 2016, [http://www.modernhealthcare.com/article/20160419/BLOG/160419918](http://www.modernhealthcare.com/article/20160419/BLOG/160419918) (Accessed June 29, 2016).
from every provider of every stripe, an administrative nightmare. Plans have all this information and thus they are the entities targeted by laws like Vermont’s. See, e.g., David M. Frankford and Sara Rosenbaum, Taming Healthcare Spending: Could State Rate Setting Work?, Robert Wood Johnson Foundation (forthcoming 2016).*

Finally, many have pointed to the possibility that DOL, perhaps in combination with HHS, can collect the data or authorize states to perform the task. Some merely assume that such authority exists, see, e.g., Brown & King, supra; William Sage, Out of Many, One: ERISA Preemption, State All-Payer Claims Database Laws, and the Goals of Transparency, Health Affairs Blog, March 10, 2016, http://healthaffairs.org/blog/2016/03/10/out-of-many-one-erisa-preemption-state-all-payer-claims-database-laws-and-the-goals-of-transparency/ (Accessed June 29, 2016), but as we indicate above, while DOL and HHS might have the necessary authority, that conclusion cannot be assumed. Additionally, there are significant logistical obstacles for federal agencies to collect the data. As Brown and King observe, “This solution is actually harder than it sounds. No federal agency, whether the Department of Labor or HHS, currently collects anything like APCD, claim level price and quality data. Even if one of these agencies agreed to collect plan data, to be effective it would have to be willing to gather the kind of timely, granular, and locality specific data mandated by APCDs. Statistical or summary data would have little value to the type of analysis needed to assess, for example, whether the prices charged by a large health system jumped when they acquired a physician group.”

If, according to Judge Ginsburg, all these factors are relevant simply to classify a state law as touching on (interfering with?) ERISA’s core functions, isn’t everything in the opinions in Gobeille a masquerade party hiding the fact that the Court is using conflict preemption, with differing opinions regarding whether there is a conflict and the degree of that conflict? Is the analysis any different than that mandated by Travelers for state laws that do not directly affect core concerns? On the other hand, given the majority’s factual description of a core concern as something that we know when we see it, what sort of analysis is the Court using to elucidate the reach of Section 514?

Last, consider the incentives of Liberty Mutual. The insurer did not litigate as an issuer of health insurance but as a self-insured employer. Although it employed only 137 persons in Vermont, one might speculate that it anticipates that laws like Vermont’s might pop up like daisies across the United States—given the huge effort in creating these databases we can be skeptical but let’s go with it. Aren’t Liberty Mutual’s expenditures affected by everyone else’s expenditures? Given that, who benefits from these laws if they achieve their aims? As we discussed above, no single insurer (or plan) has the capability or incentive to create what is necessary—all-payer claims databases—yet all would benefit from them if they succeed in controlling expenditures and raising

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* Options available to states (and DOL) are currently being assessed by a working group formed by the National Academy for State Health Policy and the All-Payer Claims Database Council, https://www.apcdcouncil.org/news/2016/04/nashp-convenes-gobeille-state-work-group-partnership-apcd-council (Accessed June 29, 2016).
quality of care. Isn’t such a problem of collective action one that is traditionally solved, within a state, by its power to regulate insurance? Do think that in enacting section 514 Congress attempted to deprive the states of that authority? Think back also to the discussion of how all-payer claims databases save administrative expenses for everyone, an achievement not possible if pursued by issuers and plans individually.

On the other hand, if it is in the interest of all self-insured plans to support laws like Vermont’s, then why did Liberty Mutual even litigate this case? Is it (and groups like the American Benefits Council, the ERISA Industry Committee, the HR Policy Association and the National Business Group on Health, which together filed an amicus brief in support of Liberty Mutual) just being stupid? Is Liberty Mutual biting its nose just to spit its own face, in this particular instance, in order to stave off state regulation of self-insured plans more generally? We noted above that insurers and providers will often fight very hard to protect their prices as trade secrets. Why do you think they do that? Contracts between plan sponsors and insurers, whether the latter underwrite risk or merely administer plans, are not made public. Who do you think benefits from the fact that without laws like Vermont’s, the prices struck in those bargains—or the prices with providers negotiated on behalf of self-insured plans—remain secret? Is it relevant that most of the business groups filing briefs to support Liberty Mutual are dominated by large employers? Does not the secrecy of those prices affect the process of competition? See Chapter 25 (Antitrust). Would a provider that has negotiated a discount necessarily be interested in having that discount disclosed? Isn’t this yet one more element of the dog-eat-dog world in which each plan/insurer/provider is out for itself? See generally Reinhardt, Health Care Price Transparency and Economic Theory; David Cutler & Leemore Dafny, Designing Transparency for Medical Care Prices, 364 NEW ENG. J. MED. 895 (2011); Anna D. Sinaiko & Meredith B. Rosenthal, Increased Price Transparency in Health Care—Challenges and Potential Effects, 364 NEW ENG. J. MED. 891 (2011). Ask again: Did Congress really mean to remove state authority as a means to ameliorate the fragmentation that characterizes our (non)system and leads to expenditures that are nearly one and one-half times higher than those in the nations with the next highest levels?

But finally, one must pose the following question: In numerous ways, the Affordable Care Act reflects a Congressional desire to at least encourage system-wide efforts to gain control over cost and quality within a fractured payment structure, even if lawmakers could not bring themselves to really do anything about the problem. But if this is true, then why did lawmakers not amend ERISA at least to expressly clarify that state all-payer claims laws fall outside of the scope of federal reporting requirements and are not preempted? Technically at least, it would have been so easy to do this. Now we have this legal mess.

* Maine’s rules on making data public include specific restrictions that prevent provider discounts with payers from being released. Why would a state do that? Do you think that to establish these databases states need buy-in from a variety of stakeholders like providers? See Porter et al., The Basics of All-Payer Claims Database.
Of course, one might argue that there was no need for such clarification because Congress relied on the Court’s common sense reading of ERISA under *Travelers* as protecting such laws. But seriously folks, would some clarity coming from Congress have been such a burden? On the other hand, think about the lengths Congress went *not* to touch the structure and design of larger ERISA insured plans, as well as self-insured plans, other than some relative tinkering around the edges. Do you imagine that the politics of ERISA were such that lawmakers sought to steer clear of anything that might inflame employers in the electrifying environment of the ACA legislative process? Doesn’t Liberty Mutual’s dogged determination to fight against turning over some claims data all the way to the Supreme Court in fact confirm these Congressional fears?

3. *No matter what, transparency is needed to get our house in order.* Price transparency is clearly a very hot topic and growing. Whether increased price transparency will enable “consumer-directed care” to be successful is an issue we do not directly address in this Note because the use of markets is something we consider throughout the Book. However, even single or coordinated payer systems demand the existence and use of transparent and standardized price information. Therefore, price transparency is crucial no matter what future path the United States takes.*

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**Insert at textbook p. 636 at the end of Chapter 12:**

**Epilogue: Reference Pricing**

Reference pricing is an attempt to reduce the prices of select services by effectively combining elements of cost sharing and use of narrow networks to impose “cost consciousness” on patients and providers. A payer negotiates the reference price for the particular service—say a knee replacement—and obtains providers’ agreement to furnish the service at that reference price. Plan members, in theory, are informed of the reference price and the list of providers—“designated providers”—that have agreed to abide by the price. Members needing that service, therefore, have a choice: They can go to one of the designated providers; or instead, they can go to a non-designated provider and pay the difference, *in addition to* the cost-sharing they otherwise would owe. In other words, members who choose a provider that does not agree to the reference price are treated as if they have gone out of network for care, even though they are receiving care from an in-network provider. Not only do they have to pay whatever deductible and copayments/coinsurance they might owe, but they also pay the balance of the provider’s bill for the service (i.e., the extent to which that provider’s price for the service exceeds the reference price), just as they would face balance billing for going out of network. And, as with balance billing by out-of-network providers, the additional out-of-pocket expense does not count toward satisfaction of the plan’s annual cost-sharing limits for covered

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* A note inserted to Chapter 25 (Antitrust) more fully discusses the question whether there are benefits from price transparency, as part of an effort to spur competition, as well as potential costs from anti-competitive behavior. You’ll see also that the next note on reference pricing has some bearing on this subject.
services, which under the Affordable Care Act, are about $6000 for individual coverage and over $12,000 for a family plan in 2015. (We say much more on the effect of the ACA below). In effect, therefore, patients will pay a higher price for the privilege of seeing a network provider, albeit a pricier one.

Reference pricing supposedly achieves certain goals: increasing the plan’s control over the composition and behavior of its network; protecting “consumer choice”; reducing the variation in the prices charged by different providers; and most importantly perhaps, lowering the price for services subject to reference pricing. Members are “steered” to the lower-priced providers without—it is claimed—being forced to do so. As a result, reference pricing, it is claimed, is superior to using narrow provider networks to control costs because members are not completely foreclosed from obtaining care from non-designated providers. Instead, they get to vote with their dollars as to whether it is worth it to them to use higher-priced providers. In turn, providers are effectively placed on network “tiers” by virtue of what they charge; they are forced to compete with regard to price, and prices tend to fall toward the reference price.

But what sounds strikingly like comparison shopping for, say, a television becomes a lot more complicated in health care. A lot of moving parts have to work really well. And if for various reasons, one has qualms about the use of markets in health care, then one is going to have qualms about reference pricing. See Panos Kanavos & Uwe Reinhardt, Reference Pricing for Drugs: Is It Compatible with U.S. Health Care? 22 HEALTH AFFAIRS 16, 22 (2003). Because this ground is covered throughout the Book, we do not rehash those more general problems here but instead focus on particular wrinkles raised by reference pricing.

1. Information problems

Of course, achieving the goal of reference pricing—lowering or at least controlling expenditures while protecting “consumer choice”—depends heavily on the information transmitted to members. If subscribers do not understand the process or the information is incomplete or inaccurate (e.g., good price and quality comparison measures are not available or the right information is not collected), then there is no real choice, and the entire point of the strategy is wholly or partially be defeated. Potentially plan members simply are left with cheap and shoddy goods and services. Or if members continue to use higher-priced providers (because they don’t understand that they are just getting ripped off if the higher price provider does not offer higher quality), then reference pricing simply would shift from the plan to its members the higher cost exposure resulting from non-designated providers (i.e., those that do not agree to discount their prices). On the supply side, providers (other than perhaps subpar providers interested in volume over value) would have no incentive to lower their prices down to the reference price. Furthermore, reference pricing could have a perverse effect by incentivizing lower-priced providers to increase their prices up to the reference price. Paradoxically, reference pricing, if done poorly, could actually increase expenditure. But unlike the realm of television purchasing, where consumers can make reasonably good choices in the market and on their own, health care is so outrageously complicated that
there must be some sort of intermediary (the entity with the money, aka, the health plan) whose job is to organize all of this information and make it reliable and complete.

The potential information problems must be considered in light of current uses of reference pricing. Reporting indicates that in 2012, 11% of employers were using some type of reference pricing and another 16% were considering it. See Paul Fronstin & M. Christopher Roebuck, Reference Pricing for Health Care Services: A New Twist on the Defined Contribution Concept in Employment-Based Health Benefits, EMPLOYEE BENEFIT RESEARCH INSTITUTE ISSUE BRIEF No. 398, at 4 (April 2014), http://www.ebri.org/pdf/briefspdf/EBRI_IB_398_Apr14_RefPricing.pdf (Accessed July 15, 2014). The leading experiment has been a joint effort between the California Public Employees’ Retirement System (“CalPERS”) and Anthem Blue Cross, which sells its networks, particularly PPOs, to CalPERS. In the experiment CalPERS (which has long been recognized for its health care purchasing innovations and whose members probably are accustomed to a higher level of plan sophistication) and Anthem negotiated with hospitals a reference price for routine, non-emergent hip and knee replacements. Anthem provided to subscribers a list of 45 designated hospitals, all of which had agreed to accept the reference price. It also “engaged in both broad-based and targeted communications” with subscribers, which included mailed announcements about reference pricing, inclusion of information in open-enrollment meetings and packets, and sending notices to all physicians and hospitals in Anthem’s network. Anthem also sent letters to all members who had seen an orthopedic surgeon in the past year for any knee or hip issue, and, perhaps most importantly, the reference pricing was explained to members during the required preauthorization process for hip and knee replacements. See Amanda E. Lechner et al., The Potential of Reference Pricing To Generate Health Care Savings: Lessons from a California Pioneer, CENTER FOR STUDYING HEALTH SYSTEM CHANGE RESEARCH BRIEF No. 30, at 4 (Dec. 2013), http://www.hschange.org/CONTENT/1397/1397.pdf (Accessed July 24, 2015).

In light of this experiment, ask yourself whether this degree of effort is likely to be replicated by other insurers or plan sponsors, particularly by plans operating in markets, such as the new Exchange markets, where nearly 60 percent were uninsured prior to purchasing a plan. Liz Hamel et al., Survey of Nongroup Health Insurance Enrollees, Kaiser Family Foundation http://kff.org/health-reform/report/survey-of-nongroup-health-insurance-enrollees/ (Accessed July 25, 2015). Also ask yourself about the quantity and quality of information that is likely to be transmitted to members if reference pricing is used for procedures other than just routine, non-emergent hip and knee replacement. Also ask yourself whether the experiences of a relatively sophisticated membership accustomed to insurer innovation can be extrapolated to the broader population, especially millions of newly eligible privately insured people with no long-time experience as insured consumers.

In this regard consider evidence that exists concerning Anthem’s and others’ expansion to other procedures, such as outpatient colonoscopies, cataract surgeries, arthroscopy, and certain imaging and lab tests. It has been reported, for example, that enrollees “experienced confusion” about whether to go to hospital outpatient departments
or free-standing facilities for these procedures. Lechner et al. at 7. These facilities “may be outwardly indistinguishable to patients.” Id. Additionally, when procedures are not subject to preauthorization there is no opportunity to explain to members the design of the reference pricing. What happens if reference pricing is expanded to even more services and, moreover, to more complicated procedures than routine, non-emergent hip and knee replacements, simple tests and the like?

Consider also that subscribers tend to focus on price alone and often erroneously correlate higher prices with higher quality. See, e.g., Lechner et al. Patients often get overloaded by too many choices and too much information. Moreover, subscribers’ understanding of health insurance, including concepts like out-of-network costs or tiered networks, is generally low even among members of employer-sponsored plans, and substantially worse for those new to health insurance, many of whom are poor, sick or members of vulnerable populations. See, e.g., Saurabh Bhargava et al., Do Individuals Make Sensible Health Insurance Decisions? Evidence from a Menu with Dominated Options, NBER WORKING PAPERS No. 21160 (May 2015), http://www.nber.org/papers/w21160 (Accessed July 24, 2015); George Loewenstein et al., Consumers’ Misunderstanding of Health Insurance, 32 J. HEALTH ECON. 850 (2013). Most fundamentally, given the evidence regarding the lack of “health-insurance literacy,” will plan members even understand the key component of reference pricing—that the plan has created a network within a network and that they are at risk for substantial out-of-pocket expenses even if they get treated by a network provider? See Jon Glaudemans et al., Reference Pricing and Network Adequacy: Conflict or Concord, HEALTH AFFAIRS (BLOG), http://healthaffairs.org/blog/2014/09/18/reference-pricing-and-network-adequacy-standards-conflict-or-concord/ (Accessed July 24, 2015).

And then there is the question of what services reference price actually includes. What if the price does not include certain add-on procedures that are necessary in the ordinary course of treatment? Understanding automobile “upgrades”—purely discretionary luxuries like super sound systems—are one thing, but are there discretionary add-ons in the case of necessary surgeries? Aside from, perhaps, a private room and one-on-one nursing care, it is hard to think of an equivalent to a car upgrade. And what if there are complications requiring services in addition to those included in the reference price? At the very least, to make the system comprehensible and reduce the risk of sticker shock from large bills for services not included in the reference price, the “shoppable” service subject to a reference price should include the whole bundled package of services members will need for a particular condition, such as a hip or knee replacement, e.g., pre-surgical imaging and testing, post-surgical imaging and testing, a stay in a rehabilitation facility, outpatient physical therapy, home care like physical therapy and so on. See François de Brantes et al., Reference Pricing and Bundled Payment: A Match to Change Markets, Health Care Incentives Improvement Institute (2013), http://www.catalyzepaymentreform.org/images/documents/matchtochangemarkets.pdf (Accessed July 24, 2015); see also Suzanne Delbanco, The Payment Reform Landscape: Benefit and Network Design Strategies to Complement Payment Reform, HEALTH AFFAIRS (BLOG) (Nov. 4, 2014), http://healthaffairs.org/blog/2014/11/04/the-payment-
Think also about the information requirements for plan sponsors and insurers. Aren’t they likely to experience significant information problems in designing their program? Prices for services vary greatly. Which one is appropriate as the reference price? See Kanavos & Reinhardt at 23–24. Do the necessary data even exist to make the necessary decisions regarding price? To what extent are those data available if they do exist? Will availability differ among insurers and plan sponsors depending on their size and locations, as well as the size and locations of providers?

Think also about the administrative costs imposed by reference pricing. Provider networks constantly change, especially in the still-emerging Exchange-based markets. Even within a single plan, designated providers for various services subject to reference pricing will be different—i.e., no single provider will offer all the reference-priced services because there will be different providers designated for different services—and these combinations will change over time. Health plans—as well as the federal and state regulators who must oversee and enforce reasonable access standards—will need large data sets concerning price, quality, distance and other access indicators. It is extremely difficult to reach a point at which crucial information regarding designated providers, prices and quality is sufficiently available to members to make the process workable. Indeed, in its 2016 Issuers Letter for the Federally-facilitated Marketplace, see CMS, Final 2016 Letter to Issuers in the Federally-Facilitated Marketplaces (Feb. 20, 2015), http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf (Accessed July 24, 2015), CMS has been struggling just to ensure that the most basic network information is up to date, and the National Association of Insurance Commissioners has yet to articulate even the minimum access standard that would be the starting point for determining data collection and enforcement needs. Even provider directories, conveying simple information, frequently contain wrong, incomplete or outdated information. See, e.g., Jack S. Resneck et al., The Accuracy of Dermatology Network Physician Directories Posted by Medicare Advantage Health Plans in an Era of Narrow Networks, 150 JAMA DERMATOLOGY 1290 (2014).

* Along these lines, if you think it is easy to articulate what goes into a health care “product” like knee or hip replacement, consider a proposed rule issued by the Centers for Medicare and Medicaid Services on July 14 2015 (80 Fed. Reg. 41,198). The proposal seeks to introduce a bundled payment system into Medicare on a test basis for certain joint replacements. The new bundled system, known as the Comprehensive Care for Joint Replacement (CCJR) model, would not place Medicare beneficiaries at higher cost-sharing risk if they do not use a facility covered by the payment model. But the bundling rules themselves provide insight into how hard it is to delineate just for a handful of surgical procedures what is inside and outside the bundle. Much of the 120 page proposed rule is devoted to what is included in the payment bundle and how payment will work. See 42 C.F.R. §510.200 for an extensive list of the procedures that are and are not in the payment bundle.
2. Quality and strategic behavior

The CalPERS experiment was carefully designed in an attempt to avoid any variation among providers in quality. If quality varies across providers in a manner which is undetectable to payers or to patients, then any gains in decreased prices might occur at the cost of diminishing quality to the harm of patients. CalPERS chose hip and knee replacements because, they found—and we question this finding immediately below—that there is little quality variation among providers for those procedures—and a lot of “unexplained” price variation. In choosing providers CalPERS studied its extensive data, obtained because it is a very large plan sponsor, and chose designated providers because they met performance measures like 30-day rates of complications and infections, and 90-day readmission rates. They also chose high-volume providers because for these procedures practice makes perfect. See Lechner et al. at 2–3. Aside from questions asked above regarding data availability, how generalizable are these methods to control for quality, particularly if reference pricing is extended to more complicated services? How good are the quality measures themselves? If you had a knee or hip replacement, would you consider it to be a success if you suffered no complication, infection or readmission but still could not walk? Isn’t there a whole lot more to quality than the metrics used?*

In the Book we have seen the other side of the coin: what if quality is detectable on the provider side but not on the payer side? What opportunities would arise in that case for strategic behavior? Could providers reduce quality and yet obtain the price set with reference to some assumed level of quality? Could providers select the least complicated cases and shift elsewhere the more complicated ones? Do you think these possibilities are rare in the health care system?

3. Discrimination and equity

If the quality of knee and hip replacements were the same across all providers, then plan members’ choices of higher-priced providers would turn on factors like geographical location, perhaps private rooms, quality of hospital food, and other factors, all of which could be characterized as “amenities” for which members should be responsible. Their shouldering the responsibility for amenities would be indicated by their willingness-to-pay. This is consumer sovereignty.

Take location first. CalPERS and Anthem made strategic choices in designing their experiment. They made sure that enrollees were generally within fifty miles of a

* While a retrospective study, conduct by Anthem’s parent company, Wellpoint, of the CalPERS experiment found no diminution in quality, and perhaps an increase, see Chia-hsuan (Winnie) Li et al., Effects of a Reference-Based Purchasing Design on Healthcare Utilization and Outcomes of Knee and Hip Replacement Surgeries, Paper presented at the Academy Health 2013 Annual Research Meeting, Seattle, WA, 2013, http://academyhealth.org/files/2013/sunday/li.pdf (Accessed July 24, 2015), it is important to understand that the point we are making pertains to prospective choice of services to be put under reference pricing. More importantly, aggregate findings of quality are far less important than the variability of quality among providers. Finally, this study used the same crude quality metrics to measure outcomes retrospectively as were used prospectively in design of the experiment.
designated hospital. If any enrollee had to travel farther, travel costs were covered. See Lechner at al. at 4.

How generalizable do you think that design will be? How well would patients fare in rural areas? Urban areas? What about medically underserved areas? What if only certain providers are fluent in Spanish or certain African dialects in a region in which there are large populations whose primary language is not English? What sorts of patients do you think would suffer most from problems of distance to designated facilities? Who do you think would suffer because there is no means of transportation to designated facilities that might even be relatively close by?

Now remove the stipulation that knee and hip replacements do not vary in quality, and think about extension of reference pricing to other services. In the end, what is the bite of reference pricing? Who do you think is likely to suffer poorer quality or other problems of access, i.e., are any populations more likely to get bitten?

Finally, is it possible to use reference pricing for discrimination for invidious purposes? Does location of designated providers raise any potential problems of invidious discrimination? How about choices of procedures for which to set reference prices? What about the level of the reference prices?

4. Fragmentation and the overall effect on expenditures, prices and quality

Routine, non-emergent procedures like hip and knee replacements and outpatient services like imaging are often “discretionary.” The famous Rand health experiment, discussed in the Book, studied the effects of out-of-pocket expenses on utilization of discretionary services. Its finding was that discretionary services were the most likely type of care to be delayed or forgone altogether, along with potentially greater negative effects on health—and expenditures—incurred later because patients finally access the system when they are much sicker than they would have been if services had not been delayed or forgone. Numerous subsequent studies have confirmed that very often an ounce of prevention is worth a pound of cure. Because the cost-sharing of reference pricing is likely to be very steep (again, we discuss the ACA below), what might be the overall impact on health and expenditures? Is this effect more or less likely given the fragmentation, discussed in this chapter, across payers and providers? Are payers’ and providers’ short and long-term incentives the same or different, given this fragmentation? What incentives does that create in designing reference pricing?

To grasp these problems, let’s get to the results of the CalPERS experiment. They are striking. In the first year of use, steering clearly occurred as the use of relative low-priced, designated hospitals increased by 21.2%, while that for relatively high-priced, non-designated facilities decreased by 34.3%. Price competition also ensued. Prices charged to CalPERS members declined by 5.6% at the low-price, designated facilities and by 34.3 percent at high-price, non-designated facilities. See James C. Robinson & Timothy T. Brown, Increases in Consumer Cost Sharing Redirect Patient Volumes and Reduce Hospital Prices for Orthopedic Surgery, 32 HEALTH AFFAIRS 1392 (2013). Indeed, after the first year the number of designated hospitals grew from 45 to 54, and some non-
designated hospitals agreed to waive charges above the reference price to retain the business of CalPERS members. See Lechner et al. at 3. Overall in that first year CalPERS saved $2.8 million and members saved $.03 million in lower cost-sharing. See Robinson & Brown.

However, in considering these findings think first about the fact that orthopedic surgeons are considered to be among the most powerful physicians in hospitals. Many hospitals were pressured to adhere to the reference prices by surgeons who threatened to admit their patients elsewhere. See Lechner et al. at 3. What does this suggest about generalizing the results of the CalPERS experiment to other services?

Consider also the history of price inflation, presented largely in Chapter 6, and the phenomenon that numerous “shocks”—like the shock of managed care—in the short term stem increases in expenditures but in the long run, after the shock has worn off, price inflation tends to bounce back up. What might that suggest about the finding that reference pricing was a success in the CalPERS experiment?

Also, think about hospital pricing strategies discussed partially in this Chapter (and you will see more detail in Chapters 23 and 25 on taxation and antitrust)—hospitals mark up services where they can because they have an advantage and mark down prices on services where they must because they are at a disadvantage. Even if the reference pricing system enabled CalPERS to save money on hip and knee replacements, does that mean that the payer saved money overall? Doesn’t one also have to look at the prices charged for other services to answer this question?

Additionally, and most importantly, think about the effects of reference pricing in the context of the discussion of Medicare’s IPPS in this Chapter. A major point was that even a huge program like Medicare has had difficulty controlling its expenditures because of fragmentation in payment—that even if the program has been able to push down its prices, in the long run its prices have been increased because the fragmented private payers have been unable to match Medicare’s power, thereby enabling resources to continue to be poured into the system, dragging up Medicare’s prices too. Consider the effect of this fragmentation on overall expenditures. To what extent do you think that smaller payers will succeed in making reference prices stick? Even given that CalPERS is relatively a very large payer, what does the Medicare experience suggest regarding the prices CalPERS will have to pay over the long run even if its reference pricing allows it to reduce its prices relative to other payers? What does the Medicare experience suggest about the level of expenditures over all payers?

Also consider that reference pricing may extend only to relatively few procedures, like hip and knee replacements, in which quality variance is relatively low while price variation is high. The $2.8 million saved by CalPERS in 2011 was 0.26% of its total health care spending of about $1.1 billion for all of its Anthem enrollees. See Lechner et al. at 8. Similarly, a recent study of the use of reference pricing for outpatient lab testing by a multinational supermarket chain found savings for the costs of the lab tests but lab test constitute only 1.25% of the employer’s total medical expenditures. See L. Doug

Also consider the fact that reference pricing will have limited or no effect in markets experiencing provider consolidation, whose numbers are rapidly increasing. The solution to address that power lies not in reference pricing but in stricter enforcement of antitrust laws, state rate-setting, see Keith Brand et al., Reference Pricing Is Not a Substitute for Competition in Health Care, FTC BLOG COMPETITION MATTERS (Sept. 22, 2014), https://www.ftc.gov/news-events/blogs/competition-matters/2014/09/reference-pricing-not-substitute-competition-health (Accessed July 24, 2015), or perhaps some in-between form of state regulation like Certificates of Public Advantage (COPAs). See Randall B. Bovbjerg & Robert A. Berenson, Certificates of Public Advantage: Can They Address Provider Market Power, Urban Institute (Feb. 2015), http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000111-Certificates-of-Public-Advantage.pdf (Accessed July 24, 2015). (A COPA is a limited regulatory mechanism for allowing providers that would be competitors to merge or collaborate.) Additionally, reference pricing, like other strategies discussed in the Chapter, does not take volume into account.

Now think about all the issues just discussed and compare the magnitude of the effort that must be mounted to make reference pricing work—in the terms of protecting consumer choice while holding down prices—with the size of the likely effect. Is it likely to be worth the effort? See Lechner et al. at 8-9.*

5. Interactions with the ACA (and some other laws)

To understate, it is not clear how reference pricing interacts with the ACA. To begin with, as noted in Chapter 6, with regard to health benefit plans and insurance issuers—i.e., self-insured, large, small and individual plans—the ACA bans annual and lifetime dollar caps and imposes maximums on out-of-pocket expenses. These

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* Fronstin and Roebuck find potential savings of $9.4 billion, a full 1.6% of all employment-based, under-65-years-old spending in 2010, if all employers across the nation adopted reference pricing for hip and knee replacements, colonoscopy, MRI of the spine, CT scans of the head or brain, nuclear stress tests of the heart and echocardiograms. These “results” were obtained by collapsing price variations for these services (in ill-defined markets) to a median, assumed to be a chosen reference price. This prediction rests on too many heroic assumptions than can be canvassed here and one cannot even conclude that it sets an upper limit on savings, much less a prediction of savings that could actually obtain in the real world. It’s about as useful as concluding that other life-forms might exist in the universe because we can’t rule them out.
restrictions apply only to care that falls within the essential health benefit packages and is in-network. Just pertaining to these provisions, three questions arise.

First, does the reference price apply to care that falls within the essential health benefit categories? If it does, then the limits are applicable. If it does not, subject to numerous other potential bars discussed immediately below, the reference price is allowed.

Second, if a member of the plan chooses care that is more expensive than the reference price, is the consequent out-of-pocket expense subject to the caps? The maximums apply to “cost-sharing,” which is defined in the Act as “deductibles, coinsurance, copayments, or similar charges” but specifically excludes “premiums, balance billing amounts for non-network providers, or spending for non-covered services.” ACA § 1302(c)(3). Out-of-pocket expenses exceeding a reference price are definitely not “spending for non-covered services,” nor are they a “premium.” Are they “balance billing amounts for non-network providers”?

Third and following, does a system of reference prices create a “network”? In order to fall within the exception for non-network balance billing one has to consider the system of reference pricing to create a “network,” i.e., for non-designated providers to be “out of network,” the designated providers must constitute a network. As we have seen in the CalPERS experiment, the designated providers have one aspect of a network in that the plan sponsor or insurer negotiates the reference price with them. However, contemporaneous use of the term “network” is more robust than the mere existence of a negotiated price. These days, networks have other aspects such as credentialing of network participants, utilization review and some active monitoring of quality. These are features of even the loosest form of networks, IPA-type networks or PPOs. If this analysis is correct, then the cost-sharing imposed by reference pricing should be subject to the maximums imposed by the ACA.

Beyond the questions regarding the ACA’s cap on out-of-pocket expenses, other issues arise regarding the nature of reference pricing.

First, is it a form of utilization review? The ACA explicitly preserves the plan sponsor’s or insurer’s ability to “carry[] out utilization management techniques that are commonly used as of the date of enactment of this Act.” ACA §1563(d). However, reference pricing does not seem to fall within “utilization management techniques that are commonly used.” The key feature of utilization review is that it involves a determination of medical necessity, something entirely lacking in reference pricing. Additionally, even if reference pricing involves utilization review it was not “commonly used when the ACA was enacted.” If this analysis is correct, then the implementing agencies would have authority to limit or ban reference pricing.

Second, how does reference pricing affect a plan’s actuarial value, a question relevant to numerous provisions of the Act, such as the employer’s shared responsibility obligation and the tiering of Exchange plans into bronze, silver, gold and platinum.

Third, how does reference pricing interact with the network adequacy requirement? Qualified health plans sold in the health insurance marketplace must satisfy a regulatory requirement that provider networks not result in access that is “unreasonable.” Reference pricing applies to covered services, but we also saw above that the fact that only certain providers may agree to the reference price may in fact create barriers to access for some plan members. In the CalPERS experiment, CalPERS and Anthem strategically ensured that almost all members had to travel no more than 50 miles to a provider and that travel expenses were reimbursed for the few members who had to travel more. Assuming, contrary to what is stated above, that the designated providers constitute a network,* would the network be adequate if patients had to travel 50 miles for, say, lab tests, CT scans, and so forth? Even if that distance does not render the network inadequate, what about other barriers to access such as lack of transportation to designated providers? Is a network adequate if a member cannot reasonably travel to a designated provider but can travel to a non-designated provider yet pay the difference between the reference price and a high price charged by the provider to whom travel is reasonable?

Finally, leaving aside all these other questions, how does reference pricing interact with the numerous anti-discrimination provisions in the ACA and elsewhere, such as the Americans with Disabilities Act (ADA)? Is reference pricing just part of plan coverage design and therefore immune from claims of discrimination (recall Doe v Mutual of Omaha in Chapter 9, which focuses on the interaction of the settlor function of insurance design and the ADA). Does a reference price or a system of reference prices constitute discrimination based on pre-existing illness? Discrimination based on a particular condition or conditions? Could it violate the bar, in the case of health plans governed by the essential health benefit provisions of the ACA (Chapter 6), against use of benefit design features that discriminate based on disability? We’ve discussed elsewhere in this Update the complaint filed against plans and insurers for their charging higher prices for drugs used by members with HIV/AIDS. See, e.g., Michelle Andrews, Some Plans Skew Drug Benefits To Drive Away Patients, Advocates Warn, http://www.kaiserhealthnews.org/Stories/2014/July/08/Some-Plans-Skew-Drug-Benefits-To-Drive-Away-Patients-Advocates-Warn.aspx?utm_campaign=KHN%3A+Daily+Health+Policy+Report&utm_source=hs_email&utm_medium=email&utm_content=13402390&_hsenc=p2ANqtz--6UP1qu79FoUkdcBigadASnd7hxgNWNwJeNaL5irQgNPNjijj4naizzGuOa54Z0Het0u6hUrnDN7zMyhQD6aqU8gUHBh07ZshrZZJ7hcLu7LE8DObM&_hsmi=13402390 (Accessed July 24, 2015). Also, there are reports that plans or insurers are attempting to

* The plan’s network, no matter how defined, would still have to be adequate.

In May 2014 the Departments of Labor and Health and Human Services answered only a very few of these questions in a FAQ, http://www.dol.gov/ebsa/faqs/faq-aca19.html (Accessed July 24, 2015). The sum total of this guidance was the following:

If large group market coverage or self-insured group health plan has a reference-based pricing structure, under which the plan pays a fixed amount for a particular procedure (for example, a knee replacement), which certain providers will accept as payment in full, how does the out-of-pocket limitation apply when an individual uses a provider that does not accept that amount as payment in full?

Reference pricing aims to encourage plans to negotiate cost effective treatments with high quality providers at reduced costs. At the same time, the Departments are concerned that such a pricing structure may be a subterfuge for the imposition of otherwise prohibited limitations on coverage, without ensuring access to quality care and an adequate network of providers.

Accordingly, the Departments invite comment on the application of the out-of-pocket limitation to the use of reference based pricing. The Departments are particularly interested in standards that plans using reference-based pricing structures should be required to meet to ensure that individuals have meaningful access to medically appropriate, quality care. Please send comments by August 1, 2014 to E-OHPSCA-FAQ.ebsa@dol.gov.

Until guidance is issued and effective, with respect to a large group market plan or self-insured group health plan that utilizes a reference-based pricing program, the Departments will not consider a plan or issuer as failing to comply with the out-of-pocket maximum requirements of PHS Act section 2707(b) because it treats providers that accept the reference amount as the only in-network providers, provided the plan uses a reasonable method to ensure that it provides adequate access to quality providers.

For non-grandfathered health plans in the individual and small group markets that must provide coverage of the essential health benefit package under section 1302(a) of the Affordable Care Act, additional requirements apply.
The FAQ is noteworthy in at least five respects. First, for now it allows large group and self-insured plans to use reference pricing subject to “a reasonable method to ensure that it provides adequate access to quality providers,” the first time the agencies have even implicitly addressed the issue of network adequacy in the large plan market. Second, it assumes, without discussion, that designated providers constitute a network, which opens the possibility that the cost-sharing maximums do not apply. Third, the permission to use reference pricing at least temporarily does not apply to small group and individual plans. Fourth, the FAQ fails to address most of the issues discussed above. Fifth, in calling for comments with regard to the cap on out-of-pocket expenses, the FAQ indicates that the interaction between reference pricing and the ACA remains in play.

This FAQ in May 2014 was followed by a second one in October, see FAQs about Affordable Care Act Implementation (Part XXI) (Oct. 14, 2014), http://www.dol.gov/ebsa/faqs/faq-aca21.html (Accessed July 24, 2015), that added a stipulation that emergency services cannot be subject to reference pricing, as well as requirements with regard to quality, disclosure and members’ access to services. For present purposes we’re only interested in the latter. The enforcement agencies discussion of the new network adequacy requirements was as follows:

Reasonable access. Plans should have procedures to ensure that an adequate number of providers that accept the reference price are available to participants and beneficiaries. For this purpose, plans are encouraged to consider network adequacy approaches developed by States, as well as reasonable geographic distance measures, and whether patient wait times are reasonable. (Insured coverage is also subject to any applicable requirements under State law.)

... . . .

Exceptions process. Plans should have an easily accessible exceptions process, allowing services rendered by providers that do not accept the reference price to be treated as if the services were provided by a provider that accepts the reference price if:

a. Access to a provider that accepts the reference price is unavailable (for example, the service cannot be obtained within a reasonable wait time or travel distance).

b. The quality of services with respect to a particular individual could be compromised with the reference price provider (for example, if co-morbidities present complications or patient safety issues).

Id.

The question is whether these requirements are sufficient. The most important part is the statement that plans may adopt network adequacy requirements developed by
States. (But how about self-insured plans exempt from state insurance regulation under ERISA preemption principles? Will the federal government step in with better standards than those articulated to date?) The bottom line is that there are considerable risks in merely encouraging health plans to borrow state standards where they exist and failing to impose minimum federal time, travel, language, and other requirements as the quid pro quo for exempting reference price-linked cost sharing from the ACA’s annual out of pocket limits. CMS has now twice indicated that at least with regard to plans sold in the federal Marketplace, it intends to articulate federal standards in future rule making, see CMS, Patient Protection and Affordable Care Act; Notice of Benefit and Payment Parameters for 2016; Final Rule, 80 Fed. Reg.10,750 (Feb. 27, 2015); CMS, Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces (Feb. 20, 2015), http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016_Letter_to_Issuers_2_20_2015.pdf (Accessed July 24, 2015). In these releases CMS has also indicated that it is waiting for the NAIC to revise its Managed Care Network Adequacy Model Act. See NAIC Health Benefit Plan Network Access and Adequacy Model Act, Draft Nov. 12, 2014, http://www.naic.org/documents/committees_b_rftf_namr_sg_exposure_draft_proposed_revisions_mcpna_model_act.pdf (Accessed July 24, 2015). However, regulatory action is needed for all types of plans and the current requirements, relying on state rules, are insufficient.


limits for travel by public transportation, waiting times, subscriber-to-provider ratios, and numbers of providers accepting new patients. Reasonableness standards are typically very general formulations such as a requirement that plans “include sufficient numbers and types of providers to ensure reasonable access.” As such, they allow for flexibility to account for variations in geography, population density, market conditions, referral patterns and the like, but the standards are subjective. On the other hand, objective standards may preclude flexibility.

Nonetheless, effective rules in the middle of this dichotomy do exist. For example, Medicare Advantage places counties into five categories, rather than lumping them into broad groups like “urban” and “rural.” Quantified requirements can offer both flexibility and objectivity. In looking to state requirements, the agencies ignored stronger federal requirements such as those used by Medicare Advantage. See CMS, CY2015 MA Network Adequacy Criteria Guidance (Oct. 7, 2014), http://www.cms.gov/Medicare/Medicare-Advantage/MedicareAdvantageApps/Downloads/CY2015_MA_HSD_Network_Criteria_Guidance.pdf (Accessed July 24, 2015). Recent proposed regulations will impose similar, strict requirements on Medicaid managed care organizations. See CMS, Medicaid and Children’s Health Insurance Program (CHIP); Medicaid Managed Care; Proposed Rules, 80 Fed. Reg. 31,098 (June 1, 2015). Further, as CMS relies on the states to oversee network adequacy, it ignores the fact that states do not have the capacity to enforce network adequacy rules. See, e.g., Corlette et al., Narrow Provider Networks in New Health Plans; Health Management Associates, Ensuring Consumers’ Access to Care: Network Adequacy State Insurance Survey Findings and Recommendations for Regulatory Reforms in a Changing Insurance Market (Nov. 2014), http://www.naic.org/documents/committees_conliaison_network_adequacy_report.pdf (Accessed July 24, 2015). Stricter federal rules and enforcement are needed now, and should cover such matters as those contained in California’s recent Provider Network Adequacy Emergency Regulations, which specify provider types, distances, wait times and other important details that impact patients’ access to providers. See California Provider Network Adequacy Emergency Regulation (Jan. 12, 2015), http://www.insurance.ca.gov/0400-news/0100-press-releases/2015/upload/nr012-NetworkAdequacyApproval.pdf (Accessed July 24, 2015).

6. The complications of half-way measures

This plethora of issues is illustrative of the complications of half-way measures that are designed to address health care spending (and a host of other issues, such as the social function of insurance more generally) in the United States. As such, it is a perfect epilogue for this chapter.

As indicated in the Chapter, other nations rely on a host of mechanisms to control expenditures, from negotiations with groups representing providers, to control of capital, to expenditure caps and budgets, and coordinated and single payment systems. With the demise of managed care’s tight network requirements and utilization controls, payers have no tools remaining other than imposing a greater share of expenditures on plan
members. Despite the labels—copayments, deductibles, cost sharing, health savings accounts—these mechanisms are a form of de-insurance. Reference pricing is perhaps more tightly targeted to particular services than other methods but it is de-insurance nonetheless, and it is de-insurance at levels much higher than previous mechanisms. No other advanced nation tolerates the effects we have discussed here and, moreover, because they use methods other than price—most saliently coordinated or single payment—no other advanced nation needs to rely on a method that causes such effects. Reference pricing is yet one more half-way measure in a continuing attempt to control expenditures in the United States. As we have indicated, like its ancestors it is likely to fail or at most affect expenditures only marginally, and the only impact will be to inflict more pain on patients.

7. Dueling articles online

First Postscript to Part Two: *NFIB v Sebelius*, and the limits of Medicaid unconstitutional coercion

Replace “Postscript: The Patient Protection and Affordable Care Act in the United States Supreme Court” (textbook, pp. 637-45), with the following new material:

The Patient Protection and Affordable Care Act and the United States Supreme Court

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I. Introduction

In National Federation of Independent Business v Sebelius, 132 S. Ct. 2566 (2012), the United States Supreme Court on June 28, 2012, upheld the constitutionality of the Patient Protection and Affordable Care Act. In ruling in the Act’s favor however, the Court effectively made the earth move on a number of constitutional law fronts. The decision also creates important new legal challenges for ongoing implementation with respect to the Act’s Medicaid expansion. Indeed, the impact of the decision on prospects for Medicaid coverage of nearly all poor Americans became clear in revised cost estimates issued by the Congressional Budget Office in July, 2012, which showed a 6 million person drop in the reach of the program by 2022, only partially offset by access to coverage through state health insurance Exchanges for some. We will return to this in the notes following the Medicaid portion of the case.

The decision is long, complex, and fractured. Chief Justice Roberts announced the judgment of the Court but otherwise wrote just for himself at times, while at other times, for different pluralities of Justices of different composition and at varying points pertaining to various issues. Reading the almost 200 pages of text is akin to parsing a balkanized map.

For this reason, we approach the case in chunks. We begin with the Chief Justice’s recitation of the history of the litigation. We then turn to those portions of the case that deal with the constitutionality of the Act’s “personal responsibility payment” (the so-called individual mandate), which imposes a tax penalty on taxpayers who can afford to purchase health insurance but fail to do so. We divide the issues concerning the mandate into two components, one concerning Congress’s power under the Commerce Clause—here we also include discussion of Congress’s power under the Necessary and Proper Clause—and the other, Congress’s power to tax. We then move to the Medicaid portion of the case, which encompasses two distinct questions: first, whether the expansion is constitutional; and second the remedy that will be adopted if, in fact, the Medicaid expansion amounts to unconstitutional coercion on the states. Notes follow each discussion section.

We omit discussion of the Anti-Injunction Act (“AIA”). The Justices unanimously concluded that the AIA did not bar consideration of the individual mandate’s constitutionality, despite the fact that the mandate ultimately was upheld as a tax.

II. History of the Litigation

Chief Justice Roberts began his decision with a history of the case:

I

In 2010, Congress enacted the Patient Protection and Affordable Care Act. The Act aims to increase the number of Americans covered by health insurance and decrease
the cost of health care. The Act’s 10 titles stretch over 900 pages and contain hundreds of provisions. This case concerns constitutional challenges to two key provisions, commonly referred to as the individual mandate and the Medicaid expansion.

The individual mandate requires most Americans to maintain “minimum essential” health insurance coverage. 26 U.S.C. § 5000A. The mandate does not apply to some individuals, such as prisoners and undocumented aliens. § 5000A(d). Many individuals will receive the required coverage through their employer, or from a government program such as Medicaid or Medicare. See § 5000A(f). But for individuals who are not exempt and do not receive health insurance through a third party, the means of satisfying the requirement is to purchase insurance from a private company.

Beginning in 2014, those who do not comply with the mandate must make a “[s]hared responsibility payment” to the Federal Government. § 5000A(b)(1). That payment, which the Act describes as a “penalty,” is calculated as a percentage of household income, subject to a floor based on a specified dollar amount and a ceiling based on the average annual premium the individual would have to pay for qualifying private health insurance. § 5000A(c). In 2016, for example, the penalty will be 2.5 percent of an individual’s household income, but no less than $695 and no more than the average yearly premium for insurance that covers 60 percent of the cost of 10 specified services (e.g., prescription drugs and hospitalization). Ibid.; 42 U.S.C. § 18022. The Act provides that the penalty will be paid to the Internal Revenue Service with an individual’s taxes, and “shall be assessed and collected in the same manner” as tax penalties, such as the penalty for claiming too large an income tax refund. 26 U.S.C. § 5000A(g)(1). The Act, however, bars the IRS from using several of its normal enforcement tools, such as criminal prosecutions and levies. § 5000A(g)(2). And some individuals who are subject to the mandate are nonetheless exempt from the penalty—for example, those with income below a certain threshold and members of Indian tribes. § 5000A(e).

On the day the President signed the Act into law, Florida and 12 other States filed a complaint in the Federal District Court for the Northern District of Florida. Those plaintiffs—who are both respondents and petitioners here, depending on the issue—were subsequently joined by 13 more States, several individuals, and the National Federation of Independent Business. The plaintiffs alleged, among other things, that the individual mandate provisions of the Act exceeded Congress’s powers under Article I of the Constitution. The District Court agreed, holding that Congress lacked constitutional power to enact the individual mandate. 780 F.Supp.2d 1256 (N.D.Fla.2011). The District Court determined that the individual mandate could not be severed from the remainder of the Act, and therefore struck down the Act in its entirety. Id., at 1305–1306.

The Court of Appeals for the Eleventh Circuit affirmed in part and reversed in part. The court affirmed the District Court’s holding that the individual mandate exceeds Congress’s power. 648 F.3d 1235 (2011). The panel unanimously agreed that the individual mandate did not impose a tax, and thus could not be authorized by Congress’s power to “lay and collect Taxes.” A majority also held that the individual mandate was not supported by Congress’s power to “regulate Commerce ... among the several States.”
Id.. According to the majority, the Commerce Clause does not empower the Federal Government to order individuals to engage in commerce, and the Government’s efforts to cast the individual mandate in a different light were unpersuasive. Judge Marcus dissented, reasoning that the individual mandate regulates economic activity that has a clear effect on interstate commerce.

Having held the individual mandate to be unconstitutional, the majority examined whether that provision could be severed from the remainder of the Act. The majority determined that, contrary to the District Court’s view, it could. The court thus struck down only the individual mandate, leaving the Act’s other provisions intact. 648 F.3d, at 1328.

Other Courts of Appeals have also heard challenges to the individual mandate. The Sixth Circuit and the D.C. Circuit upheld the mandate as a valid exercise of Congress’s commerce power. See Thomas More Law Center v. Obama, 651 F.3d 529 (C.A.6 2011); Seven–Sky v. Holder, 661 F.3d 1 (C.A.D.C.2011). The Fourth Circuit determined that the Anti–Injunction Act prevents courts from considering the merits of that question. See Liberty Univ., Inc. v. Geithner, 671 F.3d 391 (2011). That statute bars suits “for the purpose of restraining the assessment or collection of any tax.” 26 U.S.C. § 7421(a). A majority of the Fourth Circuit panel reasoned that the individual mandate’s penalty is a tax within the meaning of the Anti–Injunction Act, because it is a financial assessment collected by the IRS through the normal means of taxation. The majority therefore determined that the plaintiffs could not challenge the individual mandate until after they paid the penalty.

The second provision of the Affordable Care Act directly challenged here is the Medicaid expansion. Enacted in 1965, Medicaid offers federal funding to States to assist pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care. See 42 U.S.C. § 1396a(a)(10). In order to receive that funding, States must comply with federal criteria governing matters such as who receives care and what services are provided at what cost. By 1982 every State had chosen to participate in Medicaid. Federal funds received through the Medicaid program have become a substantial part of state budgets, now constituting over 10 percent of most States’ total revenue.

The Affordable Care Act expands the scope of the Medicaid program and increases the number of individuals the States must cover. For example, the Act requires state programs to provide Medicaid coverage to adults with incomes up to 133 percent of the federal poverty level, whereas many States now cover adults with children only if their income is considerably lower, and do not cover childless adults at all. See § 1396a(a)(10)(A)(i)(VIII). The Act increases federal funding to cover the States’ costs in expanding Medicaid coverage, although States will bear a portion of the costs on their own. § 1396d(y)(1). If a State does not comply with the Act’s new coverage requirements, it may lose not only the federal funding for those requirements, but all of its federal Medicaid funds. See § 1396c.
Along with their challenge to the individual mandate, the state plaintiffs in the Eleventh Circuit argued that the Medicaid expansion exceeds Congress’s constitutional powers. The Court of Appeals unanimously held that the Medicaid expansion is a valid exercise of Congress’s power under the Spending Clause. And the court rejected the States’ claim that the threatened loss of all federal Medicaid funding violates the Tenth Amendment by coercing them into complying with the Medicaid expansion. 648 F.3d, at 1264, 1268.

We granted certiorari to review the judgment of the Court of Appeals for the Eleventh Circuit with respect to both the individual mandate and the Medicaid expansion. 132 S.Ct. 603 (2011). Because no party supports the Eleventh Circuit’s holding that the individual mandate can be completely severed from the remainder of the Affordable Care Act, we appointed an amicus curiae to defend that aspect of the judgment below. And because there is a reasonable argument that the Anti–Injunction Act deprives us of jurisdiction to hear challenges to the individual mandate, but no party supports that proposition, we appointed an amicus curiae to advance it.

III. Is the Act’s “Personal Responsibility Payment” a Constitutional Exercise of the Commerce Clause?

A majority of the Court—Chief Justice Roberts, writing for himself; and Justices Scalia, Kennedy, Thomas and Alito, writing jointly (and ultimately dissenting from the judgment, as we shall see)—held that Congress’s use of the “personal responsibility payment,” aka “the individual mandate,” exceeds its power under the Commerce Clause. The majority found that an individual’s failure to purchase health insurance amounts to “inactivity”—a “failure to engage in commerce”—that lies beyond Congress’s regulatory powers. By contrast, Justice Ginsburg, writing on this issue for herself as well as Justices Breyer, Sotomayor and Kagan, maintained that the mandate fell well within the Commerce Clause. As you read the three opinions on this issue, ask yourselves, “What is the ‘activity’ being regulated and does that ‘activity’ amount to ‘commerce’?”

A. Chief Justice Roberts’s Opinion (For Himself) That the Individual Mandate Exceeds Congress’s Power under the Commerce Clause

The Government’s first argument is that the individual mandate is a valid exercise of Congress’s power under the Commerce Clause and the Necessary and Proper Clause. According to the Government, the health care market is characterized by a significant cost-shifting problem. Everyone will eventually need health care at a time and to an extent they cannot predict, but if they do not have insurance, they often will not be able to pay for it. Because state and federal laws nonetheless require hospitals to provide a certain degree of care to individuals without regard to their ability to pay, see, e.g., 42 U.S.C. §1395dd; Fla. Stat. Ann. §395.1041, hospitals end up receiving compensation for only a portion of the services they provide. To recoup the losses, hospitals pass on the
cost to insurers through higher rates, and insurers, in turn, pass on the cost to policy holders in the form of higher premiums. Congress estimated that the cost of uncompensated care raises family health insurance premiums, on average, by over $1,000 per year. 42 U.S.C. §18091(2)(F).

In the Affordable Care Act, Congress addressed the problem of those who cannot obtain insurance coverage because of preexisting conditions or other health issues. It did so through the Act’s “guaranteed-issue” and “community-rating” provisions. These provisions together prohibit insurance companies from denying coverage to those with such conditions or charging unhealthy individuals higher premiums than healthy individuals. See §§300gg, 300gg-1, 300gg-3, 300gg-4.

The guaranteed-issue and community-rating reforms do not, however, address the issue of healthy individuals who choose not to purchase insurance to cover potential health care needs. In fact, the reforms sharply exacerbate that problem, by providing an incentive for individuals to delay purchasing health insurance until they become sick, relying on the promise of guaranteed and affordable coverage. The reforms also threaten to impose massive new costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage. This will lead insurers to significantly increase premiums on everyone.

The individual mandate was Congress’s solution to these problems. By requiring that individuals purchase health insurance, the mandate prevents cost-shifting by those who would otherwise go without it. In addition, the mandate forces into the insurance risk pool more healthy individuals, whose premiums on average will be higher than their health care expenses. This allows insurers to subsidize the costs of covering the unhealthy individuals the reforms require them to accept. The Government claims that Congress has power under the Commerce and Necessary and Proper Clauses to enact this solution.

The Government contends that the individual mandate is within Congress’s power because the failure to purchase insurance “has a substantial and deleterious effect on interstate commerce” by creating the cost-shifting problem. The path of our Commerce Clause decisions has not always run smooth, see United States v. Lopez, 514 U.S. 549, 552-559 (1995), but it is now well established that Congress has broad authority under the Clause. We have recognized, for example, that “[t]he power of Congress over interstate commerce is not confined to the regulation of commerce among the states,” but extends to activities that “have a substantial effect on interstate commerce.” United States v. Darby, 312 U.S. 100 (1941). Congress’s power, moreover, is not limited to regulation of an activity that by itself substantially affects interstate commerce, but also extends to activities that do so only when aggregated with similar activities of others. See Wickard, 317 U.S., at 127-128.

Given its expansive scope, it is no surprise that Congress has employed the commerce power in a wide variety of ways to address the pressing needs of the time. But
Congress has never attempted to rely on that power to compel individuals not engaged in commerce to purchase an unwanted product. Legislative novelty is not necessarily fatal; there is a first time for everything. But sometimes “the most telling indication of [a] severe constitutional problem . . . is the lack of historical precedent” for Congress’s action. Free Enterprise Fund v. Public Company Accounting Oversight Bd., 130 S. Ct. 3138, 3159 (2010) (internal quotation marks omitted). At the very least, we should “pause to consider the implications of the Government’s arguments” when confronted with such new conceptions of federal power. Lopez, supra, at 564.

The Constitution grants Congress the power to “regulate Commerce.” Art. I, § 8, cl. 3 (emphasis added). The power to regulate commerce presupposes the existence of commercial activity to be regulated. If the power to “regulate” something included the power to create it, many of the provisions in the Constitution would be superfluous. For example, the Constitution gives Congress the power to “coin Money,” in addition to the power to “regulate the Value thereof.” Id., cl. 5. And it gives Congress the power to “raise and support Armies” and to “provide and maintain a Navy,” in addition to the power to “make Rules for the Government and Regulation of the land and naval Forces.” Id., cl. 12-14. If the power to regulate the armed forces or the value of money included the power to bring the subject of the regulation into existence, the specific grant of such powers would have been unnecessary. The language of the Constitution reflects the natural understanding that the power to regulate assumes there is already something to be regulated.

Our precedent also reflects this understanding. As expansive as our cases construing the scope of the commerce power have been, they all have one thing in common: They uniformly describe the power as reaching “activity.” It is nearly impossible to avoid the word when quoting them. See, e.g., Lopez, supra, at 560 (“Where economic activity substantially affects interstate commerce, legislation regulating that activity will be sustained”); Perez, 402 U.S., at 154, (“Where the class of activities is regulated and that class is within the reach of federal power, the courts have no power to excise, as trivial, individual instances of the class” (emphasis in original; internal quotation marks omitted)); Wickard, supra, at 125 (“[E]ven if appellant’s activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce”); NLRB v. Jones & Laughlin Steel Corp., 301 U.S. 1 (1937) (“Although activities may be intrastate in character when separately considered, if they have such a close and substantial relation to interstate commerce that their control is essential or appropriate to protect that commerce from burdens and obstructions, Congress cannot be denied the power to exercise that control”)

The individual mandate, however, does not regulate existing commercial activity. It instead compels individuals to become active in commerce by purchasing a product, on the ground that their failure to do so affects interstate commerce. Construing the Commerce Clause to permit Congress to regulate individuals precisely because they are doing nothing would open a new and potentially vast domain to congressional authority. Every day individuals do not do an infinite number of things. In some cases they decide
not to do something; in others they simply fail to do it. Allowing Congress to justify federal regulation by pointing to the effect of inaction on commerce would bring countless decisions an individual could potentially make within the scope of federal regulation, and—under the Government’s theory—empower Congress to make those decisions for him.

Applying the Government’s logic to the familiar case of *Wickard v. Filburn* shows how far that logic would carry us from the notion of a government of limited powers. In *Wickard*, the Court famously upheld a federal penalty imposed on a farmer for growing wheat for consumption on his own farm. 317 U.S., at 114-115. That amount of wheat caused the farmer to exceed his quota under a program designed to support the price of wheat by limiting supply. The Court rejected the farmer’s argument that growing wheat for home consumption was beyond the reach of the commerce power. It did so on the ground that the farmer’s decision to grow wheat for his own use allowed him to avoid purchasing wheat in the market. That decision, when considered in the aggregate along with similar decisions of others, would have had a substantial effect on the interstate market for wheat. *Id.*, at 127-129.

*Wickard* has long been regarded as “perhaps the most far reaching example of Commerce Clause authority over intrastate activity,” *Lopez*, 514 U.S., at 560, but the Government’s theory in this case would go much further. Under *Wickard* it is within Congress’s power to regulate the market for wheat by supporting its price. But price can be supported by increasing demand as well as by decreasing supply. The aggregated decisions of some consumers not to purchase wheat have a substantial effect on the price of wheat, just as decisions not to purchase health insurance have on the price of insurance. Congress can therefore command that those not buying wheat do so, just as it argues here that it may command that those not buying health insurance do so. The farmer in *Wickard* was at least actively engaged in the production of wheat, and the Government could regulate that activity because of its effect on commerce. The Government’s theory here would effectively override that limitation, by establishing that individuals may be regulated under the Commerce Clause whenever enough of them are not doing something the Government would have them do.

Indeed, the Government’s logic would justify a mandatory purchase to solve almost any problem. See *Seven-Sky*, 661 F. 3d, at 14-15 (noting the Government’s inability to “identify any mandate to purchase a product or service in interstate commerce that would be unconstitutional” under its theory of the commerce power). To consider a different example in the health care market, many Americans do not eat a balanced diet. That group makes up a larger percentage of the total population than those without health insurance. The failure of that group to have a healthy diet increases health care costs, to a greater extent than the failure of the uninsured to purchase insurance. Those increased costs are borne in part by other Americans who must pay more, just as the uninsured shift costs to the insured. Congress addressed the insurance problem by ordering everyone to buy insurance. Under the Government’s theory, Congress could address the diet problem by ordering everyone to buy vegetables.
People, for reasons of their own, often fail to do things that would be good for them or good for society. Those failures—joined with the similar failures of others—can readily have a substantial effect on interstate commerce. Under the Government’s logic, that authorizes Congress to use its commerce power to compel citizens to act as the Government would have them act.

That is not the country the Framers of our Constitution envisioned. James Madison explained that the Commerce Clause was “an addition which few oppose and from which no apprehensions are entertained.” The Federalist No. 45, at 293. While Congress’s authority under the Commerce Clause has of course expanded with the growth of the national economy, our cases have “always recognized that the power to regulate commerce, though broad indeed, has limits.” Maryland v. Wirtz, 392 U.S. 183, 196 (1968). The Government’s theory would erode those limits, permitting Congress to reach beyond the natural extent of its authority, “everywhere extending the sphere of its activity and drawing all power into its impetuous vortex.” The Federalist No. 48, at 309 (J. Madison). Congress already enjoys vast power to regulate much of what we do. Accepting the Government’s theory would give Congress the same license to regulate what we do not do, fundamentally changing the relation between the citizen and the Federal Government.6

To an economist, perhaps, there is no difference between activity and inactivity; both have measurable economic effects on commerce. But the distinction between doing something and doing nothing would not have been lost on the Framers, who were “practical statesmen,” not metaphysical philosophers. Industrial Union Dept., AFL-CIO v. American Petroleum Institute, 448 U.S. 607, 673 (1980) (Rehnquist, J., concurring in judgment). As we have explained, “the framers of the Constitution were not mere visionaries, toying with speculations or theories, but practical men, dealing with the facts of political life as they understood them, putting into form the government they were creating, and prescribing in language clear and intelligible the powers that government was to take.” South Carolina v. United States, 199 U.S. 437, 449 (1905). The Framers gave Congress the power to regulate commerce, not to compel it, and for over 200 years both our decisions and Congress’s actions have reflected this understanding. There is no reason to depart from that understanding now.

The Government sees things differently. It argues that because sickness and injury are unpredictable but unavoidable, “the uninsured as a class are active in the market for health care, which they regularly seek and obtain.” Brief for United States 50. The individual mandate “merely regulates how individuals finance and pay for that active participation—requiring that they do so through insurance, rather than through attempted self-insurance with the back-stop of shifting costs to others.” Ibid.

6 In an attempt to recast the individual mandate as a regulation of commercial activity, JUSTICE GINSBURG suggests that “[a]n individual who opts not to purchase insurance from a private insurer can be seen as actively selecting another form of insurance: self-insurance.” But “self-insurance” is, in this context, nothing more than a description of the failure to purchase insurance. Individuals are no more “activ[e]l in the self-insurance market” when they fail to purchase insurance, than they are active in the “rest” market when doing nothing.
The Government repeats the phrase “active in the market for health care” throughout its brief, see id., at 7, 18, 34, 50, but that concept has no constitutional significance. An individual who bought a car two years ago and may buy another in the future is not “active in the car market” in any pertinent sense. The phrase “active in the market” cannot obscure the fact that most of those regulated by the individual mandate are not currently engaged in any commercial activity involving health care, and that fact is fatal to the Government’s effort to “regulate the uninsured as a class.” Id., at 42. Our precedents recognize Congress’s power to regulate “class[es] of activities,” Gonzales v. Raich, 545 U.S. 1, 17 (2005) (emphasis added), not classes of individuals, apart from any activity in which they are engaged, see, e.g., Perez, 402 U.S., at 153 (“Petitioner is clearly a member of the class which engages in ‘extortionate credit transactions’ . . .” (emphasis deleted)).

The individual mandate’s regulation of the uninsured as a class is, in fact, particularly divorced from any link to existing commercial activity. The mandate primarily affects healthy, often young adults who are less likely to need significant health care and have other priorities for spending their money. It is precisely because these individuals, as an actuarial class, incur relatively low health care costs that the mandate helps counter the effect of forcing insurance companies to cover others who impose greater costs than their premiums are allowed to reflect. See 42 U.S.C. §18091(2)(I) (recognizing that the mandate would “broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums”). If the individual mandate is targeted at a class, it is a class whose commercial inactivity rather than activity is its defining feature.

The Government, however, claims that this does not matter. The Government regards it as sufficient to trigger Congress’s authority that almost all those who are uninsured will, at some unknown point in the future, engage in a health care transaction. Asserting that “[t]here is no temporal limitation in the Commerce Clause,” the Government argues that because “[e]veryone subject to this regulation is in or will be in the health care market,” they can be “regulated in advance.” Tr. of Oral Arg. 109 (Mar. 27, 2012).

The proposition that Congress may dictate the conduct of an individual today because of prophesied future activity finds no support in our precedent. We have said that Congress can anticipate the effects on commerce of an economic activity. See, e.g., Consolidated Edison Co. v. NLRB, 305 U.S. 197 (1938) (regulating the labor practices of utility companies); Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241 (1964) (prohibiting discrimination by hotel operators); Katzenbach v. McClung, 379 U.S. 294 (1964) (prohibiting discrimination by restaurant owners). But we have never permitted Congress to anticipate that activity itself in order to regulate individuals not currently engaged in commerce. Each one of our cases, including those cited by JUSTICE GINSBURG. post, at 20-21, involved preexisting economic activity. See, e.g., Wickard, 317 U.S., at 127-129 (producing wheat); Raich, supra, at 25, (growing marijuana).
Everyone will likely participate in the markets for food, clothing, transportation, shelter, or energy; that does not authorize Congress to direct them to purchase particular products in those or other markets today. The Commerce Clause is not a general license to regulate an individual from cradle to grave, simply because he will predictably engage in particular transactions. Any police power to regulate individuals as such, as opposed to their activities, remains vested in the States.

The Government argues that the individual mandate can be sustained as a sort of exception to this rule, because health insurance is a unique product. According to the Government, upholding the individual mandate would not justify mandatory purchases of items such as cars or broccoli because, as the Government puts it, “[h]ealth insurance is not purchased for its own sake like a car or broccoli; it is a means of financing health-care consumption and covering universal risks.” Reply Brief for United States 19. But cars and broccoli are no more purchased for their “own sake” than health insurance. They are purchased to cover the need for transportation and food.

The Government says that health insurance and health care financing are “inherently integrated.” But that does not mean the compelled purchase of the first is properly regarded as a regulation of the second. No matter how “inherently integrated” health insurance and health care consumption may be, they are not the same thing: They involve different transactions, entered into at different times, with different providers. And for most of those targeted by the mandate, significant health care needs will be years, or even decades, away. The proximity and degree of connection between the mandate and the subsequent commercial activity is too lacking to justify an exception of the sort urged by the Government. The individual mandate forces individuals into commerce precisely because they elected to refrain from commercial activity. Such a law cannot be sustained under a clause authorizing Congress to “regulate Commerce.”

The Government next contends that Congress has the power under the Necessary and Proper Clause to enact the individual mandate because the mandate is an “integral part of a comprehensive scheme of economic regulation”—the guaranteed-issue and community-rating insurance reforms. Under this argument, it is not necessary to consider the effect that an individual’s inactivity may have on interstate commerce; it is enough that Congress regulate commercial activity in a way that requires regulation of inactivity to be effective.

The power to “make all Laws which shall be necessary and proper for carrying into Execution” the powers enumerated in the Constitution, Art. I, § 8, cl. 18, vests Congress with authority to enact provisions “incidental to the [enumerated] power, and conducive to its beneficial exercise,” McCulloch, 17 U.S., at 418. Although the Clause gives Congress authority to “legislate on that vast mass of incidental powers which must be involved in the constitution,” it does not license the exercise of any “great substantive and independent power[s]” beyond those specifically enumerated. Id., 17 U.S., at 411. Instead, the Clause is “merely a declaration, for the removal of all uncertainty, that the
means of carrying into execution those [powers] otherwise granted are included in the grant.” *Kinsella v. United States*, 361 U.S. 234, 247 (quoting VI Writings of James Madison 383 (G. Hunt ed. 1906)).

As our jurisprudence under the Necessary and Proper Clause has developed, we have been very deferential to Congress’s determination that a regulation is “necessary.” We have thus upheld laws that are “convenient, or useful” or “conducive” to the authority’s “beneficial exercise.” *Comstock*, 130 S. Ct. 1949, 1956 (quoting *McCulloch*, supra, 17 U.S., at 413, 418). But we have also carried out our responsibility to declare unconstitutional those laws that undermine the structure of government established by the Constitution. Such laws, which are not “consist[ent] with the letter and spirit of the constitution,” *McCulloch*, 17 U.S., at 421, are not “proper [means] for carrying into Execution” Congress’s enumerated powers. Rather, they are, “in the words of The Federalist, ‘merely acts of usurpation’ which ‘deserve to be treated as such.’” *Printz v. United States*, 521 U.S. 898, 924 (1997) (alterations omitted) (quoting The Federalist No. 33, at 204 (A. Hamilton)); see also *New York*, 505 U.S., at 177; *Comstock, supra*, 130 S. Ct. 1949, 1967. (KENNEDY, J., concurring in judgment) (“It is of fundamental importance to consider whether essential attributes of state sovereignty are compromised by the assertion of federal power under the Necessary and Proper Clause . . .”).

Applying these principles, the individual mandate cannot be sustained under the Necessary and Proper Clause as an essential component of the insurance reforms. Each of our prior cases upholding laws under that Clause involved exercises of authority derivative of, and in service to, a granted power. For example, we have upheld provisions permitting continued confinement of those *already in federal custody* when they could not be safely released, *Comstock, supra*, 130 S. Ct. 1949; criminalizing bribes involving organizations *receiving federal funds*, *Sabri v. United States*, 541 U.S. 600, 602, 605 (2004); and tolling state statutes of limitations while cases are *pending in federal court*, *Jinks v. Richland County*, 538 U.S. 456, 459, 462 (2003). The individual mandate, by contrast, vests Congress with the extraordinary ability to create the necessary predicate to the exercise of an enumerated power.

This is in no way an authority that is “narrow in scope,” *Comstock*, 130 S. Ct. 1949, 1964, or “incidental” to the exercise of the commerce power, *McCulloch*, 17 U.S., at 418. Rather, such a conception of the Necessary and Proper Clause would work a substantial expansion of federal authority. No longer would Congress be limited to regulating under the Commerce Clause those who by some preexisting activity bring themselves within the sphere of federal regulation. Instead, Congress could reach beyond the natural limit of its authority and draw within its regulatory scope those who otherwise would be outside of it. Even if the individual mandate is “necessary” to the Act’s insurance reforms, such an expansion of federal power is not a “proper” means for making those reforms effective.

The Government relies primarily on our decision in *Gonzales v. Raich*. In *Raich*, we considered “comprehensive legislation to regulate the interstate market” in marijuana. 545 U.S., at 22. Certain individuals sought an exemption from that regulation on the
ground that they engaged in only intrastate possession and consumption. We denied any exemption, on the ground that marijuana is a fungible commodity, so that any marijuana could be readily diverted into the interstate market. Congress’s attempt to regulate the interstate market for marijuana would therefore have been substantially undercut if it could not also regulate intrastate possession and consumption. Id., at 19. Accordingly, we recognized that “Congress was acting well within its authority” under the Necessary and Proper Clause even though its “regulation ensnare[d] some purely intrastate activity.” Id., at 22; see also Perez, 402 U.S., at 154. Raich thus did not involve the exercise of any “great substantive and independent power,” McCulloch, supra, at 411, of the sort at issue here. Instead, it concerned only the constitutionality of “individual applications of a concededly valid statutory scheme.” Raich, supra, at 23 (emphasis added).

Just as the individual mandate cannot be sustained as a law regulating the substantial effects of the failure to purchase health insurance, neither can it be upheld as a “necessary and proper” component of the insurance reforms. The commerce power thus does not authorize the mandate.

**B. Joint Opinion by Justices Scalia, Kennedy, Thomas and Alito That the Individual Mandate Exceeds Congress’s Power under the Commerce Clause**

**I**

We do not doubt that the buying and selling of health insurance contracts is commerce generally subject to federal regulation. But when Congress provides that (nearly) all citizens must buy an insurance contract, it goes beyond “adjust[ing] by rule or method,” Johnson, supra, or “direct[ing] according to rule,” Ash, supra; it directs the creation of commerce.

In response, the Government offers two theories as to why the Individual Mandate is nevertheless constitutional. Neither theory suffices to sustain its validity.

**A**

First, the Government submits that §5000A is “integral to the Affordable Care Act’s insurance reforms” and “necessary to make effective the Act’s core reforms.” Brief for Petitioners in No. 11-398 (Minimum Coverage Provision) 24 (hereinafter Petitioners’ Minimum Coverage Brief). Congress included a “finding” to similar effect in the Act itself. See 42 U.S.C. §18091(2)(H).

[T]he Act contains numerous health insurance reforms, but most notable for present purposes are the “guaranteed issue” and “community rating” provisions, §§300gg to 300gg-4. The former provides that, with a few exceptions, “each health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage.” §300gg-1(a). That is, an insurer may not deny coverage on the basis of, among other
things, any pre-existing medical condition that the applicant may have, and the resulting insurance must cover that condition. See §300gg-3.

Under ordinary circumstances, of course, insurers would respond by charging high premiums to individuals with pre-existing conditions. The Act seeks to prevent this through the community-rating provision. Simply put, the community-rating provision requires insurers to calculate an individual’s insurance premium based on only four factors: (i) whether the individual’s plan covers just the individual or his family also, (ii) the “rating area” in which the individual lives, (iii) the individual’s age, and (iv) whether the individual uses tobacco. §300gg(a)(1)(A). Aside from the rough proxies of age and tobacco use (and possibly rating area), the Act does not allow an insurer to factor the individual’s health characteristics into the price of his insurance premium. This creates a new incentive for young and healthy individuals without pre-existing conditions. The insurance premiums for those in this group will not reflect their own low actuarial risks but will subsidize insurance for others in the pool. Many of them may decide that purchasing health insurance is not an economically sound decision—especially since the guaranteed-issue provision will enable them to purchase it at the same cost in later years and even if they have developed a pre-existing condition. But without the contribution of above-risk premiums from the young and healthy, the community-rating provision will not enable insurers to take on high-risk individuals without a massive increase in premiums.

The Government presents the Individual Mandate as a unique feature of a complicated regulatory scheme governing many parties with countervailing incentives that must be carefully balanced. Congress has imposed an extensive set of regulations on the health insurance industry, and compliance with those regulations will likely cost the industry a great deal. If the industry does not respond by increasing premiums, it is not likely to survive. And if the industry does increase premiums, then there is a serious risk that its products—insurance plans—will become economically undesirable for many and prohibitively expensive for the rest.

This is not a dilemma unique to regulation of the health-insurance industry. Government regulation typically imposes costs on the regulated industry—especially regulation that prohibits economic behavior in which most market participants are already engaging, such as “piecing out” the market by selling the product to different classes of people at different prices (in the present context, providing much lower insurance rates to young and healthy buyers). And many industries so regulated face the reality that, without an artificial increase in demand, they cannot continue on. When Congress is regulating these industries directly, it enjoys the broad power to enact “‘all appropriate legislation’” to “‘protect[t]’ and “‘advanc[e]’” commerce, *NLRB v. Jones & Laughlin Steel Corp.*, 301 U.S. 1, 36-37 (1937) (quoting *The Daniel Ball*, 77 U.S. 557 (1871)) . Thus, Congress might protect the imperiled industry by prohibiting low-cost competition, or by according it preferential tax treatment, or even by granting it a direct subsidy.
Here, however, Congress has impressed into service third parties, healthy individuals who could be but are not customers of the relevant industry, to offset the undesirable consequences of the regulation. Congress’ desire to force these individuals to purchase insurance is motivated by the fact that they are further removed from the market than unhealthy individuals with pre-existing conditions, because they are less likely to need extensive care in the near future. If Congress can reach out and command even those furthest removed from an interstate market to participate in the market, then the Commerce Clause becomes a font of unlimited power, or in Hamilton’s words, “the hideous monster whose devouring jaws . . . spare neither sex nor age, nor high nor low, nor sacred nor profane.” The Federalist No. 33, p. 202 (C. Rossiter ed. 1961).

At the outer edge of the commerce power, this Court has insisted on careful scrutiny of regulations that do not act directly on an interstate market or its participants. In New York v. United States, 505 U.S. 144 (1992), we held that Congress could not, in an effort to regulate the disposal of radioactive waste produced in several different industries, order the States to take title to that waste. Id., at 174-177. In Printz v. United States, 521 U.S. 898 (1997), we held that Congress could not, in an effort to regulate the distribution of firearms in the interstate market, compel state law-enforcement officials to perform background checks. Id., at 933-935. In United States v. Lopez, 514 U.S. 549 (1995), we held that Congress could not, as a means of fostering an educated interstate labor market through the protection of schools, ban the possession of a firearm within a school zone. Id., at 559-563. And in United States v. Morrison, 529 U.S. 598 (2000), we held that Congress could not, in an effort to ensure the full participation of women in the interstate economy, subject private individuals and companies to suit for gender-motivated violent torts. Id., at 609-619. The lesson of these cases is that the Commerce Clause, even when supplemented by the Necessary and Proper Clause, is not carte blanche for doing whatever will help achieve the ends Congress seeks by the regulation of commerce. And the last two of these cases show that the scope of the Necessary and Proper Clause is exceeded not only when the congressional action directly violates the sovereignty of the States but also when it violates the background principle of enumerated (and hence limited) federal power.

The case upon which the Government principally relies to sustain the Individual Mandate under the Necessary and Proper Clause is Gonzales v. Raich, 545 U.S. 1 (2005). That case held that Congress could, in an effort to restrain the interstate market in marijuana, ban the local cultivation and possession of that drug. Id., at 15-22. Raich is no precedent for what Congress has done here. That case’s prohibition of growing (cf. Wickard, 317 U.S. 111), and of possession (cf. innumerable federal statutes) did not represent the expansion of the federal power to direct into a broad new field. The mandating of economic activity does, and since it is a field so limitless that it converts the Commerce Clause into a general authority to direct the economy, that mandating is not “consistent with the letter and spirit of the constitution.” McCulloch v. Maryland, 17 U.S. 316 (1819).

Moreover, Raich is far different from the Individual Mandate in another respect. The Court’s opinion in Raich pointed out that the growing and possession prohibitions

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Note: The text provided is a natural representation of the content of the image, focusing on the legal and constitutional analysis of the Commerce Clause as it applies to the Affordable Care Act (ACA) and related cases.
were the only practicable way of enabling the prohibition of interstate traffic in marijuana to be effectively enforced. 545 U.S., at 22. See also Shreveport Rate Cases, 234 U.S. 342 (1914) (Necessary and Proper Clause allows regulations of intrastate transactions if necessary to the regulation of an interstate market). Intrastate marijuana could no more be distinguished from interstate marijuana than, for example, endangered-species trophies obtained before the species was federally protected can be distinguished from trophies obtained afterwards—which made it necessary and proper to prohibit the sale of all such trophies, see Andrus v. Allard, 444 U.S. 51 (1979).

With the present statute, by contrast, there are many ways other than this unprecedented Individual Mandate by which the regulatory scheme’s goals of reducing insurance premiums and ensuring the profitability of insurers could be achieved. For instance, those who did not purchase insurance could be subjected to a surcharge when they do enter the health insurance system. Or they could be denied a full income tax credit given to those who do purchase the insurance.

The Government was invited, at oral argument, to suggest what federal controls over private conduct (other than those explicitly prohibited by the Bill of Rights or other constitutional controls) could not be justified as necessary and proper for the carrying out of a general regulatory scheme. It was unable to name any. As we said at the outset, whereas the precise scope of the Commerce Clause and the Necessary and Proper Clause is uncertain, the proposition that the Federal Government cannot do everything is a fundamental precept. See Lopez, 514 U.S., at 564 (“[I]f we were to accept the Government’s arguments, we are hard pressed to posit any activity by an individual that Congress is without power to regulate”). Section 5000A is defeated by that proposition.

B

The Government’s second theory in support of the Individual Mandate is that §5000A is valid because it is actually a “regulat[ion of] activities having a substantial relation to interstate commerce, . . . i.e., . . . activities that substantially affect interstate commerce.” Id., at 558-559. See also Shreveport Rate Cases, supra. This argument takes a few different forms, but the basic idea is that §5000A regulates “the way in which individuals finance their participation in the health-care market.” Petitioners’ Minimum Coverage Brief 33 (emphasis added). That is, the provision directs the manner in which individuals purchase health care services and related goods (directing that they be purchased through insurance) and is therefore a straightforward exercise of the commerce power.

The primary problem with this argument is that §5000A does not apply only to persons who purchase all, or most, or even any, of the health care services or goods that the mandated insurance covers. Indeed, the main objection many have to the Mandate is that they have no intention of purchasing most or even any of such goods or services and thus no need to buy insurance for those purchases. The Government responds that the health-care market involves “essentially universal participation,” id., at 35. The principal difficulty with this response is that it is, in the only relevant sense, not true. It is true
enough that everyone consumes “health care,” if the term is taken to include the purchase of a bottle of aspirin. But the health care “market” that is the object of the Individual Mandate not only includes but principally consists of goods and services that the young people primarily affected by the Mandate do not purchase. They are quite simply not participants in that market, and cannot be made so (and thereby subjected to regulation) by the simple device of defining participants to include all those who will, later in their lifetime, probably purchase the goods or services covered by the mandated insurance. Such a definition of market participants is unprecedented, and were it to be a premise for the exercise of national power, it would have no principled limits.

In a variation on this attempted exercise of federal power, the Government points out that Congress in this Act has purported to regulate “economic and financial decision[s] to forego [sic] health insurance coverage and [to] attempt to self-insure,” 42 U.S.C. §18091(2)(A), since those decisions have “a substantial and deleterious effect on interstate commerce,” Petitioners’ Minimum Coverage Brief 34. But as the discussion above makes clear, the decision to forgo participation in an interstate market is not itself commercial activity (or indeed any activity at all) within Congress’ power to regulate. It is true that, at the end of the day, it is inevitable that each American will affect commerce and become a part of it, even if not by choice. But if every person comes within the Commerce Clause power of Congress to regulate by the simple reason that he will one day engage in commerce, the idea of a limited Government power is at an end.

Wickard v. Filburn has been regarded as the most expansive assertion of the commerce power in our history. A close second is Perez v. United States, 402 U.S. 146 (1971), which upheld a statute criminalizing the eminently local activity of loan-sharking. Both of those cases, however, involved commercial activity. To go beyond that, and to say that the failure to grow wheat or the refusal to make loans affects commerce, so that growing and lending can be federally compelled, is to extend federal power to virtually everything. All of us consume food, and when we do so the Federal Government can prescribe what its quality must be and even how much we must pay. But the mere fact that we all consume food and are thus, sooner or later, participants in the “market” for food, does not empower the Government to say when and what we will buy. That is essentially what this Act seeks to do with respect to the purchase of health care. It exceeds federal power.

C

A few respectful responses to JUSTICE GINSBURG’s dissent on the issue of the Mandate are in order. That dissent duly recites the test of Commerce Clause power that our opinions have applied, but disregards the premise the test contains. It is true enough that Congress needs only a “‘rational basis’ for concluding that the regulated activity substantially affects interstate commerce[.]” But it must be activity affecting commerce that is regulated, and not merely the failure to engage in commerce. And one is not now purchasing the health care covered by the insurance mandate simply because one is likely to be purchasing it in the future. Our test’s premise of regulated activity is not invented out of whole cloth, but rests upon the Constitution’s requirement that it be commerce
which is regulated. If all inactivity affecting commerce is commerce, commerce is everything. Ultimately the dissent is driven to saying that there is really no difference between action and inaction, a proposition that has never recommended itself, neither to the law nor to common sense. To say, for example, that the inaction here consists of activity in “the self-insurance market,” *ibid.*, seems to us wordplay. By parity of reasoning the failure to buy a car can be called participation in the non-private-car-transportation market. Commerce becomes everything.

The dissent claims that we “fail[1] to explain why the individual mandate threatens our constitutional order.” But we have done so. It threatens that order because it gives such an expansive meaning to the Commerce Clause that *all* private conduct (including failure to act) becomes subject to federal control, effectively destroying the Constitution’s division of governmental powers. Thus the dissent, on the theories proposed for the validity of the Mandate, would alter the accepted constitutional relation between the individual and the National Government. The dissent protests that the Necessary and Proper Clause has been held to include “the power to enact criminal laws, . . . the power to imprison, . . . and the power to create a national bank[.]” Is not the power to compel purchase of health insurance much lesser? No, not if (unlike those other dispositions) its application rests upon a theory that everything is within federal control simply because it exists.

The dissent’s exposition of the wonderful things the Federal Government has achieved through exercise of its assigned powers, such as “the provision of old-age and survivors’ benefits” in the Social Security Act, is quite beside the point. The issue here is whether the federal government can impose the Individual Mandate through the Commerce Clause. And the relevant history is not that Congress has achieved wide and wonderful results through the proper exercise of its assigned powers in the past, but that it has never before used the Commerce Clause to compel entry into commerce. The dissent treats the Constitution as though it is an enumeration of those problems that the Federal Government can address-among which, it finds, is “the Nation’s course in the economic and social welfare realm,” *ibid.*, and more specifically “the problem of the uninsured[.]” The Constitution is not that. It enumerates not federally soluble *problems*, but federally available *powers*. The Federal Government can address whatever problems it wants but can bring to their solution only those powers that the Constitution confers, among which is the power to regulate commerce. None of our cases say anything else. Article I contains no whatever-it-takes-to-solve-a-national-problem power.

The dissent dismisses the conclusion that the power to compel entry into the health-insurance market would include the power to compel entry into the new-car or broccoli markets. The latter purchasers, it says, “will be obliged to pay at the counter before receiving the vehicle or nourishment,” whereas those refusing to purchase health-insurance will ultimately get treated anyway, at others’ expense. “[T]he unique attributes of the health-care market . . . give rise to a significant free-riding problem that does not occur in other markets.” And “a vegetable-purchase mandate” (or a car-purchase mandate) is not “likely to have a substantial effect on the health-care costs” borne by other Americans. Those differences make a very good argument by the dissent’s own
lights, since they show that the failure to purchase health insurance, unlike the failure to purchase cars or broccoli, creates a national, social-welfare problem that is (in the dissent’s view) included among the unenumerated “problems” that the Constitution authorizes the Federal Government to solve. But those differences do not show that the failure to enter the health-insurance market, unlike the failure to buy cars and broccoli, is an activity that Congress can “regulate.” (Of course one day the failure of some of the public to purchase American cars may endanger the existence of domestic automobile manufacturers; or the failure of some to eat broccoli may be found to deprive them of a newly discovered cancer-fighting chemical which only that food contains, producing health-care costs that are a burden on the rest of us—in which case, under the theory of JUSTICE GINSBURG’s dissent, moving against those inactivities will also come within the Federal Government’s unenumerated problem-solving powers.)

C. Justice Ginsburg’s Opinion, Joined by Justices Breyer, Sotomayor and Kagan, Finding That the Individual Mandate Satisfies the Commerce Clause

II

A

The Commerce Clause, it is widely acknowledged, “was the Framers’ response to the central problem that gave rise to the Constitution itself.” EEOC v. Wyoming, 460 U.S. 226, 244, 245, n. 1, (1983) (Stevens, J., concurring) (citing sources). Under the Articles of Confederation, the Constitution’s precursor, the regulation of commerce was left to the States. This scheme proved unworkable, because the individual States, understandably focused on their own economic interests, often failed to take actions critical to the success of the Nation as a whole. See Vices of the Political System of the United States, in James Madison: Writings 69, 71, P5 (J. Rakove ed. 1999) (As a result of the “want of concert in matters where common interest requires it,” the “national dignity, interest, and revenue [have] suffered.”).

What was needed was a “national Government . . . armed with a positive & compleat authority in all cases where uniform measures are necessary.” See Letter from James Madison to Edmund Randolph (Apr. 8, 1787), in 9 Papers of James Madison 368, 370 (R. Rutland ed. 1975). See also Letter from George Washington to James Madison (Nov. 30, 1785), in 8 id., at 428, 429 (“We are either a United people, or we are not. If the former, let us, in all matters of general concern act as a nation, which ha[s] national objects to promote, and a national character to support.”). The Framers’ solution was the Commerce Clause, which, as they perceived it, granted Congress the authority to enact economic legislation “in all Cases for the general Interests of the Union, and also in those Cases to which the States are separately incompetent.” 2 Records of the Federal Convention of 1787, pp. 131-132, P8 (M. Farrand rev. 1966). See also North American Co. v. SEC, 327 U.S. 686, 705 (1946) (“[The commerce power] is an affirmative power commensurate with the national needs.”).
The Framers understood that the “general Interests of the Union” would change over time, in ways they could not anticipate. Accordingly, they recognized that the Constitution was of necessity a “great outlin[e],” not a detailed blueprint, see *McCulloch v. Maryland*, 17 U.S. 316 (1819), and that its provisions included broad concepts, to be “explained by the context or by the facts of the case,” Letter from James Madison to N. P. Trist (Dec. 1831), in 9 Writings of James Madison 471, 475 (G. Hunt ed. 1910). “Nothing . . . can be more fallacious,” Alexander Hamilton emphasized, “than to infer the extent of any power, proper to be lodged in the national government, from . . . its immediate necessities. There ought to be a CAPACITY to provide for future contingencies[,] as they may happen; and as these are illimitable in their nature, it is impossible safely to limit that capacity.” The Federalist No. 34, pp. 205, 206 (John Harvard Library ed. 2009). See also *McCulloch*, 4 Wheat., at 415 (The Necessary and Proper Clause is lodged “in a constitution[,] intended to endure for ages to come, and consequently, to be adapted to the various crises of human affairs.”).

B

Consistent with the Framers’ intent, we have repeatedly emphasized that Congress’ authority under the Commerce Clause is dependent upon “practical” considerations, including “actual experience.” We afford Congress the leeway “to undertake to solve national problems directly and realistically.” *American Power & Light Co. v. SEC*, 329 U.S. 90 (1946).

Until today, this Court’s pragmatic approach to judging whether Congress validly exercised its commerce power was guided by two familiar principles. First, Congress has the power to regulate economic activities “that substantially affect interstate commerce.” *Gonzales v. Raich*, 545 U.S. 1, 17 (2005). This capacious power extends even to local activities that, viewed in the aggregate, have a substantial impact on interstate commerce. See *ibid.* See also *Wickard*, 317 U.S., at 125 (“[E]ven if appellee’s activity be local and though it may not be regarded as commerce, it may still, whatever its nature, be reached by Congress if it exerts a substantial economic effect on interstate commerce.”) (emphasis added)).

Second, we owe a large measure of respect to Congress when it frames and enacts economic and social legislation. See *Raich*, 545 U.S., at 17. See also *Pension Benefit Guaranty Corporation v. R. A. Gray & Co.*, 467 U.S. 717, 729 (1984) (“[S]trong deference [is] accorded legislation in the field of national economic policy.”); *Hodel v. Indiana*, 452 U.S. 314, 326 (1981) (“This [C]ourt will certainly not substitute its judgment for that of Congress unless the relation of the subject to interstate commerce and its effect upon it are clearly non-existent.” (internal quotation marks omitted)). When appraising such legislation, we ask only (1) whether Congress had a “rational basis” for concluding that the regulated activity substantially affects interstate commerce, and (2) whether there is a “reasonable connection between the regulatory means selected and the asserted ends.” *Id.*, at 323-324. In answering these questions, we presume the statute under review is constitutional and may strike it down only on a “plain showing” that Congress acted irrationally. *United States v. Morrison*, 529 U.S. 598, 607 (2000).
Straightforward application of these principles would require the Court to hold that the minimum coverage provision is proper Commerce Clause legislation. Beyond dispute, Congress had a rational basis for concluding that the uninsured, as a class, substantially affect interstate commerce. Those without insurance consume billions of dollars of health-care products and services each year. Those goods are produced, sold, and delivered largely by national and regional companies who routinely transact business across state lines. The uninsured also cross state lines to receive care. Some have medical emergencies while away from home. Others, when sick, go to a neighboring State that provides better care for those who have not prepaid for care.

Not only do those without insurance consume a large amount of health care each year; critically, as earlier explained, their inability to pay for a significant portion of that consumption drives up market prices, foists costs on other consumers, and reduces market efficiency and stability. Given these far-reaching effects on interstate commerce, the decision to forgo insurance is hardly inconsequential or equivalent to “doing nothing.” ante, at 20; it is, instead, an economic decision Congress has the authority to address under the Commerce Clause. See also Wickard, 317 U.S., at 128 (“It is well established by decisions of this Court that the power to regulate commerce includes the power to regulate the prices at which commodities in that commerce are dealt in and practices affecting such prices.” (emphasis added)).

The minimum coverage provision, furthermore, bears a “reasonable connection” to Congress’ goal of protecting the health-care market from the disruption caused by individuals who fail to obtain insurance. By requiring those who do not carry insurance to pay a toll, the minimum coverage provision gives individuals a strong incentive to insure. This incentive, Congress had good reason to believe, would reduce the number of uninsured and, correspondingly, mitigate the adverse impact the uninsured have on the national health-care market.

Congress also acted reasonably in requiring uninsured individuals, whether sick or healthy, either to obtain insurance or to pay the specified penalty. As earlier observed, because every person is at risk of needing care at any moment, all those who lack insurance, regardless of their current health status, adversely affect the price of health care and health insurance. Moreover, an insurance-purchase requirement limited to those in need of immediate care simply could not work. Insurance companies would either charge these individuals prohibitively expensive premiums, or, if community-rating regulations were in place, close up shop. See also Brief for State of Maryland and 10 Other States et al. as Amici Curiae in No. 11-398, p. 28 (hereinafter Maryland Brief) (“No insurance regime can survive if people can opt out when the risk insured against is only a risk, but opt in when the risk materializes.”).

“[W]here we find that the legislators . . . have a rational basis for finding a chosen regulatory scheme necessary to the protection of commerce, our investigation is at an
end.” Katzenbach, 379 U.S., at 303-304. Congress’ enactment of the minimum coverage provision, which addresses a specific interstate problem in a practical, experience-informed manner, easily meets this criterion.

D

Rather than evaluating the constitutionality of the minimum coverage provision in the manner established by our precedents, THE CHIEF JUSTICE relies on a newly minted constitutional doctrine. The commerce power does not, THE CHIEF JUSTICE announces, permit Congress to “compel[.] individuals to become active in commerce by purchasing a product.”

THE CHIEF JUSTICE’s novel constraint on Congress’ commerce power gains no force from our precedent and for that reason alone warrants disapprobation. But even assuming, for the moment, that Congress lacks authority under the Commerce Clause to “compel individuals not engaged in commerce to purchase an unwanted product,” such a limitation would be inapplicable here. Everyone will, at some point, consume health-care products and services. Thus, if THE CHIEF JUSTICE is correct that an insurance-purchase requirement can be applied only to those who “actively” consume health care, the minimum coverage provision fits the bill.

THE CHIEF JUSTICE does not dispute that all U.S. residents participate in the market for health services over the course of their lives. See ante, at 16 ("Everyone will eventually need health care at a time and to an extent they cannot predict."). But, THE CHIEF JUSTICE insists, the uninsured cannot be considered active in the market for health care, because “[t]he proximity and degree of connection between the [uninsured today] and [their] subsequent commercial activity is too lacking.”

This argument has multiple flaws. First, more than 60% of those without insurance visit a hospital or doctor’s office each year. Nearly 90% will within five years. An uninsured’s consumption of health care is thus quite proximate: It is virtually certain to occur in the next five years and more likely than not to occur this year.

Equally evident, Congress has no way of separating those uninsured individuals who will need emergency medial care today (surely their consumption of medical care is sufficiently imminent) from those who will not need medical services for years to come. No one knows when an emergency will occur, yet emergencies involving the uninsured arise daily. To capture individuals who unexpectedly will obtain medical care in the very near future, then, Congress needed to include individuals who will not go to a doctor anytime soon. Congress, our decisions instruct, has authority to cast its net that wide. See Perez v. United States, 402 U.S. 146 (1971) (‘‘[W]hen it is necessary in order to prevent
an evil to make the law embrace more than the precise thing to be prevented it may do so.” (internal quotation marks omitted)).

Second, it is Congress’ role, not the Court’s, to delineate the boundaries of the market the Legislature seeks to regulate. THE CHIEF JUSTICE defines the health-care market as including only those transactions that will occur either in the next instant or within some (unspecified) proximity to the next instant. But Congress could reasonably have viewed the market from a long-term perspective, encompassing all transactions virtually certain to occur over the next decade, not just those occurring here and now.

Third, contrary to THE CHIEF JUSTICE’s contention, our precedent does indeed support “[t]he proposition that Congress may dictate the conduct of an individual today because of prophesied future activity.” In Wickard, the Court upheld a penalty the Federal Government imposed on a farmer who grew more wheat than he was permitted to grow under the Agricultural Adjustment Act of 1938 (AAA). 317 U.S., at 114-115. He could not be penalized, the farmer argued, as he was growing the wheat for home consumption, not for sale on the open market. Id., 317 U.S. at 119. The Court rejected this argument. Id., 317 U.S. at 127-129. Wheat intended for home consumption, the Court noted, “overhangs the market, and if induced by rising prices, tends to flow into the market and check price increases [intended by the AAA].” Id., 317 U.S. at 128.

Similar reasoning supported the Court’s judgment in Raich, which upheld Congress’ authority to regulate marijuana grown for personal use. 545 U.S., at 19. Home-grown marijuana substantially affects the interstate market for marijuana, we observed, for “the high demand in the interstate market will [likely] draw such marijuana into that market.” Ibid.

Our decisions thus acknowledge Congress’ authority, under the Commerce Clause, to direct the conduct of an individual today (the farmer in Wickard, stopped from growing excess wheat; the plaintiff in Raich, ordered to cease cultivating marijuana) because of a prophesied future transaction (the eventual sale of that wheat or marijuana in the interstate market). Congress’ actions are even more rational in this case, where the future activity (the consumption of medical care) is certain to occur, the sole uncertainty being the time the activity will take place.

Maintaining that the uninsured are not active in the health-care market, THE CHIEF JUSTICE draws an analogy to the car market. An individual “is not ‘active in the car market,’” THE CHIEF JUSTICE observes, simply because he or she may someday buy a car. The analogy is inapt. The inevitable yet unpredictable need for medical care and the guarantee that emergency care will be provided when required are conditions nonexistent in other markets. That is so of the market for cars, and of the market for

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5 Echoing THE CHIEF JUSTICE, the joint dissenters urge that the minimum coverage provision impermissibly regulates young people who “have no intention of purchasing [medical care]” and are too far “removed from the [health-care] market.” This criticism ignores the reality that a healthy young person may be a day away from needing health care. A victim of an accident or unforeseen illness will consume extensive medical care immediately, though scarcely expecting to do so.
broccoli as well. Although an individual might buy a car or a crown of broccoli one day, there is no certainty she will ever do so. And if she eventually wants a car or has a craving for broccoli, she will be obliged to pay at the counter before receiving the vehicle or nourishment. She will get no free ride or food, at the expense of another consumer forced to pay an inflated price. See *Thomas More Law Center v. Obama*, 651 F.3d 529, 565 (CA6 2011) (Sutton, J., concurring in part) (“Regulating how citizens pay for what they already receive (health care), never quite know when they will need, and in the case of severe illnesses or emergencies generally will not be able to afford, has few (if any) parallels in modern life.”). Upholding the minimum coverage provision on the ground that all are participants or will be participants in the health-care market would therefore carry no implication that Congress may justify under the Commerce Clause a mandate to buy other products and services.

Nor is it accurate to say that the minimum coverage provision “compel[s] individuals . . . to purchase an unwanted product,” or “suite of products,” (joint opinion of SCALIA, KENNEDY, THOMAS, and ALITO, JJ.). If unwanted today, medical service secured by insurance may be desperately needed tomorrow. Virtually everyone, I reiterate, consumes health care at some point in his or her life. Health insurance is a means of paying for this care, nothing more. In requiring individuals to obtain insurance, Congress is therefore not mandating the purchase of a discrete, unwanted product. Rather, Congress is merely defining the terms on which individuals pay for an interstate good they consume: Persons subject to the mandate must now pay for medical care in advance (instead of at the point of service) and through insurance (instead of out of pocket). Establishing payment terms for goods in or affecting interstate commerce is quintessential economic regulation well within Congress’ domain. See, e.g., *United States v. Wrightwood Dairy Co.*, 315 U.S. 110 (1942). (joint opinion of SCALIA, KENNEDY, THOMAS, and ALITO, JJ.) (recognizing that “the Federal Government can prescribe [a commodity’s] quality . . . and even [its price]”).

THE CHIEF JUSTICE also calls the minimum coverage provision an illegitimate effort to make young, healthy individuals subsidize insurance premiums paid by the less hale and hardy. This complaint, too, is spurious. Under the current health-care system, healthy persons who lack insurance receive a benefit for which they do not pay: They are assured that, if they need it, emergency medical care will be available, although they cannot afford it. Those who have insurance bear the cost of this guarantee. By requiring the healthy uninsured to obtain insurance or pay a penalty structured as a tax, the minimum coverage provision ends the free ride these individuals currently enjoy.

In the fullness of time, moreover, today’s young and healthy will become society’s old and infirm. Viewed over a lifespan, the costs and benefits even out: The young who pay more than their fair share currently will pay less than their fair share when they become senior citizens. And even if, as undoubtedly will be the case, some individuals, over their lifespans, will pay more for health insurance than they receive in health services, they have little to complain about, for that is how insurance works. Every insured person receives protection against a catastrophic loss, even though only a subset of the covered class will ultimately need that protection.
In any event, THE CHIEF JUSTICE’s limitation of the commerce power to the regulation of those actively engaged in commerce finds no home in the text of the Constitution or our decisions. Article I, § 8, of the Constitution grants Congress the power “[t]o regulate Commerce . . . among the several States.” Nothing in this language implies that Congress’ commerce power is limited to regulating those actively engaged in commercial transactions. Indeed, as the D. C. Circuit observed, “[a]t the time the Constitution was [framed], to ‘regulate’ meant,” among other things, “to require action.” See Seven-Sky v. Holder, 661 F.3d 1, 16 (2011).

Arguing to the contrary, THE CHIEF JUSTICE notes that “the Constitution gives Congress the power to ‘coin Money,’ in addition to the power to ‘regulate the Value thereof,’” and similarly “gives Congress the power to ‘raise and support Armies’ and to ‘provide and maintain a Navy,’ in addition to the power to ‘make Rules for the Government and Regulation of the land and naval Forces.’” (citing Art. I, § 8, cls. 5, 12-14). In separating the power to regulate from the power to bring the subject of the regulation into existence, THE CHIEF JUSTICE asserts, “[t]he language of the Constitution reflects the natural understanding that the power to regulate assumes there is already something to be regulated.”

This argument is difficult to fathom. Requiring individuals to obtain insurance unquestionably regulates the interstate health-insurance and health-care markets, both of them in existence well before the enactment of the ACA. See Wickard, 317 U.S., at 128 (“The stimulation of commerce is a use of the regulatory function quite as definitely as prohibitions or restrictions thereon.”). Thus, the “something to be regulated” was surely there when Congress created the minimum coverage provision.

Nor does our case law toe the activity versus inactivity line. In Wickard, for example, we upheld the penalty imposed on a farmer who grew too much wheat, even though the regulation had the effect of compelling farmers to purchase wheat in the open market. Id., at 127-129. “[F]orcing some farmers into the market to buy what they could provide for themselves” was, the Court held, a valid means of regulating commerce. Id., at 128-129. In another context, this Court similarly upheld Congress’ authority under the commerce power to compel an “inactive” land-holder to submit to an unwanted sale. See Monongahela Nav. Co. v. United States, 148 U.S. 312, 335-337 (1893) (“[U]pon the [great] power to regulate commerce[,]” Congress has the authority to mandate the sale of real property to the Government, where the sale is essential to the improvement of a navigable waterway (emphasis added)); Cherokee Nation v. Southern Kansas R. Co., 135 U.S. 641,657-659 (1890) (similar reliance on the commerce power regarding mandated sale of private property for railroad construction).

In concluding that the Commerce Clause does not permit Congress to regulate commercial “inactivity,” and therefore does not allow Congress to adopt the practical solution it devised for the health-care problem, THE CHIEF JUSTICE views the Clause as a “technical legal conception,” precisely what our case law tells us not to do. Wickard,
317 U.S., at 122 (internal quotation marks omitted). This Court’s former endeavors to impose categorical limits on the commerce power have not fared well. In several pre-New Deal cases, the Court attempted to cabin Congress’ Commerce Clause authority by distinguishing “commerce” from activity once conceived to be noncommercial, notably, “production,” “mining,” and “manufacturing.” See, e.g., *United States v. E. C. Knight Co.*, 156 U.S. 1 (1895) (“Commerce succeeds to manufacture, and is not a part of it.”); *Carter v. Carter Coal Co.*, 298 U.S. 238, 304 (1936) (“Mining brings the subject matter of commerce into existence. Commerce disposes of it.”). The Court also sought to distinguish activities having a “direct” effect on interstate commerce, and for that reason, subject to federal regulation, from those having only an “indirect” effect, and therefore not amenable to federal control. See, e.g., *A. L. A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 548 (1935) (“[T]he distinction between direct and indirect effects of intrastate transactions upon interstate commerce must be recognized as a fundamental one.”).

These line-drawing exercises were untenable, and the Court long ago abandoned them. “[Q]uestions of the power of Congress [under the Commerce Clause],” we held in *Wickard*, “are not to be decided by reference to any formula which would give controlling force to nomenclature such as ‘production’ and ‘indirect’ and foreclose consideration of the actual effects of the activity in question upon interstate commerce.” 317 U.S., at 120. Failing to learn from this history, THE CHIEF JUSTICE plows ahead with his formalistic distinction between those who are “active in commerce,” *ante*, at 20, and those who are not.

It is not hard to show the difficulty courts (and Congress) would encounter in distinguishing statutes that regulate “activity” from those that regulate “inactivity.” As Judge Easterbrook noted, “it is possible to restate most actions as corresponding inactions with the same effect.” *Archie v. Racine*, 847 F.2d 1211, 1213 (CA7 1988) (en banc). Take this case as an example. An individual who opts not to purchase insurance from a private insurer can be seen as actively selecting another form of insurance: self-insurance. See *Thomas More Law Center*, 651 F. 3d, at 561 (Sutton, J., concurring in part) (“No one is inactive when deciding how to pay for health care, as self-insurance and private insurance are two forms of action for addressing the same risk.”). The minimum coverage provision could therefore be described as regulating activists in the self-insurance market.7 *Wickard* is another example. Did the statute there at issue target activity (the growing of too much wheat) or inactivity (the farmer’s failure to purchase wheat in the marketplace)? If anything, the Court’s analysis suggested the latter. See 317 U.S., at 127-129.

At bottom, THE CHIEF JUSTICE’s and the joint dissenters “‘view that an individual cannot be subject to Commerce Clause regulation absent voluntary,

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7 THE CHIEF JUSTICE’s characterization of individuals who choose not to purchase private insurance as “doing nothing,” *ante*, at 20, is similarly questionable. A person who self-insures opts against prepayment for a product the person will in time consume. When aggregated, exercise of that option has a substantial impact on the health-care market.
affirmative acts that enter him or her into, or affect, the interstate market expresses a concern for individual liberty that [is] more redolent of Due Process Clause arguments.” Seven-Sky, 661 F. 3d, at 19. See also Troxel v. Granville, 530 U.S. 57, 65 (plurality opinion) (“The [Due Process] Clause also includes a substantive component that provides heightened protection against government interference with certain fundamental rights and liberty interests.” (internal quotation marks omitted)). Plaintiffs have abandoned any argument pinned to substantive due process, however, see 648 F.3d 1235, 1291, n. 93 (CA11 2011), and now concede that the provisions here at issue do not offend the Due Process Clause.8

Underlying THE CHIEF JUSTICE’s view that the Commerce Clause must be confined to the regulation of active participants in a commercial market is a fear that the commerce power would otherwise know no limits. See, e.g., ante, at 23 (Allowing Congress to compel an individual not engaged in commerce to purchase a product would “permi[t] Congress to reach beyond the natural extent of its authority, everywhere extending the sphere of its activity, and drawing all power into its impetuous vortex.” (internal quotation marks omitted)). The joint dissenters express a similar apprehension. See post, at 8 (If the minimum coverage provision is upheld under the commerce power then “the Commerce Clause becomes a font of unlimited power, . . . the hideous monster whose devouring jaws . . . spare neither sex nor age, nor high nor low, nor sacred nor profane.” (internal quotation marks omitted)). This concern is unfounded.

First, THE CHIEF JUSTICE could certainly uphold the individual mandate without giving Congress carte blanche to enact any and all purchase mandates. As several times noted, the unique attributes of the health-care market render everyone active in that market and give rise to a significant free-riding problem that does not occur in other markets.

Nor would the commerce power be unbridled, absent THE CHIEF JUSTICE’s “activity” limitation. Congress would remain unable to regulate noneconomic conduct that has only an attenuated effect on interstate commerce and is traditionally left to state law. See Lopez, 514 U.S., at 567. In Lopez, for example, the Court held that the Federal Government lacked power, under the Commerce Clause, to criminalize the possession of a gun in a local school zone. Possessing a gun near a school, the Court reasoned, “is in no sense an economic activity that might, through repetition elsewhere—where, substantially affect any sort of interstate commerce.” 514 U.S., at 567; ibid. (noting that the Court

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8 Some adherents to the joint dissent have questioned the existence of substantive due process rights. See McDonald v. City of Chicago, 130 S. Ct. 3020 (2010) (THOMAS, J., concurring) (The notion that the Due Process Clause “could define the substance of th[e] righ[t to liberty] strains credulity.”); Albright v. Oliver, 510 U.S. 266, 275 (1994) (SCALIA, J., concurring) (“I reject the proposition that the Due Process Clause guarantees certain (unspecified) liberties[.]”). Given these Justices’ reluctance to interpret the Due Process Clause as guaranteeing liberty interests, their willingness to plant such protections in the Commerce Clause is striking.
would have “to pile inference upon inference” to conclude that gun possession has a substantial effect on commerce).

An individual’s decision to self-insure, I have explained, is an economic act with the requisite connection to interstate commerce. Other choices individuals make are unlikely to fit the same or similar description. As an example of the type of regulation he fears, THE CHIEF JUSTICE cites a Government mandate to purchase green vegetables. One could call this concern “the broccoli horrible.” Congress, THE CHIEF JUSTICE posits, might adopt such a mandate, reasoning that an individual’s failure to eat a healthy diet, like the failure to purchase health insurance, imposes costs on others. See ibid.

Consider the chain of inferences the Court would have to accept to conclude that a vegetable-purchase mandate was likely to have a substantial effect on the health-care costs borne by lithe Americans. The Court would have to believe that individuals forced to buy vegetables would then eat them (instead of throwing or giving them away), would prepare the vegetables in a healthy way (steamed or raw, not deep-fried), would cut back on unhealthy foods, and would not allow other factors (such as lack of exercise or little sleep) to trump the improved diet. Such “piling of inference upon inference” is just what the Court refused to do in Lopez and Morrison.

Supplementing these legal restraints is a formidable check on congressional power: the democratic process. See Raich, 545 U.S., at 33; Wickard, 317 U.S., at 120 (repeating Chief Justice Marshall’s “warning that effective restraints on [the commerce power’s] exercise must proceed from political rather than judicial processes” (citing Gibbons v. Ogden, 9 Wheat. 1 (1824)). As the controversy surrounding the passage of the Affordable Care Act attests, purchase mandates are likely to engender political resistance. This prospect is borne out by the behavior of state legislators. Despite their possession of unquestioned authority to impose mandates, state governments have rarely done so. See Hall, Commerce Clause Challenges to Health Care Reform, 159 U. Pa. L. Rev. 1825, 1838 (2011).

When contemplated in its extreme, almost any power looks dangerous. The commerce power, hypothetically, would enable Congress to prohibit the purchase and home production of all meat, fish, and dairy goods, effectively compelling Americans to eat only vegetables. Yet no one would offer the “hypothetical and unreal possibilit[y],” Pullman Co. v. Knott, 235 U.S. 23, 26 (1914), of a vegetarian state as a credible reason to deny Congress the authority ever to ban the possession and sale of goods. THE CHIEF JUSTICE accepts just such specious logic when he cites the broccoli horrible as a reason to deny Congress the power to pass the individual mandate. Cf. R. Bork, The Tempting of America 169 (1990) (“Judges and lawyers live on the slippery slope of analogies; they are not supposed to ski it to the bottom.”). But see, e.g., post, at 3 (joint opinion of SCALIA, KENNEDY, THOMAS, and ALITO, JJ.) (asserting, outlandishly, that if the minimum coverage provision is sustained, then Congress could make “breathing in and out the basis for federal prescription”).
To bolster his argument that the minimum coverage provision is not valid Commerce Clause legislation, THE CHIEF JUSTICE emphasizes the provision’s novelty. While an insurance-purchase mandate may be novel, THE CHIEF JUSTICE’s argument certainly is not. For decades, the Court has declined to override legislation because of its novelty, and for good reason. As our national economy grows and changes, we have recognized, Congress must adapt to the changing “economic and financial realities.” Hindering Congress’ ability to do so is shortsighted; if history is any guide, today’s constriction of the Commerce Clause will not endure.

III

A

For the reasons explained above, the minimum coverage provision is valid Commerce Clause legislation. When viewed as a component of the entire ACA, the provision’s constitutionality becomes even plainer.

The Necessary and Proper Clause “empowers Congress to enact laws in effectuation of its [commerce] power that are not within its authority to enact in isolation.” Raich, 545 U.S., at 39 (SCALIA, J., concurring in judgment). Hence, “[a] complex regulatory program . . . can survive a Commerce Clause challenge without a showing that every single facet of the program is independently and directly related to a valid congressional goal.” Indiana, 452 U.S., at 329, n. 17. “It is enough that the challenged provisions are an integral part of the regulatory program and that the regulatory scheme when considered as a whole satisfies this test.” Ibid. (collecting cases). See also Raich, 545 U.S., at 24-25 (A challenged statutory provision fits within Congress’ commerce authority if it is an “essential part of a larger regulation of economic activity,” such that, in the absence of the provision, “the regulatory scheme could be undercut.” (quoting Lopez, 514 U.S., at 561)); Raich, 545 U.S., at 37 (SCALIA, J., concurring in judgment) (“Congress may regulate even noneconomic local activity if that regulation is a necessary part of a more general regulation of interstate commerce. The relevant question is simply whether the means chosen are ‘reasonably adapted’ to the attainment of a legitimate end under the commerce power.” (citation omitted)).

Recall that one of Congress’ goals in enacting the Affordable Care Act was to eliminate the insurance industry’s practice of charging higher prices or denying coverage to individuals with preexisting medical conditions. The commerce power allows Congress to ban this practice, a point no one disputes.

Congress knew, however, that simply barring insurance companies from relying on an applicant’s medical history would not work in practice. Without the individual mandate, Congress learned, guaranteed-issue and community-rating requirements would trigger an adverse-selection death-spiral in the health-insurance market: Insurance premiums would skyrocket, the number of uninsured would increase, and insurance companies would exit the market. When complemented by an insurance mandate, on the
other hand, guaranteed issue and community rating would work as intended, increasing access to insurance and reducing uncompensated care. The minimum coverage provision is thus an “essential part of a larger regulation of economic activity”; without the provision, “the regulatory scheme [w]ould be undercut.” *Raich*, 545 U.S., at 24-25 (internal quotation marks omitted). Put differently, the minimum coverage provision, together with the guaranteed-issue and community-rating requirements, is “reasonably adapted’ to the attainment of a legitimate end under the commerce power”: the elimination of pricing and sales practices that take an applicant’s medical history into account. See id., 545 U.S. at 37 (SCALIA, J., concurring in judgment).

B

Asserting that the Necessary and Proper Clause does not authorize the minimum coverage provision, THE CHIEF JUSTICE focuses on the word “proper.” A mandate to purchase health insurance is not “proper” legislation, THE CHIEF JUSTICE urges, because the command “undermine[s] the structure of government established by the Constitution.” If long on rhetoric, THE CHIEF JUSTICE’s argument is short on substance.

THE CHIEF JUSTICE cites only two cases in which this Court concluded that a federal statute impermissibly transgressed the Constitution’s boundary between state and federal authority: *Printz v. United States*, 521 U.S. 898 (1997), and *New York v. United States*, 505 U.S. 144 (1992). The statutes at issue in both cases, however, compelled state officials to act on the Federal Government’s behalf.

The minimum coverage provision, in contrast, acts “directly upon individuals, without employing the States as intermediaries.” *New York*, 505 U.S., at 164. The provision is thus entirely consistent with the Constitution’s design. See *Printz*, 521 U.S., at 920 (“[T]he Framers explicitly chose a Constitution that confers upon Congress the power to regulate individuals, not States.” (internal quotation marks omitted)).

Lacking case law support for his holding, THE CHIEF JUSTICE nevertheless declares the minimum coverage provision not “proper” because it is less “narrow in scope” than other laws this Court has upheld under the Necessary and Proper Clause. THE CHIEF JUSTICE’s reliance on cases in which this Court has affirmed Congress’ “broad authority to enact federal legislation” under the Necessary and Proper Clause, *Comstock*, 130 S. Ct. 1949, 1956, is underwhelming.

Nor does THE CHIEF JUSTICE pause to explain why the power to direct either the purchase of health insurance or, alternatively, the payment of a penalty collectible as a tax is more far-reaching than other implied powers this Court has found meet under the Necessary and Proper Clause. These powers include the power to enact criminal laws; the power to imprison, including civil imprisonment; and the power to create a national bank.

In failing to explain why the individual mandate threatens our constitutional order, THE CHIEF JUSTICE diserves future courts. How is a judge to decide, when ruling on
the constitutionality of a federal statute, whether Congress employed an “independent power,” ante, at 28, or merely a “derivative” one, ante, at 29. Whether the power used is “substantive,” ante, at 30, or just “incidental,” ante, at 29? The instruction THE CHIEF JUSTICE, in effect, provides lower courts: You will know it when you see it.

It is more than exaggeration to suggest that the minimum coverage provision improperly intrudes on “essential attributes of state sovereignty.” Ibid. (internal quotation marks omitted). First, the Affordable Care Act does not operate “in [an] arena[s] such as criminal law enforcement or education where States historically have been sovereign.” *Lopez*, 514 U.S., at 564. As evidenced by Medicare, Medicaid, the Employee Retirement Income Security Act of 1974 (ERISA), and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Federal Government plays a lead role in the health-care sector, both as a direct payer and as a regulator.

Second, and perhaps most important, the minimum coverage provision, along with other provisions of the ACA, addresses the very sort of interstate problem that made the commerce power essential in our federal system. The crisis created by the large number of U.S. residents who lack health insurance is one of national dimension that States are “separately incompetent” to handle. See also Maryland Brief 15-26 (describing “the impediments to effective state policymaking that flow from the interconnectedness of each state’s healthcare economy” and emphasizing that “state-level reforms cannot fully address the problems associated with uncompensated care”). Far from trampling on States’ sovereignty, the ACA attempts a federal solution for the very reason that the States, acting separately, cannot meet the need. Notably, the ACA serves the general welfare of the people of the United States while retaining a prominent role for the States. See *id.*, at 31-36 (explaining and illustrating how the ACA affords States wide latitude in implementing key elements of the Act’s reforms).11

IV

In the early 20th century, this Court regularly struck down economic regulation enacted by the peoples’ representatives in both the States and the Federal Government.

11 In a separate argument, the joint dissenters contend that the minimum coverage provision is not necessary and proper because it was not the “only . . . way” Congress could have made the guaranteed-issue and community-rating reforms work. Congress could also have avoided an insurance-market death spiral, the dissenters maintain, by imposing a surcharge on those who did not previously purchase insurance when those individuals eventually enter the health-insurance system. Or Congress could “den[y] a full income tax credit” to those who do not purchase insurance. Neither a surcharge on those who purchase insurance nor the denial of a tax credit to those who do not would solve the problem created by guaranteed-issue and community-rating requirements. Neither would prompt the purchase of insurance before sickness or injury occurred. But even assuming there were “practicable” alternatives to the minimum coverage provision, “we long ago rejected the view that the Necessary and Proper Clause demands that an Act of Congress be ‘absolutely necessary’ to the exercise of an enumerated power.” *Jinks v. Richland County*, 538 U.S. 456, 462 (2003) (quoting *McCulloch v. Maryland*, 17 U.S. 316 (1819)). Rather, the statutory provision at issue need only be “conducive” and “reasonably adapted” to the goal Congress seeks to achieve. *Jinks*, 538 U.S., at 462 (internal quotation marks omitted). The minimum coverage provision meets this requirement.
See, e.g., *Lochner v. New York*, 198 U.S. 45 (1905). THE CHIEF JUSTICE’s Commerce Clause opinion, and even more so the joint dissenters’ reasoning, bear a disquieting resemblance to those long-overruled decisions.

Ultimately, the Court upholds the individual mandate as a proper exercise of Congress’ power to tax and spend “for the . . . general Welfare of the United States.” Art. I, § 8, cl. 1; *ante*, at 43–44. I concur in that determination, which makes THE CHIEF JUSTICE’s Commerce Clause essay all the more puzzling. Why should THE CHIEF JUSTICE strive so mightily to hem in Congress’ capacity to meet the new problems arising constantly in our ever-developing modern economy? I find no satisfying response to that question in his opinion.12

**Notes**

1. *The significance of constitutional meta-theory.* In the interest of space we have heavily redacted the decision but the opinions are notable for the manner in which the contending sides frame the stakes of the decision. The joint dissent contains a lengthy paean to the limitations of federal power and the countervailing liberty of the individual and sovereignty of the states. It frames the issue such that it involves whether “mere breathing in and out” can be the “basis for federal prescription and to extend federal power to virtually all human activity.” By contrast, Justice Ginsburg’s opinion initially details the national scope of the problems of the uninsured and of the health care financing system, the practical inability of the states to solve these problems, the dire necessity for federal action, and the fact that the national constitution was created precisely to create national capacity in the face of state incapacity. In turn, the Chief Justice’s opinion is for the most part remarkably free of any constitutional meta-theory and quite workmanlike in his approach to the particular issues presented by particular clauses. * He position in the middle—albeit the middle of a debate that has shifted quite far to the right in recent decades—is vividly clear.

2. *What “activity” is being regulated as commerce by the individual mandate?* The “Rashamon” effect. *Rashamon*, the classic film directed by Akiro Kurasawa, is a fable of truth and perspective. In the film, one story (an assault) is told from four different perspectives, each one of which is constrained (or boosted) by its version of reality and

12 THE CHIEF JUSTICE states that he must evaluate the constitutionality of the minimum coverage provision under the Commerce Clause because the provision “reads more naturally as a command to buy insurance than as a tax.” THE CHIEF JUSTICE ultimately concludes, however, that interpreting the provision as a tax is a “fairly possible” construction. That being so, I see no reason to undertake a Commerce Clause analysis that is not outcome determinative.

* We write “for the most part” because the Chief Justice, like the joint dissent, trots out a less hyperbolic version of the “broccoli horrible,” as he imagines a world in which federal power controls what we eat, intones that such a nation is “not the country the Framers of our Constitution envisioned,” and warns of the potentially omnivorous maelstrom of federal power. It’s a question of degree, as one compares such language with that of the joint dissent, quoting Hamilton: “‘the hideous monster whose devouring jaws . . . spare neither sex nor age, nor high nor low, nor sacred nor profane.’ The Federalist No. 33, p. 202 (C. Rossiter ed. 1961).”
truth. Here, we see the Rashamon effect in full force. A key to understanding the opinions is to consider precisely how they attempt to get behind the law itself in order to frame the activity or inactivity being regulated. In so doing, they use the same facts, at least superficially. The same statutory provisions are considered. The same case law precedents are cited. But the results are dramatically different.

To the Chief Justice and the joint dissenters, the “reality” is a bunch of people (mostly young and healthy) sitting around and doing nothing, disengaged from commerce. The fact that the health insurance industry is doing plenty—charging high rates to sicker and older individuals and groups, excluding entire groups of people entirely—is not legally relevant to the Chief Justice and the dissenters, since the power to reach the industry is merely derivative of the underlying power to regulate commerce, which here is missing. For them, the case is about the freedom to do nothing, even if tomorrow the young and the healthy—and the uninsured—become a major burden to the health care economy as a result of illness or injury. The ACA is nothing less than a compulsion to go out and buy health insurance. The ACA therefore regulates and impinges upon individual consumption decisions.

Of course, this vantage point, along with the narrowing of the Necessary and Proper Clause to regulatory activities that derive their constitutionality from a separate grant of constitutional powers, means that even if one posits that the ACA regulates health insurance (by definition a collective, economic activity), Congress has no power. However, to hold that health insurance devolves into individual consumption decisions is as stupid as saying that Robinson Crusoe’s mumbling to himself constitutes language for, just as it takes more than one person to engage in dialogue—unless one dines with Andre—it takes more than one person to insure—to pool risk.

From there all the slope arguments and the specter of unlimited Congressional power—including the “broccoli horrible”—fall like a stack of cards. Because health insurance is inexorably collective activity, it gives rise to the problems of collective action we have detailed in this part and will continue to explicate throughout the Book, most saliently the strategic use of information and the imposition of costs on everyone else to the extent law allows. In order to save private health insurance—which is as commerce as commerce gets—the ACA is aimed precisely at solving these problems of collective action and the imposition of externalities. Cars, broccoli and all other fruits and vegetables are neither produced nor consumed in such a pooled fashion, and they are therefore simply not relevant to the task at hand. A holding that Congress has the power to save private health insurance by forcing individuals to pay in premiums in advance of their drawing out benefits—even Robinson Crusoe could escape only one of the inexorable evils of death and taxes—would not have spilled over into “mere breathing in and out.” Indeed one of the ironies of the entire litigation is that the ACA represents a very conservative solution, coming from think-tanks like the Heritage Foundation, to shore up this nation’s very conservative approach to financing modern health care. The fact that five conservative Justices found this approach to be beyond the reach of the Commerce Clause is rather mind-boggling.
This framing of the issue as one that involves pushing people into the commercial market stands in stark contrast to the viewpoint taken by Justice Ginsburg, and shared by Justices Breyer, Sotomayor, and Kagan. Her entire decision stems from a vantage point that focuses on the health economy as the object of the regulation. She is acutely aware of the fact that at any given moment in time millions of people (and yes, even young immortals) are moving in and out of the market for health care, sometimes intentionally (getting a health exam and a flu shot), sometimes accidentally (crashing one’s bike during a road race; running to class and falling down the stairs), sometimes tragically (a diagnosis of leukemia). Framed this way, the legal result is profoundly different, a matter underscored by the fact that both sides cite the very same litany of Commerce Clause classics to bolster their view.

Something to ponder. First, what if you were to discover that contrary to the Chief Justice’s and the dissent’s Seinfeldian view of life – young immortals happy in their uninsured state and not willing to do anything about it – most young adults are eager to purchase health insurance yet cannot do so because of either cost or the presence of a pre-existing condition. Would this change your mind? Move you from one point of view to the other? An analysis published in June 2012 by the Commonwealth Fund found that nearly 14 million young adults either remained on or joined their parents’ health insurance plans in 2010-11. Six million of these young adults (ages 19-25) were able to do so because of the Affordable Care Act, which, as discussed earlier in Part Two, requires non-grandfathered health insurers and employer-sponsored health plans to permit young adults to remain on their parents’ policies until age 26. Coverage is not free, of course. Either a parent or the young adult must pay a premium, which would run roughly several hundred dollars per month in 2012. Does this sound like people who prefer the individual liberty of doing nothing to having access to health insurance at affordable rates? In the Commonwealth Fund Survey, nearly 40 percent of young adults ages 19-29 were without health insurance during all or part of 2011; disproportionately they had lower incomes (<250 percent of the federal poverty level). Sixty percent of young adults without health insurance reported that they had put off getting needed care, had trouble paying bills, or were burdened with bills they had to pay over time. Sara Collins et al., Young, Uninsured, and in Debt: Why Young Adults Lack Health Insurance Coverage and How the Affordable Care Act is Helping (Commonwealth Fund, 2012) http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Jun/1604_collins_young_uninsured_in_debt_v4.pdf.

3. The nature of freedom at issue. This discussion should clarify for you exactly the nature of liberty defended by the Chief Justice and the joint dissent. As we develop throughout the Book, in health care everybody subsidizes everyone else to some extent. On the facts Justice Ginsburg correctly calls out her interlocutors for positing a world of rugged individualists who, hale and hardy, for years exercise their autonomy to steer clear of the health care system. While Robinson Crusoe doesn’t have to share his broccoli with anyone, in this world we all share the burden of illness and mortality, and this sharing is reflected in the manner in which we organize health care and finance this collective activity. As a result, the freedom not to pay into the system when one is young or hale and hardy—or simply cannot afford to do so—is the right to force others to
shoulder a larger share of what must be a collective endeavor if it is to exist at all. This freedom is a far cry from the “right to be let alone,” the negative liberty valorized by the Chief Justice and the joint dissent.

4. The federalism tension. In an analysis published soon after the decision, Wendy Mariner, Leonard Glantz and George Annas conclude that the “decisive issue” for the five-vote majority on the Commerce Clause issue was “their view of federalism, specifically how to distinguish federal authority to regulate commerce from the inherent authority of the state (‘police power’) to directly regulate individuals.” Wendy Mariner, Leonard Glantz, & George Annas, Reframing Federalism—The Affordable Care Act (and Broccoli) in the Supreme Court, New Eng. J. Med. (10.1056/NEJMhle1208437 (July 18, 2012). Of course (as the authors go on to discuss in the context of Justice Ginsburg’s dissent) such a view effectively creates a “no man’s (or woman’s) land” in which states systematically fail to act in the face of an overwhelming national problem such as health care, and the federal government’s hands are tied simply because the remedy involves regulation of individual behavior. Given the complex problems facing 21st century America, what are the problems with creating this “no man’s (or woman’s) land” in which the states cannot or will not act effectively and the Court has deprived the federal government of regulatory authority? Is the majority view one that—if followed in subsequent cases—will consign us either to no solutions (because we have to wait around for 50 states to get their act together and to do so in a unified fashion, which is never going to happen) or instead, only to solutions that amount to taxes on certain behavior? Instead, are the two sets of dueling powers (as the majority sees it) better understood as an overlapping Venn diagram, with Congress empowered to act when (as here) problems become acute enough to begin to subvert a national market?

5. How widespread will the penalty actually be? One might think that tens of millions of people will be hit by the penalty under the Act. In fact, the penalty will apply to very few because the vast majority of Americans have coverage either at the workplace, are publicly insured, or are expected to enroll in a health plan once affordable coverage becomes available through state Exchanges in 2014. Indeed, the Congressional Budget Office has estimated that only 1.2 percent of all persons covered by the law (4 million people) will pay a penalty for failing to get affordable insurance in 2016. Congressional Budget Office, Selected Health Care Publications (December, 2010), http://cbo.gov/sites/default/files/cbofiles/ftpdocs/120xx/doc12033/12-23-selectedhealthcarepublications.pdf (Accessed online, July 29, 2012) pp. 71-73. See also, Paul Van de Water, CBO Estimates that only 1.2 Percent of Americans will Pay a Penalty for Not Getting Health Coverage, (Center on Budget and Policy Priorities, 2012), http://www.offthecartblog.org/cbo-estimates-that-only-1-2-percent-of-americans-will-pay-penalty-for-not-getting-health-coverage/ (Accessed online July 29, 2012). This fact also presents itself in the Chief Justice’s taxing power decision, below.
IV. Is the Act’s “Personal Responsibility Payment” a Constitutional Exercise of Congress’s Power to Tax?

A majority of the Court, in an opinion written by the Chief Justice and joined in this portion by Justices Breyer, Ginsburg, Sotomayor and Kagan, upheld the individual mandate as a constitutional use of Congress’s power to tax. The four joint dissenters, by contrast, would have held the mandate unconstitutional altogether as a “penalty” and not a “tax.” As you read the two opinions on this issue, ask yourselves, “Given the holding that Congress cannot constitutionally compel an individual to ‘actively engage in commerce,’ can Congress attempt to achieve the same end through its power to tax?” Also, contrast the degree of deference accorded to legislative authority by Justice Roberts with regard to the power to tax with the degree of deference accorded by him under the Commerce Clause. Can the difference be justified?

A. Chief Justice Robert’s Opinion for the Court Upholding the Individual Mandate as a Tax

C

The exaction the Affordable Care Act imposes on those without health insurance looks like a tax in many respects. The “[s]hared responsibility payment,” as the statute entitles it, is paid into the Treasury by “taxpayer[s]” when they file their tax returns. 26 U.S.C. §5000A(b). It does not apply to individuals who do not pay federal income taxes because their household income is less than the filing threshold in the Internal Revenue Code. §5000A(e)(2) . For taxpayers who do owe the payment, its amount is determined by such familiar factors as taxable income, number of dependents, and joint filing status. §§5000A(b)(3), (c)(2), (c)(4). The requirement to pay is found in the Internal Revenue Code and enforced by the IRS, which—as we previously explained—must assess and collect it “in the same manner as taxes.” This process yields the essential feature of any tax: it produces at least some revenue for the Government. United States v. Kahriger, 345 U.S. 22, 28, n. 4 (1953). Indeed, the payment is expected to raise about $4 billion per year by 2017.

It is of course true that the Act describes the payment as a “penalty,” not a “tax.” But while that label is fatal to the application of the Anti-Injunction Act, it does not determine whether the payment may be viewed as an exercise of Congress’s taxing power. It is up to Congress whether to apply the Anti-Injunction Act to any particular statute, so it makes sense to be guided by Congress’s choice of label on that question. That choice does not, however, control whether an exaction is within Congress’s constitutional power to tax.

Our precedent reflects this: In 1922, we decided two challenges to the “Child Labor Tax” on the same day. In the first, we held that a suit to enjoin collection of the so-called tax was barred by the Anti-Injunction Act. George, 259 U.S., at 20, 42 S. Ct. 419, 66 L. Ed. 816. Congress knew that suits to obstruct taxes had to await payment under the Anti-Injunction Act; Congress called the child labor tax a tax; Congress therefore
intended the Anti-Injunction Act to apply. In the second case, however, we held that the same exaction, although labeled a tax, was not in fact authorized by Congress’s taxing power. *Drexel Furniture*, 259 U.S., at 38. That constitutional question was not controlled by Congress’s choice of label.

We have similarly held that exactions not labeled taxes nonetheless were authorized by Congress’s power to tax. In the *License Tax Cases*, for example, we held that federal licenses to sell liquor and lottery tickets—for which the licensee had to pay a fee—could be sustained as exercises of the taxing power. 5 Wall., at 471. And in *New York v. United States* we upheld as a tax a “surcharge” on out-of-state nuclear waste shipments, a portion of which was paid to the Federal Treasury. 505 U.S., at 171. We thus ask whether the shared responsibility payment falls within Congress’s taxing power, “[d]isregarding the designation of the exaction, and viewing its substance and application.” *United States v. Constantine*, 296 U.S. 287, 294; cf. *Nelson v. Sears*, *Roebuck & Co.*, 312 U.S. 359, 363 (1941) (“In passing on the constitutionality of a tax law, we are concerned only with its practical operation, not its definition or the precise form of descriptive words which may be applied to it” (internal quotation marks omitted)).

Our cases confirm this functional approach. For example, in *Drexel Furniture*, we focused on three practical characteristics of the so-called tax on employing child laborers that convinced us the “tax” was actually a penalty. First, the tax imposed an exceedingly heavy burden—10 percent of a company’s net income—on those who employed children, no matter how small their infraction. Second, it imposed that exaction only on those who knowingly employed underage laborers. Such scienter requirements are typical of punitive statutes, because Congress often wishes to punish only those who intentionally break the law. Third, this “tax” was enforced in part by the Department of Labor, an agency responsible for punishing violations of labor laws, not collecting revenue. 259 U.S., at 36-37; see also, e.g., *Kurth Ranch*, 511 U.S., at 780-782 (considering, *inter alia*, the amount of the exaction, and the fact that it was imposed for violation of a separate criminal law); *Constantine*, *supra*, at 295 (same).

The same analysis here suggests that the shared responsibility payment may for constitutional purposes be considered a tax, not a penalty: First, for most Americans the amount due will be far less than the price of insurance, and, by statute, it can never be more. It may often be a reasonable financial decision to make the payment rather than purchase insurance, unlike the “prohibitory” financial punishment in *Drexel Furniture*. 259 U.S., at 37. Second, the individual mandate contains no scienter requirement. Third, the payment is collected solely by the IRS through the normal means of taxation—except that the Service is not allowed to use those means most suggestive of a punitive sanction, such as criminal prosecution. See §5000A(g)(2). The reasons the Court in *Drexel*  

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8 In 2016, for example, individuals making $35,000 a year are expected to owe the IRS about $60 for any month in which they do not have health insurance. Someone with an annual income of $100,000 a year would likely owe about $200. The price of a qualifying insurance policy is projected to be around $400 per month. See D. Newman, CRS Report for Congress, Individual Mandate and Related Information Requirements Under PPACA 7, and n. 25 (2011).
Furniture held that what was called a “tax” there was a penalty support the conclusion that what is called a “penalty” here may be viewed as a tax.

None of this is to say that the payment is not intended to affect individual conduct. Although the payment will raise considerable revenue, it is plainly designed to expand health insurance coverage. But taxes that seek to influence conduct are nothing new. Some of our earliest federal taxes sought to deter the purchase of imported manufactured goods in order to foster the growth of domestic industry. See W. Brownlee, Federal Taxation in America 22 (2d ed. 2004); cf. 2 J. Story, Commentaries on the Constitution of the United States §962, p. 434 (1833) (“the taxing power is often, very often, applied for other purposes, than revenue”). Today, federal and state taxes can compose more than half the retail price of cigarettes, not just to raise more money, but to encourage people to quit smoking. And we have upheld such obviously regulatory measures as taxes on selling marijuana and sawed-off shotguns. See United States v. Sanchez, 340 U.S. 42 (1950); Sonzinsky v. United States, 300 U.S. 506 (1937). Indeed, “[e]very tax is in some measure regulatory. To some extent it interposes an economic impediment to the activity taxed as compared with others not taxed.” Sonzinsky, supra, at 513. That §5000A seeks to shape decisions about whether to buy health insurance does not mean that it cannot be a valid exercise of the taxing power.

In distinguishing penalties from taxes, this Court has explained that “if the concept of penalty means anything, it means punishment for an unlawful act or omission.” United States v. Reorganized CF&I Fabricators of Utah, Inc., 518 U.S. 213, 224 (1996); see also United States v. La Franca, 282 U.S. 568, 572 (1931) (“[A] penalty, as the word is here used, is an exaction imposed by statute as punishment for an unlawful act”). While the individual mandate clearly aims to induce the purchase of health insurance, it need not be read to declare that failing to do so is unlawful. Neither the Act nor any other law attaches negative legal consequences to not buying health insurance, beyond requiring a payment to the IRS. The Government agrees with that reading, confirming that if someone chooses to pay rather than obtain health insurance, they have fully complied with the law.

Indeed, it is estimated that four million people each year will choose to pay the IRS rather than buy insurance. See Congressional Budget Office, supra, at 71. We would expect Congress to be troubled by that prospect if such conduct were unlawful. That Congress apparently regards such extensive failure to comply with the mandate as tolerable suggests that Congress did not think it was creating four million outlaws. It suggests instead that the shared responsibility payment merely imposes a tax citizens may lawfully choose to pay in lieu of buying health insurance.

The plaintiffs contend that Congress’s choice of language—stating that individuals “shall” obtain insurance or pay a “penalty”—requires reading §5000A as punishing unlawful conduct, even if that interpretation would render the law unconstitutional. We have rejected a similar argument before. In New York v. United States we examined a statute providing that “‘[e]ach State shall be responsible for providing . . . for the disposal of . . . low-level radioactive waste.”’ 505 U.S., at 169
(quoting 42 U.S.C. §2021c(a)(1)(A)). A State that shipped its waste to another State was exposed to surcharges by the receiving State, a portion of which would be paid over to the Federal Government. And a State that did not adhere to the statutory scheme faced “[p]enalties for failure to comply,” including increases in the surcharge. §2021e(e)(2); New York, 505 U.S., at 152-153. New York urged us to read the statute as a federal command that the state legislature enact legislation to dispose of its waste, which would have violated the Constitution. To avoid that outcome, we interpreted the statute to impose only “a series of incentives” for the State to take responsibility for its waste. We then sustained the charge paid to the Federal Government as an exercise of the taxing power. Id., at 169-174. We see no insurmountable obstacle to a similar approach here.

The joint dissenters argue that we cannot uphold §5000A as a tax because Congress did not “frame” it as such. In effect, they contend that even if the Constitution permits Congress to do exactly what we interpret this statute to do, the law must be struck down because Congress used the wrong labels. An example may help illustrate why labels should not control here. Suppose Congress enacted a statute providing that every taxpayer who owns a house without energy efficient windows must pay $50 to the IRS. The amount due is adjusted based on factors such as taxable income and joint filing status, and is paid along with the taxpayer’s income tax return. Those whose income is below the filing threshold need not pay. The required payment is not called a “tax,” a “penalty,” or anything else. No one would doubt that this law imposed a tax, and was within Congress’s power to tax. That conclusion should not change simply because Congress used the word “penalty” to describe the payment. Interpreting such a law to be a tax would hardly “[impose] a tax through judicial legislation.” Post, at 25. Rather, it would give practical effect to the Legislature’s enactment.

There may, however, be a more fundamental objection to a tax on those who lack health insurance. Even if only a tax, the payment under §5000A(b) remains a burden that the Federal Government imposes for an omission, not an act. If it is troubling to interpret the Commerce Clause as authorizing Congress to regulate those who abstain from commerce, perhaps it should be similarly troubling to permit Congress to impose a tax for not doing something.

Three considerations allay this concern. First, and most importantly, it is abundantly clear the Constitution does not guarantee that individuals may avoid taxation through inactivity. A capitatio, after all, is a tax that everyone must pay simply for existing, and capitations are expressly contemplated by the Constitution. The Court today holds that our Constitution protects us from federal regulation under the Commerce Clause so long as we abstain from the regulated activity. But from its creation, the Constitution has made no such promise with respect to taxes. See Letter from Benjamin Franklin to M. Le Roy (Nov. 13, 1789) (“Our new Constitution is now established . . . but in this world nothing can be said to be certain, except death and taxes”).

Whether the mandate can be upheld under the Commerce Clause is a question about the scope of federal authority. Its answer depends on whether Congress can exercise what all acknowledge to be the novel course of directing individuals to purchase
insurance. Congress’s use of the Taxing Clause to encourage buying something is, by contrast, not new. Tax incentives already promote, for example, purchasing homes and professional educations. See 26 U.S.C. §§163(h), 25A. Sustaining the mandate as a tax depends only on whether Congress has properly exercised its taxing power to encourage purchasing health insurance, not whether it can. Upholding the individual mandate under the Taxing Clause thus does not recognize any new federal power. It determines that Congress has used an existing one.

Second, Congress’s ability to use its taxing power to influence conduct is not without limits. A few of our cases policed these limits aggressively, invalidating punitive exactions obviously designed to regulate behavior otherwise regarded at the time as beyond federal authority. See, e.g., United States v. Butler, 297 U.S. 1 (1936); Drexel Furniture, 259 U.S. 20. More often and more recently we have declined to closely examine the regulatory motive or effect of revenue-raising measures. See Kahriger, 345 U.S., at 27-31 (collecting cases). We have nonetheless maintained that “‘there comes a time in the extension of the penalizing features of the so-called tax when it loses its character as such and becomes a mere penalty with the characteristics of regulation and punishment.’” Kurth Ranch, 511 U.S., at 779 (quoting Drexel Furniture, supra, at 38).

We have already explained that the shared responsibility payment’s practical characteristics pass muster as a tax under our narrowest interpretations of the taxing power. Because the tax at hand is within even those strict limits, we need not here decide the precise point at which an exaction becomes so punitive that the taxing power does not authorize it. It remains true, however, that the “‘power to tax is not the power to destroy while this Court sits.’” Oklahoma Tax Comm’n v. Texas Co., 336 U.S. 342, 364 (1949) (quoting Panhandle Oil Co. v. Mississippi ex rel. Knox, 277 U.S. 218, 223 (1928) (Holmes, J., dissenting)).

Third, although the breadth of Congress’s power to tax is greater than its power to regulate commerce, the taxing power does not give Congress the same degree of control over individual behavior. Once we recognize that Congress may regulate a particular decision under the Commerce Clause, the Federal Government can bring its full weight to bear. Congress may simply command individuals to do as it directs. An individual who disobeys may be subjected to criminal sanctions. Those sanctions can include not only fines and imprisonment, but all the attendant consequences of being branded a criminal: deprivation of otherwise protected civil rights, such as the right to bear arms or vote in elections; loss of employment opportunities; social stigma; and severe disabilities in other controversies, such as custody or immigration disputes.

By contrast, Congress’s authority under the taxing power is limited to requiring an individual to pay money into the Federal Treasury, no more. If a tax is properly paid, the Government has no power to compel or punish individuals subject to it. We do not make light of the severe burden that taxation—especially taxation motivated by a regulatory purpose—can impose. But imposition of a tax nonetheless leaves an individual with a lawful choice to do or not do a certain act, so long as he is willing to pay a tax levied on that choice.
The Affordable Care Act’s requirement that certain individuals pay a financial penalty for not obtaining health insurance may reasonably be characterized as a tax. Because the Constitution permits such a tax, it is not our role to forbid it, or to pass upon its wisdom or fairness.

B. Joint Dissent by Justices Scalia, Kennedy, Thomas and Alito That the Individual Mandate Is a Penalty Not a Tax and Is Therefore Unconstitutional

II

Congress has attempted to regulate beyond the scope of its Commerce Clause authority, and §5000A is therefore invalid. The Government contends, however, as expressed in the caption to Part II of its brief, that “THE MINIMUM COVERAGE PROVISION IS INDEPENDENTLY AUTHORIZED BY CONGRESS’S TAXING POWER.” The phrase “independently authorized” suggests the existence of a creature never hitherto seen in the United States Reports: A penalty for constitutional purposes that is also a tax for constitutional purposes. In all our cases the two are mutually exclusive. The provision challenged under the Constitution is either a penalty or else a tax. Of course in many cases what was a regulatory mandate enforced by a penalty could have been imposed as a tax upon permissible action; or what was imposed as a tax upon permissible action could have been a regulatory mandate enforced by a penalty. But we know of no case, and the Government cites none, in which the imposition was, for constitutional purposes, both. The two are mutually exclusive. Thus, what the Government’s caption should have read was “ALTERNATIVELY, THE MINIMUM COVERAGE PROVISION IS NOT A MANDATE-WITH-PENALTY BUT A TAX.” It is important to bear this in mind in evaluating the tax argument of the Government and of those who support it: The issue is not whether Congress had the power to frame the minimum-coverage provision as a tax, but whether it did so.

In answering that question we must, if “fairly possible,” *Crowell v. Benson*, 285 U.S. 22, 62 (1932), construe the provision to be a tax rather than a mandate-with-penalty, since that would render it constitutional rather than unconstitutional (*ut res magis valeat quam pereat*). But we cannot rewrite the statute to be what it is not. In this case, there is simply no way, “without doing violence to the fair meaning of the words used,” *Grenada County Supervisors v. Brogden*, 112 U.S. 261, 269 (1884), to escape what Congress enacted: a mandate that individuals maintain minimum essential coverage, enforced by a penalty.

Our cases establish a clear line between a tax and a penalty: “[A] tax is an enforced contribution to provide for the support of government; a penalty . . . is an exaction imposed by statute as punishment for an unlawful act.” *United States v. Reorganized CF&I Fabricators of Utah, Inc.*, 518 U.S. 213, 224 (1996) (quoting *United States v. La Franca*, 282 U.S. 568, 572 (1931)). In a few cases, this Court has held that a “tax” imposed upon private conduct was so onerous as to be in effect a penalty. But we have never held—never—that a penalty imposed for violation of the law was so trivial as
to be in effect a tax. We have never held that any exaction imposed for violation of the law is an exercise of Congress’ taxing power—even when the statute calls it a tax, much less when (as here) the statute repeatedly calls it a penalty. When an act “adopt[s] the criteria of wrongdoing” and then imposes a monetary penalty as the “principal consequence on those who transgress its standard,” it creates a regulatory penalty, not a tax. *Child Labor Tax Case*, 259 U.S. 20, 38 (1922).

So the question is, quite simply, whether the exaction here is imposed for violation of the law. It unquestionably is. The minimum-coverage provision is found in 26 U.S.C. §5000A, entitled “Requirement to maintain minimum essential coverage.” (Emphasis added.) It commands that every “applicable individual shall . . . ensure that the individual . . . is covered under minimum essential coverage.” *Ibid.* (emphasis added). And the immediately following provision states that, “[i]f . . . an applicable individual . . . fails to meet the requirement of subsection (a) . . . there is hereby imposed . . . a penalty.” §5000A(b) (emphasis added). And several of Congress’ legislative “findings” with regard to §5000A confirm that it sets forth a legal requirement and constitutes the assertion of regulatory power, not mere taxing power. See 42 U.S.C. §18091(2)(A) (“The requirement regulates activity . . .”); §18091(2)(C) (“The requirement . . . will add millions of new consumers to the health insurance market . . .”); §18091(2)(D) (“The requirement achieves near-universal coverage”); §18091(2)(H) (“The requirement is an essential part of this larger regulation of economic activity, and the absence of the requirement would undercut Federal regulation of the health insurance market”); §18091(3) (“T]he Supreme Court of the United States ruled that insurance is interstate commerce subject to Federal regulation”).

The Government and those who support its view on the tax point rely on *New York v. United States*, 505 U.S. 144 to justify reading “shall” to mean “may.” The “shall” in that case was contained in an introductory provision—a recital that provided for no legal consequences—which said that “[e]ach State shall be responsible for providing . . . for the disposal of . . . low-level radioactive waste.” 42 U.S.C. §2021c(a)(1)(A). The Court did not hold that “shall” could be construed to mean “may,” but rather that this preliminary provision could not impose upon the operative provisions of the Act a mandate that they did not contain: “We . . . decline petitioners’ invitation to construe §2021c(a)(1)(A), alone and in isolation, as a command to the States independent of the remainder of the Act.” *New York*, 505 U.S., at 170. Our opinion then proceeded to “consider each [of the three operative provisions] in turn.” *Ibid.* Here the mandate—the “shall”—is contained not in an inoperative preliminary recital, but in the dispositive operative provision itself. *New York* provides no support for reading it to be permissive.

Quite separately, the fact that Congress (in its own words) “imposed . . . a penalty,” 26 U.S.C. §5000A(b)(1), for failure to buy insurance is alone sufficient to render that failure unlawful. It is one of the canons of interpretation that a statute that penalizes an act makes it unlawful: “[W]here the statute inflicts a penalty for doing an act, although the act itself is not expressly prohibited, yet to do the act is unlawful, because it cannot be supposed that the Legislature intended that a penalty should be inflicted for a lawful act.” *Powhatan Steamboat Co. v. Appomattox R. Co.*, 65 U.S. 247
Or in the words of Chancellor Kent: “If a statute inflicts a penalty for doing an act, the penalty implies a prohibition, and the thing is unlawful, though there be no prohibitory words in the statute.” 1 J. Kent, Commentaries on American Law 436 (1826).

We never have classified as a tax an exaction imposed for violation of the law, and so too, we never have classified as a tax an exaction described in the legislation itself as a penalty. To be sure, we have sometimes treated as a tax a statutory exaction (imposed for something other than a violation of law) which bore an agnostic label that does not entail the significant constitutional consequences of a penalty—such as “license” (License Tax Cases, 72 U.S. 462 (1867)) or “surcharge” (New York v. United States, supra.). But we have never—never—treated as a tax an exaction which faces up to the critical difference between a tax and a penalty, and explicitly denominates the exaction a “penalty.” Eighteen times in §5000A itself and elsewhere throughout the Act, Congress called the exaction in §5000A itself and elsewhere throughout the Act, Congress called the exaction a “penalty.”

That §5000A imposes not a simple tax but a mandate to which a penalty is attached is demonstrated by the fact that some are exempt from the tax who are not exempt from the mandate—a distinction that would make no sense if the mandate were not a mandate. Section 5000A(d) exempts three classes of people from the definition of “applicable individual” subject to the minimum coverage requirement: Those with religious objections or who participate in a “health care sharing ministry,” §5000A(d)(2); those who are “not lawfully present” in the United States, §5000A(d)(3); and those who are incarcerated, §5000A(d)(4). Section 5000A(e) then creates a separate set of exemptions, excusing from liability for the penalty certain individuals who are subject to the minimum coverage requirement: Those who cannot afford coverage, §5000A(e)(1); who earn too little income to require filing a tax return, §5000A(e)(2); who are members of an Indian tribe, §5000A(e)(3); who experience only short gaps in coverage, §5000A(e)(4); and who, in the judgment of the Secretary of Health and Human Services, “have suffered a hardship with respect to the capability to obtain coverage,” §5000A(e)(5). If §5000A were a tax, these two classes of exemption would make no sense; there being no requirement, all the exemptions would attach to the penalty (renamed tax) alone.

In the face of all these indications of a regulatory requirement accompanied by a penalty, the Solicitor General assures us that “neither the Treasury Department nor the Department of Health and Human Services interprets Section 5000A as imposing a legal obligation,” Petitioners’ Minimum Coverage Brief 61, and that “[i]f [those subject to the Act] pay the tax penalty, they’re in compliance with the law,” Tr. of Oral Arg. 50 (Mar. 26, 2012). These self-serving litigating positions are entitled to no weight. What counts is what the statute says, and that is entirely clear. It is worth noting, moreover, that these assurances contradict the Government’s position in related litigation. Shortly before the Affordable Care Act was passed, the Commonwealth of Virginia enacted Va. Code Ann. §38.2-3430.1:1 (Lexis Supp. 2011), which states, “No resident of [the] Commonwealth . . . shall be required to obtain or maintain a policy of individual insurance coverage except as required by a court or the Department of Social Services . . . .” In opposing Virginia’s assertion of standing to challenge §5000A based on this statute, the Government said that
“if the minimum coverage provision is unconstitutional, the [Virginia] statute is unnecessary, and if the minimum coverage provision is upheld, the state statute is void under the Supremacy Clause.” Brief for Appellant in No. 11-1057 etc. (CA4), p. 29. But it would be void under the Supremacy Clause only if it was contradicted by a federal “require[ment] to obtain or maintain a policy of individual insurance coverage.”

Against the mountain of evidence that the minimum coverage requirement is what the statute calls it—a requirement—and that the penalty for its violation is what the statute calls it—a penalty—the Government brings forward the flimsiest of indications to the contrary. It notes that “[t]he minimum coverage provision amends the Internal Revenue Code to provide that a non-exempted individual . . . will owe a monetary penalty, in addition to the income tax itself,” and that “[t]he [Internal Revenue Service (IRS)] will assess and collect the penalty in the same manner as assessable penalties under the Internal Revenue Code.” Petitioners’ Minimum Coverage Brief 53. The manner of collection could perhaps suggest a tax if IRS penalty-collection were unheard-of or rare. It is not. See, e.g., 26 U.S.C. §527(j) (2006 ed.) (IRS-collectible penalty for failure to make campaign finance disclosures); §5761(c) (IRS-collectible penalty for domestic sales of tobacco products labeled for export); §9707 (IRS-collectible penalty for failure to make required health-insurance premium payments on behalf of mining employees). In Reorganized CF&I Fabricators of Utah, Inc., 518 U.S. 213, we held that an exaction not only enforced by the Commissioner of Internal Revenue but even called a “tax” was in fact a penalty. “[I]f the concept of penalty means anything,” we said, “it means punishment for an unlawful act or omission.” Id., at 224. Moreover, while the penalty is assessed and collected by the IRS, §5000A is administered both by that agency and by the Department of Health and Human Services (and also the Secretary of Veteran Affairs), see §5000A(e)(1)(D), (e)(5), (f)(1)(A)(v), (f)(1)(E) (2006 ed., Supp. IV), which is responsible for defining its substantive scope—a feature that would be quite extraordinary for taxes.

The Government points out that “[t]he amount of the penalty will be calculated as a percentage of household income for federal income tax purposes, subject to a floor and [a] ca[p].” and that individuals who earn so little money that they “are not required to file income tax returns for the taxable year are not subject to the penalty” (though they are, as we discussed earlier, subject to the mandate). Petitioners’ Minimum Coverage Brief 12, 53. But varying a penalty according to ability to pay is an utterly familiar practice. See, e.g., 33 U.S.C. §1319(d) (2006 ed., Supp. IV) (“In determining the amount of a civil penalty the court shall consider . . . the economic impact of the penalty on the violator”).

The last of the feeble arguments in favor of petitioners that we will address is the contention that what this statute repeatedly calls a penalty is in fact a tax because it contains no scienter requirement. The presence of such a requirement suggests a penalty—though one can imagine a tax imposed only on willful action; but the absence of such a requirement does not suggest a tax. Penalties for absolute-liability offenses are commonplace. And where a statute is silent as to scienter, we traditionally presume a mens rea requirement if the statute imposes a “severe penalty.” Staples v. United States, 511 U.S. 600, 618 (1994). Since we have an entire jurisprudence addressing when it is
that a scienter requirement should be inferred from a penalty, it is quite illogical to suggest that a penalty is not a penalty for want of an express scienter requirement.

And the nail in the coffin is that the mandate and penalty are located in Title I of the Act, its operative core, rather than where a tax would be found-in Title IX, containing the Act’s “Revenue Provisions.” In sum, “the terms of [the] act rendre[r] it unavoidable,” Parsons v. Bedford, 28 U.S. 433 (1830), that Congress imposed a regulatory penalty, not a tax.

For all these reasons, to say that the Individual Mandate merely imposes a tax is not to interpret the statute but to rewrite it. Judicial tax-writing is particularly troubling. Taxes have never been popular, see, e.g., Stamp Act of 1765, and in part for that reason, the Constitution requires tax increases to originate in the House of Representatives. See Art. I, § 7, cl. 1. That is to say, they must originate in the legislative body most accountable to the people, where legislators must weigh the need for the tax against the terrible price they might pay at their next election, which is never more than two years off. The Federalist No. 58 “defend[ed] the decision to give the origination power to the House on the ground that the Chamber that is more accountable to the people should have the primary role in raising revenue.” United States v. Munoz-Flores, 495 U.S. 385, 395 (1990). We have no doubt that Congress knew precisely what it was doing when it rejected an earlier version of this legislation that imposed a tax instead of a requirement-with-penalty. See Affordable Health Care for America Act, H. R. 3962, 111th Cong., 1st Sess., §501 (2009); America’s Healthy Future Act of 2009, S. 1796, 111th Cong., 1st Sess., §1301. Imposing a tax through judicial legislation inverts the constitutional scheme, and places the power to tax in the branch of government least accountable to the citizenry.

Notes

1. A rose by any other name? As you can tell from the two opinions, it is often difficult to distinguish a tax from a penalty. An exaction can have many of the earmarks of a tax—collected by the Internal Revenue Service; differentiated by income levels or the like; labeled as such in its enactment—and yet be a penalty if it goes too far—is too coercive, is based on unlawful activity or is exacted by an agency not usually charged with revenue collection. Still, one must ask, as the joint dissent does, if the infirmity under the Commerce Clause is that the individual mandate compels activity by penalizing inactivity, how is it that the personal responsibility payment suddenly sheds its compulsory skin for purposes of the Taxation Clause? Because it is so low as to have very little compulsive effect?

2. The practical significance of grounding Congressional authority in the Tax Power rather than the Commerce Clause. If that is the answer—that the holding boils down to the fact that the personal responsibility payment is set so low that it will actually compel very few individuals to buy health insurance rather than just pay it as a throw-away—what does that tell you about the constitutionality of future attempts to force people into the insurance pool? Remember that this answer affects not just efforts to
prevent free-riding by individuals but also by groups. Suppose, for example, that private insurers do start dropping their insurance coverage in order to shift their workers into the state Exchanges, the crowd-out of private insurance predicted by many. Given the Chief Justice’s decision, what powers would Congress be able to exercise constitutionally to reverse this tide? Toward the end of his opinion, Chief Justice Roberts fended off the point, raised in the previous note, that penalizing inactivity was still penalizing inactivity whether the analysis was under the Commerce or Taxation Clause. Recall that part of his response was that the Commerce Clause permitted a whole host of remedies, including command-and-control regulation, criminalization and so forth. If the ACA fails to stem the demise of the private insurance system and if the holding in this case means that Congress can only impose monetary exactions that have little coercive effect, what means are left to the Congress? And if our country cannot get its political act together and join the rest of the world in creating some all-payer or single-payer system, how will we finance health care?

3. **Deference to Congress’s choice among means.** That brings us to the last set of questions. The Chief Justice went to great lengths to construe the personal responsibility payment as a tax, applying a test of reasonableness in construction to save it under the Tax Power. By contrast, Congress’s choice among means for purposes of the Commerce Clause was accorded no such deference. Given the differences in the manner in which Congress may exercise power under each clause and given the manner by which the Chief Justice distinguishes a tax from a penalty, in the end what is the effect on the nature of federal power to solve the problem of the uninsured?

**V. Is the Medicaid Expansion Constitutional, and if Not, What is the Proper Remedy?**

In what was perhaps the most unanticipated legal shocker in the decision, seven Justices ruled that the Medicaid expansion was unconstitutionally coercive. The majority on this issue consisted of Chief Justice Roberts—who wrote for himself and in this part of his opinion also for Justices Breyer and Kagan—and Justices Scalia, Kennedy, Thomas and Alito, who together issued a joint dissent, as they did with regard to the Commerce Clause and Taxation Clause issues. Together these opinions represent the first time that the Court has ever applied the coercion doctrine (termed “amorphous” by the appeals court in ruling the Medicaid expansion constitutional, HHS v State of Florida, 648 F. 3d 1235, 1267 (11th Cir., 2011)), to strike down a federal spending law. (In two previous cases, federal laws have been overturned on the ground that they unconstitutionally commandeered state officials to enforce federal laws (New York v United States, 505 U.S. 144 (1992); Printz v U.S. 521 U.S. 898 (1997)); coercion is a different matter.

But that was not all. In an equally stunning move, five Justices combined to effectively save the Medicaid expansion from the legal and financial oblivion to which
the dissenting four Justices would have consigned it.* The Chief Justice again wrote for himself and Justices Breyer and Kagan, ruling that while the Medicaid expansion coerced the states, it could be “saved” by severing its funding from other Medicaid funding—i.e., the remedy for a state’s failure to expand its Medicaid program as stipulated by the ACA would be the loss of the funding for the expansion alone.** Justices Ginsburg wrote separately for herself and Justice Sotomayor to complete the five-member majority to “save” the expansion. While Justices Ginsburg and Sotomayor concurred in the judgment, they would have upheld the Medicaid expansion as enacted by Congress in its entirety.

We excerpt from the three opinions below: (1) Chief Justice Roberts, writing for himself and Justices Breyer and Kagan; (2) Justice Ginsburg’s concurrence, joined by Justice Sotomayor, in the judgment; and (3) the joint dissent of Justices Scalia, Kennedy, Thomas and Alito. Notes and questions follow.

A. Chief Justice Roberts’ Opinion, Joined by Justices Breyer and Kagan, That the Medicaid Expansion Coerces the States But Is Severable from the Rest of the Program

IV

A

The States contend that the Medicaid expansion exceeds Congress’s authority under the Spending Clause. They claim that Congress is coercing the States to adopt the changes it wants by threatening to withhold all of a State’s Medicaid grants, unless the State accepts the new expanded funding and complies with the conditions that come with

* Because the expansion was enacted as an amendment to Medicaid, which is a permanent open-ended entitlement program, the federal funding obligation is perpetual. But if an Act of Congress is declared unconstitutional, funding in connection with the Act would effectively disappear along with the legislation itself. That is, once a law is declared a nullity, the money goes away, disappearing from the “legislative baseline” from which all future spending is calculated. Thus, the dissent’s position not only would have overturned the law but also would have meant the end of roughly $500 billion in new federal funding unless Congress had quickly invented an alternative to the (newly invalidated) Medicaid expansion. Given the shifting political sands, there is no way that Congress would have come up with a replacement (e.g., Medicaid as an option and extension of premium credits and Exchange enrollment to individuals in states that do not expand Medicaid) by 2012. Under such an alternative some states might in fact choose to enroll the poorest residents in Medicaid, which offers broader coverage with no cost-sharing, while others might opt to enroll all residents in federally subsidized Exchange plans. But giving states this flexibility also might be more expensive, since health plans sold in state Exchanges are projected to be more costly than Medicaid managed care because Exchange plans’ provider payment rates are expected to be higher.

** The questioning by Kagan and Breyer of Paul Clement, who represented the states, during the Medicaid oral arguments on March 28, 2012 left little doubt that they had minimal patience with the coercion doctrine argument advanced by the states. Justice Kagan now famously asked Mr. Clement how the states possibly could complain about receiving a “boatload” of money. For his part, Justice Breyer pointed out that any effort by the Secretary to withhold a state’s entire federal Medicaid budget (the ultimate remedy) in the case of states that refused to comply with the expansion would not, in his view, withstand judicial review as a reasonable agency action under the Administrative Procedures Act. One can only surmise that faced with the loss of the Medicaid expansion entirely (with the Chief Justice joining the four dissenters in totally wiping the expansion off the law books), Justices Kagan and Breyer agreed to accept the coercion argument in exchange for the Chief’s agreement to the lesser penalty.
it. This, they argue, violates the basic principle that the “Federal Government may not compel the States to enact or administer a federal regulatory program.”

There is no doubt that the Act dramatically increases state obligations under Medicaid. The current Medicaid program requires States to cover only certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled. 42 U.S.C. § 1396a(a)(10). There is no mandatory coverage for most childless adults, and the States typically do not offer any such coverage. The States also enjoy considerable flexibility with respect to the coverage levels for parents of needy families. § 1396a(a)(10)(A)(ii). On average States cover only those unemployed parents who make less than 37 percent of the federal poverty level, and only those employed parents who make less than 63 percent of the poverty line. Kaiser Comm’n on Medicaid and the Uninsured, Performing Under Pressure 11, and fig. 11 (2012).

The Medicaid provisions of the Affordable Care Act, in contrast, require States to expand their Medicaid programs by 2014 to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line. § 1396a(a)(10)(A)(i)(VIII). The Act also establishes a new “[e]ssential health benefits” package, which States must provide to all new Medicaid recipients—a level sufficient to satisfy a recipient’s obligations under the individual mandate. §§ 1396a(k)(1), 1396u–7(b)(5), 18022(b). The Affordable Care Act provides that the Federal Government will pay 100 percent of the costs of covering these newly eligible individuals through 2016. § 1396d(y)(1). In the following years, the federal payment level gradually decreases, to a minimum of 90 percent. Ibid. In light of the expansion in coverage mandated by the Act, the Federal Government estimates that its Medicaid spending will increase by approximately $100 billion per year, nearly 40 percent above current levels. Statement of Douglas W. Elmendorf, CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010, p. 14, Table 2 (Mar. 30, 2011).

The Spending Clause grants Congress the power “to pay the Debts and provide for the ... general Welfare of the United States.”. We have long recognized that Congress may use this power to grant federal funds to the States, and may condition such a grant upon the States’ “taking certain actions that Congress could not require them to take.” College Savings Bank, 527 U.S., at 686. Such measures “encourage a State to regulate in a particular way, [and] influence[e] a State’s policy choices.” New York, supra, at 166. The conditions imposed by Congress ensure that the funds are used by the States to “provide for the ... general Welfare” in the manner Congress intended.

At the same time, our cases have recognized limits on Congress’s power under the Spending Clause to secure state compliance with federal objectives. “We have repeatedly characterized ... Spending Clause legislation as ‘much in the nature of a contract.’” Barnes v. Gorman, 536 U.S. 181, 186 (quoting Pennhurst State School and Hospital v. Halderman, 451 U.S. 1, 17 (1981)). The legitimacy of Congress’s exercise of the spending power “thus rests on whether the State voluntarily and knowingly accepts the terms of the ‘contract.’” Pennhurst, supra, at 17. Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as
independent sovereigns in our federal system. For this reason, “the Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress’ instructions.” New York, supra, at 162. Otherwise the two-government system established by the Framers would give way to a system that vests power in one central government, and individual liberty would suffer.

That insight has led this Court to strike down federal legislation that commandeers a State’s legislative or administrative apparatus for federal purposes. See, e.g., Printz, 521 U.S., at 933 (striking down federal legislation compelling state law enforcement officers to perform federally mandated background checks on handgun purchasers); New York, supra, at 174–175 (invalidating provisions of an Act that would compel a State to either take title to nuclear waste or enact particular state waste regulations). It has also led us to scrutinize Spending Clause legislation to ensure that Congress is not using financial inducements to exert a “power akin to undue influence.” Steward Machine Co. v. Davis, 301 U.S. 548, 590 (1937). Congress may use its spending power to create incentives for States to act in accordance with federal policies. But when “pressure turns into compulsion,” ibid., the legislation runs contrary to our system of federalism.

Permitting the Federal Government to force the States to implement a federal program would threaten the political accountability key to our federal system. Spending Clause programs do not pose this danger when a State has a legitimate choice whether to accept the federal conditions in exchange for federal funds. In such a situation, state officials can fairly be held politically accountable for choosing to accept or refuse the federal offer. But when the State has no choice, the Federal Government can achieve its objectives without accountability, just as in New York and Printz. Indeed, this danger is heightened when Congress acts under the Spending Clause, because Congress can use that power to implement federal policy it could not impose directly under its enumerated powers.

We addressed such concerns in Steward Machine. That case involved a federal tax on employers that was abated if the businesses paid into a state unemployment plan that met certain federally specified conditions. An employer sued, alleging that the tax was impermissibly “driv[ing] the state legislatures under the whip of economic pressure into the enactment of unemployment compensation laws at the bidding of the central government.” 301 U.S., at 587. We acknowledged the danger that the Federal Government might employ its taxing power to exert a “power akin to undue influence” upon the States. Id., at 590. But we observed that Congress adopted the challenged tax and abatement program to channel money to the States that would otherwise have gone into the Federal Treasury for use in providing national unemployment services. Congress was willing to direct businesses to instead pay the money into state programs only on the condition that the money be used for the same purposes. Predicating tax abatement on a State’s adoption of a particular type of unemployment legislation was therefore a means to “safeguard [the Federal Government’s] own treasury.” Id., at 591. We held that “[i]n such circumstances, if in no others, inducement or persuasion does not go beyond the bounds of power.” Ibid.
As our decision in *Steward Machine* confirms, Congress may attach appropriate conditions to federal taxing and spending programs to preserve its control over the use of federal funds. In the typical case we look to the States to defend their prerogatives by adopting “the simple expedient of not yielding” to federal blandishments when they do not want to embrace the federal policies as their own. *Massachusetts v. Mellon*, 262 U.S. 447, 482 (1923). The States are separate and independent sovereigns. Sometimes they have to act like it.

The States, however, argue that the Medicaid expansion is far from the typical case. They object that Congress has “crossed the line distinguishing encouragement from coercion,” *New York*, supra, at 175 in the way it has structured the funding: Instead of simply refusing to grant the new funds to States that will not accept the new conditions, Congress has also threatened to withhold those States’ existing Medicaid funds. The States claim that this threat serves no purpose other than to force unwilling States to sign up for the dramatic expansion in health care coverage effected by the Act.

Given the nature of the threat and the programs at issue here, we must agree. We have upheld Congress’s authority to condition the receipt of funds on the States’ complying with restrictions on the use of those funds, because that is the means by which Congress ensures that the funds are spent according to its view of the “general Welfare.” Conditions that do not here govern the use of the funds, however, cannot be justified on that basis. When, for example, such conditions take the form of threats to terminate other significant independent grants, the conditions are properly viewed as a means of pressuring the States to accept policy changes.

In *South Dakota v. Dole*, we considered a challenge to a federal law that threatened to withhold five percent of a State’s federal highway funds if the State did not raise its drinking age to 21. The Court found that the condition was “directly related to one of the main purposes for which highway funds are expended—safe interstate travel.” 483 U.S. at 208. At the same time, the condition was not a restriction on how the highway funds—set aside for specific highway improvement and maintenance efforts—were to be used.

We accordingly asked whether “the financial inducement offered by Congress” was “so coercive as to pass the point at which ‘pressure turns into compulsion.’” We observed that “all South Dakota would lose if she adheres to her chosen course as to a suitable minimum drinking age is 5%” of her highway funds. Ibid at 211. In fact, the federal funds at stake constituted less than half of one percent of South Dakota’s budget at the time. Whether to accept the drinking age change “remain[ed] the prerogative of the States not merely in theory but in fact.” Id., at 211–212.

In this case, the financial “inducement” Congress has chosen is much more than “relatively mild encouragement”—it is a gun to the head. Section 1396c of the Medicaid Act provides that if a State’s Medicaid plan does not comply with the Act’s requirements, the Secretary of Health and Human Services may declare that “further payments will not
be made to the State.” 42 U.S.C. § 1396c. A State that opts out of the Affordable Care Act’s expansion in health care coverage thus stands to lose not merely “a relatively small percentage” of its existing Medicaid funding, but all of it. Dole, supra, at 211. Medicaid spending accounts for over 20 percent of the average State’s total budget, with federal funds covering 50 to 83 percent of those costs. The Federal Government estimates that it will pay out approximately $3.3 trillion between 2010 and 2019 in order to cover the costs of pre-expansion Medicaid. In addition, the States have developed intricate statutory and administrative regimes over the course of many decades to implement their objectives under existing Medicaid. It is easy to see how the Dole Court could conclude that the threatened loss of less than half of one percent of South Dakota’s budget left that State with a “prerogative” to reject Congress’s desired policy, “not merely in theory but in fact.” 483 U.S., at 211–212. The threatened loss of over 10 percent of a State’s overall budget, in contrast, is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.12

Justice GINSBURG claims that Dole is distinguishable because here “Congress has not threatened to withhold funds earmarked for any other program.” But that begs the question: The States contend that the expansion is in reality a new program and that Congress is forcing them to accept it by threatening the funds for the existing Medicaid program. We cannot agree that existing Medicaid and the expansion dictated by the Affordable Care Act are all one program simply because “Congress styled” them as such. If the expansion is not properly viewed as a modification of the existing Medicaid program, Congress’s decision to so title it is irrelevant.13

Here, the Government claims that the Medicaid expansion is properly viewed merely as a modification of the existing program because the States agreed that Congress could change the terms of Medicaid when they signed on in the first place. The Government observes that the Social Security Act, which includes the original Medicaid provisions, contains a clause expressly reserving “[t]he right to alter, amend, or repeal any provision” of that statute. 42 U.S.C. § 1304. So it does. But “if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.” Pennhurst, 451 U.S., at 17. A State confronted with statutory language reserving the right to “alter” or “amend” the pertinent provisions of the Social Security Act might reasonably assume that Congress was entitled to make adjustments to the Medicaid

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12 Justice GINSBURG observes that state Medicaid spending will increase by only 0.8 percent after the expansion. That not only ignores increased state administrative expenses, but also assumes that the Federal Government will continue to fund the expansion at the current statutorily specified levels. It is not unheard of, however, for the Federal Government to increase requirements in such a manner as to impose unfunded mandates on the States. More importantly, the size of the new financial burden imposed on a State is irrelevant in analyzing whether the State has been coerced into accepting that burden. “Your money or your life” is a coercive proposition, whether you have a single dollar in your pocket or $500.

13 Nor, of course, can the number of pages the amendment occupies, or the extent to which the change preserves and works within the existing program, be dispositive. Take, for example, the following hypothetical amendment: “All of a State’s citizens are now eligible for Medicaid.” That change would take up a single line and would not alter any “operational aspect[ ] of the program” beyond the eligibility requirements. Yet it could hardly be argued that such an amendment was a permissible modification of Medicaid, rather than an attempt to foist an entirely new health care system upon the States.
program as it developed. Congress has in fact done so, sometimes conditioning only the
new funding, other times both old and new. See, e.g., Social Security Amendments of
1972, 86 Stat. 1381–1382, 1465 (extending Medicaid eligibility, but partly conditioning
only the new funding); Omnibus Budget Reconciliation Act of 1990, § 4601, 104 Stat.
1388–166 (extending eligibility, and conditioning old and new funds).

The Medicaid expansion, however, accomplishes a shift in kind, not merely
degree. The original program was designed to cover medical services for four particular
categories of the needy: the disabled, the blind, the elderly, and needy families with
dependent children. See 42 U.S.C. § 1396a(a)(10). Previous amendments to Medicaid
eligibility merely altered and expanded the boundaries of these categories. Under the
Affordable Care Act, Medicaid is transformed into a program to meet the health care
needs of the entire nonelderly population with income below 133 percent of the poverty
level. It is no longer a program to care for the neediest among us, but rather an element of
a comprehensive national plan to provide universal health insurance coverage.14

Indeed, the manner in which the expansion is structured indicates that while
Congress may have styled the expansion a mere alteration of existing Medicaid, it
recognized it was enlisting the States in a new health care program. Congress created a
separate funding provision to cover the costs of providing services to any person made
newly eligible by the expansion. While Congress pays 50 to 83 percent of the costs of
covering individuals currently enrolled in Medicaid, § 1396d(b), once the expansion is
fully implemented Congress will pay 90 percent of the costs for newly eligible persons, §
1396d(y)(1). The conditions on use of the different funds are also distinct. Congress
mandated that newly eligible persons receive a level of coverage that is less
comprehensive than the traditional Medicaid benefit package. § 1396a(k)(1). A State
could hardly anticipate that Congress’s reservation of the right to “alter” or “amend” the
Medicaid program included the power to transform it so dramatically.

Justice GINSBURG claims that in fact this expansion is no different from the
previous changes to Medicaid, such that “a State would be hard put to complain that it
lacked fair notice.” But the prior change she discusses—presumably the most dramatic
alteration she could find—does not come close to working the transformation the
expansion accomplishes. She highlights an amendment requiring States to cover pregnant
women and increasing the number of eligible children. But this modification can hardly
be described as a major change in a program that—from its inception—provided health
care for “families with dependent children.” Previous Medicaid amendments simply do
not fall into the same category as the one at stake here.

14 Justice GINSBURG suggests that the States can have no objection to the Medicaid expansion, because
“Congress could have repealed Medicaid [and,] [t]hereafter, . . . could have enacted Medicaid II, a new
program combining the pre–2010 coverage with the expanded coverage required by the ACA.” But it
would certainly not be that easy. Practical constraints would plainly inhibit, if not preclude, the Federal
Government from repealing the existing program and putting every feature of Medicaid on the table for
political reconsideration. Such a massive undertaking would hardly be “ritualistic.” The same is true of
Justice GINSBURG’s suggestion that Congress could establish Medicaid as an exclusively federal program.
The Court in Steward Machine did not attempt to “fix the outermost line” where persuasion gives way to coercion. 301 U.S., at 591. The Court found it “[e]nough for present purposes that wherever the line may be, this statute is within it.” Ibid. We have no need to fix a line either. It is enough for today that wherever that line may be, this statute is surely beyond it. Congress may not simply “conscript state [agencies] into the national bureaucratic army,” FERC v. Mississippi, 456 U.S. 742 (1982) and that is what it is attempting to do with the Medicaid expansion.

B

Nothing in our opinion precludes Congress from offering funds under the Affordable Care Act to expand the availability of health care, and requiring that States accepting such funds comply with the conditions on their use. What Congress is not free to do is to penalize States that choose not to participate in that new program by taking away their existing Medicaid funding. Section 1396c gives the Secretary of Health and Human Services the authority to do just that. It allows her to withhold all “further [Medicaid] payments ... to the State” if she determines that the State is out of compliance with any Medicaid requirement, including those contained in the expansion. 42 U.S.C. § 1396c. In light of the Court’s holding, the Secretary cannot apply § 1396c to withdraw existing Medicaid funds for failure to comply with the requirements set out in the expansion.

That fully remedies the constitutional violation we have identified. The chapter of the United States Code that contains § 1396c includes a severability clause confirming that we need go no further. That clause specifies that “[i]f any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby.” §1303. Today’s holding does not affect the continued application of § 1396c to the existing Medicaid program. Nor does it affect the Secretary’s ability to withdraw funds provided under the Affordable Care Act if a State that has chosen to participate in the expansion fails to comply with the requirements of that Act.

This is not to say, as the joint dissent suggests, that we are “rewriting the Medicaid Expansion.” Instead, we determine, first, that § 1396c is unconstitutional when applied to withdraw existing Medicaid funds from States that decline to comply with the expansion. We then follow Congress’s explicit textual instruction to leave unaffected “the remainder of the chapter, and the application of [the challenged] provision to other persons or circumstances.” § 1303. When we invalidate an application of a statute because that application is unconstitutional, we are not “rewriting” the statute; we are merely enforcing the Constitution.

The question remains whether today’s holding affects other provisions of the Affordable Care Act. In considering that question, “[w]e seek to determine what Congress would have intended in light of the Court’s constitutional holding.” United States v. Booker, 543 U.S. 220 (2005) (internal quotation marks omitted). The question
here is whether Congress would have wanted the rest of the Act to stand, had it known that States would have a genuine choice whether to participate in the new Medicaid expansion. We are confident that Congress would have wanted to preserve the rest of the Act. It is fair to say that Congress assumed that every State would participate in the Medicaid expansion, given that States had no real choice but to do so.* The States contend that Congress enacted the rest of the Act with such full participation in mind; they point out that Congress made Medicaid a means for satisfying the mandate, 26 U.S.C. § 5000A(f)(1)(A)(ii), and enacted no other plan for providing coverage to many low-income individuals. According to the States, this means that the entire Act must fall.

We disagree. The Court today limits the financial pressure the Secretary may apply to induce States to accept the terms of the Medicaid expansion. As a practical matter, that means States may now choose to reject the expansion; that is the whole point. But that does not mean all or even any will. Some States may indeed decline to participate, either because they are unsure they will be able to afford their share of the new funding obligations, or because they are unwilling to commit the administrative resources necessary to support the expansion. Other States, however, may voluntarily sign up, finding the idea of expanding Medicaid coverage attractive, particularly given the level of federal funding the Act offers at the outset. We have no way of knowing how many States will accept the terms of the expansion, but we do not believe Congress would have wanted the whole Act to fall, simply because some may choose not to participate. Confident that Congress would not have intended anything different, we conclude that the rest of the Act need not fall in light of our constitutional holding.

**B. Justice Ginsburg’s Opinion, joined by Justice Sotomayor, That the Medicaid Expansion as Enacted Is Not Coercive**

Unlike THE CHIEF JUSTICE I would hold that the Spending Clause permits the Medicaid expansion exactly as Congress enacted it.

V

Through Medicaid, Congress has offered the States an opportunity to furnish health care to the poor with the aid of federal financing. To receive federal Medicaid funds, States must provide health benefits to specified categories of needy persons, including pregnant women, children, parents, and adults with disabilities. Guaranteed eligibility varies by category: for some it is tied to the federal poverty level (incomes up

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* Recall that with very limited exceptions, all citizens and long-term legal residents are subject to the mandate regardless of household income, although the Act does exempts individuals whose incomes are below the federal tax filing threshold from the penalty if they do not participate. 26 U.S.C. §5000A as added by PPACA §1501. However, individuals with incomes below 100 percent of the federal poverty level are not entitled to premium tax credits if they enroll in qualified health plans sold through state health insurance Exchanges. For these individuals, Medicaid is effectively the only source of a federal subsidy (of course a state always could offer individuals state-financed subsidies for Exchange coverage, but what state in its right mind would do that if the federal government will pick up the lion’s share of the cost of subsidizing coverage for the poor?
to 100% or 133%); for others it depends on criteria such as eligibility for designated state or federal assistance programs. The ACA enlarges the population of needy people States must cover to include adults under age 65 with incomes up to 133% of the federal poverty level. The spending power conferred by the Constitution permits Congress to define the contours of programs financed with federal funds. And to expand coverage, Congress could have recalled the existing legislation, and replaced it with a new law making Medicaid as embracive of the poor as Congress chose.

The question posed by the 2010 Medicaid expansion, then, is essentially this: To cover a notably larger population, must Congress take the repeal/reenact route, or may it achieve the same result by amending existing law? The answer should be that Congress may expand by amendment the classes of needy persons entitled to Medicaid benefits. A ritualistic requirement that Congress repeal and reenact spending legislation in order to enlarge the population served by a federally funded program would advance no constitutional principle and would scarcely serve the interests of federalism.

Medicaid is a prototypical example of federal-state cooperation in serving the Nation’s general welfare. Rather than authorizing a federal agency to administer a uniform national health-care system for the poor, Congress offered States the opportunity to tailor Medicaid grants to their particular needs, so long as they remain within bounds set by federal law. In shaping Medicaid, Congress did not endeavor to fix permanently the terms participating states must meet; instead, Congress reserved the “right to alter, amend, or repeal” any provision of the Medicaid Act. 42 U.S.C. § 1304. States, for their part, agreed to amend their own Medicaid plans consistent with changes from time to time made in the federal law. And from 1965 to the present, States have regularly conformed to Congress’ alterations of the Medicaid Act.

THE CHIEF JUSTICE acknowledges that Congress may “condition the receipt of [federal] funds on the States’ complying with restrictions on the use of those funds” but nevertheless concludes that the 2010 expansion is unduly coercive. His conclusion rests on three premises, each of them essential to his theory. First, the Medicaid expansion is, in THE CHIEF JUSTICE’s view, a new grant program, not an addition to the Medicaid program existing before the ACA’s enactment. Congress, THE CHIEF JUSTICE maintains, has threatened States with the loss of funds from an old program in an effort to get them to adopt a new one. Second, the expansion was unforeseeable by the States when they first signed on to Medicaid. Third, the threatened loss of funding is so large that the States have no real choice but to participate in the Medicaid expansion. THE CHIEF JUSTICE therefore—for the first time ever—finds an exercise of Congress’ spending power unconstitutionally coercive.

Medicaid, as amended by the ACA, however, is not two spending programs; it is a single program with a constant aim—to enable poor persons to receive basic health care when they need it. Given past expansions, plus express statutory warning that Congress may change the requirements participating States must meet, there can be no tenable claim that the ACA fails for lack of notice. Moreover, States have no entitlement to receive any Medicaid funds; they enjoy only the opportunity to accept funds on
Congress’ terms. Future Congresses are not bound by their predecessors’ dispositions; they have authority to spend federal revenue as they see fit. The Federal Government, therefore, is not, as THE CHIEF JUSTICE charges, threatening States with the loss of “existing” funds from one spending program in order to induce them to opt into another program. Congress is simply requiring States to do what States have long been required to do to receive Medicaid funding: comply with the conditions Congress prescribes for participation.

A majority of the Court, however, buys the argument that prospective withholding of funds formerly available exceeds Congress’ spending power. Given that holding, I entirely agree with THE CHIEF JUSTICE as to the appropriate remedy. It is to bar the withholding found impermissible—not, as the joint dissenters would have it, to scrap the expansion altogether. The dissenters’ view that the ACA must fall in its entirety is a radical departure from the Court’s normal course. When a constitutional infirmity mars a statute, the Court ordinarily removes the infirmity. It undertakes a salvage operation; it does not demolish the legislation. That course is plainly in order where, as in this case, Congress has expressly instructed courts to leave untouched every provision not found invalid. See 42 U.S.C. § 1303. Because THE CHIEF JUSTICE finds the withholding—not the granting—of federal funds incompatible with the Spending Clause, Congress’ extension of Medicaid remains available to any State that affirms its willingness to participate.

A

Expansion has been characteristic of the Medicaid program. Akin to the ACA in 2010, the Medicaid Act as passed in 1965 augmented existing federal grant programs jointly administered with the States.\textsuperscript{13} States were not required to participate in Medicaid. But if they did, the Federal Government paid at least half the costs. To qualify for these grants, States had to offer a minimum level of health coverage to beneficiaries of four federally funded, state-administered welfare programs: Aid to Families with Dependent Children; Old Age Assistance; Aid to the Blind; and Aid to the Permanently and Totally Disabled. At their option, States could enroll additional “medically needy” individuals; these costs, too, were partially borne by the Federal Government at the same, at least 50%, rate. \textit{Ibid.}

Since 1965, Congress has amended the Medicaid program on more than 50 occasions, sometimes quite sizably. Most relevant here, between 1988 and 1990, Congress required participating States to include among their beneficiaries pregnant

\textsuperscript{13} Medicaid was “plainly an extension of the existing Kerr–Mills” grant program. [Nicole] Huberfeld, Federalizing Medicaid, 14 U. Pa. J. Const. L. 431, 444–445 (2011). Indeed, the “section of the Senate report dealing with Title XIX”—the title establishing Medicaid—“was entitled, ‘Improvement and Extension of Kerr–Mills Medical Assistance Program.’” Stevens & Stevens, Welfare Medicine in America 51 (1974). Setting the pattern for Medicaid, Kerr–Mills reimbursed States for a portion of the cost of health care provided to welfare recipients if States met conditions specified in the federal law, \textit{e.g.}, participating States were obliged to offer minimum coverage for hospitalization and physician services. See Huberfeld, \textit{supra}, at 443–444.
women with family incomes up to 133% of the federal poverty level, children up to age 6 at the same income levels, and children ages 6 to 18 with family incomes up to 100% of the poverty level. Between 1966 and 1990, annual federal Medicaid spending grew from $631.6 million to $42.6 billion; state spending rose to $31 billion over the same period. Enlargement of the population and services covered by Medicaid, in short, has been the trend.

Compared to past alterations, the ACA is notable for the extent to which the Federal Government will pick up the tab. Nor will the expansion exorbitantly increase state Medicaid spending. The Congressional Budget Office (CBO) projects that States will spend 0.8% more than they would have, absent the ACA. See CBO, Spending & Enrollment Detail for CBO’s March 2009 Baseline. Whatever the increase in state obligations after the ACA, it will pale in comparison to the increase in federal funding.15

Finally, any fair appraisal of Medicaid would require acknowledgment of the considerable autonomy States enjoy under the Act. Far from “conscription[ing] state agencies into the national bureaucratic army,” Medicaid “is designed to advance cooperative federalism.” Wisconsin Dept. of Health and Family Servs. v. Blumer, 534 U.S. 473 (2002) Subject to its basic requirements, the Medicaid Act empowers States to “select dramatically different levels of funding and coverage, alter and experiment with different financing and delivery modes, and opt to cover (or not to cover) a range of particular procedures and therapies. States have leveraged this policy discretion to generate a myriad of dramatically different Medicaid programs over the past several decades.” Ruger, Of Icebergs and Glaciers, 75 Law & Contemp. Probs. 215, 233 (2012). The ACA does not jettison this approach. States, as first-line administrators, will continue to guide the distribution of substantial resources among their needy populations.

The alternative to conditional federal spending, it bears emphasis, is not state autonomy but state marginalization.16 In 1965, Congress elected to nationalize health coverage for seniors through Medicare. It could similarly have established Medicaid as an exclusively federal program. Instead, Congress gave the States the opportunity to partner in the program’s administration and development. Absent from the nationalized model, of course, is the state-level policy discretion and experimentation that is Medicaid’s hallmark; undoubtedly the interests of federalism are better served when States retain a meaningful role in the implementation of a program of such importance.17

15 Even the study on which the plaintiffs rely concludes that “[w]hile most states will experience some increase in spending, this is quite small relative to the federal matching payments and low relative to the costs of uncompensated care that [the states] would bear if the[re] were no health reform.” See Kaiser Commission on Medicaid & the Uninsured, Medicaid Coverage & Spending in Health Reform 16 (May 2010). Thus there can be no objection to the ACA’s expansion of Medicaid as an “unfunded mandate.” Quite the contrary, the program is impressively well funded.
16 In 1972, for example, Congress ended the federal cash-assistance program for the aged, blind, and disabled. That program previously had been operated jointly by the Federal and State Governments, as is the case with Medicaid today. Congress replaced the cooperative federal program with the nationalized Supplemental Security Income (SSI) program. See Schweiker v. Gray Panthers, 453 U.S. 34, 38 (1981).
17 THE CHIEF JUSTICE and the joint dissenters perceive in cooperative federalism a “threat[,] to “political accountability.” By that, they mean voter confusion: Citizens upset by unpopular government
Although Congress “has no obligation to use its Spending Clause power to disburse funds to the States,” *College Savings Bank v. Florida Prepaid Postsecondary Ed. Expense Bd.*, 527 U.S. 666, 686 (1999), it has provided Medicaid grants notable for their generosity and flexibility. “[S]uch funds,” we once observed, “are gifts,” *id.*, at 686–687 and so they have remained through decades of expansion in their size and scope.

**B**

The Spending Clause authorizes Congress “to pay the Debts and provide for the ... general Welfare of the United States.” To ensure that federal funds granted to the States are spent “to ‘provide for the ... general Welfare’ in the manner Congress intended,” Congress must of course have authority to impose limitations on the States’ use of the federal dollars. This Court, time and again, has respected Congress’ prescription of spending conditions, and has required States to abide by them. In particular, we have recognized Congress’ prerogative to condition a State’s receipt of Medicaid funding on compliance with the terms Congress set for participation in the program.

Congress’ authority to condition the use of federal funds is not confined to spending programs as first launched. The legislature may, and often does, amend the law, imposing new conditions grant recipients henceforth must meet in order to continue receiving funds. Yes, there are federalism-based limits on the use of Congress’ conditional spending power. In the leading decision in this area, *South Dakota v. Dole*, 483 U.S. 203 (1987), the Court identified four criteria. The conditions placed on federal grants to States must (a) promote the “general welfare,” (b) “unambiguously” inform States what is demanded of them, (c) be germane “to the federal interest in particular national projects or programs,” and (d) not “induce the States to engage in activities that would themselves be unconstitutional.” *Id.*, at 207–208, 210 (internal quotation marks omitted).

The Court in *Dole* mentioned, but did not adopt, a further limitation, one hypothetically raised a half-century earlier: In “some circumstances,” Congress might be prohibited from offering a “financial inducement ... so coercive as to pass the point at which ‘pressure turns into compulsion.’” *Id.*, at 211. Prior to today’s decision, however, the Court has never ruled that the terms of any grant crossed the indistinct line between temptation and coercion.

*Dole* involved the National Minimum Drinking Age Act, 23 U.S.C. § 158, enacted in 1984. That Act directed the Secretary of Transportation to withhold 5% of the federal highway funds otherwise payable to a State if the State permitted purchase of alcoholic beverages by persons less than 21 years old. Drinking age was not within the authority of Congress to regulate, South Dakota argued, because the Twenty–First Amendment gave the States exclusive power to control the manufacture, transportation,
and consumption of alcoholic beverages. The small percentage of highway-construction funds South Dakota stood to lose by adhering to 19 as the age of eligibility to purchase 3.2% beer, however, was not enough to qualify as coercion, the Court concluded.

This case does not present the concerns that led the Court in *Dole* even to consider the prospect of coercion. In *Dole*, the condition—set 21 as the minimum drinking age—did not tell the States how to use funds Congress provided for highway construction. Further, in view of the Twenty–First Amendment, it was an open question whether Congress could directly impose a national minimum drinking age. The ACA, in contrast, relates solely to the federally funded Medicaid program; if States choose not to comply, Congress has not threatened to withhold funds earmarked for any other program. Nor does the ACA use Medicaid funding to induce States to take action Congress itself could not undertake. The Federal Government undoubtedly could operate its own health-care program for poor persons, just as it operates Medicare for seniors’ health care. See *supra*, at 2632.

That is what makes this such a simple case, and the Court’s decision so unsettling. Congress, aiming to assist the needy, has appropriated federal money to subsidize state health-insurance programs that meet federal standards. The principal standard the ACA sets is that the state program cover adults earning no more than 133% of the federal poverty line. Enforcing that prescription ensures that federal funds will be spent on health care for the poor in furtherance of Congress’ present perception of the general welfare.

C

THE CHIEF JUSTICE asserts that the Medicaid expansion creates a “new health care program.” *Ante*, at 2606. Moreover, States could “hardly anticipate” that Congress would “transform [the program] so dramatically.” *Ante*, at 2606. Therefore, THE CHIEF JUSTICE maintains, Congress’ threat to withhold “old” Medicaid funds based on a State’s refusal to participate in the “new” program is a “threat[t] to terminate [an]other ... independent gran[t].” And because the threat to withhold a large amount of funds from one program “leaves the States with no real option but to acquiesce [in a newly created program].” THE CHIEF JUSTICE concludes, the Medicaid expansion is unconstitutionally coercive.

1

The starting premise on which THE CHIEF JUSTICE’s coercion analysis rests is that the ACA did not really “extend” Medicaid; instead, Congress created an entirely new program to co-exist with the old. THE CHIEF JUSTICE calls the ACA new, but in truth, it simply reaches more of America’s poor than Congress originally covered. Medicaid was created to enable States to provide medical assistance to “needy persons.” See S. Rep. No. 404, 89th Cong., 1st Sess., pt. 1, p. 9 (1965). The Medicaid Act contains hundreds of provisions governing operation of the program, setting conditions ranging from “Limitation on payments to States for expenditures attributable to taxes,” 42 U.S.C. § 1396a(t) (2006 ed.), to “Medical assistance to aliens not lawfully admitted for permanent
residence,” § 1396b(v) (2006 ed. and Supp. IV). The Medicaid expansion leaves unchanged the vast majority of these provisions; it adds beneficiaries to the existing program and specifies the rate at which States will be reimbursed for services provided to the added beneficiaries. See ACA §§ 2001(a)(1), (3), 124 Stat. 271–272. The ACA does not describe operational aspects of the program for these newly eligible persons; for that information, one must read the existing Medicaid Act.

Congress styled and clearly viewed the Medicaid expansion as an amendment to the Medicaid Act, not as a “new” health-care program. To the four categories of beneficiaries for whom coverage became mandatory in 1965, and the three mandatory classes added in the late 1980’s the ACA adds an eighth: individuals under 65 with incomes not exceeding 133% of the federal poverty level. The expansion is effectuated by § 2001 of the ACA, aptly titled: “Medicaid Coverage for the Lowest Income Populations.” 124 Stat. 271. That section amends Title 42, Chapter 7, Subchapter XIX: Grants to States for Medical Assistance Programs. Commonly known as the Medicaid Act, Subchapter XIX filled some 278 pages in 2006. Section 2001 of the ACA would add approximately three pages.

Congress has broad authority to construct or adjust spending programs to meet its contemporary understanding of “the general Welfare.” Helvering v. Davis, 301 U.S. 619 (1937). Courts owe a large measure of respect to Congress’ characterization of the grant programs it establishes. See Steward Machine, 301 U.S., at 594. Even if courts were inclined to second-guess Congress’ conception of the character of its legislation, how would reviewing judges divine whether an Act of Congress, purporting to amend a law, is in reality not an amendment, but a new creation? At what point does an extension become so large that it “transforms” the basic law?

Endeavoring to show that Congress created a new program, THE CHIEF JUSTICE cites three aspects of the expansion. First, he asserts that, in covering those earning no more than 133% of the federal poverty line, the Medicaid expansion, unlike pre-ACA Medicaid, does not “care for the neediest among us.” What makes that so? Single adults earning no more than $14,856 per year—133% of the current federal poverty level—surely rank among the Nation’s poor.

Second, according to THE CHIEF JUSTICE, “Congress mandated that newly eligible persons receive a level of coverage that is less comprehensive than the traditional Medicaid benefit package.” Ibid. That less comprehensive benefit package, however, is not an innovation introduced by the ACA; since 2006, States have been free to use it for many of their Medicaid beneficiaries. The level of benefits offered therefore does not set apart post-ACA Medicaid recipients from all those entitled to benefits pre-ACA.

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20 The Deficit Reduction Act of 2005 authorized States to provide “benchmark coverage” or “benchmark equivalent coverage” to certain Medicaid populations. See § 6044, 120 Stat. 88, 42 U.S.C. § 1396u–7. States may offer the same level of coverage to persons newly eligible under the ACA. See § 1396a(k).
Third, THE CHIEF JUSTICE correctly notes that the reimbursement rate for participating States is different regarding individuals who became Medicaid-eligible through the ACA. But the rate differs only in its generosity to participating States. Under pre-ACA Medicaid, the Federal Government pays up to 83% of the costs of coverage for current enrollees, § 1396d(b); under the ACA, the federal contribution starts at 100% and will eventually settle at 90%, § 1396d(y). Even if one agreed that a change of as little as 7 percentage points carries constitutional significance, is it not passing strange to suggest that the purported incursion on state sovereignty might have been averted, or at least mitigated, had Congress offered States less money to carry out the same obligations?

Consider also that Congress could have repealed Medicaid. Thereafter, Congress could have enacted Medicaid II, a new program combining the pre–2010 coverage with the expanded coverage required by the ACA. By what right does a court stop Congress from building up without first tearing down?

2

THE CHIEF JUSTICE finds the Medicaid expansion vulnerable because it took participating States by surprise. For the notion that States must be able to foresee, when they sign up, alterations Congress might make later on, THE CHIEF JUSTICE cites only one case: *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1.

In *Pennhurst*, residents of a state-run, federally funded institution for the mentally disabled complained of abusive treatment and inhumane conditions in alleged violation of the Developmentally Disabled Assistance and Bill of Rights Act. 451 U.S., at 5–6. We held that the State was not answerable in damages for violating conditions it did not “voluntarily and knowingly accept[.]” *Id.*, at 17. Inspecting the statutory language and legislative history, we found that the Act did not “unambiguously” impose the requirement on which the plaintiffs relied: that they receive appropriate treatment in the least restrictive environment. Satisfied that Congress had not clearly conditioned the States’ receipt of federal funds on the States’ provision of such treatment, we declined to read such a requirement into the Act. Congress’ spending power, we concluded, “does not include surprising participating States with post-acceptance or ‘retroactive’ conditions.” *Id.*, at 24–25.

*Pennhurst* thus instructs that “if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously.” That requirement is met in this case. Section 2001 does not take effect until 2014. The ACA makes perfectly clear what will be required of States that accept Medicaid funding after that date: They must extend eligibility to adults with incomes no more than 133% of the federal poverty line. See 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII).

THE CHIEF JUSTICE appears to find in *Pennhurst* a requirement that, when spending legislation is first passed, or when States first enlist in the federal program, Congress must provide clear notice of conditions it might later impose. If I understand his point correctly, it was incumbent on Congress, in 1965, to warn the States clearly of the
size and shape potential changes to Medicaid might take. And absent such notice, sizable changes could not be made mandatory. Our decisions do not support such a requirement.21

In Bennett v. New Jersey, 470 U.S. 632 (1985), the Secretary of Education sought to recoup Title I funds based on the State’s noncompliance, from 1970 to 1972, with a 1978 amendment to Title I. Relying on Pennhurst, we rejected the Secretary’s attempt to recover funds based on the States’ alleged violation of a rule that did not exist when the State accepted and spent the funds. See 470 U.S., at 640. When amendment of an existing grant program has no such retroactive effect, however, we have upheld Congress’ instruction. In Bennett v. Kentucky Dept. of Ed., 470 U.S. 656 (1985), the Secretary sued to recapture Title I funds based on the Commonwealth’s 1974 violation of a spending condition Congress added to Title I in 1970. Rejecting Kentucky’s argument pinned to Pennhurst, we held that the Commonwealth suffered no surprise after accepting the federal funds. As these decisions show, Pennhurst’s rule demands that conditions on federal funds be unambiguously clear at the time a State receives and uses the money—not at the time, perhaps years earlier, when Congress passed the law establishing the program.

In any event, from the start, the Medicaid Act put States on notice that the program could be changed: “The right to alter, amend, or repeal any provision of [Medicaid],” the statute has read since 1965, “is hereby reserved to the Congress.” 42 U.S.C. § 1304. The “effect of these few simple words” has long been settled. By reserving the right to “alter, amend, [or] repeal” a spending program, Congress “has given special notice of its intention to retain ... full and complete power to make such alterations and amendments ... as come within the just scope of legislative power.”

Our decision in Bowen v. Public Agencies Opposed to Social Security Entrapment, 477 U.S. 41 (1986), is guiding here. As enacted in 1935, the Social Security Act did not cover state employees. In response to pressure from States that wanted coverage for their employees, Congress, in 1950, amended the Act to allow States to opt into the program. The statutory provision giving States this option expressly permitted them to withdraw from the program. Beginning in the late 1970’s, States increasingly exercised the option to withdraw. Id., at 46. Concerned that withdrawals were threatening the integrity of Social Security, Congress repealed the termination provision. Congress thereby changed Social Security from a program voluntary for the States to one from which they could not escape. California objected, arguing that the change impermissibly deprived it of a right to withdraw from Social Security. We unanimously rejected California’s argument. By including in the Act “a clause expressly reserving to it ‘[t]he right to alter, amend, or repeal any provision’ of the Act,” we held, Congress put States on notice that the Act

21 THE CHIEF JUSTICE observes that “Spending Clause legislation [i]s much in the nature of a contract.” But the Court previously has recognized that “[u]nlike normal contractual undertakings, federal grant programs originate in and remain governed by statutory provisions expressing the judgment of Congress concerning desirable public policy.” Bennett v. Kentucky Dept. of Ed., 470 U.S. 656, 669 (1985).
“created no contractual rights.” The States therefore had no law-based ground on which to complain about the amendment, despite the significant character of the change.

THE CHIEF JUSTICE nevertheless would rewrite § 1304 to countenance only the “right to alter somewhat,” or “amend, but not too much.” Congress, however, did not so qualify § 1304. Indeed, Congress retained discretion to “repeal” Medicaid, wiping it out entirely. As Bowen indicates, no State could reasonably have read § 1304 as reserving to Congress authority to make adjustments only if modestly sized.

In fact, no State proceeded on that understanding. In compliance with Medicaid regulations, each State expressly undertook to abide by future Medicaid changes. See 42 CFR § 430.12(c)(1) (2011) (“The [state Medicaid] plan must provide that it will be amended whenever necessary to reflect ... [c]hanges in Federal law, regulations, policy interpretations, or court decisions.”). Whenever a State notifies the Federal Government of a change in its own Medicaid program, the State certifies both that it knows the federally set terms of participation may change, and that it will abide by those changes as a condition of continued participation.

THE CHIEF JUSTICE insists that the most recent expansion, in contrast to its predecessors, “accomplishes a shift in kind, not merely degree.” But why was Medicaid altered only in degree, not in kind, when Congress required States to cover millions of children and pregnant women? Congress did not “merely alter[r] and expand[d] the boundaries of” the Aid to Families with Dependent Children program. Rather, Congress required participating States to provide coverage tied to the federal poverty level (as it later did in the ACA), rather than to the AFDC program. In short, given § 1304, this Court’s construction of § 1304’s language in Bowen, and the enlargement of Medicaid in the years since 1965, a State would be hard put to complain that it lacked fair notice when, in 2010, Congress altered Medicaid to embrace a larger portion of the Nation’s poor.

3

THE CHIEF JUSTICE ultimately asks whether “the financial inducement offered by Congress ... pass[ed] the point at which pressure turns into compulsion.” The financial inducement Congress employed here, he concludes, crosses that threshold: The threatened withholding of “existing Medicaid funds” is “a gun to the head” that forces States to acquiesce.24 THE CHIEF JUSTICE sees no need to “fix the outermost line.”

24 The joint dissenters, for their part, would make this the entire inquiry. “[I]f States really have no choice other than to accept the package,” they assert, “the offer is coercive.” THE CHIEF JUSTICE recognizes Congress’ authority to construct a single federal program and “condition the receipt of funds on the States’ complying with restrictions on the use of those funds.” For the joint dissenters, however, all that matters, it appears, is whether States can resist the temptation of a given federal grant. On this logic, any federal spending program, sufficiently large and well-funded, would be unconstitutional. The joint dissenters point to smaller programs States might have the will to refuse. But how is a court to judge whether “only 6.6% of all state expenditures” is an amount States could or would do without? Speculations of this genre are characteristic of the joint dissent. The joint dissenters are long on conjecture and short on real-world examples.
Steward Machine, 301 U.S., at 591, “where persuasion gives way to coercion.” Neither do the joint dissenters. Notably, the decision on which they rely, Steward Machine, found the statute at issue inside the line, “wherever the line may be.” 301 U.S., at 591.

When future Spending Clause challenges arrive, as they likely will in the wake of today’s decision, how will litigants and judges assess whether “a State has a legitimate choice whether to accept the federal conditions in exchange for federal funds”? Are courts to measure the number of dollars the Federal Government might withhold for noncompliance? The portion of the State’s budget at stake? And which State’s—or States’—budget is determinative: the lead plaintiff, all challenging States (26 in this case, many with quite different fiscal situations), or some national median? Does it matter that Florida, unlike most States, imposes no state income tax, and therefore might be able to replace foregone federal funds with new state revenue? Or that the coercion state officials in fact fear is punishment at the ballot box for turning down a politically popular federal grant? The coercion inquiry, therefore, appears to involve political judgments that defy judicial calculation.

At bottom, my colleagues’ position is that the States’ reliance on federal funds limits Congress’ authority to alter its spending programs. This gets things backwards: Congress, not the States, is tasked with spending federal money in service of the general welfare. And each successive Congress is empowered to appropriate funds as it sees fit. When the 110th Congress reached a conclusion about Medicaid funds that differed from its predecessors’ view, it abridged no State’s right to “existing,” or “pre-existing,” funds. For, in fact, there are no such funds. There is only money States anticipate receiving from future Congresses.

D

Congress has delegated to the Secretary of Health and Human Services the authority to withhold, in whole or in part, federal Medicaid funds from States that fail to comply with the Medicaid Act as originally composed and as subsequently amended. 42 U.S.C. § 1396c. THE CHIEF JUSTICE, however, holds that the Constitution precludes

25 The joint dissenters also rely heavily on Congress’ perceived intent to coerce the States. We should not lightly ascribe to Congress an intent to violate the Constitution (at least as my colleagues read it). This is particularly true when the ACA could just as well be comprehended as demonstrating Congress’ mere expectation, in light of the uniformity of past participation and the generosity of the federal contribution, that States would not withdraw.
26 Federal taxation of a State’s citizens, according to the joint dissenters, may diminish a State’s ability to raise new revenue. This, in turn, could limit a State’s capacity to replace a federal program with an “equivalent” state-funded analog. But it cannot be true that “the amount of the federal taxes extracted from the taxpayers of a State to pay for the program in question is relevant in determining whether there is impermissible coercion.” When the United States Government taxes United States citizens, it taxes them “in their individual capacities” as “the people of America”—not as residents of a particular State.
27 As THE CHIEF JUSTICE observes, the Secretary is authorized to withhold all of a State’s Medicaid funding. But total withdrawal is what the Secretary may, not must, do. She has discretion to withhold only a portion of the Medicaid funds otherwise due a noncompliant State. See § 1396c; cf. 45 CFR § 80.10(f) (2011) (Secretary may enforce Title VI’s nondiscrimination requirement through “refusal to grant or continue Federal financial assistance, in whole or in part.” The Secretary, it is worth noting, may herself
the Secretary from withholding “existing” Medicaid funds based on States’ refusal to comply with the expanded Medicaid program. For the foregoing reasons, I disagree that any such withholding would violate the Spending Clause. Accordingly, I would affirm the decision of the Court of Appeals for the Eleventh Circuit in this regard.

But in view of THE CHIEF JUSTICE’s disposition, I agree with him that the Medicaid Act’s severability clause determines the appropriate remedy. That clause provides that “[i]f any provision of [the Medicaid Act], or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby.” 42 U.S.C. § 1303. The Court does not strike down any provision of the ACA. It prohibits only the “application” of the Secretary’s authority to withhold Medicaid funds from States that decline to conform their Medicaid plans to the ACA’s requirements. Thus the ACA’s authorization of funds to finance the expansion remains intact, and the Secretary’s authority to withhold funds for reasons other than noncompliance with the expansion remains unaffected.

Even absent § 1303’s command, we would have no warrant to invalidate the Medicaid expansion. In this case, that objective was to increase access to health care for the poor by increasing the States’ access to federal funds. THE CHIEF JUSTICE is undoubtedly right to conclude that Congress may offer States funds “to expand the availability of health care, and requir[e] that States accepting such funds comply with the conditions on their use.” I therefore concur in the judgment with respect to Part IV–B of THE CHIEF JUSTICE’s opinion.

C. Joint Dissent by Justices Scalia, Kennedy, Thomas, and Alito That the Medicaid Expansion Is Coercive, Not Severable and Therefore Entirely Unconstitutional

IV

The ACA does not legally compel the States to participate in the expanded Medicaid program, but the Act authorizes a severe sanction for any State that refuses to go along: termination of all the State’s Medicaid funding. For the average State, the annual federal Medicaid subsidy is equal to more than one-fifth of the State’s expenditures. A State forced out of the program would not only lose this huge sum but would almost certainly find it necessary to increase its own health-care expenditures substantially, requiring either a drastic reduction in funding for other programs or a large increase in state taxes. And these new taxes would come on top of the federal taxes already paid by the State’s citizens to fund the Medicaid program in other States.

experience political pressures, which would make her all the more reluctant to cut off funds Congress has appropriated for a State’s needy citizens.

7 “State expenditures” is used here to mean annual expenditures from the States’ own funding sources, and it excludes federal grants unless otherwise noted.
The States challenging the constitutionality of the ACA’s Medicaid Expansion contend that, for these practical reasons, the Act really does not give them any choice at all. As proof of this, they point to the goal and the structure of the ACA. The goal of the Act is to provide near-universal medical coverage, 42 U.S.C. § 18091(2)(D), and without 100% State participation in the Medicaid program, attainment of this goal would be thwarted. Even if States could elect to remain in the old Medicaid program, while declining to participate in the Expansion, there would be a gaping hole in coverage. And if a substantial number of States were entirely expelled from the program, the number of persons without coverage would be even higher.

In light of the ACA’s goal of near-universal coverage, petitioners argue, if Congress had thought that anything less than 100% state participation was a realistic possibility, Congress would have provided a backup scheme. But no such scheme is to be found anywhere in the more than 900 pages of the Act. This shows, they maintain, that Congress was certain that the ACA’s Medicaid offer was one that no State could refuse. In response to this argument, the Government contends that any congressional assumption about uniform state participation was based on the simple fact that the offer of federal funds associated with the expanded coverage is such a generous gift that no State would want to turn it down. To evaluate these arguments, we consider the extent of the Federal Government’s power to spend money and to attach conditions to money granted to the States.

A

No one has ever doubted that the Constitution authorizes the Federal Government to spend money, but for many years the scope of this power was unsettled. Madison, it has been said, thought that the phrase “amounted to no more than a reference to the other powers enumerated in the subsequent clauses of the same section,” while Hamilton “maintained the clause confers a power separate and distinct from those later enumerated [and] is not restricted in meaning by the grant of them.”

The Court resolved this dispute in United States v Butler, 297 U.S. 1 (1936). Writing for the Court, Justice Roberts opined that the Madisonian view would make Article I’s grant of the spending power a “mere tautology.” To avoid that, he adopted Hamilton’s approach and found that “the power of Congress to authorize expenditure of public moneys for public purposes is not limited by the direct grants of legislative power found in the Constitution.” Instead, he wrote, the spending power’s “confines are set in the clause which confers it, and not in those of section 8 which bestow and define the legislative powers of the Congress.” The power to make any expenditure that furthers “the general welfare” is obviously very broad, and shortly after Butler was decided the Court gave Congress wide leeway to decide whether an expenditure qualifies. Since that time, the Court has never held that a federal expenditure was not for “the general welfare.”
B

One way in which Congress may spend to promote the general welfare is by making grants to the States. As of 2010, federal outlays to state and local governments came to over $608 billion or 37.5% of state and local government expenditures. When Congress makes grants to the States, it customarily attaches conditions, and this Court has long held that the Constitution generally permits Congress to do this. See *Pennhurst State School and Hospital v. Halderman*, 451 U.S. 1 (1981); *South Dakota v. Dole*, 483 U.S. 203, 206 (1987); *Steward Machine*, supra, at 593, 57 S. Ct. 883.

C

This practice of attaching conditions to federal funds greatly increases federal power. “[O]bjectives 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.” *Dole*, *supra*, at 207. This formidable power, if not checked in any way, would present a grave threat to the system of federalism created by our Constitution. If Congress’ “Spending Clause power to pursue objectives outside of Article I’s enumerated legislative fields,” *Davis v. Monroe County Bd. of Ed.*, 526 U.S. 629, 654 (1999) (KENNEDY, J., dissenting) is “limited only by Congress’ notion of the general welfare, the reality, given the vast financial resources of the Federal Government, is that the Spending Clause gives ‘power to the Congress to tear down the barriers, to invade the states’ jurisdiction, and to become a parliament of the whole people, subject to no restrictions save such as are self-imposed,’” *Dole*, *supra*, at 217 (O’Connor, J., dissenting). “[T]he Spending Clause power, if wielded without concern for the federal balance, has the potential to obliterate distinctions between national and local spheres of interest and power by permitting the Federal Government to set policy in the most sensitive areas of traditional state concern, areas which otherwise would lie outside its reach.” *Davis*, *supra*, at 654–655 (KENNEDY, J., dissenting).

Recognizing this potential for abuse, our cases have long held that the power to attach conditions to grants to the States has limits. Conditions must also be related “to the federal interest in particular national projects or programs,” *Massachusetts v. United States*, 435 U.S. 444 (1978), and the conditional grant of federal funds may not “induce the States to engage in activities that would themselves be unconstitutional,” *Dole*, *supra*. Finally, while Congress may seek to induce States to accept conditional grants, Congress may not cross the “point at which pressure turns into compulsion, and ceases to be inducement.” *Steward Machine*, 301 U.S., at 590.

When federal legislation gives the States a real choice whether to accept or decline a federal aid package, the federal-state relationship is in the nature of a contractual relationship. *Pennhurst*, 451 U.S., at 17. And just as a contract is voidable if coerced, “[t]he legitimacy of Congress’ power to legislate under the spending power ... rests on whether the State voluntarily and knowingly accepts the terms of the ‘contract.’” *Ibid.* (emphasis added). Coercing States to accept conditions risks the destruction of the “unique role of the States in our system.” *Davis*, at 685 (KENNEDY, J., dissenting).
Congress effectively engages in this impermissible compulsion when state participation in a federal spending program is coerced, so that the States’ choice whether to enact or administer a federal regulatory program is rendered illusory. Where all Congress has done is to “encourag[e] state regulation rather than compe[ll] it, state governments remain responsive to the local electorate’s preferences; state officials remain accountable to the people. [But] where the Federal Government compels States to regulate, the accountability of both state and federal officials is diminished.” New York at 168.

Amici who support the Government argue that forcing state employees to implement a federal program is more respectful of federalism than using federal workers to implement that program. They note that Congress, instead of expanding Medicaid, could have established an entirely federal program to provide coverage for the same group of people. By choosing to structure Medicaid as a cooperative federal-state program, they contend, Congress allows for more state control.

This argument reflects a view of federalism that our cases have rejected—and with good reason. When Congress compels the States to do its bidding, it blurs the lines of political accountability. If the Federal Government makes a controversial decision while acting on its own, “it is the Federal Government that makes the decision in full view of the public, and it will be federal officials that suffer the consequences if the decision turns out to be detrimental or unpopular.” New York, 505 U.S., at 168. But when the Federal Government compels the States to take unpopular actions, “it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision.” Id., at 169. For this reason, federal officeholders may view this “departur[e] from the federal structure to be in their personal interests ... as a means of shifting responsibility for the eventual decision.” New York, 505 U.S., at 182–183. And even state officials may favor such a “departure from the constitutional plan,” since uncertainty concerning responsibility may also permit them to escape accountability. Id., at 182. If a program is popular, state officials may claim credit; if it is unpopular, they may protest that they were merely responding to a federal directive.

Once it is recognized that spending-power legislation cannot coerce state participation, two questions remain: (1) What is the meaning of coercion in this context? (2) Is the ACA’s expanded Medicaid coverage coercive? We now turn to those questions.

D

I

The answer to the first of these questions—the meaning of coercion in the present context—is straightforward. As we have explained, the legitimacy of attaching conditions to federal grants to the States depends on the voluntariness of the States’ choice to accept or decline the offered package. Therefore, if States really have no choice other than to accept the package, the offer is coercive, and the conditions cannot be sustained under the spending power. And as our decision in South Dakota v. Dole makes clear, theoretical voluntariness is not enough.
In *South Dakota v. Dole*, we considered whether the spending power permitted Congress to condition 5% of the State’s federal highway funds on the State’s adoption of a minimum drinking age of 21 years. South Dakota argued that the program was impermissibly coercive, but we disagreed, reasoning that “Congress ha[d] directed only that a State desiring to establish a minimum drinking age lower than 21 lose a relatively small percentage of certain federal highway funds.” 483 U.S., at 211. Because “all South Dakota would lose if she adhere[d] to her chosen course as to a suitable minimum drinking age [was] 5% of the funds otherwise obtainable under specified highway grant programs,” we found that “Congress ha[d] offered relatively mild encouragement to the States to enact higher minimum drinking ages than they would otherwise choose.” Ibid. Thus, the decision whether to comply with the federal condition “remain[ed] the prerogative of the States not merely in theory but in fact,” and so the program at issue did not exceed Congress’ power. Id., at 211–212 (emphasis added).

The question whether a law enacted under the spending power is coercive in fact will sometimes be difficult, but where Congress has plainly “crossed the line distinguishing encouragement from coercion,” *New York*, supra, at 175, a federal program that coopts the States’ political processes must be declared unconstitutional.

The Federal Government’s argument in this case at best pays lip service to the anticoercion principle. The Federal Government suggests that it is sufficient if States are “free, as a matter of law, to turn down” federal funds. According to the Federal Government, neither the amount of the offered federal funds nor the amount of the federal taxes extracted from the taxpayers of a State to pay for the program in question is relevant in determining whether there is impermissible coercion. This argument ignores reality. When a heavy federal tax is levied to support a federal program that offers large grants to the States, States may, as a practical matter, be unable to refuse to participate in the federal program and to substitute a state alternative. Even if a State believes that the federal program is ineffective and inefficient, withdrawal would likely force the State to impose a huge tax increase on its residents, and this new state tax would come on top of the federal taxes already paid by residents to support subsidies to participating States.13

Acceptance of the Federal Government’s interpretation of the anticoercion rule would permit Congress to dictate policy in areas traditionally governed primarily at the state or local level. Suppose, for example, that Congress enacted legislation offering each State a grant equal to the State’s entire annual expenditures for primary and secondary education. Suppose also that this funding came with conditions governing such things as school curriculum, the hiring and tenure of teachers, the drawing of school districts, the

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13 Justice GINSBURG argues that “[a] State ... has no claim on the money its residents pay in federal taxes.” This is true as a formal matter. “When the United States Government taxes United States citizens, it taxes them ‘in their individual capacities’ as ‘the people of America’—not as residents of a particular State.” But unless Justice GINSBURG thinks that there is no limit to the amount of money that can be squeezed out of taxpayers, heavy federal taxation diminishes the practical ability of States to collect their own taxes.
length and hours of the school day, the school calendar, a dress code for students, and rules for student discipline. As a matter of law, a State could turn down that offer, but if it did so, its residents would not only be required to pay the federal taxes needed to support this expensive new program, but they would also be forced to pay an equivalent amount in state taxes. And if the State gave in to the federal law, the State and its subdivisions would surrender their traditional authority in the field of education. Asked at oral argument whether such a law would be allowed under the spending power, the Solicitor General responded that it would.

E

Whether federal spending legislation crosses the line from enticement to coercion is often difficult to determine, and courts should not conclude that legislation is unconstitutional on this ground unless the coercive nature of an offer is unmistakably clear. In this case, however, there can be no doubt. In structuring the ACA, Congress unambiguously signaled its belief that every State would have no real choice but to go along with the Medicaid Expansion. If the anticoercion rule does not apply in this case, then there is no such rule.

1

The dimensions of the Medicaid program lend strong support to the petitioner States’ argument that refusing to accede to the conditions set out in the ACA is not a realistic option. Before the ACA’s enactment, Medicaid funded medical care for pregnant women, families with dependents, children, the blind, the elderly, and the disabled. The ACA greatly expands the program’s reach, making new funds available to States that agree to extend coverage to all individuals who are under age 65 and have incomes below 133% of the federal poverty line. Any State that refuses to expand its Medicaid programs in this way is threatened with a severe sanction: the loss of all its federal Medicaid funds. See § 1396c.

Medicaid has long been the largest federal program of grants to the States. In 2010, the Federal Government directed more than $552 billion in federal funds to the States. See Nat. Assn. of State Budget Officers, 2010 State Expenditure Report: Examining Fiscal 2009–2011 State Spending, p. 7 (2011) (NASBO Report). Of this, more than $233 billion went to pre-expansion Medicaid.\footnote{14} This amount equals nearly

\footnote{14} The Federal Government has a higher number for federal spending on Medicaid. According to the Office of Management and Budget, federal grants to the States for Medicaid amounted to nearly $273 billion in Fiscal Year 2010. See Office of Management and Budget, Historical Tables, Budget of the U.S. Government, Fiscal Year 2013, Table 12.3—Total Outlays for Grants to State and Local Governments by Function, Agency, and Program: 1940–2013, http://www.whitehouse.gov/omb/budget/Historicals. In that Fiscal Year, total federal outlays for grants to state and local governments amounted to over $608 billion, see Table 12.1, and state and local government expenditures from their own sources amounted to $1.6 trillion, see Table 15.2. Using these numbers, 44.8% of all federal outlays to both state and local governments was allocated to Medicaid, amounting to 16.8% of all state and local expenditures from their own sources.
22% of all state expenditures combined. The States devote a larger percentage of their budgets to Medicaid than to any other item. Federal funds account for anywhere from 50% to 83% of each State’s total Medicaid expenditures, see § 1396d(b); most States receive more than $1 billion in federal Medicaid funding; and a quarter receive more than $5 billion, NASBO Report 47. These federal dollars total nearly two thirds—64.6%—of all Medicaid expenditures nationwide. 15

The Court of Appeals concluded that the States failed to establish coercion in this case in part because the “states have the power to tax and raise revenue, and therefore can create and fund programs of their own if they do not like Congress’s terms.” 648 F.3d 1235, 1268 (C.A.11 2011) But the sheer size of this federal spending program in relation to state expenditures means that a State would be very hard pressed to compensate for the loss of federal funds by cutting other spending or raising additional revenue. The States are far less reliant on federal funding for any other program. After Medicaid, the next biggest federal funding item is aid to support elementary and secondary education, which amounts to 12.8% of total federal outlays to the States and equals only 6.6% of all state expenditures combined. And even in States with less than average federal Medicaid funding, that funding is at least twice the size of federal education funding as a percentage of state expenditures.

A State forced out of the Medicaid program would face burdens in addition to the loss of federal Medicaid funding. For example, a nonparticipating State might be found to be ineligible for other major federal funding sources, such as Temporary Assistance for Needy Families (TANF), which is premised on the expectation that States will participate in Medicaid. See 42 U.S.C. § 602(a)(3) (requiring that certain beneficiaries of TANF funds be “eligible for medical assistance under the State[’s Medicaid] plan”). And withdrawal or expulsion from the Medicaid program would not relieve a State’s hospitals of their obligation under federal law to provide care for patients who are unable to pay for medical services. The Emergency Medical Treatment and Active Labor Act, § 1395dd, requires hospitals that receive any federal funding to provide stabilization care for indigent patients but does not offer federal funding to assist facilities in carrying out its mandate. Many of these patients are now covered by Medicaid. If providers could not look to the Medicaid program to pay for this care, they would find it exceedingly difficult to comply with federal law unless they were given substantial state support.

For these reasons, the offer that the ACA makes to the States—go along with a dramatic expansion of Medicaid or potentially lose all federal Medicaid funding—is quite unlike anything that we have seen in a prior spending-power case. In South Dakota v. Dole, the total amount that the States would have lost if every single State had refused to comply with the 21–year–old drinking age was approximately $614.7 million—or about 0.19% of all state expenditures combined. South Dakota stood to lose, at most, funding that amounted to less than 1% of its annual state expenditures. Under the ACA, by

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15 The Federal Government reports a higher percentage. According to Medicaid.gov, in Fiscal Year 2010, the Federal Government made Medicaid payments in the amount of nearly $260 billion, representing 67.79% of total Medicaid payments of $383 billion.
contrast, the Federal Government has threatened to withhold 42.3% of all federal outlays to the states, or approximately $233 billion. South Dakota stands to lose federal funding equaling 28.9% of its annual state expenditures. Withholding $614.7 million, equaling only 0.19% of all state expenditures combined, is aptly characterized as “relatively mild encouragement,” but threatening to withhold $233 billion, equaling 21.86% of all state expenditures combined, is a different matter.

What the statistics suggest is confirmed by the goal and structure of the ACA. In crafting the ACA, Congress clearly expressed its informed view that no State could possibly refuse the offer that the ACA extends. The stated goal of the ACA is near-universal health care coverage. To achieve this goal, the ACA mandates that every person obtain a minimum level of coverage. It attempts to reach this goal in several different ways. The guaranteed issue and community-rating provisions are designed to make qualifying insurance available and affordable for persons with medical conditions that may require expensive care. Other ACA provisions seek to make such policies more affordable for people of modest means. Finally, for low-income individuals who are simply not able to obtain insurance, Congress expanded Medicaid, transforming it from a program covering only members of a limited list of vulnerable groups into a program that provides at least the requisite minimum level of coverage for the poor. This design was intended to provide at least a specified minimum level of coverage for all Americans, but the achievement of that goal obviously depends on participation by every single State. If any State—not to mention all of the 26 States that brought this suit—chose to decline the federal offer, there would be a gaping hole in the ACA’s coverage.

If Congress had thought that States might actually refuse to go along with the expansion of Medicaid, Congress would surely have devised a backup scheme so that the most vulnerable groups in our society, those previously eligible for Medicaid, would not be left out in the cold. But nowhere in the over 900–page Act is such a scheme to be found. By contrast, because Congress thought that some States might decline federal funding for the operation of a “health benefit exchange,” Congress provided a backup scheme; if a State declines to participate in the operation of an exchange, the Federal Government will step in and operate an exchange in that State. See 42 U.S.C. § 18041(c)(1). Likewise, knowing that States would not necessarily provide affordable health insurance for aliens lawfully present in the United States—because Medicaid does not require States to provide such coverage—Congress extended the availability of the new federal insurance subsidies to all aliens. See 26 U.S.C. § 36B(c)(1)(B)(ii) (excepting from the income limit individuals who are “not eligible for the medicaid program ... by reason of [their] alien status”). Congress did not make these subsidies available for citizens with incomes below the poverty level because Congress obviously assumed that they would be covered by Medicaid. If Congress had contemplated that some of these citizens would be left without Medicaid coverage as a result of a State’s withdrawal or expulsion from the program, Congress surely would have made them eligible for the tax subsidies provided for low-income aliens.
These features of the ACA convey an unmistakable message: Congress never dreamed that any State would refuse to go along with the expansion of Medicaid. Congress well understood that refusal was not a practical option. The Federal Government does not dispute the inference that Congress anticipated 100% state participation, but it argues that this assumption was based on the fact that ACA’s offer was an “exceedingly generous” gift. As the Federal Government sees things, Congress is like the generous benefactor who offers $1 million with few strings attached to 50 randomly selected individuals. Just as this benefactor might assume that all of these 50 individuals would snap up his offer, so Congress assumed that every State would gratefully accept the federal funds (and conditions) to go with the expansion of Medicaid.

This characterization of the ACA’s offer raises obvious questions. If that offer is “exceedingly generous,” as the Federal Government maintains, why have more than half the States brought this lawsuit, contending that the offer is coercive? And why did Congress find it necessary to threaten that any State refusing to accept this “exceedingly generous” gift would risk losing all Medicaid funds? Congress could have made just the new funding provided under the ACA contingent on acceptance of the terms of the Medicaid Expansion. Congress took such an approach in some earlier amendments to Medicaid, separating new coverage requirements and funding from the rest of the program so that only new funding was conditioned on new eligibility extensions. See, e.g., Social Security Amendments of 1972, 86 Stat. 1465.

Congress’ decision to do otherwise here reflects its understanding that the ACA offer is not an “exceedingly generous” gift that no State in its right mind would decline. Instead, acceptance of the offer will impose very substantial costs on participating States. It is true that the Federal Government will bear most of the initial costs associated with the Medicaid Expansion, first paying 100% of the costs of covering newly eligible individuals between 2014 and 2016. 42 U.S.C. § 1396d(y). But that is just part of the picture. Participating States will be forced to shoulder substantial costs as well, because after 2019 the Federal Government will cover only 90% of the costs associated with the Expansion, with state spending projected to increase by at least $20 billion by 2020 as a consequence. Statement of Douglas W. Elmendorf, CBO’s Analysis of the Major Health Care Legislation Enacted in March 2010, p. 24 (Mar. 30, 2011); see also R. Bovbjerg, B. Ormond, & V. Chen, Kaiser Commission on Medicaid and the Uninsured, State Budgets under Federal Health Reform: The Extent and Causes of Variations in Estimated Impacts 4, n. 27 (Feb. 2011) (estimating new state spending at $43.2 billion through 2019).

After 2019, state spending is expected to increase at a faster rate; the CBO estimates new state spending at $60 billion through 2021. Statement of Douglas W. Elmendorf, supra, at 24. And these costs may increase in the future because of the very real possibility that the Federal Government will change funding terms and reduce the percentage of funds it will cover. This would leave the States to bear an increasingly large percentage of the bill. Finally, after 2015, the States will have to pick up the tab for 50% of all administrative costs associated with implementing the new program, see §§ 1396b(a)(2)-(5), (7), costs that could approach $12 billion between fiscal years 2014 and 2020.
In sum, it is perfectly clear from the goal and structure of the ACA that the offer of the Medicaid Expansion was one that Congress understood no State could refuse. The Medicaid Expansion therefore exceeds Congress’ spending power and cannot be implemented.

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Seven Members of the Court agree that the Medicaid Expansion, as enacted by Congress, is unconstitutional. Because the Medicaid Expansion is unconstitutional, the question of remedy arises. The most natural remedy would be to invalidate the Medicaid Expansion. However, the Government proposes—in two cursory sentences at the very end of its brief—preserving the Expansion. Under its proposal, States would receive the additional Medicaid funds if they expand eligibility, but States would keep their pre-existing Medicaid funds if they do not expand eligibility. We cannot accept the Government’s suggestion.

The reality that States were given no real choice but to expand Medicaid was not an accident. Congress assumed States would have no choice, and the ACA depends on States’ having no choice, because its Mandate requires low-income individuals to obtain insurance many of them can afford only through the Medicaid Expansion. Furthermore, a State’s withdrawal might subject everyone in the State to much higher insurance premiums. That is because the Medicaid Expansion will no longer offset the cost to the insurance industry imposed by the ACA’s insurance regulations and taxes, a point that is explained in more detail in the severability section below. To make the Medicaid Expansion optional despite the ACA’s structure and design “‘would be to make a new law, not to enforce an old one. This is no part of our duty.’” Trade–Mark Cases, 100 U.S. 82, 99 (1879).

Worse, the Government’s proposed remedy introduces a new dynamic: States must choose between expanding Medicaid or paying huge tax sums to the federal fisc for the sole benefit of expanding Medicaid in other States. If this divisive dynamic between and among States can be introduced at all, it should be by conscious congressional choice, not by Court-invented interpretation. We do not doubt that States are capable of making decisions when put in a tight spot. We do doubt the authority of this Court to put them there.

The Government cites a severability clause codified with Medicaid in Chapter 7 of the United States Code stating that if “any provision of this chapter, or the application thereof to any person or circumstance, is held invalid, the remainder of the chapter, and the application of such provision to other persons or circumstances shall not be affected thereby.” 42 U.S.C. § 1303. But that clause tells us only that other provisions in Chapter 7 should not be invalidated if § 1396c, the authorization for the cut-off of all Medicaid funds, is unconstitutional. It does not tell us that § 1396c can be judicially revised, to say what it does not say. Such a judicial power would not be called the doctrine of severability but perhaps the doctrine of amendatory invalidation—similar to the
amendatory veto that permits the Governors of some States to reduce the amounts appropriated in legislation. The proof that such a power does not exist is the fact that it would not preserve other congressional dispositions, but would leave it up to the Court what the “validated” legislation will contain. The Court today opts for permitting the cut-off of only incremental Medicaid funding, but it might just as well have permitted, say, the cut-off of funds that represent no more than $x$ percent of the State’s budget. The Court severs nothing, but simply revises § 1396c to read as the Court would desire.

We should not accept the Government’s invitation to attempt to solve a constitutional problem by rewriting the Medicaid Expansion so as to allow States that reject it to retain their pre-existing Medicaid funds. Worse, the Government’s remedy, now adopted by the Court, takes the ACA and this Nation in a new direction and charts a course for federalism that the Court, not the Congress, has chosen; but under the Constitution, that power and authority do not rest with this Court.

Notes

1. The impact of the decision on implementation of the Medicaid expansion. The impact of the decision was both electrifying and predictable. Within slightly more than two weeks of the decision, Governors of at least ten states declared that either that they would not participate in the Medicaid expansion or were leaning in that direction. Advisory Board, Where Each State Stands on ACA’s Medicaid Expansion. http://www.advisory.com/Daily-Briefing/2012/07/05/Where-each-state-stands-of-the-Medicaid-expansion (accessed online July 22, 2012).

As of July 2015, 30 states and the District of Columbia have implemented the expansion, either as originally drafted or with modifications approved by the HHS Secretary pursuant to her special demonstration authority under §1115 of the Social Security Act. In modifying the expansion, states have sought permission to charge premiums in the case of people with incomes between 100 percent and 138 percent of the federal poverty level (who would have had to pay a 2 percent premium had the state remained a non-expansion state and they had bought coverage through the Exchange). They have also sought (and have been granted) permission to trim benefits, raise cost-sharing, and (in the case of Indiana) impose a 6-month lock-out on certain beneficiaries who fail to make payments. Sara Rosenbaum and Carla Hurt, How States Are Expanding Medicaid to Low Income People Through Section 1115 Waiver Demonstrations (Commonwealth Fund, 2014) http://www.commonwealthfund.org/publications/issue-briefs/2014/dec/how-states-are-expanding-medicaid (Accessed July 18, 2015)

But many of the initial opposing Governors (especially in the South) have continued to oppose expansion. It is evident that the failure to expand will take a terrible toll, not only costing more than 3 million people (2 million in Florida and Texas alone) affordable insurance, but causing major spillover effects on the health care system, in particular the system of safety net providers serving low-income patients. One 2012 study examining the impact of states’ failure to participate in the Medicaid expansion found that non-participation could cut the projected growth of the nation’s community health
centers by some 5.3 million patients, one quarter of the planned expansion. This is because health centers’ ability to grow their capacity is directly linked to the Medicaid expansion, given their high dependence on Medicaid as a source of operational revenue. Katherine Hayes, Peter Shin, & Sara Rosenbaum, How the Supreme Court’s Decision May Affect Health Centers: An Early Estimate (George Washington University, July 19, 2012).


The Medicaid portion of the decision raised two immediate legal issues. First, how far does the Court’s bar against the Secretary’s full use of her enforcement powers reach? Second, should the Court’s decision be interpreted as altering the structure of the Medicaid statute itself, perhaps giving the Secretary additional leeway to negotiate with states in ways not contemplated when the law was enacted? For example, did the Court’s decision mean that the Secretary suddenly had new flexibility to allow states to partially expand their coverage of poor adults, say, up to 100% of the federal poverty level (or a lower level), rather than implementing the full expansion as written by Congress?

In an August, 2012 article in Health Affairs, Professors Sara Rosenbaum and Timothy Westmoreland argued that the Court’s ruling was narrow; that is, the bar against use of federal enforcement powers appears to be limited to the Medicaid adult eligibility expansion alone that, beginning in 2014, extends coverage to all nonelderly persons with incomes up to 133 percent of the federal poverty level. As a result, other ACA Medicaid amendments, such as a restructuring of the eligibility determination and enrollment process through a comprehensive simplification initiative, remained fully in effect, as did the Act’s expansion of coverage to young adults formerly in state foster care systems, and a “maintenance of effort” requirement barring reductions in existing coverage levels. Sara Rosenbaum & Timothy Westmoreland, The Supreme Court’s Surprising Decision On The Medicaid Expansion: How Will The Federal Government And States Proceed? 31 Health Affairs 8, (August 2012).

On December 10, 2012, the Centers for Medicare and Medicaid Services issued a policy statement that essentially adopted this argument. The HHS policy permits states to opt out of the adult expansion, and it also allows them to initiate their expansions after 2014 or eliminate coverage at a later point in time and still receive enhanced funding as prescribed under the Act. But the Secretary concluded that nothing in the Court’s opinion altered the underlying terms of the Medicaid statute itself; instead the decision spoke only her powers under the Social Security Act to withhold federal funding from existing programs in states that did not adopt the adult expansion. As the CMS policy concluded, because the decision did not turn the expansion group into an optional coverage category but instead simply dealt with the question of enforcement, the Secretary lacked the power to allow states to cover fewer than all adults falling within the expansion group and still qualify for the highly enhanced federal funding.
Congress of course could have decided to give states added flexibility, while still providing enhanced funding. But thus far, Congress has not chosen to do so. Why not, in your opinion?

2. The Congressional Budget Office gets it right—and wrong. In July 2012, the CBO released revised projections examining the impact of the decision on its earlier ACA cost estimates. [http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf](http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf) (Accessed online, July 29, 2012). In a nutshell, the new estimate finds that the number of persons enrolling in Medicaid by 2022 can be expected to fall by 6 million people, either because of a complete state failure to implement the expansion (leaving the poorest state residents with no access to coverage) or because states implement the expansion only partially, that is, only up to 100 percent of the federal poverty level. This projection is based on the fact that the Exchange subsidy system utilizes a 100 percent-of-poverty threshold; this means that the partial implementation states, in CBO’s view, will extend coverage under Medicaid only to the very poorest residents, leaving the less destitute (those with incomes between 100 percent and 133 percent of poverty) to rely on the Exchange.

However, this alternative pathway to coverage works only for those with incomes at 100 percent of poverty or greater. Unfortunately, as CBO also points out, only one third of the children and adults potentially ineligible for Medicaid as a result of states’ failure to implement the expansion (either fully or at all) in the wake of the decision can be expected possess incomes *high enough* to meet the Exchange 100-percent-of-poverty threshold. Two thirds are *so poor* that they cannot qualify for admission to the Exchange (think of poverty as a pre-existing condition). Furthermore, those who are fortunate enough to be less than completely and utterly destitute and who have incomes that would have qualified them for Medicaid under the ACA expansion group as drafted, will face a premium payment of 2 percent of income, which they would have been spared had they been able to secure their coverage through Medicaid.

The December 2012 CMS ruling regarding how the decision affects its powers to bend the federal Medicaid statute seems to have put an end to these CBO musings regarding partial implementation.

3. Probing underpinnings of the coercion doctrine and its future application in the wake of the Court’s holding. As presented in the opinions of the seven Justices who concluded that the Medicaid expansion was unconstitutionally coercive, the coercion doctrine appears to rest on a fundamental antipathy toward the belief that duly elected federal lawmakers should have broad powers to: (a) define a social problem as one of such national importance that reliance on state actions was no longer desirable or feasible; (b) raise the needed revenues to support a solution; (c) fashion a solution that builds on federalism; and (d) send implementation money back to the states in the form of federal grants containing conditions. This approach to federal policymaking defines the essence of social welfare spending in the U.S. over the past half century in dozens of areas: financing health care for the poor (Medicaid); cash welfare assistance to deeply disadvantaged dependent children and their caretakers (Temporary Aid to Needy
Families); the treatment of children in foster care (The Child Welfare Act); elementary and secondary education (The Elementary and Secondary Education Act); the building of highways (The National Highway Act); assuring adequate housing for low-income individuals and families (The Housing and Economic Development Act); and laws that assure that public and private entities that accept federal funding do not discriminate on the basis of race, national origin, sex, or disability and handicap (the federal civil rights laws explored in Part One).

What seems to push matters over the edge, for the Court’s majority, is Medicaid’s sheer size, an issue that, as Justice Ginsburg argues, really does not make any legal difference whatsoever in analyzing whether unconstitutional coercion exists. Medicaid’s size and importance to the U.S. health care system—reviewed at length by the Chief Justice, Justice Ginsburg, and the dissenting Justices—is a testament to countless political decisions by multiple Congresses and Presidents to establish and grow the program. And Justice Ginsburg’s questions are the right questions. How are future judges to decide (since the Chief Justice pointedly refuses to establish parameters for when the point of coercion is reached) whether an amendment to Medicaid (or to any other federal spending law for that matter) amounts to a “gun to the head” or an “economic dragooning” as a matter of law, rather than as a matter of politics? As Justice Ginsburg so aptly puts it:

When future Spending Clause challenges arrive, as they likely will in the wake of today’s decision, how will litigants and judges assess whether “a State has a legitimate choice whether to accept the federal conditions in exchange for federal funds”? Are courts to measure the number of dollars the Federal Government might withhold for noncompliance? The portion of the State’s budget at stake? And which State’s—or States’—budget is determinative: the lead plaintiff, all challenging States (26 in this case, many with quite different fiscal situations), or some national median? Does it matter that Florida, unlike most States, imposes no state income tax, and therefore might be able to replace foregone federal funds with new state revenue? Or that the coercion state officials in fact fear is punishment at the ballot box for turning down a politically popular federal grant? The coercion inquiry, therefore, appears to involve political judgments that defy judicial calculation.

Are there aspects of the unique situation presented by the Affordable Care Act—beyond Medicaid’s size—that you think might have pushed seven Justices into this unprecedented holding? The fact that the ACA provides no mechanism (other than Medicaid) to finance health care for the poor, thereby presuming universal state

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26 Federal taxation of a State’s citizens, according to the joint dissenters, may diminish a State’s ability to raise new revenue. This, in turn, could limit a State’s capacity to replace a federal program with an “equivalent” state-funded analog. But it cannot be true that “the amount of the federal taxes extracted from the taxpayers of a State to pay for the program in question is relevant in determining whether there is impermissible coercion.” When the United States Government taxes United States citizens, it taxes them “in their individual capacities” as “the people of America”—not as residents of a particular State.
participation? The fact that twenty-six states joined the lawsuit? As for the former concern, doesn’t that pretty much describe Medicaid anyway? Is there some alternative to financing health care for the poor, so that were a state to refuse to participate in Medicaid the poor residents of that state would have other options? In fact, Arizona did not participate in Medicaid until 1982 and then agreed to do so under special federal demonstration authority that allowed the state to fundamentally refashion the program from its “fee-for-service” roots into a statewide compulsory managed care system. What options for the poor existed in Arizona before that? Recall that in Thompson v Sun City (Part One) Arizona provided direct financing to hospitals and clinics to furnish indigent health care services and coupled this direct financing approach with an emergency care obligation that was a forerunner to EMTALA (discussed in Part One). So the fact that Medicaid under the ACA is the only real choice for financing health care for the poor really is nothing new: Medicaid has been the only choice for financing health care for the poor for nearly half a century.

As for the point that twenty-six states sued, Justice Scalia perhaps summed it up best when he observed during oral argument (to much courtroom laughter) that the Governors of those states must have predominantly been members of the opposite political party.

In the end, a sizable majority of the Court was willing to take a step not taken in any previous decision outside of cases involving the commandeering of state enforcement powers (a fact established in both Printz v U.S. and New York v U.S. as noted in the opinions). It set some limitation on Congressional powers to tax and spend, a stopping point that supposedly reflects the concept of federalism embodied in the Tenth Amendment. Where that stopping point is, we don’t know. The floor seems to be .5 percent of state budgets, and the ceiling, 10 percent of total state spending. A second way of looking at the floor is that it is characterized as a revision to an “existing” program rather than a “new” program that is different “in kind” but not “degree.” Good luck with defining that.

How many times the coercion doctrine will be invoked in “new” programs invoking the Spending Power we also don’t know. Indeed, the impact of the Court’s decision may be to lock all federal spending programs into some strange status quo, in which future efforts to update or revise applicable conditions of participation will hinge on the federal government’s willingness to invoke only a mild remedy (e.g., the loss of new funding) if states that fail to implement the reforms.

Imagine that you are the Legislative Counsel to the House Commerce Committee, which has jurisdiction over Medicaid and other federal grant-in-aid programs. How would you explain the impact of the Court’s ruling, and what legislative remedies might you identify as still viable in the wake of its decision, in the case of non-compliance by a state that accepts federal funding?

4. The eternal problem of Medicaid enforcement. Recall the decision in Douglas (Part Two, p. 537). The ultimate paradox of the Medicaid coercion analysis in NFIB v
Sebelius is the specter of government crackdown on recalcitrant states, compared to the reality of federal Medicaid enforcement powers. Douglas concerned a group of providers and beneficiaries who sued under the Supremacy Clause to enforce federal standards regarding access to Medicaid services in the face of the federal government’s utter failure to enforce one particular provision of existing Medicaid law (the so-called “equal access” provision) against a state when it implemented deep reductions in Medicaid payments. In that case, a group of former HHS officials filed a powerful brief, arguing that private enforcement rights were crucial, in light of the fact that HHS had neither the human nor financial resources to assure state compliance with federal law. And of course, where the state’s non-compliance involves not spending money that the federal government wants it to spend (e.g., not covering certain persons, not paying providers sufficiently, not covering a required benefit), the federal government is in even a bigger pickle. There really are no good remedies when a state refuses to spend in its Medicaid program what it is supposed to spend. The only realistic remedy is to replace Medicaid with a federal program over which the federal government has the unalloyed power to make the investments required by law. This is likely to happen when it snows in July.

Beyond the fact of failed federal enforcement is the reality of the Medicaid enforcement statute itself. The provision at issue, 42 U.S.C. § 1396c, expressly authorizes the Secretary, in her discretion, to limit federal payments “to categories under or parts of the State plan not affected by such failure.” In other words, the statute explicitly recognizes federal remedies far more gentle than a full withholding of federal funds; indeed, such a remedy is unthinkable in light of the harm it would cause Medicaid beneficiaries and the providers that serve them. Furthermore, as Justice Breyer pointed out during oral argument (Oral Argument Tr. 10–14, March 28, 2012), were the Secretary ever to withhold all federal Medicaid funding, the reasonableness of her actions would be subject to close judicial scrutiny under the Administrative Procedures Act. Given the seeming failure of Medicaid enforcement, the attempt to characterize the federal government as a draconian presence in the lives of weak states, whose entire budgets are at risk, seems especially curious.

5. Medicaid mandates v Medicaid options. If the Court is right in noting that its decision changes nothing about the structure of the statute, merely the enforcement powers of the federal government, then imagine this: It is 2014, and you are a nonelderly low-income adult in Texas, who would have been entitled to Medicaid under the expansion. The state has refused to implement the expansion. Consistent with the principles of private enforcement of government-conferrned rights discussed earlier in Part Two, would you have a right of action under 42 U.S.C. §1983 to enforce your entitlement to coverage? If not, why not?

6. A final a reminder about Medicaid’s importance. The Medicaid materials earlier in Part Two explore the challenges the program has faced over its nearly 50 years of existence. But it is worth remembering—especially in light of the CBO estimates regarding the impact of the decision on Medicaid expansion—Medicaid’s impact on access to health care and health outcomes. A study published in the New England Journal of Medicine in July 2012 underscores this point. The authors found a statistically

7. The limits of the Medicaid unconstitutional coercion argument begin to come into view. In addition to rejecting coverage of nonelderly low income adults ages 18-64 (aka, the adult Medicaid expansion)—and thereby leaving over 20,000 poor adults (approximately one-sixth of the state’s uninsured residents) without coverage, http://kff.org/health-reform/fact-sheet/state-profiles-uninsured-under-aca-maine/ (accessed July 10, 2015), the state of Maine also attempted to eliminate coverage for 19 and 20-year-old adolescents, whom the state had covered prior to passage of the Affordable Care Act. Since 1991 in fact, Maine had covered these adolescents as “optional categorically needy” beneficiaries, meaning that they were as poor as the mandatory coverage group of children up to age 18, but coverage was an option with states under the traditional Medicaid program as it existed prior to the expansion. Under traditional Medicaid eligibility principles, therefore, adolescents were treated as children.

The Affordable Care Act added a “maintenance of effort” requirement to Medicaid, 42 U.S.C. §1396a(gg). The ACA maintenance of effort provision, which builds on an earlier provision contained in the American Recovery and Reinvestment Act, (Pub. L. 111-5, 111th Cong., 1st Sess.), bars Medicaid-participating states from reducing children’s coverage until October 1, 2019. (The Recovery Act tied its maintenance of effort requirement to the receipt of additional Medicaid funding as part of the economic stimulus package; in order to receive these funds, participating states had to maintain their existing eligibility standards.)

The purpose of the ACA extension amendment was to ensure that states would not eliminate Medicaid coverage of children and adolescents who met pre-ACA eligibility criteria (which in many states exceeded the threshold income eligibility standard for federal premium subsidies) in favor of coverage through the Exchange, which is less generous than Medicaid, particularly for children. Hence, due to the maintenance of effort provision, Maine could not eliminate coverage of the “optional” 19 and 20-year-olds. As far as Maine was concerned however, the ACA adult Medicaid expansion (which it refused to adopt) converted this optional group of older children into part of the new adult expansion population, which Maine refused to cover, as was its right after NFIB v Sebelius. Furthermore, the LePage Administration simply had no
interest in continuing coverage for optional adolescents. To make matters more infuriating to Governor LePage, because the Administration treated older adolescents as part of a “traditional” optional population, rather than as part of the expansion group, their coverage qualified only for the standard federal Medicaid contribution, which in Maine’s case is about 60 percent of every dollar spent by the state, compared to 100 percent for the Medicaid expansion population over the 2014-2016 time period, eventually declining slightly to 90 percent federal funding by 2020.

In Mayhew v Burwell, 772 F.3d 80 (1st Cir. 2014), cert. den. 2015 WL 686884, U.S. (June 08, 2015), the United States Court of Appeals for the First Circuit rejected Maine’s argument that the maintenance of effort provision amounted to unconstitutional coercion. In reviewing both the plurality decision and the dissenting view regarding Medicaid coercion in NFIB, the court concluded that not only did Maine’s argument fail, but that “the plurality opinion precludes us from finding that there is a Spending Clause problem with §1396gg.” 772 F. 3d 80, 89. According to the court, for a Medicaid provision to amount to an unconstitutional coercion, two conditions would need to be present under the narrower plurality opinion in NFIB: “(1) that the expansion placed a condition on the receipt of funds that did not govern the use of those funds, and (2) that the condition was unduly coercive.” Id at 88.

In applying the coercion test, the court determined that the maintenance of effort provision applied “to the long-standing provision of care to 19- and 20-year-olds, [which] unlike the new Medicaid program expansion first appearing in the ACA, is not a new program. It is simply an unexceptional alteration of the boundaries of the categories of individuals covered under the old Medicaid program, completely analogous to the many past alterations of the program that NFIB expressly found to be constitutional.” Id. at 89. Low income children under 21 represent a population “that has historically been covered by Medicaid.” Id. Thus, Maine’s payment for that population was independent from its choice whether to accept the expansion.

Maine attempted to rebut this position, arguing that in fact, coverage of 19 and 20 year olds (recall, that federal Medicaid law traditionally classified these people as children) was an “integral part” of the adult expansion, which classifies the new coverage group as individuals ages 18-64 who meet the income eligibility standard of 138 percent of the federal poverty level. In other words, Maine tried to argue that the ACA effectively turned a traditional group into part of the expansion group, thereby allowing the state to bootstrap itself into the territory of unconstitutional coercion. The court rebuffed this argument, noting that nothing in the ACA even touched on the maintenance of effort provision or in any way altered the traditional rules by which states had extended eligibility to a group classified as children since 1965. Indeed, the maintenance of effort provision, the court noted, was set to last for only 9 years; it was time-limited. The adult expansion, by contrast, has no end date.*

* A policy issuance from HHS in the wake of NFIB makes clear that the effect of the Court’s decision means that states that do expand their programs to cover all low income nonelderly adults can eliminate
The state next tried to argue that the maintenance of effort provision effectively turned what had previously been an optional expansion group into a mandatory group, thereby subjecting the state to the loss of all federal funding for its refusal to cover a new mandatory group. But, as the court pointed out, Congress previously did exactly that in the case of children and pregnant women, converting what had been optional groups into mandatory coverage groups, without running afoul of the Constitution. As the court noted, “the *NFIB* plurality expressly said Congress is allowed to do so, so long as the change effected by the expansion is a shift in degree rather than a shift in kind.” Id. at 92.

To Maine’s argument that the maintenance of effort provision is inherently coercive because Maine has no choice but to participate in Medicaid, the court countered that this was not, in fact, the coercion test adopted by the *NFIB* plurality. The plurality simply did not hold that the requirements of the traditional Medicaid program are coercive.

Maine further argued that application of the maintenance of effort mandate, which had the effect of turning a previously optional coverage group into a mandatory group, violated the anti-retroactivity principle embodied in *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1 (1981). The court’s response to this assertion was that, as Justices Ginsburg and Sotomayor argued in their dissent in *NFIB*, throughout the program’s existence Congress has expressly reserved the right to alter and amend Medicaid. “Here, Congress . . . merely required that states continue providing coverage to children on the same terms as were in effect on the date of the ACA’s passage. Maine . . . appears to argue that it could not have foreseen that in exchange for stimulus funds it would be locked into those coverage levels at a later time. But this modest change falls within the Medicaid Act’s broad reservation clause. Maine was on notice, before and after accepting stimulus funds, that an incremental alteration of Medicaid might change the conditions of participation in the Medicaid program in the way that §1396gg has. Put differently, Maine was not unaware of the conditions on its participation in Medicaid or unable to ascertain what was expected of it.” Id. at 93.

Finally, the court rejected Maine’s argument, drawn from *Shelby County v Holder*, 133 S. Ct. 2612 (2013), which involved the constitutionality of §§4 and 5 of the Voting Rights Act of 1965, which identifies certain states that must comply with preclearance requirements prior to altering their voting procedures. Maine took the position that, like the preclearance requirement, the Medicaid maintenance of effort requirement violated its right to equal sovereignty to design its program as other states do. Stating that the state’s position “failed at every step of the analysis,” the court noted that nothing in §1396gg singled any state out for disparate treatment, nor is the requirement a federal intrusion into a sensitive area of state or local policymaking, nor does application of the statute result in disparate treatment, since the statute’s requirement was simply meant to fix a

problem that it was designed to address, namely, how to encourage states to cover low income children.

So where does this leave things? Basically, changes in federal requirements that are perceived by the courts as alterations in the traditional program’s terms of eligibility, coverage, and other conditions of federal financial participation can be enforced on a mandatory basis because they amount to shifts in degree, not kind, simply tinker around the edges as it were, and thus fall within the Medicaid statute’s historic notice rules. But changes in the law that fall outside of these parameters—wherever they might begin and end—have the potential to fail the coercion test. In truth, most long-time observers of Medicaid would say that as a policy and practical matter, the adult expansion was in a class of its own; that is, the expansion amounted to a re-purposing of Medicaid well beyond its traditional roots. However, this does not render the NFIB plurality opinion sound; indeed, as a matter of law, this profound re-purposing simply entailed adding one new mandatory coverage group to a long list of other mandatory groups, and paying enormous sums to boot in order to ease the path to state adoption. As a matter of policy, the addition of all poor adults was profound; as a legal matter, it was just one of literally thousands of Medicaid amendments enacted over the five decades of Medicaid’s existence.
Second Postscript to Part Two: *King v. Burwell*, the ongoing saga over contraception coverage, and federalism in enforcement

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1. Are people who enroll through the federal Marketplace entitled to tax subsidies?

*King v Burwell*

2015 WL 2473448

Chief Justice ROBERTS delivered the opinion of the Court.

The Patient Protection and Affordable Care Act adopts a series of interlocking reforms designed to expand coverage in the individual health insurance market. First, the Act bars insurers from taking a person’s health into account when deciding whether to sell health insurance or how much to charge. Second, the Act generally requires each person to maintain insurance coverage or make a payment to the Internal Revenue Service. And third, the Act gives tax credits to certain people to make insurance more affordable.

In addition to those reforms, the Act requires the creation of an “Exchange” in each State—basically, a marketplace that allows people to compare and purchase insurance plans. The Act gives each State the opportunity to establish its own Exchange, but provides that the Federal Government will establish the Exchange if the State does not.

This case is about whether the Act’s interlocking reforms apply equally in each State no matter who establishes the State’s Exchange. Specifically, the question presented is whether the Act’s tax credits are available in States that have a Federal Exchange.

I

A

The Patient Protection and Affordable Care Act grew out of a long history of failed health insurance reform. In the 1990s, several States began experimenting with ways to expand people’s access to coverage. One common approach was to impose a pair of insurance market regulations—a “guaranteed issue” requirement, which barred insurers from denying coverage to any person because of his health, and a “community
rating” requirement, which barred insurers from charging a person higher premiums for the same reason. Together, those requirements were designed to ensure that anyone who wanted to buy health insurance could do so.

The guaranteed issue and community rating requirements achieved that goal, but they had an unintended consequence: They encouraged people to wait until they got sick to buy insurance. Why buy insurance coverage when you are healthy, if you can buy the same coverage for the same price when you become ill? This consequence—known as “adverse selection”—led to a second: Insurers were forced to increase premiums to account for the fact that, more and more, it was the sick rather than the healthy who were buying insurance. And that consequence fed back into the first: As the cost of insurance rose, even more people waited until they became ill to buy it.

This led to an economic “death spiral.” As premiums rose higher and higher, and the number of people buying insurance sank lower and lower, insurers began to leave the market entirely. As a result, the number of people without insurance increased dramatically.

This cycle happened repeatedly during the 1990s. For example, in 1993, the State of Washington reformed its individual insurance market by adopting the guaranteed issue and community rating requirements. Over the next three years, premiums rose by 78 percent and the number of people enrolled fell by 25 percent. By 1999, 17 of the State’s 19 private insurers had left the market, and the remaining two had announced their intention to do so.

For another example, also in 1993, New York adopted the guaranteed issue and community rating requirements. Over the next few years, some major insurers in the individual market raised premiums by roughly 40 percent. By 1996, these reforms had effectively eliminated the commercial individual indemnity market in New York with the largest individual health insurer exiting the market.

In 1996, Massachusetts adopted the guaranteed issue and community rating requirements and experienced similar results. But in 2006, Massachusetts added two more reforms: The Commonwealth required individuals to buy insurance or pay a penalty, and it gave tax credits to certain individuals to ensure that they could afford the insurance they were required to buy. The combination of these three reforms—insurance market regulations, a coverage mandate, and tax credits—reduced the uninsured rate in Massachusetts to 2.6 percent, by far the lowest in the Nation.

B

The Affordable Care Act adopts a version of the three key reforms that made the Massachusetts system successful. First, the Act adopts the guaranteed issue and community rating requirements. The Act also bars insurers from charging higher premiums on the basis of a person’s health.
Second, the Act generally requires individuals to maintain health insurance coverage or make a payment to the IRS. Congress recognized that, without an incentive, many individuals would wait to purchase health insurance until they needed care. So Congress adopted a coverage requirement to minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. In Congress’s view, that coverage requirement was essential to creating effective health insurance markets. Congress also provided an exemption from the coverage requirement for anyone who has to spend more than eight percent of his income on health insurance.

Third, the Act seeks to make insurance more affordable by giving refundable tax credits to individuals with household incomes between 100 percent and 400 percent of the federal poverty line. Individuals who meet the Act’s requirements may purchase insurance with the tax credits, which are provided in advance directly to the individual’s insurer.

These three reforms are closely intertwined. As noted, Congress found that the guaranteed issue and community rating requirements would not work without the coverage requirement. And the coverage requirement would not work without the tax credits. The reason is that, without the tax credits, the cost of buying insurance would exceed eight percent of income for a large number of individuals, which would exempt them from the coverage requirement. Given the relationship between these three reforms, the Act provided that they should take effect on the same day—January 1, 2014.

C

In addition to those three reforms, the Act requires the creation of an “Exchange” in each State where people can shop for insurance, usually online. An Exchange may be created in one of two ways. First, the Act provides that “[e]ach State shall . . . establish an American Health Benefit Exchange . . . . for the State.” [42 U.S.C. §18031(a)]. Second, if a State nonetheless chooses not to establish its own Exchange, the Act provides that the Secretary of Health and Human Services “shall . . . establish and operate such Exchange within the State.” [42 U.S.C. §18041(c)(1)].

The issue in this case is whether the Act’s tax credits are available in States that have a Federal Exchange rather than a State Exchange. The Act initially provides that tax credits “shall be allowed” for any “applicable taxpayer.” 26 U.S.C. §36B(a). The Act then provides that the amount of the tax credit depends in part on whether the taxpayer has enrolled in an insurance plan through “an Exchange established by the State” under section 1311 of the Patient Protection and Affordable Care Act [hereinafter 42 U.S.C. § 18031].” 26 U.S.C. §§ 36B(b)-(c) (emphasis added).

The IRS addressed the availability of tax credits by promulgating a rule that made them available on both State and Federal Exchanges. As relevant here, the IRS Rule provides that a taxpayer is eligible for a tax credit if he enrolled in an insurance plan through “an Exchange,” 26 CFR § 1.36B–2 (2013), which is defined as “an Exchange
serving the individual market . . . . regardless of whether the Exchange is established and operated by a State . . . . or by HHS,” 45 CFR §155.20 (2014). At this point, 16 States and the District of Columbia have established their own Exchanges; the other 34 States have elected to have HHS do so.

D

Petitioners are four individuals who live in Virginia, which has a Federal Exchange. They do not wish to purchase health insurance. In their view, Virginia’s Exchange does not qualify as an Exchange established by the State, so they should not receive any tax credits. That would make the cost of buying insurance more than eight percent of their income, which would exempt them from the Act’s coverage requirement.

Under the IRS Rule, however, Virginia’s Exchange would qualify as “an Exchange established by the State” so petitioners would receive tax credits. That would make the cost of buying insurance less than eight percent of petitioners’ income, which would subject them to the Act’s coverage requirement. The IRS Rule therefore requires petitioners to either buy health insurance they do not want, or make a payment to the IRS.

Petitioners challenged the IRS Rule in Federal District Court. The District Court dismissed the suit, holding that the Act unambiguously made tax credits available to individuals enrolled through a Federal Exchange. The Court of Appeals for the Fourth Circuit affirmed. The Fourth Circuit viewed the Act as ambiguous and subject to at least two different interpretations. The court therefore deferred to the IRS’s interpretation under Chevron U.S.A. Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).

The same day that the Fourth Circuit issued its decision, the Court of Appeals for the District of Columbia Circuit vacated the IRS Rule in a different case, holding that the Act “unambiguously restricts” the tax credits to State Exchanges. Halbig v. Burwell. We granted certiorari in the present case.

II

The Affordable Care Act addresses tax credits in what is now Section 36B of the Internal Revenue Code. That section provides: “In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle . . . an amount equal to the premium assistance credit amount.” 26 U.S.C. § 36B(a). Section 36B then defines the term “premium assistance credit amount” as “the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.” §36B(b)(1) (emphasis added). Section 36B goes on to define the two italicized terms—“premium assistance amount” and “coverage month”—in part by referring to an insurance plan that is enrolled in through “an Exchange established by the State under [42 U.S.C. § 18031].” 26 U.S.C. §§36B(b)(2)(A), (c)(2)(A)(i).
The parties dispute whether Section 36B authorizes tax credits for individuals who enroll in an insurance plan through a Federal Exchange. Petitioners argue that a Federal Exchange is not “an Exchange established by the State under [42 U.S.C. §18031],” and that the IRS Rule therefore contradicts Section 36B. The Government responds that the IRS Rule is lawful because the phrase “an Exchange established by the State under [42 U.S.C. §18031]” should be read to include Federal Exchanges.

When analyzing an agency’s interpretation of a statute, we often apply the two-step framework announced in Chevron. Under that framework, we ask whether the statute is ambiguous and, if so, whether the agency’s interpretation is reasonable. This approach “is premised on the theory that a statute’s ambiguity constitutes an implicit delegation from Congress to the agency to fill in the statutory gaps.” FDA v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 159 (2000). In extraordinary cases, however, there may be reason to hesitate before concluding that Congress has intended such an implicit delegation.

This is one of those cases. The tax credits are among the Act’s key reforms, involving billions of dollars in spending each year and affecting the price of health insurance for millions of people. Whether those credits are available on Federal Exchanges is thus a question of deep “economic and political significance” that is central to this statutory scheme; had Congress wished to assign that question to an agency, it surely would have done so expressly. Utility Air Regulatory Group v. EPA, 573 U.S. ——, ——— (2014). It is especially unlikely that Congress would have delegated this decision to the IRS, which has no expertise in crafting health insurance policy of this sort. This is not a case for the IRS.

It is instead our task to determine the correct reading of Section 36B. If the statutory language is plain, we must enforce it according to its terms. But oftentimes the meaning—or ambiguity—of certain words or phrases may only become evident when placed in context. So when deciding whether the language is plain, we must read the words in their context and with a view to their place in the overall statutory scheme.

A

We begin with the text of Section 36B. As relevant here, Section 36B allows an individual to receive tax credits only if the individual enrolls in an insurance plan through “an Exchange established by the State under [42 U.S.C. §18031].” In other words, three things must be true: First, the individual must enroll in an insurance plan through “an Exchange.” Second, that Exchange must be “established by the State.” And third, that Exchange must be established “under [42 U.S.C. § 18031].” We address each requirement in turn.

First, all parties agree that a Federal Exchange qualifies as “an Exchange” for purposes of Section 36B. Section 18031 provides that “[e]ach State shall . . . establish an American Health Benefit Exchange . . . for the State.” §18031(b)(1). Although phrased as a requirement, the Act gives the States “flexibility” by allowing them to “elect” whether
they want to establish an Exchange. §18041(b). If the State chooses not to do so, §18041 provides that the Secretary “shall . . . establish and operate such Exchange within the State.” §18041(c)(1) (emphasis added).

By using the phrase “such Exchange,” §18041 instructs the Secretary to establish and operate the same Exchange that the State was directed to establish under §18031. In other words, State Exchanges and Federal Exchanges are equivalent—they must meet the same requirements, perform the same functions, and serve the same purposes. Although State and Federal Exchanges are established by different sovereigns, §§18031 and 18041 do not suggest that they differ in any meaningful way. A Federal Exchange therefore counts as “an Exchange” under §36B.

Second, we must determine whether a Federal Exchange is “established by the State” for purposes of §36B. At the outset, it might seem that a Federal Exchange cannot fulfill this requirement. After all, the Act defines “State” to mean “each of the 50 States and the District of Columbia”—a definition that does not include the Federal Government. 42 U.S.C. §18024(d). But when read in context, “with a view to [its] place in the overall statutory scheme,” the meaning of the phrase “established by the State” is not so clear.

After telling each State to establish an Exchange, §18031 provides that all Exchanges “shall make available qualified health plans to qualified individuals.” Section 18032 then defines the term “qualified individual” in part as an individual who “resides in the State that established the Exchange.” §18032(f)(1)(A). And that’s a problem: If we give the phrase “the State that established the Exchange” its most natural meaning, there would be no “qualified individuals” on Federal Exchanges. But the Act clearly contemplates that there will be qualified individuals on every Exchange. As we just mentioned, the Act requires all Exchanges to “make available qualified health plans to qualified individuals”—something an Exchange could not do if there were no such individuals. §18031(d)(2)(A). And the Act tells the Exchange, in deciding which health plans to offer, to consider “the interests of qualified individuals . . . in the State or States in which such Exchange operates”—again, something the Exchange could not do if qualified individuals did not exist. §18031(e)(1)(B). This problem arises repeatedly throughout the Act. See, e.g., §18031(b)(2) (allowing a State to create “one Exchange . . . for providing . . . services to both qualified individuals and qualified small employers,” rather than creating separate Exchanges for those two groups).1

These provisions suggest that the Act may not always use the phrase “established by the State” in its most natural sense. Thus, the meaning of that phrase may not be as clear as it appears when read out of context.

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1 The dissent argues that one would “naturally read instructions about qualified individuals to be inapplicable to the extent a particular Exchange has no such individuals.” But the fact that the dissent’s interpretation would make so many parts of the Act “inapplicable” to Federal Exchanges is precisely what creates the problem. It would be odd indeed for Congress to write such detailed instructions about customers on a State Exchange, while having nothing to say about those on a Federal Exchange.
Third, we must determine whether a Federal Exchange is established “under [42 U.S.C. §18031].” This too might seem a requirement that a Federal Exchange cannot fulfill, because it is §18041 that tells the Secretary when to “establish and operate such Exchange.” But here again, the way different provisions in the statute interact suggests otherwise.

The Act defines the term “Exchange” to mean “an American Health Benefit Exchange established under section 18031.” If we import that definition into §18041, the Act tells the Secretary to “establish and operate such ‘American Health Benefit Exchange established under §18031.’” That suggests that §18041 authorizes the Secretary to establish an Exchange under §18031, not (or not only) under §18041. Otherwise, the Federal Exchange, by definition, would not be an “Exchange” at all.

This interpretation of “under [42 U.S.C. § 18031]” fits best with the statutory context. All of the requirements that an Exchange must meet are in §18031, so it is sensible to regard all Exchanges as established under that provision. In addition, every time the Act uses the word “Exchange,” the definitional provision requires that we substitute the phrase “Exchange established under §18031.” If Federal Exchanges were not established under Section 18031, therefore, literally none of the Act’s requirements would apply to them. Finally, the Act repeatedly uses the phrase “established under [42 U.S.C. §18031]” in situations where it would make no sense to distinguish between State and Federal Exchanges. See, e.g., 26 U.S.C. §125(f)(3)(A) (“The term ‘qualified benefit’ shall not include any qualified health plan . . . offered through an Exchange established under [42 U.S.C. §18031]); 26 U.S.C. §6055(b)(1)(B)(iii)(I) (requiring insurers to report whether each insurance plan they provided “is a qualified health plan offered through an Exchange established under [42 U.S.C. §18031].”). A Federal Exchange may therefore be considered one established “under [42 U.S.C. §18031].”

The upshot of all this is that the phrase “an Exchange established by the State under [42 U.S.C. § 18031]” is properly viewed as ambiguous. The phrase may be limited in its reach to State Exchanges. But it is also possible that the phrase refers to all Exchanges—both State and Federal—at least for purposes of the tax credits. If a State chooses not to follow the directive in §18031 that it establish an Exchange, the Act tells the Secretary to establish “such Exchange.” §18041. And by using the words “such Exchange,” the Act indicates that State and Federal Exchanges should be the same. But State and Federal Exchanges would differ in a fundamental way if tax credits were available only on State Exchanges—one type of Exchange would help make insurance more affordable by providing billions of dollars to the States’ citizens; the other type of Exchange would not.2

2 The dissent argues that the phrase “such Exchange” does not suggest that State and Federal Exchanges “are in all respects equivalent.” In support, it quotes the Constitution’s Elections Clause, which makes the state legislature primarily responsible for prescribing election regulations, but allows Congress to “make or alter such Regulations.” No one would say that state and federal election regulations are in all respects equivalent, the dissent contends, so we should not say that State and Federal Exchanges are. But the Elections Clause does not precisely define what an election regulation must look like, so Congress can prescribe regulations that differ from what the State would prescribe. The Affordable Care Act does
The conclusion that §36B is ambiguous is further supported by several provisions that assume tax credits will be available on both State and Federal Exchanges. For example, the Act requires all Exchanges to create outreach programs that must “distribute fair and impartial information concerning . . . the availability of premium tax credits under section 36B,” §18031(i)(3)(B). The Act also requires all Exchanges to “establish and make available by electronic means a calculator to determine the actual cost of coverage after the application of any premium tax credit under section 36B.” §18031(d)(4)(G). And the Act requires all Exchanges to report to the Treasury Secretary information about each health plan they sell, including the “aggregate amount of any advance payment of such credit,” “[a]ny information . . . necessary to determine eligibility for, and the amount of, such credit,” and any “[i]nformation necessary to determine whether a taxpayer has received excess advance payments.” 26 U.S.C. §36B(f)(3). If tax credits were not available on Federal Exchanges, these provisions would make little sense.

Petitioners and the dissent respond that the words “established by the State” would be unnecessary if Congress meant to extend tax credits to both State and Federal Exchanges. But our preference for avoiding surplusage constructions is not absolute. The canon against surplusage is not an absolute rule. And specifically with respect to this Act, rigorous application of the canon does not seem a particularly useful guide to a fair construction of the statute.

The Affordable Care Act contains more than a few examples of inartful drafting. Several features of the Act’s passage contributed to that unfortunate reality. Congress wrote key parts of the Act behind closed doors, rather than through the traditional legislative process. And Congress passed much of the Act using a complicated budgetary procedure known as “reconciliation,” which limited opportunities for debate and amendment, and bypassed the Senate’s normal 60–vote filibuster requirement. As a result, the Act does not reflect the type of care and deliberation that one might expect of such significant legislation.

Anyway, we must do our best, bearing in mind the fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme. After reading Section 36B along with other related provisions in the Act, we cannot conclude that the phrase “an Exchange established by the State under [Section 18031]” is unambiguous.

**B**

Given that the text is ambiguous, we must turn to the broader structure of the Act to determine the meaning of Section 36B. Here, the statutory scheme compels us to reject petitioners’ interpretation because it would destabilize the individual insurance market in

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*precisely define what an Exchange must look like, however, so a Federal Exchange cannot differ from a State Exchange*
any State with a Federal Exchange, and likely create the very “death spirals” that Congress designed the Act to avoid.

As discussed above, Congress based the Affordable Care Act on three major reforms: first, the guaranteed issue and community rating requirements; second, a requirement that individuals maintain health insurance coverage or make a payment to the IRS; and third, the tax credits for individuals with household incomes between 100 percent and 400 percent of the federal poverty line. In a State that establishes its own Exchange, these three reforms work together to expand insurance coverage. The guaranteed issue and community rating requirements ensure that anyone can buy insurance; the coverage requirement creates an incentive for people to do so before they get sick; and the tax credits—it is hoped—make insurance more affordable. Together, those reforms “minimize . . . adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums.”

Under petitioners’ reading, however, the Act would operate quite differently in a State with a Federal Exchange. As they see it, one of the Act’s three major reforms—the tax credits—would not apply. And a second major reform—the coverage requirement—would not apply in a meaningful way. As explained earlier, the coverage requirement applies only when the cost of buying health insurance (minus the amount of the tax credits) is less than eight percent of an individual’s income. So without the tax credits, the coverage requirement would apply to fewer individuals. And it would be a lot fewer. In 2014, approximately 87 percent of people who bought insurance on a Federal Exchange did so with tax credits, and virtually all of those people would become exempt.

The combination of no tax credits and an ineffective coverage requirement could well push a State’s individual insurance market into a death spiral. One study predicts that premiums would increase by 47 percent and enrollment would decrease by 70 percent. E. Saltzman & C. Eibner, The Effect of Eliminating the Affordable Care Act’s Tax Credits in Federally Facilitated Marketplaces (2015). Another study predicts that premiums would increase by 35 percent and enrollment would decrease by 69 percent. L. Blumberg, M. Buettgens, & J. Holahan, The Implications of a Supreme Court Finding for the Plaintiff in King vs. Burwell: 8.2 Million More Uninsured and 35% Higher Premiums (2015). And those effects would not be limited to individuals who purchase insurance on the Exchanges. Because the Act requires insurers to treat the entire individual market as a single risk pool, 42 U.S.C. §18032(c)(1), premiums outside the Exchange would rise along with those inside the Exchange.

It is implausible that Congress meant the Act to operate in this manner. See National Federation of Independent Business v. Sebelius (SCALIA, KENNEDY, THOMAS, and ALITO, JJ., dissenting) (“Without the federal subsidies . . . the exchanges would not operate as Congress intended and may not operate at all.”). Congress made the guaranteed issue and community rating requirements applicable in every State in the Nation. But those requirements only work when combined with the coverage requirement
and the tax credits. So it stands to reason that Congress meant for those provisions to apply in every State as well.\footnote{The dissent argues that our analysis “show[s] only that the statutory scheme contains a flaw,” one “that appeared as well in other parts of the Act.” For support, the dissent notes that the guaranteed issue and community rating requirements might apply in the federal territories, even though the coverage requirement does not. The confusion arises from the fact that the guaranteed issue and community rating requirements were added as amendments to the Public Health Service Act, which contains a definition of the word “State” that includes the territories, while the later-enacted Affordable Care Act contains a definition of the word “State” that excludes the territories. The predicate for the dissent’s point is therefore uncertain at best. The dissent also notes that a different part of the Act “established a long-term-care insurance program with guaranteed-issue and community-rating requirements, but without an individual mandate or subsidies.” True enough. But the fact that Congress was willing to accept the risk of adverse selection in a comparatively minor program does not show that Congress was willing to do so in the general health insurance program—the very heart of the Act. Moreover, Congress said expressly that it wanted to avoid adverse selection in the health insurance markets. § 18091(2)(I).}

Petitioners respond that Congress was not worried about the effects of withholding tax credits from States with Federal Exchanges because “Congress evidently believed it was offering states a deal they would not refuse.” Congress may have been wrong about the States’ willingness to establish their own Exchanges, petitioners continue, but that does not allow this Court to rewrite the Act to fix that problem. That is particularly true, petitioners conclude, because the States likely would have created their own Exchanges in the absence of the IRS Rule, which eliminated any incentive that the States had to do so.

Section 18041 refutes the argument that Congress believed it was offering the States a deal they would not refuse. That section provides that, if a State elects not to establish an Exchange, the Secretary “shall . . . establish and operate such Exchange within the State.” 42 U.S.C. §18041(c)(1)(A). The whole point of that provision is to create a federal fallback in case a State chooses not to establish its own Exchange. Contrary to petitioners’ argument, Congress did not believe it was offering States a deal they would not refuse—it expressly addressed what would happen if a State did refuse the deal.

Finally, the structure of Section 36B itself suggests that tax credits are not limited to State Exchanges. Section 36B(a) initially provides that tax credits “shall be allowed” for any “applicable taxpayer.” Section 36B(c)(1) then defines an “applicable taxpayer” as someone who (among other things) has a household income between 100 percent and 400 percent of the federal poverty line. Together, these two provisions appear to make anyone in the specified income range eligible to receive a tax credit.

According to petitioners, however, those provisions are an empty promise in States with a Federal Exchange. In their view, an applicable taxpayer in such a State would be eligible for a tax credit—but the amount of that tax credit would always be zero. And that is because—diving several layers down into the Tax Code—Section 36B says that the amount of the tax credits shall be “an amount equal to the premium assistance
credit amount,” §36B(a); and then says that the term “premium assistance credit amount” means “the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year,” §36B(b)(1); and then says that the term “premium assistance amount” is tied to the amount of the monthly premium for insurance purchased on “an Exchange established by the State under [42 U.S.C. § 18031],” § 36B(b)(2); and then says that the term “coverage month” means any month in which the taxpayer has insurance through “an Exchange established by the State under [42 U.S.C. § 18031],” §36B(c)(2)(A)(i).

We have held that Congress does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions. But in petitioners’ view, Congress made the viability of the entire Affordable Care Act turn on the ultimate ancillary provision: a sub-sub-sub section of the Tax Code. We doubt that is what Congress meant to do. Had Congress meant to limit tax credits to State Exchanges, it likely would have done so in the definition of “applicable taxpayer” or in some other prominent manner. It would not have used such a winding path of connect-the-dots provisions about the amount of the credit. 5

D

Petitioners’ arguments about the plain meaning of Section 36B are strong. But while the meaning of the phrase “an Exchange established by the State under [42 U.S.C. § 18031]” may seem plain when viewed in isolation, such a reading turns out to be “untenable in light of [the statute] as a whole.” In this instance, the context and structure of the Act compel us to depart from what would otherwise be the most natural reading of the pertinent statutory phrase.

Reliance on context and structure in statutory interpretation is a subtle business, calling for great wariness lest what professes to be mere rendering becomes creation and attempted interpretation of legislation becomes legislation itself. For the reasons we have given, however, such reliance is appropriate in this case, and leads us to conclude that Section 36B allows tax credits for insurance purchased on any Exchange created under the Act. Those credits are necessary for the Federal Exchanges to function like their State Exchange counterparts, and to avoid the type of calamitous result that Congress plainly meant to avoid.

In a democracy, the power to make the law rests with those chosen by the people. Our role is more confined—“to say what the law is.” Marbury v. Madison. That is easier in some cases than in others. But in every case we must respect the role of the Legislature, and take care not to undo what it has done. A fair reading of legislation demands a fair understanding of the legislative plan.

5 The dissent cites several provisions that “make[ ] taxpayers of all States eligible for a credit, only to provide later that the amount of the credit may be zero.” None of those provisions, however, is crucial to the viability of a comprehensive program like the Affordable Care Act. No one suggests, for example, that the first-time-homebuyer tax credit, §36, is essential to the viability of federal housing regulation.
Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter. Section 36B can fairly be read consistent with what we see as Congress’s plan, and that is the reading we adopt.

The judgment of the United States Court of Appeals for the Fourth Circuit is Affirmed.

Justice SCALIA, with whom Justice THOMAS and ALITO join, dissenting.

The Court holds that when the Patient Protection and Affordable Care Act says “Exchange established by the State” it means “Exchange established by the State or the Federal Government.” That is of course quite absurd, and the Court’s 21 pages of explanation make it no less so.

I

The Patient Protection and Affordable Care Act makes major reforms to the American health-insurance market. It provides, among other things, that every State “shall . . . establish an American Health Benefit Exchange”—a marketplace where people can shop for health-insurance plans. 42 U.S.C. §18031(b)(1). And it provides that if a State does not comply with this instruction, the Secretary of Health and Human Services must “establish and operate such Exchange within the State.” §18041(c)(1).

A separate part of the Act—housed in §36B of the Internal Revenue Code—grants “premium tax credits” to subsidize certain purchases of health insurance made on Exchanges. The tax credit consists of “premium assistance amounts” for “coverage months.” 26 U.S.C. §36B(b)(1). An individual has a coverage month only when he is covered by an insurance plan “that was enrolled in through an Exchange established by the State under [§18031].” §36B(c)(2)(A). And the law ties the size of the premium assistance amount to the premiums for health plans which cover the individual “and which were enrolled in through an Exchange established by the State under [§18031].” §36B(b)(2)(A).

This case requires us to decide whether someone who buys insurance on an Exchange established by the Secretary gets tax credits. You would think the answer would be obvious—so obvious there would hardly be a need for the Supreme Court to hear a case about it. In order to receive any money under §36B, an individual must enroll in an insurance plan through an “Exchange established by the State.” The Secretary of Health and Human Services is not a State. So an Exchange established by the Secretary is not an Exchange established by the State—which means people who buy health insurance through such an Exchange get no money under §36B.

Words no longer have meaning if an Exchange that is not established by a State is “established by the State.” It is hard to come up with a clearer way to limit tax credits to
state Exchanges than to use the words “established by the State.” And it is hard to come up with a reason to include the words “by the State” other than the purpose of limiting credits to state Exchanges. Under all the usual rules of interpretation, in short, the Government should lose this case. But normal rules of interpretation seem always to yield to the overriding principle of the present Court: The Affordable Care Act must be saved.

II

The Court interprets §36B to award tax credits on both federal and state Exchanges. It accepts that the “most natural sense” of the phrase “Exchange established by the State” is an Exchange established by a State. (Understatement, thy name is an opinion on the Affordable Care Act!) Yet the opinion continues, with no semblance of shame, that “it is also possible that the phrase refers to all Exchanges—both State and Federal.” (Impossible possibility, thy name is an opinion on the Affordable Care Act!) The Court claims that “the context and structure of the Act compel [it] to depart from what would otherwise be the most natural reading of the pertinent statutory phrase.”

I wholeheartedly agree with the Court that sound interpretation requires paying attention to the whole law, not homing in on isolated words or even isolated sections. Context always matters. Let us not forget, however, why context matters: It is a tool for understanding the terms of the law, not an excuse for rewriting them.

Any effort to understand rather than to rewrite a law must accept and apply the presumption that lawmakers use words in their natural and ordinary signification. Ordinary connotation does not always prevail, but the more unnatural the proposed interpretation of a law, the more compelling the contextual evidence must be to show that it is correct. Today’s interpretation is not merely unnatural; it is unheard of. Who would ever have dreamt that “Exchange established by the State” means “Exchange established by the State or the Federal Government”? Little short of an express statutory definition could justify adopting this singular reading. Yet the only pertinent definition here provides that “State” means “each of the 50 States and the District of Columbia.” 42 U.S.C. § 18024(d). Because the Secretary is neither one of the 50 States nor the District of Columbia, that definition positively contradicts the eccentric theory that an Exchange established by the Secretary has been established by the State.

Far from offering the overwhelming evidence of meaning needed to justify the Court’s interpretation, other contextual clues undermine it at every turn. To begin with, other parts of the Act sharply distinguish between the establishment of an Exchange by a State and the establishment of an Exchange by the Federal Government. The States’ authority to set up Exchanges comes from one provision, §18031(b); the Secretary’s authority comes from an entirely different provision, §18041(c). Funding for States to establish Exchanges comes from one part of the law, §18031(a); funding for the Secretary to establish Exchanges comes from an entirely different part of the law, §18121. States generally run state-created Exchanges; the Secretary generally runs federally created Exchanges. §18041(b)-(c). And the Secretary’s authority to set up an Exchange in a State depends upon the State’s “failure to establish [an] Exchange.” §18041(c) (emphasis
added). Provisions such as these destroy any pretense that a federal Exchange is in some sense also established by a State.

Reading the rest of the Act also confirms that, as relevant here, there are only two ways to set up an Exchange in a State: establishment by a State and establishment by the Secretary. So saying that an Exchange established by the Federal Government is “established by the State” goes beyond giving words bizarre meanings; it leaves the limiting phrase “by the State” with no operative effect at all. That is a stark violation of the elementary principle that requires an interpreter to give effect, if possible, to every clause and word of a statute. In weighing this argument, it is well to remember the difference between giving a term a meaning that duplicates another part of the law, and giving a term no meaning at all. Lawmakers sometimes repeat themselves. Lawmakers do not, however, tend to use terms that “have no operation at all.” So while the rule against treating a term as a redundancy is far from categorical, the rule against treating it as a nullity is as close to absolute as interpretive principles get. The Court’s reading does not merely give “by the State” a duplicative effect; it causes the phrase to have no effect whatever.

Making matters worse, the reader of the whole Act will come across a number of provisions beyond §36B that refer to the establishment of Exchanges by States. Adopting the Court’s interpretation means nullifying the term “by the State” not just once, but again and again throughout the Act.

Congress did not, by the way, repeat “Exchange established by the State under [§18031]” by rote throughout the Act. Quite the contrary, clause after clause of the law uses a more general term such as “Exchange” or “Exchange established under [§18031].” It is common sense that any speaker who says “Exchange” some of the time, but “Exchange established by the State” the rest of the time, probably means something by the contrast.

Equating establishment “by the State” with establishment by the Federal Government makes nonsense of other parts of the Act. The Act requires States to ensure (on pain of losing Medicaid funding) that any “Exchange established by the State” uses a “secure electronic interface” to determine an individual’s eligibility for various benefits (including tax credits). 42 U.S.C. § 1396w–3(b)(1)(D). How could a State control the type of electronic interface used by a federal Exchange? The Act allows a State to control contracting decisions made by “an Exchange established by the State.” §18031(f)(3). Why would a State get to control the contracting decisions of a federal Exchange? The Act also provides “Assistance to States to establish American Health Benefit Exchanges” and directs the Secretary to renew this funding “if the State . . . is making progress . . . toward . . . establishing an Exchange.” §18031(a). Does a State that refuses to set up an Exchange still receive this funding, on the premise that Exchanges established by the Federal Government are really established by States? It is presumably in order to avoid these questions that the Court concludes that federal Exchanges count as state Exchanges only “for purposes of the tax credits.” (Contrivance, thy name is an opinion on the Affordable Care Act!)
It is probably piling on to add that the Congress that wrote the Affordable Care Act knew how to equate two different types of Exchanges when it wanted to do so. The Act includes a clause providing that “[a] territory that . . . establishes . . . an Exchange . . . shall be treated as a State” for certain purposes. §18043(a) (emphasis added). Tellingly, it does not include a comparable clause providing that the Secretary shall be treated as a State for purposes of §36B when she establishes an Exchange.

Faced with overwhelming confirmation that “Exchange established by the State” means what it looks like it means, the Court comes up with argument after feeble argument to support its contrary interpretation. None of its tries comes close to establishing the implausible conclusion that Congress used “by the State” to mean “by the State or not by the State.”

The Court emphasizes that if a State does not set up an Exchange, the Secretary must establish “such Exchange.” §18041(c). It claims that the word “such” implies that federal and state Exchanges are “the same.” To see the error in this reasoning, one need only consider a parallel provision from our Constitution: “The Times, Places and Manner of holding Elections for Senators and Representatives, shall be prescribed in each State by the Legislature thereof; but the Congress may at any time by Law make or alter such Regulations.” Just as the Affordable Care Act directs States to establish Exchanges while allowing the Secretary to establish “such Exchange” as a fallback, the Elections Clause directs state legislatures to prescribe election regulations while allowing Congress to make “such Regulations” as a fallback. Would anybody refer to an election regulation made by Congress as a “regulation prescribed by the state legislature”? Would anybody say that a federal election law and a state election law are in all respects equivalent? Of course not. The word “such” does not help the Court one whit. The Court’s argument also overlooks the rudimentary principle that a specific provision governs a general one. Even if it were true that the term “such Exchange” in §18041(c) implies that federal and state Exchanges are the same in general, the term “established by the State” in §36B makes plain that they differ when it comes to tax credits in particular.

The Court’s next bit of interpretive jiggery-pokery involves other parts of the Act that purportedly presuppose the availability of tax credits on both federal and state Exchanges. [E]ach of the provisions mentioned by the Court is perfectly consistent with limiting tax credits to state Exchanges. One of them says that the minimum functions of an Exchange include (alongside several tasks that have nothing to do with tax credits) setting up an electronic calculator that shows “the actual cost of coverage after the application of any premium tax credits.” What stops a federal Exchange’s electronic calculator from telling a customer that his tax credit is zero? Another provision requires an Exchange’s outreach program to educate the public about health plans, to facilitate enrollment, and to “distribute fair and impartial information” about enrollment and “the availability of premium tax credits.” What stops a federal Exchange’s outreach program from fairly and impartially telling customers that no tax credits are available? A third provision requires an Exchange to report information about each insurance plan sold—including level of coverage, premium, name of the insured, and “amount of any advance
payment” of the tax credit. What stops a federal Exchange’s report from confirming that no tax credits have been paid out?

The Court persists that these provisions “would make little sense” if no tax credits were available on federal Exchanges. Even if that observation were true, it would show only oddity, not ambiguity. Laws often include unusual or mismatched provisions. At any rate, the provisions cited by the Court are not particularly unusual. Each requires an Exchange to perform a standardized series of tasks, some aspects of which relate in some way to tax credits. It is entirely natural for slight mismatches to occur when, as here, lawmakers draft a single statutory provision to cover different kinds of situations.

Roaming even farther afield from §36B, the Court turns to the Act’s provisions about “qualified individuals.” Qualified individuals receive favored treatment on Exchanges, although customers who are not qualified individuals may also shop there. The Court claims that the Act must equate federal and state establishment of Exchanges when it defines a qualified individual as someone who (among other things) lives in the “State that established the Exchange,” 42 U.S.C. §18032(f)(1)(A). Otherwise, the Court says, there would be no qualified individuals on federal Exchanges, contradicting (for example) the provision requiring every Exchange to take the “interests of qualified individuals” into account when selecting health plans. Pure applesauce. There is no need to rewrite the term “State that established the Exchange” in the definition of “qualified individual,” much less a need to rewrite the separate term “Exchange established by the State” in a separate part of the Act.

Least convincing of all, however, is the Court’s attempt to uncover support for its interpretation in “the structure of Section 36B itself.” The Court finds it strange that Congress limited the tax credit to state Exchanges in the formula for calculating the amount of the credit, rather than in the provision defining the range of taxpayers eligible for the credit. Had the Court bothered to look at the rest of the Tax Code, it would have seen that the structure it finds strange is in fact quite common. Consider, for example, the many provisions that initially make taxpayers of all incomes eligible for a tax credit, only to provide later that the amount of the credit is zero if the taxpayer’s income exceeds a specified threshold. See, e.g., 26 U.S.C. §24 (child tax credit); §32 (earned-income tax credit); §36 (first-time-homebuyer tax credit). Or consider, for an even closer parallel, a neighboring provision that initially makes taxpayers of all States eligible for a credit, only to provide later that the amount of the credit may be zero if the taxpayer’s State does not satisfy certain requirements. See §35 (health-insurance-costs tax credit). One begins to get the sense that the Court’s insistence on reading things in context applies to “established by the State,” but to nothing else.

For what it is worth, lawmakers usually draft tax-credit provisions the way they do—i.e., the way they drafted §36B—because the mechanics of the credit require it. Many Americans move to new States in the middle of the year. Mentioning state Exchanges in the definition of “coverage month”—rather than (as the Court proposes) in the provisions concerning taxpayers’ eligibility for the credit—accounts for taxpayers who live in a State with a state Exchange for a part of the year, but a State with a federal
Exchange for the rest of the year. In addition, §36B awards a credit with respect to insurance plans “which cover the taxpayer, the taxpayer’s spouse, or any dependent . . . of the taxpayer and which were enrolled in through an Exchange established by the State.” §36B(b)(2)(A) (emphasis added). If Congress had mentioned state Exchanges in the provisions discussing taxpayers’ eligibility for the credit, a taxpayer who buys insurance from a federal Exchange would get no money, even if he has a spouse or dependent who buys insurance from a state Exchange—say a child attending college in a different State. It thus makes perfect sense for “Exchange established by the State” to appear where it does, rather than where the Court suggests. Even if that were not so, of course, its location would not make it any less clear.

The Court has not come close to presenting the compelling contextual case necessary to justify departing from the ordinary meaning of the terms of the law. Quite the contrary, context only underscores the outlandishness of the Court’s interpretation. Reading the Act as a whole leaves no doubt about the matter: “Exchange established by the State” means what it looks like it means.

III

For its next defense of the indefensible, the Court turns to the Affordable Care Act’s design and purposes. As relevant here, the Act makes three major reforms. The guaranteed-issue and community-rating requirements prohibit insurers from considering a customer’s health when deciding whether to sell insurance and how much to charge; its famous individual mandate requires everyone to maintain insurance coverage or to pay what the Act calls a “penalty,” and what we have nonetheless called a tax, see National Federation of Independent Business v. Sebelius; and its tax credits help make insurance more affordable. The Court reasons that Congress intended these three reforms to “work together to expand insurance coverage”; and because the first two apply in every State, so must the third.

This reasoning suffers from no shortage of flaws. To begin with, even the most formidable argument concerning the statute’s purposes could not overcome the clarity [of] the statute’s text. Statutory design and purpose matter only to the extent they help clarify an otherwise ambiguous provision. Could anyone maintain with a straight face that §36B is unclear? To mention just the highlights, the Court’s interpretation clashes with a statutory definition, renders words inoperative in at least seven separate provisions of the Act, overlooks the contrast between provisions that say “Exchange” and those that say “Exchange established by the State,” gives the same phrase one meaning for purposes of tax credits but an entirely different meaning for other purposes, and (let us not forget) contradicts the ordinary meaning of the words Congress used. On the other side of the ledger, the Court has come up with nothing more than a general provision that turns out to be controlled by a specific one, a handful of clauses that are consistent with either understanding of establishment by the State, and a resemblance between the tax-credit provision and the rest of the Tax Code. If that is all it takes to make something ambiguous, everything is ambiguous.
Having gone wrong in consulting statutory purpose at all, the Court goes wrong again in analyzing it. The purposes of a law must be “collected chiefly from its words,” not “from extrinsic circumstances.” Only by concentrating on the law’s terms can a judge hope to uncover the scheme of the statute, rather than some other scheme that the judge thinks desirable. Like it or not, the express terms of the Affordable Care Act make only two of the three reforms mentioned by the Court applicable in States that do not establish Exchanges. It is perfectly possible for them to operate independently of tax credits. The guaranteed-issue and community-rating requirements continue to ensure that insurance companies treat all customers the same no matter their health, and the individual mandate continues to encourage people to maintain coverage, lest they be “taxed.”

The Court protests that without the tax credits, the number of people covered by the individual mandate shrinks, and without a broadly applicable individual mandate the guaranteed-issue and community-rating requirements “would destabilize the individual insurance market.” If true, these projections would show only that the statutory scheme contains a flaw; they would not show that the statute means the opposite of what it says. Moreover, it is a flaw that appeared as well in other parts of the Act. A different title established a long-term-care insurance program with guaranteed-issue and community-rating requirements, but without an individual mandate or subsidies. This program never came into effect “only because Congress, in response to actuarial analyses predicting that the [program] would be fiscally unsustainable, repealed the provision in 2013.” How could the Court say that Congress would never dream of combining guaranteed-issue and community-rating requirements with a narrow individual mandate, when it combined those requirements with no individual mandate in the context of long-term-care insurance?

Similarly, the Department of Health and Human Services originally interpreted the Act to impose guaranteed-issue and community-rating requirements in the Federal Territories, even though the Act plainly does not make the individual mandate applicable there. This combination, predictably, [threw] individual insurance markets in the territories into turmoil. Responding to complaints from the Territories, the Department at first insisted that it had “no statutory authority” to address the problem and suggested that the Territories seek legislative relief from Congress instead. The Department changed its mind a year later, after what it described as a careful review of [the] situation and the relevant statutory language. How could the Court pronounce it “implausible” for Congress to have tolerated instability in insurance markets in States with federal Exchanges, when even the Government maintained until recently that Congress did exactly that in American Samoa, Guam, the Northern Mariana Islands, Puerto Rico, and the Virgin Islands?

Compounding its errors, the Court forgets that it is no more appropriate to consider one of a statute’s purposes in isolation than it is to consider one of its words that way. No law pursues just one purpose at all costs, and no statutory scheme encompasses just one element. Most relevant here, the Affordable Care Act displays a congressional preference for state participation in the establishment of Exchanges: Each State gets the first opportunity to set up its Exchange, States that take up the opportunity receive federal
funding for “activities . . . related to establishing an Exchange”; and the Secretary may establish an Exchange in a State only as a fallback. But setting up and running an Exchange involve significant burdens. A State would have much less reason to take on these burdens if its citizens could receive tax credits no matter who establishes its Exchange. So even if making credits available on all Exchanges advances the goal of improving healthcare markets, it frustrates the goal of encouraging state involvement in the implementation of the Act. This is what justifies going out of our way to read “established by the State” to mean “established by the State or not established by the State”?

Worst of all for the repute of today’s decision, the Court’s reasoning is largely self-defeating. The Court predicts that making tax credits unavailable in States that do not set up their own Exchanges would cause disastrous economic consequences there. If that is so, however, wouldn’t one expect States to react by setting up their own Exchanges? And wouldn’t that outcome satisfy two of the Act’s goals rather than just one: enabling the Act’s reforms to work and promoting state involvement in the Act’s implementation? The Court protests that the very existence of a federal fallback shows that Congress expected that some States might fail to set up their own Exchanges. So it does. It does not show, however, that Congress expected the number of recalcitrant States to be particularly large. The more accurate the Court’s dire economic predictions, the smaller that number is likely to be. That reality destroys the Court’s pretense that applying the law as written would imperil the viability of the entire Affordable Care Act. All in all, the Court’s arguments about the law’s purpose and design are no more convincing than its arguments about context.

IV

Perhaps sensing the dismal failure of its efforts to show that “established by the State” means “established by the State or the Federal Government,” the Court tries to palm off the pertinent statutory phrase as “inartful drafting.” This Court, however, has no free-floating power “to rescue Congress from its drafting errors.” Only when it is patently obvious to a reasonable reader that a drafting mistake has occurred may a court correct the mistake. It is entirely plausible that tax credits were restricted to state Exchanges deliberately—for example, in order to encourage States to establish their own Exchanges. We therefore have no authority to dismiss the terms of the law as a drafting fumble.

Let us not forget that the term “Exchange established by the State” appears twice in §36B and five more times in other parts of the Act that mention tax credits. What are the odds, do you think, that the same slip of the pen occurred in seven separate places? No provision of the Act—none at all—contradicts the limitation of tax credits to state Exchanges. And as I have already explained, uses of the term “Exchange established by the State” beyond the context of tax credits look anything but accidental. If there was a mistake here, context suggests it was a substantive mistake in designing this part of the law, not a technical mistake in transcribing it.
The Court’s decision reflects the philosophy that judges should endure whatever interpretive distortions it takes in order to correct a supposed flaw in the statutory machinery. That philosophy ignores the American people’s decision to give Congress not this Court responsibility for both making laws and mending them. This Court holds only the judicial power—the power to pronounce the law as Congress has enacted it. We lack the prerogative to repair laws that do not work out in practice, just as the people lack the ability to throw us out of office if they dislike the solutions we concoct.

Rather than rewriting the law under the pretense of interpreting it, the Court should have left it to Congress to decide what to do about the Act’s limitation of tax credits to state Exchanges.

Just ponder the significance of the Court’s decision to take matters into its own hands. The Court’s revision of the law authorizes the Internal Revenue Service to spend tens of billions of dollars every year in tax credits on federal Exchanges. It affects the price of insurance for millions of Americans. It diminishes the participation of the States in the implementation of the Act. It vastly expands the reach of the Act’s individual mandate, whose scope depends in part on the availability of credits.

Today’s opinion changes the usual rules of statutory interpretation for the sake of the Affordable Care Act. That, alas, is not a novelty. In *National Federation of Independent Business v. Sebelius* this Court revised major components of the statute in order to save them from unconstitutionality. The Act that Congress passed provides that every individual “shall” maintain insurance or else pay a “penalty.” This Court, however, saw that the Commerce Clause does not authorize a federal mandate to buy health insurance. So it rewrote the mandate-cum-penalty as a tax. The Act that Congress passed also requires every State to accept an expansion of its Medicaid program, or else risk losing all Medicaid funding. This Court, however, saw that the Spending Clause does not authorize this coercive condition. So it rewrote the law to withhold only the incremental funds associated with the Medicaid expansion. Having transformed two major parts of the law, the Court today has turned its attention to a third. The Act that Congress passed makes tax credits available only on an “Exchange established by the State.” This Court, however, concludes that this limitation would prevent the rest of the Act from working as well as hoped. So it rewrites the law to make tax credits available everywhere. We should start calling this law SCOTUScare.

Perhaps the Patient Protection and Affordable Care Act will attain the enduring status of the Social Security Act or the Taft–Hartley Act; perhaps not. But this Court’s two decisions on the Act will surely be remembered through the years. The somersaults of statutory interpretation they have performed will be cited by litigants endlessly, to the confusion of honest jurisprudence. And the cases will publish forever the discouraging truth that the Supreme Court of the United States favors some laws over others, and is prepared to do whatever it takes to uphold and assist its favorites.
I dissent.

Notes

1. Have we all just wasted four years and millions of dollars? King amounted to a three-year nightmare. The philosophical underpinnings (why would anyone deliberately set out to deprive millions of people of affordable insurance, after all?) of the case are best captured in Michael Cannon’s blueprint, 50 Vetoes: How States Can Stop the Obama Health Care Law (Cato Institute) http://object.cato.org/sites/cato.org/files/pubs/pdf/50-vetoes-white-paper_1.pdf (accessed July 8, 2015). 50 Vetoes allows the reader to see the libertarian essence of the case: if people cannot get subsidies they will be exempt from the individual mandate since in most cases their insurance will be unaffordable. Cannon’s work built on the writings of Professor Jonathan Adler, whose Taxation Without Representation: The Illegal IRS Rule to Expand Tax Credits Under the PPACA, http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2106789 (accessed July 8, 2015), laid out the legal theory that became four cases mounted by a battalion of lawyers across several federal circuits with the specific intent to bring the ACA to a halt. Jeffrey Toobin, Doom for a Cynical Assault on Obamacare. http://www.newyorker.com/news/daily-comment/doom-for-a-cynical-assault-on-obamacare (accessed July 8, 2015).

The machinery on the other side was just as massive, beginning with the Department of Justice resources needed to defend the case for the government. A flood of amicus briefs (several of which were highly influential to the majority’s thinking, including briefs filed by America’s Health Insurance Plans and a group of health economists in support of the Affordable Care Act) poured in, and major research organizations, most notably the Urban Institute and the RAND Corporation, undertook studies showing the massive impact that eliminating subsidies would have on insured people and premium costs. Public health Deans and scholars and the American Public Health Association, in their amicus brief, estimated an annual death rate of nearly 10,000 people, using data from studies calculating the impact of insurance on mortality.

The health sector was likewise somewhat topsy-turvy, particularly insurers and hospitals, as they tried to cope with the uncertainty. As just one example, before King was decided, carriers had to turn over their rate proposals for their products to be sold in the Marketplaces when the next open season occurs in October 2016. Their business plans, necessarily, depend on how much their premiums are and the effect of premiums on other parts of their plans, such as how narrow or wide their networks will be and how large will be cost-sharing like deductibles and copayments. Moreover, of course, if subsidies were not available on the federal Exchange, insurers’ expected volume would drop precipitously because many purchasers, ineligible for subsidies if the Court had gone the other way, could not afford to buy the insurers’ products. Likewise, hospitals in states using the federal Exchange had to plan for the possibility that there would be a much greater number of uninsured patients showing up at their doors in need of medical care. In short, lots of money in the private sector was wasted planning for two scenarios, one with the subsidies continuing to be available in federal exchanges, and one without.
The upshot of the Court’s decision in \textit{King}, of course, has been preservation of the subsidies, but at what a cost. For three years (of course mostly in the months after the Court decided to hear the case in November 2014) the Administration’s attention, and that of its supporters, was heavily diverted; life became all-\textit{King} all the time. After a slow start, popular and specialty media outlets flooded the news with stories (Googling \textit{King v Burwell} on July 2, 2015 returned over 1.6 million hits). The arguments that ultimately led to \textit{King} began to unfold for real in 2013, with the filing of the first cases, just as the massive final ramp-up to fully implement the ACA was occurring. This had the effect of further magnifying the initial crisis surrounding coverage, including the failed computer technology and notices by insurers cancelling non-compliant insurance policies that typically cost less than the new more comprehensive policies that conform to the ACA’s essential health benefit requirements.

What made the entire \textit{King} episode all so unbelievable is that from the perspective of reality (which all too often does a disappearing act in legal disputes), the case was at best a total waste of time and at worst, terrifyingly damaging to millions of sick people. \textit{50 Vetoes} made clear that the purpose of the litigation was to stop the law from taking effect. In fact, not a single member of Congress — including those who opposed the law — agreed with the plaintiffs’ position that Congress intended subsidies only to go to residents of states that established their own Exchanges. Jeffrey Toobin, \textit{Doom for a Cynical Assault on Obamacare}, \url{http://www.newyorker.com/news/daily-comment/doom-for-a-cynical-assault-on-obamacare} See also, Robert Pear, \textit{Four Words That Imperil Health Care Law Were All a Mistake, Writers Now Say}, New York Times (May 25, 2015) \url{http://www.nytimes.com/2015/05/26/us/politics/contested-words-in-affordable-care-act-may-have-been-left-by-mistake.html?_r=0}

Of course, as Justice Scalia notes in his vitriolic dissent, the Court does not fix mistakes made by Congress. Therefore, had the Court concluded, as the plaintiffs intended, that the law really did limit subsidies to a handful of states (either because Congress erred in its judgment about how states would respond to the threat of excluding their residents from subsidies and taking out their insurance markets, or because Congress erred in drafting its law), the problem would roll back to Congress. And of course in the current climate, there is no chance that such a mistake in judgment or drafting could be fixed (which of course explains why the case was brought in the first place). If anyone harbored any thoughts that Congress might rise to the occasion in the event of a win by plaintiffs, this hope was dispelled by the laughter that broke out in the Court during oral arguments when Justice Scalia stated that he trusted Congress to fix errors, to which Solicitor General Verrilli responded, “This Congress?”. The notion that Congress could or would fix things was further dispelled by legislative proposals introduced by Republic Members of Congress as concerns over the elimination of subsidies grew. These proposals ranged from total repeal of the ACA to a measure introduced by Senator Ron Johnson (R-WI) and endorsed by 31 other Senators (including the Majority Leader and the Chair of the Senate Finance Committee, with jurisdiction over much of the ACA), which proposed to create an “off-ramp” for coverage. This “off-ramp” consisted of a subsidy “fig leaf” to give House Members political cover during the 2016 Presidential election season while they gutted the key operating components of the
law and shut down help for millions. The Johnson proposal would have continued subsidies for people who already had them while shutting down subsidies to new people (both federal and state Exchange enrollees). His plan also would have dismantled core provisions of the ACA such as the individual and employer mandates and the essential health benefit requirement. By ending subsidies and eliminating the mandate (but preserving the market reforms at least in some semblance), the proposal would have ensured the very insurance death spiral that the “interlocking” provisions of the ACA were meant to avert. The disingenuous nature of the measure was astutely revealed by that organizational hotbed of liberals, the American Academy of Actuaries, which analyzed the impact of the Johnson measure in Implications of Proposed Changes to the ACA In Response to King v Burwell, http://www.actuary.org/files/HPC_Imp_Prop_Changes_ACA_KvB_052715.pdf (accessed July 8, 2015). But so reviled is the ACA and the President that despite the impact of killing the law on persons of (heavily Republican) federal Exchange states, no Republican Member of Congress proposed to simply clarify the availability of subsidies in all states.

2. Another bullet dodged, the employer mandate. Overlooked by the Court and much of the media is that elimination of the subsidies in states with the federal Exchange would have wiped out the employer mandate in those states. Recall from Chapter Six that the employer mandate’s penalty kicks in only if the employer (of appropriate size) has at least one employee receiving a subsidy on an Exchange. If there are no subsidies available in a state because the state has elected not to run its own Exchange, then the penalty cannot be triggered. Without the penalty, goodbye employer mandate, with potentially a significant impact because employers would then have less of a disincentive to drop, or fail to create, coverage.

3. What about NFIB? In King Justice Roberts makes a compelling case—in fact as compelling as compelling can be—that the individual mandate is an inherent part of Congress’s “interlocking” reforms for achieving its fundamental aim: to dramatically reduce the number of uninsured Americans. To do so, Congress layered onto the existing system of employer insurance, Medicare and Medicaid, a restrucured individual market open to serve everyone else, and with subsidies for those who could not afford to purchase coverage. This required reforms such as guaranteed renewal, nondiscrimination against the sick, community rating, and a decent level of coverage. To make sure that the risk pool would be strong enough to hold insurers to these standards, Congress enacted the individual mandate. As the Court discusses, states that tried to impose these reforms without an individual mandate saw their individual insurance markets collapse because of an insurance death spiral. Bringing the previously uninsurable, i.e., relatively sick people, into an insurance pool tends to increase premiums and, with higher premiums, the relatively young and healthy elect not to buy insurance until they need it, i.e., they engage in adverse selection. The death spiral is stopped by forcing the relatively young and healthy into the insurance pool. Put differently, the absolutely clear implication of Justice Robert’s opinion in King is that Congress has the authority to regulate insurance to prevent the death spiral and that a necessary—much less reasonable—means to doing so was by imposing an individual mandate. So long as Congress has authority in an area,
like saving health insurance, isn’t the choice of means usually left to it so long as the means chosen are reasonable? Of course we can avoid facing up to the contradiction between *King* and *NFIB* by characterizing the dollars an individual pays for not obeying the mandate as a “tax,” not a “penalty,” but remember from the notes after *NFIB* that there are real consequences from characterization of the mandate as an exercise under the Tax Power, as opposed to the Commerce Clause.

4. *Why did the Court hear the case, anyway?* There has been much speculation about why the Court agreed to hear the case at all, since there was no split in the circuits by November 2014, when the Court took the case. People familiar with Court dynamics tend to believe that Justice Kennedy provided the fourth vote for *certiorari* (only four Justices need to decide to hear a case), because he continued to harbor a good deal of resentment over *NFIB v Sebelius*, in which the Chief Justice reportedly decided at the eleventh hour to join forces with the Court’s liberal wing in order to save the law (Justice Kennedy was in the dissent as a result). On the other hand, it is possible that the liberals, joined by the Chief Justice, decided to hear the case in order to put an end to a festering wound, get the arguments out in the open, and dispose of matters. But if the liberal wing took the case to simply quickly dispose of it, then why was the decision not quickly issued a month after oral argument as opposed to waiting until nearly the last day of the Court’s term? This all remains a mystery.

Whatever its reasoning, the Court aggressively inserted itself, with the Chief Justice reminding everyone of his 2005 confirmation hearing, in which he portrayed the role of the Court as an umpire who calls balls and strikes. Citing *Marbury v Madison*, he made clear that it was the Court, not some government agency with no health policy experience, that would decide what the law meant. As a result, the Court has decisively sent the ball back to Congress’ court; a new Administration that might have other ideas about which Americans should receive premium subsidies, would be unable to reinterpret the law.

Still, in thinking again about the enormous cost of the entire enterprise, consider what law was made by the Supreme Court in *King*. Did the decision break any new ground in the interpretation of statutes? Did it create new constitutional law? In the end, aren’t we back at exactly the same place we would have been had the whole *King* enterprise never occurred? Assuming the Court’s reading of the ACA provisions creating the subsidy was correct, wouldn’t government have worked a whole lot better if Congress had simply passed technical amendments just as it has, in great numbers, for massive new programs like Medicare in the past? What does this say about the state of our democracy?

5. *Dueling opinions.* If there ever were a case that exemplified *Rashomon*, Akira Kurasawa’s classic film about the truth, *King* would be it. The majority and the minority look at the same words and purport to apply the same principles of statutory construction and yet come out in completely different places. For the majority, it is simply not possible to read isolated words without considering the entire context of the law, including its underlying purpose. According to Professor Abbe Gluck, an expert in statutory construction, this is, in fact, how the interpretation of laws is supposed to

6. What happens next? King clears the way for life to get back to normal. Or does it? The crucial holding is that subsidies are available to qualified individuals regardless of whether they reside in states that use the federal Exchange. Today 16 states and the District of Columbia have established state Exchanges. http://www.commonwealthfund.org/interactives-and-data/maps-and-data/state-exchange-map (accessed July 8, 2015) (This map also shows the population impact in states using the federal Exchange had the plaintiffs prevailed). But in a number of the states that established their own Exchange, the Marketplace has been fraught with functional problems. One possible upshot is that all states would switch to the federal Exchange or at least begin using the federal technology platform (now working reasonably well) to support their state-established Exchange as a federal-state partnership. No one expects states that have not already done so to start their own Exchanges (Pennsylvania and Delaware indicated that they would when it looked as if subsidies in the federal Exchange would possibly go down, but no one expects either state to make the transition now that the coast is clear). The state politics surrounding the Affordable Care Act have been immensely complicated, as the tragic arc of the Medicaid expansion (made optional in NFIB v Sebelius and still not adopted by 21—mostly Southern—states) has illustrated, and the politics of the ACA don’t always break along clean party lines. David K. Jones, King v Burwell and the Importance of State Politics http://healthaffairs.org/blog/2015/07/01/king-v-burwell-and-the-importance-of-state-politics/ (accessed July 8, 2015).

But wait. The federal Exchange depends on—you guessed it—federal appropriations to support it. And Congressional opponents to the ACA (who of course control both the House and Senate) are in no mood to fund the federal Exchange. In their FY 2016 appropriations measures, lawmakers appear poised to appropriate zero support for the Exchange, making its survival the next big political battle. Whether Congress is able to exact concessions from the White House as the price for funding enrollment remains to be seen. High on lawmakers’ list, as noted, is an end to the individual mandate, the employer mandate, the essential health benefit federal coverage standard, and repeal of the ACA’s Independent Payment Advisory Board (established under the ACA to regulate Medicare provider payments, but never implemented). Also on the list is repeal of the so-called “Cadillac tax,” which imposes a 40 percent, non-deductible excise tax on high cost employer sponsored plans beginning in 2018. A 2014 study by the National

* Until his murder in June 2015, the Reverend Clemente Pinkney of South Carolina, also a member of that state’s legislature, was perhaps the state’s leading and most outspoken advocate for Medicaid expansion. Nearly 4 million people—disproportionately African American and exceptionally poor—remain completely uninsured because their incomes are too low to be eligible to receive Exchange premium subsidies, which in non-Medicaid-expansion states become available when household income reaches 100 percent of the federal poverty level.
Business Group on Health found that over 40 percent of all employers already were taking steps to reduce coverage (typically with high deductibles, higher cost-sharing, and exclusion of premium support for employed spouses) in order to avoid the tax. [https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234](https://www.businessgrouphealth.org/pressroom/pressRelease.cfm?ID=234) (accessed July 9, 2015). The tax has affected every employer sector, and employers are responding urgently. Jorge Castro, As Employers Try to Avoid the Cadillac Tax, Treasury and the IRS Need to Act [http://healthaffairs.org/blog/2015/05/12/as-employers-try-to-avoid-the-cadillac-tax-treasury-and-the-irs-need-to-act/](http://healthaffairs.org/blog/2015/05/12/as-employers-try-to-avoid-the-cadillac-tax-treasury-and-the-irs-need-to-act/) (accessed July 9, 2015).

So Congress might play hardball, or at least try. The problem for opponents is that every part of the ACA is, as the majority noted, interlocking. This means that repealing the individual and employer mandates have the effect of hiking premiums and reducing revenues to the federal government, since both the individual and employer penalties were expected to produce significant revenues. Indeed, the Congressional Budget Office has estimated that a full repeal of the ACA would actually increase the budget deficit by more than $350 billion over a ten-year time period, even if it eliminates the Medicaid expansion funds and federal tax subsidies, since these expenditures were more than offset by new taxes and reductions in Medicare spending. Congressional Budget Office, *Budgetary and Economic Effects of Repealing the Affordable Care Act* (June 19, 2015) [https://www.cbo.gov/publication/50252](https://www.cbo.gov/publication/50252) (accessed July 8, 2015). Of course, lawmakers could simply ignore the budgetary impact of getting rid of a law they hate (the Congressional Budget Act is their law, after all), but politically this would at least presumably be disastrous, not to mention the impact on millions as an election year approaches.

7. Is there more litigation? *King* is generally understood to be the last of the massive legal attacks on the ACA. But wait, there’s more. As part of a virtual symposium sponsored by the health policy journal *Health Affairs* on the future of the Affordable Care Act in the wake of *King*, [http://healthaffairs.org/blog/2015/07/02/thirteen-ways-of-looking-at-king-v-burwell-a-virtual-symposium/](http://healthaffairs.org/blog/2015/07/02/thirteen-ways-of-looking-at-king-v-burwell-a-virtual-symposium/) (accessed July 8, 2015), Professor Tim Jost describes the outstanding litigation, noting that over a dozen challenges to one or more parts of the ACA are pending at various levels in the federal courts. [http://healthaffairs.org/blog/2015/06/23/implementing-health-reform-aca-litigation-beyond-king-v-burwell/](http://healthaffairs.org/blog/2015/06/23/implementing-health-reform-aca-litigation-beyond-king-v-burwell/) (accessed July 8, 2015). Chief among these is a challenge brought against the Administration by the United States House of Representatives and alleging that the Administration has exceeded its authority by granting cost-sharing subsidies to people who receive premium subsidies toward the cost of Exchange plans and have household incomes below 250 percent of the federal poverty level. Were this case (*House v Burwell*, D.D.C.) to succeed, millions of lower income families would lose crucial cost-sharing assistance and would be left with the equivalent of high-deductible health plans that place the cost of all but covered preventive services and the most expensive emergency treatments out of reach. This of course is a particular problem for low income children and adults with serious and ongoing health conditions such as cancer, heart ailments, pediatric asthma, diabetes, or mental illness, for whom access to continuous affordable care is crucial.
Still to be decided, as well, and included in a separate part of this 2015 Update, is a cluster of cases that concern whether the federal government has properly accommodated employers that are covered by the Religious Freedom Restoration Act and that object on religious grounds to coverage of all FDA-approved contraceptives under their employee health benefit plans. Contraceptive coverage at no cost is one of the ACA’s most important coverage reforms, and the requirement extends to all non-grandfathered health plans sold in the group and individual markets. More on this to follow.

2. Contraceptive Coverage, Corporate Exemptions, and Religious Accommodation under the Affordable Care Act

A fundamental purpose of health insurance is to further the concept of risk solidarity, that is, the pooling of health risks across ages, the sexes, and the healthy and sick. The logic of such solidarity is that we all age, we all get sick, and of course, even those of us who are men have a fundamental interest in the health of women. Part One of the Textbook explores the issue of gender discrimination at length. The contraceptive cases arising out of the Affordable Care Act represent an issue of crucial importance to women’s health and the public’s health. They also represent a remarkable example of the clash that comes when the crucial goal of population health solidarity comes face to face with opponents of such a solidarity approach. In the contraceptive cases, the opposition has been cloaked in religion as a result of a 1993 law predating the Affordable Care Act, the Religious Freedom Restoration Act (RFRA). This law permits challenges to federal public health laws that otherwise would pass constitutional muster, on the ground that such laws pose a substantial burden on religious beliefs, cannot be justified by a compelling government interest, and have not been tailored as narrowly as possible.

As the contraceptive cases drag on, they raise an ultimate solidarity question to ponder: Does the federal government have a compelling interest in population health sufficient to require coverage of contraceptives—which can be quite costly—even if a minority of religious individuals object to their inclusion in insurance plans? As you will read below, the contraceptive coverage cases appear to be heading toward the result that there exists a broad exemption from the coverage requirement for employers claiming such an exemption on religious grounds. And, as you will see, as of July 2018 the basis for this result appears to rest on the assertion by the government, that it no longer has a compelling government interest, and have not been tailored as narrowly as possible.

* * *

The Affordable Care Act amends Title XXVII of Public Health Service Act to establish minimum federal standards for state-regulated insurance plans sold in the individual and group markets to require that all “non-grandfathered” health plans.* PHSA

* PPACA § 1251. Health plans in operation at the time of enactment can retain their coverage designs but forfeit their grandfathered status if they make significant changes in coverage or cost-sharing as defined in
Title XXVII, § 2713, as added. The ACA also makes this provision applicable to all health plans governed by ERISA. PPACA § 1563; 29 C.F.R. 2590.715-2713. Required preventive services include immunizations recommended by the Advisory Committee on Immunization Practice to the Centers for Disease Control and Prevention, screenings for infants, children and adolescents, and other “preventive services and screenings” for women as recommended by the Health Resources and Services Administration (HRSA), part of the United States Department of Health and Human Services. Following consultation with the Institute of Medicine, in 2011 HRSA determined that a review of evidence-based preventive services data required that insurance plans cover—without cost to beneficiaries—all FDA-approved contraceptive methods, including oral contraceptives, intrauterine devices, emergency contraception, sterilization, as well as patient counseling and education about these options. 76 Fed. Reg. 46621-01 (August 3, 2011) (codified at 45 C.F.R. §147. 131 et seq.

In applying this coverage standard the Obama Administration, in compliance with long-standing IRS regulatory policy and following considerable public debate and comment, see Timothy Jost, On Objections To Contraceptive Coverage, Trump Administration Appears Set To Reverse Obama Approach (Health Affairs Blog, June 2, 2017), http://healthaffairs.org/blog/2017/06/02/on-objections-to-contraceptive-coverage-trump-administration-appears-set-to-reverse-obama-approach/ (Accessed July 9, 2017), granted an exemption to “churches, their integrated auxiliaries, and conventions or associations of churches, as well as the exclusively religious activities of any religious order.” See Internal Revenue Service, Tax guide for Churches and Related Organizations, https://www.irs.gov/pub/irs-pdf/p1828.pdf. In addition, as described in the Hobby Lobby case below, the rules created an accommodation (rather than an outright exemption) for certain nonprofit entities that hold themselves out as religious organizations and that, on religious grounds, object to including some or all contraceptive services in the coverage they provide to employees, students or clients. The accommodation was only available to non-profit entities with religious objections.

Organizations eligible for the accommodation had to file a one-page form with their health insurance issuer, which was then required to provide payment for contraception for women in the plan at no cost to the women or to the organization. Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services under Patient Protection and Affordable Care Act, 78 Fed. Reg. 8456, 8461 (February 6, 2013). The accommodation was designed to ensure that women continue to receive the coverage to which they are entitled while effectively taking the religious employer out of the picture.

The original rule was issued jointly by the three federal agencies with combined jurisdiction over the health insurance/employer health plan market (HHS, Labor, and

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federal regulations. 29 C.F.R. § 2590.715-1251. As of 2014, about 26% of all workers were covered by grandfathered plans; this number is expected to decline over time. Laurie Sobel et al., Private Insurance Coverage of Contraception (Kaiser Family Foundation, 2016), http://www.kff.org/womens-health-policy/issue-brief/private-insurance-coverage-of-contraception/ (Accessed July 9, 2017).
Treasury). The rule required religiously-affiliated nonprofit organizations seeking an exemption from the coverage rule to notify their insurer or plan administrator that they qualified for the accommodation, using a one-page “EBSA Form 700,” issued by the Department of Labor as part of its ERISA oversight and enforcement responsibilities. Filing the notice would mean that the plan excluded the benefits. Then, in accordance with federal law, the insurer or plan administrator would directly, and without involving the employer, comply with the law by providing contraceptive coverage to plan participants and beneficiaries. The federal government assumed that insurers could absorb the cost of coverage, given the evidence that outlays for contraceptive services would be offset by the savings achieved from the prevention of unintended pregnancy. Brief of the Guttmacher Institute and Professor Sara Rosenbaum, *Burwell v Hobby Lobby*, https://www.guttmacher.org/sites/default/files/article_files/guttmacher_zubik_scotus_amicus_brief.pdf (accessed July 9, 2017) In the case of third-party plan administrators providing services to self-insuring employers, the regulations provided for reimbursement of the plan administrator for compliance-related costs.

Many employers challenged the regulations. The first cases to reach the Court were brought by closely-held, for-profit corporations that argued that their owners’ religious beliefs meant that they, too, should qualify for a religious exemption. The second group of cases (which ran into the dozens and spanned nearly every federal circuit) was mounted by nonprofit religious organizations. Essentially these organizations wanted the same complete exemption from the contraception requirement that churches receive.

**Round One—Hobby Lobby v Burwell**

ALITO, J., delivered the opinion of the Court, in which ROBERTS, C. J., AND SCALIA, KENNEDY, and THOMAS, JJ., joined. KENNEDY, J., filed a concurring opinion. GINSBURG, J., filed a dissenting opinion, in which SOTOMAYOR, J., joined, and in which BREYER and KAGAN, JJ., joined as to all but Part III–C–1. BREYER and KAGAN, JJ., filed a dissenting opinion.

We must decide in these cases whether the Religious Freedom Restoration Act of 1993 (RFRA), 42 U.S.C. § 2000bb et seq., permits the United States Department of Health and Human Services (HHS) to demand that three closely held corporations provide health-insurance coverage for methods of contraception that violate the sincerely held religious beliefs of the companies’ owners. We hold that the regulations that impose this obligation violate RFRA, which prohibits the Federal Government from taking any action that substantially burdens the exercise of religion unless that action constitutes the least restrictive means of serving a compelling government interest.

In holding that the HHS mandate is unlawful, we reject HHS’s argument that the owners of the companies forfeited all RFRA protection when they decided to organize their businesses as corporations rather than sole proprietorships or general partnerships. The plain terms of RFRA make it perfectly clear that Congress did not discriminate in
this way against men and women who wish to run their businesses as for-profit corporations in the manner required by their religious beliefs.

Since RFRA applies in these cases, we must decide whether the challenged HHS regulations substantially burden the exercise of religion, and we hold that they do. The owners of the businesses have religious objections to abortion, and according to their religious beliefs the four contraceptive methods at issue are abortifacients. If the owners comply with the HHS mandate, they believe they will be facilitating abortions, and if they do not comply, they will pay a very heavy price—as much as $1.3 million per day, or about $475 million per year, in the case of one of the companies. If these consequences do not amount to a substantial burden, it is hard to see what would.

Under RFRA, a Government action that imposes a substantial burden on religious exercise must serve a compelling government interest, and we assume that the HHS regulations satisfy this requirement. But in order for the HHS mandate to be sustained, it must also constitute the least restrictive means of serving that interest, and the mandate plainly fails that test. There are other ways in which Congress or HHS could equally ensure that every woman has cost-free access to the particular contraceptives at issue here and, indeed, to all FDA-approved contraceptives.

In fact, HHS has already devised and implemented a system that seeks to respect the religious liberty of religious nonprofit corporations while ensuring that the employees of these entities have precisely the same access to all FDA-approved contraceptives as employees of companies whose owners have no religious objections to providing such coverage. The employees of these religious nonprofit corporations still have access to insurance coverage without cost sharing for all FDA-approved contraceptives; and according to HHS, this system imposes no net economic burden on the insurance companies that are required to provide or secure the coverage.

Although HHS has made this system available to religious nonprofits that have religious objections to the contraceptive mandate, HHS has provided no reason why the same system cannot be made available when the owners of for-profit corporations have similar religious objections. We therefore conclude that this system constitutes an alternative that achieves all of the Government’s aims while providing greater respect for religious liberty. And under RFRA, that conclusion means that enforcement of the HHS contraceptive mandate against the objecting parties in these cases is unlawful.

[O]ur holding is very specific. We do not hold, as the principal dissent alleges, that for-profit corporations and other commercial enterprises can “opt out of any law (saving only tax laws) they judge incompatible with their sincerely held religious beliefs.” Nor do we hold, as the dissent implies, that such corporations have free rein to take steps that impose “disadvantages . . . on others” or that require “the general public [to] pick up the tab.” And we certainly do not hold or suggest that “RFRA demands accommodation of a for-profit corporation’s religious beliefs no matter the impact that accommodation may have on . . . thousands of women employed by Hobby Lobby.” The effect of the HHS-created accommodation on the women employed by Hobby Lobby and
the other companies involved in these cases would be precisely zero. Under that accommodation, these women would still be entitled to all FDA-approved contraceptives without cost sharing.

[We omit the portion of the Court’s decision that explains why in its view RFRA applies to not only to individuals, but to some corporations. At several points, the Court noted that it was limiting its holding to family-owned-and-operated, closely held corporations.]

Because RFRA applies in these cases, we must next ask whether the HHS contraceptive mandate “substantially burden[s]” the exercise of religion. [ ] We have little trouble concluding that it does. The Hahns and Greens have a sincere religious belief that life begins at conception. They therefore object on religious grounds to providing health insurance that covers methods of birth control that, as HHS acknowledges, may result in the destruction of an embryo. By requiring the Hahns and Greens and their companies to arrange for such coverage, the HHS mandate demands that they engage in conduct that seriously violates their religious beliefs. If the Hahns and Greens and their companies do not yield to this demand, the economic consequences will be severe. [They will be subject to significant fines and penalties.] These sums are surely substantial.

It is true that the plaintiffs could avoid these assessments by dropping insurance coverage altogether and thus forcing their employees to obtain health insurance on one of the exchanges established under ACA. But if at least one of their full-time employees were to qualify for a subsidy on one of the government-run exchanges, this course would also entail substantial economic consequences. [Omit discussion of the reasons that eliminating health insurance coverage for employees is costly, impractical, and violates plaintiffs’ ethical commitments to their employees.]

In sum, [w]e doubt that the Congress that enacted RFRA—or, for that matter, ACA—would have believed it a tolerable result to put family-run businesses to the choice of violating their sincerely held religious beliefs or making all of their employees lose their existing healthcare plans.

In taking the position that the HHS mandate does not impose a substantial burden on the exercise of religion, HHS’s main argument (echoed by the principal dissent) is basically that the connection between what the objecting parties must do (provide health-insurance coverage for four methods of contraception that may operate after the fertilization of an egg) and the end that they find to be morally wrong (destruction of an embryo) is simply too attenuated. HHS and the dissent note that providing the coverage would not itself result in the destruction of an embryo; that would occur only if an employee chose to take advantage of the coverage and to use one of the four methods at issue.

This argument dodges the question that RFRA presents (whether the HHS mandate imposes a substantial burden on the ability of the objecting parties to conduct
business in accordance with their religious beliefs) and instead addresses a very different question that the federal courts have no business addressing (whether the religious belief asserted in a RFRA case is reasonable). The Hahns and Greens believe that providing the coverage demanded by the HHS regulations is connected to the destruction of an embryo in a way that is sufficient to make it immoral for them to provide the coverage. Arrogating the authority to provide a binding national answer to this religious and philosophical question, HHS and the principal dissent in effect tell the plaintiffs that their beliefs are flawed. For good reason, we have repeatedly refused to take such a step. [T]he Hahns and Greens and their companies sincerely believe that providing the insurance coverage demanded by the HHS regulations lies on the forbidden side of the line, and it is not for us to say that their religious beliefs are mistaken or insubstantial. Instead, our narrow function * * * in this context is to determine whether the line drawn reflects an honest conviction, and there is no dispute that it does.

HHS nevertheless compares these cases to decisions in which we rejected the argument that the use of general tax revenue to subsidize the secular activities of religious institutions violated the Free Exercise Clause. But in those cases, while the subsidies were clearly contrary to the challengers’ views on a secular issue, namely, proper church-state relations, the challengers never articulated a religious objection to the subsidies. Here, in contrast, the plaintiffs do assert that funding the specific contraceptive methods at issue violates their religious beliefs, and HHS does not question their sincerity. Because the contraceptive mandate forces them to pay an enormous sum of money—as much as $475 million per year in the case of Hobby Lobby—if they insist on providing insurance coverage in accordance with their religious beliefs, the mandate clearly imposes a substantial burden on those beliefs.

Since the HHS contraceptive mandate imposes a substantial burden on the exercise of religion, we must move on and decide whether HHS has shown that the mandate both (1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest.

HHS asserts that the contraceptive mandate serves a variety of important interests, but many of these are couched in very broad terms, such as promoting “public health” and “gender equality.” RFRA, however, contemplates a “more focused” inquiry: It “requires the Government to demonstrate that the compelling interest test is satisfied through application of the challenged law ‘to the person’—the particular claimant whose sincere exercise of religion is being substantially burdened. This requires us to loo[k] beyond broadly formulated interests” and to “scrutiniz[e] the asserted harm of granting specific exemptions to particular religious claimants”—in other words, to look to the marginal interest in enforcing the contraceptive mandate in these cases.

In addition to asserting these very broadly framed interests, HHS maintains that the mandate serves a compelling interest in ensuring that all women have access to all FDA-approved contraceptives without cost sharing. Under our cases, women (and men) have a constitutional right to obtain contraceptives, see Griswold v. Connecticut, and HHS tells us that [s]tudies have demonstrated that even moderate copayments for
preventive services can deter patients from receiving those services. The objecting parties contend that HHS has not shown that the mandate serves a compelling government interest, and it is arguable that there are features of ACA that support that view. As we have noted, many employees—those covered by grandfathered plans and those who work for employers with fewer than 50 employees—may have no contraceptive coverage without cost sharing at all.

HHS responds that many legal requirements have exceptions and the existence of exceptions does not in itself indicate that the principal interest served by a law is not compelling. We find it unnecessary to adjudicate this issue. We will assume that the interest in guaranteeing cost-free access to the four challenged contraceptive methods is compelling within the meaning of RFRA, and we will proceed to consider the final prong of the RFRA test, i.e., whether HHS has shown that the contraceptive mandate is “the least restrictive means of furthering that compelling governmental interest.”

The least-restrictive-means standard is exceptionally demanding, and it is not satisfied here. HHS has not shown that it lacks other means of achieving its desired goal without imposing a substantial burden on the exercise of religion by the objecting parties in these cases. The most straightforward way of doing this would be for the Government to assume the cost of providing the four contraceptives at issue to any women who are unable to obtain them under their health-insurance policies due to their employers’ religious objections. This would certainly be less restrictive of the plaintiffs’ religious liberty, and HHS has not shown that this is not a viable alternative.

In the end, however, we need not rely on the option of a new, government-funded program in order to conclude that the HHS regulations fail the least-restrictive-means test. HHS itself has demonstrated that it has at its disposal an approach that is less restrictive than requiring employers to fund contraceptive methods that violate their religious beliefs. As we explained above, HHS has already established an accommodation for nonprofit organizations with religious objections. Under that accommodation, the organization can self-certify that it opposes providing coverage for particular contraceptive services. If the organization makes such a certification, the organization’s insurance issuer or third-party administrator must \* ** “[p]rovide separate payments for any contraceptive services required to be covered” without imposing “any cost-sharing requirements . . . on the eligible organization, the group health plan, or plan participants or beneficiaries.”

We do not decide today whether an approach of this type complies with RFRA for purposes of all religious claims. At a minimum, however, it does not impinge on the plaintiffs’ religious belief that providing insurance coverage for the contraceptives at issue here violates their religion, and it serves HHS’s stated interests equally well. The principal dissent identifies no reason why this accommodation would fail to protect the asserted needs of women as effectively as the contraceptive mandate, and there is none. Under the accommodation, the plaintiffs’ female employees would continue to receive contraceptive coverage without cost sharing for all FDA-approved contraceptives, and they would continue to face minimal logistical and administrative obstacles, because their employers’ insurers would be responsible for providing information and coverage.
HHS and the principal dissent argue that a ruling in favor of the objecting parties in these cases will lead to a flood of religious objections regarding a wide variety of medical procedures and drugs, such as vaccinations and blood transfusions, but HHS has made no effort to substantiate this prediction. HHS points to no evidence that insurance plans in existence prior to the enactment of ACA excluded coverage for such items. Nor has HHS provided evidence that any significant number of employers sought exemption, on religious grounds, from any of ACA’s coverage requirements other than the contraceptive mandate.

It is HHS’s apparent belief that no insurance-coverage mandate would violate RFRA—no matter how significantly it impinges on the religious liberties of employers—that would lead to intolerable consequences. Under HHS’s view, RFRA would permit the Government to require all employers to provide coverage for any medical procedure allowed by law in the jurisdiction in question—for instance, third-trimester abortions or assisted suicide. The owners of many closely held corporations could not in good conscience provide such coverage, and thus HHS would effectively exclude these people from full participation in the economic life of the Nation. RFRA was enacted to prevent such an outcome.

In any event, our decision in these cases is concerned solely with the contraceptive mandate. Our decision should not be understood to hold that an insurance-coverage mandate must necessarily fall if it conflicts with an employer’s religious beliefs. Other coverage requirements, such as immunizations, may be supported by different interests (for example, the need to combat the spread of infectious diseases) and may involve different arguments about the least restrictive means of providing them.

HHS also raises for the first time in this Court the argument that applying the contraceptive mandate to for-profit employers with sincere religious objections is essential to the comprehensive health-insurance scheme that ACA establishes. HHS analogizes the contraceptive mandate to the requirement to pay Social Security taxes, which we upheld in [United States v. Lee, 455 U.S. 252(1982)] despite the religious objection of an employer, but these cases are quite different. Our holding in Lee turned primarily on the special problems associated with a national system of taxation. We observed that “[t]he tax system could not function if denominations were allowed to challenge the tax system because tax payments were spent in a manner that violates their religious belief.”

Lee was a free-exercise, not a RFRA, case, but if the issue in Lee were analyzed under the RFRA framework, the fundamental point would be that there simply is no less restrictive alternative to the categorical requirement to pay taxes. Because of the enormous variety of government expenditures funded by tax dollars, allowing taxpayers to withhold a portion of their tax obligations on religious grounds would lead to chaos. Recognizing exemptions from the contraceptive mandate is very different. Recognizing a religious accommodation under RFRA for particular coverage requirements, therefore, does not threaten the viability of ACA’s comprehensive scheme in the way that
recognizing religious objections to particular expenditures from general tax revenues would.

Justice KENNEDY, concurring.

[T]he record in these cases shows that there is an existing, recognized, workable, and already-implemented framework to provide coverage. That framework is one that HHS has itself devised, that the plaintiffs have not criticized with a specific objection that has been considered in detail by the courts in this litigation, and that is less restrictive than the means challenged by the plaintiffs in these cases.

[I]n other instances the Government has allowed the same contraception coverage in issue here to be provided to employees of nonprofit religious organizations, as an accommodation to the religious objections of those entities. The accommodation works by requiring insurance companies to cover, without cost sharing, contraception coverage for female employees who wish it. That accommodation equally furthers the Government’s interest but does not impinge on the plaintiffs’ religious beliefs. On this record and as explained by the Court, the Government has not met its burden of showing that it cannot accommodate the plaintiffs’ similar religious objections under this established framework. RFRA is inconsistent with the insistence of an agency such as HHS on distinguishing between different religious believers—burdening one while accommodating the other—when it may treat both equally by offering both of them the same accommodation.

Justice GINSBURG, with whom Justice Sotomayor joins, and with whom Justice BREYER and Justice KAGAN join as to all but Part III–C–1, dissenting.

In a decision of startling breadth, the Court holds that commercial enterprises, including corporations, along with partnerships and sole proprietorships, can opt out of any law (saving only tax laws) they judge incompatible with their sincerely held religious beliefs. Compelling governmental interests in uniform compliance with the law, and disadvantages that religion-based opt-outs impose on others, hold no sway, the Court decides, at least when there is a “less restrictive alternative.” And such an alternative, the Court suggests, there always will be whenever, in lieu of tolling an enterprise claiming a religion-based exemption, the government, i.e., the general public, can pick up the tab.

The Court does not pretend that the First Amendment’s Free Exercise Clause demands religion-based accommodations so extreme, for our decisions leave no doubt on that score. In the Court’s view, RFRA demands accommodation of a for-profit corporation’s religious beliefs no matter the impact that accommodation may have on third parties who do not share the corporation owners’ religious faith—in these cases, thousands of women employed by Hobby Lobby and Conestoga or dependents of persons those corporations employ. Persuaded that Congress enacted RFRA to serve a far less radical purpose, and mindful of the havoc the Court’s judgment can introduce, I dissent.
“The ability of women to participate equally in the economic and social life of the Nation has been facilitated by their ability to control their reproductive lives.” Planned Parenthood of Southeastern Pa. v. Casey. [ ] Congress acted on that understanding when, as part of a nationwide insurance program intended to be comprehensive, it called for coverage of preventive care responsive to women’s needs. Carrying out Congress’ direction, the Department of Health and Human Services (HHS), in consultation with public health experts, promulgated regulations requiring group health plans to cover all forms of contraception approved by the Food and Drug Administration (FDA). The genesis of this coverage should enlighten the Court’s resolution of these cases.

[Omit discussion of the Women’s Health Care amendment to the Affordable Care Act to specify that required preventive care that must be included in insurance without cost sharing must include the “full range” of FDA approved contraceptive methods.]

While the Women’s Health Amendment succeeded, a countermove proved unavailing. The Senate voted down the so-called “conscience amendment,” which would have enabled any employer or insurance provider to deny coverage based on its asserted “religious beliefs or moral convictions.” The exemption sought by Hobby Lobby and Conestoga would override significant interests of the corporations’ employees and covered dependents. It would deny legions of women who do not hold their employers’ beliefs access to contraceptive coverage that the ACA would otherwise secure.

[Note: The dissent’s analysis regarding what it believes to be the majority’s errors in interpreting and applying RFRA to the cases is omitted. Justice Ginsburg argues that the sole purpose of RFRA was to restore the stricter test of constitutionality used prior to Smith and not to expand religious rights or freedoms. Given the limited purpose underlying RFRA, Justice Ginsburg concludes that the companies are not “persons” who “exercise religion” under the law and thus cannot invoke protection. (Justices Breyer and Kagan do not join this portion of Justice Ginsburg’s opinion). Justice Ginsburg’s opinion picks up again at the point at which she analyzes the “substantial burden,” “compelling interest,” and “least restrictive means” elements of RFRA]

Even if Hobby Lobby and Conestoga were deemed RFRA “person[s],” to gain an exemption, they must demonstrate that the contraceptive coverage requirement “substantially burden[s] [their] exercise of religion.” The Court barely pauses to inquire whether any burden imposed by the contraceptive coverage requirement is substantial. Instead, it rests on the Greens’ and Hahns’ “belie[f] that providing the coverage demanded by the HHS regulations is connected to the destruction of an embryo in a way that is sufficient to make it immoral for them to provide the coverage.” I agree with the Court that the Green and Hahn families’ religious convictions regarding contraception are sincerely held. But those beliefs, however deeply held, do not suffice to sustain a RFRA claim. RFRA, properly understood, distinguishes between factual allegations that [plaintiffs’] beliefs are sincere and of a religious nature, which a court must accept as true, and the legal conclusion . . . that [plaintiffs’] religious exercise is substantially burdened, an inquiry the court must undertake. [T]oday’s decision elides entirely the distinction
between the sincerity of a challenger’s religious belief and the substantiality of the burden placed on the challenger.

Undertaking the inquiry that the Court forgoes, I would conclude that the connection between the families’ religious objections and the contraceptive coverage requirement is too attenuated to rank as substantial. The requirement carries no command that Hobby Lobby or Conestoga purchase or provide the contraceptives they find objectionable. Instead, it calls on the companies covered by the requirement to direct money into undifferentiated funds that finance a wide variety of benefits under comprehensive health plans. Those plans, in order to comply with the ACA, must cover contraceptive coverage without cost sharing, just as they must cover an array of other preventive services.

Importantly, the decisions whether to claim benefits under the plans are made not by Hobby Lobby or Conestoga, but by the covered employees and dependents, in consultation with their health care providers. Should an employee of Hobby Lobby or Conestoga share the religious beliefs of the Greens and Hahns, she is of course under no compulsion to use the contraceptives in question. It is doubtful that Congress, when it specified that burdens must be “substantial[,]” had in mind a linkage thus interrupted by independent decisionmakers (the woman and her health counselor) standing between the challenged government action and the religious exercise claimed to be infringed. Any decision to use contraceptives made by a woman covered under Hobby Lobby or Conestoga’s plan will not be propelled by the Government, it will be the woman’s autonomous choice, informed by the physician she consults.

Even if one were to conclude that Hobby Lobby and Conestoga meet the substantial burden requirement, the Government has shown that the contraceptive coverage for which the ACA provides furthers compelling interests in public health and women’s wellbeing.

That Hobby Lobby and Conestoga resist coverage for only 4 of the 20 FDA-approved contraceptives does not lessen these compelling interests. Notably, the corporations exclude intrauterine devices (IUDs), devices significantly more effective, and significantly more expensive than other contraceptive methods. Moreover, the Court’s reasoning appears to permit commercial enterprises like Hobby Lobby and Conestoga to exclude from their group health plans all forms of contraceptives.

It bears note in this regard that the cost of an IUD is nearly equivalent to a month’s full-time pay for workers earning the minimum wage; that almost one-third of women would change their contraceptive method if costs were not a factor; and that only one-fourth of women who request an IUD actually have one inserted after finding out how expensive it would be.

Stepping back from its assumption that compelling interests support the contraceptive coverage requirement, the Court notes that small employers and grandfathered plans are not subject to the requirement. If there is a compelling interest in contraceptive coverage, the Court suggests, Congress would not have created these
exclusions. Federal statutes often include exemptions for small employers, and such provisions have never been held to undermine the interests served by these statutes. The ACA’s grandfathering provision, 42 U.S.C. § 18011, allows a phasing-in period for compliance with a number of the Act’s requirements (not just the contraceptive coverage or other preventive services provisions). Once specified changes are made, grandfathered status ceases. The percentage of employees in grandfathered plans is steadily declining, having dropped from 56% in 2011 to 48% in 2012 to 36% in 2013. In short, far from ranking as a categorical exemption, the grandfathering provision is temporary, intended to be a means for gradually transitioning employers into mandatory coverage.

The Court ultimately acknowledges a critical point: RFRA’s application “must take adequate account of the burdens a requested accommodation may impose on nonbeneficiaries.” After assuming the existence of compelling government interests, the Court holds that the contraceptive coverage requirement fails to satisfy RFRA’s least restrictive means test.

Then let the government pay (rather than the employees who do not share their employer’s faith), the Court suggests. The ACA, however, requires coverage of preventive services through the existing employer-based system of health insurance so that [employees] face minimal logistical and administrative obstacles. Impeding women’s receipt of benefits by requiring them to take steps to learn about, and to sign up for, a new [government funded and administered] health benefit was scarcely what Congress contemplated. Moreover, Title X of the Public Health Service Act is the nation’s only dedicated source of federal funding for safety net family planning services.

And where is the stopping point to the “let the government pay” alternative? Suppose an employer’s sincerely held religious belief is offended by health coverage of vaccines, or paying the minimum wage, or according women equal pay for substantially similar work? Does it rank as a less restrictive alternative to require the government to provide the money or benefit to which the employer has a religion-based objection? Because the Court cannot easily answer that question, it proposes something else: Extension to commercial enterprises of the accommodation already afforded to nonprofit religion-based organizations. “At a minimum,” according to the Court, such an approach would not “impinge on [Hobby Lobby’s and Conestoga’s] religious belief.” [T]he “special solicitude” [is] generally accorded nonprofit religion-based organizations that exist to serve a community of believers, solicitude never before accorded to commercial enterprises comprising employees of diverse faiths.

Ultimately, the Court hedges on its proposal to align for-profit enterprises with nonprofit religion-based organizations. “We do not decide today whether [the] approach [the opinion advances] complies with RFRA for purposes of all religious claims.” Conestoga suggests that, if its employees had to acquire and pay for the contraceptives (to which the corporation objects) on their own, a tax credit would qualify as a less restrictive alternative. A tax credit, of course, is one variety of “let the government pay.” In addition to departing from the existing employer-based system of health insurance, Conestoga’s alternative would require a woman to reach into her own pocket in the first
instance, and it would do nothing for the woman too poor to be aided by a tax credit. In sum, in view of what Congress sought to accomplish, i.e., comprehensive preventive care for women furnished through employer-based health plans, none of the proffered alternatives would satisfactorily serve the compelling interests to which Congress responded.

Among the pathmarking pre-Smith decisions RFRA preserved is United States v. Lee, [ ] (1982). Lee, a member of the Old Order Amish, sincerely believed that withholding Social Security taxes from his employees or paying the employer’s share of such taxes would violate the Amish faith. This Court held that, although the obligations imposed by the Social Security system conflicted with Lee’s religious beliefs, the burden was not unconstitutional. The Court dismisses Lee as a tax case.

But the Lee Court made two key points one cannot confine to tax cases. When followers of a particular sect enter into commercial activity as a matter of choice, the Court observed, the limits they accept on their own conduct as a matter of conscience and faith are not to be superimposed on statutory schemes which are binding on others in that activity. The statutory scheme of employer-based comprehensive health coverage involved in these cases is surely binding on others engaged in the same trade or business as the corporate challengers here. Further, the Court recognized in Lee that allowing a religion-based exemption to a commercial employer would operate to impose the employer’s religious faith on the employees.

Why should decisions of this order be made by Congress or the regulatory authority, and not this Court? Hobby Lobby and Conestoga surely do not stand alone as commercial enterprises seeking exemptions from generally applicable laws on the basis of their religious beliefs. See, e.g., Newman v. Piggie Park Enterprises, Inc., [ ] (owner of restaurant chain refused to serve black patrons based on his religious beliefs opposing racial integration) 390 U.S. 400 (1968); In re Minnesota ex rel. McClure, [ ] (Minn.1985) (born-again Christians who owned closely held, for-profit health clubs believed that the Bible proscribed hiring or retaining an “individua[l] living with but not married to a person of the opposite sex,” “a young, single woman working without her father’s consent or a married woman working without her husband’s consent,” and any person “antagonistic to the Bible,” including “fornicators and homosexuals” Elane Photography, LLC v. Willock, N.M. 2013 [ ] (for-profit photography business owned by a husband and wife refused to photograph a lesbian couple’s commitment ceremony based on the religious beliefs of the company’s owners), cert. denied, 572 U.S. —— (2014). Would RFRA require exemptions in cases of this ilk? And if not, how does the Court divine which religious beliefs are worthy of accommodation, and which are not? Isn’t the Court disarmed from making such a judgment given its recognition that “courts must not presume to determine . . . the plausibility of a religious claim”?

Would the exemption the Court holds RFRA demands for employers with religiously grounded objections to the use of certain contraceptives extend to employers with religiously grounded objections to blood transfusions (Jehovah’s Witnesses); antidepressants (Scientologists); medications derived from pigs, including anesthesia,
intravenous fluids, and pills coated with gelatin (certain Muslims, Jews, and Hindus); and vaccinations (Christian Scientists, among others)? According to counsel for Hobby Lobby, “each one of these cases . . . would have to be evaluated on its own . . . applying the compelling interest-least restrictive alternative test.” Not much help there for the lower courts bound by today’s decision.

The Court, however, sees nothing to worry about. Today’s cases, the Court concludes, are “concerned solely with the contraceptive mandate.” But the Court has assumed, for RFRA purposes, that the interest in women’s health and well-being is compelling and has come up with no means adequate to serve that interest, the one motivating Congress to adopt the Women’s Health Amendment.

There is an overriding interest, I believe, in keeping the courts out of the business of evaluating the relative merits of differing religious claims, or the sincerity with which an asserted religious belief is held. The Court, I fear, has ventured into a minefield, by its immoderate reading of RFRA. I would confine religious exemptions under that Act to organizations formed “for a religious purpose,” “engage[d] primarily in carrying out that religious purpose,” and not “engaged . . . substantially in the exchange of goods or services for money beyond nominal amounts.”

Justice BREYER and Justice KAGAN, dissenting.

We agree with Justice GINSBURG that the plaintiffs’ challenge to the contraceptive coverage requirement fails on the merits. We need not and do not decide whether either for-profit corporations or their owners may bring claims under the Religious Freedom Restoration Act of 1993. Accordingly, we join all but Part III–C–1 of Justice GINSBURG’s dissenting opinion.

Round Two: The Religious Accommodation: Wheaton College v Burwell and Zubik v. Burwell

In the years that Hobby Lobby was pending, eight Circuit Courts of Appeals considered claims from religious non-profit organizations arguing that the requirement to notify their insurers or third party claims administrator if they had religious objections to providing insurance coverage for some or all contraception violated RFRA. Seven circuits concluded that the requirement to file a notice imposed no significant burden on the exercise of religion. See e.g. University of Notre Dame v. Burwell, 786 F.3d 606 (7th Cir. 2015) (Posner, J); Geneva College v. Secretary of HHS, 778 F3d. 422 (3rd Cir. 2015). However one circuit, after finding a substantial burden, held that the notice requirement was not the least restrictive alternative and that the government had options such as creating a publicly funded program or offering separate, subsidized contraception policies to employees of objecting organizations. Sharpe Holdings v Burwell 801 F. 3d 927 (8th Cir, 2015) Laurie Sobel and Alina Salganicoff, Round 2 on the Legal Challenges to Contraceptive Coverage: Are Nonprofits “Substantially Burdened” by the “Accommodation”? (Kaiser Family Foundation, 2015), http://www.kff.org/womens-health-policy/issue-brief/round-2-on-the-legal-challenges-to-contraceptive-coverage-are-

This set up the issue of the legality of the accommodation itself for appeal.

Given the Court’s seeming endorsement of the Hobby Lobby accommodation then in effect, many were surprised when it granted certiorari on the accommodation appeals. Even more surprising, on July 3, 2014, only three days after the Hobby decision, the Court issued an injunction in a separate case, barring the government from enforcing the accommodation as written and requiring that it permit an employer to simply register its objection in writing with the HHS Secretary, thereby requiring the government to directly notify the insurer or plan administrator in question regarding the employer’s decision. Wheaton College v Burwell, 134 S. Ct. 2806 (2014). Justices Kagan, Ginsburg, and Sotomayor dissented.

Following Wheaton College, the Administration, taking the hint, finalized regulations in fall 2015 that permit religious nonprofits and “closely held” corporations to notify either the HHS Secretary or their insurer or plan administrator regarding their desire not to include contraception in their plans. Under the regulation, a privately held corporation entitled to accommodation is one that is not publicly traded, is majority-owned by a relatively small number of individuals, and objects to providing contraceptive coverage based on its owners’ religious beliefs. 80 Fed. Reg. 41318 (July 14, 2015).

This concession was not enough. Following the split in the circuits over the legality of the accommodation itself, the Court granted certiorari, consolidating all of the cases under the name Zubik v. Burwell (the name of one of the plaintiffs in the Third Circuit decision upholding the accommodation). Oral argument took place on March 24, 2016, one month after the death of Justice Antonin Scalia. A likely 4-4 decision would leave the circuit split in place. One week following oral argument, however, the Court issued an order directing the parties to file supplemental briefs “that address whether and how contraceptive coverage may be obtained by petitioners’ employees through petitioners’ insurance companies, but in a way that does not require any involvement of petitioners beyond their own decision to provide health insurance without contraceptive coverage to their employees.” Subsequent to the supplemental briefing, on May 16, 2016, the Court issued a per curium opinion.

Following oral argument, the Court requested supplemental briefing from the parties addressing whether contraceptive coverage could be provided to petitioners’ employees, through petitioners’ insurance companies, without any such notice from petitioners. Both petitioners and the Government now confirm that such an option is feasible. Petitioners have clarified that their religious exercise is not infringed where they need to do nothing more than contract for a plan that does not include coverage for some or all forms of contraception, even if their employees receive cost-free contraceptive coverage from the same insurance company. The Government has confirmed that the challenged procedures for employers with insured plans could be modified to operate in the manner posited in the Court’s order while still ensuring that the affected women receive
contraceptive coverage seamlessly, together with the rest of their health coverage.

In light of the positions asserted by the parties in their supplemental briefs, the Court vacates the judgments below and remands to the respective United States Courts of Appeals[]. Given the gravity of the dispute and the substantial clarification and refinement in the positions of the parties, the parties on remand should be afforded an opportunity to arrive at an approach going forward that accommodates petitioners' religious exercise while at the same time ensuring that women covered by petitioners' health plans receive full and equal health coverage, including contraceptive coverage. We anticipate that the Courts of Appeals will allow the parties sufficient time to resolve any outstanding issues between them.

The Court finds the foregoing approach more suitable than addressing the significantly clarified views of the parties in the first instance. Although there may still be areas of disagreement between the parties on issues of implementation, the importance of those areas of potential concern is uncertain, as is the necessity of this Court’s involvement at this point to resolve them. This Court has taken similar action in other cases in the past. The Court expresses no view on the merits of the cases. In particular, the Court does not decide whether petitioners’ religious exercise has been substantially burdened, whether the Government has a compelling interest, or whether the current regulations are the least restrictive means of serving that interest.

Nothing in this opinion, or in the opinions or orders of the courts below, is to affect the ability of the Government to ensure that women covered by petitioners’ health plans obtain, without cost, the full range of FDA-approved contraceptives. Through this litigation, petitioners have made the Government aware of their view that they meet the requirements for exemption from the contraceptive coverage requirement on religious grounds. Nothing in this opinion, or in the opinions or orders of the courts below, precludes the Government from relying on this notice, to the extent it considers it necessary, to facilitate the provision of full contraceptive coverage going forward. Because the Government may rely on this notice, the Government may not impose taxes or penalties on petitioners for failure to provide the relevant notice.

It is so ordered.

135 S. Ct. 1557.
In a separate concurrence, Justices Sotomayor, joined by Justice Ginsburg, wrote:

I join the Court’s per curium opinion because it expresses no view on the merits of the cases, whether petitioners’ religious exercise has been substantially burdened, or whether the current regulations are the least restrictive means of serving” a compelling governmental interest. Ante, at 1560–1561. Lower courts, therefore, should not construe either today’s per curium or our order of March 29, 2016, as signals of where this Court stands. We have included similarly explicit disclaimers in previous orders. See, e.g., Wheaton College v. Burwell, 573 U.S. ——, 134 S. Ct. 2806 (2014) (“[T]his order should not be construed as an expression of the Court's views on the merits”). Yet some lower courts have ignored those instructions. See, e.g., Sharpe Holdings, Inc. v. Department of Health and Human Servs., 801 F.3d 927, 944 (C.A.8 2015) On remand in these cases, the Courts of Appeals should not make the same mistake.

I also join the Court’s opinion because it allows the lower courts to consider only whether existing or modified regulations could provide seamless contraceptive coverage to petitioners’ employees, through petitioners’ insurance companies, without any . . . notice from petitioners. The opinion does not, by contrast, endorse the petitioners’ position that the existing regulations substantially burden their religious exercise or that contraceptive coverage must be provided through a separate policy, with a separate enrollment process. Such separate contraceptive-only policies do not currently exist, and the Government has laid out a number of legal and practical obstacles to their creation. Requiring standalone contraceptive-only coverage would leave in limbo all of the women now guaranteed seamless preventive-care coverage under the Affordable Care Act. And requiring that women affirmatively opt into such coverage would “impose precisely the kind of barrier to the delivery of preventive services that Congress sought to eliminate.

Today’s opinion does only what it says it does: afford[s] an opportunity for the parties and Courts of Appeals to reconsider the parties’ arguments in light of petitioners’ new articulation of their religious objection and the Government’s clarification about what the existing regulations accomplish, how they might be amended, and what such an amendment would sacrifice. As enlightened by the parties’ new submissions, the Courts of Appeals remain free to reach the same conclusion or a different one on each of the questions presented by these cases.

The *per curiam* opinion in *Zubik* resulted in a vacating of the judgments by the appeals courts and a remand back to the circuits to reconsider their respective cases “in light of the substantial clarification and refinement in the positions of the parties” in their supplemental briefs. 136 S. Ct. 1557, 1560 (2016). As of July 2017, the cases all sit in
their respective appellate courts, unresolved. In the meantime, Judge Neil Gorsuch, one of the dissenting judges in the 10th Circuit decision upholding the accommodation as lawful, has assumed the seat left vacant by the death of Justice Scalia.

In order to effectively try to bring the remanded cases to a resolution, in July 2016, the Obama administration published a “request for information” seeking comments from interested parties as to whether a resolution of the dispute was possible that would meet the objections of the religious entities but still ensure women’s access to health care. The administration received over 54,000 comments. On January 9, 2017, the Obama administration released its response, in the form of a “Frequently Asked Questions,” a subregulatory document. https://www.dol.gov/sites/default/files/ebsa/about-ebsa/our-activities/resource-center/faqs/aca-part-36.pdf In the release the Administration indicated that it would issue no revised religious accommodation. It concluded that a process like the one suggested by the Court would not be acceptable to the religious entities and would present administrative and operational challenges that would undermine women’s access to health care. Insurers commented that the Court’s compromise would not work, because without clear instructions from employers (either directly or through a third party) they would not know what additional administration steps would be needed. The compromise also did not resolve what to do about self-insured plans, which cover more than half of all employees.

The January 9th FAQs also rejected a suggestion made by the religious employers’ suggestion in their Supreme Court briefs—as well as by a number of commenters—who suggested that the answer lay in the sale of individual contraceptive-only policies to women. The Administration concluded that such a result was not feasible. As a stand-alone product, such coverage would be too costly; indeed, far from being offset by savings from a reduction in unintended pregnancies, the premium set by insurers would have to equal the cost of covering contraceptives over the term of the policy. This premium could easily exceed $1000 for the most effective long-acting, reversible contraception. And even if such a policy made financial sense, it would be up to the states to determine what types of insurance could lawfully be sold. Unless a new Republican President and Congress would enact such a preemptive law, the federal government could not force any state to agree to approve such as strategy. As of July 2017, only 28 states require insurers to cover contraceptives at least to some degree, and as you learned in Chapter 8, states cannot mandate such coverage by self-insured plans. Guttmacher Institute, Insurance Coverage of Contraceptives, https://www.guttmacher.org/state-policy/explore/insurance-coverage-contraceptives (Accessed July 9, 2017)

Notes

As noted, also unaddressed is the situation of self-insuring employers. If an employer with religious objections administers its own plan, there is no one to whom it can give notice or to shift the responsibility of providing coverage for contraception. What if the insurance company or plan administrator itself has religious objections to contraception? Catholic insurance companies have administered Medicaid in many states for many years, on the understanding that they could do this work only if they made arrangements to assure that women eligible for Medicaid would have seamless access to all of the services to which they were entitled under Medicaid, including contraception. What does Zubik say about this common arrangement? See Julie Rover, *Rise of Catholic Insurance Plans Raises Questions About Contraceptive Coverage*, Kaiser Health News, Sept. 17, 2014, [http://khn.org/news/rise-of-catholic-insurance-plans-raises-questions-about-contraceptive-coverage/](http://khn.org/news/rise-of-catholic-insurance-plans-raises-questions-about-contraceptive-coverage/) (Accessed July 21, 2017).

The practical sweep of the decision is also unclear. On the one hand hundreds of thousands of employers are subject the ACA requirements that insurance plans cover essential benefits, including contraception, and millions of Americans depend on this insurance coverage. The agencies estimated that as of July 2015, there were 140,000 large (over 100 employees) plans covering 93.2 million participants, and 2.2 million small (100 or fewer employees) ERISA health plans covering 36 million participants. Because the rules were issued by three agencies (HHS, the Department of Labor, and the Department of the Treasury), the final rule also reaches ERISA-exempt public employers covered by regulations issued under the Public Health Service Act. The agencies estimated there were 128,000 large governmental plans, with 39 million participants in large plans and 2.8 million in small plans. (The agencies also noted that 12.26 million people were covered by individual insurance policies, whose issuers of course must comply with all preventive services rules). The agencies noted that some 500 issuers offered individual and group insurance coverage and that the proportion of employers offering at least one grandfathered plan as of 2014 had dropped to 37 percent, with only 26 percent of all workers enrolled in a grandfathered plan that year. On the other hand, it is unclear how many employers would seek to refuse to provide coverage for contraception. As noted in the Book at page 130, between 1995 and 2010 the proportion of employers including a full range of contraception services in their insurance plans increased from 30 to 90 percent. The recent exclusion of contraception from otherwise broad coverage of prescription drugs was not, for the most part, defended on the basis of employer religious or moral concerns, but rather by a gendered belief that contraception is cosmetic and pregnancy a life-style choice. The broad social and political forces that produced these recent dramatic changes in insurance coverage for contraception may discourage employers from invoking the accommodation. The Kaiser Family Foundation’s Annual Employer Health Benefit Survey estimates that only 3% of all nonprofit firms of any size offering coverage might be expected to self-certify as having a religious objection to coverage of contraception, a figure that rises to 10% among the largest nonprofits (1000 employees or higher). The Kaiser data provide no estimate regarding the number of closely-held for-profit firms that might be expected to seek an exemption. See Laurie Sobel, *Data Notes: Are Nonprofits Requesting an Accommodation for Contraceptive Coverage?* (Dec. 1, 2015). [http://kff.org/womens-health-policy/issue-brief/data-note-are-nonprofits-requesting-an-accommodation-for-contraceptive-coverage/](http://kff.org/womens-health-policy/issue-brief/data-note-are-nonprofits-requesting-an-accommodation-for-contraceptive-coverage/)
Still, for the significant numbers of women affected by an employer’s decisions to exclude coverage for contraception, the impact is enormous.

2. *Is Hobby Lobby’s view of RFRA cogent?* The imagery surrounding the case has made resolution of the issue seemingly impossible. It’s not the employers’ plans that have been hijacked in this instance—it is the characterization of the issues themselves. Rather than understanding the government’s accommodation as the means of carrying out Congress’s vision of seamless coverage, the case became all about the hijacking of health plans. The fact that seamlessness is achieved while still exempting employers from the coverage requirement is irrelevant under this hijacking theory of the case. Instead, the image of the employer’s plan as the conduit for birth control became indelibly stamped on everyone’s brain, including several of the Justices who heard the case.

Justice Alito’s opinion in *Hobby Lobby* effectively created an impossible bind. All a plaintiff has to do is simply allege not only a sincerely held religious belief but also a substantial burden on that belief, at which point the burden of proof shifts to the government to show that the accommodation serves a compelling interest and is the least restrictive means by which the government can further that interest. The evidence of substantial burden is based on allegation alone, just as is the evidence of sincerely-held religious belief, something that is not questioned in a RFRA case. This analysis flows directly from Justice Alito’s opinion:

The *Hobby Lobby* plaintiffs believe that providing the coverage demanded by the HHS regulations is connected to the destruction of an embryo in a way that is sufficient to make it immoral for them to provide the coverage. Arrogating the authority to provide a binding national answer to this religious and philosophical question, HHS and the principal dissent in effect tell the plaintiffs that their beliefs are flawed. For good reason, we have repeatedly refused to take such a step. [The plaintiffs] sincerely believe that providing the insurance coverage demanded by the HHS regulations lies on the forbidden side of the line, and it is not for us to say that their religious beliefs are mistaken or insubstantial. Instead, our narrow function * * * in this context is to determine whether the line drawn reflects an honest conviction, and there is no dispute that it does.

134 S.Ct. at 2778. In dissent, Justice Ginsburg wrote that “today’s decision elides entirely the distinction between the sincerity of a challenger’s religious belief and the substantiality of the burden placed on the challenger,” id. at 2799, but she also saw the basic problem: “how does the Court divine which religious beliefs are worthy of accommodation, and which are not? Isn’t the Court disarmed from making such a judgment given its recognition that ‘courts must not presume to determine . . . the plausibility of a religious claim?’” Id. at 2804.

The dueling opinions and positions attempt to elide this problem by playing games with causation. Those defending the accommodation point out the “but, for” causation games in the numerous iterations of the challengers’ complicity argument,
stressing most saliently that independent agents—the government, the insurers, and one could add, female employees and students who desire contraception—break the causal chain and end religious employers’ claimed complicity. However, challengers assert that religious doctrine rejects precisely the role of such independent agency in stopping complicity. To argue that complicity ends because they don’t pay, don’t have to file a form, etc., in fact amounts to a rejection of a sincerely held religious belief.

If we adhere to *Hobby Lobby*, they have a point, do they not? What the religious entity objects to—whether the analysis comes at the “substantial burden” or the “less restrictive alternative” stage—is an assessment of its beliefs by any authority other than those that constitute the religion’s authoritative sources or controlling authorities. The problem is embedded in the very analysis, which involves balancing, as the very word “accommodation” invokes. However, what is left to be balanced if the religious actor sincerely believes that any form of accommodation violates its religion? In essence, if we take *Hobby Lobby* seriously, so long as the religious belief that the accommodation violates is sincerely held, the cases boil down to a clash between two sovereigns, the sovereign authority of secular law and the sovereign authority established by religious doctrine: Which trumps the other?

This paradox, for better or worse, renders Justice Alito’s opinion in *Hobby Lobby* incoherent. Using the tri-part burden shifting mechanism invoked there, Justice Alito writes, first, that so long as the objectors’ sincerely held religious beliefs are that some action demanded of them violates their beliefs, there is a substantial burden. He then holds that there is a less restrictive alternative and therefore objectors prevail. The first part of the analysis stays within the religious beliefs, while the second part moves outside of them by objectively analyzing the impacts on both the objectors’ beliefs and the government’s goals of various alternatives. However, if the basis of the doctrine in the burden portion of the analysis is that it is illegitimate to assess burden from a perspective outside of religious beliefs, then it is equally illegitimate to analyze those burdens in an objective assessment of various alternatives in the third part of the balancing test. Given that the belief, at least in Catholic doctrine, is that any involvement in any fashion with non-approved forms of contraception and abortion is a mortal sin, then any action related to access to contraception and abortion and required of them at all violates sincerely held beliefs.

Thus, if the Supreme Court were to take a case again, it would have two, honest options. First, it could say that it was wrong in *Hobby Lobby* to state that a court cannot legitimately assess the degree of burden on religion, and thus *Hobby Lobby* was wrong. Second, in the third step it could say that there is no alternative that does not substantially burden sincerely held religious beliefs, and therefore *Hobby Lobby* was wrong in holding that there were alternatives. The *Hobby Lobby* plaintiffs should have lost. Talk about being between a rock and a hard place. The Court also could continue on its less-than-honest path of applying different standards of review to challenges to government policies and challenges to government accommodations of those policies.
If you read between the lines in *Zubik’s* per curiam opinion, do you think the Court wants to see these cases again? Given the opinion in *Hobby Lobby*, can you understand why?

3. *Is there a less restrictive alternative?* Of course, even if a law substantially burdens a religious observer, that is not the end of the story under RFRA. If the government can show a compelling interest and if the accommodation offered represents the least restrictive alternative, the law is upheld. In a world in which 150 million people depend on employer insurance, adding the coverage to the benefits covered under the employer plan would seem to be the least restrictive alternative.

According to the Guttmacher Institute, the nation’s leading source of information on contraception, reproduction, and abortion, 38 million women of reproductive age were in need of contraceptive services in 2014, and among them, 20 million (over half) needed publicly funded services because of low family income. While Medicaid covers millions of women of childbearing age and provides family planning services and supplies as a required services, millions remain without coverage, particularly in the 19 states that to date have refused to expand Medicaid under the Affordable Care Act. Furthermore, mandatory Medicaid coverage ends at 138 percent of the federal poverty level. Additionally, women with employer coverage that meets the “minimum essential coverage” test* are barred from securing subsidized coverage in the Exchange. Even were Congress to amend the ACA to enable women without employer coverage to buy a subsidized plan through the Exchange, the burden would shift to them to secure their coverage. Simply having their plan insurer or administer provide benefits as a supplement makes sense both from a patient perspective but also from a population health perspective.

To provide a flavor of the political complexity of trying to set up a separate contraception plan, consider the fate of Title X of the Public Health Service Act, which provides grants for the development and support of clinics that furnish low-cost family planning services. Title X plays a crucial role because it provides direct funding to clinics to support their operations in underserved communities and enables clinics to reach women without insurance. Yet in 2014, total Title X federal funding stood at only $228 million (about $10 annually for every woman needing publicly subsidized services). Furthermore, public funding for family planning through Title X fell 71% in real-dollar terms between 1980 and 2010. Adam Sonfield and Rachel Benson Gold, Public Funding for Family Planning, Sterilization, and Abortion Services, 1980-2010, [http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf](http://www.guttmacher.org/pubs/Public-Funding-FP-2010.pdf) (Accessed July 21, 2017). Given this history, how realistic is it that Congress would establish such a program on a national scale for all members of all types of health insurance plans?

4. *The accommodation viewed from a moral perspective.* M. Cathleen Kaveny of Boston College of Law School writes about the contraception accommodation and its role in religion in a pluralistic society. In her view, the claim made by some religious

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* In order to be considered minimum essential coverage, an employer plan must cover at least 60% of the premium for self-only coverage.
advocates that religious observers deserve on legal or constitutional grounds to be exempted from broadly applicable laws does not automatically flow from the teachings of the Church. Indeed, she points out, a core tenet of the Church is a respect for pluralism. Given the diversity of views that would be expected among employees of a hospital or a university or a large social services agency, is it not consistent with the Church’s teachings, she argues, for the Church to respect such pluralism in the moral underpinnings it brings to the question of employee compensation, in this case, health benefits? M. Cathleen Kaveny, Law, Religion and Conscience in a Pluralistic Society: The Case of Little Sisters of the Poor. (Boston College Law School Research Paper 394, March 2016), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2756148 (Accessed July 21, 2017).

Round Three: Contraception Coverage and the Trump/Pence Administration.

President Trump issued an executive order on May 4, 2017, instructing the Departments of HHS, Treasury and Labor to develop regulations to “address conscience-based objections to the preventive-care mandate,” requiring coverage for contraception under the ACA. He announced the order in a Rose Garden ceremony honoring The Little Sisters of the Poor, and assuring them that their “long ordeal will soon be over.” Robert Pear, White House Acts to Ross Back Birth-Control Mandate for Religious Employers, New York Times, May 29, 2017. A May 23 draft of a rule, still under review by the Office of Management and Budget as of July 9 2017, has been widely reported in the press. https://www.documentcloud.org/documents/3761268-Preventive-Services-Final-Rule-0.html (Accessed July 21, 2017).

On October 13th, 2017, the administration issued two sets of interim final rules granting sweeping new exemptions from the contraceptive coverage requirement based on religious (82 Fed. Reg. 47792) or moral (82 Fed. Reg. 47838) grounds. In December 2017, the United States District Court for the Northern District of California granted a nationwide preliminary injunction against their enforcement and required reinstatement of the regulations in effect as of the date of the interim final rules.

State of CALIFORNIA

v.

United States Department of Health and Human Services
281 F. Supp. 3d 806 (N.D. CA 2017)

Haywood S. Gilliam, District Judge

I. INTRODUCTION

Pending before the Court is a motion for a preliminary injunction that would enjoin two interim final rules (“IFRs”) exempting certain entities from the Affordable Care Act’s mandate to employers to provide contraceptive coverage. Plaintiffs are the
Defendants begin their brief in opposition to the motion for preliminary injunction with the contention that “[t]his case is about religious liberty and freedom of conscience.” And without question, that is one of the important values at issue in this case. But Defendants’ characterization leaves out an equally critical aspect of what this case is about. Since its enactment, the Affordable Care Act (“ACA”) has required group health insurance plans to provide women access to preventive care, including contraceptives, without imposing any cost sharing requirement. Less than two years ago, in April 2016, Defendants (or, in the case of the individual defendants, their predecessors) represented to the Supreme Court that the United States Government has a compelling interest in ensuring access to such coverage for women. *Zubik v. Burwell*, 136 S.Ct. 1557 (2016). Moreover, Defendants have consistently recognized the need to balance this compelling interest with the important goal of “minimiz[ing] any burden on religious exercise.”

But the Defendants have now changed their position, dramatically. In the IFRs that became effective on October 6, 2017, Defendants asserted that there is no such compelling interest after all. They also markedly expanded the scope of the exemption available to religious entities under the ACA’s contraceptive coverage mandate, and created an entirely new exemption based on moral objections. In sum, the IFRs represent an abandonment of the Defendants’ prior position with regard to the contraceptive coverage requirement, and a reversal of their approach to striking the proper balance between substantial governmental and societal interests.

These highly-consequential IFRs were implemented without any prior notice or opportunity to comment. The Court finds that, at a minimum, Plaintiffs are likely to succeed in showing that this process violated the Administrative Procedure Act, and that this violation will cause them imminent harm if enforcement of the IFRs is not enjoined.

II. BACKGROUND

Before turning to Plaintiffs’ challenge to the IFRs at issue in this case, the Court recounts the sequence of events which began with the enactment of the Affordable Care Act in 2010.

A. The Affordable Care Act

In March 2010, Congress enacted the Affordable Care Act. The ACA included a provision known as the Women’s Health Amendment, which states:

A group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide
coverage for and shall not impose any cost sharing requirements for . . . with respect to women, such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.


B. The 2010 IFR and Subsequent Regulations

On July 19, 2010, under the authority of the Women’s Health Amendment, several federal agencies (including HHS, the Department of Labor, and the Department of the Treasury) issued an interim final rule (“the 2010 IFR”). It required, in part, that health plans provide “evidence-informed preventive care” to women, without cost sharing and in compliance with “comprehensive guidelines” to be provided by HHS’ Health Resources and Services Administration (“HRSA”).

The agencies found they had statutory authority “to promulgate any interim final rules that they determine[d were] appropriate to carry out the” relevant statutory provisions. The agencies also determined they had good cause to forgo the general notice of proposed rulemaking required under the Administrative Procedure Act (“APA”), 5 U.S.C. § 553. Specifically, the agencies determined that issuing such notice would be “impracticable and contrary to the public interest” because it would not allow sufficient time for health plans to be timely designed to incorporate the new requirements under the ACA, which were set to go into effect approximately two months later. The agencies requested that comments be submitted by September 17, 2010, the date the IFR was scheduled to go into effect.

On September 17, 2010, the agencies first promulgated regulations pursuant to the 2010 IFR. [The] regulations were substantively identical to the IFR, stating that HRSA was to provide “binding, comprehensive health plan coverage guidelines.”

C. The 2011 HRSA Guidelines

From November 2010 to May 2011, a committee convened by the Institute of Medicine (“IOM”) met in response to the charge of HHS’ Office of the Assistant Secretary for Planning and Evaluation: to “convene a diverse committee of experts” related to, as relevant here, women’s health issues. In July 2011, the committee issued a report recommending that private health insurance plans be required to cover all contraceptive methods approved by the Food and Drug Administration (“FDA”), without cost sharing. On August 1, 2011, HRSA issued its preventive care guidelines (“2011
Guidelines”), defining preventive care coverage to include all FDA-approved contraceptive methods.\(^3\)

D. The 2011 IFR and the Original Religious Exemption

On August 3, 2011, the agencies issued an IFR amending the 2010 IFR. Based on the “considerable feedback” they received regarding contraceptive coverage for women, the agencies stated that it was “appropriate that HRSA, in issuing [its 2011] Guidelines, take[ ] into account the effect on the religious beliefs of certain religious employers if coverage of contraceptive services were required . . . .” As such, the agencies provided HRSA with the “additional discretion to exempt certain religious employers from the [2011] Guidelines where contraceptive services are concerned.” They defined a “religious employer” as one that:

- (1) [h]as the inculcation of religious values as its purpose;
- (2) primarily employs persons who share its religious tenets;
- (3) primarily serves persons who share its religious tenets; and
- (4) is a non-profit organization under [the relevant statutory provisions, which] refer to churches, their integrated auxiliaries, and conventions or associations of churches, as well as to the exclusively religious activities of any religious order.

The 2011 IFR went into effect on August 1, 2011. The agencies again found that they had both statutory authority and good cause to forgo the APA’s advance notice and comment requirement. Specifically, they found that “providing for an additional opportunity for public comment [was] unnecessary, as the [2010 IFR] . . . provided the public with an opportunity to comment on the implementation of the preventive services requirement in this provision, and the amendments made in [the 2011 IFR were] in fact based on such public comments.” The agencies also found that notice and comment would be “impractical and contrary to the public interest,” because that process would result in a delay of implementation of the 2011 Guidelines. The agencies further stated that they were issuing the rule as an IFR in order to provide the public with some opportunity to comment. They requested comments by September 30, 2011.

On February 15, 2012, after considering more than 200,000 responses, the agencies issued a final rule adopting the definition of “religious employer” set forth in the

2011 IFR. The final rule also established a temporary safe harbor, during which the agencies

plan[ned] to develop and propose changes to these final regulations that would meet two goals—providing contraceptive coverage without cost-sharing to individuals who want it and accommodating non-exempted, non-profit organizations’ religious objections to covering contraceptive services . . .

E. The Religious Accommodation

On March 21, 2012, the agencies issued an advance notice of proposed rulemaking (“ANPR”) requesting comments on “alternative ways of providing contraceptive coverage without cost sharing in order to accommodate non-exempt, non-profit religious organizations with religious objections to such coverage.” They specifically sought to “require issuers to offer group health insurance coverage without contraceptive coverage to such an organization (or its plan sponsor),” while also “provid[ing] contraceptive coverage directly to the participants and beneficiaries covered under the organization’s plan with no cost sharing.” The agencies requested comment by June 19, 2012.

On February 6, 2013, after reviewing more than 200,000 comments, the agencies issued proposed rules that (1) simplified the criteria for the religious employer exemption; and (2) established an accommodation for eligible organizations with religious objections to providing contraceptive coverage. The proposed rule defined an “eligible organization” as one that (1) “opposes providing coverage for some or all of the contraceptive services required to be covered”; (2) “is organized and operates as a nonprofit entity”; (3) “holds itself out as a religious organization”; and (4) self-certifies that it satisfies these criteria. Comments on the proposed rule were due April 5, 2013.

On July 2, 2013, after reviewing more than 400,000 comments, the agencies issued final rules simplifying the religious employer exemption and establishing the religious accommodation. With respect to the latter, the final rule retained the definition of “eligible organization” set forth in the proposed rule. Under the accommodation, an eligible organization that met a “self-certification standard” was “not required to contract, arrange, pay, or refer for contraceptive coverage,” but its “plan participants and beneficiaries . . . [would] still benefit from separate payments for contraceptive services without cost sharing or other charge,” as required by law. The final rules were effective August 1, 2013.

F. The Hobby Lobby and Wheaton College Decisions

4 As to the definition of a religious employer, the final rule “eliminate[ed] the first three prongs and clarif[ied] the fourth prong of the definition” adopted in 2012. Under this new definition, “an employer that [was] organized and operate[d] as a nonprofit entity and [was] referred to in section 6033(a)(3)(A)(i) or (iii) of the Code [was] considered a religious employer for purposes of the religious employer exemption.”
On June 30, 2014, the Supreme Court issued its opinion in *Burwell v. Hobby Lobby Stores, Inc.*, in which three closely-held corporations challenged the requirement that they “provide health-insurance coverage for methods of contraception that violate[d] the sincerely held religious beliefs of the companies’ owners.” 134 S. Ct. 2751 (2014). The Court held that this requirement violated the Religious Freedom Restoration Act of 1993 (“RFRA”), 42 U.S.C. § 2000bb et seq., because it was not the “least restrictive means” of serving the compelling interest in guaranteeing cost-free access to certain methods of contraception. The Court pointed to the religious accommodation as support for this point: “HHS itself has demonstrated that it has at its disposal an approach that is less restrictive than requiring employers to fund contraceptive methods that violate their religious beliefs. . . . HHS has already established an accommodation for nonprofit organizations with religious objections.” The Court stated that the *Hobby Lobby* ruling “[did] not decide whether an approach of this type complies with RFRA for purposes of all religious claims,” and said its opinion “should not be understood to hold that an insurance-coverage mandate must necessarily fall if it conflicts with an employer’s religious beliefs.”

Several days later, the Court issued its opinion in *Wheaton College v. Burwell*, 134 S. Ct. 2806 (2014). The plaintiff was a nonprofit college in Illinois that was eligible for the accommodation. Wheaton College sought an injunction, however, “on the theory that its filing of a self-certification form [would] make it complicit in the provision of contraceptives by triggering the obligation for someone else to provide the services to which it objects.” The Court granted the application for an injunction, ordering that it was sufficient for the college to “[i]nform[ ] the Secretary of Health and Human Services in writing that it is a nonprofit organization that holds itself out as religious and has religious objections to providing coverage for contraceptive services . . . .” In other words, the college was not required to “use the form prescribed by the [g]overnment,” nor did it need to “send copies to health insurance issuers or third-party administrators.” The Court stated the order “should not be construed as an expression of the Court’s views on the merits.”

**G. Post–Hobby Lobby and -Wheaton Regulatory Action**

Shortly thereafter, on August 27, 2014, the agencies initiated two regulatory actions. First, in light of *Hobby Lobby*, they issued proposed rules “amend[ing] the definition of an eligible organization [for purposes of the religious accommodation] to include a closely held for-profit entity that has a religious objection to providing coverage for some or all of the contraceptive services otherwise required to be covered.” Comments were due on October 21, 2014.

Second, in light of *Wheaton*, the agencies issued IFRs (“the 2014 IFRs”) providing “an alternative process for the sponsor of a group health plan or an institution of higher education to provide notice of its religious objection to coverage of all or a

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5 The Court assumed without deciding that such an interest was compelling within the meaning of RFRA.
subset of contraceptive services, as an alternative to the EBSA Form 700 [i.e., the standard] method of self-certification.” The agencies asserted they had both statutory authority and good cause to forgo the notice and comment period, stating that such a process would be “impracticable and contrary to the public interest,” particularly in light of *Wheaton*. The IFRs were effective immediately, and comments were due October 27, 2014.

After considering more than 75,000 comments on the proposed rule, the agencies issued final rules “extend[ing] the accommodation to a for-profit entity that is not publicly traded, is majority-owned by a relatively small number of individuals, and objects to providing contraceptive coverage based on its owners’ religious beliefs”—i.e., to closely-held entities. The agencies also issued a final rule “continu[ing] to allow eligible organizations to choose between using EBSA Form 700 or the alternative process consistent with the Wheaton interim order.”

**H. The Zubik Opinion and Subsequent Impasse**

On May 16, 2016, the Supreme Court issued its opinion in *Zubik v. Burwell*, 136 S.Ct. 1557 (2016) (per curiam). The petitioners, primarily non-profit organizations, were eligible for the religious accommodation, but challenged the requirement that they submit notice to either their insurer or the federal government as a violation of RFRA. “Following oral argument, the Court requested supplemental briefing from the parties addressing ‘whether contraceptive coverage could be provided to petitioners’ employees, through petitioners’ insurance companies, without any such notice from petitioners.’” After the parties stated that “such an option [was] feasible,” the Court remanded to afford them “an opportunity to arrive at an approach going forward that accommodates petitioners’ religious exercise while at the same time ensuring that women covered by petitioners’ health plans receive full and equal health coverage, including contraceptive coverage.’” (emphasis added). As in *Wheaton*, “[t]he Court express[ed] no view on the merits of the cases,” and did not decide “whether petitioners’ religious exercise has been substantially burdened, whether the [g]overnment has a compelling interest, or whether the current regulations are the least restrictive means of serving that interest.”

On July 22, 2016, the agencies issued a request for information (“RFI”) on whether, in light of *Zubik*,

> there are alternative ways (other than those offered in current regulations) for eligible organizations that object to providing coverage for contraceptive services on religious grounds to obtain an accommodation, while still ensuring that women enrolled in the organizations’ health plans have access to seamless coverage of the full range of [FDA]-approved contraceptives without cost sharing.

Comments were due September 20, 2016. On January 9, 2017, the agencies issued a document titled “FAQs About Affordable Care Act Implementation Part 36”
(“FAQs”). The FAQs stated that, based on the 54,000 comments received in response to the July 2016 RFI, there was “no feasible approach . . . at this time that would resolve the concerns of religious objectors, while still ensuring that the affected women receive full and equal health coverage, including contraceptive coverage.”

I. The 2017 IFRs at Issue

On May 4, 2017, the President issued Executive Order No. 13,798, directing the secretaries of the departments of the Treasury, Labor, and HHS to “consider issuing amended regulations, consistent with applicable law, to address conscience-based objections to the preventive care mandate . . . .” Subsequently, the agencies issued the Religious Exemption IFR and the Moral Exemption IFR at issue in this case (collectively, “the 2017 IFRs”). The 2017 IFRs departed from the prior regulations in several important ways.

1. The Religious Exemption IFR

First, with the Religious Exemption IFR, the agencies substantially broadened the scope of the religious exemption, extending it “to encompass entities, and individuals, with sincerely held religious beliefs objecting to contraceptive or sterilization coverage,” and “making the accommodation process optional for eligible organizations.” Such entities “will not be required to comply with a self-certification process.” Just as the IFR expanded eligibility for the exemption, it “likewise” expanded eligibility for the optional accommodation.

In introducing these changes, the agencies stated they “recently exercised [their] discretion to reevaluate these exemptions and accommodations,” and considered factors including: “the interests served by the existing Guidelines, regulations, and accommodation process”; the “extensive litigation”; the President’s executive order; the interest in protecting the free exercise of religion under the First Amendment and RFRA; the discretion afforded under the relevant statutory provisions; and “the regulatory process and comments submitted in various requests for public comments.” The agencies advanced several arguments they claimed justified the lack of an advance notice and comment process for the Religious Exemption IFR, which became effective immediately.

First, the agencies cited 26 U.S.C. § 9833, 29 U.S.C. § 1191c, and 42 U.S.C. § 300gg–92, asserting that those statutes authorized the agencies “to promulgate any interim final rules that they determine are appropriate to carry out” the relevant statutory provisions. Second, the agencies asserted that even if the APA did apply, they had good cause to forgo notice and comment because implementing that process “would be impracticable and contrary to the public interest.” Third, the agencies noted that “[i]n response to several of the previous rules on this issue—including three issued as IFRs under the statutory authority cited above—the Departments received more than 100,000 public comments on multiple occasions,” which included “extensive discussion about whether and by what extent to expand the exemption.” For all of these reasons, the agencies asserted, “it would be impracticable and contrary to the public interest to engage
in full notice and comment rulemaking before putting these interim final rules into effect . . . .” Comments were due on December 5, 2017.

2. The Moral Exemption IFR

Also on October 6, 2017, the agencies issued the Moral Exemption IFR, “expand[ing] the exemption[ ] to include additional entities and persons that object based on sincerely held moral convictions.” Additionally, “consistent with [their] expansion of the exemption, [the agencies] expand[ed] eligibility for the accommodation to include organizations with sincerely held moral convictions concerning contraceptive coverage,” while also making the accommodation process optional for those entities. Id. The agencies included in the IFR a section called “Congress’ History of Providing Exemptions for Moral Convictions,” referencing statutes and legislative history, case law, executive orders, and state analogues. The agencies justified the immediate issuance of the Moral Exemption IFR without an advance notice and comment process on grounds similar to those offered regarding the Religious Exemption IFR, stating that “[o]therwise, our regulations would simultaneously provide and deny relief to entities and individuals that are, in the [agencies’] view, similarly deserving of exemptions and accommodations consistent[ ] with similar protections in other federal laws.” Comments were due on December 5, 2017.

III. LEGAL STANDARD

A preliminary injunction is a matter of equitable discretion and is “an extraordinary remedy that may only be awarded upon a clear showing that the plaintiff is entitled to such relief.” A plaintiff seeking preliminary injunctive relief must establish that [it] is likely to succeed on the merits, that [it] is likely to suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in [its] favor, and that an injunction is in the public interest.

IV. ANALYSIS

The Court first addresses the threshold issues of standing and venue, then turns to the preliminary injunction analysis.

A. Plaintiffs Have Standing to Sue.

1. Plaintiffs have Article III standing.

States are not normal litigants for the purposes of invoking federal jurisdiction, and thus are entitled to special solicitude in [the] standing analysis. State or not, a plaintiff invoking federal jurisdiction bears the burden of establishing the irreducible constitutional minimum of standing. That is, the plaintiff must have suffered an injury in
fact—an invasion of a legally protected interest that is concrete, particularized, and actual or imminent, rather than conjectural or hypothetical. The plaintiff’s injury must also be fairly traceable to the challenged conduct of the defendant, as well as likely to be redressed by a favorable judicial decision.

Agency action that causes a state to “incur significant costs” is sufficient to constitute injury in fact. *See Tex. v. U.S.*, 809 F.3d 134, 155 (5th Cir. 2015) (finding that Texas had standing to sue federal government because Deferred Action for Parents of Americans and Lawful Permanent Residents program required the state to issue driver’s licenses to program beneficiaries “at a financial loss”). Federal courts may also recognize a ‘procedural injury’ when a procedural requirement has not been met, so long as the plaintiff also asserts a ‘concrete interest’ that is threatened by the failure to comply with that requirement.

Plaintiffs have stated a procedural injury that is sufficient for the purposes of Article III standing. They assert that Defendants failed to comply with the APA’s notice and comment requirement, resulting in Plaintiffs’ being “denied the opportunity to comment and be heard, prior to the effective date of the [2017] IFRs, concerning the impact of the rules on the States and their residents.” Plaintiffs must also show that these procedures are designed to protect some concrete threatened interest” that “is the ultimate basis of [their] standing. Plaintiffs do so by explaining that they have an “interest in ensuring that women have access to no-cost contraceptive coverage” under the ACA, in large part because without that access, Plaintiffs will incur economic obligations, either to cover contraceptive services necessary to fill in the gaps left by the 2017 IFRs or for “expenses associated with unintended pregnancies.” [The court cites affidavits from state officials showing costs related to unintended pregnancies: “Unintended pregnancies cost the state approximately $689 million . . . in 2010.”]; California pays for 64 percent of unplanned births, with the average cost estimated at more than $15,000 per birth]. Accordingly, Plaintiffs are more than merely a “nominal party” in this suit asserting a quasi-sovereign interest in the physical health and well-being of their citizens. Rather, they have shown that the 2017 IFRs will impact their fiscs in a manner that corresponds with the IFRs’ impact on their citizens’ access to contraceptive care. And, while the causation and redressability requirements are relaxed in cases of procedural injury, Plaintiffs also satisfy those prongs of the standing inquiry. The injury asserted is directly traceable to Defendants’ decision to issue the IFRs without advance notice and comment, and granting a preliminary injunction would enjoin enforcement of those IFRs until the Court can assess the merits.9

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9 While Defendants’ primary argument is that Plaintiffs lack standing, they fail to address, or even acknowledge, Plaintiffs’ asserted procedural injury under the APA in this context, focusing instead on opposing Plaintiffs’ standing to bring any substantive claims. Defendants thus fail to contend with the “relaxed” causation and redressability requirements. They also inaccurately cast Plaintiffs’ allegations regarding their fiscal injury as “conclusory,” failing to address the substantial declarations supporting Plaintiffs’ motion.
2. Statutory Standing

In addition to the requirements of Article III, “[a] plaintiff must also satisfy the non-constitutional standing requirements of the statute under which [it] seeks to bring suit.” The APA provides that “[a] person . . . adversely affected or aggrieved by agency action within the meaning of a relevant statute is entitled to judicial review thereof.” Courts have interpreted this provision to require a petitioner bringing suit under the APA to establish (1) that there has been final agency action adversely affecting the plaintiff, and (2) that, as a result, it suffers legal wrong or that its injury falls within the zone of interests of the statutory provision the plaintiff claims was violated. The IFRs are final agency action. Despite the presence of the word “interim” in “interim final rule,” the key word . . . is not interim, but final, because interim refers only to the Rule’s intended duration—not its tentative nature.

Plaintiffs’ asserted injury is also squarely within the APA’s “zone of interests.” Here, Plaintiffs allege a procedural injury because Defendants failed to comply with the APA’s notice and comment requirement, arguing they have been denied the opportunity to comment and be heard, prior to the effective date of the IFRs, concerning the impact of the rules on the States and their residents. Plaintiffs accordingly have statutory standing under the APA.

[Discussion of venue is omitted; the court finds that venue is proper in the Northern District of California.]

C. Plaintiffs Have Shown They Are Entitled to a Preliminary Injunction.

Plaintiffs are entitled to a preliminary injunction because (1) they have shown that, at a minimum, they are likely to succeed on their claim that Defendants violated the APA by issuing the 2017 IFRs without advance notice and comment; (2) they have shown that they are likely to suffer irreparable harm as a result of this procedural violation; and (3) the balance of equities tips in Plaintiffs’ favor, and the public interest favors granting the injunction.

1. Plaintiffs are likely to succeed in showing that Defendants violated the APA in issuing the 2017 IFRs without advance notice and comment.

The most important factor is likelihood of success on the merits.

a. With few exceptions, the APA requires agencies to publish notice of proposed rules and consider public comment before final promulgation.

Plaintiffs contend that “Defendants evaded their obligations under the APA by promulgating rules without proper notice and comment.” The Court agrees. Under the APA, an agency promulgating a rule normally must first publish a “[g]eneral notice of

10 The Court is satisfied that Plaintiffs are persons under the APA.
proposed rule making” in the Federal Register.[.] After such notice has issued, “the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments with or without opportunity for oral presentation.” The agency must then consider any “relevant matter presented . . . .” As relevant here, these notice and comment requirements do not apply “when the agency for good cause finds . . . that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.”

The APA’s notice and comment requirement reflects Congress’ judgment that notions of fairness and informed administrative decisionmaking require that agency decisions be made only after affording interested persons notice and an opportunity to comment. Accordingly, an agency must overcome a high bar if it seeks to invoke the good cause exception to bypass the notice and comment requirement,” given that the exception “is essentially an emergency procedure. In other words, a failure to comply with the APA’s notice and comment procedures may be excused only in those narrow circumstances in which delay would do real harm. The inquiry as to whether an agency has demonstrated good cause proceeds case-by-case, sensitive to the totality of the factors at play.

On October 6, 2017, Defendants promulgated the Religious Exemption IFR and Moral Exemption IFR, effective immediately. Although both IFRs solicited public comment until December 5, 2017, their immediate promulgation violated the APA’s notice and comment requirement because Defendants failed to publish the required advance notice of proposed rulemaking. Nor did they provide the public with an advance opportunity to comment, making it impossible for the agency to consider the input of any interested parties before enactment. Thus, the issuance of the 2017 IFRs was unlawful unless either (a) the APA does not apply or (b) the Defendants can show that an exception to its requirements applies.

b. Defendants had no statutory authority to forgo the APA’s notice and comment requirement as to the 2017 IFRs.

Defendants first argue that they had “express statutory authorization” to promulgate the IFRs, thus exempting them from the APA’s advance notice and comment requirement. Specifically, Defendants cite the authority conferred upon them by 26 U.S.C. § 9833, 29 U.S.C. § 1191c, and 42 U.S.C. § 300gg–92. Each of those provisions, in turn, contains this nearly identical phrase: “[t]he Secretary may promulgate any interim final rules as the Secretary determines are appropriate to” carry out its statutory duties in this realm. Defendants interpret this as a signal that Congress intended to free them from the APA’s requirements. But the APA provides that no subsequent statute shall be deemed to modify it except to the extent that it does so expressly.

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12 Defendants do not argue that notice and comment was “unnecessary” for either the Religious Exemption IFR, or the Moral Exemption IFR.
Here, the statutory authority cited by Defendants does not support their argument that Congress intended to displace the APA's notice and comment requirements. [The court finds that other cases cited by the defendant considers statutes containing language showing either Congressional “intent to displace” normal APA procedures or establish “any analogous procedure (or any procedure at all)” other than the process outlined in the APA.]

c. The “totality of factors” establishes that Defendants had no good cause to forgo advance notice and comment for the 2017 IFRs.

The Court also finds that the “totality of factors” compels the conclusion that Defendants had no good cause to forgo notice and comment. Defendants argue that engaging in notice and comment before issuing the 2017 IFRs would have been “impracticable and contrary to the public interest.” Notice and comment is “impracticable when the agency cannot both follow [APA requirements] and execute its statutory duties. And it is contrary to the public interest when public rule-making procedures . . . prevent an agency from operating.”

Defendants fail to show that their decision to forgo advance notice and comment was justified by good cause under [APA] section 553. In the Religious Exemption IFR, they set forth several purported justifications: (1) the “[d]ozens” of pending lawsuits challenging the contraceptive mandate; (2) the desire to cure violations of RFRA, based on the contention that “requiring certain objecting entities or individuals to choose between the Mandate, accommodation, or penalties for [noncompliance]” constitutes such a violation; (3) the desire to bring HRSA guidelines into “accord with the legal realities” of the temporary injunctions issued in various cases; (4) the desire “to provide immediate resolution” to parties with religious objections to the mandate; (5) the desire to avoid increases in the costs of health insurance caused by entities remaining on more expensive grandfathered plans—which are exempt from the mandate—to avoid becoming subject to the mandate; and (6) the desire to avoid delay in making the accommodation available to a broader category of entities. In the Moral Exemption IFR, Defendants set forth similar justifications.

None of these proffered reasons justified the use of the “emergency procedure” that is the good-cause exception. Defendants make no argument that the above considerations made it impossible for them to both satisfy the notice and comment requirement and execute their statutory duties under the ACA. Defendants also fail to establish (or even claim) that notice and comment would have effectively prevented them from operating. Instead, they argue that “any additional delay in issuing the Rules would be contrary to the public interest,” because “[p]rompt effectiveness would provide entities and individuals facing burdens on their sincerely held religious beliefs and moral convictions with important and urgent relief.” But “[i]f good cause could be satisfied by

13 Indeed, as to the public interest justification, Defendants estimated at oral argument that they have received hundreds of thousands of comments regarding the 2017 IFRs. This weakens the suggestion that
an Agency’s assertion that normal procedures were not followed because of the need to provide immediate guidance and information . . . then an exception to the notice requirement would be created that would swallow the rule.”

Defendants also argue that they “demonstrated a willingness to consider public comment, both prior and following issuance of the rules.” But Defendants’ willingness to consider comments “on the exemption and accommodation issues” generally does not excuse their failure to do so before enacting the 2017 IFRs. This is particularly true because the 2017 IFRs represent a direct repudiation of Defendants’ prior well-documented and well-substantiated public positions. Moreover, these IFRs are much broader in scope, and introduce an entirely new moral conviction basis for objecting to the contraceptive mandate. Until October 6, 2017, the public had no notice of Defendants’ intent to dramatically broaden eligibility for the exemption and to make the accommodation optional. The fact that the public may have previously commented on these broad topics in the context of past iterations of the rules does not change that.

In addition, whether or not Defendants are willing to consider post-promulgation comments, it remains antithetical to the structure and purpose of the APA for an agency to implement a rule first, and then seek comment later. (internal quotation marks omitted). The same reasoning defeats Defendants’ argument that “the Rules are effective only until final rules are issued.” And that argument is further undercut by the fact that on November 30, 2017 the Centers for Medicare & Medicaid Services, which are part of HHS, issued guidance for the implementation of the 2017 IFRs. The Court agrees with Plaintiffs that the issuance of this guidance, before the end of the post-promulgation comment period, suggests that “it does not appear that the Defendants expect public comment to inform implementation.”

d. Defendants’ failure to provide an advance notice and comment process for the 2017 IFRs was not harmless error.

Defendants argue that, in any event, “any error in forgoing notice and comment was harmless,” citing the APA’s instruction to take “due account” of “the rule of prejudicial error.” The Court, however, exercises “great caution in applying the harmless error rule in the administrative rulemaking context,” lest it “gut[ ] the APA’s procedural requirements. [T]he failure to provide notice and comment is harmless only where the agency’s mistake clearly had no bearing on the procedure used or the substance of decision reached. Defendants’ actions . . . precluded public participation in the promulgation of the 2017 IFRs before those rules became effective. As such, there is no way to conclude that Defendants’ violation clearly had no bearing on the procedure used or the substance of decision reached, meaning that the error was not harmless.

Defendant argues that “the Rules were issued after the Agencies received more than 100,000 public comments throughout six years of publishing and modifying these engaging in advance notice and comment would have been contrary to the public interest, given the public’s evident real interest in this matter.
regulations.” But as discussed above, that does not render harmless this procedural error, regarding these IFRs. Nor does it take into account the substantial differences between the previous iterations of these rules and the IFRs at issue. Far from being harmless, Defendants’ error prevented Plaintiffs from vindicating the purpose of the APA’s notice and comment requirement. For these reasons, Plaintiffs are, at a minimum, likely to succeed in showing that Defendants violated the APA’s procedural requirements.

2. Plaintiffs are likely to suffer irreparable harm unless the Court enjoins the 2017 IFRs.

A procedural injury may serve as a basis for a finding of irreparable harm when a preliminary injunction is sought. Plaintiffs are not only likely to suffer irreparable procedural harm in the absence of a preliminary injunction, they already have done so. Because the 2017 IFRs were effective immediately, Plaintiffs’ harm is ongoing. Every day the IFRs stand is another day Defendants may enforce regulations likely promulgated in violation of the APA’s notice and comment provision, without Plaintiffs’ advance input. And Plaintiffs’ right to provide such input does not exist in a vacuum. Rather, it is in large part defined by what is at stake: the health of Plaintiffs’ citizens and Plaintiffs’ fiscal interests. For a substantial number of women, the 2017 IFRs transform contraceptive coverage from a legal entitlement to an essentially gratuitous benefit wholly subject to their employer’s discretion. The impact on the rules governing the health insurance coverage of Plaintiffs’ citizens—and the stability of that coverage—was immediate, which also implicates Plaintiffs’ fiscal interests as described above. If the Court ultimately finds in favor of Plaintiffs on the merits, any harm caused in the interim by rescinded contraceptive coverage would not be susceptible to remedy.

3. The balance of the equities tips in Plaintiffs’ favor, and a public interest favors granting preliminary injunctive relief.

Plaintiffs also prevail on the balance of equities and public interest analyses. Here, but for the APA violation the Court has found likely to be shown, Plaintiffs ‘could have participated in Defendants’ rulemaking process, explain[ed] the practical effects of [the] rule before [it was] implemented, and helped ensure[ ] that the agency proceed in a fully informed manner, exploring alternative, less harmful approaches” to expanding eligibility for the exemption and making the accommodation optional.

With those interests in mind, the Court concludes that the balance of equities tips in Plaintiffs’ favor. Plaintiffs face potentially dire public health and fiscal consequences as a result of a process as to which they had no input. On the other hand, returning to the state of affairs before the enactment of the 2017 IFRs—in which eligible entities still would be permitted to avail themselves of the exemption or the accommodation—does not constitute an equivalent harm to the Defendants pending resolution of the merits. While Defendants’ interest in “protecting religious liberty and conscience” is unquestionably legitimate, the Court believes it likely that the prior framing of the religious exemption and accommodation permissibly ensured such protection. That is to
say, the Court views as likely correct the reasoning of the eight Circuit Courts of Appeals (of the nine to have considered the issue) which found that the procedure in place prior to the 2017 IFRs did not impose a substantial burden on religious exercise under RFRA.\(^{17}\) The balance of equities thus tips in Plaintiffs’ favor.

**D. This Preliminary Injunction Effectively Reinstates the Regime in Place Before the Issuance of the 2017 IFRs.**

The Court next turns to the contours of Plaintiffs’ remedy. Under the circumstances, the Court finds it appropriate to issue a nationwide preliminary injunction. Defendants did not violate the APA just as to Plaintiffs: no member of the public was permitted to participate in the rulemaking process via advance notice and comment. Accordingly, Defendants are (1) preliminarily enjoined from enforcing the 2017 IFRs, and (2) required to continue under the regime in place before October 6, 2017, pending a determination on the merits. This is consistent with the general practice of invalidating rules not promulgated in compliance with the APA and reinstating the “rule previously in force,” and maintains the status quo that existed before the implementation of the likely invalid 2017 IFRs.

The Court notes that simply enjoining Defendants from enforcing the 2017 IFRs, without requiring them to proceed under the prior regime pending resolution of the merits, would result in a problematic regulatory vacuum, in which the rights of both women seeking cost-free contraceptive coverage and employers seeking religious exemption or accommodation would be uncertain. Returning to the state of affairs before October 6, 2017 means just that: the exemption and accommodation as they existed following the Zubik remand remain in effect, as do any court orders enjoining Defendants from enforcing those rules against specific plaintiffs.

Notes

1. **Interim final rules.** In implementing the contraceptive coverage guarantee, as the decision shows, the Obama administration made frequent use of interim final rules. In scores of challenges to the Obama administration’s exemption and accommodation standards, the employer plaintiffs who objected to providing contraceptive coverage focused on the rules’ substantive requirements rather than the rulemaking process itself. In your view, would they have had an equally good procedural argument as that raised by the state plaintiffs in this case? To the extent that the Obama Administration argued that the need for clarity regarding coverage requirements and the short time frame for implementing the ACA justified its decision to set the coverage standard in advance of public comment, would these justifications justify a departure from APA requirements? Or do you concur with the court that “[i]f ‘good cause’ could be satisfied by an Agency’s assertion that ‘normal procedures were not followed because of the need to provide immediate guidance and information . . . then an exception to the notice requirement would be created that would swallow the rule[]’”? In fact, as this case shows, courts apply a very fact-specific test when balancing the right to comment in advance against the government’s need to act quickly. In the case of the Obama-era rules, speed was justified by the need to implement the ACA’s sweeping coverage expansions in time for health plans to know what they would be expected to offer. Here, the need for speed was justified as a means of honoring the religious beliefs of what the government itself argued was a small number of employers that actually would use the exemption.

2. **The government’s compelling interest in women’s access to contraceptive coverage.** This case—and indeed, the *Hobby Lobby* and *Zubik* collection of cases that ultimately got us to this point, and for that matter, the Institute of Medicine and HRSA guidelines—all rest on a single, fundamental, question of overwhelming importance to public health policy and practice: Does government in have a compelling interest in assuring women’s access to affordable contraceptives? If so, then one would expect the government to favor as narrow a religious exemption as possible under RFRA; one also would expect an accommodation for religious, but non-exempt, employers that, as the *per curiam* decision in *Zubik* underscored, utilizes a process that essentially tips the balance in favor of women’s continued seamless access to the contraceptive coverage to which they are entitled under their employer’s plan. If government does not perceive its interest as compelling, then one might expect a broad religious exemptions and a mere tip of the hat to the concept of accommodating the coverage interests of plan participants and beneficiaries.

This is exactly what happened, prior to the change in Administrations; the Obama Administration argued its compelling interest in the matter in *Hobby Lobby* (an interest the Court assumed but did not explore), while the Trump Administration dismissed such a claim in its interim final rule. It is this profound policy issue that lies at the core of the 180-degree swing between the Obama and Trump Administrations’ rules. On this
question, the Trump administration offers multiple justifications for changing its mind on the question of compelling interest (82 Fed. Reg. 47800-47806):

II. RFRA and Government Interests Underlying the Mandate

RFRA provides that the Government “shall not substantially burden a person’s exercise of religion even if the burden results from a rule of general applicability” unless the Government “demonstrates that application of the burden to the person—(1) is in furtherance of a compelling governmental interest; and (2) is the least restrictive means of furthering that compelling governmental interest.” 42 U.S.C. 2000bb-1(a) and (b).

* * *

A. Elements of RFRA

2. COMPELLING INTEREST

Although the Departments previously took the position that the application of the Mandate to certain objecting employers was necessary to serve a compelling governmental interest, the Departments have now concluded, after reassessing the relevant interests and for the reasons stated below, that it does not. . . . Here, informed by the Departments’ reassessment of the relevant interests, as well as by our desire to bring to a close the more than 5 years of litigation over RFRA challenges to the Mandate, the Departments have determined that the appropriate administrative response is to create a broader exemption, rather than simply adjusting the accommodation process.

RFRA requires the Government to respect religious beliefs under “the most demanding test known to constitutional law”: Where the Government imposes a substantial burden on religious exercise, it must demonstrate a compelling governmental interest and show that the law or requirement is the least restrictive means of furthering that interest. . . .

Upon further examination of the relevant provisions of the Affordable Care Act and the administrative record on which the Mandate was based, the Departments have concluded that the application of the Mandate to entities with sincerely held religious objections to it does not serve a compelling governmental interest. The Departments have reached that conclusion for multiple reasons, no one of which is dispositive.

First, Congress did not mandate that contraception be covered at all under the Affordable Care Act. Instead, Congress merely provided for coverage of “such additional preventive care and screenings” for women
“provided for in comprehensive guidelines supported by [HRSA].” Congress, thus, left the identification of any additional required preventive services for women to administrative discretion. The fact that Congress granted the Departments the authority to promulgate all rules appropriate and necessary . . . including by channeling the discretion Congress afforded to HRSA to decide whether to require contraceptive coverage, indicates that the Departments’ judgment should carry particular weight . . . .

Second, while Congress specified that many health insurance requirements added by the Affordable Care Act were so important that they needed to be applied to all health plans immediately, the preventive services requirement in section 2713 of the PHS Act was not made applicable to “grandfathered plans.” That feature of the Affordable Care Act is significant: As cited above, seven years after the Affordable Care Act’s enactment, approximately 25.5 million people are estimated to be enrolled in grandfathered plans not subject to section 2713 of the PHS Act.* Congress’ decision to leave section 2713 out . . . informs the Departments’ assessment of the weight of the Government’s interest in applying the Guidelines issued pursuant to section 2713 of the PHS Act to religious objectors.

Third, various entities that brought legal challenges to the Mandate (including some of the largest employers) have been willing to provide coverage of some, though not all, contraceptives.

Fourth, the case for a compelling interest is undermined by the existing accommodation process, and how it applies to certain similarly situated entities based on whether or not they participate in certain self-insured group health plans, known as church plans, under applicable law . . . . Where a non-exempt religious organization uses an insured group health plan instead of a self-insured church plan, the health insurance issuer would be obliged to provide contraceptive coverage or payments to the plan’s participants under the accommodation. Even in a self-insured church plan context, the preventive services requirement in section 2713(a)(4) of the PHS Act applies to the plan, and through the Code, to

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*The term “grandfathered” health plans describes health plans in effect at the time of enactment of the ACA, have been continuously in existence since this date, and have not been changed significantly in terms of premiums, cost-sharing, or coverage, as defined in federal regulations. Among other matters, grandfathered plans are not covered by the preventive services mandate. See https://www.healthcare.gov/health-care-law-protections/grandfathered-plans/ (Accessed July 23, 2019). In its annual survey of employer-sponsored plans, 23% of firms offering health plans report that their offers include at least one grandfathered plan. Kaiser further reports that 17% of covered workers were covered under a grandfathered plan in 2017. Kaiser Family Foundation, 2017 Employer Health Benefits Survey, Ch. 13, available at https://www.kff.org/report-section/ehbs-2017-section-13-grandfathered-health-plans/ (Accessed July 23, 2019).
the religious organization that sponsors the plan. But under the accommodation, once a self-insured church plan files a self-certification or notice, the accommodation relieves it of any further obligation with respect to contraceptive services coverage. Having done so, the accommodation process would normally transfer the obligation to provide or arrange for contraceptive coverage to a self-insured plan’s third party administrator (TPA). But the Departments lack authority to compel church plan TPAs to provide contraceptive coverage or levy fines against those TPAs for failing to provide it. This is because church plans are exempt from ERISA pursuant to section 4(b)(2) of ERISA. . . . The combined result of PHS Act section 2713’s authority to remove contraceptive coverage obligations from self-insured church plans, and HHS’s and DOL’s lack of authority under the PHS Act or ERISA to require TPAs to become administrators of those plans to provide such coverage, has led to significant incongruity in the requirement to provide contraceptive coverage among nonprofit organizations with religious objections to the coverage.

More specifically, issuers and third party administrators for some, but not all, religious nonprofit organizations are subject to enforcement for failure to provide contraceptive coverage under the accommodation, depending on whether they participate in a self-insured church plan. . . . The effect is that many similar religious organizations are being treated very differently with respect to their employees receiving contraceptive coverage—depending on whether the organization is part of a church plan—even though the Departments claimed a compelling interest to deny exemptions to all such organizations.

Fifth, the Departments’ previous assertion that the exemption for houses of worship was offered to respect a certain sphere of church autonomy does not adequately explain some of the disparate results of the existing rules. And the desire to respect church autonomy is not grounds to prevent the Departments from expanding the exemption to other religious entities. As [an] example, two religious colleges might have the same level of religiosity and commitment to defined ideals, but one might identify with a specific large denomination and choose to be in a self-insured church plan offered by that denomination, while another might not be so associated or might not have as ready access to a church plan and so might offer its employees a fully insured health plan. Under the accommodation, employees of the college using a fully insured plan (or a self-insured plan that is not a church plan) would receive coverage of contraceptive services without cost sharing, while employees of the college participating in the self-insured church plan would not receive the coverage where that plan required its third party administrator to not offer the coverage.
[The] Departments acknowledge that the church plan exemption not only includes some non-houses-of-worship as organizations whose employees can be covered by the plan, but also, in certain circumstances, may include plans that are not themselves established and maintained by houses of worship. Yet, such entities and plans—if they file a self-certification or notice through the existing accommodation—are relieved of obligations under the contraceptive Mandate and their third party administrators are not subject to a requirement that they provide contraceptive coverage to their plan participants and beneficiaries. . . . After considering the differential treatment of various religious nonprofit organizations under the previous accommodation, the Departments conclude that it is appropriate to expand the exemption to other religious nonprofit organizations with sincerely held religious beliefs opposed to contraceptive coverage.

Sixth, the Government’s interest in ensuring contraceptive coverage for employees of particular objecting employers is undermined by the characteristics of many of those employers, especially nonprofit employers. . . . Based in part on our experience litigating against such organizations, the Departments now disagree with our previous assertion that “[h]ouses of worship and their integrated auxiliaries that object to contraceptive coverage on religious grounds are more likely than other employers to employ people of the same faith who share the same objection.” Although empirical data was not required to reach our previous conclusion, we note that the conclusion was not supported by any specific data or other source, but instead was intended to be a reasonable assumption. Nevertheless, in the litigation and in numerous public comments submitted throughout the regulatory processes described above, many religious nonprofit organizations have indicated that they possess deep religious commitments even if they are not houses of worship or their integrated auxiliaries. Religious nonprofit organizations that engage in expressive activity generally have a First Amendment right of expressive association and religious free exercise to choose to hire persons (or, in the case of students, to admit them) based on whether they share, or at least will be respectful of, their beliefs.

Given the sincerely held religious beliefs of many religious organizations, imposing the contraceptive-coverage requirement on those that object based on such beliefs might undermine the Government’s broader interests in ensuring health coverage by causing the entities to stop providing health coverage.

Seventh, we now believe the administrative record on which the Mandate rests is insufficient to meet the high threshold to establish a compelling governmental interest in ensuring that women covered by plans of objecting organizations receive cost-free contraceptive coverage.
through those plans. To begin, in support of the IOM’s recommendations, which HRSA adopted, the IOM identified several studies showing a preventive services gap because women require more preventive care than men. Those studies did not identify contraceptives or sterilization as composing a specific portion of that gap, and the IOM did not consider or establish in the report whether any cost associated with that gap remains after all other women’s preventive services are covered without cost-sharing. Even without knowing what the empirical data would show about that gap, the coverage of the other women’s preventive services required under both the HRSA Guidelines and throughout section 2713(a) of the PHS Act—including annual well-woman visits and a variety of tests, screenings, and counseling services—serves at a minimum to diminish the cost gap identified by IOM for women whose employers decline to cover some or all contraceptives on religious grounds.

Moreover, there are multiple Federal, State, and local programs that provide free or subsidized contraceptives for low-income women. Such Federal programs include, among others, Medicaid (with a 90 percent Federal match for family planning services), Title X, community health center grants, and Temporary Assistance for Needy Families. According to the Guttmacher Institute, government-subsidized family planning services are provided at 8,409 health centers overall. The Title X program, for example, administered by the HHS Office of Population Affairs (OPA), provides a wide variety of voluntary family planning information and services for clients based on their ability to pay, through a network that includes nearly 4,000 family planning centers. Individuals with family incomes at or below the HHS poverty guideline (for 2017, $24,600 for a family of four in the 48 contiguous States and the District of Columbia) receive services at no charge unless a third party (governmental or private) is authorized or obligated to pay for these services. Individuals with incomes in excess of 100 percent up to 250 percent of the poverty guideline are charged for services using a sliding fee scale based on family size and income. Unemancipated minors seeking confidential services are assessed fees based on their own income level rather than their family’s income. The availability of such programs to serve the most at-risk women (as defined in the IOM report) diminishes the Government’s interest in applying the Mandate to objecting employers. Many forms of contraception are available for around $50 per month, including long-acting methods such as the birth control shot and intrauterine devices (IUDs). Other, more permanent forms of contraception like implantables bear a higher one-time cost, but when calculated over the duration of use, cost a similar amount. Various State programs supplement the Federal programs referenced above, and 28 States have their own mandates of contraceptive coverage as a matter of State law. This existing inter-governmental structure for obtaining contraceptives significantly
diminishes the Government’s interest in applying the Mandate to employers over their sincerely held religious objections.

The record also does not reflect that the Mandate is tailored to the women most likely to experience unintended pregnancy, identified by the 2011 IOM report as “women who are aged 18 to 24 years and unmarried, who have a low income, who are not high school graduates, and who are members of a racial or ethnic minority.” For example, with respect to religiously objecting organizations, the Mandate applies in employer-based group health plans and student insurance at private colleges and universities. It is not clear that applying the Mandate among those objecting entities is a narrowly tailored way to benefit the most at-risk population. The entities appear to encompass some such women, but also appear to omit many of them and to include a significantly larger cross-section of women as employees or plan participants. At the same time, the Mandate as applied to objecting employers appears to encompass a relatively small percentage of the number of women impacted by the Mandate overall, since most employers do not appear to have conscientious objections to the Mandate. The Guttmacher Institute, on which the IOM relied, further reported that 89 percent of women who are at risk of unintended pregnancy and are living at 0 through 149 percent of the poverty line are already using contraceptives, as are 92 percent of those with incomes of 300 percent or more of the Federal poverty level.

The rates of—and reasons for—unintended pregnancy are notoriously difficult to measure. In particular, association and causality can be hard to disentangle, and the studies referred to by the 2011 IOM Report speak more to association than causality. [The Departments cite to studies contained in the IOM report—all of which show a decline in abortion and unintended pregnancy as use of the most effective forms of birth control rose—and note that these studies support an association, not causality.]

Contraception’s association with positive health effects might also be partially offset by an association with negative health effects. In 2013 the National Institutes of Health indicated, in funding opportunity announcement for the development of new clinically useful female contraceptive products, that “hormonal contraceptives have the disadvantage of having many undesirable side effects[,] are associated with adverse events, and obese women are at higher risk for serious complications such as deep venous thrombosis.” In addition, IOM 2011 stated that “[l]ong-term use of oral contraceptives has been shown to reduce a woman’s risk of endometrial cancer, as well as protect against pelvic inflammatory disease and some benign breast diseases (PRB, 1998). The Agency for Healthcare Research and Quality (AHRQ) concluded that “[t]here is insufficient evidence to recommend for or against the use of
[over the counter contraceptives] solely for the primary prevention of ovarian cancer. . . . [T]he harm/benefit ratio for ovarian cancer prevention alone is uncertain, particularly when the potential quality-of-life impact of breast cancer and vascular events are considered.”

In addition, in relation to several studies cited above, imposing a coverage Mandate on objecting entities whose plans cover many enrollee families who may share objections to contraception could, among some populations, affect risky sexual behavior in a negative way. For example, it may not be a narrowly tailored way to advance the Government interests identified here to mandate contraceptive access to teenagers and young adults who are not already sexually active and at significant risk of unintended pregnancy.

[E]vidence from studies that post-date the Mandate is not inconsistent with the observations the Departments make here. In 2016, HRSA awarded a 5-year cooperative agreement to the American College of Obstetricians and Gynecologists to develop recommendations for updated Women’s Preventive Services Guidelines. The awardee formed an expert panel called the Women’s Preventive Services Initiative that issued a report (the WPSI report). [The] WPSI report cited studies through 2013 stating that application of HRSA Guidelines had applied preventive services coverage to 55.6 million women and had led to a 70 percent decrease in out-of-pocket expenses for contraceptive services among commercially insured women. The WPSI report relied on a 2015 report of the HHS Office of the Assistant Secretary for Planning and Evaluation (ASPE), “The Affordable Care Act Is Improving Access to Preventive Services for Millions of Americans,” which estimated that persons who have private insurance coverage of preventive services without cost sharing includes 55.6 million women.

As discussed above and based on the Departments’ knowledge of litigation challenging the Mandate, during the time ASPE estimated the scope of preventive services coverage (2011-2013), houses of worship and integrated auxiliaries were exempt from the Mandate, other objecting religious nonprofit organizations were protected by the temporary safe harbor, and hundreds of accommodated self-insured church plan entities were not subject to enforcement of the Mandate through their third party administrators. In addition, dozens of for-profit entities that had filed lawsuits challenging the Mandate were protected by court orders pending the Supreme Court’s resolution of Hobby Lobby in June 2014. It would therefore appear that the benefits recorded by the report occurred even though most objecting entities were not in compliance. Additional data indicates that, in 28 States where contraceptive coverage mandates have been imposed statewide, those mandates have not necessarily lowered rates of unintended pregnancy (or abortion) overall.
The Departments need not take a position on these empirical questions. Our review is sufficient to lead us to conclude that significantly more uncertainty and ambiguity exists in the record than the Departments previously acknowledged when we declined to extend the exemption to certain objecting organizations and individuals as set forth herein, and that no compelling interest exists to counsel against us extending the exemption.

Attempting to offer a rationale for its decision to do a policy 180 on the prior administration’s position, the Trump Administration essentially argues that government now has no compelling interest in improving access to birth control through workplace coverage. As a result, the governmental interest in overcoming barriers to coverage are outweighed by the sincerely held religious beliefs of employers that want to excise birth control from their health plans. The Administration offers a multi-pronged rationale to defeat the claim that the interest behind the prior regulations is compelling, outweighs any burden imposed on some, and that the solutions used are sufficiently tailored to achieve a compelling interest while imposing as little burden as possible.

The Trump Administration relies on the following “factual” assertions, in our current world of “alternative facts”: (1) the “fact” that the grandfathered plan exemption makes coverage less than complete; (2) the similar “fact” that exists because of the exemption granted to churches, a longstanding custom in the U.S., and the resulting complexity of how to apply the mandate to non-exempt religious organizations whose employees are covered through self-insured church plans; (3) the “fact” that non-exempt religious organizations are more likely to hire people who share their organizations’ religious beliefs and don’t want to use contraceptives anyway; (4) the “fact” that many religious employers are likely to offer some coverage while excising others found repugnant; (5) the “fact” that many women at special risk for unintended pregnancy in fact don’t have access to employer coverage; (6) the “fact” that the availability of public family planning clinics and services and the low cost of contraceptives makes the governmental interest less pressing; (7) the “fact” that the health risks associated with certain forms of contraception likewise diminishes the governmental interest; and (8) the “fact” that only a relatively small number of employers will take advantage of the exemption if offered. Most amazingly, perhaps, the government offers skepticism about whether birth control is effective in reducing teenage pregnancy, unintended pregnancy, and abortion.

It is worth reflecting on these rationales for reducing access to a form of health care named by CDC as one of the 20th century’s 10 most important public health advances. CDC, Achievements in Public Health, 1900-1999: Family Planning (48 Morbidity and Mortality Weekly Report 1073, December 03, 1999) available at https://www.cdc.gov/Mmwr/preview/mmwrhtml/mm4847a1.htm.

The first and most obvious problem is the fact that the Trump Administration offers no discussion of the vast literature documenting the health risks associated with unintended pregnancy—risks that vastly outweigh the health risks associated with certain
forms of birth control. See Brief of the Guttmacher Institute and Professor Sara Rosenbaum as Amici Curiae in Support of the Government (United States Supreme Court, Zubik v. Burwell) https://www.guttmacher.org/sites/default/files/article_files/guttmacher_zubik_scotus_amicus_brief.pdf. Planned pregnancies enable women to carry pregnancy in far better health; births that are unplanned are associated with elevated maternal as well as infant mortality and lifelong disability and a host of economic and social problems. Although some in power now apparently doubt it, government scientists report that birth control—particularly the most effective, long-acting birth control methods such as IUDs—are strongly linked to the reduction in abortion. CDC, Abortion Surveillance—United States 2014 (66 Morbidity and Mortality Weekly Report 1, 2017) available at https://www.cdc.gov/mmwr/volumes/66/ss/ss6624a1.htm?s_cid=ss6624a1_e.

Second, those in the Trump Administration apparently think that the fact that the U.S. health system is unbelievably complicated and offers no single pathway to preventive health care—universal free access to preventive health care including contraceptive services—makes its interest in any single pathway lesser. It is true that many women at risk for unintended pregnancy lack employer coverage and depend on public programs such as publicly funded family planning clinics. Guttmacher Institute, Publicly Funded Family Planning Services in the United States: Who Needs Contraceptive Services? (September 2016) available at https://www.guttmacher.org/fact-sheet/publicly-funded-family-planning-services-united-states Millions of women depend on Medicaid to help pay for services. Does any of this make employer coverage less important? What about the large number of working women with employer coverage who work at lower-paying jobs? As the Administration dismissively notes, contraceptives can cost $50 per month, and inserting an IUD costs in the multiples of this. This is a boatload of money for lower income wage earners.

In this regard it is also worth noting that the same Administration that espouses the value of publicly funded family planning has made a concerted effort to roll back access to publicly funded family planning services. As delineated early in this Update, its efforts have included a sustained attack on Planned Parenthood through legislation aimed at excluding the organization from Medicaid as part of the massive and failed Affordable Care Act “repeal and replace” effort spanning the spring and summer of 2017. The administration also has proposed to reformulate regulatory policy under Title X of the Public Health Service Act—the nation’s most important source of grant funding for family planning programs—to exclude Planned Parenthood, give grants to providers that offer few or no forms of reliable family planning, narrow the range of contraceptive services clinics will offer, and bar grantees from counseling women about pregnancy options. Sara Rosenbaum, The Assault on Family Planning—Redux (Milbank Quarterly online, May 2018), available at https://www.milbank.org/quarterly/articles/assault-family-planning-redux/; Kinsey Hasstedt, A Domestic Gag Rule And More: The Trump Administration’s Proposed Changes To Title X (Health Affairs, June 2018), available at https://www.healthaffairs.org/do/10.1377/hblog20180614.838675/full/.
Finally, consider the basic reasoning that supposedly supports the new rule: the fact that any exception exists to law or regulation that imposes a burden on some, and fails to reach entirely all persons within its aims, defeats the claim that the interest lying behind the rule is compelling and sufficiently tailored. Seriously? Can this Administration wreak such a fundamental change in our interpretation of statutory and regulatory action, our Constitution, and our basic understanding of the role of government and the rights and obligations of the populace comprising our nation and our society?

* * *

As we have said many times before in these materials, the issue of access to birth control is a big one, not just for individuals but for the health of the nation as a whole. Not only is safe and effective birth control one of the great modern public health advances, but moreover, the most effective forms of birth control (long-acting reversible contraception, in the form of intrauterine devices (IUDs) or implants) are significantly more costly than, say, birth control pills. Women’s ability to afford the best protection possible against unplanned childbearing—which elevates the health risks for both women (including rising maternal mortality rates) and their children, while also measurably increasing abortion odds—thus emerges as a key health priority. According to the CDC, long-acting reversible contraception show failure rates well below 1 percent; by contrast, the failure rate for birth control pills is estimated at 7 percent. Centers for Disease Control and Prevention, Contraception: Birth Control Methods, https://www.cdc.gov/reproductivehealth/contraception/index.htm (Accessed July 23, 2019). But long-acting reversible contraception is also far more costly, and cost becomes a key barrier in use of the most reliable forms of birth control.*

Naturally, one would think, assuring access to effective and affordable birth control would be high on the list of any Presidential administration as implacably opposed to abortion rights as this one is. Similarly, one might reasonably imagine that improving access to affordable, highly effective contraception would be a top priority for

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*The evidence underscoring the nation’s need for a generous policy when it comes to access to birth control is summarized in Azar v. American Medical Association, Brief of Amici Curiae Public Health and Health Policy Deans, Chair, and Scholars and the American Public Health Association in Support of Plaintiffs-Appellees and Affirmance, Case No. 19-35386 (9th Cir. 2019), http://cdn.ca9.uscourts.gov/datastore/general/2019/07/08/19-35386%20- %20Amicus%20Brief%20of%20Public%20Health%20and%20Policy%20Deans,%20et%20al..pdf (Accessed July 23, 2019). This case, one of several, challenges yet another assault on family planning, the final Trump Administration regulations imposing insurmountable restrictions on provider participation in the Title X family planning program, the only federal program devoted exclusively to funding provision of family planning services and targeting medically underserved communities. The restrictions in the new rule mirror those imposed by the Reagan Administration in 1988 and upheld by the United States Supreme Court in Rust v Sullivan, 500 U.S. 173 (main text, Part One). This time, however, the rules (known as “gag rules” because, among other restrictions, they prohibit participating providers from fully counseling pregnant women about all options including pregnancy termination and how to obtain help) follow on the heels of Congressional efforts in legislation enacted post-Rust to ban federal regulations prohibiting full and accurate disclosure of all health care options.

As noted above, a nationwide injunction against the Trump Administration’s interim final contraceptive coverage rule (published without notice or opportunity to submit advance comments in late 2017) already was in place. Nonetheless, even as it was appealing the earlier preliminary injunction ruling, the administration went ahead and issued final rules governing both religious and moral exemptions. 83 Fed. Reg. 15,536 (Nov. 15, 2018) (religious exemption); 83 Fed. Reg. 57,592 (Nov. 15, 2018). Like the interim rules, the final rules extend well beyond the furthest reaches of Hobby Lobby (Update), granting full exemptions to all non-profit, closely-held for profit, and publicly-held companies. The final rules also make the religious accommodation process described in Zubik (also in this Update) voluntary, effectively giving employers the right to opt out completely rather than being “complicit” (as they term it) in women’s access to affordable contraceptive. Making the accommodation purely voluntary flies directly in the face of the Court’s instructions to the lower courts when it remanded for settlement Zubik and the other contraceptive coverage cases (also described in these update materials).

The Third Circuit (the same court that decided Zubik to begin with and thus upheld the Obama administration’s religious accommodation rules) affirmed the nationwide injunction against the final Trump Administration rules. Its affirmance focused on two main issues. First, under the Administrative Procedure Act, the final Trump rule could not escape the procedural problems raised by the interim final rules; nothing in the ACA itself permitted the agencies to forgo the notice and comment requirements applicable to rulemaking, and the agencies lacked good cause for dispensing with such requirements. Because they had failed to adhere to the APA to begin with, their effort to paper over matters through an after-the-fact consideration of comments could not cure the problem.

Second, the court concluded, the final rules raise “serious substantive problems,” since “neither of the statutes on which the Agencies rely, the ACA and RFRA, authorize or require the final rules.” As a result, the final rules were “in excess of statutory jurisdiction, authority, or limitations, or short of statutory right, making them arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” The court first determined that the ACA itself does not extend authority to the agencies to create exemptions; instead it empowers the Secretary only to set the required coverage parameters. Looking next at the agency grant of powers under RFRA, the court reasoned that “even assuming that RFRA provides statutory authority for the Agencies to issue regulations to address religious burdens the Contraceptive Mandate may impose on certain individuals, RFRA does not require the enactment of the Religious Exemption to
address this burden.” Observing that RFRA is a remedial statute that authorizes challenges to federal rules by plaintiffs asserting a substantial burden on religion, the court concluded that RFRA authorizes courts to intervene when individuals have made out a *prima facie* religious discrimination claim and then to review government justifications under the statute’s special heightened scrutiny standard. What RFRA is not, in the court’s opinion, is a legislative invitation permitting government to create broad prospective exemptions or to make religious accommodations voluntary. Indeed, in *Zubik*, the Supreme Court remanded the cases not to wholesale gut the accommodation process but to allow a determination of whether there might be alternatives to the Obama administration’s approach that nonetheless preserved “seamless” access to full contraceptive coverage.

*So where do matters stand?* Per *Hobby Lobby*, along with ensuring Obama administration rules, privately-held for-profit corporations, along with nonprofit religious employers, can qualify for an accommodation. Rules granting broad exemptions have been halted for the time being, along with provisions in the same rules that would make the accommodation merely voluntary. The coverage guarantee has had a marked impact on access to affordable services, reducing by over two-thirds the share of insured women reporting out-of-pocket spending for oral contraceptives. Ten states plus the District of Columbia now require coverage of contraceptives with no cost-sharing under all employer plans. See Laurie Sobel et al., New Regulations Broadening Employer Exemptions to Contraceptive Coverage: Impact on Women (Kaiser Family Foundation, 2018), [https://www.kff.org/health-reform/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/](https://www.kff.org/health-reform/issue-brief/new-regulations-broadening-employer-exemptions-to-contraceptive-coverage-impact-on-women/) (Accessed). Of course this requirement would not apply to self-insured employer plans that escape state insurance regulation under ERISA.

*Adding insult to injury.* In the interim final rules the Trump Administration disavowed any impact of the rule on access to affordable contraception, arguing, among other justifications for their conclusion of no harm, that women who did lose their employer benefits could go to any Title X-funded clinic to find affordable benefits. The Title X gag rule now under legal challenge, as noted, are expected to have a major impact on the willingness to participate in the program by physicians and advanced practice nurses (both of whom are absolutely essential to the ability of any Title X-funded clinic to operate). Other aspects of the rule—in particular the rule that conditions Title X funding on a complete physical and financial separation of family planning and abortion service—are expected to drive hundreds of clinics out of the program, affecting access for millions. See Public Health and Health Policy Deans and Scholars brief, *supra*. So much for Title X as a fallback for women if both sets of rules ultimately are allowed to take effect.

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3. Regulating Health Insurance as a Complicated Dance Between Federal and State Enforcement Agencies

The ACA creates a complex web of federal standards for insurance products, superimposed on state insurance regulation. The assumption, as evidenced in the market reforms (including the essential health benefit (EHB) rules), is that health plans will comply with both sets of standards, with broad federal requirements sitting atop state insurance laws. As of April 8, 2016, only Missouri, Oklahoma, Texas and Wyoming have notified the federal government that they do not have the authority to enforce or are not otherwise enforcing the Affordable Care Act market reform provisions. https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/compliance.html (Accessed July 4, 2016). The preemption provision of the Public Health Service Act, unlike ERISA preemption (both of which are discussed in Chapter 8 of the Book), gives states the power either to enforce federal law as written or establish more stringent state standards. In a study from 2014 researchers examined how states approach the various market reforms (enforcement as written or more stringent standards). The author found that on various reforms, certain states exceeded federal minimums.* Equally notable, however, was the large number of states that on any measure have implemented the federal floor as written, without additional guarantees. See Justin Giovannelli, et al., Implementing the Affordable Care Act: State Action to Reform the Individual Health Insurance Market (Commonwealth Fund, July 2014), http://www.commonwealthfund.org/~media/files/publications/issue-brief/2014/jul/1758_giovannelli_implementing_aca_state_reform_individual_market_rb.pdf (Accessed July 4, 2016).

For example, federal rules implementing essential health benefits (45 C.F.R. §126.100 et seq.) require plans to cover 10 broad classes of benefits** and to comply with state benefit mandates falling within these 10 broad categories, in effect as of December 31, 2011, and included in the state’s benchmark plan as of that date. 45 C.F.R. §156.110. In the case of state benchmarks that lack one or more of the 10 EHB categories (for example habilitative services typically were not included in the state-regulated small employer group market, pre ACA), the federal regulation lays out minimum steps for supplementing benchmarks by adding coverage. Throughout the EHB rule, however, health plans, as a matter of federal law, are given enormous discretion to devise their own cost-sharing strategies and design the details of EHB coverage to suit their market preferences. A study by Giovannelli and colleagues found that as of 2014 10 states had imposed certain coverage and cost-sharing standardization requirements on issuers selling in the EHB-governed market, but that, of course, means that 40 states had not.

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* Set forth in the study as guaranteed issue and renewal, dependent coverage to age 26, rescissions, modified community rating, pre-existing condition exclusion ban, coverage of essential health benefits, coverage of preventive benefits without cost sharing, annual cost-sharing limits, annual out-of-pocket limits, lifetime out-of-pocket limits, and transparency in coverage.

** PPACA §1302(b)(1) specifies 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, preventive and wellness services and chronic disease management, and pediatric services including oral and vision care.
The same researchers found similar disparities among the states in the manner in which they have defined the essential health benefits requirement, many of which might be obstructing the purpose of the requirement. Justin Giovannelli et al., Implementing the Affordable Care Act: Revisiting the ACA’s Essential Health Benefits Requirements (Commonwealth Fund, Oct. 2014), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/oct/1783_giovannelli_implementing_aca_essential_hlt_benefits_rb.pdf (Accessed July 4, 2016).

Similarly, in order to avoid adverse selection, the federal Marketplace standard provides for operation in accordance with an annual open enrollment period. The study reports that Nevada, by contrast, requires year-round open enrollment, using a 90-day coverage waiting period instead in order to guard against adverse selection. Other states have added to the special enrollment periods recognized by the federal government.

Thus, what has unfolded is a combination of transformational changes in the standards applicable to the individual Marketplace, coupled with age-old state-to-state variation in the strength of states’ regulatory regimes and the level of protection extended to consumers. With regard to the Medicaid expansion discussed above, one sees a widening gap in insurance coverage between states which have accepted the expansion and those which have not, with many of the poorest states in the latter category and therefore falling even further behind. One sees a similar gap with regard to regulation of insurance, as states with fairly aggressive regulation generally pulling further away from states with relatively lax regulation. See Katie Keith & Kevin W. Lucia, Implementing the Affordable Care Act: The State of the States (Commonwealth Fund, Jan. 2014), http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2014/Jan/1727_Keith_implementing_ACA_state_of_states.pdf (Accessed July 4, 2016). A report by the National Conference of State Legislators in May 2016 compiled a fairly remarkable number of state laws and actions aimed to obstruct many components of the ACA, such as laws that require explicit legislative approval of further compliance with the ACA. State Laws and Actions Challenging Certain Health Reforms, http://www.ncsl.org/research/health/state-laws-and-actions-challenging-ppaca.aspx (Accessed July 4, 2016).

In general, what remains especially murky is exactly how the federal oversight process will work. In state-based Marketplaces, a state is expected to ensure compliance with federal and state law. But in the federal Marketplace (running in 34 states) any oversight will be the responsibility of the federal government, specifically the Center for Consumer Information and Insurance Oversight (CCIIO). CCIIO, a small and beleaguered office now having to oversee 34 Marketplaces, also has primary responsibility for enforcing the market-wide standards (e.g. guaranteed issue and renewal, modified community rating, a ban on lifetime and annual limits on covered services, preventive services coverage, essential community benefit coverage in applicable plans, and so forth). A tall order, indeed.
Federal regulations set forth a process that will be used by HHS in cases in which the agency receives information or otherwise learns that federal requirements are not being enforced. 45 C.F.R. §150 et. seq. (As of summer 2015 there appears to be no ongoing oversight effort other than the federal health plan certification process for the 34 states in which the federal government is operating the Marketplace, either alone or with a state partner). Other than these rules, however, there appears to be no available federal complaint process as is the case with the HIPAA privacy rule, which offers complainants a clear pathway to filing claims with the HHS Office of Civil Rights. In a nutshell, in the federal enforcement process—a testament to the delicate federalism dance that must be carried out with state regulators—the Secretary of HHS basically gets on the phone with state regulators in the problem state and attempts to work things out. The law (Public Health Service Act §2723) does give the Secretary fallback direct enforcement powers in the form of civil money penalties, but the thrust of the law is reliance on state enforcement.

Bear in mind, as noted in the Book (Chapter 8) that unlike ERISA, the Public Health Service Act creates no express federal right of action for private individuals whose states fail to ensure compliance with federal standards. Virtually all states create enforcement rights for insurance policy holders (potentially a complaint to the state insurance department followed by judicial appeals), but what if the issue is the state’s failure to follow federal requirements, such as allowing plans to be sold that cover fewer than all CDC-recommended immunizations at zero cost, a requirement under the preventive benefit provision of the ACA? And what if the issue is an allegation that the state has failed to ensure that plans sold in the Marketplace offer adequate networks, as required under the ACA?

The question of whether an implied right of action exists for individuals who allege injuries arising from the failure of states to follow federal law is one that looms large in the Medicaid program (Chapter 11 and the materials in this Update), and the questions are just as important here.
Third Postscript to Part Two: The (Almost) Great Unraveling

[This Postscript was written in the summer of 2017. We have retained it because it provides history invaluable to understanding where we are today in the summer of 2018 and what may lie ahead. The Fourth Postscript follows and updates this one.]

Introduction

As this Update is being written, the Senate’s effort to “repeal and replace Obamacare” appears to have collapsed, Majority Leader McConnell’s bill a victim of defections by Senators from both wings of his own Republican Party. The Majority Leader has vowed to hold a recorded vote on the threshold question of whether to move to full debate, but as of July 23, 2017, the outcome of such a vote is in doubt.

From the beginning, the Majority Leader had rejected a bipartisan strategy and had sought to design a measure that could pass with a bare majority of 50 Republican Senators, allowing a margin of only two “no” votes on his side and relying on a Republican Vice President to break the tie. In the end, and for very different reasons, four Senators withdrew their support for the version of the replacement bill released on July 13th, and at least three indicated that they would refuse to support a straight repeal vote with no replacement. In the end, Senator McConnell simply could not bridge the divide within his own Republican caucus—between Senators who wanted to “pull out Obamacare root and branch” as McConnell had promised and those who, much like many Democrats, simply wanted to fix parts of the Affordable Care Act that need to work better.

In the immediate aftermath of the apparent collapse, President Trump has demanded that Congress remain in town long enough to finish the job and simultaneously has vowed to push the ACA into a quick and complete demise by refusing to pay subsidies owed to health insurers participating in the health insurance marketplaces created by the law. Thomas Kaplan, ‘Let Obamacare Fail,’ Trump Says as GOP Health Bill Collapses (NY Times, July 19, 2017) https://www.nytimes.com/2017/07/18/us/politics/republicans-obamacare-repeal-now-replace-later.html?_r=0 (Accessed July 22, 2017). Whether the Administration carries through on this threat—effectively costing millions of low and moderate income people their insurance coverage—remains to be seen.

It could be that the ACA’s demise will be furthered before 2017 ends. The betting is that everyone will move on and leave matters semi-alone through the 2018 mid-term elections, hoping for a more positive political climate after that. Mid-term elections, however, typically are not kind to the party in power, particularly with a president with the sort of low polling numbers like those of President Trump.

We shall see.
This epic story—which speaks volumes not only about the political dimension of health law but also the extent to which the laws that help define the contours of the American health care system have a real, human impact—can be summed up as follows: After seven years of unremitting attacks on the Affordable Care Act (ACA) that saw opponents land several crippling blows, and following a watershed Presidential election in 2016 that also saw the Republicans capture both Houses of Congress, at least so far it has turned out to be impossible to roll back the law’s foundational elements. This is not simply because health reform is hard (as the President and Congressional leaders have repeatedly noted); it is also because, despite everything, the law is working for nearly 30 million people—10 million people who receive subsidized private insurance through the health insurance marketplace, 15 million additional people enrolled in Medicaid, and several million young adults who have been able to enroll in insurance coverage through their parents’ plans.

The collapse of the repeal-and-whatever effort has many mothers and fathers, but in the end, it can be traced to two basic factors. The first factor turned out to be mistaken belief on the part of those lawmakers for whom overturning the Affordable Care Act was propelled by deeply-held philosophical concerns about the role of government in health care markets that the public was with them enough to accept the loss of coverage by an estimated 22-23 million people (and by 35 million were the ACA simply to be repealed with no replacement) as a necessary price to be paid for turning this belief into reality. By more than a 3 to 2 margin, the public viewed the replacement bills unfavorably; many of these, Democrats and Republicans alike, absolutely despised them. Kaiser Family Foundation, Kaiser Health Tracking Poll—July 2017: What’s Next for Republican ACA Repeal and Replacement Plan Efforts? (July 13, 2017) http://www.kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-july-2017-whats-next-for-republican-aca-repeal-and-replacement-plan-efforts/ (Accessed July 19, 2017). Another poll, taken in late June, showed that only 17 percent of the American public approves of the Senate bill, http://maristpoll.marist.edu/wp-content/misc/usapolls/us170621_PBS_NPR/NPR_PBS%20NewsHour_Marist%20Poll_National%20Nature%20of%20the%20Sample%20and%20Tables_Trump_Congress_Health%20Care_June%202017.pdf#page=3 (Accessed July 22, 2017). The level of antipathy turned out to be especially potent to the attempted changes to Medicaid, a 52-year-old program of health insurance for the most vulnerable Americans, which has turned out to be deeply popular among Americans. Its sheer size—some 75 million people enrolled today—means that Medicaid directly touches more than one in five Americans. Over 60 percent of the population reports knowing someone who depends on the program. Julia Paradise, Medicare and Medicaid at 50 (Kaiser Family Foundation, 2015), http://www.kff.org/medicaid/poll-finding/medicare-and-medicaid-at-50/ (Accessed July 19, 2017). Simply put, proponents of repeal/replace could not sell their product.

The second factor—which helped boost the first—can be found in the structure of the legislation itself. Upon close inspection, it became evident to everyone that the House and Senate measures were (a) remarkably devoid of any real understanding of what it takes to make the individual health insurance market function properly and thus carried the potential to blow the market sky-high; and (b) a massive and blatant legislative
Overreach whose ultimate purpose was to give nearly a trillion dollars in tax breaks to wealthy people and corporations by cutting nearly a trillion dollars out of Medicaid and the system of subsidies that make ACA Marketplace plans affordable.

Overturning the ACA is not—and except for the most naïve lawmakers, really never was—the goal of repeal/replace. Any student who has had the opportunity to even briefly peruse the ACA—all 1000 pages of it—knows that it is not simply a freestanding body of law that can simply be repealed. By and large, the ACA is a hodgepodge of obscure amendments to existing, vastly complex federal laws, each of which governs different aspects of the U.S. health insurance system, and each of which has different implications for how health care is organized, financed, and delivered. Taken together, the ACA represents a grand attempt to cobble together a plethora of underlying laws to create an operational insurance system for nearly all Americans. Undoing the ACA was thus fraught with danger, because any effort would risk unraveling far more than legal provisions impacted by just a narrow set of amendments, with untold spillover effects.

As one works through the collapse of repeal/replace, it is worth recapping the ACA itself. The 2010 legislation represents a modification of several bedrock laws on which the nation’s health insurance system rests. One is the Internal Revenue Code; the ACA established tax penalties (the so-called mandates) on individuals who fail to buy affordable coverage and large employers that fail to provide it. The ACA also creates a system of tax subsidies whose purpose is to make premiums affordable for low and moderate income people who purchase coverage through the health insurance Marketplace. The ACA also restructured tax laws to raise the funds needed to pay for its insurance expansions.

Another bedrock law on which the ACA rests is Medicaid, which, as noted, is the nation’s largest public health care financing program for the nation’s poorest and most vulnerable populations. The ACA amended Medicaid to remove its historic exclusion of poor working-age adults who need affordable health insurance but do not fit neatly into classic welfare categories (pregnant women, exceptionally poor parents of minor children, or adults with disabilities severe enough to prevent them from working).

A third law that undergirds the ACA is the Employee Retirement Income Security Act (ERISA), which governs all employer-sponsored health and welfare benefit plans other than those sponsored by churches and public employers. ERISA is tremendously complex in its application and, as you learned in Chapter 8, its interaction with state insurance laws has been a matter of great political tension over the years. In the ACA, Congress largely left ERISA unaffected in order not to overreach, particularly with regard to larger, self-insuring employers, but lawmakers did not avoid political problems, as the contraceptive coverage cases discussed in these update materials underscore.

The final major body of law on which the ACA rests is the Public Health Service Act, whose many titles include one establishing minimum federal standards governing the health insurance market. Extension of the PHS Act to the private insurance market was a hallmark of the Health Insurance Portability and Accountability Act, explored in
Chapter 6; the ACA built on this groundwork, adding new federal standards and fleshing out and modifying others.

Together the ACA amendments were designed to create a system in which virtually all poor Americans would be covered through Medicaid and those without employer coverage would be able to buy affordable insurance through the individual market. A simple vision, but in practice, very hard to execute.

When a major Act of Congress like the ACA amends existing laws in literally thousands of ways, and those amendments begin to take hold throughout the entire health care system, it is not possible to simply roll back its provisions without running into a lot of spillover effects. Indeed, any effort to do so would disrupt the single largest piece of the U.S. economy, approximately 18 percent of GDP. Furthermore, these amendments would be equally complex in order to restore prior law and effectively restore the status quo ante; their impact and cost would need to be individually weighed, as with any major piece of legislation. This is the job of the Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT), which, under the 1974 Congressional Budget Act, advise Congress on the financial, broader economic, and practical effects of pending legislation.

Furthermore, certain bells can’t simply be unrung. For example, the ACA changes the ways that Medicare pays participating hospitals, imposing new penalties for failure to meet certain quality goals, such as reducing clinically unnecessary readmission rates, altering complex payment methodologies, and establishing entirely new types of health care delivery structures as participating provider organizations, known as Accountable Care Organizations (ACOs), whose numbers today surpass 400 and that provide care to nearly 30 million people. Mike Stankeiwicz, Accountable Care Organizations Experience Growth, Challenges (BNA Health Care Daily Report, June 14, 2017). These changes in law (addressed in Parts Two and Three of the main textbook) have had an enormous effect on health care is organized, delivered, and paid for. They are huge and consequential reforms no one wants to abandon, just as virtually no one wants to get rid of the ACA amendment permitting parents to keep their children on their employer health plans until age 26.

And of course, making sweeping changes in law is unbelievably complicated politically. This is especially true in the Senate, where Senators enjoy far greater autonomy than in the House, in which the majority party tends to rule with an iron fist. Normally 60 votes—a super-majority—are needed to pass laws of great consequence, as was the case with the ACA. But the Budget Act also gives Congress a fast-track “reconciliation” process that requires only bare-majority passage in the Senate. While the Republicans control the Senate, as noted they have only 52 votes—not enough for “regular order” bills requiring a 60-vote margin (unless, of course, they craft bills that attract bipartisan support, a non-starter in the case of health reform to put it mildly, where Democrats have insisted on fixing the ACA while Republicans have insisted on repeal).
The reconciliation process is further complicated by a special rule, known as the Byrd Rule, which demands that all provisions in a fast-track bill adopted through the reconciliation process directly affect the revenues or outlays of the United States in a fashion that is “not merely incidental to another purpose.” Timothy Jost, Senate Parliamentarian Rules Several BCRA Provisions Violate the Byrd Rule, Health Affairs Blog, July 21, 2017, [http://healthaffairs.org/blog/2017/07/21/senate-parliamentarian-rules-several-bcra-provisions-violate-the-byrd-rule/](http://healthaffairs.org/blog/2017/07/21/senate-parliamentarian-rules-several-bcra-provisions-violate-the-byrd-rule/) (Accessed July 23, 2017). On July 21, the Senate Parliamentarian ruled that key operational and politically sensitive provisions of the repeal/replace legislation in fact violated the Byrd Rule. This means that either these provisions—near and dear to the heart of certain Senators or essential to the measure’s operation*—must be stripped out of the bill before the vote or else 60 Senators would need to vote to override the ruling. As a practical matter, this is an impossibility given that not even all 52 Republican Senators likely would vote to at least consider the measure. Essentially, the Majority Leader would need to unilaterally blow up the rules of the Senate to preserve these crucial provisions as part of his bill. In order to avoid the Byrd Rule, the Senate bill already had avoided including certain flexibility powers demanded by Governors to alter the scope of their Medicaid programs in the face of extreme loss of federal funding, in particular the flexibility to eliminate the entitlement to coverage among people who are eligible that Medicaid establishes (see Chapter 11). Letter to Congressional Leadership from Governors Kasich, Sandoval, Snyder, and Hutchinson (March 2017), [https://assets.documentcloud.org/documents/3519424/Governors-Letter-3-16-2017.pdf](https://assets.documentcloud.org/documents/3519424/Governors-Letter-3-16-2017.pdf) (Accessed June 30, 2017). But this concession to Parliamentary rules turned out not to be enough, although the Parliamentarian let stand a new provision that will permit states to impose work requirements on “able-bodied” adults, which for two decades has been part of the Temporary Aid to Needy Families (TANF), a modest program of cash welfare assistance to the poorest Americans. Sara Rosenbaum et al., What Might a Medicaid Work Requirement Mean? (Commonwealth Fund, 2017), [http://www.commonwealthfund.org/publications/blog/2017/may/medicaid-work-requirement](http://www.commonwealthfund.org/publications/blog/2017/may/medicaid-work-requirement) (Accessed July 23, 2017).

Given the constraints of bare-majority lawmaking in the Senate, the real goal of repeal/replace proponents has been to get rid of the pieces of the ACA they hate the most: the individual mandate, seen as a fundamental abuse of government power and whose constitutionality was affirmed in [National Federation of Independent Businesses v Sebelius 124 S. Ct. 2566 (2012) (Textbook Update); the employer mandate; the Medicaid expansion for low income working-age adults; the taxes whose revenues support the expansion of Medicaid and the cost of the law’s private insurance tax subsidies; and the

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* Included in the Parliamentarian’s exclusionary ruling is a provision that would bar federal Medicaid funding for Planned Parenthood for a year—long sought by opponents of abortion and family planning given Plan Parenthood’s outsized role in making both services accessible to low income women. Also stripped from the bill under her ruling is a provision meant to protect against people who delay buying insurance coverage until they are sick, a phenomenon known as adverse selection—that would sink any health insurance market. [https://www.budget.senate.gov/imo/media/doc/Background%20on%20Byrd%20Rule%20decisions_7.21%5b1%5d.pdf](https://www.budget.senate.gov/imo/media/doc/Background%20on%20Byrd%20Rule%20decisions_7.21%5b1%5d.pdf) (Accessed July 23, 2017).
law’s minimum federal regulatory standards applicable to the insurance market, such as making insurance available to everyone regardless of health status, eliminating discrimination in pricing and access based on age, health status, and gender, establishing minimum coverage standards for policies sold in the individual and small group markets, and adopting uniform coverage for preventive health services, including preventive services for women. Perhaps most surprising to many observers—although not to those who have followed Medicaid’s storied and difficult history for decades—is that getting rid of Medicaid—not just the ACA amendments but effectively the program as we know it—emerged as arguably Goal #1, with an eye toward ending the nation’s largest means-tested legal entitlement and recapturing nearly a trillion dollars to spend on tax breaks. Robert Pear and Thomas Kaplan, Senate Health Care Bill Includes Deep Cuts to Medicaid, NY Times (June 22, 2017) https://www.nytimes.com/2017/06/22/us/politics/senate-health-care-bill.html (Accessed July 2, 2017).

In understanding why repeal/replace has thus far failed so spectacularly, it is also important to understand the ACA’s accomplishments and shortcomings. Both are considerable, although a number of the shortcomings are, in fact, traceable to the law’s basic design, necessary to obtain its initial passage, and to direct interference by opponents in the law’s implementation. Indeed, the ACA’s operational shortcomings have turned out to be relatively easy to diagnose, although its most glaring failure—the law essentially does nothing to directly address underlying health care costs and instead aspires to achieve savings in the long term by coupling population-wide coverage with weak incentives to encourage delivery and payment reform—represents the most enduring policy challenge.

For five years this textbook has explored the ACA. We now pick up the thread again in order to tell the story of the likely collapse of the repeal/replace legislative effort. This story is the stuff of books, which, we are sure, will be written. We attempt here to boil it down for you. We begin with a recap of the ACA’s elements and its chief features, its achievements, and its challenges. We then turn to the repeal/replace legislation that so far has failed in order to examine its provisions and assess its likely effects, at least as projected by a blizzard of analyses, both governmental and privately funded.

The Affordable Care Act: Principal Aims, Achievements, and Challenges

Despite its length and complexity, the ACA was designed to address, in an incremental fashion, the American health care system’s most basic problem: The lack of accessible, affordable private health insurance offering decent coverage for working-age Americans and their families who—for any number of reasons given the weaknesses of the insurance system (explored in Chapters 1 and 6)—lack coverage.

The ACA sought to accomplish this goal through a series of interlocking and detailed reforms to the private health insurance market, and by restructuring Medicaid. From a purely mechanical perspective, fixing Medicaid actually turned out to be the far simpler of the two tasks, while fixing the private insurance market required a feat of
structural engineering. As we shall see, the Medicaid solution proved to be the far bigger political deal, however.

The ACA’s Medicaid reform. Medicaid and private insurance are fundamentally different, and from an operational perspective, growing Medicaid in fact is far easier, assuming that the money can be found. This fact helps explain why Medicaid has grown so big—enlarging its contours does not raise the hellishly complex problems that crop up in the case of private insurance. Indeed, Medicaid is designed to embrace, rather than avoid, risk; most Medicaid funding is spent insuring higher cost, higher-need people, who make up about one-third of all program beneficiaries. This is not to say that the states and the federal government do not struggle mightily to hold down costs. But Medicaid grows because people’s needs grow and because the program pays for so many things that private insurance does not, such as long term care for children and adults with severe disabilities. One need only look at which insurer pays the largest share (by far) of treatment for the opioid epidemic to understand Medicaid’s singular role among all sources of coverage. Kaiser Family Foundation, Addressing Medicaid’s Role in the Opioid Epidemic (March 2017), http://www.kff.org/infographic/medicains-role-in-addressing-opioid-epidemic/ (Accessed July 2, 2017).

As discussed at length in Chapter 11, Medicaid operates as a legal entitlement. People who need Medicaid have a legal right to apply, and if found eligible, they have a right to medical assistance furnished with “reasonable promptness,” that is, from the date on which eligibility is determined, and potentially, up to 3 months prior to the date of application. Medical assistance—that is, the coverage offered by Medicaid—is very comprehensive, with only limited cost sharing. Medicaid’s status as a legal entitlement allows the program to function as a form of health insurance, which creates contractual rights in individuals. But Medicaid is also far sturdier, resting on public financing that allows the program to grow if political consensus is reached and the needed revenues can be found. (This, of course, is a problem for states because health care is so expensive and has such a crowd-out effect on other necessary social welfare needs).

While its details are complicated, the ACA Medicaid expansion can be boiled down as follows: To Medicaid’s many mandatory minimum requirements, Congress added a new mandatory eligibility category consisting of adults ages 18-64 who do not qualify for coverage under one of the traditional categories and whose household incomes are at or below 138% of the federal poverty level. Because Medicaid is a shared federal-state financial responsibility, and because states were extremely concerned about the cost of covering an estimated 15 million more people, Congress provided for enhanced federal Medicaid funding, setting it for the expansion group at 100% during calendar years 2014

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* Medicaid’s status as a “safety net” program is underscored by things such as its retroactive eligibility rule. 42 U.S.C. § 1396a(a)(34). Retroactive eligibility, part of the original law, is designed to encourage providers to begin caring for indigent patients as soon as care is needed, even if furnished prior to enrollment. Needless to say, private insurance doesn’t work that way; coverage begins typically one month after enrollment.

** In NFIB the Chief Justice does a great job—not as great as the magisterial dissent written by Justice Ginsburg—in describing this principal change to the program.
(the first year of implementation) through 2016, after which the federal contribution would slowly decline to 90% in 2020 and thereafter. This 90% figure—certainly lower than 100%—is well in excess of the normal federal Medicaid contribution rate, which varies greatly among the states in reverse proportion to their wealth and tops out in 2017 at about 75% of total state spending on the cost of covered services for enrolled populations.

Despite the enormity of the federal financial bargain, however, 26 states sought to overturn the expansion as unconstitutional coercion. Ultimately, in NFIB v Sebelius (Update) a majority of the Supreme Court agreed, characterizing the expansion as a “new program” in which states were forced to participate as a condition of receiving federal funding for what the Court characterized (dishonestly, in view of the text of the statute itself) as a separate traditional program. At the state time, the Court declared that the expansion could survive as a discrete state option, not enforced by denying federal funding for states’ traditional Medicaid programs.

As of July 2017, 31 states and the District of Columbia have adopted the expansion. Kaiser Family Foundation, State Medicaid Expansion Approaches (April 2016) http://www.kff.org/medicaid/fact-sheet/state-medicaid-expansion-approaches/ (Accessed June 30, 2017). Non-expansion states are concentrated in the historic South as well as in the Plains states. Approximately 2.6 million adults—disproportionately African American—are excluded from any subsidized insurance coverage as a result, since the tax subsidies needed to make Marketplace coverage affordable were designed not to kick in until the poverty threshold was reached, on the assumption that the poorest people would be covered through Medicaid. Kaiser Family Foundation, Who is Impacted by the Coverage Gap in States that Have Not Adopted the Medicaid Expansion? (November 2016), http://www.kff.org/slideshow/who-is-impacted-by-the-coverage-gap-in-states-that-have-not-adopted-the-medicaid-expansion/ (Accessed June 30, 2017). These states have foregone hundreds of billions of dollars in federal funding in order to stand by their principles. And the residents of these states who have been deprived of Medicaid are left with no health insurance because their incomes fall below the tax subsidy lower threshold of 100% of the federal poverty level. Additionally, the states’ safety net providers and economies more generally have taken major hits because of the loss of these billions of dollars and the diminished health and productivity of their citizens.

Private health insurance. From an operational perspective, fixing the private insurance market turned out to be far more arduous. Compared to Medicaid, which has been characterized as the “workhorse” of the American health care system, private health insurance is a hot-house flower. Medicaid can grow and expand with health care needs; private insurance has to be carefully structured if the goal is convincing private insurance companies to take on a lot of financial risk. Other wealthy nations that finance care through insurance, as we have noted, don’t take this tack. Instead they manage population health needs and their attendant financial costs by pooling financial risk at a large population level (e.g., nationally or regionally) and then select among various

* Alan Weil, There’s Something About Medicaid,” 22 Health Affairs 13 (2003).
insurance options (e.g., a single governmental insurance program akin to Medicare or per capita payments to private (typically nonprofit) insurers operating nationally or regionally). With the exception of Medicare, which is governmental social insurance, the U.S. does not pool risk at a population level and combine such pooling with strong cost management rules. Instead, the U.S. private insurance system for working age Americans and their families historically was characterized by millions of employer plans floating on their own bottoms and operating alongside a dysfunctional individual market for people without access to either employer coverage or public insurance. Many of the people who needed individual insurance were older and sicker. They were either excluded entirely through medical underwriting or else were denied more than the most minimal insurance coverage, often referred to as junk insurance. Reed Abelson, In Clash over Health Bill, a Growing Fear of Junk Insurance (New York Times, July 16, 2017) https://www.nytimes.com/2017/07/15/health/senate-health-care-obamacare.html?smprod=nytcore-iphone&smid=nytcore-iphone-share (Accessed July 19, 2017).

The tools private insurers used to shield themselves from bad risks in the individual market took many forms. They excluded people with pre-existing conditions or who exhibited certain health risks; they charged the sick higher rates and charged women more than men (owing heavily to the cost of maternity care and higher use of health care generally among women); and they denied renewals to those who became sick or they attempted to rescind their policies. They also offered skinny plans that covered little and that came with high-cost sharing for what was covered and imposed annual and lifetime limits on how much they would pay toward the cost of covered services. In other words, policies covered very little and excluded a lot.

As Chapter 6 notes, the 1996 Health Insurance Portability and Accountability Act (HIPAA) addressed some of these problems in the group insurance market, but left the individual market virtually untouched. Furthermore, HIPAA did nothing to address the comprehensiveness or quality of insurance coverage itself—only its accessibility.

In order to address the needs of people who simply could not buy an individual insurance policy at any price, many states turned to high risk pools to help the concentrated few with high health costs—although as it turns out this number is not so small: one in four Americans has a condition that in the pre-ACA market would have rendered them uninsurable. Karen Pollitz, High Risk Pools for Uninsurable Individuals (Kaiser Family Foundation, 2017), http://www.kff.org/health-reform/issue-brief/high-risk-pools-for-uninsurable-individuals/ (Accessed June 30, 2017). High risk pools were supposed to take care of a core problem, namely, that in any given year, the healthiest 50% of the population accounts for less than 3% of total health spending, while the sickest 10% account for two-thirds of health spending. Id. But they did not. Because the high-risk pools consisted only of sick people, they were unbelievably expensive to
operate, since there were no cross-subsidies from healthier members. State subsidies were inadequate, premiums were extraordinarily high and benefits were extremely limited."

Where private health insurance is concerned—in particular, policies sold in the individual market—the Affordable Care Act was designed to fix this basic and interlocking set of problems so that, regardless of health or economic circumstances, reasonable coverage would be available. By 2009, Congress knew that such a strategy was possible, since under President George W. Bush, an earlier Congress had used precisely the same tools to create a working private health insurance market for prescription drugs for Medicare beneficiaries, known as Medicare Part D. (Chapter 10). The Part D market is of course very different from the market created under the ACA, since it is voluntary and consists strictly of Medicare beneficiaries. Yet other than the ACA’s individual mandate (Part D uses a late enrollment penalty instead), Part D’s operating components are a virtual precursor to the ACA: (i) subsidies to make coverage affordable; (ii) a reasonably robust and relatively standardized benefit design to ensure adequate (even if not comprehensive) coverage and to deter benefit gaming (such as exclusion of certain high-cost drugs) that skew products toward healthy customers and away from sick ones; and (iii) use of three types of market stabilizers—risk corridors, which place aggregate overall limits on the amount of money that an insurer can lose in any given year, reinsurance, which limits insurers’ losses attributable to specific high-cost cases, and risk adjustment, a process by which insurers with healthier insured populations help cross-subsidize insurers whose members experience higher-than-normal losses from sicker members. Cynthia Cox et al., Explaining Health Care Reform: Risk Adjustment, Reinsurance, and Risk Corridors (Kaiser Family Foundation, 2016), http://www.kff.org/health-reform/issue-brief/explaining-health-care-reform-risk-adjustment-reinsurance-and-risk-corridors/ (Accessed June 30, 2017); Health Affairs Health Policy Brief: Risk Corridors (2015), available at http://healthaffairs.org/healthpolicybriefs/briefpdfs/healthpolicybrief_134.pdf (Accessed July 2, 2017).

This knowledge was put to work in the ACA’s private insurance reforms. The key contours of these reforms, discussed at greater length in Chapter 6, are summarized here.

First, Congress substituted a tax penalty for a late enrollment penalty given evidence that it would be more effective in getting healthy people to enroll rather than merely penalizing those who are already sick with higher premiums. (The mandate has indeed appeared to have a real impact on bringing healthy people into the pool. http://www.commonwealthfund.org/publications/blog/2017/jul/no-substitute-for-the-individual-mandate ) Other than this change, Congress used the same strategy as in Part D to create favorable conditions for stable insurance plans to operate, by incentivizing enrollment of healthy people, critical to properly function risk-spreading. The tax penalty

* The Supreme Court’s decision in *King v Burwell* (2015) (found in this Update), which concerned the availability of tax subsidies in the federal Marketplace, does an excellent job of summarizing the essential problems with the pre-ACA health insurance market and describing its key elements.
is owed by people who, as a matter of law, can “afford” coverage (pegged at 8% of adjusted gross income) but fail to obtain it.

Second, Congress restructured the federal regulatory scheme governing both the individual and group health insurance markets and, to a lesser degree, the market for ERISA-governed self-insured employer plans. Essentially, this restructured regulatory scheme is designed to: (a) open the market to everyone regardless of age or health status and (b) assure that health insurance plans are reasonable. To accomplish these two basic goals, among its most important changes the ACA: (i) bars insurers from segmenting their individual insurance markets and requires that they maintain a single statewide risk pool; (ii) bars insurers from using pre-existing condition exclusions or refusing to renew policies based on health status (although they are permitted to adjust prices to reflect local market prices; (iii) holds down premiums for older people, by limiting age-banding to a 3:1 age-rating ratio that prevents insurers from charging older customers more than 3 times what younger adults pay for the same product;* (iv) requires insurance plans sold in the individual and small group markets to cover an “essential health benefits”** package that includes the categories of covered benefits offered under a “typical” employer-sponsored plan with an actuarial value of at least 70%;*** (v) bars insurers and employer-sponsored health plans from imposing an annual or lifetime cap on any plan benefit falling into the essential health benefit category; and (vi) requires all “non-grandfathered”**** health plans to cover preventive benefits without cost sharing, including contraception coverage.*****

Third, in order to make coverage affordable, the ACA established a system of refundable premium tax credits for people with household incomes between 100% and 400% of the federal poverty level. The law also provided cost-sharing subsidies to help people receiving tax credits and with incomes up to 250% of poverty pay their deductibles and coinsurance. The cost sharing assistance for ACA-qualified health plans sold in the Marketplace is essential, because the benchmark health plans to which the subsidies are tied have an actuarial value of only 70%, meaning that they pay only 70 cents out of each dollar owed for covered benefits. The cost sharing subsidies help low income plan members, in effect raising the actuarial value of a plan to 94% for the lowest income members and 87% for the near-poor. This effectively lowers the cost sharing

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* Historically insurers used age ratios of 5:1 or even higher, meaning a plan costing a 25-year-old $3000 would cost a 60-year-old $15,000.

** The essential health benefits package consists of 10 broad benefit classes: inpatient and outpatient hospital care, maternity and newborn coverage, prescription drugs, diagnostic services, mental health and substance use disorder care including rehabilitation services, habilitation services for children and adults for developmental disabilities, preventive services, and pediatric care including vision and oral health care.

*** Under certain conditions, insurers can sell plans with a 60% actuarial value, and 60% is used as the lower threshold to determine which large employers are subject to tax penalties for failing to offer what the ACA calls “minimum essential coverage.”

**** Grandfathered health plans are plans in effect as of the date of enactment of the ACA and that have remained essentially unchanged in terms of scope of coverage and cost sharing. Each year the number of grandfathered plans shrinks.

***** The issue of grandfathered health plans and contraceptive coverage is dealt with in the Update materials on the ACA and contraceptive coverage.

Fourth, the ACA established a premium stabilization system paralleling that used in Part D in order to help insurers cushion the initial blow of having to absorb much higher-cost members while the mandate ramped up and the new normal of health insurance began to take hold population-wide, even among younger, healthier people. Unlike Part D, reinsurance and risk corridors were only adopted on a temporary three-year basis on the assumption that when the new normal was reached there would be plenty of young, healthy covered people to counterbalance those who were older and sicker. Risk adjustment from low to high cost plans was made a permanent feature of the new insurance market.

Finally the ACA established Exchanges, which are now known as the Marketplaces, whose job is to make it possible for people to pick plans and enroll and to also obtain the premium and cost-sharing subsidies to which they may be entitled. Contrary to initial expectations, 38 states rely on the federal Marketplace rather than operating their own.

Implementation and Challenges. The ACA’s two major coverage reforms—the Medicaid expansion (which suffered a terrible setback in 2012 but which has been adopted by the majority of states) and the private insurance reforms moved to full implementation in late 2013. The course of implementation has been rocky, not surprising for so epic a law enacted under such fraught political circumstances, the work of a then single, dominant political party, which then suffered a staggering defeat that switched both Houses of Congress. One underlying factor that explained the rockiness was having to start up all of the moving parts of this immense and immensely complicated engine, particularly getting all of the regulations in place, working with states to implement these regulatory reforms, moving the Medicaid expansion into place, and so forth.

Another was technical ineptness: who can forget the initial meltdown of healthcare.gov, as well as many of the state-operated Marketplaces?

A third factor that has continued to haunt implementation was a crisis of the Obama Administration’s own making. It began when insurers, eager to sell new and more costly ACA-compliant policies, began sending plan cancellation notices in the fall of 2013 to policyholders of ACA-non-compliant plans. Many of these existing policyholders tended to be healthier and were happy with their skinny plans that were less costly. The public outcry over the cancellation notices—estimated to affect between one and three million people in the individual market—was extremely loud and sustained. With the iconic adage from the ACA battle days—“if you like your health plan you can keep it”—thrown in his face, President Obama elected to allow states to continue to
permit insurers to sell ACA-noncompliant plans subject to their own coverage rules and sold through a separate risk pool. This decision, heavily criticized as unsupported by law, also meant that in states that decided to permit this practice, the newly forming risk pool for ACA-compliant plans were deprived of a lot of healthier people. Not surprisingly, the states that permit the sale of non-compliant plans, with their attendant impact on the broader risk pool, are also states that generally opposed the ACA. Tim Jost, Administration Allows States to Extend Transitional Policies Again (Health Affairs Blog, February 23, 2017), http://healthaffairs.org/blog/2017/02/23/administration-allows-states-to-extend-transitional-policies-again/ (Accessed June 30, 2017).

A fourth factor contributing to the rockiness of the ACA’s implementation has been the mountain of litigation challenges to the law. In addition to NFIB, the grand-daddy of them all, was the lawsuit challenging the availability of premium subsidies in the 38 states that depended on the federal Marketplace. This litigation, which threatened the very survival of the insurance market (only the sickest people would buy insurance if there were no subsidies, thereby causing the death of the industry), culminated in the Supreme Court’s decision in King v Burwell (presented in this Update) that upheld the legality of federal regulations that make tax subsidies available to qualified residents of all states, regardless of whether the state operates its own Marketplace or relies on the federal Marketplace.

But by no means did the litigation stop there. In 2014 the House of Representatives, in firm Republican control, voted to sue the Administration to stop the payment of cost-sharing subsidies—which are not paid to indigent plan members but directly to health plans—alleging that unlike the premium payments, the ACA did not make such funds automatically available but instead subjecting such payments to annual appropriations, which a hostile Congress under Republican control had not made. As such, the House Members argued, the Administration’s payments violated its Constitutional authority to appropriate funds. Following a landmark decision upholding the House’s standing and rejecting the Obama Administration’s claim that the suit raised a non-justiciable political question (United States House of Representatives v. Burwell, 130 F. Supp. 3d 53 D.D.C. 2015), the district court went on to strike down the payments. United States House of Representatives v. Burwell, 185 F. Supp. 3d 165 (2016).

The House v Burwell merits decision has been stayed pending appeal on the standing question. But the litigation has added to the cloud of uncertainty over the ongoing availability of such payments, worth billions of dollars annually. Timothy Jost, The House and the ACA—Litigation Over Cost-Sharing Reductions, 374 New Eng. J. Med. 5 (2016). Congress has refused to appropriate funding in advance of the repeal/replace de nu monde. The Senate bill now pending for a vote would appropriate funds for 2 additional years before ending the program and giving states the responsibility of deciding who gets subsidies from a much smaller pool. (Ironically the Parliamentarian has ruled that this appropriation must be struck under the Byrd Rule presumably because it would not affect revenues and outlays given the fact that the stay in House v Burwell means that these revenues are now flowing). By contrast, the House-passed bill would do away with cost sharing reductions immediately, instead giving states
the responsibility for sorting out cost-sharing virtually immediately. For its part, the Trump Administration, which has repeatedly moved to delay the appeal, also has refused to unequivocally commit to making the payments while the stay is in place, something that its own Congressional supporters have urged the Administration to do. In other words, the Administration and Congressional leaders have exacerbated the very uncertainty over the financial viability of the insurance market that companies hate. Pedro Alcocer et al., A Bridget Too Far? The Most Likely Fates of ACA CSR Payments and Impacts on the Individual Markets. (Milliman 2017), http://www.milliman.com/insight/2017/A-bridge-too-far-The-most-likely-fates-of-ACA-CSR-payments-and-impacts-on-the-individual-market/ (Accessed July 1, 2017); Henry Aaron et al., Turmoil in the Individual Insurance Market—Where it Came From and How to Fix It, New Eng. J. Med. (June 26, 2017), http://www.nejm.org/doi/pdf/10.1056/NEJMp1707593 (Accessed July 2, 2017).

A fifth factor in the rocky implementation has been Congress’s refusal to provide the needed funding for payment of reinsurance and risk corridor payments. Like the cost sharing subsidies, lawmakers have essentially brought the stabilization program to a halt. Insurers have brought numerous lawsuits to recover these funds, since they are owed billions of dollars. But with the exception of one positive decision, the litigation has failed on the ground that under the terms of the statute and implementing regulations, no funds are owed until after 2017, meaning that suits to recover payments are premature. Timothy Jost, ACA Round-Up: Risk Corridor Suit Dismissed as Premature; Supreme Court Ends Challenge to Administrative Fix (Health Affairs Blog, April 19, 2017), http://healthaffairs.org/blog/2017/04/19/aca-round-up-risk-corridor-suit-dismissed-as-premature-supreme-court-ends-challenge-to-administrative-fix/ (Accessed July 1, 2017); Nicholas Bagley, Trouble on the Exchanges: Does the U.S. Owe Billions to Health Insurers? 375 New Eng. J. Med. 2017 (2016), http://www.nejm.org/doi/full/10.1056/NEJMp1612486 (Accessed July 1, 2017).

By 2017, this deluge of issues—much lower enrollment than predicted owing to subsidies that needed to be more generous, a weak mandate weakly implemented, a weak risk pool, constant and disruptive litigation, and the withholding of billions in funds by Congress—had taken a major toll in the eyes of the public. Coupling heavily damaging blows with a drumbeat of “Obamacare is broken,” a Congress and a President dedicated to repealing the ACA used every one of these problems—serious but entirely fixable—to drive home their case, to set the stage for repeal. Turmoil in the Individual Insurance Market op cit.; U.S. House of Representatives Committee on Energy and Commerce ( Minority) and U.S. Senate, Committee on Health, Education, Labor, and Pensions ( Minority), A Manufactured Crisis: Trump Administration and Republican Sabotage of the Health Care System (2017), https://democrats-energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/A%20Manufactured%20Crisis%20%20Trump%20Administration%20and%20Republican%20Sabotage%20of%20the%20Health%20Care%20System_FINAL.pdf (Accessed July 1, 2017).
What has the ACA accomplished and what changes are needed? With all the hysteria, it is easy to overlook two things: What the ACA has accomplished and the relatively straightforward set of changes that would make the individual market work more smoothly. (The Medicaid expansion, by contrast, has worked smoothly, indeed, too smoothly for its opponents, who have separately sought to undermine the expansion as a federal giveaway for “ablebodied” adults—an old welfare trope tossed at the nation’s single largest insurer).

The ACA’s Achievements. Despite everything, the ACA has had an enormous impact on the problem of being uninsured in the U.S. The Council of Economic Advisors, in a 2016 report, concluded that as a result of the ACA, 20 million people have gained insurance coverage, the fundamental prerequisite, in the world’s costliest health care system, to access to health care. https://obamawhitehouse.archives.gov/blog/2016/12/13/economic-record-obama-administration-reforming-health-care-system (Accessed July 1, 2017). In 2010, 15% of all Americans lacked health insurance; by 2016, that figure had fallen to less than 9%. Children’s uninsured rate, already lower than that for their parents as a result of Medicaid and CHIP, fell still lower, with 3 million children gaining coverage between 2008 and 2016. Young adults—those most likely to be in good health and most likely to be without coverage—saw their uninsured rate drop by 53 percent through the second quarter of 2016. Some of this decline is the result of remaining on their parents’ insurance plans, but a significant proportion followed implementation of the Marketplace system.

The ACA’s coverage gains have been particularly notable in states that expanded Medicaid, because the uninsured tend to be poorer people and because in Medicaid expansion states, people with the highest health risks have public insurance coverage up to 138% of the federal poverty level. This means that in expansion states, the Marketplace covers people who are not quite as poor and whose health is better, resulting in somewhat lower premium costs. Today some 12 million people are covered as a result of the Medicaid expansion, while over 60 million have coverage as traditional beneficiaries. In Medicaid expansion states such as Kentucky and Arkansas, two states with very high poverty, the uninsured rate has dropped by half or more.

The outcome of the ACA has not only been on the insurance coverage front. The point of health insurance is to secure access to health care. One recent study of the three-year impact of the ACA on access to care and health outcomes assessed the law’s impact between 2014 and 2016 in three states—Arkansas and Kentucky, which both expanded Medicaid, and Texas, which did not. In Arkansas and Kentucky, uninsurance rates dropped by over 20 percentage points relative to Texas, which saw far lesser gains. Furthermore, the Medicaid expansion was associated with a 41 percentage point increase in having a usual source of care (key to health care access), significant increases in use of preventive care such as diabetes testing and immunization, and a major increase in self-reported health as excellent. Adults in Medicaid expansion states reported greater affordability of care, more regular care for health conditions, improved medication adherence, and better overall health. Benjamin D. Sommers et al., Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income
In sum, overcoming many odds, the ACA has dramatically reduced the uninsured rate among Americans through a combination of Medicaid expansion and private insurance market reforms. For those who have gained insurance coverage, these gains have translated into improved health care access, improved use of health care, and better health outcomes—movement in precisely the law’s intended impact.

How to fix the ACA’s problems. This is not to paper over the problems. In 19 states, the poorest residents have no access to coverage at all because their states have not expanded Medicaid and they are too poor to qualify for tax credits. Furthermore, the Marketplace is not functioning like it ought to. Many insurance markets that were weak before the ACA took effect remain weak today, with about one-third of counties being able to attract only one Marketplace insurer. Cynthia Cox et al., 2017 Premium Changes and Insurer Participation in the Affordable Care Act’s Health Insurance Marketplaces (Kaiser Family Foundation, 2016), http://www.kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/ (Accessed July 22, 2017). To be sure, many of these markets were quite weak (particularly low-population rural markets) even before the ACA, Reed Abelson & Hayeoun Park, Obamacare Didn’t Destroy Insurance Markets, but It Also Didn’t Fix Them, NY Times (June 6, 2017), https://www.nytimes.com/interactive/2017/06/06/health/insurance-market-before-and-after-aca.html (Accessed July 2, 2017); Reed Abelson & Margo Sanger-Katz, There’s Only One Grocery Store in Most Rural Areas. Should We Expect Two Health Insurers?, NY Times June 29, 2017, https://www.nytimes.com/2017/06/29/upshot/theres-only-one-grocery-store-in-most-rural-areas-should-we-expect-two-health-insurers.html (Accessed July 2, 2017). It is also possible that certain states, on a state-wide basis, could be left with only one insurer willing to sell in the Marketplace. Tony Leys, Iowa may be without individual health plans if insurer pulls out (USA Today, May 3, 2017), https://www.usatoday.com/story/news/nation-now/2017/05/03/iowa-health-insurers-obamacare/309955001/ (Accessed July 2, 2017). Plans that are available have high deductibles and high cost sharing, a function of the fact that, at a 70% actuarial value, ACA policies sold in the individual market leave policyholders with heavy financial exposure.

Medicaid. In the case of Medicaid, the central challenge, of course, is how to get the remaining 19 states to expand coverage. President Obama and Democratic Members of Congress have proposed to extend the ACA’s special three-year, 100% financing rule,
which expired in 2016, to the first three years of coverage in any state that now elects to move forward, dropping to the enhanced rate (90 percent) over time and then made permanent, as was the case for the original expansion states. Furthermore, the Trump Administration could continue what the Obama Administration began, namely, using the HHS Secretary’s special federal demonstration powers under § 1115 of the Social Security Act to allow states to modify the ACA Medicaid expansion in certain ways that would have more appeal in politically conservative environments. Sara Rosenbaum et al., How Will Section 1115 Medicaid Expansion Demonstrations Inform Federal Policy? (Commonwealth Fund, 2016), http://www.commonwealthfund.org/publications/issue-briefs/2016/may/how-will-section-1115-medicaid-expansion-demonstrations-inform-federal-policy (Accessed July 1, 2017). For example, the Obama Administration permitted several states, as part of a demonstration project,* to impose premiums on eligible people, something normally prohibited under federal law for beneficiaries with incomes below 150% of the federal poverty level.** Other proposed demonstrations were rejected however, particularly proposals by states to impose a work requirement on Medicaid applicants. Presumably, the Obama Administration rejected this concept because, as noted, the impact of such a requirement could be expected to be minimal, given the high proportion of poor people who either work or else are unable to work, while the potential for coverage disruption, along with the added burdens on the application and ongoing enrollment process would have been huge. In other words, no plausible Medicaid program objectives would have been satisfied by adding such a requirement. Sara Rosenbaum et al., What Might a Medicaid Work Requirement Mean? (Commonwealth Fund, 2017), http://www.commonwealthfund.org/publications/blog/2017/may/medicaid-work-requirement (Accessed July 1, 2017). The Trump Administration might find merit in such proposals, and indeed, the current HHS Secretary has made clear his interest in Medicaid

* Section 1115, the demonstration statute, is complex. Lawful demonstrations must further Medicaid program objectives. Medicaid’s objective, as set forth in the law, is to enable states to extend medical assistance to people in financial need. Furthermore, complex procedural requirements apply to the task of developing, implementing, and evaluating the results of demonstrations. The Obama Administration’s use of demonstration authority was relatively bold, permitting states to bend normal Medicaid rules in ways that do not appear to further program objectives. Nonetheless, even if under harsher terms, the Administration succeeded in working with six states that otherwise would not have expanded. How Will Medicaid Demonstrations Inform Federal Policy? op. cit. See also, Jane Perkins & Catherine McKee, Sec. 1115 Waiver Requests: Transparency & Opportunity for Public Comment (National Health Law Program, 2017), http://www.healthlaw.org/issues/medicaid/waivers/sec-1115-waiver-requests-transparency-opportunity-public-comment#.WVja4k3fPcs (Accessed July 2, 2017); Jane Perkins, Background to Medicaid and Section 1115 of the Social Security Act (National Health Law Program, 2017), http://www.healthlaw.org/issues/medicaid/waivers/background-to-medicaid-section-1115-social-security-act#.WVjbS03fPcs (Accessed July 2, 2017).

** In states that have not adopted the Medicaid expansion up to 138% of poverty, eligibility for premium tax credits drops to 100% of the federal poverty level. All people entitled to tax credits must pay a premium, even the poorest, and for people with the lowest incomes, the premium is set at 2% of adjusted gross income. Allowing premiums for Medicaid beneficiaries with incomes 100%-138% of poverty (which otherwise are unlawful under the Program, § 1916 of the Social Security Act) would seem to be no more than a more modern policy update of Medicaid to parallel the ACA policy. It is striking that as recently as 2006, when § 1916 was last amended by Congress, the concept of premiums on the poor was considered unwise, even by a conservative President and a Republican Congress. Four years later, a Democratic President and Congress would impose premiums beginning at 100 percent of poverty.
Private insurance. Fixing the Marketplace is technically more complicated, but well within the bounds of reasonableness. The current problems can be traced to several key factors: a weakly enforced individual mandate for which the penalties are too low; and tax subsidies and cost sharing assistance that are too skimpy to make coverage affordable, leaving many in the situation that even if they shell out money to buy insurance, the value of what they buy is simply not enough. The Congressional Budget Office originally estimated that there would be well over 20 million Marketplace customers; by 2017, total enrollment stands at only slightly more than 10 million, skewed toward older and sicker people. Insurers have failed to receive the Marketplace stabilization funds they were promised. Repairing these problems thus means coupling better enforcement of the tax penalty with timely and reliable payment of the cost sharing subsidies that are owed, as well as making the reinsurance and risk corridor programs permanent and paying back amounts owed. This is how it is done under Medicare Part D, and several states, notably Alaska, have instituted their own reinsurance program to stabilize their markets. Timothy Jost, Alaska Reinsurance Plan Could Be Model for ACA Reform, Health Affairs Blog, June 16, 2016, http://healthaffairs.org/blog/2016/06/16/alaska-reinsurance-plan-could-be-model-for-aca-reform-plus-other-aca-developments/ (Accessed July 23, 2017).

Would fixing Medicaid and stabilizing the market work? The figure below depicts who remained uninsured in the U.S. at the end of 2016. It shows that if all states expanded Medicaid, and if all people entitled to premium tax credits or Medicaid were actually to enroll in the form of health insurance for which they were eligible, the number of remaining uninsured Americans would drop by 43%.
Figure 1

Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2016

Ineligible for Financial Assistance due to Income 3.0 M
Ineligible for Financial Assistance due to ESI Offer 4.5 M
Ineligible for Coverage Due to Immigration Status 5.4 M
Medicaid/Other Public Eligible Adult 3.8 M
Medicaid/Other Public Eligible Child 2.6 M
Tax Credit Eligible 5.3 M
In the Coverage Gap 2.6 M

Eligible for Financial Assistance 43%

Total = 27.2 Million Nonelderly Uninsured

NOTES: Numbers may not sum to totals due to rounding. Tax Credit Eligible share includes adults in MN and NY who are eligible for coverage through the Basic Health Plan. Medicaid/Other Public also includes CHIP and some state-funded programs for immigrants otherwise ineligible for Medicaid.

Repeal and Replace: The American Health Care Act and the Better Care Reconciliation Act

The repeal/replace measures rest on two basic goals. The first goal is to cut premiums for some at the expense of hiking costs for others. The strategies used to achieve this goal can be boiled down to (a) re-establishing a health insurance market in which plans are designed to cover far less, thereby shifting costs onto policyholders; (b) re-segmenting the market either by pushing older and sicker people into separate high risk pools or allowing insurers to sell cheap policies to the healthy and costly policies to the sick; and (c) discouraging enrollment by higher cost people who are older and/or sicker by dramatically escalating the cost of coverage through a dramatic reduction in subsidies.

The second goal is to end Medicaid as we know it, an aim long sought by House Speaker Paul Ryan, who has used his leadership position over many years to advance his aim. His position on ending Medicaid has shown up in the federal budget and spending blueprints he previously authored as Chair of the House Budget Committee, as well as in a manifesto released in 2016 entitled A Better Way, https://www.speaker.gov/sites/speaker.house.gov/files/documents/ABetter-Booklet.pdf (Accessed July 22, 2017), in which the Speaker sets forth his federal policy aims.

The first goal would rewind the world of private health insurance back to where it sat circa 2010. The second would unwind the nation’s largest health care entitlement.

For purposes of this analysis, we will rely primarily on the House-passed bill, noting key differences in the Senate bill where it departs from the House bill in significant ways. Following a summary of the bill’s major elements, we present both the Congressional Budget Office’s analysis of the measure’s likely effects while also examining additional studies to date on the potential impact of the measure.


In place of the individual mandate, the bill would establish a late-enrollment penalty, a strategy used in Medicare Part D to encourage people to enroll and remain enrolled. (The Senate bill would use a waiting period for those with lapsed coverage rather than a late-enrollment fee). While the measure would retain the ACA prohibition against discriminatory rating based on health, it would also allow states to permit insurers to reintroduce health-related rating in the case of people who fail to maintain continuous
coverage. The bar against gender rating would be preserved, but as noted below, states could adopt policies that remove key services for women from health plans.

In addition to eliminating the individual mandate, in 2020 the measure would eliminate the ACA’s tying of subsidies to the cost of a plan with a 70 percent actuarial value, as well as the ACA’s income-sensitive premium credits and cost-sharing subsidies for low income purchasers. (The Senate bill would retain income sensitivity to a degree but not enough to change the impact of the measure on older people, as revealed in the CBO estimates discussed below). In order to favor the young and the healthy, the House bill would introduce a new methodology for calculating premium tax subsidies; in 2020 the bill would establish a tax credit that, while phasing out at a far higher income level than is the case under current law, is also based strictly on age and lacks income sensitivity. Young adults up to age 29 would receive a tax credit of $2000, and the credit would top out at $4000 for adults ages 60 and older. Family credits would be capped at $14,000 annually. Credits would rise annually in value at the general consumer price index for urban areas plus 1 percentage point—below the rate of medical inflation.

Along with reducing premium subsidies for older individuals, the House bill would also reinstate the 5:1 age ratio, meaning that issuers could charge older adults up to 5 times the amount paid by those who are younger. States would have the option to set the ratio higher still. (States could begin to do so in 2018). To the extent that tax credits are available, they could not be used to purchase plans that cover abortion. (Such plans can be purchased today).

Regarding the scope of coverage, the House would retain the essential health benefit package while also permitting states to waive the requirement in favor of plans with more limited benefits, including plans that exclude coverage for maternity care or mental health and substance abuse treatment, two relatively costly types of coverage.* (The Senate would take a similar approach). This authority would be in addition to the elimination of the 70% actuarial value rule, meaning that insurers once again would be permitted to offer plans with highly limited coverage and seriously reduced actuarial value for the coverage that is offered. (The Senate bill would reduce the actuarial value of a standard plan to 58%, pushing 42% of costs for covered benefits directly onto policyholders). The combination of the two approaches would result in far higher cost sharing (typically in the form of very substantial deductibles) for the coverage that is made available.

In the House bill, states would have been encouraged to segment sicker and older people into separate high risk pools, already recognized for a long time as unworkable. In the Senate bill, a late concession to the Senate’s most conservative members would have allowed insurers to sell cheap, medically underwritten policies to the healthy if they also

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* Note that the bill would not affect the Pregnancy Discrimination Act of 1978, which bars discrimination (including coverage discrimination) on the “basis of pregnancy, childbirth, or related medical conditions.” The Act exempts health plans covering fewer than 15 persons. In states that do not extend the Act’s prohibitions to all workplace coverage, a rollback of the essential health benefit standard could reach workplace coverage for small employers.
sold ACA-compliant bills (although at a much lower actuarial value) to higher need populations. While insurers cautiously expressed their concerns over the House bill’s return to high risk pools, their two major associations, the American Health Insurance Program and the Blue Cross Blue Shield Association, jointly and adamantly expressed their opposition to the concept of re-segmenting the market, as envisioned in the Senate bill, calling the idea of re-segmenting insurance product markets into the healthy and the sick “simply unworkable.”  

In order to help people unable to obtain coverage at all because of high premiums or able to buy only coverage that omits crucial benefits and/or comes with such high cost-sharing as to render it virtually worthless, both the House and Senate bills would established funds to permit states to subsidize coverage either through direct aid to individuals or through reinsurance payments to plans. All told, however, the funds are a drop in the bucket compared to the subsidies that would disappear—less than $150 billion over 9 years under the House bill and a bit higher in the Senate bill. Under each bill, the fund could be used for several purposes, all aimed at mitigating the loss of coverage entirely or the loss of coverage for specified benefits: financial help to individuals deemed high risk (in the form of subsidies to promote access to preventive services and cost sharing assistance); overcoming the loss of affordable premiums in states that waive community rating requirements; and paying for maternity and newborn care and mental health and substance abuse services. States could use the fund to help re-establish high-risk pools for people deemed high risk; in lieu of segregated pools, states could also use their funds to reinsure insurers who enroll high-risk members.

One important spillover effect of the essential health benefit changes on the employer market is that the ACA’s industry-wide bar against annual and lifetime caps, as noted, applies to benefits deemed essential health benefits. This means that in any state that waives the essential health benefit coverage requirement, insurers selling plans in the group market could reintroduce caps in that market as well. *

Among the essential health benefits are preventive benefits which, as noted, encompass contraceptive coverage. States waiving preventive benefits as a form of essential health benefit would effectively eliminate the coverage guarantee for all FDA-approved birth control methods. Health plans covering abortions would also be banned from the tax credit market.

* It is unclear how a state’s action to unravel essential health benefits would affect self-insured employer plans, since ERISA preemption principles applicable to state laws regulating insurance, and these principles would continue to apply. See chapter 8.

Medicaid: It is important to begin by noting that the House measure (as is also true with the Senate bill) would codify in statute the result of NFIB; that is, federal Medicaid law would be amended to permanently give states the option of covering all low income working-age adults, not just traditional categories (i.e., very poor parents of minor children, pregnant women, and adults with disabilities). At the same time, the
House bill (as well as its Senate counterpart) would so seriously affect the financial conditions under which states operate their Medicaid programs that any likelihood of coverage for the expansion population would drop precipitously. Indeed, several states, in adopting the coverage expansion, did so under state laws that call for an immediate end to the expansion if the ACA’s special enhanced federal funding level is eliminated.

The enormous financial impact on state Medicaid programs comes in two forms. The first is elimination of the ACA adult expansion enhancement formula. The House would end the enhancement rate in one fell swoop, from the 90% rate scheduled under current law for 2020, dropping down to a state’s normal federal payment rate (between 50% and 75%) beginning right away.

The second impact would be by placing a flat upper limit (known as a per capita cap) on the amount of federal funding states could receive to operate their Medicaid programs overall. This cap methodology would begin in FY 2020; the cap would employ a crude rate-setting approach to limit federal expenditures by using FY 2016 as a base and then allowing a stipulated annual percentage increase with no adjustments going forward for new services, greater intensity of care, or new technology. The new capped approach to federal Medicaid contributions would apply to all 75 million beneficiaries—not only the expansion population but to the entire Medicaid population, including children, pregnant women, parents, the elderly, and people who qualify for coverage based on disability. In the near-term, both the House and Senate would utilize an update formula linked to medical inflation rate; beginning in FY 2025, the cap in the Senate draft would drop the annual cap updates back to the general rate of inflation for urban areas, with no medical index adjuster.

The per capita cap alteration would fundamentally alter a bedrock Medicaid operating principle, a core element of the program since 1965: states are entitled to federal funding to offset a portion of their program expenditures without regard to artificial upper payment limits. Sara Rosenbaum et al., What Would Block Grants or Limits on Per Capita Spending Mean for Medicaid? (Commonwealth Fund, 2016), http://www.commonwealthfund.org/publications/issue-briefs/2016/nov/medicaid-block-grants (Accessed July 3, 2017); Sara Rosenbaum et al., How Will Repealing the ACA Affect Medicaid? Impact on Health Care Coverage, Delivery, and Payment (Commonwealth Fund, 2017), http://www.commonwealthfund.org/publications/issue-briefs/2017/mar/repeal-aca-medicaid (Accessed July 3, 2017). By replacing this seminal principle with one that imposes fixed upper limits pegged to annual growth rates slower than the actual growth in the cost of health care, the cap, over time, would have the effect of pushing a vast amount of indigent health care spending entirely back onto state and local governments. Sara Rosenbaum, Medicaid Round Two: The Senate’s Draft Better Reconciliation Care Act of 2017 (Health Affairs Blog), http://healthaffairs.org/blog/2017/06/24/medicaid-round-two-the-senates-draft-better-care-reconciliation-act-of-2017/ (Accessed July 3, 2017). In effect, states would face the Hobson’s choice of either coming up with more of their own funding to cover the federal losses while maintaining their current programs or cut out portions of their programs entirely by eliminating optional items and services or optional populations. The latter
strategy would of course be a losing proposition since every dollar of Medicaid spending cut out of a state’s program costs a state between 50% and 75% in federal contributions, up to the cap.

For reasons having to do with the complexities of the reconciliation process, neither the House nor Senate bill (whose cap is tighter than that imposed by the House) does much to expand state flexibility to trim Medicaid spending. For example, under current law, states must cover all prescription drugs approved as safe and effective by the FDA. In exchange for this “open formulary” coverage standard, manufacturers give states a rebate on their purchases. States have long sought the power to employ more restrictive formularies, much as Medicare prescription drug plans and private insurers do, in order to gain more bargaining leverage. Neither the House bill nor the Senate draft does this, nor do they alter existing eligibility and coverage options. Importantly, however, both measures would give states the power to impose work requirements on poor adults, which probably do little more than delay and disrupt coverage. Both bills also allow states to run a portion of their Medicaid programs as block grants that are stripped of virtually all eligibility, coverage, and cost sharing rules, but only if they agree to accept an even lower federal funding levels. The House would extend this block grant option to poor children and adults, while the Senate bill would confine it to poor adults only. Working with extremely limited funds—the bills essentially provide no funding update after the base year—states would be free to create waiting lists of poor people who are eligible but who cannot be enrolled. States could also eliminate benefits, require the poor to pay premiums and engage in work, employ fixed coverage time limits (much like the time limits that apply under the cash welfare block grant program known as Temporary Aid to Needy Families (TANF)) and make other changes that dramatically hold down costs.

With this downstream impact of lost Medicaid funding, one must bear in mind that the poor don’t disappear—only their Medicaid does.

The practical consequences of all of this are discussed below. The per capita caps also might raise at least one quite important legal question—their constitutionality. In light of *NFIB v Sebelius*, the Medicaid per capta cap appears to raise an important question. The per capita cap acts as a major new federal stricture on sums otherwise due states under the existing federal funding formula. Superimposing a flat annual limit on Medicaid’s historic federal funding formula – effectively changing the rules of the 50-year-old program and leaving states on the hook for hundreds of billions of dollars in lost revenues -- is an astounding political and policy move. Is it constitutional? Recall that the Court’s decision in *Sebelius* essentially turned on its conclusion that the eligibility expansion effectively operated as a “new” program whose adoption was a requirement of receiving funds under the “traditional” program. Could the caps similarly be framed as a new federal funding formula grafted onto Medicaid’s traditional open-ended financing scheme, the acceptance of which becomes a condition of any federal funding for states’ traditional programs? Expect this question to be tested if a per capita cap becomes law.

Whether or not a cap is a constitutional exercise of Congress’s powers, its impact would be astonishing. States would have to respond to this stricture either by paying far
more of the cost of Medicaid just to maintain their programs, or else they would need to start eliminating optional benefits and services they can no longer afford in their view. (Of course, by failing to put up more money and simply rolling costs back onto their own economies, states end up effectively costing themselves far more in the form of lost federal funding). Sara Rosenbaum, Medicaid and the Latest Version of the BCRA: Massive Federal Funding Losses Remain, Health Affairs Blog, July 14, 2017, http://healthaffairs.org/blog/2017/07/14/medicaid-and-the-latest-version-of-the-bcra-massive-federal-funding-losses-remain/ (Accessed July 23, 2017. The question thus becomes whether the per capita cap amounts to a “gun to the head” in the words of the Chief Justice in NFIB—that is, a condition of participation (lower funding for the same program) that amounts to unconstitutional coercion. It is too soon to know whether states might advance such a claim.

There are also important private insurance/Medicaid interactions to ponder. As private health insurance once again becomes unattainable for those who are sick, and as the State Stabilization Fund begins to run dry, will states try to expand coverage for adults, at least as a way of softening the blow from the end of the insurance reforms? If they do, will states accept the lower federal Medicaid funds as at least partial federal subsidization for these costs? Adults must be extremely disabled to qualify for Medicaid based on disability, but at least some coverage might be possible for those whose incomes are low enough to qualify as low income adults as defined in the expansion population. Will the private insurance reforms, in other words, trigger state Medicaid expansion efforts, even though the federal financing for the Medicaid expansion is at a lower rate? The possibilities facing states trying to hold on to coverage for the population are seemingly endless, in other words: Do they keep a rigorous and relatively robust private insurance market and potentially risk all insurers leaving the state? Do they let insurers take care of the young and healthy and use Medicaid for everyone else who doesn’t make the cut, accepting lower funding but effectively using Medicaid as default insurance?

Gauging the Impact of Repeal and Replace

Past experience with the impact of dramatic health care funding reductions for vulnerable populations—not to mention common sense—tells us that such a move would have a boatload of consequences: rising levels of uncompensated hospital care; a high demand for free and reduced-cost care at whatever public hospital clinics, county or city public health clinics, and community health centers manage to survive a major decline in operational funding resulting from cutting insurance programs for the poor; growing pressure to make up these losses on other sources of state funding needed for infrastructure, education and social services, such as sales taxes and property taxes; and escalating private health insurance premiums as health care providers attempt to pass costs along to those with health insurance.

States could turn to these other sources of funding to make up for the major loss of federal funding. But one study, which examined scenarios regarding state funding choices following a major Medicaid cut, found an enormous impact on taxes and other
necessary social services spending. For example, based on state taxing and spending data, the study estimates that repealing the enhanced Medicaid expansion funds plus a 20% reduction in overall federal funding would trigger enormous consequences that obviously would be the most severe in an expansion state. Overall, in expansion states, the median tax increase would be between 8.5% and 9.0% in expansion states, while the median cut in spending per K-12 pupil would exceed 15%. Allison Valentine & Robin Rudowitz, Implications of Reduced Federal Medicaid Funds: How Could States Fill the Funding Gap? (Kaiser Family Foundation, March 2017), http://www.kff.org/medicaid/issue-brief/implications-of-reduced-federal-medicaid-funds-how-could-states-fill-the-funding-gap/ (Accessed July 4, 2017). States already are rationing critically necessary types of health care to Medicaid beneficiaries because they cannot afford to spend at needed coverage levels, a reality that has become painfully obvious with the advent of prescription drugs that can treat and cure hepatitis C, a devastating illness that kills over time. But the drug is terribly costly, and even under today’s relatively favorable funding conditions, states have set medical necessity criteria that so vastly exceed what is appropriate that patients literally must be dying before they can be treated. Carolyn Johnson, One idea to counter high drug prices: federal intervention (Washington Post, July 4, 2017).

Taken together, the Medicaid funding reductions along with the funding reductions aimed at older and sicker populations who depend on subsidized private health insurance can be expected to have a major effect on population level access to health care, use of effective health services, and health outcomes. Just as the Health Affairs study cited earlier documented the relationship between insurance expansions and positive health outcomes, so have researchers documented the adverse health effects of withdrawing coverage for the poor. When a program like Medicaid is cut, the impact is felt in places that might surprise you. For example, it turns out that Medicaid is the third biggest source of federal funding for public schools—yes schools. Why? Because it is Medicaid coverage of the poorest children that powers the school-based health care required to ensure that children with disabilities are able to get a free and appropriate public education under the Individuals with Disabilities Education Act (IDEA). Medicaid also enables schools located in poorer communities to maintain onsite health clinics for students who need health care—a major source of care, as it turns out, in communities that lack adequate primary health care. Emma Brown, GOP health-care bill could cut funds schools use to help special-ed students, Washington Post, June 30 2017, https://www.washingtonpost.com/local/education/gop-health-care-bill-could-stri-public-schools-of-billions-for-special-education/2017/06/27/05650ad4-5aa5-11e7-a9f6-7c3296387341_story.html?utm_term=.3f8ac0fe8d13 (Accessed July 4, 2017).

Perhaps the most notable and well-documented research on the subject occurred in California following major cuts in indigent health care financing following passage of tax reform legislation that led to significant reductions in the amount of funds available to furnish health care for the poor. Researchers engaged in comprehensive and ongoing research were able to document the decline of services in the wake of the loss of public funds as well as the impact of this funding decline on access to health care. Ultimately they were able to show how the loss of funding led to reduced health status and death.
For a history of California’s indigent care programs as well as the major funding reductions that occurred in the 1980s see Deborah Reidy Kelch, Caring for Medically Indigent Adults in California: A History (California Health Care Foundation, 2005), http://www.chcf.org/~/media/MEDIA%20LIBRARY%20Files/PDF/PDF%20C/PDF%20CaringForMedicallyIndigentAdults.pdf (Accessed July 3, 2017).

The CBO analysis:

These likely effects are charted by private researchers. But calculating the impact of significant legislation is also a matter of public policy. This is because the Congressional Budget Office, working with the Joint Committee on Taxation, is tasked with preparing estimates of impact both budgetary and practical. CBO estimates typically are disputed by legislative sponsors when they don’t like the results, particularly when the estimates show that a bill costs more than they had hoped, produces effects they would rather not make public or document, or both. Thus, when the CBO cost estimates for both the House and Senate bills emerged, legislative sponsors rushed to discredit their conclusions. In fact, CBO, by law a nonpartisan entity that brings gold-standard analytic methods to bear on determinations of the effects of complex legislation, has been more accurate over the years than other major economic forecasters in predicting the likely effects of both legislative measures and major shifts in policy, such as the Supreme Court’s decision in NFIB, that affect the course of legislative implementation. Sherry Glied et al., The CBO’s Crystal Ball: How Well Did It Forecast the Effects of the Affordable Care Act?, http://www.commonwealthfund.org/publications/issue-briefs/2015/dec/cbo-crystal-ball-forecast-aca (Accessed July 3, 2017).

The beginning point for the CBO analyses of the House and Senate bills, available at https://www.cbo.gov/publication/52849 (Senate) and https://www.cbo.gov/publication/52752 (House), is the similarity of their conclusions.* The agency finds that under the House bill, 23 million people would lose coverage; under the Senate bill the figure would be 22 million. In other words—and not surprising if one reflects on what the measures are designed by law to do—both bills would effectively wipe out the ACA’s gains and possibly then some given the combined effects of the Medicaid reductions and the destabilization of the private insurance market.

CBO’s analytic work sheds great light on why the bills would have this effect and which effects might fall on the private insurance market versus Medicaid. CBO’s estimates are for a 10-year budget window, although in a later document published in connection with the Senate bill, CBO provides an additional 10-year analysis of the Medicaid effects of the Senate bill draft. https://www.cbo.gov/publication/52859 (Accessed July 4, 2017).

* CBO released a subsequent analysis of a slightly later version of the Senate bill on July 20th, https://www.cbo.gov/publication/52941 (Accessed July 23, 2017). This version delivered the same verdict as the earlier one. In addition, CBO analyzed the effects of simply repealing the ACA Medicaid expansions and insurance subsidies (the version of repeal/replace sent to President Obama as a sort of test run for what came in 2017, which he naturally vetoed) and found that such a bill would de-insure about 32 million people. https://www.cbo.gov/publication/52939 (Accessed July 23, 2017).
**Budgetary effects.** By reducing the amount spent by the federal government on premium tax subsidies by $276 billion and federal Medicaid outlays by $834 billion, the House bill would drop federal spending on health care for low income people in excess of $1 trillion. Of this amount, the House bill would reinvest over $660 billion in tax reductions primarily aimed at wealthy individuals (eliminating additional Medicare Trust Fund payments on high-income earners as well as taxes on unearned incomes), large employers (eliminating tax penalties for failure to provide insurance, and insurers (special excise taxes). Some of the savings—less than $150 billion over the time period—would be sent back to states in the form of grants, as noted previously. About $120 billion would go to deficit reduction. Thus, in the view of some, the House bill in reality is a major tax cut for insurers, large employers, and the wealthy, funded by reducing federal assistance to poor and low income people.

**Insurance effects:** Beginning in 2018, people would begin to lose coverage, predominantly because with the repeal of the individual mandate, failure to enroll in affordable coverage would no longer trigger tax penalties. As the effects of reduced assistance for people in need would begin to kick in, the number of uninsured would steadily rise, reaching 23 million below current law estimates by 2026. That year, the number of uninsured Americans would stand at 51 million—essentially where we were in 2010, and tens of millions more than the 28 million uninsured today.

The CBO estimate (Table 5) develops profiles of how the House bill’s new private insurance subsidy system would affect people at different ages in the same local insurance market. Under current law, a 21-year-old, a 40-year-old, and a 64-year-old with incomes of $26,500 (175% of the federal poverty level) each pays $1700 annually in out-of-pocket premium costs after application of the tax subsidy. The premiums vary considerably ($5,100 for the 21-year-old, $6,500 for the 40-year-old, and $15,300 for the 64-year-old). But because the subsidies are income-sensitive and also adjusted for local market conditions, each would pay the same premium amount annually relative to income. Because their incomes are below 250% of the federal poverty level, all three also would qualify for cost sharing assistance, reducing their net-out-of-pocket spending still further and elevating the actuarial value of their health plans to 84%.

Under the American Health Care Act, the results would be as follows in terms of out-of-pocket premium obligations in a state not waiving the ACA’s community rating rules and changes in the essential health benefit structure but bound by the new 5:1 age ratio: $1750 for the 21-year-old; $2,900 for the 40-year-old; and $16,100 for the 64-year-old. Cost sharing reduction assistance would disappear, and the actuarial value of the plans might drop. States might use some of their premium stabilization funds to buy down the cost of coverage for older residents or shield insurers from higher-cost effects, but of course if they did so, this would increase access and utilization, further driving up premiums.

In states that make changes in current community rating and/or essential health benefit standards (where CBO estimates about half the population lives) the CBO has developed a standard state profile of what those changes look like in terms of benefits.
waived and health status adjustments to premiums permitted. It concludes that in states that pursue aggressive overrides of ACA community rating and EHB protections, the cost picture would look as follows: $1,250 for 21-year-olds; $2,100 for 40-year-olds, and $13,600 for 64-year-olds. CBO also notes that the market for private insurance would be much less stable in these states as insurers are permitted to sell thin coverage to young people, charge people with breaks in health insurance coverage higher premiums, and eliminate costlier essential health benefits. Again, these states might use some of their funds (which would expire after 9 years) to help their older residents or shield insurers from higher-cost cases; but again, such assistance presumably would affect utilization, thereby raising premiums. In other words, the House bill (and the Senate bill similarly) would dramatically increase costs for older, lower income people. Ultimately, in states that waive community rating and essential health benefit rules, the estimates tell us, insurance for older people could become totally out of reach.

The estimate then considers what the uninsured increase would look like. Among young lower-income adults, even though their costs would drop, the proportion without insurance coverage would double. The same would be true for lower income adults ages 30-39. For lower income adults ages 50-64 with incomes below twice poverty, the percentage without health insurance would more than double. (Figure 2).

**Medicaid.** According to CBO, the combined effects of the Medicaid reductions, for both the expansion population and per-person spending, would result in a steady drop of people with Medicaid as states cut back on eligibility and look to trim coverage of their traditional populations. In the first year, Medicaid enrollment would fall by more than 3 million. By 2026, enrollment would decline by about 14 million by 2026. That year states would receive federal funding 26% below current law estimates; under the Senate bill, moreover, the supplemental CBO estimate projecting Medicaid losses out to 2036 shows that by the 20th year, states would experience a 35% reduction in federal Medicaid funding.

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Follow-on estimates of the repeal/replace legislation on states and people showed a devastating impact, explaining why everyone hates the bills. Researchers concluded that facing enormous Medicaid losses, states would inevitably move away from insuring higher cost populations and services to those that are less risky. Even though Medicaid does not operate on risk principles, the impact of funding losses, as noted, simply would be too big for states to be able to maintain their current programs. Adults and children with disabilities likely would feel the effects quickly, as would Medicare beneficiaries for whom Medicaid is the only source of payment for long term care. States would vary in what they cut, simply because state per capita Medicaid spending also varies tremendously, for reasons related to local health care conditions, local costs, state approaches to provider payment (Medicaid already is a low payer, so there is not much left to cut), and state policy choices regarding what and whom to cover. Timothy Layton et al., The Downstream Consequences of Per Capita Spending Caps in Medicaid (Health Affairs Blog June 26, 2017), [http://healthaffairs.org/blog/2017/06/26/the-downstream-](http://healthaffairs.org/blog/2017/06/26/the-downstream-).
Under one way of looking at the issue of Medicaid funding reduction consequences, states most at risk for the deepest Medicaid cuts are those that expanded.

Another way of considering the problem is thinking about which states have the most minimal programs with the least room for cutting, either by rolling back eligibility, reducing benefits, or cutting provider payments still further. Depending on how one frames the at-risk problem, the states facing the worst crises may be those with the least generous, or most generous programs. Robin Rudowitz et al., Factors Affecting States’ Ability to Respond to Federal Medicaid Cuts and Caps: Which States are Most at Risk?, http://www.kff.org/medicaid/issue-brief/factors-affecting-states-ability-to-respond-to-federal-medicaid-cuts-and-caps-which-states-are-most-at-risk/ (Accessed July 4, 2017).

Overall, the American Health Care Act is projected to trigger a 37% growth in state spending simply to offset the impact of the legislation on their Medicaid programs. Vernon K. Smith, Can States Survive the Per Capita Medicaid Caps in the AHCA? (Health Affairs Blog, May 17, 2017), http://healthaffairs.org/blog/2017/05/17/can-states-survive-the-per-capita-medicaid-caps-in-the-ahca/ (Accessed July 4, 2017). State-by-state Medicaid loss projections under the House bill by 2022 range from $81 million (South Dakota, a non-expansion state with a small population and limited coverage) to more than $14.7 billion in California, with the nation’s largest program covering about one-third of the state’s population. The impact on insurance coverage rates would be profound. Kentucky, an extremely poor Medicaid expansion state with high Medicaid dependence, would see a 223% increase in its uninsured by 2022, while in Mississippi, a state with a limited program and no expansion, would see its uninsured numbers grow by 15%. Linda Blumberg et al., State-by-State Coverage and Government Spending Implications of the American Health Care Act (Urban Institute, June 2017), http://www.urban.org/research/publication/state-state-coverage-and-government-spending-implications-american-health-care-act (Accessed July 4, 2017).

These Medicaid cuts would be in addition to the loss of insurance subsidies for Marketplace participants. By dramatically cutting subsidies and restoring insurers’ ability to set prices based on health status and using a 5:1 age-rating system, the American Health Care Act would trigger a crisis for those Marketplace enrollees with the types of conditions that trigger health underwriting. The number of people with this type of condition is estimated at 2.2 million, over 20% of Marketplace enrollees. For a population of this size, the Act’s Patient and State Stability Fund is disastrously low; researchers estimate that at its current size, the Fund could support affordable insurance for only about 30% of the population in need of high subsidies. And coverage at this level would be possible only if states spent their entire funds on high risk pools, with no funding for services such as maternity care and mental health and substance abuse, which likely would not be covered under subsidized health plans in order to keep premiums low. Avalere Health, Proposed High Risk Pool Funding Likely Insufficient to Cover Insurance Needs for Individuals with Preexisting Conditions (May 4, 2017), http://avalere.com/expertise/managed-care/insights/proposed-high-risk-pool-funding-likely-insufficient-to-cover-insurance-need (Accessed July 4, 2017).
Big laws have big consequences. Medicare and Medicaid changed the trajectory of American health care for the entire population. The Affordable Care Act built on that trajectory, moving the nation closer to universal health insurance with the potential to begin to achieve the types of population-wide reforms in access, quality, cost, and health outcomes that should be the focus of any wealthy democracy. Other nations do it, why don’t we?

The ACA was a complicated way of moving us toward this goal. Advocates on the left would have preferred Medicare for all, shorthand for what we call a single-payer system in which government-sponsored insurance covers the population, administered either directly by the government or by private insurers. At the opposite end of the spectrum there are those who advocated for a system of in which the government relies on individuals to make purchasing decisions, incentivized to do so through subsidies, penalties, and a broad cultural expectation of coverage. In such a system insurers may work together to achieve system-wide delivery and payment reforms of the type essential to holding down costs over time while promoting access to effective care.

For better or worse, U.S. lawmakers in 2010 chose to build on what we have—employer-sponsored insurance for most working-age Americans and their families, Medicaid for the poor and vulnerable, Medicare for the elderly and for workers with major disabilities, and an accessible individual market for those who for all kinds of reasons don’t fit into any of the above.

For a host of political reasons, implementation of the ACA suffered major setbacks, and yet it was working. The effort to undo the reforms—and indeed, to undo Medicaid, a 50-year-old program that is a bulwark of the health care system—has, as of July 23, 2017, apparently failed. The Trump administration is threatening to do what it can to make the ACA fail even without passage of legislation, but it is unclear whether it will follow through on its threats. Will the ACA be allowed to continue on its path? Will attempts to unravel it continue? Stay tuned. The nation watches, with bated breath.
Fourth Postscript to Part Two: The Affordable Care Act: Closing in on Ten Years

It is safe to say that no American social welfare law ever has come even close to experiencing the sustained pummeling endured by the Affordable Care Act (ACA)—in Congress; in state legislatures; from a President; in the courts; and in the constant chatter of opposition social media. But the law has endured, bringing insurance coverage to over 20 million people and introducing health care reforms that touch the lives of almost all Americans.

To be sure, the ACA was as ambitious as it gets; its goal was to do no less than insure nearly all Americans. But its structure is quite modest, especially compared to a Medicare-for-all approach that, in its most orthodox form, would end most private insurance and move the country to a publicly financed, government-administered health insurance program. (In truth, there are many variations of single payer, which tend to get glossed over in the debate. See, e.g., Sherry Glied et al., Considering “Single Payer” Proposals in the U.S.: Lessons from Abroad (Commonwealth Fund, 2019), https://www.commonwealthfund.org/publications/2019/apr/considering-single-payer-proposals-lessons-from-abroad (Accessed July 18, 2019).

Despite its ambition, the ACA structurally is a mass of amendments to three major sources of insurance; in combination, these revisions to existing insurance arrangements—the individual insurance market, employer-sponsored health plans (especially small plans that historically have been far less stable than larger ones), and Medicaid—are designed to make them more accessible and fair. In truth, many of these reforms had been discussed for years, and incremental federal policies already had been moving in their direction. For example, the insurance market reforms are by and large an outgrowth of earlier, more modest changes made by HIPAA in 1996 (Chapter 6). Similarly, Medicaid already had begun its expansion journey well in advance of the ACA, with expansion for children and parents of minors already having occurred and extension to all low income adults having been tested by numerous states using special federal experimental authority under Section 1115 of the Social Security Act. This authority, now being used aggressively by the Trump administration in an attempt to reduce coverage, empowers the HHS Secretary to test innovations that promote the objectives of certain Social Security Act state-administered public welfare programs including Medicaid. See Brief of Deans, Chairs, and Scholars as Amici Curiae in Support of

* Omitted are residents not legally present in the U.S. Actually this is not an uncommon omission in nations that have in place some sort of policy for achieving universal coverage. Kristine Onarheim et. al., Towards universal health coverage: Including undocumented migrants, 3 BMJ Global Health (2018), https://gh.bmj.com/content/3/5/e001031.full (Accessed July 18, 2019). This is not to say that these nations sanction the denial of care, but access to care may come outside the country’s universal coverage scheme, e.g., hospitals and clinics funded to provide care to all without regard to legal status. In this sense, the U.S. is similar in its use of community health centers, which serve their communities without regard to any attribute other than the need for health care. Similarly, of course, EMTALA’s duties apply to all persons who present at an emergency department in the specified medical condition.
Plaintiffs Appellees, Gresham v Azar and Stewart v Azar, Nos. 19-5094 & 19-5096 (Gresham); Nos. 19-5095 & 19-5097 (Stewart) (D.C. Cir. 2019).

Regardless of its modest approach to ambitious goals, the ACA has been a battleground over its entire existence; the intensity of the fighting has never ceased to amaze those of us who have spent our careers in health law and policy. But even as its opponents continue to seek to rip the law out root and branch, some argue that in fact the law has reached a status of “superstatute,” that is, a statute that transcends narrower confines of law, whose existence becomes part of the social fabric of a nation. See Abbe Gluck, Take Care (2018), https://takecareblog.com/contributors/abbe-gluck (Accessed July 18, 2019). The extraordinary collapse of the effort in 2017 to repeal the Act proved that point. So, ironically, do the endless claims by ACA opponents that they are for “pre-existing conditions”—a turn of phrase that always amuses; despite its clumsiness, being “for pre-existing conditions” in political speak essentially is shorthand for recognizing that Americans now believe that everyone should qualify for health insurance regardless of health status. Only a decade ago, this bedrock concept did not exist.

But for those who continue to hate the ACA, there are two basic methods of attack. One is the “blow it up way” by using Congress or the courts. National Federation of Independent Businesses v Sebelius, 567 U.S. 519 (2012) (this Supplement) exemplified this approach. Now we have another case, discussed immediately below, that essentially seeks to do the same. The other way to go after the law is to eat away at it through regulatory disruption in order to undermine and destabilize it.

To illustrate these two basic strategies, we select among the many examples in order to focus on a few: Texas v U.S., now pending in the United States Court of Appeals for the Fifth Circuit (a blow-up strategy if there ever was one); and, as examples of the regulatory strategy, regulations allowing the sale of short-term, limited-duration health plans; expanding the market to include association health plans; and Medicaid work experiments under § 1115 of the Social Security Act.

Blowing up the law in court

The stage for the latest judicial run at total demolition—Texas v United States—was set by the Tax Cuts and Jobs Act of 2017 (Pub. L. 115-97, 115th Cong., 1st sess.). Among its multitude of provisions, the law zeroed out the ACA’s tax penalty imposed on individuals who fail to maintain “minimum essential coverage.” 26 U.S.C. § 5000A(a). Other than this, the 2017 Act did not touch the ACA. This left intact the clause earlier in the same provision in which the ACA ties this tax penalty to a requirement that “applicable taxpayers” maintain “minimum essential coverage” (MEC) or pay the specified penalty. MEC includes public insurance (e.g., Medicare or Medicaid), employer coverage, or an individual health insurance policy with an actuarial value of at least 60 percent of the chosen benchmark plan. * 26 U.S.C. § 5000A(f). People subject to the

* The term actuarial value means the percent of a covered claim paid by the insurer. In the case of a covered claim worth $100, 60 percent would be $60.
requirement (certain groups are exempt) are required to pay a tax penalty; there are also certain people covered by the requirement who nonetheless are exempt from the tax penalty itself. Depending on income, the penalty originally was either a flat dollar amount or a certain percentage of income. The 2017 tax law kept the requirement to maintain minimum essential coverage but reset the penalty for not doing so at zero, beginning in 2019. 26 U.S.C. § 5000A(c)(2)(B). Therefore, people who are required but fail to purchase affordable insurance pay no penalty, and the requirement effectively is no longer enforceable.

Following the zeroing out of the penalty, opponents of the ACA (about 20 states and a few individuals) filed suit in federal court in the northern district of Texas—a clear instance of forum shopping to bring the litigation before a judge generally known for his conservative decisions—that challenged the ACA as unconstitutional in its entirety. Plaintiffs’ theory rested on two basic arguments. First, plaintiffs argued that, by zeroing out the tax penalty, Congress removed the constitutional basis for what plaintiffs referred to as the individual mandate—that is, the enforcement mechanism was no longer a constitutional tax. This fact, they argued, was part of Chief Justice Roberts’ decision upholding the law in NFIB, in which he pointed out that a tax set at zero lacks the critical attributes of a tax because it produces no revenue. By zeroing out the penalty, Congress lost the constitutional basis for the mandate, since, as the Court also concluded in NFIB, the Commerce Clause did not offer an alternative constitutional basis.

Second, plaintiffs argued, with the constitutional basis for the mandate gone, the ACA became unconstitutional in its entirety—not just the insurance reforms but also the Medicaid expansion, the Medicare reforms, the whole nine yards—because Congress never would have enacted these provisions without the mandate deemed essential to producing the stable insurance market on which the law ultimately rests. (In fact, in recent years, experts have concluded that without the mandate a stable insurance market can be achieved. Enrollment may fall but the market can survive. See, e.g., Congressional Budget Office, Repealing the Individual Health Insurance Mandate: An Updated Estimate (November 2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/reports/53300-individualmandate.pdf (Accessed July 18, 2019). Indeed, they argued, Congress intended to unravel the ACA in its entirety by dropping the penalty to zero—effectively a sneak attack on the whole statute. They made this claim despite the fact (a point that would later be reiterated during the oral arguments on appeal) Members of Congress at the time of the tax law repeatedly stated that they intended to do nothing other than zero out the penalty, having just come through the bruising “repeal and replace” legislative battle of 2017 that went down in flames following official estimates by the Congressional Budget Office that millions of people who would lose coverage.

The district court agreed with plaintiffs’ arguments and declared the entire Affordable Care Act unconstitutional as a result of a single clause in the tax law that reduces the penalty to zero. The court went on to find that the rest of the law was inseverable. Texas et al. v. United States of America, 340 F. Supp. 3d 579 (N.D. Tex. 2018). (Importantly, the court left unaddressed the question of whether the states opposed to the ACA had standing to bring the suit. These plaintiff states on appeal have argued
that they have standing because they are in fact injured whenever one of their residents is mandated to buy an ACA-compliant health plan. (We aren’t kidding. See Letter from Ken Paxton, Texas Attorney General, to the Clerk of the Court for the Fifth Circuit, where the case is pending, citing the Supreme Court’s 2019 decision in *Department of Commerce v New York* and arguing that states have standing whenever a third party forces their residents to do something that will hurt them. In this case the harm would be the effects of a mandate that remain, according to the trial court, even though the mandate has been rendered completely unenforceable by the Tax Act.)

As of July, 2019 the case is on appeal to the Fifth Circuit. A decision is expected later in the summer. Originally the Trump Administration, while not challenging the concept of a distinct legal mandate or its unconstitutionality in the wake of tax reform, confined its position on inseverability to the law’s key market reforms (guaranteed issue and renewal, the ban on the use of pre-existing condition exclusions, and the community rating requirement.) But then, in yet another bizarre twist, the Administration suddenly announced that it was switching sides and supporting the decision’s total inseverability holding as well, and thereby supporting plaintiffs’ claim that the Act, in its entirety, has been rendered unconstitutional by Congress’s zeroing-out the tax. See, e.g., Katie Keith, Trump Administration Asks Court To Strike Down Entire ACA, Health Affairs Blog, [https://www.healthaffairs.org/do/10.1377/hblog20190326.572950/full/](https://www.healthaffairs.org/do/10.1377/hblog20190326.572950/full/) (Accessed July 18, 2019). Perhaps even more bizarrely, the Administration then announced that it would no longer defend the suit, leading states and the now-Democratically-controlled House to intervene to do so.

There is widespread speculation as to what the appeals court might do, although there is little doubt that whatever it does, the case will end up at the United States Supreme Court, which has twice saved the law from oblivion. (*NFIB*, in this Supplement; *King v. Burwell*, 567 U.S. ___ (2015), in this Supplement). The Fifth Circuit appears to have doubts that the law’s defender-intervenors on appeal (a group of supportive states led by California and the U.S. House of Representatives) have standing to do so and has sought briefing on this matter. See, e.g., Katie Keith, Fifth Circuit Questions Standing of Parties Defending ACA in Texas v. Azar, Health Affairs Blog (June 28, 2019), [https://www.healthaffairs.org/do/10.1377/hblog20190628.614120/full/?utm_source=Newsletter&utm_medium=email&utm_content=Another+Twist+In+Ongoing+ACA+Litigation+%3B+Medicare+s+Direct+Provider+Contracting%3B+Book+Reviews&utm_campaign=HAT+6-28-19I](https://www.healthaffairs.org/do/10.1377/hblog20190628.614120/full/?utm_source=Newsletter&utm_medium=email&utm_content=Another+Twist+In+Ongoing+ACA+Litigation+%3B+Medicare+s+Direct+Provider+Contracting%3B+Book+Reviews&utm_campaign=HAT+6-28-19I) (Accessed July 18, 2019). It is possible that the law will be left without any defender on appeal, since the court conceivably could conclude that only the Department of Justice has the right to appeal, and if DOJ chooses not to do so, then that’s the end.* If the Fifth Circuit lets the decision stand, does a federal trial court in Texas really get to declare the entire ACA unconstitutional? Obviously not. The ACA legal and

* In Virginia House of Delegates v Bethune-Hill, 139 S. Ct. 1945 (2019) the United States Supreme Court, during its 2018-2019 term, denied Virginia’s Republican House of Delegates standing to intervene and appeal a redistricting case that the Commonwealth’s Democratic Attorney General had settled after the trial court ruling. The Court concluded that the state had designated the Attorney General, not part of its legislative apparatus, as the exclusive representative of its civil litigation interests.
policy blogosphere—which is as vast as the universe—has gone wild with speculation, as have experts specializing in constitutional law more generally.

Putting aside the legal mess spawned by the trial court decision, a blizzard of mind-blowing questions arise when one stops to think about repealing a 10-year-old law that in actuality is hundreds of amendments to existing laws that are now embedded in the very fabric of health law, not to mention in the American health care system itself.

How does one unwind something like the ACA? What would the post-unwinding world look like? Would 23 million Medicaid beneficiaries and people with subsidized health plans simply have to give up coverage? (For state-by-state coverage loss estimates, see Linda Blumberg et al., State-by-State Estimates of the Coverage and Funding Consequences of Full Repeal of the ACA (Urban Institute, 2019)), https://www.urban.org/research/publication/state-state-estimates-coverage-and-funding-consequences-full-repeal-aca (Accessed July 18, 2019)). The answer would be yes, presumably, since they are too poor to afford coverage without subsidies. Would millions of people who have access to insurance today despite pre-existing conditions simply lose their plans? Yes presumably, since without subsidies insurers would go back to their pre-ACA underwriting practices and exclude persons with pre-existing conditions, as well as cancelling policies when insureds become ill,—i.e., goodbye guaranteed issue and renewal, and charging very high premiums for older people and women. Would children under the age of 26 get kicked off their parents’ policies? Presumably yes in any state that did not maintain a similar protection under state law. Would Medicare, much of whose various provider payment systems were overhauled by the ACA, simply revert to its old payment structures? Presumably so, leading to health care industry chaos. Would the hundreds of community health centers built and maintained with expanded ACA grant funding simply cease to exist for nearly 30 million people? Probably so, since these grants are essential to operation. Would women lose affordable contraceptive coverage? Likely so. Would families with children lose free well child checkups? Yep. Would people give up covered immunizations? Indeed. Do families who now have coverage for at least some habilitative care for children with developmental disabilities give up coverage once the essential health benefit standard goes away? You bet. Would women whose individual or small employer group policies cover maternity care lose this benefit? Probably since it is costly and the Pregnancy Discrimination Act does not apply to individuals or very small groups. And what about all the changes wrought by the ACA in the area of health care fraud, medical education, health care workforce more generally, etc., etc., etc., and so forth (to quote a King who would appear to have been much wiser than this)?

These questions and a million other “what if” additional ones give you a sense of what blowing up the ACA would look like. And what do the President and Congress do? Immediately sit down and figure out a replacement? Look how well that worked out in

* This brings to mind the indelible scene in It’s a Wonderful Life when George Bailey, thinking he has lost everything, stands on a bridge in a blizzard and says “I wish I had never been born” and the angel Clarence then shows him the grimness of how the world would have been.
the near-decade effort of Republicans to come up with “something better,” particularly in the summer of 2017 (discussed earlier in this supplement, whose most epic moment was Senator McCain’s unforgettable thumbs down). What makes you think they could figure anything out before the parade of horribles occurs?

Is this catastrophe what plaintiffs had in mind when they filed the litigation? Triggering a totally manufactured crisis for people, insurers, state governments, public health, and the health care industry? It’s hard to understand the practical logic behind the lawsuit, although it is easy to understand its ideological basis. At least one of the Fifth Circuit judges who heard the case on appeal remarked during oral argument that were the court to find the law inseverable, Congress could just quickly re-enact the ACA in its entirety. Apparently he slept through the summer of 2017.

**Regulatory destabilization and disruption**

In a system of coverage that relies heavily on two coverage sources for the under-65 population—private insurance and Medicaid—disrupting either coverage pathway through regulatory interference can go a long way toward reducing the system’s effectiveness. Frankly, were we to attempt to canvass the numerous ways in which the Trump Administration has tried to destabilize the ACA’s Marketplaces and subvert its insurance reforms this essay would run into hundreds of pages. Among other things the Administration has: shortened the open enrollment period for individual coverage; nearly entirely defunded the Navigator program, which offers enrollment assistance to people not accustomed to buying insurance policies; refused to refund insurers, in direct violation of the ACA, the money they have spent to relieve relatively poor enrollees of their out-of-pocket cost-sharing obligations;* and allowed larger employers to avoid their ACA obligation to provide health insurance or pay a tax, by authorizing them instead to offer their employees cash, a defined contribution rather than defined benefits (see Katie Keith, Final Rule On Health Reimbursement Arrangements Could Shake Up Markets, Health Affairs Blog (June 14, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190614.388950/full/ (Accessed July 20, 2019).

Rather than explicate all of the ways the Administration has tried reverse and diminish the Medicaid expansion and insurance reforms, we have selected three examples that illustrate these strategies: short-term, limited-duration health plans; association health plans; and Medicaid work experiments.

**Short-term, limited-duration health plans and association health plans**

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* Definitive research—indeed, one of the largest insurance studies ever conducted—shows that high cost sharing deters poor people from using medically necessary health care. See RAND Corporation, 40 Years of the Rand Health Insurance Experiment, available at https://www.rand.org/health-care/projects/HIE-40.html (Accessed July 20, 2019). The ACA sought to remove this deterrent by reducing cost sharing amounts paid by plan members with household incomes of 250 percent of poverty or below. PPACA §1402.
While the ACA reforms much of the insurance market, it allows continuation of two types of health insurance products with troubled histories. Short-term limited-duration insurance (STLDI) policies were exempted from the original HIPAA reforms in 1996, with the power to define what is “short term” and “limited duration” left to the enforcement agencies (HHS, Labor, and Treasury, as is the case with the ACA). The ACA continued this exemption. STLDI policies are non-ACA compliant and thus do not qualify for premium tax subsidies or cost sharing assistance. They also can be sold only to the best risks because they use pre-existing condition exclusions, charging older less healthy people far more; furthermore, there are no coverage rules and policies can be cancelled when people get sick. Congress held onto this market on the expectation that people might need policies to fill short-term coverage gaps in between jobs or open enrollment periods but, as in HIPAA, it left the definition to the agencies.

The same fact problems have characterized Association Health Plans (AHPs), originally conceived as a way for small groups of employers to band together to form larger plans shielded by ERISA (and state regulation as well) from the regulation that applied to small employers. The ACA allowed such plans to continue but with ERISA regulations in effect prior to the ACA that were designed to bar fake associations from forming only in order to sell junk policies to individuals. Congress assumed that individuals would move into the ACA-compliant plan market where exclusions and discrimination based on health status were barred and policies were held to minimum coverage standards. Those with lower and moderate incomes would qualify for insurance affordability tax credits and cost sharing assistance.

Tax credits effectively provide a check on the monthly cost of insurance as a percent of family income. But many people don’t qualify for tax credits since at the credits taper out and end at 400 percent of the federal poverty level (about $82,000 for a family of three in 2019). The fact that premium credits are not available to many families of moderate income means that the cost of insurance is a stretch or out of reach for them. But individuals who fail to qualify for tax credits are exposed to the full price of individual plans. As the cost of insurance rose precipitously as a result of the ACA reforms and lower enrollment by healthy people than expected (despite the tax penalty), subsidized people remained protected by the tax credit system. But about 2 million people with incomes exceeding the upper tax credit threshold were hit hard in the non-subsidized market.

The cost problem was compounded when a Republican Congress tried to harm the ACA Marketplace further by refusing to appropriate funds to repay insurers for their cost-sharing reduction expenditures. This left insurers holding the bag for literally billions of dollars in unrecovered costs. The Obama administration and state regulators offset these losses by allowing insurers to raise their prices in the subsidized marketplaces for their “silver” plans, the types of plans that qualify for premium tax credits and cost-sharing assistance. This strategy (known as “silver loading”) meant that insurers could target loss recovery to the subsidized plan market. This solution precipitously raised costs for the federal government but held down costs for people who
qualified for subsidies. But still, millions of people in the non-subsidized markets were left with no help—a very basic flaw of the ACA.

Problems with implementing vast new insurance law always arise, and historically Congress has simply stepped in to make corrections. This is the story of Medicare and Medicaid over the decades. But rather than arguing for an expansion of the credit system, the Trump Administration and its supporters have pursued a strategy of expanding access to short-term and association plans that carry a cheaper price tag but don’t have to play by the ACA market rules in terms of eligibility without regard to health status, community pricing, or benefits and coverage. People may get to buy something that goes by the name of “insurance” but it is shallow indeed and subject to all the sorts of games the ACA was enacted to foreclose. One could argue that the true fault lies with Congress for letting these non-compliant markets survive the ACA at all. (The House bill would have shut these practices down more effectively but of course it was the Senate bill that became law).

A bit more about these two ACA-non-compliant markets.

**Short-term plans.** Short-term, limited-duration plans do not have to meet the ACA’s market reforms or coverage standards; insurers can medically underwrite customers, cancel or refuse to renew policies if customers get sick, and offer whatever benefits they want. Basically it’s the pre-ACA world. While, as noted, the ACA did not outlaw the sale of short-term plans, the Obama Administration, having uncovered corrupt sales practices by companies trying to palm these policies off as ACA-compliant coverage, effectively tried to shut down the market by limiting plan duration to 3 months—really short term, in other words. The Trump Administration not only lifted the 3-month limit but issued a rule allowing the legal sale of short-term plans of as much as a year in duration, with two years of renewals, effectively turning them into coverage that could be maintained for up to 3 years. See 83 Fed. Reg. 38212 (Aug. 3, 2018); Katie Keith, The Short-Term, Limited-Duration Coverage Final Rule: The Background, the Content, and What Could Come Next, Health Affairs Blog (Aug. 1, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180801.169759/full/?utm_term=The Short-Term, Limited-Duration Coverage Final Rule%3A The Background, The Content, And What Could Come Next&utm_campaign=Health Affairs Sunday Update&utm_content=email&utm_source=Act-On Software--email--ACA Round-Up%3B Fixing The Individual Market%5Cu2019s Central Flaw%3B Physician Perspectives In Year 1 Of MACRA--The Short-Term, Limited-Duration Coverage Final Rule%3A The Background, The Content, And What Could Come Next (Accessed July 18, 2019).

**Association plans.** Association health plans have been around for decades; employer associations frequently offer them. ERISA sets important requirements for such plans, most notably, that the employer associations offering them really be employer associations, not fly-by-night operations whose aim is to sell junk to individuals and micro-employers. These requirements, which are strengthened by the ACA, were adopted through regulations in the wake of extensive scandals uncovered by federal and state
regulators. Katie Keith, Court Invalidates Rule on Association Health Plans, Health Affairs (2019), https://www.healthaffairs.org/do/10.1377/hblog20190329.393236/full/ (Accessed July 20, 2019). So long as it’s legal, the benefit of an association plan is that small employers can band together to be treated as a single large group plan—big enough to qualify for the more limited ACA rules that apply to large groups (e.g., no essential health benefit minimum standard) and, if big enough, able to self-insure thereby avoiding state regulation as a self-insured ERISA plan.

Despite this history of fraud, the Trump Administration reversed course, loosening the association plan rules so as to effectively allow associations to form solely for the purpose of selling insurance without the commonality of employer interest required under prior rules. Mark Hall and Michael McCue, Experiences Under the ACA Suggest Association Health Plans Could Harm the Small-Group Insurance Market, Commonwealth Fund (2018), https://www.commonwealthfund.org/blog/2018/experiences-under-aca-suggest-association-health-plans-could-harm-small-group-insurance (Accessed July 20, 2019). By relaxing the employer requirement, the rule essentially would allow the formation of large “employer” group plans, thereby avoiding the ACA rules applicable to small groups and potentially avoiding state regulation altogether as self-insured plans. Estimates of the number of people who would then leave the ACA-compliant plan market in favor of cheaper association plans reached as high as 4. See Katie Keith, Final Rule Rapidly Eases Restrictions on Non-ACA-Compliant Association Health Plans, Health Affairs Blog (June 21, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180621.671483/full/ (Accessed July 18, 2019).

You might ask, “So what? People should have the right to buy non-compliant junk if they want, and now that the penalty is gone, what difference does it make?” The answer (outside of the need to protect people from insurance fraud and other corrupt practices) lies in the consequent impact on the risk pool. Any insurance law, whether tied to public or private insurance, depends on a strong “risk pool” to make the law work, that is, to keep costs reasonable for everyone by assuring both a lot of healthy people coupled with subsidies to keep rates affordable.

The ACA is particularly sensitive to risk pooling, since the market for individual coverage, even if robust, remains relatively small (most people have employer coverage or are poor enough to qualify for Medicaid). Any policy change that encourages people to leave the ACA-compliant market for cheaper plans is effectively segmenting the overall risk pool because it creates an incentive for sellers to structure their products to provide shallow, even to the point of illusory, coverage in order to allow them to decrease premiums so as to make those plans attractive to young healthy people—i.e., to enable the sort of risk and adverse selection the ACA was designed to eradicate. To the extent that these “better risks” leave the ACA-compliant insurance risk pool, the pool is destabilized, and of course, prices charged the federal subsidy system climb still higher.

In the Trump Administration’s final short-term, limited-duration regulation, the Administration estimated minimal initial effects, with the impact rising to more than 1

In effect, by promoting both short term limited duration policy and association health plan strategies in combination, the Trump administration found a way to exploit a fundamental failing of the ACA, namely, its failure to have a robust, funded affordability test for everyone in need of an individual insurance policy. (That these strategies had been planned for a long time—even before the repeal and replace fight—is seen in early Presidential Executive Orders deregulating the insurance markets. For a history of these orders, see The Council of Economic Advisors, Deregulating Health Insurance Markets: Value to Market Participants (2019), https://www.whitehouse.gov/wp-content/uploads/2019/02/Deregulating-Health-Insurance-Markets-FINAL.pdf (Accessed July 20, 2019). By leaving millions of Americans totally exposed to the post-tax price of private insurance policies, Congress in 2010 basically gave opponents a lethal opening—those left out in the cold by the limitations of its structure. Naturally, these people need help and will seek it in the form of junk insurance. Estimates by experts of the spillover effect of such strategies show that as the risk pool loses healthy people and as prices go up, more people simply become uninsured—unable to afford a compliant policy while also ineligible for either an association plan (for example it is unlikely that a 61-year-old man in poor health could join the Downhill Skiers Association, which, after all, was built to keep people like him out) or a short term plan.

Not surprisingly, perhaps, given how much Administrative Procedure Act cases have come to dominate health law under the Trump Administration, defenders of the law sued to stop both policies for failure to comply with the APA’s requirements. In one of the lawsuits against the new regulations allowing for more short-term plans, Association for Community Affiliated Plans v. United States (D.D.C. 2018), a decision is expected during summer 2019. In March, 2019, in another of the cases a federal district court struck down the association plan rule as a violation of ERISA and the Administrative Procedure Act. See State of New York et al. v. United States Department of Labor, 363 F. Supp. 3d 109 (D.D.C. 2019). The court found that the Trump Administration ignored decades of settled ERISA policy, as well as the ACA itself, in relaxing the standards for determining what is a “bona fide” employer association, effectively permitting self-employed individuals with no employees to create such association plans rather than purchase coverage through the ACA-compliant individual market. The heart of ERISA, as the court noted, is its goal of regulating the relationship between employers and employees, a feature that is missing when working individuals with no employees can invoke the benefit of the ERISA shield. The Administration’s regulation thus unlawfully expanded ERISA’s scope without placing any “meaningful limits” on the power to create association plans:
Notably absent from ERISA’s statement of policy is any expression of an intent to expand citizen access to healthcare benefits outside of an employment relationship or to directly regulate commercial healthcare insurance providers. Congress does regulate in these areas, but it does so through other statutory schemes—including the ACA.

State of New York, 363 F. Supp. at 129. This case is now on appeal.

However, the challenge to the administration’s STLDI rule did not fare as well, chiefly owing to a much more complicated history of deregulation. As noted, this history dates back to HIPAA in 1996, which continued to tolerate what many called the STLDI junk plan market and deferred to the agencies to define the meaning of “short term” and “limited duration.” The Clinton Administration in fact set the maximum term at 12 months. The Obama administration then waited until 2016 to reset the rules by dropping the maximum duration to three months, arguing that the ACA in fact intended to tighten this market. Then why did Obama administration officials wait till 2016? The answer lies in the fact that the administration did not act before mounting evidence of problems emerged as the cost of ACA compliant plans began to rise steeply and people turned to the short-term market. This infuriated insurers selling ACA compliant plans. The Trump administration could argue—totally truthfully—that it was simply restoring the old definition in order to help people unable to afford the cost of ACA compliant plans.

In July 2019, a federal court upheld the STLDI rule, concluding that a lengthy legislative history predating the ACA indicated Congressional intent to hold onto this market, along with a willingness to defer to the agencies on the crucial definitions of “short term” and “limited duration.” Nothing, in the court’s view, about the ACA altered Congress’s willingness to tolerate this market. Furthermore, the court held, while the Obama rules may have been a reasonable interpretation of ACA murkiness, so were those issued by the Trump administration. Under the Administrative Procedure Act, legislative ambiguity (thereby triggering the judicial Chevron deference policy), plus a rule that, on the merits, takes the major aspects of the problem into account while offering a plausible interpretation equals an agency win—even if the interpretation is not what a court or plaintiffs would have chosen. Association for Community Affiliated Plans et al. v United States Department of Treasury et al., No. 18-2133 (D.D.C. July 19, 2019). Plaintiffs have stated that they will appeal.

* The term Chevron deference is a principle of administrative law that takes its name from Chevron Inc. v Natural Resources Defense Council, 467 U.S. 837 (1984). Under the Chevron deference principle, courts will defer to an agency’s interpretations of the meaning of a statute if the statute is ambiguous and the agency is one that possesses the expertise and power to interpret the law as a matter of statutory delegation of agency authority. Here, the court concluded, there was no question that the law was ambiguous (it completely lacked a definition of STLDI); nor was there any doubt that administering agencies had the power to interpret its meaning and had done so since 1996.
Medicaid Experiments

From the time they assumed office, Trump Administration officials made clear that Medicaid—the nation’s single largest insurer and by far the largest means-tested entitlement program—was in the cross-hairs, both generally speaking but especially with respect to the ACA adult expansion that today accounts for some 15 million out of the more than 20 million newly insured Americans. (This should tell you something about how poor uninsured Americans were—their family incomes did not get them up to the poverty threshold for ACA refundable tax credits).

Of course, the Medicaid expansion has been a hot-button issue literally since the ACA was signed into law and the first lawsuits were filed. Ultimately in NFIB the majority would strike down the expansion as unconstitutional coercion on the states, even as it saved the expansion—along with a trillion dollars in federal funding over 10 years—from legislative oblivion by limiting the remedy for the constitutional problem to prohibiting the HHS Secretary from enforcing the expansion as a mandate. In effect, the Court permitted states to move ahead if they chose to do so. This in turn triggered a years-long ferocious war, fought in the resisting states (about half of all states), to block the expansion. (About half expanded immediately, with several dramatic standouts such as Ohio, whose conservative Republican Governor John Kasich nonetheless embraced the expansion as an act of financial wisdom for the state—free money!!!!—and moral compassion).

By 2017, when the Trump Administration took office, approximately 35 states had expanded. As of April 2019, the total number of expansion states stood at 36 and the District of Columbia; voter expansion initiatives have passed in several additional states, but opposition by legislatures in those states have barred movement toward implementation. https://www.commonwealthfund.org/publications/maps-and-interactives/2019/apr/status-medicaid-expansion-and-work-requirement-waivers (Accessed July 19, 2019).

One could argue that at its core, the failed Republican effort to repeal the ACA in 2017 was really all about funding the Republican tax cut, with much of the money to come from fundamentally altering Medicaid. At the heart of the repeal packages lay not only the elimination of the expansion population but also a plan to convert Medicaid from an open-ended state entitlement to federal funding to a capped block grant that would redistribute remaining funds away from the expansion states toward non-expansion ones (heavily located in the historic South), whose residents tend to be disproportionately poor and black with seriously compromised health status and include 4.4 million residents caught in the so-called Medicaid coverage gap that was the fallout from the NFIB coercion decision. These persons are too poor to qualify for premium tax credits, which kick in only when one’s income exceeds the federal poverty level, but are also made ineligible by their states for Medicaid because their income exceeds those states’ income cap. Four states—Texas, Florida, Georgia and North Carolina—account for most of the persons falling within the gap, who are disproportionately African American. Rachel Garfield et al., The Medicaid Coverage Gap: Uninsured Poor Adults in States that Do Not

Even while the Republicans’ effort to repeal the ACA was crashing and burning, the Trump Administration opened a second front—one grounded in deep and philosophical opposition to the expansion, something officials made no bones about. In a letter to the nation’s governors in early 2017, https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf (Accessed July 18, 2019), then-HHS Secretary Tom Price and Seema Verma, Administrator of the Centers for Medicare and Medicaid Services wrote:

The expansion of Medicaid through the Affordable Care Act (ACA) to non-disabled, working age adults without dependent children was a clear departure from the core, historical mission of the program. Moreover, by providing a much higher federal reimbursement rate for the expansion population, the ACA provided states with an incentive to deprioritize the most vulnerable populations. The enhanced rate also puts upward pressure on both state and federal spending. We are going to work with both expansion and non-expansion states on a solution that best uses taxpayer dollars to serve the truly vulnerable.

Do you recall ever reading a letter from agency officials effectively labeling an Act of Congress contrary to public policy, a “clear departure” from the program’s “mission”?

Forty years ago, one of us dealt with extensive Congressional opposition to Medicaid expansion for pregnant women and children; on a daily basis those advocating expansion were told that Medicaid eligibility based on financial need alone would be contrary to public policy. But what came to be an article of faith for children—that no poor child should be uninsured and that all poor children should qualify for Medicaid—has persisted as a subject of passionate opposition in the case of adults among policymakers whose views can be traced to the English Poor Laws. Sara Rosenbaum, The Myths We Tell Ourselves About the Poor: From the English Poor Law to the Council of Economic Advisers (Milbank Quarterly, 2018), https://www.milbank.org/quarterly/articles/the-myths-we-tell-ourselves-about-the-poor-from-the-english-poor-law-to-the-council-of-economic-advisers/ (Accessed July 18, 2019). This attitude persists even in the face of overwhelming evidence regarding the large number of poor who work and the barriers low-wage workers face in securing employer coverage. Among the poorest workers, especially those who work only part-time, which is very common owing to uneven work schedules, the percentage with employer coverage is effectively zero. Indeed, during the ACA debate subsidized individual insurance policies through the Marketplace were understood by Congress as having especially large relevant to low-wage workers.

When it became clear that a repeal of Medicaid was not going to happen, the Administration turned in earnest to its statutory experimental authority under Section
1115 of the Social Security Act, which empowers the HHS Secretary to undertake experiments and demonstrations that he finds are "likely to assist in promoting the objectives of" the program that is the subject to the experiment. 42 U.S.C. § 1315(a). Section 1115 predates Medicaid by three years; it was amended to permit its use in Medicaid experiments at the time of the program’s enactment.

Over a half century, 1115 has been used extensively to test Medicaid restructuring. This restructuring has included expanded eligibility, modified benefit designs, and demonstrations testing community-based systems of long-term services and supports to promote de-institutionalization. Section 1115 also has been used, notably, to introduce innovations in health care delivery itself, most significantly enabling states to shift Medicaid from an old-style fee-for-service form of insurance into what it is today—the nation’s largest purchaser of managed care, akin to narrow-network insurance plans—for more than 50 million beneficiaries. There have been times when 1115 experiments involved tradeoffs—tighter restrictions on eligibility in one aspect of the program, offset by expansions in other portions of the program. In virtually all situations, demonstrations undertaken aimed at net gains—in eligibility, coverage, or care (or all three). Indeed, because Section 1115 limits the Secretary’s authority to experiments that promote Medicaid’s objectives, experiments presumably must take into account their impact on medical assistance since by law, Medicaid’s core objective is to furnish medical assistance to eligible people. 42 U.S.C. § 1396-1. At least one court has enjoined Medicaid experiments that turned out to be nothing more than a flimsy pretext for cutting benefits and lacking an experimental design. Newton Nations v Betlach, 660 F. 3d 370 (9th Cir. 2011).

The Trump Administration’s vision for 1115 experiments did not involve net gains in medical assistance—precisely the opposite. As a result, the Administration was effectively forced to invent a pretext. On January 11th 2018, the Administration formally invited state Medicaid agencies to submit Section 1115 experimental proposals to launch work experiments. The experimental work design to be tested was a year-round, 20-hour-per-week work schedule, with limited exemptions for “medical frailty” (undefined) and certain other narrow factors. https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf (Accessed July 18, 2019). The implicit premise of the invitation was, of course, that Medicaid beneficiaries of work age do not work; in fact, 60 percent of working-age adult beneficiaries do in fact work; the 40 percent who do not do so report that they or a family member experience health problems or that they have family-care responsibilities. Working beneficiaries report significant impediments to work, typically because of the contingent nature of low-wage jobs, the lack of child care, or the paucity of transportation. Rachel Garfield et al., Understanding the Intersection of Medicaid and Work (Kaiser Family Foundation, 2018), https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/ (Accessed July 18, 2019).

Starting with this flawed premise, the Administration then had to deal with a basic problem—the impact of compelled work as a condition of eligibility on coverage. Indeed, it was well known that past work programs involving cash welfare and the Supplemental

So the Administration effectively trumped up a two-step solution. First, it sidestepped the core question of the work program’s impact on Medicaid by refusing to develop estimates of the effects of compulsory work rules that set unattainable employment goals while also imposing new (and, as it would turn out, insurmountable) reporting rules. Second, the Administration simply invented a new purpose for Medicaid—to promote health and a sense of self-worth through compelled employment. In so doing, the Administration also ignored the fact that there is no evidence that work improves health; indeed, the only evidence is that healthy people appear to work more. Brief for Deans, Chairs and Scholars as Amici Curiae for Plaintiffs, Stewart v. Azar (D.D.C. Civil Action No. 1:18-cv-152(JEB), filed April 6, 2018), https://publichealth.gwu.edu/sites/default/files/downloads/HPM/Kentucky%20Medicaid%20Proposed%20Amici%20Curiae%20Brief.pdf. (Accessed July 18, 2019). In the face of this assault on coverage (federal regulations require states to submit impact estimates with their experimental proposal, and several states, complying with the law, have pointed to a substantial adverse impact), beneficiaries sued to block the approvals that were granted to Kentucky, Arkansas, and New Hampshire.

As of July 2019 a ruling on the challenge in New Hampshire has been delayed because the state suspended the experiment since it was unable to find and notify 40 percent of the experimental population about the new eligibility rules. (This is not unusual because of the precarious living conditions of the very poor who, if not homeless, often have no fixed address). Letter to Governor Christopher Sununu from Jeffrey Meyers, Commissioner, New Hampshire Department of Health and Human Services, (July 8, 2019), https://www.dhhs.nh.gov/media/pr/2019/07082018-ga-ce-finding.htm (Accessed July 20, 2019). In the meantime, a federal court vacated the federal approvals in Kentucky and Arkansas (in Kentucky’s case twice, once in June 2018, and then again in early 2019). Sara Rosenbaum and Alex Somodevilla, Inside the Latest Medicaid Work Experiment Decisions: Stewart v Azar and Gresham v. Azar (Health Affairs Blog, April 2, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190402.282257/full/ (Accessed July 19, 2019).

The three decisions to vacate HHS’s approvals of the experiments essentially all rest on the same ground: by not considering the impact of the experiments on Medicaid beneficiaries’ coverage, the Secretary violated both 1115 and the Administrative Procedure Act, since he failed to take into account the central issue in the experiments—their effect on medical assistance. The first Stewart case follows.
James A. Boasberg, United States District Judge.

In 2010, Congress enacted the Patient Protection and Affordable Care Act—popularly known as Obamacare—which is “a comprehensive national plan to provide universal health insurance coverage” across the nation. Nat’l Fed’n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012). One central component of that statute was an expansion of Medicaid, allowing states to provide “health care to all citizens whose income falls below a certain threshold.” This “expansion,” the Supreme Court has held, represented “a shift in kind, not merely degree.” While the “original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children,” the Affordable Care Act “transformed” Medicaid “into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level.”

Defendants in this case have sought to roll back those reforms. Upon assuming office in March 2017, Defendant Seema Verma, the Administrator for the Centers for Medicare & Medicaid Services—along with then-Secretary of the Department of Health and Human Services Tom Price—immediately circulated a letter to the Governors of all states to share her belief that the ACA’s Medicaid expansion “was a clear departure from the core, historical mission of the program.” The letter encouraged states to apply for “waiver[s]” of some of the program’s coverage requirements—especially for the expansion group—promising to “fast-track” approval of such petitions.

Kentucky is one state to board that train. After the ACA went into effect, it elected to broaden Medicaid to include the expansion population, and by April 2016, more than 428,000 new residents had thereby received medical assistance. In July 2017, however, the state submitted an experimental plan to CMS called “KY HEALTH,” which is made up of several components, most significantly Kentucky HEALTH. That latter program promised to “comprehensively transform” its Medicaid program. Under that plan, the state would impose “community-engagement” requirements for the expansion population, along with some of the traditional population as well. This new mandate would require that those recipients work (or participate in other qualifying activities) for at least 80 hours each month as a condition of receiving health coverage. The project also called for, among other things, increased premiums and more stringent reporting requirements. Consistent with CMS’s earlier invitation, the Secretary approved Kentucky’s application on January 12, 2018, waiving several core Medicaid requirements in the process.

Although the Secretary is afforded significant deference in his approval of pilot projects like Kentucky’s, his discretion does not insulate him entirely from judicial review. Such review reveals that the Secretary never adequately considered whether Kentucky HEALTH would in fact help the state furnish medical assistance to its citizens, a central objective of Medicaid. This signal omission renders his determination arbitrary.
and capricious. The Court, consequently, will vacate the approval of Kentucky’s project and remand the matter to HHS for further review.

I. BACKGROUND

The Court begins with an overview of the statutes governing Medicaid and its experimental projects. It then turns more specifically to Kentucky’s challenged plan, before concluding with a brief procedural history of the current suit.

A. Statutory Background

1. Medicaid Program

Since 1965, the federal government and the states have worked together to provide medical assistance to certain vulnerable populations under Title XIX of the Social Security Act, colloquially known as Medicaid. The Centers for Medicare and Medicaid Services (CMS), a federal agency within the Department of Health and Human Services, has primary responsibility for overseeing Medicaid programs. Under the cooperative federal-state arrangement, participating states submit their “plans for medical assistance” to the Secretary of HHS. To receive federal funding, those plans—along with any material changes to them—must be approved by the Secretary. Currently, all states have chosen to participate in the program.

Before the Secretary can approve a state plan, the Medicaid Act sets out certain minimum parameters that all states must follow. One such provision requires state plans to “mak[e] medical assistance available” to certain low-income individuals. Until recently, that group included pregnant women, children, and their families; some foster children; the elderly; and people with certain disabilities. In 2010, however, Congress enacted the Affordable Care Act to increase the number of Americans covered by health insurance. Under that statute, states can choose to expand their Medicaid coverage to include additional low-income adults under 65 who would not otherwise qualify.

Generally, a state must cover all qualified individuals or forfeit its federal Medicaid funding. Although it may choose not to cover this ACA expansion population, if the state decides to provide coverage, those individuals become part of its mandatory population. In that instance, the state must afford the expansion group “full benefits”—i.e., it must provide “medical assistance for all services covered under the State plan” that are substantially equivalent “in amount, duration, or scope . . . to the medical assistance available for [other] individual[s]” covered under the Act.

2. Section 1115 of Social Security Act

Both before and after the passage of the ACA, a state wishing to deviate from the Medicaid Act’s requirements must obtain a waiver from the Secretary of HHS. 42 U.S.C. § 1315. In enacting the Social Security Act (and, later, the Medicaid program within the same title), Congress recognized that statutory requirements “often stand in the way of
experimental projects designed to test out new ideas and ways of dealing with the problems of public welfare recipients.” S. Rep. No. 1589, 87th Cong., 2d Sess. 19, reprinted in 1962 U.S.C.C.A.N. 1943, 1961–62. To that end, Section 1115 of the Social Security Act allows the Secretary to approve “experimental, pilot, or demonstration project[s]” in state medical plans that would otherwise fall outside Medicaid’s parameters. The Secretary can approve only those projects that “in [his] judgment . . . [are] likely to assist in promoting the [Act’s] objectives.” 42 U.S.C. § 1315(a). Once the Secretary has greenlighted such a project, he can then waive compliance with the requirements of Section 1396a “to the extent and for the period . . . necessary to enable [the] State . . . to carry out such project.” § 1315(a)(1).

While the ultimate decision whether to grant approval rests with the Secretary, his discretion is not boundless. Before HHS can act on a waiver application, the state “must provide at least a 30–day public notice[-]and[-]comment period” regarding the proposed program and hold at least two hearings at least 20 days before submitting the application. Once a state completes those prerequisites, it then sends an application to CMS. After the agency notifies the state that it has received the waiver application, a federal 30–day public-notice period commences, and the agency must wait at least 45 days before rendering a final decision.

B. Factual Background

1. CMS’s Actions

It is no secret that the current administration hopes to “prompt[ly] repeal[ ] the Patient Protection and Affordable Care Act.” Exec. Order No. 13765, Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, 82 Fed. Reg. 8351 (Jan. 20, 2017). “In the meantime,” it has promised to “take all actions consistent with law to minimize” the Act’s impact, including on states. To that end, the new CMS Administrator circulated a letter on March 14, 2017, alerting states of the agency’s “intent to use existing Section 1115 demonstration authority” to help revamp Medicaid. In that letter, Defendant Verma and then-Secretary Price lamented “[t]he expansion of Medicaid through the Affordable Care Act” as “a clear departure from the core, historical mission of the program.” Together they promised to find “a solution that best uses taxpayer dollars to serve” those individuals they deemed “truly vulnerable.”

On January 11, 2018, Brian Neale, Director of CMS, issued a follow-up letter to all state Medicaid Directors, fleshing out that “new policy.” The agency, he said, would “assist states in their efforts to improve Medicaid enrollee health and well-being through incentivizing work and community engagement among” certain adult mandatory Medicaid groups. This was “a shift from prior agency policy.” While other welfare programs—such as Temporary Assistance for Needy Families (TANF) and Supplemental Nutritional Assistance Program (SNAP)—condition benefits on working, there is no equivalent for the Medicaid program. Indeed, during the 50–plus years of Medicaid, CMS has not previously approved a community-engagement or work requirement as a condition of Medicaid eligibility. Instead, the agency has consistently denied these
requests, finding that work requirements “could undermine access to care” and were thus inconsistent with the purposes of Medicaid.

In the 2018 State Medical Director (SMD) letter, however, the agency espoused a new commitment to “support[ing] state efforts to test incentives that make participation in work or other community engagement a requirement for continued Medicaid eligibility” and encouraged states to apply for Section 1115 waivers for this purpose. It then “identified a number of issues for states to consider as they develop[ed]” a community-engagement requirement for the Medicaid program. To date, at least ten states have applied for such Medicaid waivers.

2. KY HEALTH

One of those states is the Commonwealth of Kentucky. On August 24, 2016, Governor Matt Bevin submitted an application to CMS requesting a Section 1115 waiver to implement an experimental project, Helping to Engage and Achieve Long Term Health, or KY HEALTH. He followed up with an amended (though similar) KY HEALTH application on July 3, 2017. That application had two key programs relevant here (as well as some others not challenged): (1) Kentucky HEALTH—not to be confused with the umbrella KY HEALTH—a “program” that applies only to “adult beneficiaries who do not qualify for Medicaid on the basis of a disability”; and (2) Substance Use Disorder (SUD) Treatment, which would be available for all Medicaid beneficiaries. The Court outlines each in turn. [The plaintiffs did not challenge the separate proposal, discussed by the court, to expand SUD treatment].

a. Kentucky HEALTH

Kentucky HEALTH is a program primarily (though not exclusively) targeting the expansion group of adults covered under the ACA. The Commonwealth believed that this project would “transform” the state’s Medicaid program by, among other things, predicking Medicaid eligibility for most of the expansion population on workforce participation or community service. On January 12, 2018 (just one day after issuing the SMD letter), the Secretary approved Kentucky HEALTH, granting waivers to implement the following features:

1) Community-engagement requirement, which requires beneficiaries to spend at least 80 hours per month on qualifying activities (including employment, job-skills training, education, community service, and participation in SUD treatment) or lose their Medicaid coverage;

2) Limits on retroactive eligibility,* which excuse the state from “provid[ing] three months of retroactive eligibility for beneficiaries receiving coverage through

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* Retroactive eligibility is one of the many design features that makes Medicaid not simply an insurer but a true safety net source of health care financing. Private health insurance enrollment and even Medicare both are limited to annual enrollment with very narrow “special enrollment period” exceptions. This is done, of
the Kentucky HEALTH program; except for pregnant women and former foster care youth;”;

3) **Monthly premiums**, including premiums varied based on income and/or length of time enrolled in Medicaid;

4) **Limits on non-emergency medical transportation**, which “relieve Kentucky of the requirement to assure non-emergency medical transportation to and from providers for the new adult group”—*i.e.*, adults without disabilities, except for those who are medically frail, former foster-care youth, or pregnant;

5) **Reporting requirements**, which mandate that individuals provide information for an annual redetermination and report changes in income or circumstances that affect Medicaid eligibility within 10 days; and

6) **Lockouts**, which allow the state to deny Medicaid coverage for up to six months for any beneficiary who (a) has an income above 100% of the FPL and (b) failed to meet her premium or reporting requirements.

Kentucky HEALTH also included “commercial market health insurance” features, such as a deductible account, an incentive and savings account called *My Rewards*. The Secretary approved each of those mechanisms as part of Kentucky HEALTH and, in doing so, agreed to “fund[]” those programs “through the Section 1115(a)(2) expenditure authority.” As part of that approval, the Secretary allowed Kentucky to penalize recipients who used the emergency room for “non-emergent” purposes, by deducting $75 from their new *My Rewards* health account (an account where Kentucky provides virtual funds for healthy behaviors).

With those programs in place, the Commonwealth expected to save roughly $331 million dollars, primarily by reducing its Medicaid population by an estimated 95,000 persons.

[The procedural history and the analysis of standing are omitted]

**II. LEGAL STANDARD**

The Administrative Procedure Act “sets forth the full extent of judicial authority to review executive agency action for procedural correctness.” It requires courts to “hold unlawful and set aside agency action, findings, and conclusions” that are “arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.” 5 U.S.C. § 706(2). Agency action is arbitrary and capricious if, for example, the agency “entirely course, to avoid adverse selection. Medicaid, on the other hand, embraces risk, not only permitting enrollment when health care is needed but making eligibility retroactive for up to three months in order to protect people against huge medical bills that otherwise could ruin them. Retroactive eligibility also is extremely important to hospitals that provide emergency care to the uninsured and otherwise would incur huge losses.
failed to consider an important aspect of the problem, offered an explanation for its
decision that runs counter to the evidence before the agency, or is so implausible that it
could not be ascribed to a difference in view or the product of agency expertise.” Motor
(1983). In other words, an agency is required to “examine the relevant data and articulate
a satisfactory explanation for its action including a rational connection between the facts
found and the choice made.” Courts, accordingly, do not defer to the agency’s conclusory
or unsupported suppositions, and agency “litigating positions” are not entitled to
deference when they are merely [agency] counsel’s “post hoc rationalizations” for agency
action, advanced for the first time in the reviewing court. Although a reviewing court
“may not supply a reasoned basis for the agency’s action that the agency itself has not
given,” a decision that is not fully explained may, nevertheless, be upheld “if the
agency’s path may reasonably be discerned.” Bowman Transp., Inc. v. Arkansas–Best

III. ANALYSIS

In this case, Plaintiffs accuse HHS of “tak[ing] by regulatory fiat what it could not
accomplish in Congress.” The Secretary and Kentucky, they say, sought to do little more
than “knock people off Medicaid and undermine the Medicaid expansion enacted by
Congress.” With that view in mind, their nine-count Complaint—which relies almost
exclusively on the APA—challenges nearly every component of Kentucky HEALTH.
[T]he Court need adjudicate only one count of Plaintiffs’ Complaint to grant them full
relief: Count VIII, which challenges the Secretary’s approval of Kentucky HEALTH as a
whole. Before the Court can reach that dispute, however, it must first address several
threshold issues. [Preliminary matters other than justiciability are omitted].

A. Threshold Issues

2. Justiciability

The Secretary maintains that even if Plaintiffs have standing, this Court has no
power to review his authority under Section 1115. Rather, he says, his actions are
“committed to agency discretion by law” and are thus barred from review under Section
701(a)(2) of the APA. The APA embodies a “basic presumption of judicial review” and
the exception is a very narrow one. Here, Section 1115 provides, inter alia:

(a) In the case of any experimental, pilot, or demonstration project which, in the
judgment of the Secretary, is likely to assist in promoting the objectives of [the Medicaid
statute,]

(1) the Secretary may waive compliance with any of the requirements of section . . . 1396a of this title, as the case may be, to the extent and for the period
he finds necessary to enable such State or States to carry out such project, and
(2)(A) costs of such project . . . shall, to the extent and for the period prescribed by the Secretary be regarded as expenditures under the State plan or plans.


In other words, the Secretary must adopt a two-fold inquiry, asking (1) whether he can approve the project pursuant to Section 1115(a); and then (2) what waivers or expenditures are necessary for that project pursuant to Sections 1115(a)(1) and (a)(2). The Court will evaluate the justiciability of each step in turn.

a. Section 1115(a)

In this case, Count VIII challenges the Secretary’s approval of Kentucky HEALTH under Section 1115. The statute required that the Secretary examine two criteria before doing so: First, whether the project is an “experimental, pilot or demonstration project”; and second, whether the project is “likely to assist in promoting the objectives” of the Act. Newton–Nations v. Betlach, 660 F.3d 370, 379–80 (9th Cir. 2011) (noting that court could review whether “Secretary [made] some judgment that the project has a research or a demonstration value”).

The Court can readily apply both standards, which are a far cry from those traditionally deemed unreviewable. [The Medicaid statute] “contains numerous, detailed, specific requirements with which states must comply in order to receive federal funding.” Beno v. Shalala, 30 F.3d 1057, 1068 (9th Cir. 1994). The Secretary is responsible for ensuring that state programs comply with these regulations and must “take certain specific steps, culminating with the loss of funding, when state plans fail to comply.” Id. While Section 1115 allows the Secretary to relax those minimum requirements in some circumstances, the Court “doubt[s] that Congress would enact such comprehensive regulations, frame them in mandatory language, require the Secretary to enforce them, and then enact a statute allowing states to evade these requirements with little or no federal agency review.” Beno, 30 F.3d at 1068–69.

Were it otherwise, the Secretary could singlehandedly rewrite the Medicaid Act. Indeed, “[e]very court which has considered the issue has concluded that” the Secretary’s Section 1115 authority is “subject to APA review.”

The Secretary resists this consensus, stressing that the statute turns on “[h]is judgment” as to whether a project is likely to further the Act’s objectives. To be sure, he “has considerable discretion to decide which projects meet these criteria.” Beno, 30 F.3d at 1069. And, as discussed below, the Court will afford him considerable deference on his “judgment” that these waivers fit the bill. “[T]he mere fact that a statute contains discretionary language,” however, “does not make agency action unreviewable.” Ultimately, the Court may properly review an agency action as long as there is some “law to apply.” There is more than enough here.
B. Merits

Appetizers now dispatched, the Court may cut into the main course. Plaintiffs’ central position here is plain: Kentucky HEALTH would “fundamentally” and impermissibly “transform Medicaid.” They thus attack nearly every component of the program. At bottom, however, most of their challenges boil down to a simple argument: the program is “not likely to assist in promoting” Medicaid’s objectives.” The parties debate the appropriate standard of review[...]. At minimum, however, both sides agree that the Secretary’s approval (if reviewable) must not be “arbitrary, capricious . . . , or otherwise not in accordance with law.”

1. Scope

The Secretary maintains that he must ask only whether a project, considered as a whole, is “likely to assist in promoting the objectives of” the Medicaid Act. Plaintiffs, meanwhile, lob multiple challenges at individual components of that project (such as the community-engagement requirement or the increased premiums). To the extent Plaintiffs mean to argue that none of those features is independently likely to further the Act’s objectives, such focus would be misplaced. While it may be relevant to the Secretary’s determination whether any given component is consistent with the Act’s objectives, he must ultimately determine whether, on balance, the project as a whole passes muster.

Although packaged inside the same application, Kentucky HEALTH was wholly distinct from other pieces of KY HEALTH, including, *inter alia*, the SUD program. As a refresher, the latter is available for all Medicaid beneficiaries, while the former applies only to adults without disabilities. Here, too, the Secretary effectively treated the SUD program and Kentucky HEALTH as two separate demonstration projects. Although he nominally referred to the latter as a program within the KY HEALTH demonstration, that label did not control. Instead, he evaluated independently whether Kentucky HEALTH would promote various objectives of the Act, including by “improv[ing] health outcomes, promot[ing] increased upward mobility and improved quality of life, increas[ing] individual engagement in health care decisions, and prepar[ing] individuals who transition to commercial health insurance coverage to be successful in this transition.” He then separately stated (1) which waivers were necessary “for the Kentucky HEALTH program” and (2) which were necessary for “the KY HEALTH demonstration as a whole.” This makes sense. When the Secretary concluded that the SUD program “was likely to promote the objectives” of the Act, he could not then piggyback other unrelated waivers onto that approval. Why not? Because he can issue only those waivers “necessary” to support the project. In this case, the Secretary determined that hardly any waivers were needed to make the SUD program run. This Court will thus treat, as the Secretary did, Kentucky HEALTH as a standalone demonstration project.

2. Arbitrary & Capricious Review

The scope of the challenge defined, the Court finally arrives at the crux of the parties’ argument: whether the Secretary acted arbitrarily or capriciously in concluding
that Kentucky HEALTH was “likely to assist in promoting the objectives” of the Medicaid Act. Under that deferential standard, the Court “is not empowered to substitute its judgment for that of the agency. Nor can it “presume even to comment upon the wisdom of [Kentucky’s] effort at Medicaid reform.” Still, it is a fundamental principle of administrative law that “agencies are required to engage in reasoned decisionmaking.” This means that an agency must “examine all relevant factors and record evidence.” At minimum, the agency “cannot entirely fail[ ] to consider an important aspect of the problem.”

With that framework in mind, Plaintiffs’ position is simple: “[T]he purpose of the [Medicaid Act] is to provide coverage and care to the most vulnerable” and, more precisely, “to provide that care generally free of charge.” The Secretary, they believe, “failed to consider adequately” the impact of Kentucky HEALTH on Medicaid coverage. Indeed, he “entirely failed to consider” Kentucky’s estimate that 95,000 persons would leave its Medicaid rolls during the 5–year project.

Plaintiffs are correct. To explain why, the Court begins with the basic “objectives” of Medicaid before turning to the Secretary’s approval in this case. It then considers—and rejects—each of Defendants’ counterarguments.

a. The Objectives of Medicaid

Before the Secretary can approve an “experimental, pilot, or demonstration” project, he must first identify the objectives of the Medicaid program. After all, he could hardly hold that Kentucky HEALTH was “likely to assist in promoting the objectives” of the Act without identifying any objectives in the first place. The Court assumes, as the Secretary maintains, that he should receive deference in interpreting the Act’s “objectives” under this section. Ordinarily, courts review an agency’s statutory interpretations using the familiar two-step Chevron framework. That inquiry calls for examining whether “Congress has directly spoken to the precise question at issue,” and, if not, whether “the agency’s answer is based on a permissible construction of the statute.” Chevron, U.S.A. Inc. v. Nat’l Res. Def. Council, Inc., 467 U.S. 837 (1984).

While the “objectives” of Section 1115 may be ambiguous, courts have traditionally looked to 42 U.S.C. §1396–1, which provides standing appropriation authority for federal support of “State plans for medical assistance,” to discern those objectives. The parties, too, agree that § 1396–1 provides at least the starting point to ascertain the “objectives” of Medicaid. That provision explains that Congress appropriated Medicaid funds

[f]or the purpose of enabling each State, as far as practicable under the conditions in such State, to furnish (1) medical assistance . . . [to] individuals[ ] whose income and resources are insufficient to meet the costs of necessary medical services, and (2) rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.
By its terms, the statute thus identifies two related objectives: allowing states, “as far as practicable,” to “furnish (1) medical assistance” and (2) “rehabilitation and other services” designed to “help individuals retain a capacity for independence.”

So what does “furnish[ing] . . . medical assistance” mean? The Medicaid statute “defines ‘medical assistance’ as ‘payment of part or all of the cost’ of medical ‘care and services’ for a defined set of individuals.” Plugging that definition into the statute, Congress evinced a clear interest in “enabling each State, as far as practicable,” to provide “payment of part or all of the cost of medical care and services.” In other words, “[t]he Medicaid program was created . . . for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons.” *Harris v. McRae*, 448 U.S. 297, 301, 100 (1980).

In 2010, Congress expanded the Medicaid program to provide medical assistance for a new population: low-income adults under 65 who would not otherwise qualify. As the name implies, the Affordable Care Act was designed to provide “quality, affordable health care for all Americans,” including by expanding the “role of public programs”—like Medicaid—in achieving that goal. Under the ACA, states can choose to expand their Medicaid coverage to include this new, low-income group. Should a state choose to do so, those individuals become part of its mandatory population.

Through the ACA, Congress made Medicaid an “element of a comprehensive national plan to provide universal health insurance coverage.” *NFIB*. As amended, one objective of Medicaid thus became “furnishing . . . medical assistance” for this new group of low-income individuals.

*b. The Secretary’s Consideration of Medicaid’s Objectives*

The Secretary agrees that *Section 1396–1* identifies at least “one purpose of Medicaid.” He also agrees that it is “obviously . . . a purpose to provide medical assistance to the expansion population” as well. That objective should therefore be a “salient factor” in his analysis.

The fundamental failure here, however, is that he ignored that objective in evaluating Kentucky HEALTH. Instead, by his own description, the Secretary examined only the following factors in his consideration of KY HEALTH generally: (1) “whether the demonstration was likely to assist in improving health outcomes”; (2) “whether it would address behavioral and social factors that influence health outcomes”; (3) “whether it would incentivize beneficiaries to engage in their own health care and achieve better health outcomes”; and (4) “whether it would familiarize beneficiaries with a benefit design that is typical of what they may encounter in the commercial market and thereby facilitate smoother beneficiary transition to commercial coverage.” When it came to Kentucky HEALTH specifically, the Secretary maintained the same focus.
While those may all be worthy goals, there was a notable omission from the list: whether Kentucky HEALTH (or, indeed, KY HEALTH) would help provide health coverage for Medicaid beneficiaries. That is, would Kentucky HEALTH help or hurt states in “funding . . . medical services for the needy”? By his own description, the Secretary “entirely failed to consider” that question. At minimum, the Secretary failed to “adequately analyze” coverage. There are two basic elements to that problem: First, whether the project would cause recipients to lose coverage. Second, whether the project would help promote coverage. The Secretary, however, neglected both.

i. Risk to coverage

The Secretary never provided a bottom-line estimate of how many people would lose Medicaid with Kentucky HEALTH in place. This oversight is glaring, especially given that the risk of lost coverage was factually substantiated in the record. In its application, Kentucky estimated that the project would cause more than 95,000 people to leave its Medicaid rolls by the fifth year. Amici maintain that such number is conservative and peg the real figure as between 175,000 and 297,500. See Amicus Br. of Deans Chairs & Scholars.

Commenters, too, put the Secretary on notice that the Act might well reduce health coverage for low-income individuals. As required, HHS provided a 30–day public notice-and-comment period regarding the proposed program. The vast majority of those comments voiced concerns that Kentucky HEALTH would significantly reduce low-income people’s participation in health coverage programs. Citing extensive research, including from past Medicaid demonstrations, commenters explained how each provision of Kentucky HEALTH—namely, the (1) community-engagement requirement, (2) increased premiums, (3) cost sharing for non-emergency use of emergency rooms, (4) suspension of retroactive eligibility, (5) reporting requirements, (6) lockouts—would likely reduce healthcare access and utilization. To top it off, numerous comments also suggested that these new administrative requirements would increase “clerical and tracking errors and delays,” which in turn would “cause inadvertent terminations.”

While the Secretary was not required to address each comment in writing, he concedes that he needed to at least “consider[]” those objections. Yet in the face of those warnings, “the record contains a rather stunning lack” of discussion about the effect of Kentucky HEALTH on health coverage. *Beno, 30 F.3d at 1074*. For starters, the Secretary never once mentions the estimated 95,000 people who would lose coverage, which gives the Court little reason to think that he seriously grappled with the bottom-line impact on healthcare. Nor did he “request . . . additional information related to the project’s impact on recipients” or offer “any information refuting plaintiffs’ substantial documentary evidence” that the action would reduce healthcare coverage.

Instead, the Secretary noted commenters’ concerns that the work requirement “would create significant barriers to access for vulnerable individuals who are not able to work or otherwise meet the requirements.” To address their objections, the Secretary cited Kentucky HEALTH’s “important protections for vulnerable individuals,” such as
exempting those who cannot work “due to a disability” or are “medically frail” from the community-engagement requirement. He also notes that the state had added flexible “on-ramps,” allowing those who lose coverage to regain it after meeting certain conditions. During the litigation, too, he stresses that these “guardrails” show that the Secretary considered coverage concerns “in substance.”

That response, however, is no answer at all. In its original application, Kentucky already exempted “vulnerable individuals,” such as those deemed medically frail, pregnant women, and children, from many of its project’s requirements. Likewise, the state included the same “on ramps” in its initial waiver application (Allowing early re-entry for persons who (1) pay past debt; (2) pay a premium for reinstatement month; and (3) participate in financial or health literacy). Even with those reforms baked in, Kentucky estimated that 95,000 people would lose coverage. The commenters, too, expressed their concerns about coverage losses with those features in mind.

Although Kentucky’s initial project may have thus included adequate protections for “vulnerable” individuals, this was not enough for the Secretary to rubber-stamp it. Rather, as the Secretary admits, it is “obviously . . . a purpose to provide medical assistance to the expansion population” as well, a group broader than the vulnerable classes identified in Kentucky HEALTH. As explained in more detail below, the Secretary therefore cannot limit his review to only “vulnerable individuals,” such as persons with disabilities and the medically frail. He must consider coverage to all groups enrolled in the project. Here, that included grappling with the fact that 95,000 people would lose Medicaid coverage, even with those “guardrails” in place.

Beyond those features, the Secretary cites only one other “guardrail” against coverage loss: a “good cause” exemption. In an early exchange between him and Kentucky, the state agreed to “provide good cause exceptions to the lockout for failure to pay premiums that would allow beneficiaries to re-enroll under certain conditions without completion of early re-entry requirements or waiting.” The Secretary’s final Special Terms and Conditions exempted from lockouts persons who were hospitalized, incapacitated, or disabled or whose immediate family members had died or become disabled. There were also exceptions for people who were evicted or became homeless, were victims of natural disasters, had gained and lost private insurance, or were victims of domestic violence. Those narrow changes, however, do not establish that the Secretary “adequately analyzed” coverage loss. He never revised Kentucky’s estimate on coverage loss with these reforms in mind. Rather, he granted the waivers with no idea of how many people might lose Medicaid coverage and thus failed to consider an important aspect of the problem.

Left with little else, the Secretary now argues that perhaps the 95,000 individuals would not lose coverage after all; instead, maybe they will simply transition to “employer-sponsored and commercial coverage.” It made no such finding below, however. While the agency spoke generally of “creating incentives for individuals to obtain and maintain coverage through private, employer-sponsored insurance,” it cited no research or evidence that this would happen, nor did it make concrete estimates of how
many beneficiaries might make that transition. And, of course, it is not obvious that the community-engagement requirement alone would help a person shift to private insurance. As the Secretary stresses, this is not a work requirement; individuals can meet it, for example, by volunteering in the community. While those unpaid activities may have long-term benefits, he never discussed how they will promote a “transition from Medicaid to commercial coverage.”

The Court thus cannot credit the Secretary’s speculations now. “[T]he mere fact that there is some rational basis within the knowledge and experience” of the agency, under which [it] might have justified its conclusion, will not suffice to validate agency decisionmaking.” Rather, “an agency’s action must be upheld, if at all, on the basis articulated by the agency itself. There was no discussion of coverage loss here.

ii. Promote coverage

At the same time, the Secretary identified only one element of Kentucky HEALTH that might promote health coverage. In a single sentence, he noted that “[t]he approval of the waiver of retroactive eligibility encourages beneficiaries to obtain and maintain health coverage, even when healthy.” This sort of “conclusory” reference cannot suffice, “especially when viewed in light of” an obvious counterargument. As is documented in the comments, restricting retroactive eligibility will, by definition, reduce coverage for those not currently on Medicaid rolls.

When asked at oral argument how Kentucky HEALTH would otherwise furnish medical assistance, the Secretary cited one last feature: the SUD program. True, that program would cover all Medicaid beneficiaries’ access to “residential treatment, crisis stabilization and withdrawal management services.” As explained above, however, it could operate regardless of Kentucky HEALTH, so the Secretary cannot cite it as a justification for approving the latter project. In any event, even had the Secretary considered KY HEALTH as a whole, he would have still needed to ask whether that project promote[d] the objectives of Medicaid assistance on balance. Yet the Secretary made no such finding here. He did not, for instance, suggest that providing SUD treatment might justify (much less require) the loss of Medicaid coverage for up to 95,000 individuals; those people, of course, will not be able to take advantage of SUD treatment. Nor did he grapple with the fact that, by the state’s estimate, roughly 80% of the expansion population did not suffer from a substance-use disorder.

* * *

At bottom, the record shows that 95,000 people would lose Medicaid coverage, and yet the Secretary paid no attention to that deprivation. Nor did he address how Kentucky HEALTH would otherwise help “furnish . . . medical assistance.” In other words, he glossed over “the impact of the state’s project” on the individuals whom Medicaid “was enacted to protect.” Beno, 30 F.3d at 1070. By doing so, he “failed to consider adequately” a salient purpose of Medicaid and, thus, an important aspect of the problem.
c. Defendants’ Counterarguments

If the Secretary did not consider the impact of Kentucky HEALTH on health coverage, what did he consider instead? Principally, three things: (1) “health and well-being”; (2) cost considerations, including “focus[ing]” the state’s resources on “traditional” populations; and (3) “self-sufficiency” and “lessen[ing]” dependence on government assistance.” The Secretary argues that he could properly focus on those three alternative criteria in approving the Act. None of those factors, however, can justify ignoring whether the project would “furnish . . . medical assistance.” To explain why, the Court discusses each in turn.

i. Health and Public Well–Being

In defending his approval, the Secretary first tries to move the target: “the objective of the Medicaid Act in the end,” he says, is really “to promote the health of Medicaid beneficiaries.” In such a case, the agency would not need to consider whether Kentucky HEALTH helped furnish medical assistance, so long as it made beneficiaries healthier on the whole. To that end, the Secretary spent much time claiming that Kentucky HEALTH would “improve health and wellness” for low-income individuals. He noted, for example, that the community-engagement requirement will “promote Medicaid’s objective of improving beneficiary health.” Likewise, he justified the premium requirements, deductibles, and limited enrollment windows as necessary “to ensure continuity of care, which is important for improving health outcomes.”

The Secretary’s SMD letter evinced the same belief that “work [would] promote health and well-being.” In its application, Kentucky, too, cited the “cornerstone” of its project as “employment initiative[s] aimed at increasing workforce participation rates in Kentucky,” which it promised was “critical to improving the health status of Kentuckians.” While Plaintiffs and their amici assert that these proclaimed health benefits are unsupported by substantial evidence, the Secretary’s analysis, instead, fails for a more basic reason: it is little more than a sleight of hand. At each step, the Secretary impermissibly conflated “improv[ing] health and wellness,” with the Medicaid Act’s more specific stated purpose of “furnish[ing] . . . medical assistance” and “rehabilitative and other services.” Put another way, this focus on health is no substitute for considering Medicaid’s central concern: covering health costs. While improving public health and health outcomes might be one consequence of “furnishing . . . medical assistance,” the Secretary cannot choose his own means to that end. To the extent Congress sought to “promote health” and “well-being” here, it chose a specific method: covering the costs of medical services.

More fundamentally, promoting health is not the only reason Congress wanted to provide health insurance to needy populations. It also had an interest in making healthcare more affordable for such people. Had Congress maintained a singular focus on promoting health, it easily could have said as much, but the text and structure of Medicaid shows its desire to provide health coverage to those groups. To be more
concrete, imagine two Kentuckians, Joe and Dan. Both are diagnosed with Hodgkin’s Lymphoma. Joe has health insurance and is able to receive treatment for a co-pay of $100. Dan has no health insurance. He, too, is able to receive treatment, but he must pay out of pocket for the treatment costing tens of thousands of dollars. To do this, he and his wife must sell the family ranch, which had been in Dan’s family for over four generations. After 18 months, both Joe and Dan are cancer free; in other words, they are equally healthy. But Dan, unlike Joe, is in financial ruin.

Dan’s story, as it happens, is not so hypothetical. Instead, in its hearings leading up to the passage of the ACA, the Senate heard similar testimony about Dan DeLong, a rancher from Montana who lost his farm to pay medical bills. See U.S. Senate Committee on Health, Education, Labor & Pensions, Full Committee Hearing (June 11, 2009) (Statement of Dennis Rivera). During the same committee hearing, Senator and Committee Chairman Chris Dodd spoke about one of his constituents, “a cancer survivor,” who paid “as much for her healthcare as she does for the mortgage on her home.” More generally, witnesses testified that “[o]ver 60 percent of bankruptcies filed in 2007 were largely attributable to medical expenses.”

Although the Court “need not rely on legislative history given the text’s clarity,” that history only supports what the Act’s text and structure already made clear: the Senate was concerned with more than making America healthier when it expanded Medicaid; it also sought to reduce the costs of healthcare for American families. To hold otherwise would have bizarre results. To borrow from the Supreme Court’s “broccoli horrible” example, *NFIB, 567 U.S. at 615* imagine that the Secretary could exercise his waiver authority solely to promote health, rather than cover healthcare costs. Nothing could stop him from conditioning Medicaid coverage on consuming more broccoli (at least on an experimental basis). Or, as Plaintiffs suggest, he might force all recipients to enroll in pilates classes or take certain nutritional supplements. The penalty for non-compliance? No more Medicaid. Either of those conditions could promote “health” or “well-being” (perhaps in a more straightforward way than “community engagement” would), but both are far afield of the basic purpose of Medicaid: reimburs[ing] certain costs of medical treatment for needy persons.

Finally, the Secretary fell back during oral argument on *Chevron* deference. To the extent he means to offer his own alternative interpretation of “medical assistance,” as defined in Section 1396–1, *Chevron* deference cannot save him. That doctrine “come[s] into play’ only when [a court] must resolve statutory ambiguity.” The Secretary’s interpretation here runs counter to the statute’s plain text, its structure, and its legislative history, and would thus fail at *Chevron* step 1. To the extent the Secretary means that he should receive deference in interpreting the “objectives” of Medicaid under Section 1115 more generally, the Court assumes he is correct. While that term may be ambiguous, the Secretary’s interpretation of it cannot “fall[ ] outside the bounds of reasonableness” at *Chevron*’s second step. Remember, the Secretary agrees that Section 1396–1 outlines at least some of the Act’s objectives. In light of that provision’s clear emphasis on promoting “medical . . . assistance,” the Secretary could not reasonably focus on “health”
and “well-being” instead. The agency needed to at least consider the project’s effect on healthcare coverage.

ii. Cost considerations

At times, the Secretary did make conclusory assurances that Kentucky HEALTH “endeavor[s] to maintain coverage,” or “ensures that resources are preserved for individuals who meet eligibility requirements.” Of course, such fleeting references mean little in the face of Kentucky’s estimates that 95,000 people would lose coverage. How did the Secretary nevertheless “endeavor[ ] to maintain coverage”? His limited analysis is difficult to parse, but the Court assumes he might have meant either that (1) Kentucky could prioritize “its finite resources on the traditional populations,” as opposed to the low-income group added by the ACA, see Reply at 13 (emphasis added); or (2) Kentucky HEALTH was needed “to maintain access for [all] currently enrolled populations.” Neither appeal to cost considerations, however, can excuse his failure to consider coverage losses here.

(a) Traditional Populations

The Secretary at times suggests that he prioritized coverage for “traditional” Medicaid populations. Even accepting that argument on its own terms, however, it would hardly justify his actions here. While Kentucky HEALTH largely affects the expansion group, it would impact some “traditional” recipients as well, noting that 20% of enrollees in Kentucky HEALTH would be part of the non-expansion group. All told, Kentucky estimated that nearly 19,765 adults from the “non-expansion” group would also leave its Medicaid rolls.

In any event, the Secretary’s focus on “traditional” Medicaid populations was misplaced. Whatever the “traditional” purpose of Medicaid, the program was amended by the Affordable Care Act. As the Supreme Court held, the “Medicaid expansion” under that Act was “a shift in kind, not merely degree.” While “the original program was designed to cover medical services for four particular categories of the needy: the disabled, the blind, the elderly, and needy families with dependent children,” the ACA “transformed” Medicaid “into a program to meet the health care needs of the entire nonelderly population with income below 133 percent of the poverty level.” It did so as part “of a comprehensive national plan to provide health insurance coverage.”

The Secretary cannot ignore that overarching purpose or turn a blind eye to Congress’s efforts to “furnish[ ] . . . medical assistance” to this group. In suggesting otherwise, he highlights that Section 1396–1 speaks specifically to furnishing “medical assistance on behalf of families with dependent children and of aged, blind, or disabled individuals.” That, he believes, allows him to limit his focus to (or at least give preference to) those “traditional” groups. The upshot of this interpretation is that Congress has no interest at all in furnishing medical assistance “to the expansion population.”
At oral argument, the Secretary wisely backtracked from that position, conceding that it is “obviously . . . a purpose [of Medicaid] to provide medical assistance to the expansion population.” For good reason. While at first blush, Section 1396–1 might indeed seem to limit the Act’s purposes to the listed categories, the meaning—or ambiguity—of certain words or phrases may only become evident when placed in context. Here, the Medicaid statute—taken as a whole—confirms that Congress intended to provide medical assistance to the expansion population. The ACA amended Section 1396a(a)(10)’s mandatory population to include all individuals whose income fell below prescribed levels. In so doing, it placed this group on equal footing with other “vulnerable” populations, requiring that states afford them “full benefits.” Under this regime, states must provide “medical assistance for all services covered under the State plan under this subchapter that is not less in amount, duration, or scope, or is determined by the Secretary to be substantially equivalent, to the medical assistance available for [other individuals]” covered under the Act. Regardless of whether the Secretary can ultimately waive that requirement, he must start with the presumption that the expansion group is on par with other protected populations.

To be sure, Congress might have made its objectives all the more express by amending Section 1396–1 directly. The Supreme Court has not hesitated to highlight, however, that “[t]he Affordable Care Act contains more than a few examples of inartful drafting.” King v. Burwell, — U.S. —, 135 S.Ct. 2480, (2015). This Court must nevertheless “do [its] best, bearing in mind the fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme. And this omission, while perhaps ill-guided, is not particularly glaring. Over time, Congress has amended Section 1396a(a)(10)(A)(i) to expand medical assistance to low-income pregnant women, emancipated children, and former foster youth. None of those groups is mentioned in Section 1396–1, yet it is inconceivable that Congress intended to establish separate Medicaid programs, with differing purposes, for each.

As explained above, the Court will afford the Secretary deference in interpreting the “objectives” of Medicaid. His interpretation, however, cannot fall outside the bounds of reasonableness. To the extent he concluded that the Act’s objectives do not include “furnish[ing] . . . medical assistance” to the expansion group, his interpretation would be “utterly unreasonable” in light of Medicaid’s text, structure, and legislative history. He must thus evaluate the effect of Kentucky HEALTH on all Medicaid recipients, including low-income individuals, and he must do so without prioritizing certain groups over others. Here, that means the Secretary had an obligation to at least consider the 95,000 people who would lose Medicaid coverage, even if those people were largely members of the expansion group.

(b) Financial Collapse

Alternatively, the Secretary’s reference to “preserving” resources might mean that the Commonwealth “would be unable to maintain access for currently enrolled populations.” In such a case, Kentucky HEALTH’s cost-saving reforms would be
necessary to keep Kentucky’s entire Medicaid program afloat and thus preserve coverage for all recipients. It is an open question whether the Secretary could approve an “experimental, demonstration, or pilot project” on that basis. \textit{Beno, 30 F.3d at 1069}. The Ninth Circuit, for instance, has held that “[a] simple benefits cut, which might save money, but has no research or experimental goal, would not satisfy” Section 1115’s requirements.

Indeed, the Secretary disclaimed any such intent during oral argument, instead framing the cost savings as a “happy side effect” of the project. He could hardly argue otherwise, as the record lacks substantial evidence that Kentucky’s Medicaid program was in danger of collapse. First, the record shows that CMS, or at least Kentucky, may have misunderstood the projected cost savings. Both Defendants repeatedly highlight that the program could save $2.2 billion. During argument, Kentucky’s counsel represented that the \textit{state} would save that amount even after federal reimbursement. He is mistaken. The Commonwealth’s own records show that while the total savings (state plus federal) would reach that figure, the state’s actual savings would be $331 million—not a trivial number, to be sure, but still significantly below that cited by the parties.

Second, Defendants made no effort to contextualize those savings. The Court is sympathetic to “the unique challenges the Commonwealth is facing,” including that “[a]most twenty percent of [its] residents live in poverty”; “nearly one-third of Kentuckians are on Medicaid”; its “workforce participation is . . . less than 60 percent”; and it “ranks third in the nation for drug related fatalities.” But basic questions remain to assess whether the state’s Medicaid program is actually at risk: What are Kentucky’s current state revenues? What is its budget generally? Is the state running a deficit?

Nor did Defendants explain why cuts to the \textit{expansion} population would be the best remedy for any budget woes. “While Congress pays 50 to 83 percent of the costs of covering individuals [traditionally] enrolled in Medicaid, the federal Government currently pays 94% of costs for the expansion group.” Even “once the expansion is fully implemented [in 2020,] Congress will pay 90 percent of the costs for newly eligible persons.” Such numbers raise the question: why target only the group receiving the most federal aid if the goal is simply to cut the budget? Without data on those points, the Secretary could not make a reasoned decision that Kentucky would truly be unable to maintain access for currently enrolled populations.

iii. Self-sufficiency

Finally, the Secretary flagged an interest in promoting “greater independence” and “reduc[ing] reliance on public assistance.” AR 4, 5. The Court has doubts whether such an objective is proper. The Secretary primarily cites \textit{Section 1396–1} in defense of that purpose, which appropriates money so that states can “furnish . . . rehabilitation and other services to help such families and individuals attain or retain capability for independence or self-care.” From there, he excises the language about “independence or self-care,” treating those as stand-alone objectives of the Act. The text, however, quite clearly limits its objectives to helping States furnish rehabilitation and other services that
might promote self-care and independence. It does not follow that limiting access to medical assistance would further the same end.

In any event, even accepting that argument, the Secretary never maintained that “self-sufficiency” is a substitute for considering healthcare (or even health). Instead, he suggests that even if the latter objective “would suffer by reason of the project’s operation,” he could properly approve Kentucky HEALTH so long as he concluded “that on balance the objectives considered together were likely to be advanced.” Whether the Secretary can make such tradeoffs, he must, at least, “balance” that objective with the statute’s others. Yet, as discussed above, the Secretary simply neglected the project’s effect on medical coverage. Given that oversight, the Court cannot hold he made a reasoned decision that the Act’s objectives considered together were likely to be advanced.

***

At the end of the day, even if the Secretary could properly consider other factors—such as health, cost, or self-sufficiency—his “failure to address” a “salient factor” in the Act—i.e., furnishing medical assistance—renders his approval arbitrary and capricious. That is not to say, of course, that the Secretary can never approve demonstration projects that might adversely affect Medicaid enrollment or reduce healthcare coverage. After all, the point of the waivers is to give states flexibility in running their Medicaid programs, and experimental projects may (at least inadvertently) adversely affect healthcare access. While there may be limits to how much loss is too much, the Court need not answer that question now. Rather, it holds today only that the Secretary must adequately consider the effect of any demonstration project on the State’s ability to help provide medical coverage. He never did so here.

3. Remedy

Such failure infected his entire approval. As previously explained, he evaluated whether Kentucky HEALTH, as a whole, was likely to promote the objectives of the Act, but he did so while neglecting the primary objective of the Medicaid program. When an agency exercises discretion using the wrong legal standard, its action cannot survive. The Court must therefore hold the approval of Kentucky HEALTH invalid in toto.

That leaves the question of remedy. When a court concludes that agency action is unlawful, the practice of the court is ordinarily to vacate the rule. That decision depends on the seriousness of the order’s deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change. Neither factor favors the Government. The D.C. Circuit recently affirmed that the “failure to address” an important aspect of the problem is a major shortcoming. Given that he neglected to consider one of Medicaid’s central objectives, the Court harbors “substantial doubt whether [he] chose correctly” in his approval. That makes vacatur appropriate. Nor would vacatur be particularly disruptive. This is not a case in which “[t]he egg has been scrambled and there is no apparent way to restore the status quo ante.” Rather,
Kentucky HEALTH has yet to take effect. Allowing it to do so during remand, on the other hand, could be exceptionally disruptive for Plaintiffs. Many of them suffer from various chronic conditions, such as diabetes, hypertension, and mental-health conditions; they thus fear even a temporary implementation of Kentucky HEALTH could cause serious harm. Defendants’ “best” argument against vacatur is that the Court should preserve “the substance abuse component of the waiver.” Defendants’ fears are unfounded. The Secretary’s decision to approve Kentucky HEALTH is severable from his approval of KY HEALTH as a whole.

IV. CONCLUSION

For the foregoing reasons, the Court will deny Defendants’ Motions for Summary Judgment. It will also grant Plaintiffs’ Motion for Summary Judgment via Count VIII, vacate the Secretary’s approval of Kentucky HEALTH, and remand to the agency.

* * *

Notes

1. Following remand, the agency opened a new public comment period and after 4 months reapproved the Kentucky proposal. Letter to Carol Steckel from Deputy Administrator Paul Mango (Nov, 20th 2018), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf (Accessed July 19, 2019). Other than being a lengthier approval letter than the first one because of the number of pages consumed by disputing the notion that there would be losses, nothing changed. Because it disputed the loss estimates, the agency once again did not consider the impact of the demonstration on medical assistance for the experimental population and the consequences of lost coverage. Plaintiffs sued again and won a second time; a plainly irritated court (the same judge heard both Kentucky cases and the Arkansas case) made clear that defendants didn’t do what the court instructed in a ruling that came as close to a “you’re wasting everyone’s time” as an opinion might come.

2. In the meantime, a second group of plaintiffs challenged Arkansas’ experiment, which actually had gone into effect in June 2018. Despite the balancing test used by the court in Stewart, the same judge had no problem vacating the Arkansas experiment, even though it was underway, given the balance of harms between having to halt an experiment and subjecting thousands to the loss of coverage, which is exactly what was happening. Gresham v Azar, 363 F. Supp.3d 165 (D.D.C. March 27, 2019). By January 2019, over 18,000 beneficiaries had lost coverage, a vivid real-time display of what the consequences of the experiment would be.

An independent evaluation—not undertaken by the government as required by law—published in the New England Journal of Medicine in June 2019 (the gold standard of health research journals) documented that 18,000 persons had lost coverage while also finding no gains in either employment or private health insurance coverage among the experimental population. Even more startling, researchers found that over 95 percent of
those losing coverage either were working the requisite amount of time or were exempt. Benjamin D. Sommers et al., Special Report: Medicaid Work Requirements: Results from the First Year in Arkansas, New Eng. J. Medicine (June 19, 2019), https://www.nejm.org/doi/full/10.1056/NEJMsr1901772 (Accessed July 19, 2019). Beneficiaries who actually met the state’s requirements but nonetheless lost coverage simply could not navigate the experiment’s online reporting system that, in addition to being inaccessible for anyone without internet access (very common for impoverished people living in very isolated communities), also for some inexplicable reason went offline after 9 P.M., so even if someone finished a job shift and was able to use the internet before going home, she would be out of luck. How hard do you think it would have been for the state to have found a way to make it easier for beneficiaries to show that they were complying with the state’s work requirements?

As noted, New Hampshire’s approval is also in litigation, but things seem stalled for now because the state is unable to locate two in five beneficiaries to tell them about the new eligibility rules. Brief of Deans, Chairs, and Scholars as Amici Curiae in Support of Plaintiffs-Appellees, Stewart v. Azar (filed June 27, 2019).*

3. Pretext. In Department of Commerce v. New York, 139 S.Ct. 2551 (June 2019), the Court concluded that the Commerce Department’s effort to include a citizenship question on the census was unlawful because its rationale was “contrived”—the agency lied about why it was doing what it was doing, in other words. Do you think the same might be argued about the states’ efforts to impose a work requirement for Medicaid eligibility, their stated justifications, and the evidence on which those stated justifications rests? What exactly might you point to in attempting to build such an argument?

* * *

Chapter 23 Tax Exemption in the Modern Health Care System

Insert at textbook, p. 1053 after the last paragraph on the page:

Since publication of the textbook the Treasury Department and the IRS have issued numerous proposed rules and instructions to implement the new section 501(r), described in the textbook from pages 1052-53. To summarize, nearly every component listed in the carryover paragraph in the textbook has been hotly contested, including, for example: (1) in creating a community health needs assessment, what is the geographic area constituting a “community” and what is a community, i.e., who are its designated representatives; how does a health care system with numerous facilities define community or communities, over which it must develop a needs assessment; what means are necessary to publicize an implementation strategy; what constitutes the required reporting in the revised Schedule H to the Form 990; (2) what does financial assistance consist of and what criteria for eligibility are required; how and when is eligibility for

* Note that while Stewart and Gresham are both on appeal to the D.C. Circuit as of summer 2019, the parties and amici have filed separate briefs in the cases. The amicus briefs are identical in both cases.
financial assistance determined, particularly given how difficult it is for impoverished individuals to document their status—and likewise for hospitals to obtain necessary information—and that impoverished individual often fall inside or outside eligibility for, say, Medicaid and CHIP; how does a nonprofit hospital document and justify the billing to eligible patients, particularly given that hospital charges are a mystery to almost everyone; (3) what is the “amount generally billed to insured individuals,” particularly given that different rates are charged to different insurers, largely through negotiations between the hospital and a given insurer; and (4), of course, what constitutes “extraordinary collection actions”? See, e.g., Internal Revenue Bulletin: 2012-32, Notice of Proposed Rulemaking Additional Requirements for Charitable Hospitals (Aug. 6, 2012) (http://www.irs.gov/pub/irs-irbs/irb12-32.pdf); 2012 Instructions for Schedule H for (Form 990) (Jan. 24, 2013) (http://www.irs.gov/pub/irs-pdf/i990sh.pdf); Internal Revenue Bulletin: 2013-21, Notice of Proposed Rulemaking Community Health Needs Assessments for Charitable Hospitals (May 20, 2013) (http://www.irs.gov/pub/irs-irbs/irb13-21.pdf).

* * *

**Insert at textbook, p. 1055 at the end of the footnote on the page:**

Finally, as perhaps the final chapter of this saga—although Professor Colombo says that a state constitutional issue remains—the Illinois legislature passed, and the Governor signed, two bills which, importantly, overrule the Illinois Supreme Court’s definition of “charity,” which was limited to a count of the number of charity care patients served and the dollar amount of services they received. Instead, “charity” is defined much more broadly to include such services, among others, as outreach and education to underserved populations; support of doctors and affiliated institutions that serve such populations; and the provision of stand-by capacity—e.g., trauma, burn and neonatal units. One of the bills also defines the required discount for assistance to eligible uninsured patients. In short, the legislation moves Illinois from the category of states that use narrow outcomes measures to the ones described in the next paragraph (the first full paragraph on page 1055 of the textbook). See Illinois Solves Property Tax Exemption Issue Surrounding Nonprofit Hospitals, 21 Health Law Reporter (BNA) 852 (June 14, 2012).

* * *

**Insert at textbook, p. 1056 before heading #2:**

The Hilltop Institute’s Hospital Community Benefit Program, http://www.hilltopinstitute.org/hcbp.cfm (Accessed July 15, 2014), provides recent comprehensive information and analysis of state community benefit requirements.
Chapter 24 Health Care Fraud and Abuse

Substitute the following for United States ex rel. Mikes v. Straus and notes 1-3 of the following notes, pp. 1129-47:

Universal Health Services, Inc. v. United States ex rel. Escobar

Justice THOMAS delivered the opinion of the Court.

The False Claims Act, 31 U.S.C. § 3729 et seq., imposes significant penalties on those who defraud the Government. This case concerns a theory of False Claims Act liability commonly referred to as “implied false certification.” According to this theory, when a defendant submits a claim, it impliedly certifies compliance with all conditions of payment. But if that claim fails to disclose the defendant’s violation of a material statutory, regulatory, or contractual requirement, so the theory goes, the defendant has made a misrepresentation that renders the claim “false or fraudulent” under § 3729(a)(1)(A). This case requires us to consider this theory of liability and to clarify some of the circumstances in which the False Claims Act imposes liability.

We first hold that, at least in certain circumstances, the implied false certification theory can be a basis for liability. Specifically, liability can attach when the defendant submits a claim for payment that makes specific representations about the goods or services provided, but knowingly fails to disclose the defendant’s noncompliance with a statutory, regulatory, or contractual requirement. In these circumstances, liability may attach if the omission renders those representations misleading.

We further hold that False Claims Act liability for failing to disclose violations of legal requirements does not turn upon whether those requirements were expressly designated as conditions of payment. Defendants can be liable for violating requirements even if they were not expressly designated as conditions of payment. Conversely, even when a requirement is expressly designated a condition of payment, not every violation of such a requirement gives rise to liability. What matters is not the label the Government attaches to a requirement, but whether the defendant knowingly violated a requirement that the defendant knows is material to the Government’s payment decision.

A misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision in order to be actionable under the False Claims Act. We clarify below how that rigorous materiality requirement should be enforced.

Because the courts below interpreted § 3729(a)(1)(A) differently, we vacate the judgment and remand so that those courts may apply the approach set out in this opinion.
Enacted in 1863, the False Claims Act “was originally aimed principally at stopping the massive frauds perpetrated by large contractors during the Civil War.” “[A] series of sensational congressional investigations” prompted hearings where witnesses “painted a sordid picture of how the United States had been billed for nonexistent or worthless goods, charged exorbitant prices for goods delivered, and generally robbed in purchasing the necessities of war.” Congress responded by imposing civil and criminal liability for 10 types of fraud on the Government, subjecting violators to double damages, forfeiture, and up to five years’ imprisonment.

Since then, Congress has repeatedly amended the Act, but its focus remains on those who present or directly induce the submission of false or fraudulent claims. See 31 U.S.C. § 3729(a) (imposing civil liability on “any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval”). A “claim” now includes direct requests to the Government for payment as well as reimbursement requests made to the recipients of federal funds under federal benefits programs. See § 3729(b)(2)(A). The Act’s scienter requirement defines “knowing” and “knowingly” to mean that a person has “actual knowledge of the information,” “acts in deliberate ignorance of the truth or falsity of the information,” or “acts in reckless disregard of the truth or falsity of the information.” § 3729(b)(1)(A). And the Act defines “material” to mean “having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” § 3729(b)(4).

Congress also has increased the Act’s civil penalties so that liability is “essentially punitive in nature.” Defendants are subjected to treble damages plus civil penalties of up to $10,000 per false claim. § 3729(a); 28 CFR § 85.3(a)(9) (2015) (adjusting penalties for inflation).

The alleged False Claims Act violations here arose within the Medicaid program, a joint state-federal program in which healthcare providers serve poor or disabled patients and submit claims for government reimbursement. The facts recited in the complaint, which we take as true at this stage, are as follows. For five years, Yarushka Rivera, a teenage beneficiary of Massachusetts’ Medicaid program, received counseling services at Arbour Counseling Services, a satellite mental health facility in Lawrence, Massachusetts, owned and operated by a subsidiary of petitioner Universal Health Services. Beginning in 2004, when Yarushka started having behavioral problems, five medical professionals at Arbour intermittently treated her. In May 2009, Yarushka had an adverse reaction to a medication that a purported doctor at Arbour prescribed after diagnosing her with bipolar disorder. Her condition worsened; she suffered a seizure that required hospitalization. In October 2009, she suffered another seizure and died. She was 17 years old.
Thereafter, an Arbour counselor revealed to respondents Carmen Correa and Julio Escobar—Yarushka’s mother and stepfather—that few Arbour employees were actually licensed to provide mental health counseling and that supervision of them was minimal. Respondents discovered that, of the five professionals who had treated Yarushka, only one was properly licensed. The practitioner who diagnosed Yarushka as bipolar identified herself as a psychologist with a Ph. D., but failed to mention that her degree came from an unaccredited Internet college and that Massachusetts had rejected her application to be licensed as a psychologist. Likewise, the practitioner who prescribed medicine to Yarushka, and who was held out as a psychiatrist, was in fact a nurse who lacked authority to prescribe medications absent supervision. Rather than ensuring supervision of unlicensed staff, the clinic’s director helped to misrepresent the staff’s qualifications. And the problem went beyond those who treated Yarushka. Some 23 Arbour employees lacked licenses to provide mental health services, yet—despite regulatory requirements to the contrary—they counseled patients and prescribed drugs without supervision.

When submitting reimbursement claims, Arbour used payment codes corresponding to different services that its staff provided to Yarushka, such as “Individual Therapy” and “family therapy.” Staff members also misrepresented their qualifications and licensing status to the Federal Government to obtain individual National Provider Identification numbers, which are submitted in connection with Medicaid reimbursement claims and correspond to specific job titles. For instance, one Arbour staff member who treated Yarushka registered for a number associated with “‘Social Worker, Clinical,’” despite lacking the credentials and licensing required for social workers engaged in mental health counseling.

After researching Arbour’s operations, respondents filed complaints with various Massachusetts agencies. Massachusetts investigated and ultimately issued a report detailing Arbour’s violation of over a dozen Massachusetts Medicaid regulations governing the qualifications and supervision required for staff at mental health facilities. Arbour agreed to a remedial plan, and two Arbour employees also entered into consent agreements with Massachusetts.

In 2011, respondents filed a qui tam suit in federal court, alleging that Universal Health had violated the False Claims Act under an implied false certification theory of liability. The operative complaint asserts that Universal Health (acting through Arbour) submitted reimbursement claims that made representations about the specific services provided by specific types of professionals, but that failed to disclose serious violations of regulations pertaining to staff qualifications and licensing requirements for these services. Specifically, the Massachusetts Medicaid program requires satellite facilities to have specific types of clinicians on staff, delineates licensing requirements for particular positions (like psychiatrists, social workers, and nurses), and details supervision requirements for other staff. See 130 Code Mass. Regs. §§ 429.422–424, 429.439 (2014). Universal Health allegedly flouted these regulations because Arbour employed unqualified, unlicensed, and unsupervised staff. The Massachusetts Medicaid program, unaware of these deficiencies, paid the claims. Universal Health thus allegedly defrauded the program, which would not have reimbursed the claims had it known that it was billed
for mental health services that were performed by unlicensed and unsupervised staff. The United States declined to intervene.

The District Court granted Universal Health’s motion to dismiss the complaint. Circuit precedent had previously embraced the implied false certification theory of liability. But the District Court held that respondents had failed to state a claim under that theory because, with one exception not relevant here, none of the regulations that Arbour violated was a condition of payment.

The United States Court of Appeals for the First Circuit reversed in relevant part and remanded. The court observed that each time a billing party submits a claim, it “implicitly communicate[s] that it conformed to the relevant program requirements, such that it was entitled to payment.” To determine whether a claim is “false or fraudulent” based on such implicit communications, the court explained, it “asks simply whether the defendant, in submitting a claim for reimbursement, knowingly misrepresented compliance with a material precondition of payment.” In the court’s view, a statutory, regulatory, or contractual requirement can be a condition of payment either by expressly identifying itself as such or by implication. The court then held that Universal Health had violated Massachusetts Medicaid regulations that “clearly impose conditions of payment.” The court further held that the regulations themselves “constitute[d] dispositive evidence of materiality,” because they identified adequate supervision as an “express and absolute” condition of payment and “repeatedly reference[d] supervision.

We granted certiorari to resolve the disagreement among the Courts of Appeals over the validity and scope of the implied false certification theory of liability. The Seventh Circuit has rejected this theory, reasoning that only express (or affirmative) falsehoods can render a claim “false or fraudulent” under 31 U.S.C. § 3729(a)(1)(A). Other courts have accepted the theory, but limit its application to cases where defendants fail to disclose violations of expressly designated conditions of payment. Yet others hold that conditions of payment need not be expressly designated as such to be a basis for False Claims Act liability.

II

We first hold that the implied false certification theory can, at least in some circumstances, provide a basis for liability. By punishing defendants who submit “false or fraudulent claims,” the False Claims Act encompasses claims that make fraudulent misrepresentations, which include certain misleading omissions. When, as here, a defendant makes representations in submitting a claim but omits its violations of statutory, regulatory, or contractual requirements, those omissions can be a basis for liability if they render the defendant’s representations misleading with respect to the goods or services provided.

To reach this conclusion, “[w]e start, as always, with the language of the statute.” The False Claims Act imposes civil liability on “any person who . . . knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval.” §
3729(a)(1)(A). Congress did not define what makes a claim “false” or “fraudulent.” But “[i]t is a settled principle of interpretation that, absent other indication, Congress intends to incorporate the well-settled meaning of the common-law terms it uses.” And the term “fraudulent” is a paradigmatic example of a statutory term that incorporates the common-law meaning of fraud.2

Because common-law fraud has long encompassed certain misrepresentations by omission, “false or fraudulent claims” include more than just claims containing express falsehoods. The parties and the Government agree that misrepresentations by omission can give rise to liability.

The parties instead dispute whether submitting a claim without disclosing violations of statutory, regulatory, or contractual requirements constitutes such an actionable misrepresentation. Respondents and the Government invoke the common-law rule that, while nondisclosure alone ordinarily is not actionable, “[a] representation stating the truth so far as it goes but which the maker knows or believes to be materially misleading because of his failure to state additional or qualifying matter” is actionable. Restatement (Second) of Torts § 529, p. 62 (1976). They contend that every submission of a claim for payment implicitly represents that the claimant is legally entitled to payment, and that failing to disclose violations of material legal requirements renders the claim misleading. Universal Health, on the other hand, argues that submitting a claim involves no representations, and that a different common-law rule thus governs: nondisclosure of legal violations is not actionable absent a special “‘duty . . . to exercise reasonable care to disclose the matter in question,’” which it says is lacking in Government contracting. Brief for Petitioner 31 (quoting Restatement (Second) of Torts § 551(1), at 119).

We need not resolve whether all claims for payment implicitly represent that the billing party is legally entitled to payment. The claims in this case do more than merely demand payment. They fall squarely within the rule that half-truths—representations that state the truth only so far as it goes, while omitting critical qualifying information—can be actionable misrepresentations.3 A classic example of an actionable half-truth in contract law is the seller who reveals that there may be two new roads near a property he is selling, but fails to disclose that a third potential road might bisect the property. “The enumeration of two streets, described as unopened but projected, was a tacit representation that the land to be conveyed was subject to no others, and certainly subject to no others materially affecting the value of the purchase.” Likewise, an applicant for an

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2 The False Claims Act abrogates the common law in certain respects. For instance, the Act’s scienter requirement “require[s] no proof of specific intent to defraud.” 31 U.S.C. § 3729(b)(1)(B). But we presume that Congress retained all other elements of common-law fraud that are consistent with the statutory text because there are no textual indicia to the contrary.

3 This rule recurs throughout the common law. In tort law, for example, “if the defendant does speak, he must disclose enough to prevent his words from being misleading.” W. Keeton, D. Dobbs, R. Keeton, & D. Owen, Prosser and Keeton on Law of Torts § 106, p. 738 (5th ed. 1984). Contract law also embraces this principle. See, e.g., Restatement (Second) of Contracts § 161, Comment a, p. 432 (1979).
adjunct position at a local college makes an actionable misrepresentation when his resume lists prior jobs and then retirement, but fails to disclose that his “retirement” was a prison stint for perpetrating a $12 million bank fraud.

So too here, by submitting claims for payment using payment codes that corresponded to specific counseling services, Universal Health represented that it had provided individual therapy, family therapy, preventive medication counseling, and other types of treatment. Moreover, Arbour staff members allegedly made further representations in submitting Medicaid reimbursement claims by using National Provider Identification numbers corresponding to specific job titles. And these representations were clearly misleading in context. Anyone informed that a social worker at a Massachusetts mental health clinic provided a teenage patient with individual counseling services would probably—but wrongly—conclude that the clinic had complied with core Massachusetts Medicaid requirements (1) that a counselor “treating children [is] required to have specialized training and experience in children’s services,” 130 Code Mass. Regs. § 429.422, and also (2) that, at a minimum, the social worker possesses the prescribed qualifications for the job, § 429.424(C). By using payment and other codes that conveyed this information without disclosing Arbour’s many violations of basic staff and licensing requirements for mental health facilities, Universal Health’s claims constituted misrepresentations.

Accordingly, we hold that the implied certification theory can be a basis for liability, at least where two conditions are satisfied: first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant’s failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.

III

The second question presented is whether, as Universal Health urges, a defendant should face False Claims Act liability only if it fails to disclose the violation of a contractual, statutory, or regulatory provision that the Government expressly designated a condition of payment. We conclude that the Act does not impose this limit on liability. But we also conclude that not every undisclosed violation of an express condition of payment automatically triggers liability. Whether a provision is labeled a condition of payment is relevant to but not dispositive of the materiality inquiry.

A

Nothing in the text of the False Claims Act supports Universal Health’s proposed restriction. Section 3729(a)(1)(A) imposes liability on those who present “false or fraudulent claims” but does not limit such claims to misrepresentations about express conditions of payment. Nor does the common-law meaning of fraud tether liability to violating an express condition of payment. A statement that misleadingly omits critical
facts is a misrepresentation irrespective of whether the other party has expressly signaled the importance of the qualifying information.

The False Claims Act’s materiality requirement also does not support Universal Health. Under the Act, the misrepresentation must be material to the other party’s course of action. But, as discussed below, statutory, regulatory, and contractual requirements are not automatically material, even if they are labeled conditions of payment.

Nor does the Act’s scienter requirement, § 3729(b)(1)(A), support Universal Health’s position. A defendant can have “actual knowledge” that a condition is material without the Government expressly calling it a condition of payment. If the Government failed to specify that guns it orders must actually shoot, but the defendant knows that the Government routinely rescinds contracts if the guns do not shoot, the defendant has “actual knowledge.” Likewise, because a reasonable person would realize the imperative of a functioning firearm, a defendant’s failure to appreciate the materiality of that condition would amount to “deliberate ignorance” or “reckless disregard” of the “truth or falsity of the information” even if the Government did not spell this out.

Universal Health nonetheless contends that False Claims Act liability should be limited to undisclosed violations of expressly designated conditions of payment to provide defendants with fair notice and to cabin liability. But policy arguments cannot supersede the clear statutory text. In any event, Universal Health’s approach risks undercutting these policy goals. The Government might respond by designating every legal requirement an express condition of payment. But billing parties are often subject to thousands of complex statutory and regulatory provisions. Facing False Claims Act liability for violating any of them would hardly help would-be defendants anticipate and prioritize compliance obligations. And forcing the Government to expressly designate a provision as a condition of payment would create further arbitrariness. Under Universal Health’s view, misrepresenting compliance with a requirement that the Government expressly identified as a condition of payment could expose a defendant to liability. Yet, under this theory, misrepresenting compliance with a condition of eligibility to even participate in a federal program when submitting a claim would not.

Moreover, other parts of the False Claims Act allay Universal Health’s concerns. “[I]nstead of adopting a circumscribed view of what it means for a claim to be false or fraudulent,” concerns about fair notice and open-ended liability “can be effectively addressed through strict enforcement of the Act’s materiality and scienter requirements.” Those requirements are rigorous.

B

As noted, a misrepresentation about compliance with a statutory, regulatory, or contractual requirement must be material to the Government’s payment decision in order to be actionable under the False Claims Act. We now clarify how that materiality requirement should be enforced.
Section 3729(b)(4) defines materiality using language that we have employed to define materiality in other federal fraud statutes: “[T]he term ‘material’ means having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” This materiality requirement descends from “common-law antecedents.” Indeed, “the common law could not have conceived of ‘fraud’ without proof of materiality.”

We need not decide whether § 3729(a)(1)(A)’s materiality requirement is governed by § 3729(b)(4) or derived directly from the common law. Under any understanding of the concept, materiality “look[s] to the effect on the likely or actual behavior of the recipient of the alleged misrepresentation.” 26 R. Lord, Williston on Contracts § 69:12, p. 549 (4th ed. 2003) (Williston). In tort law, for instance, a “matter is material” in only two circumstances: (1) “[i]f a reasonable man would attach importance to [it] in determining his choice of action in the transaction”; or (2) if the defendant knew or had reason to know that the recipient of the representation attaches importance to the specific matter “in determining his choice of action,” even though a reasonable person would not. Restatement (Second) of Torts § 538, at 80. Materiality in contract law is substantially similar. See Restatement (Second) of Contracts § 162(2), and Comment c, pp. 439, 441 (1979) (“[A] misrepresentation is material” only if it would “likely ... induce a reasonable person to manifest his assent,” or the defendant “knows that for some special reason [the representation] is likely to induce the particular recipient to manifest his assent” to the transaction).

The materiality standard is demanding. The False Claims Act is not “an all-purpose antifraud statute,” or a vehicle for punishing garden-variety breaches of contract or regulatory violations. A misrepresentation cannot be deemed material merely because the Government designates compliance with a particular statutory, regulatory, or contractual requirement as a condition of payment. Nor is it sufficient for a finding of materiality that the Government would have the option to decline to pay if it knew of the defendant’s noncompliance. Materiality, in addition, cannot be found where noncompliance is minor or insubstantial. See United States ex rel. Marcus v. Hess, 317 U.S. 537, 543, (1943) (contractors’ misrepresentation that they satisfied a non-collusive bidding requirement for federal program contracts violated the False Claims Act because “[t]he government’s money would never have been placed in the joint fund for payment to respondents had its agents known the bids were collusive”)[.]

In sum, when evaluating materiality under the False Claims Act, the Government’s decision to expressly identify a provision as a condition of payment is relevant, but not automatically dispositive. Likewise, proof of materiality can include, but is not necessarily limited to, evidence that the defendant knows that the Government consistently refuses to pay claims in the mine run of cases based on noncompliance with the particular statutory, regulatory, or contractual requirement. Conversely, if the Government pays a particular claim in full despite its actual knowledge that certain requirements were violated, that is very strong evidence that those requirements are not material. Or, if the Government regularly pays a particular type of claim in full despite
actual knowledge that certain requirements were violated, and has signaled no change in position, that is strong evidence that the requirements are not material.\textsuperscript{6}

These rules lead us to disagree with the Government’s and First Circuit’s view of materiality: that any statutory, regulatory, or contractual violation is material so long as the defendant knows that the Government would be entitled to refuse payment were it aware of the violation. See Brief for United States as Amicus Curiae 30; Tr. of Oral Arg. 43 (Government’s “test” for materiality “is whether the person knew that the government could lawfully withhold payment”). At oral argument, the United States explained the implications of its position: If the Government contracts for health services and adds a requirement that contractors buy American-made staplers, anyone who submits a claim for those services but fails to disclose its use of foreign staplers violates the False Claims Act. To the Government, liability would attach if the defendant’s use of foreign staplers would entitle the Government not to pay the claim in whole or part—irrespective of whether the Government routinely pays claims despite knowing that foreign staplers were used. Likewise, if the Government required contractors to aver their compliance with the entire U.S. Code and Code of Federal Regulations, then under this view, failing to mention noncompliance with any of those requirements would always be material. The False Claims Act does not adopt such an extraordinarily expansive view of liability.

* * *

Because both opinions below assessed respondents’ complaint based on interpretations of § 3729(a)(1)(A) that differ from ours, we vacate the First Circuit’s judgment and remand the case for reconsideration of whether respondents have sufficiently pleaded a False Claims Act violation. We emphasize, however, that the False Claims Act is not a means of imposing treble damages and other penalties for insignificant regulatory or contractual violations. This case centers on allegations of fraud, not medical malpractice. Respondents have alleged that Universal Health misrepresented its compliance with mental health facility requirements that are so central to the provision of mental health counseling that the Medicaid program would not have paid these claims had it known of these violations. Respondents may well have adequately pleaded a violation of § 3729(a)(1)(A). But we leave it to the courts below to resolve this in the first instance.

Notes

1. \textit{Isn’t the conduct in this case clearly fraud but is that the sole question?} Tally up the conduct alleged in this case: unlicensed personnel, or licensed professionals acting outside their scope of practice, provided individual therapy, family therapy, preventive

\textsuperscript{6} We reject Universal Health’s assertion that materiality is too fact intensive for courts to dismiss False Claims Act cases on a motion to dismiss or at summary judgment. The standard for materiality that we have outlined is a familiar and rigorous one. And False Claims Act plaintiffs must also plead their claims with plausibility and particularity under Federal Rules of Civil Procedure 8 and 9(b) by, for instance, pleading facts to support allegations of materiality.
medication counseling; inadequate supervision; crucial credentials like a Ph.D. were misrepresented; nurses held out as psychiatrists when medications were prescribed; misrepresentation of basic licensure and other qualifications when obtaining National Provider Identification numbers, which are granted to specific, licensed and credentialed professionals like clinical social workers. This behavior is clearly fraud. Indeed, the relevant state agencies found violations of over a dozen state Medicaid regulations.

But against whom is this fraud committed? Clearly fraud was committed against the teenager who died as a result of medication prescribed by a staff member who had no business prescribing at all, and fraud was committed against her mother and stepfather, who filed the FCA action. But did the plaintiffs sue on their own behalf? Given that they sued on behalf of Massachusetts, what fraud was allegedly committed against the state in the operation of its Medicaid program? What does that fraud consist of? Is it a violation of a regulation? Which one or ones? Why? What is the harm and what are the damages? Is it the loss of a young life? Is this about protecting fiscal integrity? Utilization? Quality? Does it matter that the defendant effectively put one over on the state by qualifying entities to participate in the Medicaid program that had no business being anywhere near patients? Should it matter that defendant’s eligibility for Medicaid essentially amounted to a scam and involved mental health services plagued by a serious shortage of qualified, participating providers?*

Consider also the multitude of causes of action and remedies that might deter this behavior or obtain compensation for the damage it caused. Conceivably some conduct was criminal. There was certainly malpractice. There were definitely administrative remedies that the state could have, and did, pursue; and potentially the federal government had remedies too. Is it appropriate to have so many remedies? If not, which one or ones should or should not exist? What are the considerations in answering these questions? Do the answers involve differing burdens of proof, institutional competence, federalism and separation of powers?

Complicated stuff, huh? Let’s start unpacking all of this.

2. When is a claim “false”? Because the cause of action was brought under the False Claims Act, we have to start with “falsity.” What is it that made claims submitted for payment “false”?

* About 17% of uninsured low income adults are estimated to have a serious mental illness, meaning that, particularly in Medicaid expansion states such as Massachusetts, there is enormous need for qualified providers who can manage mental and substance abuse conditions, particularly qualified psychiatrists and psychiatric drug prescribers. The shortage of such professionals is a matter of constant concern to state Medicaid agencies. GAO, Behavioral Health: Options for Low Income Adults to Receive Treatment in Selected States, GAO 15-449 (June, 2015), http://www.gao.gov/products/GAO-15-449 (Accessed July 18, 2016). In other words, no health care access problem poses bigger headaches for Medicaid programs than good quality mental health and addiction treatment, making basic representations about provider qualification all the more significant.
The case came to the Court to resolve a split in the circuits concerning the existence and nature of “implied certification” as the basis for asserting that claims are false. Implied certification is part of a framework that distinguishes between “factual falsity” and “legal falsity.” The former is easy: factually false claims are bills for those blind mules, goods not delivered or delivered but factually misrepresented. Legal falsity, by contrast, involves violation of some legal duty. More precisely, a claim is legally false when the claimant falsely certifies compliance with a legal obligation. Sometimes those certifications are express, e.g., the required claim form states, “I certify that I am properly licensed and qualified to provide the services listed above.” That’s easy, isn’t it? The forms either contain the certification or they don’t. Suppose the form also includes the following, “I certify that I employ only workers who have appropriately documented that they are entitled to reside and work in the United States.” Suppose that this certification is false. Could the plaintiffs in Escobar sue for relief for violations of such an express certification? How, then, do we distinguish express certifications that render a claim “false” and those that do not? We’ll return to this question below.

Other certification might be implied. Suppose the claim form states, “I certify that the items and services listed above were medically necessary and appropriate.” In Escobar, was the prescription written by a nurse, who was held out to be a psychiatrist, necessary? Appropriate? What is your ground for answering yes or no? What if a psychiatrist would have done the same thing? Would it make sense simply to have a bright-clear line, services provided by unlicensed persons or professionals acting outside their scope of license are never necessary and appropriate? Are courts competent to make such policy? Under the Constitution are courts the branch of government authorized to make these decisions? Are such decisions for the federal or state government or both? We address institutional competence, separation of powers and federalism below.

By the way, why did United Health Services fight so hard—supported by numerous amici, particularly providers—in arguing that implied certification should never be the basis for liability in an FCA action? Does recognition of implied certification as a cause of action expand or contract the possible realm of cases that relators might bring? The Supreme Court categorically resolved this controversy by holding that “at least in certain circumstances, the implied false certification theory can be a basis for liability.” Score one for potential relators and the specialized FCA plaintiffs bar. But what are those “certain circumstances”?

Let’s first set that question in doctrinal context by discussing United States ex rel. Mikes v. Straus, 274 F.3d 687 (2d Cir. 2001), cited by the Supreme Court as a leading case establishing implied certification as a basis for liability under the FCA. The relator, Patricia S. Mikes, was a board-certified pulmonologist hired by defendants when they decided to add pulmonology to their specialty practice that then included oncology and hematology. Part of the pulmonology practice was the testing of patients’ breathing functions by use of spirometry, which is the use of a machine to take measurements of certain pulmonary functions. Mikes claimed that the defendants ignored her requests that the machines be calibrated in accordance with guidelines established by the American
Thoracic Society (ATC). She claimed that the failure to follow those guidelines rendered all billing for spirometry false. (She was also fired for raising a stink, which is typical).

a. Express certification. Mikes’ express certification theory rested most heavily on a statement in the billing form, the HCFA-1500, which we’ve already seen in Krizek and which provided, “I certify that the services shown on this form were medically indicated and necessary for the health of the patient . . . .” Mikes claimed that this certification was rendered false by failure to follow the relevant standard of care provided by the ATC’s guidelines. The Second Circuit rejected this claim, finding that medical necessity relates to the “level” of care—i.e., its quantity—but not to its “quality.” This distinction raises a number of questions to be explored more fully in Part Three, which focuses on the fine line that separates coverage and quality of care in a managed care. But for now let’s discuss how the Second Circuit pushed together a number of issues.

(1) Exclusions from coverage. To support its distinction between quantity and quality, the court pointed to a number of cases holding that experimental treatments excluded from coverage cannot be medically necessary. As we have seen, certain categories of services, e.g., cosmetic services, are explicitly excluded from coverage. Attempts to bill for such services do not raise issues of utilization. The services may be medically indicated and they may be provided according to the relevant standard of care, but they are simply not part of Medicare or the relevant insurance plan. Hence, billing for such service is, in this context, the submission of a “false claim;” as long as the relevant scienter requirement is satisfied, there can be liability under the FCA. For example, suppose that a provider routinely bills for cosmetic surgery even though it knows that this is not a covered service. Such claims are “false.” In pointing to cases involving, for example, experimental care that is excluded from coverage, the Mikes court got the conclusion right, see, e.g., In re Cardiac Devices Qui Tam Litigation, 221 F.R.D. 318 (D. Conn. 2004) (court distinguished Mikes in case involving not breach of regulatory framework but billing violating terms of coverage that allegedly excluded cardiac devices that had yet to be approved by FDA and were provided in clinical trials), but its analysis needed to be more finely tuned.

(2) Services not medically indicated. On the facts in Mikes, the court’s distinction between quantity and quality worked because plaintiff made no claim that spirometry was not indicated for the patients to whom it was given, that it was not reasonable and necessary care for them. One could easily imagine instances of false claims based on this quantitative dimension. Suppose that plaintiff’s claim was that every patient who walked in the door was given spirometry regardless of whether there were any signs or history of respiratory difficulty. Spirometry is clearly not reasonable and necessary care for a patient who presents with just a serious limp. However, that was not plaintiff’s case. Rather, Mikes’ theory was that the manner in which the spirometry was performed was qualitatively deficient.

However, most often there is less to the quantity-quality distinction than meets the eye. Suppose a man has just been diagnosed with prostate cancer. Suppose the treatment options are watchful waiting—doing nothing but watching to see if the cancer
progresses—radiation, laser surgery, conventional surgery with a scalpel, etc. Which treatment is reasonable and necessary? Is this an issue of quantity or quality? Suppose that some medical centers have been performing laser surgery for a significant period of time, while others have just acquired the technology (because it is reimbursed in a lucrative manner, among other reasons). Is the decision that laser surgery at a particular center is “necessary” a quantitative or qualitative one? Suppose that this patient has laser surgery at a center that is just starting to offer the procedure; he is the first patient treated. A technician sets the device incorrectly so that the laser misses the malignancy entirely. Is this a quantitative or qualitative issue? Did the patient have “surgery” at all? Don’t quantity and quality blend together?

Krizek amply illustrates the difficulty. As summarized in vignette #5 in the beginning of the chapter, Dr. Krizek treated many severely ill patients, and part of the government’s FCA action was that he could have treated them differently than he did. Is the difference between an inpatient psychiatric stay and outpatient therapy sessions quantitative, qualitative or both? The district court dispatched the government’s allegations easily:

The government takes issue with Dr. Krizek’s method of treatment of his patients, arguing that some patients should have been discharged from the hospital sooner, and that others suffered from conditions which could not be ameliorated through psychotherapy sessions, or that the length of the psychotherapy sessions should have been abbreviated. The government’s expert witness’s opinions on this subject came from a cold review of Dr. Krizek’s notes for each patient. The government witness did not examine or interview any of the patients, or speak with any other doctors or nurses who had actually served these patients to learn whether the course of treatment prescribed by Dr. Krizek exceeded that which was medically necessary.

Dr. Krizek testified credibly and persuasively as to the basis for the course of treatment for each of the representative patients. The medical necessity of treating Dr. Krizek’s patients through psychotherapy and hospitalization was confirmed via the testimony of other defense witnesses. The Court credits Dr. Krizek’s testimony on this question as well as his interpretation of his own notes regarding the seriousness of each patient’s condition and the medical necessity for the procedures and length of hospital stay required. The Court finds that the government was unable to prove that Dr. Krizek rendered services that were medically unnecessary.

859 F. Supp. at 8.

As you read the notes below, consider whether the court should have entertained these claims at all, based on differences in professional judgment regarding course of treatment rather than instances of blatantly terrible care such that it was worthless. Additionally, the court in Mikes was quite adamant in its refusal to federalize medical
malpractices case. Are these issues properly addressed by the purported distinction used in *Mikes* between quantitative and qualitative dimensions of care or in some other fashion? Additionally, as we observed with regard to the upcoding claims in *Krizek* and equally applicable to quality-of-care FCA claims, see, e.g., Joan H. Krause, Medical Error as False Claim, 27 Am. J. Law & Med. 181, 191-92 (2001) [hereinafter “Krause, Medical Error as False Claim”], the issues addressed in the FCA cases are patterns or practices of conduct that might be categorized as submission of false claims; and we saw that complicated statistical analysis and benchmarks had to be applied to extrapolate a sample of cases across a much larger sample of allegedly false claims. How does one engage in such extrapolation when the issues involve courses of treatment represented by those claims? See, e.g., United States ex rel. Michaels v. Agape Senior Community, Inc., 2015 WL 390365 (D.S.C.) (in a case involving the medical necessity of services to nursing home patients, the court refused to allow statistical extrapolation from a sample because resolution of falsity requires a “highly fact-intensive inquiry involving medical testimony after a thorough review of the detailed medical chart of each individual patient”); United States ex rel. Wall v. Vista Hospice Care, 2016 WL 3449833 (N.D. Tex. June 20, 2016) (same).

b. **Implied certification.** The Court’s discussion in *Escobar*, particularly its reference to a portion of oral argument, amplifies very well the problem created by allowing implied certification to prove falsity. Health care providers are subject to a legion of regulations, contractual provisions, standards of care and other potential sources of legal obligations.

At oral argument, the United States explained the implications of its position: If the Government contracts for health services and adds a requirement that contractors buy American-made staplers, anyone who submits a claim for those services but fails to disclose its use of foreign staplers violates the False Claims Act. To the Government, liability would attach if the defendant’s use of foreign staplers would entitle the Government not to pay the claim in whole or part—irrespective of whether the Government routinely pays claims despite knowing that foreign staplers were used. Likewise, if the Government required contractors to aver their compliance with the entire U.S. Code and Code of Federal Regulations, then under this view, failing to mention noncompliance with any of those requirements would always be material. The False Claims Act does not adopt such an extraordinarily expansive view of liability.

As noted, one way to limit this “expansive view of liability” would be to reject the implied certification theory altogether. Short of that lower courts, like that in *Mikes*, struggled mightily to distinguish between “conditions of payment” and “conditions of eligibility,” and made this distinction outcome-determinative. The Supreme Court ruled that the distinction could not be outcome-determinative but retained the distinction as possibly relevant. In a moment we’ll question the latter judgment. For now, let’s examine whether the distinction itself is coherent.
The discussion concerning “legal” falsity should be familiar to you. A contract contains a description of the goods or services to be provided and other expressly stated obligations. The contract is executed in the context of background practices and legal rules. Courts make some of these contextual rules and practices an implied part of the contract, and some are excluded. In actions brought under the FCA the argument concerning the regulatory context is exactly parallel. The parties argue over what part of that context is a condition of performance by the government, i.e., a precondition to payment, and what part of that context is a condition of performance by the health care provider, part of its “legal” certification. Escobar, the Mikes court and others are surely correct that not every word in the Code of Federal Regulations is part of the bargain that leads to payment. The fact that a hospital fails, for example, to have the exact number of florescent lights, as stipulated somewhere in the regulatory regime under which it functions, does not render all its submitted claims “false,” but a claim submitted for an operation performed in the dark might render a bill for that surgery “false.”

The Mikes court struggles with this issue of regulatory inclusion or exclusion through use of very broad pronouncements, such as the one that none of the conditions of eligibility for participation in the Medicare program are conditions for reimbursement and therefore cannot be the basis of a false certification claim. Many courts follow this distinction. See, e.g., United States ex rel. Wilkins v. United Health Group, Inc., 2011 U.S. App. LEXIS 13322 (3rd Cir. 2011); United States ex rel. Conner v. Salina Regional Health Center, Inc., 543 F.3d 1211 (10th Cir. 2008). However, some conditions of eligibility are in fact preconditions to payment. As shown by the case in vignette #2 at the beginning of the chapter, for example, services performed without the appropriate license can be the basis of a false claim. The radiological reports prepared under the radiologist’s, Dr. Reddy’s, signature were worthless because no radiologist had viewed the images and prepared the reports, and the expertise and participation of a radiologist was necessary for the services to have any value at all. Compare, e.g., United States ex rel. Woodruff v. Hawaii Pacific Health, 560 F. Supp.2d 988 (D. Hawaii 2008), aff’d 2010 U.S. App. LEXIS 26769 (9th Cir. 2010) (unpublished opinion) (billings for procedures performed by nurse practitioners (NPs) were not false because the procedures were within scope of the NPs’ licensure although the procedures could have also been performed by physicians), with United States ex rel. Wright v. Cleo Wallace Centers, 132 F. Supp.2d 913 (D. Colo. 2000) (false claim properly pled because facility billed for swing-bed services without necessary state license to operate swing-beds). Appropriate licensure is a condition of participation and it is a condition of payment. The Mikes court similarly strained to rule that 42 U.S.C. §1320c-5(a)(2)’s requirement that services “will be of a quality which meets professionally recognized standards of health care” does not state a precondition of payment. Services are reimbursed when they are “reasonable and necessary,” and part of the definition of “reasonable and necessary” is that they meet professionally defined standards of care. The court’s conclusion in this regard is just flat wrong and stems from an overly broad, artificial separation of conditions of eligibility from conditions of reimbursement.
Indeed *Woodruff* shows how vacuous these distinctions between implied and express conditions—and between conditions of participation and conditions of payment—can be. In *Woodruff* plaintiffs claimed that defendant hospital failed to report on its cost reports that NPs performed certain procedures and that the NPs were allegedly acting outside their scope of license. In one decision the district court dismissed plaintiffs’ allegations that the hospital had made *legally* false claims. Following *Mikes*, it broadly ruled that neither the cost reports, nor the hospital’s participation agreement, nor state licensure law, conditioned payment on scope of licensure. See United States ex rel. Woodruff v. Hawaii Pacific Health, 2007 U.S. Dist. LEXIS 37059 (D. Hawaii 2007). In its subsequent decision the district court dismissed plaintiffs’ charge that the hospital made *factually* false claims. The court found that the hospital had not represented that physicians actually performed the services; and it found that the hospital’s billing was factually correct because the NPs acted within the scope of their licensure, i.e., reimbursement was properly paid given the scope of the NPs’ licensure. See *Woodruff*, 560 F. Supp.2d 988.

If the scope of NP licensure was outcome determinative—if reimbursement was conditioned on whether the nurse practitioners acted within the scope of their licenses—what possible difference does it make whether we call that linkage—materiality—“legal” or “factual”? Express and implied requirements are both part of a contract, and at least in the civil context it is senseless to split hairs about what requirements stem from “inside” the contract and which ones derive from the “outside,” i.e., what is “factually” required and what is “legally” required. In all this technical verbiage the courts and many scholars have lost the forest for the trees. Accord United States ex rel. Hutcheson v. Blackstone Medical, Inc., 2011 U.S. App. LEXIS 10972 (1st Cir. 2011) (refusing to apply distinctions between factually false and legally false, and express certification and implicit certification, because these categories “do more to obscure than clarify”); New York v. Amgen Inc., 2011 U.S. App. LEXIS 15036 (1st Cir. 2011) (same). In *Woodruff* the billing was not false because the NPs were legally authorized to perform the procedures and the hospital never represented that they were performed by anyone other than the NPs. That’s it, plain and simple. See also United States ex rel. Riley v. St. Luke’s Episcopal Hospital, 200 F. Supp.2d 673 (S.D. Tex. 2002) (false claims for service provided by foreign-licensed physician not licensed in Texas were dismissed because supervising physician signed for work and supervision arrangement was approved by Texas State Board of Medical Examiners), rev’d, 355 F.3d 370 (5th Cir. 2004) (claims improperly dismissed because fact of supervision was controverted).*

c. *Materiality and causation.* The Supreme Court clearly understood that implied certification should not be rejected in its entirety. As we have seen, the facts before it *screamed* of fraud and involved a program that could be seen as especially susceptible to precisely this type of fraud because of the serious problem of specialty Medicaid provider participation and the (unspoken) concern about pushing too hard on the provider qualification issue because of serious shortages. Yet, it also understood that the

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* Criminal prosecutions for false claims raise additional considerations and are not our focus in these materials.
distinction between conditions of payment and other sources of obligation is completely manipulable because everything and anything can be swept within a properly drafted express certification, and that some express certifications—such as the one posed above involving certification regarding documented workers—themselves should not render a claim false. Instead, the Court used materiality and scienter as the limiting standards. With regard to materiality, it wrote, “[W]e hold that the implied certification theory can be a basis for liability, at least where two conditions are satisfied: first, the claim does not merely request payment, but also makes specific representations about the goods or services provided; and second, the defendant’s failure to disclose noncompliance with material statutory, regulatory, or contractual requirements makes those representations misleading half-truths.” With regard to scienter (and materiality), in the context of denigrating the express-implied distinction, the Court stated:

A defendant can have “actual knowledge” that a condition is material without the Government expressly calling it a condition of payment. If the Government failed to specify that guns it orders must actually shoot, but the defendant knows that the Government routinely rescinds contracts if the guns do not shoot, the defendant has “actual knowledge.” Likewise, because a reasonable person would realize the imperative of a functioning firearm, a defendant’s failure to appreciate the materiality of that condition would amount to “deliberate ignorance” or “reckless disregard” of the “truth or falsity of the information” even if the Government did not spell this out.

As the Court’s example regarding firearms shows, at the extremes this scienter-materiality combo works. It does not take a rocket scientist to understand that something sold as a firearm better well shoot. Such materiality-scienter necessarily exists by virtue of the term “firearm”—indeed, we’re now in the realm of “factual falsity.” Likewise, it doesn’t take a genius to know that the following express certification is immaterial: “All claims must be submitted in 12-point font. Any claim submitted in a different font will be rejected. Compliance with this requirement is expressly made a condition of payment.” In all conceivable circumstances—at least those that your authors can come up with—submitting a bill in the wrong font does not render a claim false.

However, the proof of the pudding is in the eating of the middle (sorry!). Return to Mikes. The claim submitted states that “spirometry” was performed. Are there “specific representations about the goods and services provided”? We suppose that if what actually was done is that a surgeon removed the patient’s spleen, the “specific representations [that] the goods and services provided” were spirometry would preclude “splenectomy,” but notice that we’re back at factual falsity. The facts in Escobar were similarly factually false because the services of a nurse are not the services of a psychiatrist; nor is family therapy a session provided by someone who is not a family therapist, and so on. Doesn’t the term “spirometry” include a representation that the procedure actually does what spirometry is supposed to do, i.e., accurately measure certain pulmonary functions? And if the machine is improperly calibrated, can spirometry be accurate? Finally, wouldn’t the non-rocket-scientist-ordinary pulmonologist
understand that calibration is material to spirometry? Have we gotten anywhere with materiality? Does it clarify what legal obligations the breach of which renders a claim false?"

The statutory definition of materiality is that the breach of a legal duty has a “natural tendency to influence, or be capable of influencing, the payment or receipt of money or property.” 31 U.S.C. § 3729(b)(4). What does “natural tendency to influence, or be capable of influencing” payment actually mean? Courts seem to be managing the definition of materiality—or causation, which amounts to the same concept—by determining whether the connection between violation of some legal duty and payment is too tenuous. In some cases the connection between payment and breach of a legal obligation is obvious because the connection between the two is automatic—axiomatic in fact. All the cases finding that misreporting information about drug prices fall into this category because the amount to be paid for those drugs is automatically tied to the reported information. See, e.g., United States ex rel. Garbe v. Kmart Corp., 73 F. Supp. 3d 1002, 1029 (S.D. Ill. 2014), aff’d in relevant part, 2016 WL 3031099 (7th Cir.) (defendant’s misrepresentation of its usual and customary fees for cash sales increased defendant’s payments from Medicare Part D for the drugs it sold); In re Pharmaceutical Industry Average Wholesale Price Litigation, 582 F.3d 156 (1st Cir. 2009), cert. dismissed sub nom. AstraZeneca Pharmaceuticals v. Blue Cross Blue Shield of Massachusetts, 131 S.Ct. 60 (2010) (defendant’s misrepresentations of average wholesale prices caused payments for defendant’s drugs to be higher).

In other cases, the discretion of some actor in the causal chain seems often to render causation too tenuous. See, e.g., United States v. North American Health Care, 2015 WL 6871781 (N.D. Cal.) (the connection between payment and alleged manipulations of defendant’s Medicare Star Rating—Medicare’s primary quality indicator—through erroneous staffing reports and kickbacks to physicians, designed to affect the results of Medicare inspections by surveyors, was too tenuous because the scheme’s effect on surveyors’ decisions was unclear); United States ex rel. Swan v. Covenant Care, 279 F. Supp. 2d 1212 (E.D. Cal. 2002) (the connection between payment and alleged falsifications of patient records to hide understaffing was too tenuous because agencies have the discretion to choose among a number of enforcement tools, such as CMPs, denials of payment or exclusions, or the agencies could choose not to do anything at all and just pay). We’ve already seen that courts are very reluctant to wade into issues regarding quality because quality most often rests on complicated professional judgments, making the connection between payment and those (correct? incorrect?) judgments very unclear, thereby rendering violation of a legal duty, designed to affect those judgments,

* Medicaid managed care organizations submit claims for monthly capitation payments on behalf of its members. Is the test laid out by Justice Thomas met when the MCO fails to meet what any reasonable person would consider significant federal regulatory standards and/or state contractual requirements pertaining to its underlying qualifications? Given that the problem of Medicaid access essentially runs through Escobar as a sort of unspoken leitmotif, should every managed care organization now be on red alert that the failure to satisfy federal and state network adequacy requirements, expressed through rules or contracts—e.g., sufficient participating and available network primary care providers so that travel time for care for children and adults does not exceed 30 minutes—satisfies the materiality requirement?
On the other hand, in numerous cases intervening discretion seems not to matter. Most saliently, in cases brought to challenge pharmaceutical companies’ illegal marketing practices or their illegal marketing of off-label use of their products, a number of courts have allowed plaintiffs to proceed despite the fact that physicians prescribe drugs for all sorts of reasons that do not include the allegedly illegal conduct and would therefore render that conduct immaterial. See, e.g., United States ex rel. Bilotta v. Novartis Pharmaceuticals Corp., 50 F. Supp.3d 497 (S.D.N.Y. 2014) (detailed allegations of ten-year nationwide scheme to hold thousands of sham educational events to induce attending physicians to write more prescriptions were sufficient to allow inference that more prescriptions were written); United States ex rel. King v. Solvay S.A., 823 F. Supp.2d 472 (S.D. Tex. 2011) (detailed allegations of defendant’s scheme to target members of state Medicaid formulary committees were sufficient to allow inference that more off-label prescriptions were written). Sometimes these judgments just “seem right.” See, e.g., In re Neurontin Marketing and Sales Practices Litigation, 677 F. Supp.2d 479 (D. Mass. 2010); see also In re Neurontin Marketing and Sales Practices Litigation, 748 F. Supp.2d 34 (D. Mass. 2010) (off-label marketing was material to Kaiser’s decision to include Neurontin in its formulary—i.e., it caused prescriptions to be written—because Kaiser showed that it had exercised strict control over its formulary, actively reviewed the uses of Neurontin, made numerous requests for information from defendants, and gotten false or misleading information in return). But is that all there is to materiality? How do we judge what legal duty is just too tangential other than a court’s sense of things regarding the facts before it? Is the most that we can say is that we know it when we see it?

By contrast, the FCA’s scienter requirement is far more definitive. In Mikes the Second Circuit found summary judgment for defendants to be appropriate because their affidavits showed that they had followed the instruction manual and other documentation for the spirometers, had received training from the manufacturer’s sales technicians, had sent the machines out for periodic servicing and on occasion had sent them out for recalibration. For all defendants knew, the spirometer was properly calibrated and in investigating that issue, they did not act with reckless disregard or deliberate ignorance. The fact that defendants did not have the necessary state of mind rendered immaterial—see how scienter and materiality go hand in hand—the fact that they failed to follow the required appropriate standard of care (assuming that following the ATS guidelines was required). Suppose instead that Mikes had complained to defendants and they had done nothing in response, other than firing her? In Escobar was it relevant that the supervisor not only failed to do his or her job but actually helped misrepresent credentials and licensure? Put differently, in Mikes defendants had to know that an improperly calibrated spirometer does not do spirometry and if they had actual knowledge of, or acted recklessly or with deliberate ignorance with regard to, the fact of improper calibration,
then they misrepresented that spirometry was in fact performed—i.e., the ATS guidelines were material. Likewise, in Escobar the agents of United Health Services knew that the services billed to Massachusetts’ Medicaid program were not performed by qualified and properly licensed professional—i.e., they had actual knowledge that those services were billed but not performed—and therefore the regulations that required proper qualifications and licensure were material. But notice again, aren’t we back at factual falsity, or, put differently, that the services performed were worthless because they simply were not performed as described?

Two final observations before fully implementing that segue to the next note. First, as indicated above, the Court ruled that express and implied certification, along with conditions of payment versus conditions of eligibility, are relevant, just not outcome-determinative. Why should that be? Why are these distinctions relevant if, as the Court noted, contractual language is malleable such that any certification can be included and therefore rendered express, and any certification can be written expressly to be a condition of payment? Moreover, if materiality is to be judged objectively, as stipulated by an amendment to the FCA in 2009, see Fraud Enforcement and Recovery Act, Pub. L. No. 111-21, § 4(a), 123 Stat. 1617, 1621, then why should the existence or lack of a writing matter? Doesn’t materiality-scienter boil down to what reasonable expectations are implied by a specific designation that specific goods or services were provided? In Mikes wasn’t it true that proper calibration was material to the question whether “spirometry” was performed but that defendants acted properly in the manner in which they attempted to ensure that the spirometers were properly calibrated?

The second observation is that Justice Thomas was quite clear that the inquiry whether breach of a legal obligation is material must proceed on a fact-by-fact basis but may not have accurately portrayed the consequences of that treatment. Defendant raised the concern that materiality is too fact intensive to enable cases to be dismissed or resolved by summary judgement. Justice Thomas answered that this problem is addressed by Rule 8(b)’s requirement that materiality, as well as all other elements of an FCA cause of action—be pled with particularity, i.e., by sufficiently detailed allegations of fact. If the legal standard—materiality—is amorphous, then how does anyone—plaintiffs, defendants, courts—know what facts must be pled with particularity?

**Insert at textbook, p. 1151, first full paragraph, third sentence:**

Correct a typo by substituting for the word “narrowed” the phrase “effectively narrowed the public disclosure bar by broadening the definition of ‘original source.’” The sentence should therefore read:

Second, the PPACA effectively narrowed the public disclosure bar by broadening the definition of “original source” such that the individual need not have “direct and independent knowledge” but only “knowledge that is independent of and materially adds to the publicly disclosed allegations or transactions.”
Insert at textbook, p. 1192 before heading 4:

On April 17, 2013, the OIG “updated” its Self-Disclosure Protocol, see OIG, Notice, Updated, OIG’s Provider Self-Disclosure Protocol (http://oig.hhs.gov/compliance/self-disclosure-info/files/Provider-Self-Disclosure-Protocol.pdf)—the “SDP,” which is not to be confused with CMS’s self-disclosure protocol for Stark violations, the “self-referral disclosure protocol” (“SRDP”), as described in the textbook at pp. 1190-92). As stated in the textbook, in 2009 OIG announced that it would no longer take jurisdiction over self-reports of Stark violations, and the ACA mandated that CMS develop its own process for self-reporting of Stark violations. Although the two protocols are very similar, and given that a “self-referral” can violate both Stark and AKS, the question of which protocol to invoke—leaving aside the role of DOJ for the moment—is important. The OIG explains:

[T]he SDP is not available for disclosure of an arrangement that involves only liability under the physician self-referral law, section 1877 of the Act (the Stark Law), without accompanying potential liability under the AKS for the same arrangement. Disclosing parties must analyze each arrangement involving a physician to determine whether it raises potential liability under the AKS, the Stark Law, or both laws. Stark-only conduct should be disclosed to CMS through its Self-Referral Disclosure Protocol (SRDP). OIG reserves the right to determine whether an arrangement is appropriate for resolution in the SDP.

Notice, April 17, 2013, at 4. By contrast, conduct that also potentially violates AKS too, should be reported to the OIG.

Now, add to the mix reporting to DOJ, which, you will recall (textbook at pp. 1116-29, 1148-50), has both civil and criminal jurisdiction over violations of the FCA. Regarding civil matters, the OIG has stated:

OIG will coordinate with the Department of Justice (DOJ) on in [sic] resolving SDP matters. If OIG is the sole agency representing the Federal Government, the matter will be settled under OIG’s applicable CMP authorities. In some cases, disclosing parties may request release under the FCA, and in other cases, DOJ may choose to participate in the settlement of the matters. If DOJ participates in the settlement, the matter will be resolved as DOJ determines [what] is appropriate consistent with its resolution of FCA cases, which could include a calculation of damages resulting from violations of the AKS based on paid claims. OIG will advocate that the disclosing party receive a benefit from disclosure under the SDP and the matter be resolved consistent with OIG’s approach in similar cases. However, DOJ determines the approach in cases in which it is involved.

Notice, April 17, 2013, at 13. Regarding criminal matters, it has announced:
OIG encourages disclosing parties to disclose potential criminal conduct though the SDP process. OIG’s Office of Investigations investigates criminal matters, and any disclosure of criminal conduct through the SDP will be referred to DOJ for resolution. As in civil cases referred to DOJ, OIG will advocate that the disclosing parties receive a benefit from disclosure under the SDP.

Id.

Finally, there is a similar promise of “coordination” with CMS:

Disclosing parties need to decide whether OIG’s SDP or CMS’s SRDP is the appropriate protocol to disclose potential Stark Law violations. Both protocols should not be used for the same arrangement. As stated above, disclosing parties must analyze each arrangement to determine whether the arrangement raises potential violations of the AKS, the Stark Law, or both. If the arrangement raises a potential violation of only the AKS or of both the AKS and the Stark Law, the arrangement should be disclosed to OIG under the SDP. If the arrangement raises a potential violation of only the Stark Law, the arrangement should be disclosed to CMS under the SRDP. OIG coordinates with CMS on the review and resolution of matters disclosed to either agency as appropriate. However, OIG does not participate in SRDP settlements.

Id. at 13-14.

Suppose you are the General Counsel of a hospital. You have just learned of a potential violation of AKS and Stark. Regarding the potential AKS violation, the arrangement in question does not fall within a safe harbor and does not fit squarely within an Advisory Opinion. Given that AKS is an intent-based statute, do you report and to whom? Regarding the potential Stark violation, the arrangement in question does not fit within any of the statutory exceptions. Given that Stark is an exceptions-based statute, to whom do you report? What problems are created by this overlap between the statutes and the fact that multiple entities might have jurisdiction? Given the OIG’s and CMS’s statements regarding interpretation of the statutes they enforce that violations of AKS and Stark are “conditions of payment”—in other words, adopting the position of Thompson (textbook at pp. 1151-52) that violations of AKS or Stark are automatically false claims—what risks do you run in making the decisions whether to report and to whom? How is the risk you face affected by the fact that the FCA has a ten-year statute of limitations and that CMS is using a ten-year “look back” for purpose of the obligation to report Stark violations, while the OIG is using a look-back period of six years? Given these risks, the overlapping jurisdictions, and the different look-back periods, do you think you will earn the big bucks you are being paid to be GC?

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The following article, originally appearing at 12(3) HEALTH LAWYERS WEEKLY (Jan. 24, 2014), illustrates the complexity (and inanity) of Stark:

Norman G. Tabler, Jr., Russian Dolls as a Tool for Analyzing Stark Law Issues*

I don’t know about you, but I find it hard to analyze issues that under the Stark Law—the federal law that generally prohibits physicians from referring Medicare and Medicaid patients for designated health services to health facilities in which the physicians have a financial interest.

What makes it so difficult is that the prohibition of these so-called “self-referrals” applies generally—that is, generally but not always. It applies only generally because of all the exceptions and the exceptions to the exceptions and—I swear—the exceptions to exceptions to exceptions to exceptions. That’s right: exceptions to the fifth power.

In my desperation to find a way to navigate the maze, I may have come up with something useful. And, like all good ideas, it’s pretty simple. All I have to do is view the statute like one of those Russian doll sets—you know, the ones with several dolls, each one inside another one that’s identical, only bigger. It works like a charm.

CMS Advisory Opinion No. CMS-AO-2013-03, issued November 11, 2013, provides a good example for trying out my method. That opinion addresses the question whether the addition of 14 unlicensed observation beds to a physician-owned hospital would cause the hospital to lose the grandfather rights accorded by the Affordable Care Act to physician-owned hospitals.

The statutory background is that the Affordable Care Act repealed the “whole hospital” exception for physician-owned hospitals from the self-referral prohibition of the Stark Law, provided they don’t increase the number of operating rooms, procedure rooms, or hospital beds that were licensed on March 23, 2010.

To analyze this issue, we need to peel off several layers of exceptions to the general Stark Law prohibition: first, there’s the general prohibition; second, there’s the whole hospital exception; third, there’s the repeal of the whole hospital exception; fourth, there’s the grandfather exception to the repeal of the whole hospital exception; fifth, there’s the additional-bed exception to the grandfather exception to the repeal of the whole hospital exception; and sixth, there’s the exception for unlicensed beds to the additional-bed exception.

That’s what gave me the idea of using Russian dolls. I figured I could look at the exceptions within exceptions like they were dolls within dolls.

* [footnote in original] Norman G. Tabler, Jr., is an attorney in the health law practice group of Faegre Baker Daniels law firm. He was formerly general counsel and senior vice president of Indiana University Health, Inc.
DOLL I. GENERAL STARK PROHIBITION ON SELF-REFERRALS

Let’s try out my method. We start with the basic question whether we need the dolls at all. We take a look at the big doll—Doll I—which may or may not be part of a set. Doll I is the basic Stark Law prohibition. It applies when there is a self-referral, i.e., a physician referral of a Medicare or Medicaid patient for designated health services to an entity in which the physician or a family member has a financial interest.¹ So, the question is whether self-referrals are involved. If the answer is no, we don’t need the dolls. We’re done. The action or situation we’re analyzing is not prohibited by the Stark Law.

In our example, physicians own the hospital and want to refer Medicare patients to it. So, self-referrals are involved, and we need the dolls. We pick up the biggest one (Doll I) of what may or may not be a set. We open it. If there are no dolls—i.e., applicable exceptions—inside it, we’re done. The analysis is over, and the prohibition applies. We can’t add the beds.

But in our example, there is an exception to the general prohibition. It’s the “whole hospital exception,” which we’ll call Doll II.² And we know it applies because we’re talking about a whole 61-bed hospital.

¹ Sec. 1877 of Social Security Act (42 U.S.C. Sec. 1395nn) (the Act).
² Sec. 1877(d) (3) of the Act.
DOLL II. WHOLE HOSPITAL EXCEPTION

So now we need to take a look inside Doll II. If there’s no Doll III—i.e., no applicable exception—in there, our analysis is over. The general prohibition does not apply, because of the whole hospital exception. The action we’re analyzing—adding the 14 beds—is permissible.

But if there is a Doll III—i.e., an exception to the whole hospital exception—inside, we need to take a look at it and see if it applies. If it does apply, then the prohibition applies unless there’s Doll IV—an applicable exception to Doll III—inside. Why? Because we’re stuck with the repeal (Doll III) of the whole hospital exception (Doll II) to the prohibition (Doll I).
DOLL III. REPEAL OF WHOLE HOSPITAL EXCEPTION

In our example, there is a Doll III. It’s the repeal of the whole hospital exception—the repeal contained in the Affordable Care Act.³ So, unless we can find an applicable exception inside Doll III—a Doll IV—the prohibition will apply, and we won’t be able to add the beds.

But if there is a Doll IV inside—i.e., an applicable exception to the repeal of the whole hospital exception—then the prohibition will not apply, provided, of course, there is no Doll V—i.e., no applicable exception to the Doll IV exception. We can add the 14 beds.

DOLL IV. GRANDFATHER EXCEPTION TO REPEAL OF WHOLE HOSPITAL EXCEPTION

In our case, there is a Doll IV inside Doll III. It’s the grandfather exception—the provision that exempts existing hospitals from the effect of the repeal of the whole hospital exception.⁴

³Sec. 6001(a) (3) of Patient Protection and Affordable Care Act (Pub. L. No. 111-148 Stat. 119).
⁴Id.
Does Doll IV apply in our case? Yes, our hospital was licensed before the prescribed date, March 23, 2010. So, unless there is a Doll V inside Doll IV that applies to our case, we can add the 14 beds.

**DOLL V. ADDITIONAL BED EXCEPTION TO GRANDFATHER EXCEPTION TO REPEAL OF WHOLE HOSPITAL EXCEPTION**

In our case, the is a Doll V inside Doll IV. Doll V applies to the addition of beds beyond the March 23, 2010 number. And the addition of 14 beds is what we’re considering. So, if that’s the last doll, then we’re stuck with the prohibition. Why? Because we fall into this additional-bed exception to the grandfather exception to the repeal of the whole hospital exception to the prohibition. So, unless there’s a doll in Doll VI that applies to our situation, we can’t add the beds.

**DOLL VI. UNLICENSED BED EXCEPTION TO ADDITIONAL-BED EXCEPTION TO GRANDFATHER EXCEPTION TO REPEAL OF WHOLE HOSPITAL EXCEPTION**

Is there a Doll VI? Yes, there is a Doll VI. Advisory Opinion 2013-03 tells us that there is an exception to the additional-bed exception: this exception—Doll VI—applies to unlicensed beds. So, the additional-bed exception applies only if the new beds require a license. In our case the State does not require a license for observation beds. So, the exception (Doll VI) to the additional-bed exception (Doll V) to the grandfather exception (Doll IV) to the repeal (Doll III) of the whole hospital exception (Doll II) to the prohibition (Doll I) applies—unless, that is, there’s a Doll VII, i.e., an exception to the rule excepting unlicensed beds from the additional-bed exception to the grandfather exception to the repeal of the whole hospital exception to the prohibition of the Stark Law.

5 Id.
6 CMS Advisory Opinion No. CMS-AO-2013-03.
Is there a Doll VII in our case? No, there isn’t. Doll VII is empty. It’s the last one in the set. Therefore, our hospital is grandfathered (Doll IV) from the repeal (Doll III) of the whole hospital exception (Doll II) to the prohibition (Doll I). We can add the beds because of the exception of unlicensed beds (Doll VI) to the additional-bed exception (Doll V) to the grandfather exception (Doll IV) to the repeal (Doll III) of the whole hospital exception (Doll II) to the Stark Law’s prohibition (Doll I).

Our work is done. We can put the dolls back in the toy box.

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Chapter 25 The Application of Antitrust to Health Care

Insert at textbook, p. 1240 at the end of the carryover paragraph from p. 1239 before the call for footnote *:

Indeed, the Commission’s ruling on the merits used structural analysis in finding liability, supplemented by merger simulation analysis from the Commission’s staff. Perhaps somewhat surprisingly, given his opinion in Evanston Northwestern, Commissioner Rosch dissented from the majority’s reliance on the econometric analysis, finding it unwarranted and unnecessary, given the structural analysis. See http://www.ftc.gov/opa/2012/03/promedica.shtm.

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Insert at textbook, page 1241 before the heading b:

Postscript to Note on Evanston Northwestern Healthcare Corporation

In two recent decisions, FTC v. Penn State Hershey Medical Center, 838 F.3d 327 (3rd Cir. 2016), and FTC v. Advocate Health Care Network, 841 F.3d 460 (7th Cir. 2016), two courts of appeal have appeared to adopt much of the FTC’s new analysis of geographic market definition in hospital merger cases. The Third Circuit case involved a proposed merger between the two largest health care systems in the Harrisburg, Pennsylvania area, Penn State Hershey, the academic medical center of the Penn State College of Medicine, and PinnacleHealth System, which owned three hospitals in four-county area. The Seventh Circuit case involved the merger of the two systems that dominate the area to the northwest of Chicago, NorthShore University HealthSystem, itself formed by the merger in Evanston Northwestern and renamed, and Advocate Health Care Network, which operates two near-by hospitals and nine total in the Chicago area.

In both cases the district courts had denied the FTC’s motion for a preliminary injunction, in good part based on patient flow data interpreted under the Elzinga-Hogarty
Interestingly, the two cases were opposites of each other in terms of the direction of the patient migration. Penn State Hershey is an academic medical center to which patients come for tertiary services. The district court widened the geographic market to encompass the area from which those patients flowed into Penn State Hershey. By contrast, in the seventh circuit case patients travelled from locales near the merging hospitals to the tertiary care hospitals in the Chicago area, migration outward that led the district court in that case to broaden the geographic market to include those tertiary facilities. In both cases the district court rejected the FTC’s proposed more narrow markets and therefore ruled that the government had failed to prove the necessary increase in market concentration to obtain a preliminary injunction.

In reversing the district courts’ rulings, both circuit courts rejected the use of patient flow data and the Elzinga-Hogarty test in hospital merger cases. The courts justified overthrowing decades of precedent by pointing to “the academy’s evolving understanding of hospital markets,” 841 F.3d at 471, and particularly the writing concerning the silent majority fallacy and the fact, proven in the cases, that most patients will not travel far from home for primary and secondary services. Both courts also rejected the district courts’ reliance on patient flow data because they adopted the use of the model of two-stage competition. Both courts noted that in the first instance insurers are the purchasers of hospital services and therefore the geographic markets must be drawn around insurers’ purchasing patterns.

What is interesting is that the evidence relied upon in these decisions greatly resembles that used in Long Island Jewish Medical Center. Repeatedly, the courts looked to testimony by insurers that they could not put together marketable networks without the merging hospitals. If the courts had relied solely on this evidence, then they would implicitly have adopted the “anchor hospital” theory put forward in Long Island Jewish Medical Center, that “must-have” hospitals are markets unto themselves. However, the courts used other evidence, including actual prior attempts to create networks without the merging hospitals, and “diversion ratios,” which are expressions of the number of patients who would be diverted to other hospitals in the face of a price increase. The courts also looked to evidence regarding patient travel time in order to determine whether hospitals were too far from patients’ homes. The courts also looked to evidence of the separable demands for primary and secondary services, on the one hand, and tertiary services on the other. In this regard, the courts implicitly redefined the product markets, something we saw the court in Long Island Jewish Medical Center did explicitly, an analysis superior to either circuit court’s opinion. Given the evidence used in the cases, the opinions are not radical at all.

However, this point should not be overstated. The courts’ declaration that patient inflow and outflow will not be used to broaden geographic markets is important and, as just discussed, means that, at least in these circuits, patients’ traveling to or from distant hospitals for tertiary care effectively will no longer justify broadening of geographic markets to account for that travel. Therefore, challenges to the merger of hospitals in

* We omit discussion of other aspects of the decisions.
relatively close proximity will no longer be defeated because patients travel for tertiary care. Additionally, courts in these circuits will place primary emphasis on insurers’ decisions regarding which hospital services to purchase in assembling their networks, the first stage of hospital competition.

It is further interesting that these courts seemed oblivious, as was the FTC in *Evanston Northwestern*, to the distributional and social issues raised by their decisions. As discussed in the textbook, in some situations it is possible to protect “captive” customers by ordering divestiture of certain lines of business, such as certain pharmaceutical products, while allowing a merger to go forward. Antitrust doctrine certainly seems to be moving in the direction of protecting captive customers by defining markets narrowly. See, e.g., FTC v. Staples, Inc., 190 F. Supp.3d 100 (D.D.C. 2016) (sale and distribution of consumable office supplies to large business customers was relevant market); see also this Update, insert to textbook at 1341. However, it is not possible to order divestiture of parts of a hospital to protect captive customers, usually patients who travel to local hospitals for primary and secondary services. Furthermore, hospitals use lucrative lines of business to fund unprofitable ones that markets will not support, and society needs those services but is most often unwilling to pay for them directly. Moreover, the history of political economy in this area shows that stable funding of these services is more likely to come in the form of cross-subsidization rather than direct funding. In short, as the note in the textbook points out, these distributional and social questions need to be surfaced and addressed.

* * *

**Insert at textbook, p. 1285 before the heading 3:**

The Supreme Court’s decision in FTC v. Phoebe Putney Health System, 133 S. Ct. 1003 (2013), is its latest word on the state action exemption to the antitrust laws. In that case the FTC had challenged the acquisition of a competing hospital by the “hospital authority” of a county in Georgia. The hospital authority had been created by that county under state law that authorized political subdivisions to create special-purpose public entities, the hospital authorities, “for the operation and maintenance of needed health care facilities in the several counties and municipalities of th[e] state.” Id. at 1004. The hospital authority’s acquisition of the only other hospital in the county would have conferred significant market power by any measure.

Affirming the district court’s dismissal of the FTC’s challenge to the merger under section 7 of the Clayton Act, the Eleventh Circuit had held that such anticompetitive conduct was a “foreseeable result” of Georgia’s legislative authorization for counties to create hospital authorities. Rely on general powers granted to the authorities, such as the power to acquire and lease projects, the Eleventh Circuit had found that the foreseeability standard is satisfied if it could have been “‘reasonably anticipated’ by the state legislature.” Id. at 1009. According to the circuit court, the Georgia Legislature must have anticipated that the grant of power to hospital authorities to acquire and lease projects would produce anticompetitive effects because
“[f]oreseeably, acquisitions could consolidate ownership of competing hospitals, eliminating competition between them.”” Id. at 1009.

A unanimous Supreme Court reversed. Quoting a prior decision, the Court said that “we recognize state action immunity only when it is clear that the challenged anticompetitive conduct is undertaken pursuant to a regulatory scheme that ‘is the State’s own.’” Id. at 1010. The Court found no evidence of intent to create such a scheme, holding more specifically that the grant of general powers, including the authority to make acquisitions, does not evidence an intent to authorize displacement of competition. While the intent to displace competition does not require an “explicit statement,” “a state policy to displace federal antitrust law [is] sufficiently expressed where the displacement of competition [is] the inherent, logical, or ordinary result of the exercise of authority delegated by the state legislation.” Id. at 1012-13. The displacement of competition is not “the inherent, logical or ordinary result” of a state’s general grants of power to entities created by counties.

While many think that Phoebe Putnam made no new law but was merely a corrective to a highly aberrant decision by the Eleventh Circuit which had applied the foreseeability standard “too loosely,” id. at 1006, some members of the health care defense bar have raised the hue and cry, claiming that the decision “scaled back the availability of the state action immunity that local governments across the country have relied upon for decades to shield their activities from federal antitrust scrutiny.” John M. Gore, Beth Heifetz & Toby G. Singer, FTC v. Phoebe Putnam: A Reasonable Reliance Defense in the Brave New World of State Action Immunity, 22 Health Law Reporter (BNA) 993, 993 (June 27, 2013). Pointing to proceedings like that in Evanston Northwestern Evanston (textbook at 1227-41), these commentators predict that a more active FTC can and will use the supposed narrowing of the state action exemption wrought by Phoebe Putnam to challenge consummated arrangements. Regardless of debate over the provenance of the doctrine in Phoebe Putnam, one can question even this prediction for the reach of the Supreme Court’s decision will depend upon its interpretation by the FTC and the lower courts, none of which can be known now.

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Insert at textbook, p. 1305 before the heading b:

The FTC continues to elaborate what constitutes clinical integration. In an advisory opinion concerning a physician hospital organization (PHO) in Norman Oklahoma, staff approved an arrangement in which the PHO would require all physicians to participate in the network and would, moreover, engage in joint contracting with payers. As in TriState, staff stressed that contracts between the network and its providers are to be nonexclusive, thereby allowing payers to bypass the network and contract directly with providers. Staff also relied on the absence of any mechanisms, like MFNs, that might cause exclusion at other vertical levels. Given the absence of serious anticompetitive effects, approval followed from the existence of substantial benefits of the following forms of clinical integration:
Norman PHO represents that its participating physicians will integrate their clinical services in a manner that appears likely to create the potential for significant efficiencies that benefit patients and payers. The federal antitrust enforcement agencies have explained that clinical integration may be evidenced when a provider network “implement[s] an active and ongoing program to evaluate and modify practice patterns by the network’s physician participants and create[s] a high degree of interdependence and cooperation among the physicians to control costs and ensure quality.” Although certain aspects of Norman PHO’s proposed new program have yet to be finalized, the network and its participating providers have identified key features and mechanisms, and have invested or committed to investing substantial resources, for purposes of creating the infrastructure and capabilities necessary to jointly achieve their claimed efficiencies.

Norman PHO and its participating providers have created various mechanisms intended to monitor and control costs and utilization, while assuring quality of care. These mechanisms include the network’s collaborative, physician-centered processes for developing, implementing, and enforcing evidence-based clinical practice guidelines. Much of this work will be accomplished through the network’s newly established Specialty Advisory Groups, the Mentor’s Committee, and the Quality Assurance Committee, with the assistance and support of Norman PHO employees, including several new employees hired specifically to support clinical integration activities.

Further, Norman PRO’s new electronic capabilities reportedly will foster a high degree of transparency and visibility into the participating physicians’ actual practice patterns and accomplishments. They will permit the network to efficiently collect and review individual and aggregate data relating to cost, utilization, and quality of care. They also will enable the network to efficiently monitor and review individual and aggregate compliance with network standards, including clinical practice guidelines. For example, the network will use its electronic systems to perform medical record audits and to generate reports on individual and aggregate performance.

Additionally, Norman PHO’s newly revised Participating Practitioner Agreement provides another important mechanism for achieving network goals. It commits each physician to participate in the development, implementation, and enforcement of the network’s clinical practice guidelines, including those requiring use of the network’s electronic platform. It also enables the network to undertake corrective actions, including, in egregious instances of noncompliance, the expulsion of a participating physician.

Norman PHO and its participating physicians also apparently have made, or will make, meaningful contributions, including investments of human capital, time, and money, to the development of the infrastructure,
capabilities, and mechanisms necessary to jointly realize their projected efficiencies. As an organization, they have established new structural and operational capabilities (including the Specialty Advisory Groups, the Mentor’s Committee, and the Quality Assurance Committee), established a preliminary set of disease clinical practice guidelines, developed the network’s electronic platform, and hired key personnel. Each participating physician has invested or will invest non-trivial and continuing time and effort to support key aspects of the network’s clinical operations and infrastructure, including through participation on committees such as a Specialty Advisory Group, adoption of clinical practice guidelines, and participation in network compliance activities. Participating physicians also have already purchased and obtained training for the necessary computer hardware and software, or will be required to do so. Additionally, they have paid, or will pay, membership fees and dues, and will make other ongoing contributions, in the form of “withholds” from reimbursements made by payers who contract with the Norman PHO, to support the network’s clinical integration activities. Together, the participating physicians’ contributions of human capital, time, and money appears to give them a stake in the success of Norman PHO such that the potential loss or recoupment of their investment is likely to motivate them to work to make the program succeed.

Moreover, Norman PHO ultimately will operate as a “selective” network that includes only providers who are dedicated to the network’s collective attainment of its cost, utilization, and quality goals. Although Norman PHO anticipates that all of its current participating physicians initially will join the new program, certain of those physicians ultimately may find that they are unable or unwilling to devote the time, effort, or commitment necessary to achieve the network’s goals. For example, some physicians may not be willing or able to participate in a relevant Specialty Advisory Group, to cooperate with Norman PHO’s various compliance activities, such as medical records auditing, or, in the event noncompliance or other risks are identified, to participate in corrective actions, such as physician-to-physician mentoring and other counseling and educational activities. Over time, some participating physicians therefore may leave the network, voluntarily or otherwise, and the network may constrict in size.


* * *

Insert at textbook p. 1311, as note 7 and renumber the next note to 8:

State laws creating transparency, particularly laws creating all-payer claims databases, discussed in the note on transparency above in this Update, raise considerable

The subject of the letter was the proposed amendment of Minnesota’s “open records” law, a general sunshine law, also sometimes called “right-to-know” laws. These laws are aimed at making government more accountable through public access to documents and data it possesses, much like the federal Freedom of Information Act. This particular amendment contained provisions that would release to the public all data collected by HMOs, health plans and other health services vendors that contract with Minnesota to provide health care services for Minnesota residents. The amendment would particularly affect eight managed care plans, including five HMOs, and three county-based purchasing plans. The proposed amendment would require the plans to release their contracts with providers, as well as their subcontractors’ contracts with providers. Of course, those contracts contain price information. The FTC staff advised that the possible harms from the amendment could outweigh the possible benefits and that the Minnesota legislature should exercise “caution in mandating public disclosure of plan specifics and negotiated fee schedules between [health plans and providers].” Id. at 8. We’ll see that the letter shows that many laws promoting the publication of price information might be suspect in the eyes of the FTC staff.

As you know from this Chapter, competitors’ sharing of price information among themselves raises serious Section 1 issues and may in fact trigger per se treatment. The danger, of course, is that the sharing of price information enables sellers to coordinate their prices—i.e., it enables horizontal price-fixing. The FTC letter discusses the fact that Minnesota’s release of competitors’ prices could have the same pernicious effect as if competitors themselves share the price information.

In the instance of publicly available price data, the section 1 concern is that the release of the price data will operate in much the same way as “most-favored-nation” (MFN) clauses, discussed above in the note 4.b. after Dentsply. See, e.g., David Cutler & Leemore Dafny, Designing Transparency for Medical Care Prices, 364 NEW ENG. J. MED. 895 (2011). As we discussed in the note following Dentsply, MFN clauses in contracts at one vertical level of production might stabilize prices at that vertical level and might foreclose entry at another vertical level. The classic example, reflected in the cases discussed in that note, is that an insurer with some degree of market power includes an MFN clause in every agreement with all hospitals in a relevant geographic market. This conduct causes the reduction of price competition among the hospitals because the MFN prevents any hospital from gaining by offering a discount. Moreover, entry at the
insurance level could be foreclosed because an entrant can gain no competitive advantage from negotiating a discount with any hospital. Because of the MFN clause any discount given an entrant must likewise be given to the incumbent insurer or insurers. These dangers become more likely as the degree of concentration is greater, and the barriers to entry higher, at one or both vertical levels.

Compared with MFN clauses, the public release of price information can have an even greater pernicious effect. If all the hospitals in our example are made aware of their competitors’ prices, quite possibly none will give a further discount to an incumbent insurer or insurers or to an entrant. So far, the effects are like those of MFN clauses. However, the effects go further because, first, the disclosure could undermine the effectiveness of plans’ use of selective networks to control expenditures and quality; and it is quite possible that the prices of all hospitals will rise to the level of the highest-priced hospital.*

Of course the benefits of transparency must be considered, particularly the benefits of all-claims databases. As discussed in the note on transparency (and the note on reference pricing), making prices transparent to patients supposedly enables them to shop much better among providers. Likewise price transparency can make plans and their agents better shoppers for providers.

That’s the theory at least, but that’s really Economics 101 because the conclusion that price transparency creates benefits is a comparative statement, and one must ask, “benefit compared with what?” The “what,” which is usually just left silent, is the way health care markets operate without state intervention to create price transparency. That comparison in turn requires an assessment of the degree and significance of market failure. Any discussion of market failure requires an analysis of the information problems in health care markets, the subject of this entire set of notes.

Thus, as we developed in the immediately preceding note, California Dental stands for the proposition that any assessment of information problems in health care markets is one “susceptible to empirical analysis not a priori analysis.” California Dental, 526 U.S. at 774. However, as the FTC staff admitted, its assessment of the harms and benefits of the proposed legislative amendment at issue here was informed by little empirical evidence of the effects of transparency because such evidence simply doesn’t exist. See FTC Staff Letter on Transparency Laws at 15. What the staff used instead were studies of the effects of transparency in industries like cement manufacture, railroad grain contracting and the manufacture of motor vehicles, see id. at 15 n.47; see also Cutler & Dafny, Designing Transparency for Medical Care Prices. However, none of the industries is the least bit comparable to health care markets. As we’ve seen over and over again, the price-cost mix of most health care services—i.e., the value, which is what is

* If we relax the assumption that bargaining power doesn’t exist, then it is not clear that transparency would have this effect. “The extent to which such increases will occur is uncertain, because lower-cost providers may lack the necessary market power to make such demands (which might be why their prices were lower to begin with).” Anna D. Sinaiko & Meredith B. Rosenthal, Increased Transparency in Health Care—Challenges and Potential Effects, NEW ENG. J. MED. 891, 893 (2011).
bought and sold in health care markets—is enormously complicated, and the capability of providers to collude over price cannot be compared with the capability of producers or sellers of cement, grain or cars to coordinate. See, e.g., Chapin White et al., Healthcare Price Transparency: Policy Approaches and Estimate Impacts on Spending, at 9 (2014), http://www.westhealth.org/wp-content/uploads/2015/05/Price-Transparency-Policy-Analysis-FINAL-5-2-14.pdf (Accessed July 24, 2015). FTC staff also relied on speculative or theoretical statements at a workshop it conducted and other anecdotal evidence. See id. 7 & nn.51-53. For example, staff quoted a statement from Dr. Paul Ginsburg, an eminent health economist. The quoted statement begins: “[S]trictly from an economic theory point of view . . . .” Id. n.51. The analysis conducted by the staff cannot be made consistent with the assessment California Dental requires. Nonetheless, the staff’s letter concluded:

In particular, we encourage the Minnesota legislature to consider which types of information are likely to be the most useful to Minnesota health care consumers as they compare and select health care providers and services—such as actual or predicted out-of-pocket expenses, co-pays, and quality and performance comparisons of plans or providers. At the same time, we urge caution in mandating public disclosure of plan specifics and negotiated fee schedules between the Health Plans, hospitals, and physician service entities, which may harm competition and consumers by facilitating coordination or outright collusion on prices or other terms, especially in highly concentrated markets.

Id. at 8. This conclusion rests on a priori analysis, not empirical analysis.

Given the fact-intensive nature of inquiries such as this, the staff’s analysis should have limited reach and should not necessarily apply to many or all efforts to attain transparency, particularly the use of all-payer claims databases. The proposed Minnesota legislation was by no means tailored to attain any of the goals of other states’ efforts, such as the Vermont law at issue in Gobeille (discussed earlier in this Update in the note on transparency). It simply would require that distribution—that the sunlight shine on—raw, unvarnished data that were not standardized in any fashion, nor presented in any way to enable patients or payers to shop by price. Compared with Vermont’s law at issue in Gobeille, the benefits from the release of data were likely much fewer than those attained by a full-fledged all-payers claims data base. Thus, if one were to pay attention to the mandate of California Dental, a multitude of facts would have to be analyzed and one would not theorize about “transparency” generally.

However, the letter to the Minnesota legislature indicates that staff may not care about facts. When the staff wrote about the potential benefits from transparency, it did an excellent job drawing on all aspects of the information problem in health care markets to cast doubt that any benefits could be gained from transparency unless the ideal were attained. Staff noted in particular that "consumers cannot adequately evaluate price information without considering quality; that is, information on price alone is likely to be less helpful to consumers when selecting many procedures and services. Presenting
information in a format and medium that is understandable to consumers poses significant challenges. . . . [T]he Minnesota legislature should consider whether price transparency, standing alone, is likely to be sufficient to control spending and improve quality.” Id. at 5. Then, in passages worth quoting at length, staff continued:

As a general matter, inherent uncertainties surround information in health care markets. Consumers rarely have as much information as providers about their conditions and treatment alternatives. This asymmetry may hamper traditional market forces of supply and demand, which may lead to inefficient distribution of services.

Moreover, in order to counter existing information asymmetries, consumers need information about future prices and coverage. Consumers typically become aware of their health care costs after receiving care, such as when they receive an explanation of benefits from their insurer or a bill from their provider—in other words, when the information is no longer useful to evaluate prospective choices. Health care price and quality information that is transparent to consumers before they receive health care services is far more likely to be useful to them. Specifically, it is more likely to reduce consumers’ search costs, allow for more informed comparison-shopping among health care providers and health plans, and help them in anticipating their out-of-pocket health care costs. The ability to assess the anticipated cost of care is especially important due to the increased prevalence of high-deductible health plans and other forms of consumer cost sharing. These factors not only affect a consumer’s current expenditures, but also influence the extent to which a consumer may bear future costs from poor health care choices or worse outcomes.

Inadequate information transparency is just one factor that may hinder the efficient allocation of high quality medical care. In a 2011 study on transparency in health care markets, the U.S. Government Accountability Office noted several factors that make it difficult for consumers to obtain accurate price and quality information for health care services before selecting and receiving medical care, including: (1) the difficulty of predicting necessary health care services in advance; (2) billing from multiple providers in and out of network; (3) the variety of insurance benefit structures; and (4) contractual obligations that prevent insurers and providers from making their negotiated rates available to the public.

Id. at 5 (footnotes omitted).

Nothing of the sort was at work when staff discussed the supposed harms of the release of price information. Thus one should ask, if the considerations raised by staff indicate great market failure and cast doubt on the benefits of transparency of price data alone, then what does this say about the likelihood of collusion? Put differently, if
patients have such trouble assessing the value offered by providers, won’t providers likewise have a great deal of trouble assessing what other providers are offering? If the release of price information alone so little enhances the ability of shoppers to assess value, then won’t the release of price information alone be insufficient for providers to assess the value of competitors’ offerings? Given that tacit price-fixing requires exactly that assessment, isn’t it unlikely that the release of price data alone would greatly facilitate collusion? Of course, in concentrated markets, as a general matter, the problems of coordination are greatly simplified. At the limit, a monopolist doesn’t have to coordinate with anyone. However, the staff did not condition its assessment of harms on the presence of any type of market structure, let alone a concentrated one.

We have to dig deeper still. Ask yourselves, what does the staff’s analysis says about the entire endeavor of applying antitrust to health care and, indeed, about the use of competition to structure the finance, provision and purchase of health care? We have asked this question throughout the Book, particularly in this Part Four, and we will conclude the book with it. The staff’s letter is totally paradoxical in its assessment of harms and benefits. Isn’t the paradox inherent in the staff’s letter driven by the basic problem of relying on markets, which work best when collaboration is broken down and built up by markets’ supposedly inherent “self-correcting” feature, while simultaneously recognizing that collective action—here to be mandated by Minnesota—is necessary to solve the market failure inherent in health care markets? After all, isn’t an all-payers claims database the forced collaboration among all-payers?

Finally, let’s focus on one other aspect of the antitrust doctrine applied in the FTC staff’s letter. In the staff’s analysis of potential harms of transparency, what is the underlying view of discounts? If discounts are perceived to be an unmitigated good because they enable payers and patients to drive down providers’ prices, is anything missing from this framework? A tenet of economic theory is that price discrimination is not possible in competitive markets because sellers cannot distinguish buyers who are willing—and able—to pay more from buyers who are willing only to pay less (perhaps they are unable to pay more?). Hence, when sellers cannot discriminate among buyers based on their willingness to pay—that is, when they cannot price discriminate—the price to every buyer falls to sellers’ costs (in the main text this point is made in the notes after Northwestern Healthcare and in the notes concerning Kodak).

However, in the sale of providers’ services to payers, which is what we’re now talking about, buying and selling occur through negotiation—what economists call a “bargaining market”—and “discounts” obtained by buyers with bargaining power are not transparent (see also the note on page 1236 in the discussion of Northwestern Healthcare). So, we ask again, given their invisibility, are discounts an unmitigated good? Who do you think might be hurt by the fact that some buyers are able to get discounts while others are not? For example, who do you think might be billed the full freight—charges—at hospitals and who might not, the patient who is a member of a very large insurance plan or an uninsured patient? As another example, who do you think is likely to obtain a lower price in this “bargaining market,” a small plan covering 50 employees or Google’s plan? Are discounts an unmitigated good? See generally Uwe E.

If you think that such price discrimination is a normative problem, what do you think of the view that distributional effects don’t matter, a view built into the FTC staff’s analysis and one that is standard in antitrust? Although transparency alone cannot change distributional effects because it cannot alter bargaining power, isn’t there something to be said for making discounts transparent so that our society can have full and frank discussions about who gets what and who doesn’t? Does this sort of normative discussion appear within antitrust doctrine and the underlying economic framework that now dominates it? We return to this question at the end of the Chapter.

* * *

Insert at textbook, p. 1340 before the first paragraph:

The litigation between West Penn Allegheny Health System (West Penn), University of Pittsburgh Medical Center (UPMC) and Highmark took yet another strange turn in the highly concentrated hospital and insurance market in western Pennsylvania. After the Third Circuit’s reversal of the district court’s dismissal of West Penn’s complaint against UPMC and Highmark, as described in the textbook, Highmark (again!) switched sides. West Penn dropped its suit against Highmark and the two executed a merger agreement, as Highmark abandoned its alleged alliance with UPMC, the basis for West Penn’s suit. Both the Antitrust Division of the U.S. Department of Justice, and the Pennsylvania Insurance Department approved the merger. According to the Antitrust Division, the infusion of capital into West Penn would allow it to compete more vigorously against UPMC. See, e.g., DOJ Gives OK to Proposed Merger of Pennsylvania Insurer, Hospital Chain, 21 Health Law Reporter (BNA) 538 (March 12, 2012). In effect, West Penn got what it alleged Highmark had promised it before Highmark entered into the alleged conspiracy with UPMC. The Pennsylvania Department of Insurance, by contrast, imposed fairly stringent conditions to protect consumers and other community hospitals—dwarfed by UPMC and West Penn—and to ensure Highmark’s financial stability. Among other things, the Department banned use of MFNs by West Penn, prohibited exclusive contracts, limited provider contracts to five years and forbade West Penn from terminating contracts with other insurers, except for cause, prior to 2016. Additionally, to prevent collusion among providers in the new integrated delivery system, the Department ordered the erection of a firewall between Highmark and those providers to preclude any provider from obtaining information concerning other providers’ prices, terms, product design and the like. See, e.g., Pennsylvania Insurance Department OKs Highmark/West Penn Hospital System Merger, 22 Health Law Reporter (BNA) 670 (May 2, 2013). The litigation in federal district court between West Penn and UPMC continues. See, e.g., Discovery Order in UPMC Antitrust Case as West Penn Seeks To Amend Its Complaint, 21 Health Law Reporter (BNA) 207 (February 9, 2012).

* * *
Since the publication of the Book in 2012 the rate of consolidation in the health care industry has greatly accelerated. Two commentators have observed that the entire sector is caught in a “cycle of ‘reactive’ consolidation within the healthcare supply chain as insurers leverage up to counter the greater bargaining power of other, attempting to rapidly absorb parts of the supply chain with which they do business. These include pharmaceutical companies, Group Purchasing Organizations, Pharmacy Benefit Managers, retail pharmacies, and hospitals and physician practices.” Thomas Greaney and Diana Moss, Letter from the American Antitrust Institute to William J. Baer, Assistant Attorney General, U.S. Department of Justice Antitrust Division, Antitrust Review of the Aetna-Humana and Anthem-Cigna Mergers, at 3, http://www.antitrustinstitute.org/sites/default/files/Health%20Insurance%20Ltr_1.11.16.pdf (Accessed July 17, 2017).

As stated in the Book, consolidation has both horizontal and vertical aspects. First, mergers and other forms of horizontal affiliation continue among hospitals and among doctors. With regard to hospitals, in a recent essay Gaynor (2016) reports that from 2010-2014 there were 457 hospital mergers, and that as a result, “most urban areas in the US are now dominated by one to three hospital systems . . . .” Martin Gaynor, New Health Care Symposium: Consolidation and Competition in US Health Care.” Health Affairs Blog, March 1, 2016, at 5, http://healthaffairs.org/blog/2016/03/01/new-health-care-symposium-consolidation-and-competition-in-us-health-care/ (Accessed July 17, 2017). The consolidation shows no sign of abating. See, e.g., Dave Barkholz, Hospital Mega-Mergers Hit Fast and Furious in Q1, Modern Healthcare, April 29, 2017.

Equally, horizontal mergers among insurers have exploded: “AMA data show that 64 percent of commercial health insurance markets are already highly concentrated. Twenty percent of these markets [greatly exceed the standard criteria for high concentration]. Fifty-three percent of those markets have two insurers that account for 65 percent or more of the combined market for HMO, PPO, and POS insurance services. Other studies indicate that in 74 percent of states, the three largest insurers hold 80 percent or more of the market share in each of the individual, small group, and large group market segments. Nationally, the share of the largest four insurers increased from 74 to 83 percent from 2006 to 2014.” Greaney & Moss at 3-4. In the Medicare Advantage market, Biles, Casillas, and Guterman found that “97 percent of markets in U.S. counties are highly concentrated and therefore lacking in significant MA plan competition. Competition is considerably lower in rural counties than in urban ones. Even among the 100 counties with the greatest numbers of Medicare beneficiaries, 81 percent do not have competitive MA markets. Market power is concentrated among three nationwide


Second, as encouraged by the Medicare Shared Savings Program but occurring also simply to generate market power, hospitals are buying physician practices.* Hospitals have acquired physician practices such that 32.8 percent of physicians are now employed by hospitals. Gaynor at 5.

Finally, providers, whether vertically aggregated or not—but often so vertically integrated—are sometimes integrating vertically backward into insurance or engaging in vertical affiliation arrangements with insurers, meaning some type of contractual arrangement short of complete consolidation. See, e.g., Allan Baumgarten, Analysis of Integrated Delivery Systems and New Provider-Sponsored Health Plans, Robert Wood Johnson Foundation, June 2017, http://www.rwjf.org/content/dam/farm/reports/reports/2017/rwjf437615 (Accessed July 17, 2017).

Many reasons have been given for increased consolidation. On the provider side there are claims that greater scale is necessary to bargain effectively against consolidating insurers, to obtain efficiencies, to bear risk, to take advantage of information technologies, to prepare for and implement systems of payment supposedly based on value, to take care of populations, and to reduce duplication. See, e.g., Robert Lawton Burns, Jeff C. Goldsmith, & Aditi Sen, Horizontal and Vertical Integration of Physicians: A Tale of Two Tails, 15:Advances in Health Care Management 39–117 (2013)**; Gaynor. On the

* Another principal reason for hospitals’ purchases of physician practices is that hospitals declare the physicians’ offices to be part of their outpatient departments and therefore bill at higher rates for services identical to those performed before the acquisition. See, e.g., Ann S. O’Malley et al., supra; see also James D. Reschovsky & Chapin White, Location, Location, Location: Hospital Outpatient Prices Much Higher Than Community Settings for Identical Services, NAT’L INSTITUTE FOR HEALTH CARE REFORM RESEARCH BRIEF No. 16 (June 2014), http://www.nihcr.org/Hospital-Outpatient-Prices (Accessed July 17, 2017). In contrast to the hoopla about vertical integration, a recent study has found no social benefits from integrated delivery networks. To the contrary, there is growing evidence that hospital-physician integration has raised physician costs, hospital prices and per capita medical spending. Even from the providers’ perspective, the available evidence suggests that the greater the investment in IDNs, the lower their operating margins and return on capital. Diversification increases a firm’s size and complexity, in turn increasing its cost of coordination, information processing and governance/monitoring. See Jeff Goldsmith et al., Integrated Delivery Networks: In Search of Benefits and Market Effects, National Academy of Social Insurance, https://www.nasi.org/sites/default/files/research/Integrated_Delivery_Networks_In_Search_of_Benefits_and_Market_Effects.pdf (Accessed July 17, 2017). See also James C. Robinson & Kelly Miller, Total Expenditures per Patient in Hospital-Owned and Physician-Owned Physician Organizations in California, 312(16) JAMA 1663 (2014) (higher total expenditures in hospital-owned physicians organizations compared with physician-owned).

** This is a particularly fascinating study show a distribution of physicians collected largely at two tails. One extreme is that a large percentage of physicians continue to practice in small, particularly solo, groups.
insurer side, there is likewise a claim that enhanced bargaining power is needed to counter concentrated providers—that size will enable insurers to push down provider prices—but there are also claims of reduced administrative costs, in particular improved risk bearing, higher quality and that investment in IT can be spread across a larger base. See, e.g., Leemore Dafny, The Risks of Health Insurance Company Mergers, Harvard Business Review (2015), https://hbr.org/2015/09/the-risks-of-health-insurance-company-mergers (Accessed July 17, 2017). However, aside from highly centralized hospital systems—particularly when the system’s hospitals are few in number, close to each other geographically and tightly integrated—there is little if any empirical evidence to support these claims either on the provider side. See, e.g., Burns, Goldsmith, & Sen; Lawton Robert Burns et al., “Is the System Really the Solution? Operating Costs in Hospital Systems, 72(3) Medical Care Research and Review 247 (2015); Martin Gaynor & Robert Town, The Impact of Hospital Consolidation—Update. The Synthesis Project, Policy Brief, no. 9. Princeton, NJ: Robert Wood Johnson Foundation (2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf73261; Goldsmith et al., or the insurer side. See, e.g., Dafny.


The other extreme is a growing number of large groups primarily organized by hospitals in vertical arrangements.

The evidence regarding how consolidation affects payers is not good—for payers at least. In local markets where fragmented providers face an insurer with market power, providers’ prices either fall or stabilize. However, some evidence shows that these prices are not reflected in lower premiums for plan sponsors. See Dafny, Duggan, & Ramanarayanan. When the situation is reversed—when consolidated providers face fragmented insurers—providers’ prices rise. Insurers pass these increases onto payers in the form of higher premiums. See, e.g., Robert Town et al., The Welfare Consequences of Hospital Mergers, NBER Working Paper, no. 12244, Cambridge, MA: National Bureau of Economic Research (2006), http://www.nber.org/papers/w12244.pdf (Accessed July 17, 2017); Erin E. Trish & Bradley J. Herring, The Welfare Consequences of Hospital Mergers, NBER Working Paper, no. 12244, Cambridge, MA: National Bureau of Economic Research (2015), http://www.nber.org/papers/w12244.pdf (Accessed July 17, 2017). Finally, when both sides of the provider-insurer market are consolidated, one can infer from available evidence that the concentrated insurers do not pass along any profits they might wrest from consolidated hospitals. See Dafny, Duggan, & Ramanarayanan; Richard M. Scheffler et al., Differing Impacts of Market Concentration on Affordable Care Act Marketplace Premiums, 35(5) Health Affairs 880 (2016), http://content.healthaffairs.org/content/35/5/880.abstract (Accessed July 17, 2017). Indeed, some evidence exists, as we pointed out in the Book from pages 1339-41, that the two sides just shake hands, sharing together the increased premiums imposed on plan sponsors. See also Greaney.

It seems that consolidation at either or both levels results in higher premiums. If plan sponsors lacking market power resist the premium increases, they then have to
absorb the extra cost, which will be passed back to their workers in some form such as lower wages or benefits, see, e.g., Katherine Baicker & Amitabh Chandra, The Labor Market Effects of Rising Health Insurance Premiums, 24(3) Journal of Labor Economics 609 (2006), or accept plans with higher out-of-pocket costs for plan members, more shallow coverage, narrower networks, or some combination of the above—all forms of less comprehensive insurance. The effect of this “de-insurance” of plan members is that the consequences of power possessed by providers, insurers or both effectively get absorbed either by plan sponsors, plan members or some combination of the two.

The evidence from the Exchanges and elsewhere are consistent with this gloomy picture. Premiums on the Marketplaces were reduced sometimes by competition, see, e.g., Leemore Dafny et al., More Insurers Lower Premiums: Evidence from Initial Pricing in the Health Insurance Marketplaces, NBER WORKING PAPER No. 20140 (May 2014), http://www.nber.org/papers/w20140 (Accessed July 17, 2017); see also Scheffler et al., but more generally premiums were reduced by creating narrower networks and imposing higher out-of-pocket expenses, both occurring to the extent allowed by the ACA (recall that at least for the moment regulators have implemented the ACA such that there is no minimum network requirements other than that access be not unreasonable). If regulators were to clamp down and seriously enforce the network adequacy requirement, given what is written above concerning horizontal and vertical integration, and given that levels of premiums, aside from loss-ratio requirements, are generally unregulated, one can expect expenditures and premiums to rise.

Alternatively, if plan sponsors do push back on rising premiums, the danger is that they will shift in costs directly onto plan members through vehicles like high deductibles or tiered pricing. Further, as indicated in the note on reference pricing in this Update, a plan sponsor could effectively narrow its network by limiting the price it will pay for certain costly procedures to a defined contribution; this strategy, in turn, leaves patients holding the bag for any difference between the defined contribution and the amount charged by a provider, plus the standard cost sharing owed under the terms of the plan. See also Kevin Schulman et al., Shifting Toward Defined Contributions—Predicting the Effects, 370 NEW ENG. J. MED. 2462 (2014). Other than cost-shifting to plan members, payers are simply out of tools to stem the expenditure tide—if, fragmented as they are, they ever had any tools to begin with.

At this point horizontal and vertical consolidation in many or most parts of the health care sector is occurring at such a feverish pace that one could state, without exaggeration, that we’re in a period of merger mania. To illustrate, we provide two examples (and we could provide many, many more). First, we lay out the manner in which CVS has very rapidly morphed from a chain of brick-and-mortar drugstores to a company greatly involved in all levels and types of drug distribution and, most recently, in free-standing or in-store retail clinics and even insurance itself. The CVS story beautifully illustrates the consolidation that is occurring both horizontally and vertically, creating market power both across stages or production and up and down them. Second, we relate very recent developments in the health insurance market in which the nation-wide players attempted to merge from five to three, as four insurance behemoths would
have become two: Aetna tried to take over Humana, and Anthem tried to acquire Cigna. Antitrust enforcers and the courts stymied these attempted mergers, indicating that at some point antitrust does provide limitations. Also, it is simply too big a story for us not to include it in this Update.

a. **CVS, a new integrated health care company.**


As told in the *New York Times* article, “[t]he Consumer Value Store started as a scrappy discount health and beauty outlet in Lowell, Mass., in 1963.” Four years later, it opened its first in-store-pharmacy; and the rest is history. Through both internal growth and a number of acquisitions nation-wide—particularly the purchase of Revco in 1997 and Eckerd in 2004—CVS became one of the top pharmacy chains in the country.

At that point the real fun began as CVS—now called CVS Health—began to buy presence, if not market power, in numerous areas that either are complements to the retail sale of drugs or stand in vertical relationship to that business. The following acquisitions occurred (and we’ve left out some of the purchases of lesser significance):

- In 2006 CVS bought the drugs-store operations of Albertsons, a supermarket chain.
- In 2006 CVS acquired MinuteClinic, which operates free-standing clinics staffed by nurse practitioners and physician assistants—where allowed by state law—to treat minor illness and scrapes and bruises and give vaccinations.

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In 2007 CVS merged with Caremark, one of the nation’s dominant pharmacy benefits managers (“PBM”).

In 2012 CVS acquired the medical products distributor Cardinal Health, thereby creating the country’s largest generic drug sourcing operation.

In 2013 CVS bought Coram, a home-infusion therapy company.

In 2013 CVS bought Coram, a home-infusion therapy company.

In 2015 CVS acquired Omnicare, the nation’s dominant, by far, distributor of drugs to nursing homes and assisted living facilities and a significant player among specialty pharmacies, which distribute drugs like oral chemotherapies that necessitate advice and oversight of those product.

In 2015 CVS acquired Target’s pharmacy and retail clinic businesses.

The Times story is correct in stressing that “[t]he growth of CVS comes at a time when the way Americans get access to and pay for health care is evolving quickly.” The factors correctly cited are the growth of high-deductible plans, the fact that 30 million people who gained insurance because of the ACA do not have primary care doctors, and the fact that many people want the quick in-and-out service indicated by the name “MinuteClinic.” However, the extensive movement into the retail clinic business is only part of the story because there is so much more heft in the vertical integration, e.g., CVS’s purchase of Caremark. The latter, as a PBM, is supposed to negotiate discounts with drug manufacturers and drug distributors like CVS. By contrast, the idea of creating such a conglomerate combining both the retail and PBM functions is to avoid one side sticking it to the other by virtue of market power, and instead to create a mammoth, vertically integrated firm that has even greater ability to stick its market power into someone else, as described above in this note in both this Update and the main text. Why put up with being divided and fighting when one can unite and conquer?

Perhaps the crowning blow in this story is occurring right now, July 2019, as we write. In October 2017 CVS announced that it is buying Aetna for roughly 69 billion dollars, the largest healthcare transaction to date. See, e.g., Michael J. de la Merced & Reed Abelson, CVS to Buy Aetna for $69 Billion in Deal That May Reshape the Health Industry, New York Times, Dec. 3, 2017, https://www.nytimes.com/2017/12/03/business/dealbook/cvs-is-said-to-agree-to-buy-aetna-reshaping-health-care-industry.html (Accessed July 22, 2019); Sharon Terlep, Anna Wilde Mathews & Dana Cimilluca, CVS to Buy Aetna for $69 Billion, Combining Major Health-Care Players, Wall Street Journal, Dec. 3, 2017, https://www.wsj.com/articles/cvs-to-buy-aetna-for-69-billion-1512325099 (Accessed July 22, 2019). The stated business reasons for the merger are that CVS’s approximately 10,000 retail outlets, the largest number of any national drugstore chain, with “9,000 stores within 3 miles of 80% of the American Public,” will provide a platform for lower expenditures, improved care, even attention to the social determinants of health, and improved health outcomes. The CEO of Aetna has “sketched a vision of the future of health care in which a combined CVS-Aetna could . . . be a gateway to health, a first

The deal, vertically integrating the third largest insurer with a retail health care provider, mainly through its “Minute Clinics,” supposedly will “disrupt” the extant mode of doing things in health care—its industrial organization—in the manner in which, say, Amazon has changed many lines of business. See, e.g., Leemore S. Dafny, Does CVS-Aetna Spell the End of Business as Usual, 378(7) New England Journal of Medicine 593 (Feb. 15, 2018), https://www.nejm.org/doi/pdf/10.1056/NEJMp17171713 (Accessed July 22, 2019). Indeed, it has been commonly reported that the deal is one of many occurring in the face of the much ballyhooed entry of Amazon into health care although, as discussed below, really it is that everyone is scrambling to keep up with UnitedHealth, now the behemoth of insurance vertically integrated with many, many other functions in the sector.

Part of the basis for this business plan is, as described above, that CVS has already morphed into a provider, furnishing a number of services in its Minute Clinics. Nurses, dietitians, pharmacists and other professionals can expand the current base to treat not only things like sore throats but also provide counseling and other services to manage chronic illnesses and to provide preventive services. As described in the main text, patients prefer to receive primary care services close to home. The provision of the planned services at a convenient “one-stop-shopping” location would supposedly reduce hospitalization and the use of specialty care, effectively creating community-based clinics.

Another basis of the business plan is that, as described more fully below, CVS is already one of the largest providers of Medicare prescription drug plans. Merging these plans with the larger insurance function provided by Aetna will allegedly create savings because CVS, as a “middle man,” takes its cut, largely through a system of inscrutable rebates and fees given back to drug manufacturers; the merger will supposedly eliminate this cut by getting rid of the middle man. See, e.g., Zachary Tracer, CVS’s $68 Billion Bid to Bring One-Stop Shopping to Health Care, BNA Health Law Reporter, Dec. 14, 2017, https://www.bloomberglaw.com/exp/eyJpZCI6IjAwMDAwMTYwMzI4M2QwYzlhYm

However, as delineated in the main text and in this Update, one can be skeptical about the claimed “efficiencies.” Study after study has found that mergers, including vertical ones, have failed to create the efficiencies that are used as justification. Furthermore, if retail clinics could achieve the savings and better outcomes that are claimed, then one wonders why these savings have yet to appear and why retail clinics remain minor players in the sector. The evidence regarding retail clinics’ ability to attain lower expenditures is mixed. See, e.g., Christine K. Cassel, Can Retail Clinics Transform Health Care?, 319(18) JAMA 1855 (May 8, 2018), https://jamanetwork.com/journals/jama/article-abstract/2678844 (Accessed July 22, 2019). On the other hand, “Seamless communication among insurers, pharmacies, and prescribers would save a lot of time and misery.” Dafney at 595. More importantly, as also described in this Update and in the main text, where an insurer possesses market power, savings gained from lower payments to hospitals are retained by the insurer rather than passed back to plan sponsors or covered participants.

There is ample evidence for concern that the merger will create greater market power. For one thing, because both CVS and Aetna have a large presence in the market for Medicare prescription drug plans (“PDPs”), the deal raises horizontal problems, although this discussion will largely focus on the vertical ones simply because they are more interesting. The following figure indicates that CVS’s market share for stand-alone PDPs has grown significantly over time (largely through acquisitions):
Necessarily, the combination of Aetna and CVS will create a firm with even greater market share and an overall increase in concentration in the market, particularly for stand-alone PDPs.* “The proposed mergers of CVS Health and Aetna, and [the now-consummated] Cigna and Express Scripts would result in further consolidation of the Part D marketplace. If these mergers go through, four firms—the two merged firms plus UnitedHealth and Humana—would cover 71 percent of all Part D enrollees and 86 percent of stand-alone drug plan enrollees, based on 2018 enrollment.” Juliette Cubansky, Anthony Damico & Trisha Neuman, Medicare Part D in 2018: The Latest on Enrollment, Premiums, and Cost Sharing, Kaiser Foundation, May 17, 2018, https://www.kff.org/medicare/issue-brief/medicare-part-d-in-2018-the-latest-on-enrollment-premiums-and-cost-sharing/ (Accessed July 22, 2019). The market concentration actually will be greater because Cigna and Express Scripts have merged, as discussed more fully below.

* There is a thorny question whether PDPs included as part of Medicare Advantage plans are in the same product market as stand-alone PDPs. See, e.g., Meg McEvoy & Christina Brady, CVS-Aetna Deal Could Raise Drug Coverage Costs in Some Places, Bloomberg BNA Antitrust & Trade Regulation Report, July 20, 2018, https://www.bna.com/csvaetna-deal-drive-n73014477673/ (Accessed July 22, 2019). We omit discussion of this issue here.
Three firms—UnitedHealth, Humana, and CVS Health—cover over half of all Medicare Part D enrollees in 2018.

Total Part D Enrollment, 2018 = 43.4 million

NOTE: Includes enrollment in the territories and employer-only group plans. *BCBS excludes Anthem BCBS, which is a separate plan sponsor.
For another thing, as described in the main text and this Update, contrary to simple models that became dominant in the academy, among antitrust enforcers and in the courts, vertical mergers can create significant foreclosure and barriers to entry. First, there can be foreclosure through steering: “CVS–Aetna could ‘foreclose’ rivals, say by refusing to offer PBM services to other insurers or declining contracts to fill prescriptions for other insurers’ enrollees—perhaps in geographic areas where Aetna wishes to defend or strengthen its market share.” Dafney at 594. Steering Aetna plan members to use certain services, e.g., to CVS for prescriptions by higher copays elsewhere, is now a routine tool used by insurers to steer plan members to certain providers and therefore it can readily be used to foreclose competitors. United Health is already using such means to steer plan members to its doctors and to entice Medicare beneficiaries to choose its Medicare Advantage plans. See, e.g., Zachary Tracer, 30,000 Strong and Counting, United Health Gathers an Army, Bloomberg News, April 9, 2018, https://www.bloomberg.com/news/articles/2018-04-09/30-000-strong-and-counting-unitedhealth-gathers-a-doctor-army. (Accessed July 22, 2019). Power in the Medicare stand-alone PDP market could easily be leveraged to foreclose rivals offering PDP plans from CVS’s 10,000 retail outlets for prescriptions and other services.

For perhaps the most recent statement that vertical mergers can be anticompetitive in oligopolistic markets and need to be closely scrutinized, see Steven C. Salop, Invigorating Vertical Merger Enforcement, 127 Yale L.J. 1962 (2018).
There is also the loss of a potential entrant because Aetna would be a natural entrant “in some business segments in which CVS currently operates, such as pharmaceutical benefit management. Its rival United, after all, has a large and successful PBM subsidiary.” Dafney at 594. As described in the main text, if a firm were foreclosed but wanted to enter, entry would have to encompass two stages of production, integrating insurance with the services CVS offers—and probably CVS-Aetna’s full-line offering of nutrition, transportation, monitoring, etc., analogous to the full-line offering of Dentsply’s tied-up dealers (main text p. 1257), to be provided by the merged CVS-Aetna incumbent—a daunting task given the market consolidation, although Medicare Parts C and D are expanding markets as the population ages and the participation in these Parts has soared in recent years and will continue to do so. Finally, the Aetna-CVS deal must be viewed, not in isolation, but in the context of the consolidation going on in the PDP market and elsewhere in the sector. As noted above, Express Scripts has merged with Cigna. See, e.g. Dana Mattioli & Dana Cimilluca, Cigna Agrees to Buy Express Scripts for More Than $50 Billion, WSJ, March 8, 2018, https://www.wsj.com/articles/cigna-nears-deal-to-buy-express-scripts-1520482236 (Accessed July 22, 2019); Chad Bray & Katie Thomas, Cigna to Buy Express Scripts in $52 Billion Health Care Deal, New York Times, March 8, 2018, https://www.nytimes.com/2018/03/08/business/dealbook/cigna-express-scripts.html (Accessed July 25, 2018). Additionally Humana and Walmart are reported to be negotiating some form of tie-up. See, e.g., Dana Mattioli, Sarah Nassauer & Anna Wilde Mathews, Walmart in Early-Stage Acquisition Talks with Humana, WSJ, March 29, 2018, https://www.wsj.com/articles/walmart-in-early-stage-acquisition-talkswith-humana-1522365618 (Accessed July 22, 2019); Michael Corkery, David Gelles & Margot Sanger-Katz, Walmart in Talks to Strengthen Ties to Health Insurer Humana, New York Times, March 30, 2018, https://www.nytimes.com/2018/03/30/business/walmart-humana-merger.html (Accessed July 22, 2019); These Deals Set a New Paradigm for Healthcare Industry, AlphaStreet, June 10, 2019, https://news.alphastreet.com/these-deals-set-a-new-paradigm-for-healthcare-industry/ (Accessed July 22, 2019). Overall, the degree of potential foreclosure is rather daunting: “All three of the biggest U.S. PBMs will be tied to three of the country’s biggest insurers. CVS, Express Scripts, and UnitedHealth process more than 70 percent of all U.S. prescriptions. Post-merger, three companies will insure more than 90 million people in some capacity, process more than 3.5 billion prescription claims, and generate more than $500 billion in revenue.” Max Nisen, Amazon Is Already Reshaping Health Care: Its Threat Alone Has Helped Speed Consolidation, and Consumers May Suffer, Bloomberg News, March 26, 2018, https://www.bloomberg.com/gadfly/articles/2018-03-26/amazon-s-health-care-threat-is-already-reshaping-the-industry (Accessed July 22, 2019).*

As described in this Update and in the main text, vertical consolidation is occurring at a rapid rate throughout the sector. Hospitals are increasing their footprint by gobbling up multiple types of stand-alone facilities, physician practices and, in some instances, integrating backwards into insurance. Insurers likewise are moving heavily into service provision, with UnitedHealth as the leader in buying up, for example, Surgical Care Affiliates, one of the largest operators of ASCs in the country, see, e.g., UnitedHealth’s Optum to Acquire Surgical Care Affiliates for $2.3 Billion, Modern Healthcare, Jan. 9, 2017, http://www.modernhealthcare.com/article/20170109/NEWS/170109936 (Accessed July 25, 2018), as well as DaVita Medical Group, one of the top two operators of dialysis facilities in the United States and the owner of multiple types of free-standing facilities.** See, e.g., Reed Abelson, UnitedHealth Buys Large Doctors Group as Lines Blur in Health Care, New York Times, Dec. 6, 2017, https://www.nytimes.com/2017/12/06/health/unitedhealth-doctors-insurance.html (Accessed July 25, 2018). In fact, because UnitedHealth seems to be moving into almost every aspect of the health care sector, it is the driver of the CVS-Aetna merger, not Amazon. See, e.g., Brooke Sutherland & Max Nisen, UnitedHealth’s Splish Beats CVS-Aetna’s Splash, Bloomberg News, Dec. 6, 2017, https://www.bloomberg.com/gadfly/articles/2017-12-06/unitedhealth-davita-deal-shows-how-it-can-beat-cvs-aetna (Accessed July 22, 2018); Zachary Tracer, Forget Amazon. Health Companies Really Want to Be UnitedHealth, BNA’s Health Law Reporter, Dec. 7, 2017, https://www.bloomberglaw.com/document/XB3LV9HO000000?emc=bnahlr%3A10&jcseref=bna%252000000016022e2d447ade3fafeb0150000 - jcite (Accessed July 22, 2019). The question is whether this tumult is occurring to attain savings and improve the quality of care or to attain leverage. So far, the evidence is overwhelming that the aim is to make more money.

Despite these concerns, in late 2018 the DOJ announced that it would allow the CVS-Aetna merger to proceed so long as Aetna divested its PDP business to WellCare to prevent the horizontal concerns addressed above. Regarding the substantial concerns about vertical consolidation DOJ only addressed them in the Public Q & A it released to the public:

** Vertical Case:

16. Did the Division investigate whether the vertical integration of CVS and Aetna would reduce competition?

Yes. The Division thoroughly considered whether the merger would raise the cost of (i) CVS/Caremark’s PBM services or (ii) retail pharmacy services to Aetna’s health insurance rivals.

** As described below, in its settlement with the FTC and Colorado, UnitedHealth was allowed to acquire DaVita Medical Group so long as it divested assets in Nevada and accepted behavioral remedies in Colorado.
After a careful analysis, the Division determined that the merger is unlikely to cause CVS to increase costs to Aetna’s health insurance rivals due to competition from other PBMs and retail pharmacies.

The evidence also showed that CVS is unlikely to be able to profitably raise its PBM or retail pharmacy costs post-merger because it would lose customers and Aetna would not be able to offset those losses by capturing additional health insurance customers.


According to a number of observers, this is one unhappy judge. For example, one report contained the following:

* As discussed in the textbook on page 1247, the district court hearing the DOJ’s civil lawsuit must approve any settlement to ensure that it is in the public interest. See Section 2(b) of the Antitrust Procedure and Penalties Act, 15 U.S.C. § 16(b)-(h).
[Judge Leon] blasted the Justice Department’s counsel for doubling down on the argument that the court’s review must be limited to the divestiture of Aetna’s Medicare Part D business, which was the only aspect of the deal the government identified as potentially anticompetitive.

Leon clarified with DOJ attorney Jay Owen the government’s position that even if the judge identified additional public harm, those harms wouldn’t undermine the public interest. When Owen agreed, the judge issued a sharp rebuke.

“Are you familiar with the first law of holes?” Leon said. “If you find yourself in a hole, stop digging.”


As extraordinary as this procedure appears to be, it is not occurring in a vacuum. For one thing, in 2018 DOJ challenged AT&T’s merger with Time-Warner in litigation that raised vertical issues quite analogous to those at issue in the CVS-Aetna consolidation. Although Judge Leon himself wrote the opinion rejecting that challenge, see United States v. AT&T, Inc., 310 F. Supp.3d (D.D.C. 2018), which was affirmed on appeal, 916 F.3d 1029 (2019), both his opinion and that of the D.C. Circuit hewed close to the facts. Neither Judge Leon nor the circuit court rejected the relevance of the horizontal effects flowing from a vertical merger. Instead, both found that DOJ simply had not proved its case. It is no wonder, then, that with regard to the CVS-Aetna merger Judge Leon wants to know, in essence, what the evidence shows in the case now before him.

Moreover, both the FTC and DOJ have shown increased concern about the horizontal effects of vertical mergers and the laissez faire treatment vertical mergers have received since the Chicago School virtually took over antitrust analysis and enforcement. As mentioned above, the FTC approved UnitedHealth’s acquisition of DeVito Medical Group, as did Colorado, but the FTC ordered divestiture of assets in Nevada and Colorado ordered behavioral remedies, both in part because of potential horizontal effects of a vertical merger.” See, e.g., Jeny Maier & Adam Cella, UnitedHealth-DaVita and

* There was a difference of opinion among the FTC Commissioners whether the evidence in Colorado was strong enough to support a case there resting solely on the horizontal effects of a vertical merger without any overlapping horizontal assets. Compare Statement of Commissioner Noah Joshua Phillips & Commissioner Christine S. Wilson, https://www.ftc.gov/system/files/documents/public_statements/1529366/181_0057_united_davita_statement_of_cmmrs_p_and_w.pdf (Accessed July 23, 2019), with Statement of Commissioners Rebecca Kelly

Finally, there is substantial support in academia for much closer attention to vertical mergers. During his career Professor Stephen Salop has criticized the Chicago-School assumption that vertical mergers are simply “good,” and as indicated above he has written what might be termed a manifesto for revision of the Guidelines. See Steven C. Salop, Invigorating Vertical Merger Enforcement, 127 Yale L.J. 1962 (2018). None of this has escaped the attention of academics who specialize in health care, and one can say that there is a growing tide to paying attention to the horizontal effects of vertical mergers, much along the lines of what we have written in the Textbook and here. Professor Tim Greaney, for example, canvassed the problems raised by the CVS-Aetna merger and indicated that a fact-sensitive approach is necessary:

Applying raising rivals’ cost principles to these cases undoubtedly entails a heavily fact-intensive inquiry. Fact finders need to assess not only whether exclusion is likely to occur but also whether such exclusion will harm competition, and if so, whether merger-specific efficiencies are sufficient to prevent or mitigate the exercise of market power. While legal precedent and agency guidance establishing workable principles and presumptions are lacking, some baseline factors can be identified that should trigger concern about vertical mergers. For example, economists identify market structure conditions including market dominance, barriers to entry, scale economies and network effects as important indicia of potential competitive harm. Qualitative factors such as economic incentives to use vertical mergers to forestall entry or raise rivals’ costs and regulatory conditions that encourage vertical consolidation are also relevant.


Perhaps Judge Leon is right that he cannot determine whether the CVS-Aetna merger is in the public interest without more facts. At this writing, on July 23, 2019, we await his decision.

b. The blocked mergers from five to three national insurers.

In 2015 there was the Big Five, in descending order of size: UnitedHealth, Aetna, Anthem, Humana and Cigna. In terms of 2014 revenue, UnitedHealth was way out in front with $130.5B, Anthem second with 73.9B, Aetna in third with 58.0B, Humana fourth with 48.5B and Cigna trailing behind at $34.9B. See, e.g., Dana Cimilluca et al., UnitedHealth, Anthem Seek to Buy Smaller Rivals, WALL ST. J. (June 16, 2015), http://www.wsj.com/articles/anthem-makes takeover-approach-to-cigna-1434384734 (Accessed July 17, 2017); Liz Hoffman et al., Aetna Agrees to Buy Humana for $34.1 Billion, WALL ST. J. (July 3, 2014), http://www.wsj.com/articles/aetna-nears-deal-to-buy-humana-1435883861 (Accessed July 17, 2017). However, the hunt began as the sharks started to circle their prey, and the prey sometimes became sharks hunting other prey.* As the wonderful title of a Wall Street Journal article proclaimed, “Insurers Playing a Game of Thrones,” Christopher Weaver (July 16, 2015), http://www.wsj.com/articles/insurers-playing-a-game-of-thrones-1434497818 (Accessed July 17, 2017), the Big Five were about to duke it out to claim the kingdom. The pictorial representation, reprinted with permission from the Wall Street Journal, is likewise fantastic:

Humana was at the center of it all initially because almost everyone wanted its MA books of business, with the expectation that the MA market would continue to grow as more baby boomers, accustomed to managed care, would choose MA over traditional Medicare. Humana was an unattractive target only to UnitedHealth because it was second to UnitedHealth in the rapidly growing MA market. Thus any of the other three—Aetna, Anthem or Cigna—could purchase Humana without setting off such a huge numbers of divestitures as to make the deal not worth pursuing.

Cigna made the first move but was rebuffed by Humana, supposedly because Cigna did not put enough cash on the table to make the deal acceptable to Humana’s shareholders (or at least its board members). This gave an opening to Aetna, which then gobbled up Cigna’s (former) prey, Humana.

The question then was who would strike next. Would UnitedHealth enter the fray? Apparently not, as the two remaining boxers in the ring were Anthem and Cigna, which, after a period of negotiation, announced on July 24, 2015, that they were to marry.
Antitrust regulators, however, would have none of this, bringing suit against both mergers’ and alleging that the mergers would reduce competition where the merging companies’ business overlapped substantially, while ignoring all the products over which there was a lesser degree of overlap. With regard to the Anthem-Cigna merger, the DOJ was able to convince the district court that one relevant market consisted of the large group market, defined as firms with over 100 employees, and, moreover, another relevant market consisted of national accounts, defined as businesses with more than 5,000 employees. The latter in particular constitutes a rather small part of the overall health insurance market. Nonetheless, that is the slice on which the litigation primarily focused.

We saw identical strategies and results in the Book’s section on market definition, in which plaintiffs sought to confine the market to captive customers, e.g., patients who live near merging hospitals and who will travel only for tertiary care. When markets are defined around only captive customers other customers effectively get ignored. In this context, Anthem, like other Blue Cross Blue Shield organizations, is a huge player in the individual and small group markets, but in defining the market as national accounts the district court accepted a much smaller slice of its total products and customers. As we stated earlier in this Update, antitrust doctrine is moving in the direction of protecting captive customers—that is, protecting consumers who have limited buying options and thus are highly dependent on a particular seller—by defining markets narrowly. See, e.g., FTC v. Staples, Inc., 190 F. Supp.3d 100 (D.D.C. 2016) (sale and distribution of consumable office supplies to large business customers was relevant market). See also this Update, insert to textbook page 1241.

To some extent the cases were standard merger fare, albeit enormous given the size and importance of the mergers. As just indicated, initially there were the usual battles to define the relevant markets. In the Anthem-Cigna merger the most interesting part of that battle was the government’s effort to distinguish the national accounts market for firms with over 5,000 employees, something that was accomplished by showing its distinctiveness on both the consumption and production sides. Among other things, the evidence showed that both Anthem and Cigna established separate business units devoted to these national accounts, and each of these separate profit and loss centers had their own executives, underwriters, sales teams and customer service personnel. On the consumption side, national employers with over 5,000 employees had special needs with regard to the creation and maintenance of a national network, a high degree of plan customization, sophisticated claims administration and data reporting. All of these functions had to be supported by sophisticated IT platforms protected against data breaches by sophisticated data security measures.

In the Aetna-Humana merger, the battle was joined over whether the relevant market should encompass just competition among MA plans or should also include traditional Medicare; that is, the insurers argued that the market was all of Medicare, MA plans plus the traditional Medicare program, which still accounts for 7 in 10 beneficiaries.

most of whom could be viewed as MA prospects and all of whom are also prospects for supplemental insurance plans (known as MediGap plans) designed to fill in Medicare’s considerable deductibles, cost-sharing, and coinsurance under Parts A and B. Inclusion of the entire Medicare program would have sounded the death knell of the government’s case, since the market would have been vast. However, again the government marshalled adequate evidence that MA plans are distinct from traditional Medicare on both the consumption and production sides such that it prevailed in keeping traditional Medicare out of the relevant market. Most notably, the evidence strongly showed that the defendants themselves consider the markets to be distinctive and priced their MA plans and MediGap plans in isolation of any consideration of the other. Also, on the consumption side, the markets for traditional Medicare and MA remain distinct. That is, the great majority of MA plan beneficiaries who switch out of a MA plan enroll in a different MA plan—they don’t move between MA and traditional Medicare. This fact strongly suggested that Medicare beneficiaries themselves view MA plans as entirely different creatures from traditional Medicare paired with a supplemental private MediGap plan, and therefore, that MA plans compete amongst themselves and not with traditional Medicare.

From there both cases were slam dunks, absent affirmative defenses, because the mergers led to very high concentrations—actually, very substantial increases in already highly concentrated markets—and because they eliminated head-to-head competition between the merging parties. Indeed, Judge Bates deadpanned in *Aetna*, “There is no suspense about the outcome of this HHI analysis here . . . .” 2017 WL 325189 at 29.

Each case raised some interesting defenses. In *Aetna*, for example, the defendants asserted that they had no power to raise price because of CMS’s regulation of MA plans. They had a point, at least superficially, because payment to MA plans turns on benchmark competition, in which plans bid around the average cost of a traditional Medicare beneficiary county by county—i.e., the benchmark. To the extent that plans bid below the benchmark, they are entitled to retain some of that margin but in theory, if there is adequate competition, the plans compete away that margin in the former of lower out-of-pocket costs and extra benefits, such as eyeglasses, hearing aids and the like.* CMS also deploys numerous kinds of regulatory requirements, such as limitations on beneficiaries’ out-of-pocket costs, minimum loss ratios, network adequacy requirements and the like that might seem to constrain defendants’ ability to use market power to drive up margins they retain. However, after a close review of the regulations, and testimony from former CMS officials and players in the industry, the court determined, correctly, that the regulations merely set the contours or framework for plan participation and thus ample opportunity exists for plans with market power to assert that power to obtain supra-competitive profits.

* You will recall that beneficiaries of traditional Medicare purchase MediGap plans because the latter offer benefits traditional Medicare does not, something that MA plans likewise offer. Therefore, conceivably, the combination of traditional Medicare plus MediGap plans compete with MA plans. The court found that they do not for the reasons stated in text.
* As we indicated above, theory doesn’t match fact as Biles, Casillas, and Guterman found that 97 percent of MA markets are concentrated.
Aetna was also interesting in that after the government filed suit Aetna withdrew from the 17 ACA exchanges that were at issue in the litigation. Although the district court rejected the government’s request that the case be tried as if Aetna had not withdrawn from those counties, the court also eschewed adoption of Aetna’s position that there was no harm, no foul—no anticompetitive issue—because they had withdrawn from the problematic counties. The court was troubled by allowing Aetna to escape governmental action by eliminating the problem through its own devices and correctly found that the relevant issue was whether Aetna was likely to reenter those counties when the litigation ended. This analysis, in turn, depended on Aetna’s motives for withdrawing in the first place, and the evidence was clear that Aetna was using its participation in the Exchanges as leverage to fend off the filing of the suit and that it withdrew because the suit was filed.** The district court then found that in Florida Aetna’s plans in certain Marketplaces were profitable and that it likely would reenter. Aetna’s defense thus failed.

Probably most interesting were the efficiencies defenses, raised in Aetna but most fully litigated in Anthem, that the mergers would be allowed because they would save “medical costs.” All efficiency defenses in merger cases are controversial and the very existence and contours of the defenses are somewhat in doubt, but we’ll leave that to an antitrust course. For our purposes, we focus on the claim that, despite its anticompetitive effects, the merger should have been allowed because it would enable the merging insurers better to drive down the price of providers’ services, inuring to the benefit of plan sponsors, who either self-insure and buy administrative services only (“ASO”) or who are fully insured. The argument runs that it is plan sponsors that are buying providers’ services and therefore it is they who benefit from lower prices; those benefits, the argument continues, outweigh any anticompetitive harm flowing from Anthem’s market power. It’s a simple story with simplistic appeal but the only judge who bit on it was Judge Kavanaugh in dissent in the court of appeals,*** whose opinion was rightly criticized by his colleagues as being written at a “superficial, thirty-thousand-foot view,” 855 F.3d at 366, and as utterly failing to engage with the evidence in the record and the findings of the district court.

With the exception of Judge Kavanaugh’s opinion, all of the opinions in the two cases obliquely or explicitly understood the types of basic points supported in the literature we discussed at the outset of this note; they also understood the evidence in the record. First, driving down the price of a supplier is not an efficiency. Nothing new is created. No new way to produce something is developed. No economies are achieved. And so forth. All that happens is that wealth is transferred from the

** Given the exceedingly high levels of concentration caused by each of the two mergers—levels that were so dauntingly high that many thought that successful antitrust intervention was highly likely to the point of near certainty—one wonders if each of the two dominant firms among the merging parties, Anthem and Aetna, expected that the merger would be treated leniently because each was among the strongest supporters of the Exchanges.

*** Anthem appealed only on the issue of claimed efficiencies, which tells one something about the strength of the district court’s opinion on the definition of relevant markets and the merger’s anticompetitive effects.
supplier to the purchaser. Efficiency remains unchanged, and we’re talking only about a transfer payment.

Second, does a buyer’s exaction of that transfer payment from a seller violate the antitrust laws? It depends on the focus. Judge Kavanaugh is certainly correct that if the complaint sounds in monopsony—a buying-side issue—then monopsony must be proven and documented in the district court’s opinion; and although monopsony was alleged, the district court found it unnecessary to decide the case on that basis. Why was the court correct in ruling this way? Because the alleged “efficiencies” were raised as defenses in the context of a case in which it had been determined that the merger will cause a selling-side problem, i.e., the assertion of market power against plan sponsors who are buying either insurance or ASO. Raised in this context, the efficiency defense must rest on an “efficiency” and a transfer payment simply is not an “efficiency.” It is simply a transfer of wealth from providers to insurers.

The various opinions, particularly Judge Millet in concurrence, also make the point that the transfer payment itself is the result of an illegal outcome, the creation of market power through merger. Here Judge Kavanaugh raised a valid point, which is that one cannot assume that there is an illegal act without proving monopsony, and monopsonization requires, as we saw in Kartell in particular, a predatory act, here predatory pricing. Sounds right, doesn’t it?

No, it’s wrong because the focus has again been shifted from the selling side to the buying side. If we’re focused on the selling side, then an insurer with market power on the selling side is able to obtain “discounts” from providers and thereby erect a barrier to entry against other firms on the selling side. Unless there are few barriers to entry on the buying side, the firm thereby locks in for the long haul its power on the selling side because entrants against it will not have the power to obtain similar “discounts.” This was precisely one of the grounds for criticizing then-Judge Breyer’s opinion in Kartell, something discussed in the Book at page 1255.

Last what about Judge Kavanaugh’s point that a merger creating market power is good for plan sponsors because it drives down the prices of goods and services purchased by plan sponsors, particularly plan sponsors who are self-insured and buying administrative services only from Anthem? Here Judge Kavanaugh is correctly skewered by his colleagues for simply assuming that Anthem will just pass along those savings to its national account customers. He admits that the problem is complicated in the case of insured plan sponsors because compared with self-insured firms, Anthem has a greater ability to hide and retain the surplus it gains from providers. However, he thinks that the national account customers demand and obtain transparency such that they can prevent Anthem from doing this to them. As we develop in virtually this entire Book, the idea that anything so complicated as whether Anthem is gaining “surplus” from providers and being forced by national account customers to set its ASO fees such that this “surplus” is passed along to those customers is simply laughable; and the record in the case supports that conclusion—that Anthem certainly intended to keep for itself, and was likely capable of retaining for itself, the benefits of lower prices to providers. Last, all of the scholarly
literature we discussed at the outset of this note supports that point and the outcome in the case.

Finally, an interesting twist in *Anthem* is that Cigna clearly began to oppose the merger and was actually quite hostile to Anthem in court. The district court called this issue “the elephant in the courtroom,” 2017 WL 685563, at 4, because it undermined Anthem’s claim that efficiencies would stem from the merger: “Cigna officials provided compelling testimony undermining the projections of future savings, and the disagreement runs so deep that Cigna cross-examined the defendants’ own expert and refused to sign Anthem’s Findings of Fact and Conclusions of Law on the grounds the they ‘reflect Anthem’s perspective’ and that some of the findings ‘are inconsistent with the testimony of Cigna witnesses.’” Id. One can speculate that the merger started to fall apart because of the two firms’ different cultures and models of arranging for health care. Anthem’s model is to drive as hard a bargain with providers as possible, and that was evident in the record, while Cigna does not attempt to reduce prices as much but instead engages in a much more collaborative model such that its providers cooperate in keeping a population healthy. These different approaches undermined Anthem’s claims of medical savings, which were largely based on its leveraging its discounts into Cigna’s books of business. Conceivably, providers might revolt *en masse* in a number of ways, including leaving the network or scrimping on care. It is for this reason, among others, that the district court held that Anthem could not verify that medical savings would occur and in what amount. Likewise, it starkly shows how facile is Judge Kavanaugh’s reasoning that national account customers can demand and obtain transparency and thereby actually know what value is exchanged for the fees they pay and the value of the care provided to their thousands of employees across millions of claims. And of course, any insurer would consider information regarding how it makes its money to be proprietary, something that can be seen in the *Mondry* decision (textbook, p. 264), in which one sees the brick wall that even a sponsor of a *self-insured* plan runs into when it seeks its *own plan administrator’s* internal operating guidelines for making coverage determinations. As you know already, health care is simply too complicated for the application of Economics 101.

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* Each party is now suing the other for billions of dollars, with each alleging breach.