Law and the American Health Care System
Second Edition

2012-23 Supplement

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Table of Contents Listing Updated Chapters

Insert as the new introduction to the Book before Chapter One on page 2:

Introduction to the Book: The Coronavirus Feeds on the Pathologies of the American Health Care System

[Although this introduction was written two summers ago, we have retained it because the substantive points we make still hold true. Yes, the pandemic has evolved but one might, wryly and sadly, remark that the old is new and the new is old. When we wrote two years ago, the United States was about to enter yet another and perhaps its worst surge of the pandemic; and in terms of the number of infections and deaths it was fairing worse than many other wealthy nations. Yet even here, as we recount below, the new was old because the burdens of the United States' sorrows were quite unevenly distributed, with the less fortunate and many persons of colors bearing a far disproportionate share of the pain.

At this point, one can say that the old is the new as the world order has, one might say, reasserted itself. The United States and other wealthy nations, armed with much greater resources than other parts of the world, particularly its prowess of PHARMA, are now faring much, much better, as increasing portions of their populations become inoculated. Yet even here, the benefits are disparately distributed, with the relatively rich and powerful benefiting the most from the largesse of these resources. Hence, one might say that, of course with some variation, the rich and powerful have gotten richer and more powerful.

Our (non)system for financing and delivery of health care and our separation of finance and delivery continue to magnify these disproportionate burdens rather than ameliorate them. The financing and delivery system is focused on providing health care after the occurrence of illness, rather than preventing it in the first place. Our focus is on keeping individuals healthy instead of keeping the population well. The separation of public health from health care financing and delivery has roots deep in the political economy of the late nineteenth and early twentieth centuries when medicine consolidated its place at the top of the division of labor pertaining to health, subordinating all others with whom it might compete. The result is that enormous sums have poured into medicine to the detriment of what has been cleaved apart, public health. Furthermore, time and again, the pandemic legislation enacted by Congress over the past 16 months has failed to ensure that billions of dollars in additional emergency health care resources went to the hardest-hit institutions and communities

The fragmentation on both the financing and delivery sides has allowed our expenditures to soar relative to those of other nations, with no demonstrable improvement in the health of our population. Some services are overfunded while others are starved.

Moreover, the United States' singular use of relatively full-blown competition, the "market," to organize and allocate resources has left an institutional vacuum, with the result that we lack mechanisms that can achieve adequate coordination in the face of a pandemic, as well as support the standby capacity that is largely unused except when it is needed most.

Our country's reliance primarily on employer-provided health insurance, with the incremental additions of various populations not served by that source of insurance—e.g., the aged, children, self-employed persons, unemployed persons, the disabled, and those working in the retail, agriculture and service sectors has left us with a horde of different sponsors of health insurance, each often governed by different, sometimes overlapping, legal regimes. In short, we have bedlam and many people fall through the gaps. The pandemic was a disaster in the making as the economic crisis it caused has dropped many individuals and families out of the dominant means of insurance, employment, and left them to scramble to fit in elsewhere; many are just left out.

Finally, structural racism pervades our system. Embedded within virtually every major institution of our society—food, education, housing, health care infrastructure, transportation, child care, among others—it comes as no surprise that people of color, a vulnerable population, have been hit the hardest by this pandemic and breath-takingly so, particularly when elements of that population are stuck at or near the bottom rung of the socio-economic ladder. This structural racism deprives these people of the resources they need in their communities to face even primary health, much less the disaster wrought by this pandemic.

What was two years ago remains new today.]

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For a number of reasons it is appropriate to begin your study of law and the American health care system with the COVID-19 pandemic. For one thing, we're sure that the pandemic is very much on your minds, of interest to you, and plays an important role in your current situations. For another, the pandemic has exposed virtually every pathology of the American health care system, the subject of this entire book. In fact, the pandemic has blown open any little crack in the system to create a fissure. For these reasons, we can't think of a better way to bring you into the subject matter of this course.

In this introduction we discuss four pathologies that historically have characterized the American health system and that the pandemic has made so painfully visible. The first such pathology is failure of the United States to have a health care system that focuses on keeping people healthy, in good part due to the almost complete separation of health care finance and delivery from public health and the abysmal lack of funding of the latter.

The second is fragmentation that characterizes health care, both financing and delivery, leaving critical services chronically underfunded, vastly overcompensating others, and making it impossible to seamlessly move people through health care.

The third pathology is the absence of universal health insurance, our continuing reliance on employment for our health insurance, and our failure—even with the Affordable Care Act's landmark reforms—to establish a universal public insurance foundation. Instead, the ACA created an even more elaborate public insurance patchwork to fill the gap, one whose limitations the pandemic has made evident. And this gap is huge: one recent survey, discussed below, showed that 40% of respondents or their spouse or partner who lost a job or were furloughed depended on workplace coverage, underscoring the magnitude of the need for a temporary or permanent public fallback.

Fourth is the structural racism baked into so many aspects of American life, beginning with basic living conditions and extending to health insurance and health care itself. For this reason, the pandemic's consequences have fallen hardest on minority communities that already experience the terrible daily living conditions, a very high degree of daily stress and health risks, and a shortage of health care to prevent and treat health conditions entirely amenable to control through good health care, e.g., hypertension. For these reasons, the most terrible consequences of COVID-19 have fallen on Black, Latinx, Native Americans, and other patients of color and have far eclipsed those of White patients.

The Pandemic's Initial Course

Before proceeding, it is useful to describe the major events in the course of the pandemic and the position of the United States.[1] Scientists are still debating the origins of the novel coronavirus and its first jump to humans, so-called zoonotic transfer, but it appears that in late November or early December 2019 in Wuhan, China, the virus made its leap from the animal world to humankind.[2] Sometime during December reports of a deadly, unusual pneumonia started circulating in the medical community in Wuhan and other parts of Hubei Province.[3] On December 31, 2019, the World Health Organization ("WHO") China Country Office "was informed" of cases of pneumonia of unknown

[1] This introduction draws from David M. Frankford, Sick at Heart: A Fundamental Reason the United States Was Unprepared for the COVID-19 Emergency, 72(5) Rutgers U. L. Rev. (2020), available at https://ssrn.com/abstract=3623432 (Accessed July 18, 2020).

[2] See, e.g., Chaolin Huang et al., Clinical Features of Patients Infected with 2019 Novel Coronavirus in Wuhan, China, 395 Lancet 497 (Feb. 15, 2020), https://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(20)30183-5.pdf (Accessed May 30, 2020).

[3] Some of the timeline of events in China from late December 2019 to January 2020 is usefully summarized in Congressional Research Service ("CRS"), COVID-19 and China: A Chronology of Events (December 2019-January 2020) (May 13, 2020), https://crsreports.congress.gov/product/pdf/R/R46354 (Accessed June 4, 2020).

etiology,[4] with Wuhan's health commission issuing a statement in response to "rumors"—which were actually discussions among Wuhan's doctors for which they were denounced and disciplined[5]—that the "disease is preventable and controllable."[6]

Exactly what happened in China remains murky but it is clear from a number of sources, including an analysis of Chinese censorship of social media published in *Wired*,[7] that information on the outbreak was actively suppressed.[8] Importantly, during the first two weeks in January 2020, two official investigative teams in China reported that there was no evidence of human-to-human transmission.[9] The second report was turned over to the WHO, which repeated that conclusion in a tweet on January 14th,[10] although it is clear by then that the disease was spreading from person to person, with at least 105 infections occurring before December 31st (the number of infections may actually have reached 1,000 cases or perhaps many times more).[11]

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[4] See World Health Organization, Pneumonia of Unknown Cause—China (Jan. 5, 2020), https://www.who.int/csr/don/05-january-2020-pneumonia-of-unkown-cause-china/en/ (Accessed May 29, 2020). The passive voice appears in the official pronouncement. See also CRS, supra note _, at 6.

[5] See, e.g., Yanzhong Huang, China's Public Health Response to the COVID-19 Outbreak, China Leadership Monitor 4 (June 1, 2020), https://www.prcleader.org/huang (Accessed June 3, 2020).

[6] Chris Buckley & Steven Lee Myers, As New Coronavirus Spread, China's Old Habits Delayed Fight, New York Times (Feb. 1, 2020), https://www.nytimes.com/2020/02/01/world/asia/china-coronavirus.html (Accessed May 30, 2020).

[7] See Shawn Yuan, Inside the Early Days of China's Coronavirus Coverup: The Dawn of a Pandemic—as Seen Through the News and Social Media Posts That Vanished from China's Internet, Wired (May 1, 2020), https://www.wired.com/story/inside-the-early-days-of-chinas-coronavirus-coverup/ (Accessed May 25, 2020). See also Li Yuan, China Silences Critics Over Deadly Virus Outbreak, New York Times (Jan. 22, 2020), https://www.nytimes.com/2020/01/22/health/virus-corona.html (Accessed May 30, 2020).

[8] See also Yanzhong Huang, supra note 5, at 4-5. For perhaps the best discussion of the extent to which local and central figures complied with bureaucratic rules governing the reporting of information upward, see Michael D. Swaine, Chinese Crisis Decision Making—Managing the COVID-19 Pandemic Part One: The Domestic Component, China Leadership Monitor (June 1, 2020), https://www.prcleader.org/swaine (Accessed June 7, 2020). This account belies any simplistic claim that "China" deliberately covered up the outbreak. It shows, for example, that local officials' order to some labs to destroy samples *might* have been an effort to ensure that samples were analyzed only in qualified laboratories; that strict oversight over the flow of information, including to the public, *might* have been an effort to ensure that information was based on clear diagnostic criteria and a clear consensus among experts so as to avoid "the somewhat chaotic and panic-driven reaction to the SARS epidemic," id. At 7; and that statements about lack of evidence of human-to-human transmission *might* have been based on that cautiousness, as well as too high a degree of optimism that spread, if any, was slow.

[9] See, e.g., Kathy Gilsinan, How China Deceived the WHO, The Atlantic (April 12, 2020), https://www.theatlantic.com/politics/archive/2020/04/world-health-organization-blame-pandemic-coronavirus/609820/ (Accessed May 30, 2020); Associated Press, China Didn't Warn Public of Likely Pandemic for 6 Key Days (April 15, 2020), https://apnews.com/68a9e1b91de4ffc166acd6012d82c2f9 (Accessed May 30, 2020).

[10] See World Health Organization (Jan. 14, 2020), https://twitter.com/WHO/status/1217043229427761152?s=20 (Accessed May 30, 2020).

[11] See Jin Wu et al., How the Virus Got Out, New York Times (March 22, 2020), https://www.nytimes.com/interactive/2020/03/22/world/coronavirus-spread.html (Accessed May 30, 2020).

Initial information suppression appears to have occurred at many levels: in local hospitals;[12] by the provincial government, which appeared to have been most interested in hosting the Hubei provincial Chinese People's Political Consultative Conference and the Hubei People's Congress, including a banquet for 10,000 families to beat a Guinness Book of Records event;[13] and by Beijing, perhaps because political considerations and social stability were key considerations leading up to national Party conferences in March.[14] In the meantime, events in China unfolded along lines similar to those that have become familiar to us all as a result of the experiences of European nations (Italy went first) and later, New York City. Testing was initially quite inadequate, the hospital system quickly became overwhelmed, many health care workers became infected, and many died for lack of personal protective equipment ("PPE").[15] The timing could not have been worse as millions of people were moving around to travel for the Chinese Lunar New Year.[16]

By mid-January it became clear that China had a major problem. A national investigative team, led by Dr. Nanshan Zhan, the hero during the SARS outbreak, reported on January 20th that human-to-human transmission was occurring. Within days, city, provincial and national governments mobilized rapidly. On January 23rd Wuhan implemented a complete travel ban on its city, locking down its 11 million residents. Within two weeks, all cities in Hubei province instituted travel bans and lockdowns that forbade residents from leaving their homes except to obtain medicines and groceries, prohibiting the use of private vehicles and mandating the use of masks and temperature checks.

However, the ban on at least international travel proved to be quite ineffective. In our globalized world, infectious agents can be spread far and wide in a flash. Wuhan is an industrial-transportation hub connected in numerous ways to the rest of China by rail and by air, and with many direct flights to many countries. Reporters from the *New York Times* analyzed cell phone data and other sources to understand how the virus escaped. Among their findings: (1) on January 1, 2020, the day after the first official announcement of the novel pneumonia cases, 175,000 people left Wuhan and before travel was restricted three weeks later the total of people leaving the city reached 7 million; (2) thousands of these travelers were infected, many without symptoms, seeding infections in Beijing, Shanghai and other Chinese cities; and (3) international travel

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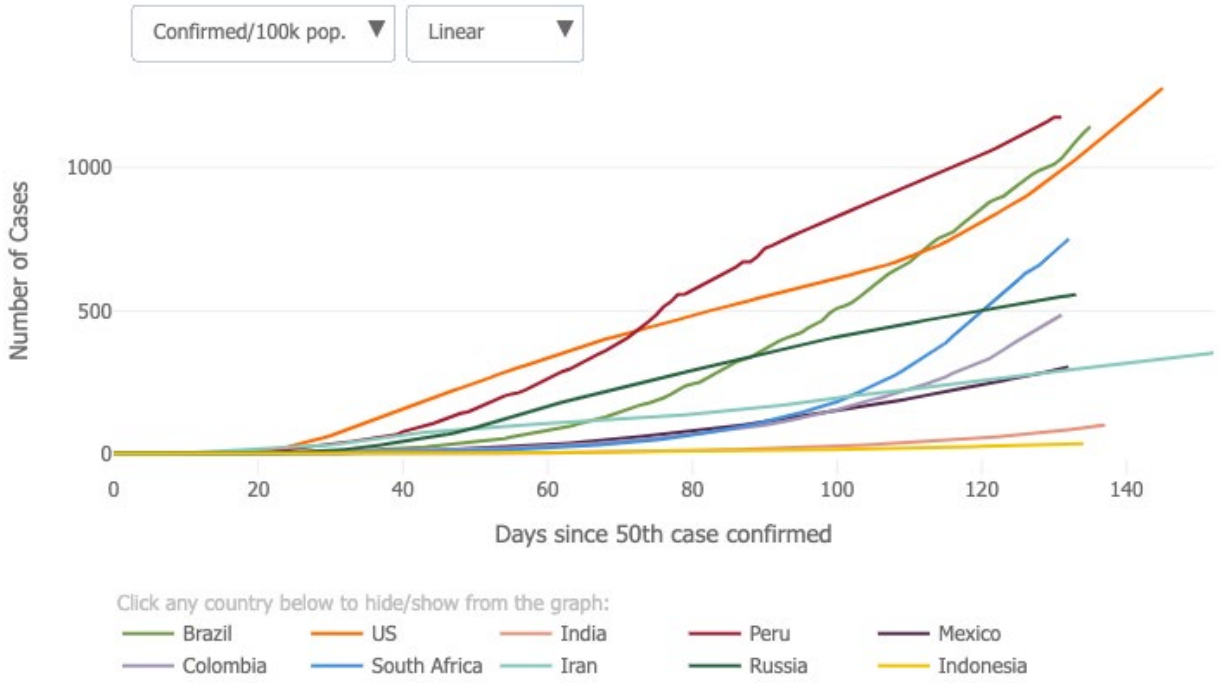
[12] See, e.g., Shawn Yuan, supra note 7.
[13] See, e.g., Buckley & Myers, supra note 6; Li Yuan, supra note 4; Lingling Wei & Chao Deng, China's Coronavirus Response is Questioned: "Everyone Was Blindly Optimistic," Wall St. J. (Jan. 24, 2020), https://www.wsj.com/articles/china-contends-with-questions-over-response-to-viral-outbreak-11579825832 (Accessed May 30, 2020).
[14] See, e.g., Associated Press, supra note 9.
[15] See, e.g., Anna Fifield, In Wuhan's Virus Wards, Plenty of Stress But Shortages of Everything Else, Washington Post (Jan. 24, 2020), https://www.washingtonpost.com/world/asia_pacific/in-wuhans-virus-wards-plenty-of-stress-but-shortages-of-everything-else/2020/01/24/ba1c70f0-3ebb-11ea-afe2-090eb37b60b1_story.html (Accessed May 30, 2020). See also Yanzhong Huang, supra note 5, at 7-9.
[16] See, e.g., Wu et al., supra note 11.

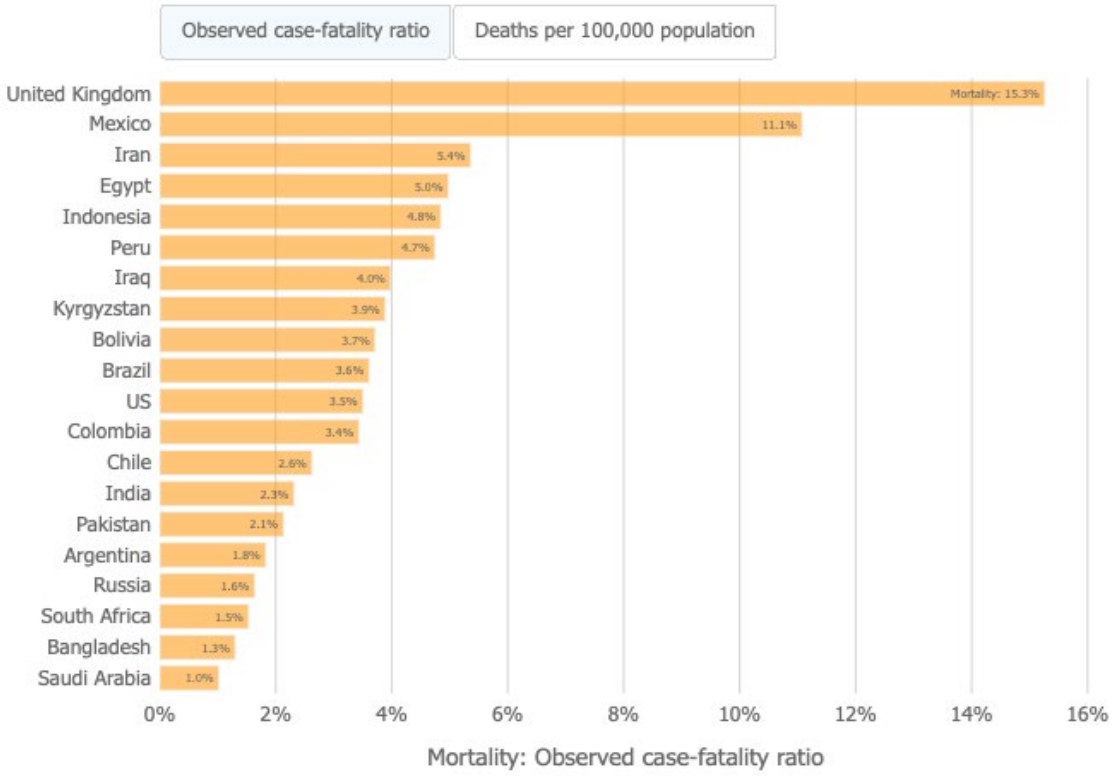
continued as normal until the end of January.[17] The virus was thus spread very rapidly to many other countries on different continents, including Italy and the western United States.[18] From Italy the virus was quickly seeded in New York City, which in turn seeded numerous places in the United States; and off we went.[19]

The Failure of the United States to Mount an Effective Response to the Pandemic

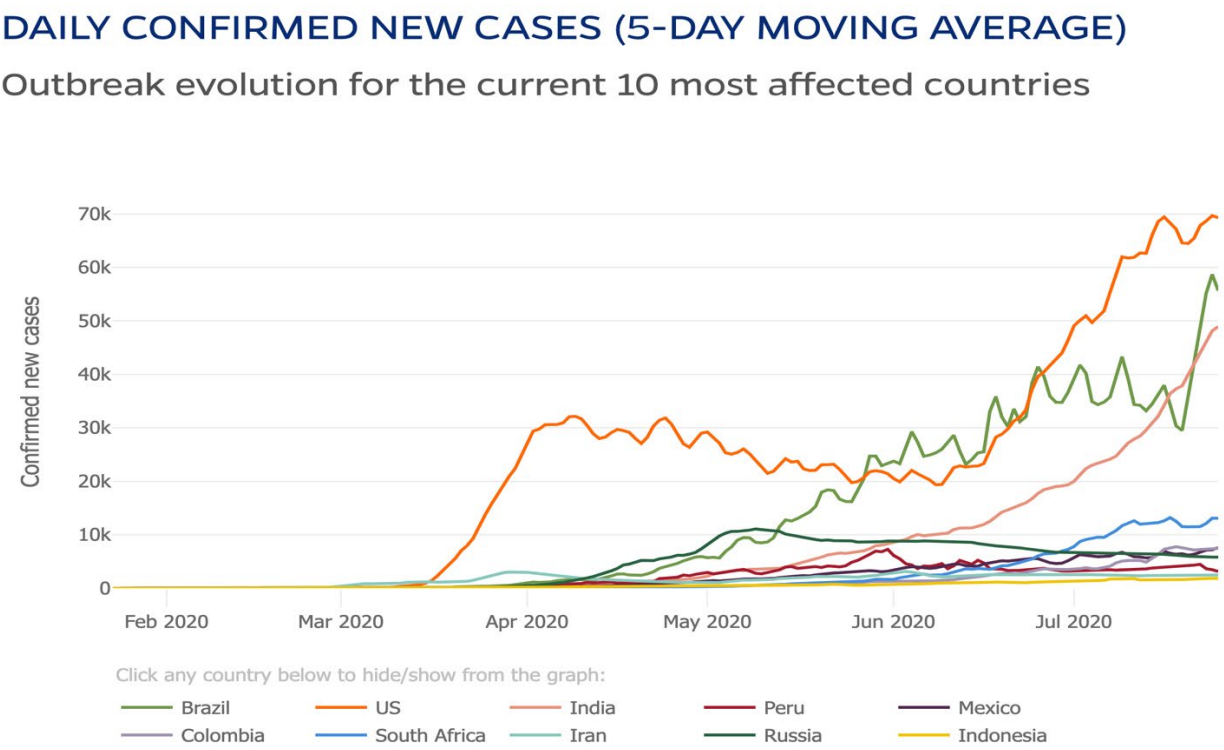
On July 8, 2020, Secretary of State Pompeo correctly stated that the United States is the "world leader in the pandemic,"[20] but that is true only in a not-so-good way. As of July 26, 2020, the time of this writing, globally there are over 16 million confirmed cases of COVID-19 with about 650 thousand deaths; about 4.2 million of those cases and around 146 thousand of those deaths are in the United States.[21] Right now the United States has over 1.9 million cases and 60 thousand deaths more than the country in second place, Brazil. By contrast, as examples, France and Germany each have just over two hundred thousand cases and Canada just over 100 thousand, with deaths of about thirty thousand in France and about nine thousand in Germany. Among the countries most affected, the United States leads the world in cases per capita and is eleventh in observed case-fatality ratio:

[17] See Wu et al., supra note 11.
[18] See, e.g., Benedict Carey & James Glanz, Travel from New York City Seeded Wave of U.S. Outbreaks, New York Times (May 7, 2020), https://www.nytimes.com/2020/05/07/us/new-york-city-coronavirus-outbreak.html (Accessed May 25, 2020).
[19] Id. Reportedly, the CDC also botched monitoring international arrivals. Among other problems was reticent leadership, the fact that the larger and more capable Influenza Division was initially not in the lead and antiquated data systems precluded accurate counts of people tested and the demographics, which forced data to be shared to local health departments reliant on these data through thousands of emailed spreadsheets, phone calls and faxes. See, e.g. Eric Lipton et al., The C.D.C. Waited "Its Entire Existence for This Moment." What Went Wrong?, New York Times (June 3, 2020), https://www.nytimes.com/2020/06/03/us/cdc-coronavirus.html (Accessed June 3, 2020).
[20] U.S. Department of State, Secretary Michael R Pompeo at a Press Availability, July 8, 2020, https://www.state.gov/secretary-michael-r-pompeo-at-a-press-availability-8/ (Accessed July 18, 2020).
[21] All facts in this paragraph derive from: Johns Hopkins University COVID-19 Resource Center, Dashboard by the Center for Systems Science and Engineering, https://coronavirus.jhu.edu/map.html (Accessed July 26, 2020).


Confirmed/100k pop.
Linear
Number of Cases
1000
500
0
0
20
40
60
80
100
120
140
Days since 50th case confirmed
Click any country below to hide/show from the graph:
Brazil
US
India
Peru
Mexico
Colombia
South Africa
Iran
Russia
Indonesia


Observed case-fatality ratio
Deaths per 100,000 population
United Kingdom
Mexico
Iran
Egypt
Indonesia
Peru
Iraq
Kyrgyzstan
Bolivia
Brazil
US
Colombia
Chile
India
Pakistan
Argentina
Russia
South Africa
Bangladesh
Saudi Arabia
Mortality: 15.3%
11.1%
5.4%
5.0%
4.8%
4.7%
4.0%
3.9%
3.7%
3.6%
3.5%
3.4%
2.6%
2.3%
2.1%
1.8%
1.6%
1.5%
1.3%
1.0%
0%
2%
4%
6%
8%
10%
12%
14%
16%
Mortality: Observed case-fatality ratio

And among the countries most affected, the United States is leading in confirmed new cases:



The federal government was very slow to react and the initial rollout of testing, which was simply crucial, was botched by the CDC, which produced testing kits that were defective (described more fully below); and without federal coordination, there were severe shortages of, among many other things, including but not limited to hospital beds, beds in ICUs and the necessary personnel to staff them, and personal protective equipment ("PPE") for health care workers who were constantly exposed to the virus because they were taking care of those infected and seriously ill.[22]

In early March, as testing crawled forward, cases were documented in an increasing number of places, including New York City, Rhode Island, New Hampshire, Maricopa County in Arizona, North Carolina, Los Angeles, Nevada, Colorado, Tennessee, Maryland and then the major outbreak of 31 cases centered around a Life Care Center nursing home in Washington near Seattle. On March 6th ten states—Hawaii, Utah, Nebraska, Kentucky, Indiana, Minnesota, Connecticut, South Carolina, Pennsylvania and Oklahoma—reported their first cases. More and more states reported cases before, belatedly, the President's declared a national emergency on March 13th.

[22] Unless otherwise noted, the events in this and the following two paragraphs are drawn from a timeline available on Wikipedia, Timeline of the COVID-19 Pandemic in the United States, https://en.wikipedia.org/wiki/Timeline_of_the_COVID-19_pandemic_in_the_United_States (Accessed on May 31, 2020).

Some states had already declared a state of emergency and imposed some type of restrictions even before President Trump's declaration of a national emergency, but the majority of states acted just before or just after that date. The goal of the shutdown was "to flatten the curve," i.e., to reduce the number of new cases, and stop the virus's spread, by keeping people apart. Different states imposed varying degrees of restrictions, ranging across "stay at home orders"; requiring that face masks be worn in public when social distancing of six feet is not possible; banning gatherings of various sizes ranging from all gatherings to those of 50 or more people; and closing schools, daycares, bars, sit-down restaurants and "non-essential" retail, in varying combinations.[23] Many types of employment, e.g., public transportation, were deemed "essential," with the consequence that those workers routinely have faced the risk of exposure, and, as discussed below, this is disproportionately true of low-wage workers and, particularly low-wage workers of color.

The effects of the restrictions on the economy have been devastating, but again disproportionately impacting certain types of businesses and workers. Relatively high-wage and highly educated workers have experienced dislocation but can largely work remotely. Schools and universities have scrambled to convert in-person classes to remote education; despite significant shortcomings (we would love to see you all in person), these jury-rigged arrangements allow life to go forward to some degree.

By contrast, as described more fully below, small businesses and some sectors, like hospitality, travel, restaurants and retail, have suffered the worst losses; many small businesses have closed entirely. Also, again as described more fully below, workers who are relatively low-wage, of lower education and of color have borne the brunt of the ensuing unemployment and loss of health insurance. At the peak of unemployment, at least 50 million Americans were out of work.[24]

You can see from the daily moving average figure above (which shows a 5-day rolling average of daily confirmed new cases), that until roughly mid-June, the number of U.S. cases was going down. However, because perhaps 40 percent of infections are pre- or asymptomatic,[25] the virus was continuing its under-the-radar spread, enhanced by the fact that many states, such as Georgia, Texas and Florida, reopened too early, too fast, or

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[23] The states' different responses are usefully summarized in Wikipedia, U.S. State and Local Government Responses to the COVID-19 Pandemic, https://en.wikipedia.org/wiki/U.S._state_and_local_government_responses_to_the_COVID-19_pandemic (Accessed July 27, 2020).

[24] See, e.g., Jack Kelly, Nearly 50 Million Americans Have Filed For Unemployment—Here's What's Really Happening, Forbes (July 9, 2020), https://www.forbes.com/sites/jackkelly/2020/07/09/nearly-50-million-americans-have-filed-for-unemployment-heres-whats-really-happening/#408f4dd427d3 (Accessed July 27, 2020).

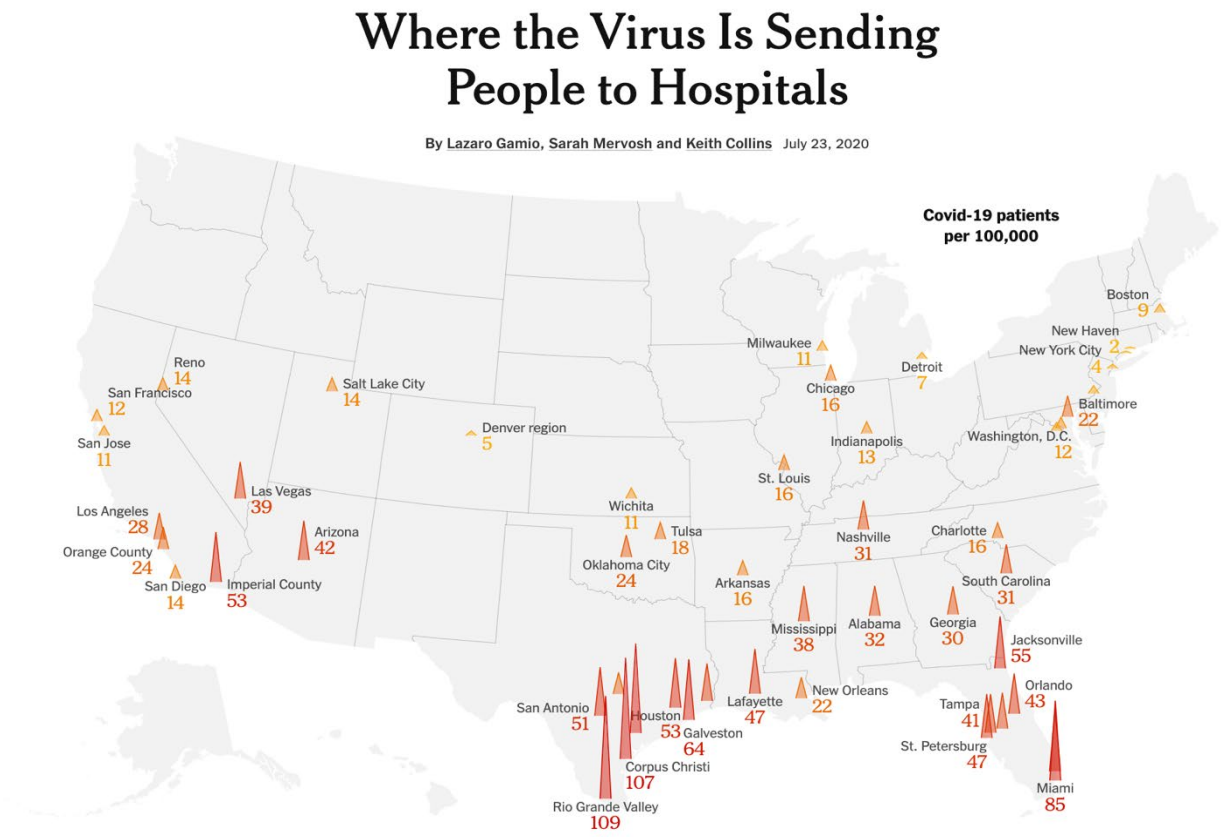
[25] See Apoorva Mandavilli, Coronavirus Infections Much Higher Than Reported Cases in Parts of U.S., Study Shows, New York Times (July 21, 2020), https://www.nytimes.com/2020/07/21/health/coronavirus-infections-us.html (Accessed July 27, 2020). "Pre-symptomatic" persons are individuals who are infected and will later develop symptoms but haven't so far. By contrast, "asymptomatic" persons are infected but will never develop symptoms.

both, egged on by a President impatient to get back to life as he previously had known it, particularly the pre-pandemic booming economy. The CDC and the White House had issued guidance on reopening,[26] to occur in three stages. Stage one was to start only if the state or region experienced, among other metrics, a 14-day downward trajectory of the percentage of tests that were positive. The guidelines also required that robust testing and contact-tracing programs be in place and specified actions for individuals and high-risk employers whose operations entailed extensive personal contact. The guidelines provided that during reopening, restrictions would be gradually lifted over a 3-stage process as conditions improved. Nonetheless, while many states started reopening in late April, evidence suggests that states located in the Northeast and parts of the mid-Atlantic complied more with the guidelines than did states in the rest of the country. (By July, however, even these states had begun to experience rises again, as people have flocked to beaches and mountain resorts).[27] But many other states simply ignored the guidelines.[28] The results were predictable given the problem of pre- and asymptomatic spread. Cases surged throughout the country. The following figure graphically shows the new geographic reality:

[26] The White House, President Donald J. Trump Announces Guidelines for Opening Up America Again (April 16, 2020), https://www.whitehouse.gov/briefings-statements/president-donald-j-trump-announces-guidelines-opening-america/ (Accessed July 27, 2020). See also The White House & CDC, Guidelines: Opening up America Again (April 16, 2020), https://www.whitehouse.gov/wp-content/uploads/2020/04/Guidelines-for-Opening-Up-America-Again.pdf (Accessed July 27, 2020); CDC, Activities and Initiatives Supporting the COVID-19 Response and the President's Plan for Opening America Up Again (May 14, 2020), https://www.cdc.gov/coronavirus/2019-ncov/downloads/php/CDC-Activities-Initiatives-for-COVID-19-Response.pdf (Accessed July 27, 2020). Actually, the CDC guidelines were in draft form much earlier than their release on May 14th. The White House and other officials criticized them as "overly prescriptive," see, e.g., Abby Goodnough & Maggie Haberman, White House Rejects C.D.C.'s Coronavirus Reopening Plan, New York Times (May 7, 2020), https://www.nytimes.com/2020/05/07/us/politics/trump-cdc.html (Accessed July 27, 2020), with the result that on April 16th the White House and the CDC issued joint guidelines, a watered-down version of what the CDC finally released a month later on its own after the press had obtained and reported on a copy. See, e.g., id.; Jason Dearen & Mike Stobbe, AP Exclusive: CDC Guidance More Restrictive Than White House, Associated Press (May 13, 2020), https://apnews.com/d4fb9744fb3524b6aaff1036f3ba9cd2 (Accessed July 27, 2020).

[27] https://www.washingtonpost.com/local/coronavirus-dc-maryland-virginia/2020/07/15/92964d38-c699-11ea-8ffe-372be8d82298_story.html (Accessed August 2, 2020).

[28] See, e.g., Ellen Barry, U.S. Northeast, Pummeled in the Spring, Now Stands Out in Virus Control, New York Times (July 22, 2020), https://www.nytimes.com/2020/07/22/us/coronavirus-northeast-governors.html (Accessed July 27, 2020).



It appears that in many locations, particularly in parts of California, Texas, and across the South, the virus is spreading rapidly; some experts have concluded that in those areas the spread is now uncontrolled.[29] If anything the future looks bleaker than before the shutdown, although that picture varies among the states; and as some of these states have re-imposed some restrictions, it appears that the number of new infections is plateauing (the number of deaths is still expected to rise at least for some period because it takes weeks for infected persons to get sick and die.). However, this plateau, if it exists, is occurring at very high levels of new cases and death and with the pandemic splintered across numerous locations across the country.[30]

This surge has been hastened by the problems that led to the shutdown, which remain largely unaddressed even into late July. There still is no national coordination, and the states are still competing among themselves, against their own towns and cities, and against the private sector (particularly health care providers) for PPE, testing

[29] See, e.g., Tucker Doherty, Spiking or Plateauing? Covid-19 Case Counts Spur Debate, Politico (July 23, 2020), https://www.politico.com/news/2020/07/23/coronavirus-spike-plateau-cases-380882 (July 27, 2020).
[30] 2nd U.S. Virus Surge Hits Plateau, but Few Experts Celebrate, Modern Healthcare (July 30, 2020), https://www.modernhealthcare.com/policy/2nd-us-virus-surge-hits-plateau-few-experts-celebrate (Accessed August 3, 2020).

technology and supplies, and even such basic equipment as test swabs and pipettes.[31] The latest shortages are perhaps even worse than those initially because now the virus is surging in so many geographic areas, many of which (such as Texas' Rio Grande Valley, Mississippi, and Alabama) are locations in which poverty is the worst and health care is in severe shortage. An immunologist at the University of California at Irvine described the situation in these terms: "It's a complete disaster," [the immunologist] said. "This is how this administration has handled this entire pandemic—conflicting messages, knee-jerk reactions, lack of cohesive plans and undermining the CDC and attacking science on a regular basis."[32]

Again, leadership at multiple levels, particularly at the top can be blamed, but nonetheless, "the most important failures of the COVID-19 pandemic have been structural and institutional, not specific mistakes made in the moment by key decision-makers."[33] We focus on these structural and institutional failures because they are largely the subject of this book.

1. We invest very heavily in delivering "the best health care services in the world" but fail to invest adequately in public health and the health of our population.

In a pandemic, public health has to lead the way. Contagious diseases spread through human contact. The novel coronavirus responsible for COVID-19 is particularly dangerous, since it spreads primarily through droplets and aerosols generated by respiration and dispersed by coughing, sneezing, talking or just plain breathing, and because so many infected people are pre- or asymptomatic. Absent human immunity, the only way to stop the spread is by finding infected persons through testing, identifying persons with whom they have been in contact while infected, and then isolating the infected persons and those whom they have exposed until the infectious period ends—in short, test, trace contacts, and isolate, thereby preventing infected or exposed persons

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[31] See, e.g., Andrew Jacobs, Grave Shortages of Protective Gear Flare Again as Covid Cases Surge, New York Times (July 8, 2020), https://www.nytimes.com/2020/07/08/health/coronavirus-masks-ppe-doc.html (Accessed July 27, 2020); Bloomberg Law, Months into Pandemic, U.S. Still Can't Get Testing Right (July 22, 2020); Christie Aschwanden, Contact Tracing, a Key Way to Slow COVID-19, Is Badly Underused by the U.S., Scientific American (July 21, 2020), https://www.scientificamerican.com/article/contact-tracing-a-key-way-to-slow-covid-19-is-badly-underused-by-the-u-s/ (Accessed July 27, 2020); Katherine J. Wu, "It's Like Groundhog Day": Coronavirus Testing Labs Again Lack Key Supplies, New York Times (July 23, 2020), https://www.nytimes.com/2020/07/23/health/coronavirus-testing-supply-shortage.html (Accessed July 27, 2020); Andrew Jacobs, FEMA Sends Faulty Protective Gear to Nursing Homes Battling Virus, New York Times (July 24, 2020), https://www.nytimes.com/2020/07/24/health/coronavirus-nursing-homes-PPE.html (Accessed July 27, 2020).

[32] Philip Rucker, Yasmeen Abutaleb & Ashley Parker, As the Coronavirus Crisis Spins Out of Control, Trump Issues Directives—But Still No Clear Plan, Washington Post (July 15, 2020), https://www.washingtonpost.com/politics/trump-coronavirus-pandemic-no-plan/2020/07/15/7581bea4-c5df-11ea-a99f-3bbdffb1af38_story.html (Accessed July 27, 2020).

[33] Harold A. Pollack, Disaster Preparedness and Social Justice in a Public Health Emergency, Journal of Health Pol., Pol'y & L. 13 (May 28, 2020), https://read.dukeupress.edu/jhppl/article/doi/10.1215/03616878-8641457/165292/Disaster-Preparedness-and-Social-Justice-in-a (Accessed June 4, 2020).

from human contact until they are no longer infectious or possibly infectious through exposure. Furthermore, because we are dealing with a disease that spreads silently, continual, widespread, preventive population-level testing becomes an imperative, especially in at-risk communities and among at-risk populations, including high-risk workers.

However, in the United States, the entire public health process has broken down because of a lack of funding and competent leadership, and sheer incompetence. First, testing in the U.S. has been woefully inadequate. Although many other nations had developed tests for the virus, the CDC, usually the world leader in this sphere, failed to start sending test kits to state-run labs until February 6th. These test kits then turned out to be defective, with the result that all viral samples had to be sent to the CDC's Atlanta laboratory instead. By contrast, on that same day, the WHO's Director General stated, "We have shipped 250,000 tests to more than 70 laboratories around the world, and we're training lab workers to use them." Researchers at labs in universities in the United States had developed their own tests but by and large the FDA's strict rules precluded their use until those rules were finally relaxed in early March. By mid-February the United States was still testing a mere hundred samples a day under unbelievably strict rules that narrowed the test to people who had travelled to China or had been in contact with persons who had travelled, or were experiencing a very narrow range of symptoms.

Second, contact tracing, usually conducted by local public health departments, has largely been a failure because of lack of trained personnel, the problems with testing, information issues, and the sheer number of infections that have overwhelmed the whole process. Contact tracing is labor-intensive, requires expertise and controllable numbers, all of which are in short supply. However, like the rest of public health, contact tracing has been chronically underfunded, understaffed and diminished in stature, especially when compared with medicine.[34] In recent years this critical infrastructure, at all levels of government, has been gutted. In December 2018 the National Association of County & City Health Officials ("NACCHO") reported that over the course of the prior decade 56,360 jobs had been eliminated in local health departments due to budgetary cuts,[35]

[34] See, e.g., Michael S. Sparer, We Need a Voice for Public Health in the President's Cabinet, New York Times (May 28, 2020), https://www.nytimes.com/2020/05/28/opinion/trump-cabinet-covid.html (Accessed May 31, 2020. See generally Nason Maani & Sandro Galea, COVID-19 and Underinvestment in the Public Health Infrastructure of the United States, Milbank Quarterly (April 24, 2020), https://www.milbank.org/quarterly/articles/covid-19-and-underinvestment-in-the-public-health-infrastructure-of-the-united-states/ (Accessed May 21, 2020); Lawrence D. Brown, The Political Face of Public Health, 32 Public Health Rev. 155 (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7100188/pdf/40985_2017_Article_BF03391596.pdf (Accessed June 6, 2020).

[35] See NACCHO, The Forces of Change in America's Local Public Health System 3 (2018), http://nacchoprofilestudy.org/wp-content/uploads/2018/12/2018-Forces-of-Change-Main-Report.pdf (Accessed May 31, 2020).

although a small percentage of those jobs have since been restored.[36] These cuts occurred literally at the frontline of fighting the pandemic.

At the national level, cuts have robbed the country of necessary expertise to provide early warning of a pandemic, part of "surveillance" discussed above, and to mobilize capacity to meet a threat.[37] President Trump wasn't alone in reducing preparedness but joins two other presidents and many sessions of Congress going back approximately 15 years. CDC's Public Health Emergency Preparedness grants to state and local public health agencies, labs, and hospitals fell, in nominal dollars, from $939 million in 2003 to $675 million in 2020; funds for hospital preparedness fell from $515 million to $275 million; the Strategic National Stockpile, the nation's supply safety net, was allowed to dwindle.[38] During the 2009 H1N1 swine-flu pandemic, President Obama used the Stockpile but then did not replenish it, in part because Congress refused requests for greater funding. Nor did President Trump rebuild the Stockpile.[39]

Under the Trump Administration the cuts became sharper, aligned with a more general war on science and the cold war on China. Among other actions, the Trump Administration eliminated the National Security Council's department in charge of global health and the Global Health Security and Biodefense Directorate, an office important to coordinate relevant agencies spread across the federal bureaucracy.[40] Also, as part of its general campaign against scientific input into decision making, the Administration has greatly reduced most CDC staff assigned to global health in China, including a key medical epidemiologist embedded within China's own CDC to train its own field

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[36] See NACCHO, NACCHO's 2019 Profile Study: Changes in Local Health Department Workforce and Finance Capacity Since 2008 (May 2020), http://nacchoprofilestudy.org/wp-content/uploads/2020/05/2019-Profile-Workforce-and-Finance-Capacity.pdf (Accessed May 31, 2020).

[37] Unless otherwise noted, the cuts discussed in this paragraph are drawn from Christopher Sellers et al., An Embattled Landscape Series, Part 2a: Coronavirus and the Three-Year Trump Quest to Slash Science at the CDC (March 23, 2020), https://envirodatagov.org/an-embattled-landscape-series-part-2a-coronavirus-and-the-three-year-trump-quest-to-slash-science-at-the-cdc/ (Accessed May 31, 2020); and Laurie Garrett, Trump Has Sabotaged America's Coronavirus Response. Foreign Policy (Jan. 31, 2020), https://foreignpolicy.com/2020/01/31/coronavirus-china-trump-united-states-public-health-emergency-response/ (Accessed May 31, 2020).

[38] Jon Greenberg, Federal Pandemic Money Fell for Years. Trump's Budgets Didn't Help, Politifact (March 30, 2020), https://www.politifact.com/article/2020/mar/30/federal-pandemic-money-fell-years-trumps-budgets-d/ (Accessed June 3, 2020).

[39] See, e.g., Sara Murray & Scott Glover, Nation's Stockpile Proves To Be No Match for a Pandemic, CNN (May 6, 2020), https://www.cnn.com/2020/05/06/politics/strategic-national-stockpile-coronavirus-trump-invs/index.html (Accessed June 7, 2020); Alexandra Berzon et al., Miscalculation at Every Level Left U.S. Unequipped to Fight Coronavirus, Wall St. J. (April 29, 2020), https://www.wsj.com/articles/miscalculation-at-every-level-left-u-s-unequipped-to-fight-coronavirus-11588170921 (Accessed June 7, 2020).

[40] See, e.g., German Lopez, The Trump Administration's Botched Coronavirus Response, Explained, Vox (March 14, 2020), https://www.vox.com/policy-and-politics/2020/3/14/21177509/coronavirus-trump-covid-19-pandemic-response (Accessed May 31, 2020).

epidemiologists[41]—our ears and eyes on the ground, so to speak—and with regard to global health more generally, narrowing its epidemic work from 49 to 10 countries.[42] Testifying at a hearing held by the House Appropriations Committee, CDC Director Robert Redfield stated that budgetary cuts were responsible for the botched rollout of tests for the coronavirus.[43] Similar reductions were imposed on the Office of the Assistant Secretary for Preparedness and Response, the part of the Department of Health and Human Services responsible for emergency preparedness. At the White House, the Trump Administration eliminated the President's Council of Advisors on Science and Technology, which in 2016 had warned against emerging infectious diseases. Public health capacity is a critical, necessary component of preparedness.

By contrast, as shown throughout the materials in this book, we overinvest—by far—in medical care, spending almost twice as much as the next highest nation. Furthermore, on many measures of quality and health, the our population fares worse. We are now paying for our upside-down system.

Compared with other nations, the United States has especially elevated rates of underlying chronic conditions such as diabetes and cardiovascular disease that heighten the potential for a severe response to COVID-19 and death.[44] But this explains only part of the problem—emphasis on "part"; health risks have been worsened by the chaos of our response and by the structural racism, described below.

As this book explains, in the United States, the distinction between the system for financing and delivering health care, on the one hand, and public health and the functions relegated to it (clean water and sanitation, disease tracing, community-wide prevention), on the other, has deep roots. This system can be traced to the ascendency of medicine in the division of labor and its success in subordinating the work of potential competitors, like public health, to it. Even within medicine, we have tended to grossly de-emphasize primary health care in favor of advanced subspecialty care that attracts the sexy technology and the big compensation bucks, through payment rules developed by

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[41] See, e.g., Marisa Taylor, U.S. Axed CDC Expert Job in China Months Before Virus Outbreak. Reuters (March 22, 2020), https://www.reuters.com/article/us-health-coronavirus-china-cdc-exclusiv/exclusive-u-s-axed-cdc-expert-job-in-china-months-before-virus-outbreak-idUSKBN21910S (Accessed May 31, 2020).

[42] See, e.g., Noah Weiland, Emily Cochrane & Maggie Haberman, White House Asks Congress for Billions to Fight Coronavirus, New York Times (Feb. 24, 2020), https://www.nytimes.com/2020/02/24/us/politics/trump-coronavirus-response.html (Accessed May 31, 2020).

[43] See, e.g., Lauren Hirsch & Yelena Dzhanova, Coronavirus Response Hurt by Lack of Funding for Public Health Labs, CDC Director Tells Congress, CNBC (March 10, 2020), https://www.cnbc.com/2020/03/10/coronavirus-testing-delays-caused-in-part-by-underfunding-cdc-director-says.html (Accessed May 31, 2020).

[44] See, e.g., Jason Douglas & Russell Gold, Covid-19 Poses More Risk to Patients with Chronic Illnesses—and That's Bad for the U.S., Wall St. J. (July 24, 2020), https://www.wsj.com/articles/covid-19-poses-more-risk-to-patients-with-chronic-illnessesand-thats-bad-for-the-u-s-11595595601 (Accessed July 26, 2020).

medical professionals themselves.[45] These results do not reflect some natural ordering of functions—functionalism—but instead, elevated social status and the degree to which that social status was put to work politically.[46]

2. The fragmentation of health care financing and delivery in the United States and its impact on mounting a coordinated national response.

As we describe in the book, every wealthy nation except for the United States provides some form of universal health insurance, ranging from Great Britain, which relies heavily on a national health service, to the social security systems in western Europe, and the mixed federal-provincial systems in the Canadian provinces and territories. In all of these cases, multiple levels of government are able to coordinate a cross-payer/multi-payer response—a useful tool during a pandemic.

By contrast, as also illustrated in this book, bedlam prevails in the United States, even in the wake of the ACA, which made important strides in enabling access to insurance, but not in rationalizing it. Over the past 45 years or so, the United States, singular among comparable nations, has created a fairly fully-blown, competitive, market-based system of financing and delivery of health care. This creation is highly fractured, with hundreds of competing health insurers, in excess of one million separate public and private employer-sponsored health plans (some of which buy insurance, and others of which are self-insured), over 35 million individually purchased insurance policies by people who buy coverage directly from an insurer, 51 separate Medicaid programs (each with its own retinue of insurers that do business with the agency), and Medicare and Medicare Advantage plans. These plans are all payers, thereby splintering the financial market for health care into a zillion buyers. Even the biggest companies become small-time buyers in this type of scenario. The legal framework that regulates this horde of purchasers is (to borrow a famous phrase from an early Medicaid decision), "unintelligible to the uninitiated" (those of you reading this essay will become initiates through this course).[47] As developed in the book, each category of this horde is subject to different, sometimes conflicting legal regimes—such as regulation by states, regulation by the Medicare law, regulation by Medicaid and so on. Moreover, each insurance plan of course looks out for its own interests, its competitive DNA on full display in a system in which the name of the game is to keep bad risks out of one's own insurance pool and stick them into another pool, and to shift costs to someone else. As you will learn, Medicaid is not supposed to work this way. But in fact the advent of Medicaid managed care, which involves risk-based contracting between states and managed care plan issuers, means that Medicaid, too, has entered the risk game, at least to a degree. Medicare has

[45] Clifford Marks, America's Looming Primary-Care Crisis, New Yorker (July 25 2020).
[46] This history is very briefly summarized in Paul Starr, The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry 180-97 (1982). A seminal work documenting this history is Barbara Gutmann Rosenkrantz, Public Health and the State: Changing Views in Massachusetts 1842-1936 (1972).
[47] Friedman v Berger 547 F.2d 724 (2d Cir. 1976).

played a similar game for years, particularly with the advent of competing Medicare Advantage plans.

The Affordable Care Act eliminated some of the worst abuses such as selecting against bad risks by refusing to issue policies at all or by cancelling policies or severely limiting coverage for people with pre-existing conditions, or charging exorbitant rates to those with even mild health problems. But risk-shifting still happens and it is still legal. It just takes different forms tied to coverage and access to care. Examples include coverage limits and benefit designs that discourage plan selection by people considered high actuarial risks (such as exclusionary drug formularies for people with HIV/AIDS), provider networks that are inaccessible to certain populations or communities or discourage certain people from enrolling, and cumbersome utilization management tools that discourage use of care, such as lengthy pre-approval processes and continuous renewal rules for people with chronic conditions.[48]

In a pandemic, resources have to be mobilized and end up in the right place at the right time. In the early period of the pandemic, the hot spot was New York City and surrounding areas. Supplies and staff had to be moved there to meet that immediate demand. At this writing in late July, Florida, Texas and California, among others, are overwhelmed and they are short of everything. Nonetheless, we have no means, in part due to leadership and in part due to the structure of our system, to deploy resources there in a coordinated, rapid fashion. Our competitive, fragmented system simply militates against that.

Necessarily, nothing in this fragmented, noncooperative, competing mess provides a backbone for coordinated action with regard to testing, along with simultaneous, coordinated community-based efforts at tracing. Furthermore, nothing in this morass provides any incentives to act for "public good" because investment in, say, surge capacity by one competitor provides benefits to other competitors—an externality problem—and hence the infrastructure needed for an emergency is simply not funded. Nor is there any incentive to coordinate with regard to human and capital supplies to move goods, services and people to places they are needed when they are needed. Additionally, as described in Chapter 12, the payment (non)system, while supportive of some public goods like medical education—but actually only because of Medicare and Medicaid—have more generally been structured to "squeeze out the fat."[49] By design and

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[48] On fragmentation in the payment system and the concomitant fragmentation in delivery, see David M. Frankford, Paying for Healthcare, in The Oxford Handbook of U.S. Healthcare Law (I. Glenn Cohen, Allison Hoffman & William M. Sage, eds. (2015), https://www.oxfordhandbooks.com/view/10.1093/oxfordhb/9780199366521.001.0001/oxfordhb-9780199366521 (Accessed June 8, 2020); David M. Frankford & Sara Rosenbaum, Taming Healthcare Spending: Could State Rate Setting Work? Robert Wood Johnson Foundation (2017), http://www.cshp.rutgers.edu/publications/taming-healthcare-spending-could-state-rate-setting-work (Accessed June 8, 2020); infra ch. 12; David M. Frankford, The Complexity of Medicare's Hospital Reimbursement System: Paradoxes of Averaging, 78 Iowa L. Rev. 517 (1993).

[49] See, e.g., Wendy E. Parmet, Unprepared: Why Health Law Fails to Prepare Us for a Pandemic, 11 J. Health & Biomedical Law 157, 179-83 (2006),

through competition, payment has, to a great extent, eliminated all the "cross-subsidies" that might have been used to maintain stand-by capacity—infrastructure that is unused except in an emergency. Society as a whole would be better off if stand-by capacity were to exist, although most of the time it sits idle. No actor in this competitive milieu can afford to invest in and carry that idle capacity.[50] As noted by Eugene Schneller regarding hospitals' failure to stockpile essential supplies for a rainy day, "'The system was doing what it was designed to do . . . But it wasn't designed to do anything about public health.'"[51] In fact, the term that is sometimes used, "slack capacity," has a pejorative connotation that the "slack" or "slackers" are inefficient, to be weeded out. In times more forgiving of such "slack," the term "surge capacity" is used in recognition that we really wish we had it to meet a crisis—like right now.

Testing for COVID-19 offers us a perfect example of the cost- and risk-shifting game that gets played by virtually every actor involved in health care delivery and financing, and the endless fighting between insurers and regulators over who should bear financial risk. As you have learned, rapidly diagnosing and treating COVID is crucial to saving lives and ultimately contributes to stopping spread. But of course, this immediately raises the question—who is going to pay for diagnosing and treating COVID? More precisely, for our purposes who is going to pay for a diagnostic test to detect a communicable disease running rampant? In this nation, testing for communicable diseases is not treated as basic public health activity financed by the government. Instead, everything comes back to insurance or out-of-pocket (or both in the case of providers that balance bill above and beyond what an insurer pays). This can be insanely expensive since the nation also does nothing to regulate prices.[52]

One might think, "Oh, but insurers are sensible companies. They will cover this essential service as they would any necessary diagnostic test. A test for COVID-19 is a diagnostic test, pretty standard stuff for insurers, and we have no public fund for ongoing communicable disease testing. Aren't diagnostic tests to uncover illness just the kind of thing we have insurance for? What insurer would not cover a test to diagnose the presence of pandemic illness?"

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https://heinonline.org/HOL/LandingPage?handle=hein.journals/jhbio2&div=16&id=&page= (Accessed June 5, 2020).

[50] A prime example is the dominance of "just-in-time inventories," described as making the United States vulnerable to massive shortages in an article in the *Wall Street Journal* that appeared on January *2006* [!!!]. See Bernard Wysocki Jr. & Sarah Lueck, Just-in-Time Inventories Make U.S. Vulnerable in a Pandemic: Low Stockpiles at Hospitals Boost Efficiency but Leave No Extras for Flu Outbreak, Wall St. J. (Jan. 12, 2006), https://www.wsj.com/articles/SB113703203939544469?mod=article_inline (Accessed May 31, 2020).

[51] Berzon et al., supra note 39. Wall Street and credit analysts monitors inventories and would clobber any entity for such "inefficiency." See id.

[52] Susannah Luthi, The $7000 Covid Test: Why States Are Stepping in to Shield Consumers," *Politico* (June 8, 2020), https://www.politico.com/news/2020/06/08/coronavirus-test-costs-304058 (Accessed August 3, 2020).

This would, of course, be the wrong way to think. Why wouldn't health insurers and employer plans try to exclude tests associated with a public health pandemic from their scope of coverage? Surely this is why the nation has a public health system and insurers should not be expected to finance a public-health emergency response. This issue in fact surfaced (quietly) during consideration of the spring 2020 COVID-19 legislation. Eventually there was a grudging recognition of an obligation to cover the test, at least among companies selling or administering what might be thought of as standard health plans sold in the individual and employer markets. (But no one was willing to rely on insurers operating in the short term, limited duration insurance market (STLDI), whose policies have extremely low actuarial value, are exempt from ACA market rules, and are riddled with exclusions and limitations?[53]

But even if insurers agreed on their own to cover diagnostic tests and treatment, there are a zillion questions to answer. Which tests? All FDA-approved tests or only ones the insurer selects for inclusion under its own guidelines? How about cost-sharing, including deductibles, coinsurance, and copayments? They obviously affect the use of care (the typical plan deductible at this point for a family can reach several thousand dollars, and cost-sharing for diagnostic testing can be high depending on an insurer's decisions about plan design). How about provider network exclusions? Would issuers and plan administrators make it possible to get the test from any authorized testing site or only from network providers? OMG, so many questions!

And then we get to the state versus federal questions. Sure, states can regulate their own individual and group insurance markets, as the ERISA materials you will read in Chapter _ teach us. They also can regulate Medicaid and the Children's Health Insurance Program (CHIP), and public employee plans. But how about plans offered by self-insured private employers? Nope. You will see that ERISA shields these plans from state regulation. How about Medicare and Medicare Advantage Plans? Nope. And what about states that resist any sort of regulation at all and simply don't want to get into it with their insurers? OMG. This is ridiculous. There is a PANDEMIC OUT THERE!

Congress recognized that it had to act, given all the uncertainty about testing coverage. The resulting legislation enacted by Congress between March and April 2020[54] offers a perfect example of the unending tension over how much to regulate insurers and shift risk. It also offers a great example of the types of punch-pulling by regulators that leaves things to blow up in patients' faces, at the point of care.

Two of the four laws enacted to date— the Families First Coronavirus Response Act[55] ("FFCRA") and the Coronavirus Aid Relief and Economic Security Act[56]

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[53] Dania Palanker et al., States Step Up to Protect Insurance Markets and Consumers from Short-Term Health Plans (Commonwealth Fund, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/may/states-step-up-protect-markets-consumers-short-term-plans) (Accessed August 2, 2020).
[54] https://www.govtrack.us/covid-19 (Accessed August 2, 2020).
[55] Pub. L. 116-136.
[56] Pub. L. 116-123.

("CARES Act") deal with coverage of diagnostic testing across both public and private insurance markets. A separate measure passed by the House in May (HEROES Act, H.R. 6800, 116th Cong., 2d sess.) addresses treatment coverage.

FFCRA establishes the basic rules for coverage of diagnostic tests, while the CARES Act further clarifies the types of diagnostic tests covered. The FFCRA testing coverage provision is as follows:

> SEC. 6001. COVERAGE OF TESTING FOR COVID–19. (a) IN GENERAL.—A group health plan and a health insurance issuer offering group or individual health insurance coverage (including a grandfathered health plan (as defined in section 1251(e) of the Patient Protection and Affordable Care Act)) shall provide coverage, and shall not impose any cost sharing (including deductibles, copayments, and coinsurance) requirements or prior authorization or other medical management requirements, for the following items and services furnished during any portion of the emergency period defined in paragraph (1)(B) of section 1135(g) of the Social Security Act (42 U.S.C. 1320b–5(g)) beginning on or after the date of the enactment of this Act: (1) In vitro diagnostic products (as defined in section 809.3(a) of title 21, Code of Federal Regulations) for the detection of SARS–CoV–2 or the diagnosis of the virus that causes COVID–19 that are approved, cleared, or authorized under section 510(k), 513, 515 or 564 of the Federal Food, Drug, and Cosmetic Act, and the administration of such in vitro diagnostic products. (2) Items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of an in vitro diagnostic product described in paragraph (1), but only to the extent such items and services relate to the furnishing or administration of such product or to the evaluation of such individual for purposes of determining the need of such individual for such product.

As these things go, this provision is a work of art, a perfect example of the convergence of regulator and regulated industry interests. Regulators want certainty in the scope of coverage. The industry wants certainty regarding what it has to pay for and that obligation to be as limited as possible. This provision gives the two sides both. And better yet for the industry, the provision is utterly silent on a central issue, swept under the rug.

So who wins?

1. The regulators get no cost sharing and no medical management requirements (a fancy term for prior authorization, chiefly).

2. The regulators get coverage during the entire period covered by the public health emergency declaration under § 1135 of the Social Security Act. The industry gets to turn off coverage as soon as the emergency ends.

3. The regulators get COVID-19 diagnostic tests. The industry gets to deny coverage for diagnostic tests for any other public health emergency that may arise, unless and until Congress amends the law again and decides to specify coverage for another emergency.

4. The regulators get compliance by insurers and plans that qualify for "grandfathered" status under the ACA because they have not materially changed their terms of coverage after March 23 2010 (i.e., have not reduced benefits or hiked cost sharing) and therefore are exempt from nearly all ACA market reforms. The industry makes an easy concession.

5. The regulators get: "items and services furnished to an individual during health care provider office visits (which term in this paragraph includes in-person visits and telehealth visits), urgent care center visits, and emergency room visits that result in an order for or administration of [a covered test]." The industry gets: "but only to the extent such items and services relate to the furnishing or administration of such [test] or to the evaluation of such individual for purposes of determining the need of such individual for such [test]."

6. The industry gets a coverage mandate that is clear and very limited, since covered tests are limited to "diagnostic" tests. Not subject to the mandate are the routine tests that are so important to workers in high-exposure industries and businesses (think agricultural workers, workers in food processing plants, child care centers, schools, restaurants, grocery stores, etc.) because they endure prolonged, intensive public exposure to the public and other workers, day after day. These folks don't get to work at home. Even if they are insured (and these jobs are far less likely to come with private insurance), they are still left out in the cold.

7. The industry also gets a super fantastic gift: complete silence on the provider network question. There is no requirement that mandates issuers and plans to pay for tests outside of their network. Neither is there a requirement that providers must accept as full payment the amount allowed by the insurer. As a result, the provider may balance bill the patient the difference between what it was paid by the insurer and the provider's charge. Nor is there a provision that requires providers to accept as payment in full what Medicare pays for diagnostic COVID-19 testing and the related visit.

Where does this leave those of us lucky enough to have private insurance? Some of us might live in a state that attempts to close some of these monster network, fee schedule, and routine testing loopholes and we may be lucky enough to either have an individual ACA-compliant policy or work for an employer that: (a) insures us and (b) offers an insured plan. States can regulate these two private markets. Others may work

for large, self-insured employers exempt from state law under ERISA. We need to be careful about where we go for testing (good luck, of course, finding any testing sites in some parts of the country), since we may face whopping out-of-pocket bills since there is no federal maximum regulating what providers are allowed to charge.

A further note—for those of us with Medicare and Medicaid, FFCRA also mandates coverage. But its provisions pertaining to Medicare and Medicaid, like those pertaining to private insurance, do not guarantee full access to the covered tests. No provision in FFCRA obligates all providers who test to participate in either program during the period of a declared emergency, and nothing in FFCRA obligates nonparticipating providers to accept what Medicaid or Medicare pays as payment in full, i.e., they can bill patients for the amounts they are not paid—balance bill. By contrast, Medicaid bans participating providers from balance-billing, which is also effectively barred, in a more convoluted fashion, by Medicare. Nor is there a requirement that state Medicaid programs, which tend to pay relatively low rates, pay for COVID-19 testing at the Medicare rate in order to encourage providers to participate.

Apparently, even a pandemic cannot get this country to adopt a universal insurance policy, just for the testing, or to regulate prices and ensure fair pricing and complete coverage without cost-sharing. Welcome to health insurance in America, fragmented as all get out.

3. The absence of universal insurance, the linkage of employment with health insurance, and the fractured nature of alternative sources of coverage.

In the book's Chapter 6 we explicate the history of health insurance. Due to a relatively obscure decision during the Second World War that health insurance was not subject to federal wage control—i.e., not "wages"—health insurance became a deductible expense for employers and not income to employees. Good deal, right? This non-taxable benefit also became popular among unions. As a benefit subject to collective bargaining unions could claim it as a victory and a benefit bestowed upon their members. Again, good deal, right?

Only if one is employed. The result was a virtual explosion. Pre-war enrollment grew from 1.4 million persons to sixty million in 1951. In its heyday in the early 1970s, employment-based insurance covered 93% of all privately insured Americans.[57]

However, millions of Americans were left out: the elderly who were no longer working; the disabled; children if the employment-based insurance failed to cover dependents; ditto non-working spouses; many workers in the non-unionized agricultural, retail and service sectors of the economy; and the self-employed. The history of health insurance in America has been the incremental addition of public programs to "pick up"

[57] John R. Gabel, Job-Based Insurance, 1977-1998: The Accidental System Under Scrutiny, 18(6) Health Affairs 62 (1999), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.18.6.62 (Accessed July 19, 2020).

persons left out of employment-based insurance: principally, but not solely, in 1965, Medicare and Medicaid for the elderly and categories of the poor, respectively; in 1977, the Children Health Insurance Program for children in families too "wealthy" to qualify for Medicaid; and the Affordable Care Act ("ACA") in 2010 for persons with no other access to "affordable" insurance, a complicated term but most importantly persons without employment-based insurance and not qualified for Medicaid for a variety of reasons but principally adults without children. These incremental gap-fillers became increasingly important from the early 1970s onward as the number of adults covered by employer-based programs declined for a variety of reasons to cover only roughly 60% of the workforce. The most important factor in this decline was the shift of the basic economy from manufacturing, typically unionized, to services, typically not; the shift of the population from the Rust Belt to the Sun Belt, less welcoming to unions; and the growing cost of health insurance, which made it unaffordable to many small and medium-sized business. At the time of the ACA's passage, the whole thing was basically unravelling, and the number of uninsured persons in the United States had reached 49.9 million, some 16.3% of the total population.[58] The ACA generally stabilized the employment-based insurance pool, increased the number of those with individual policies, and greatly increased those covered by Medicaid. The number of uninsured fell to as low as 25.6 million, 7.9% of the population,[59] before increasing due to actions of the Trump Administration described elsewhere in this Supplement. The health insurance of 60% of the working population depended on their employment.

The Great Recession of 2008 showed that employment-based insurance remained subject to the vicissitudes of the economy. However, that was child's play compared with the effect of the pandemic because job loss was higher in the first three *months* of the emergency than in the first two *years* of the Great Recession.[60] The numbers are mind-numbing. Unemployment rose from 3.8% in February 2020 to 14.4% in April, the peak of job loss from the shutdown, before reopening began. However, because of a data collection problem, the Bureau of Labor Statistics estimates that the figure might have been as high as 16%. The shutdown put at least some 50 million Americans out of work. In fact, these data ignore approximately 9 million Americans who were out of the labor

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[58] United States Census Bureau, Overview of the Uninsured in the United States: A Summary of the 2011 Current Population Survey (Sept. 13, 2011), https://aspe.hhs.gov/basic-report/overview-uninsured-united-states-summary-2011-current-population-survey - :~:text=According to the Census Bureaus,16.3%25 of the total population (Accessed July 19, 2020).

[59] Edward R. Berchick et al., Current Population Reports, Health Insurance Coverage in the United States: 2018 (2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf (Accessed July 26, 2020).

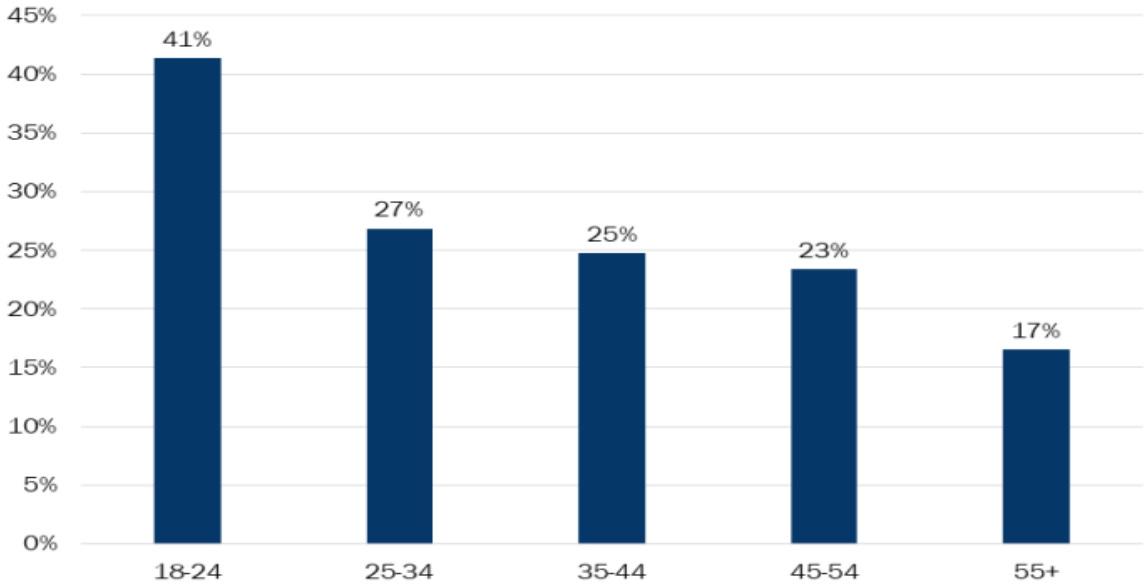
[60] Except where noted, this paragraph is largely drawn from Rakesh Kochhar, Unemployment Rose Higher in Three Months of COVID-19 Than It Did in Two Years of the Great Recession, Pew Research Center (June 11, 2020), https://www.pewresearch.org/fact-tank/2020/06/11/unemployment-rose-higher-in-three-months-of-covid-19-than-it-did-in-two-years-of-the-great-recession/?utm_ca%E2%80%A6 (Accessed July 20, 2020). The range of estimates of job loss is fairly large because of the difficulties in counting. See, e.g., Eric Morath, How Many U.S. Workers Have Lost Jobs During Coronavirus Pandemic? There Are Several Ways to Count, Wall St. J. (June 3, 2020), https://www.wsj.com/articles/how-many-u-s-workers-have-lost-jobs-during-coronavirus-pandemic-there-are-several-ways-to-count-11591176601 (Accessed July 20, 2020).

force because they had given up on finding jobs. When those people are added in the amount of unemployment rivals the estimated 25% reached during the Great Depression. One estimate puts it at 21% and even that understates the effect of the lockdown because employers were more likely to reduce wages than they were during the Great Depression.[61]

The amount of job loss varied by economic sector, related to the degree to which demand, supply or both dropped or vanished, and firm size. Hardest hit, losing roughly 28-50 percent of labor, included "arts, entertainment and recreation," "accommodation and food services," and "retail trade," as opposed to, for example, "manufacturing" and "professional, scientific, and tech services," coming in around approximately 12 percent.[62] The distributional effects followed, hitting low-wage workers the hardest. Although intuitively one might think that the distributional effects would be correlated with sector because "[l]ow-wage workers are more likely to work in restaurants, retail, and leisure services . . . ,"[63] at least these authors found that age, level of education, and firm size were more explanatory: younger workers with relatively less education are often low-wage workers in small businesses.

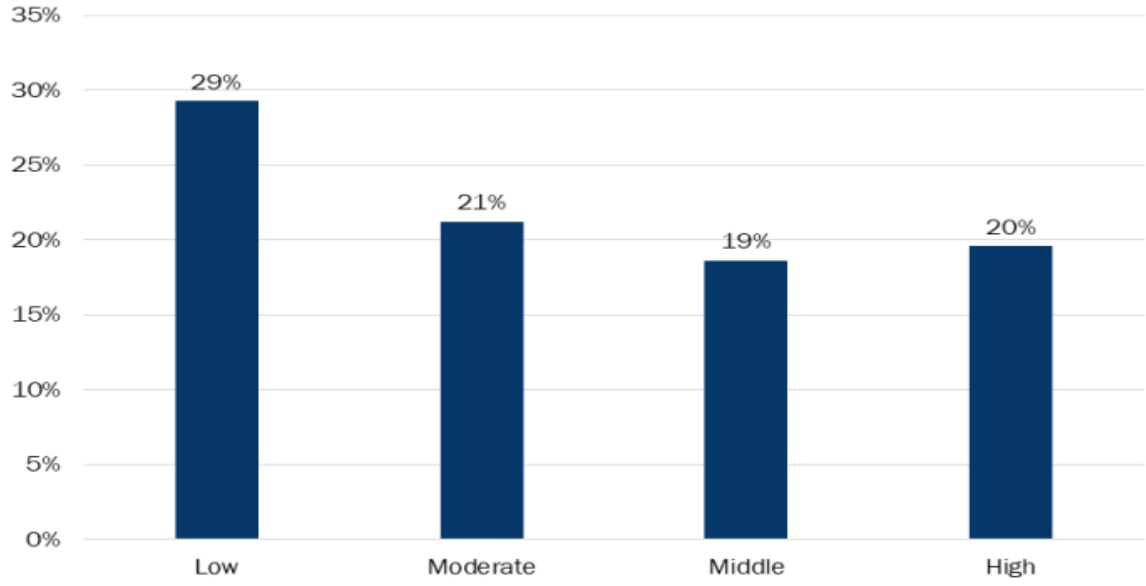
[61] Tomaz Cajner et al., The U.S. Labor Market During the Beginning of the Pandemic Recession, Becker Friedman Institute for Economics at UChicago Working Paper No. 2020-58, https://bfi.uchicago.edu/wp-content/uploads/HurstBFI_WP_202058_Revision.pdf (Accessed July 21, 2020).
[62] Id. at 11.
[63] Id. at 15.

Figure 3. Percentage of respondents reporting COVID-19-related job or income loss, by age



Source: COVID-19 Survey, Wave 1 (April 22–May 12, 2020), Social Policy Institute. BROOKINGS

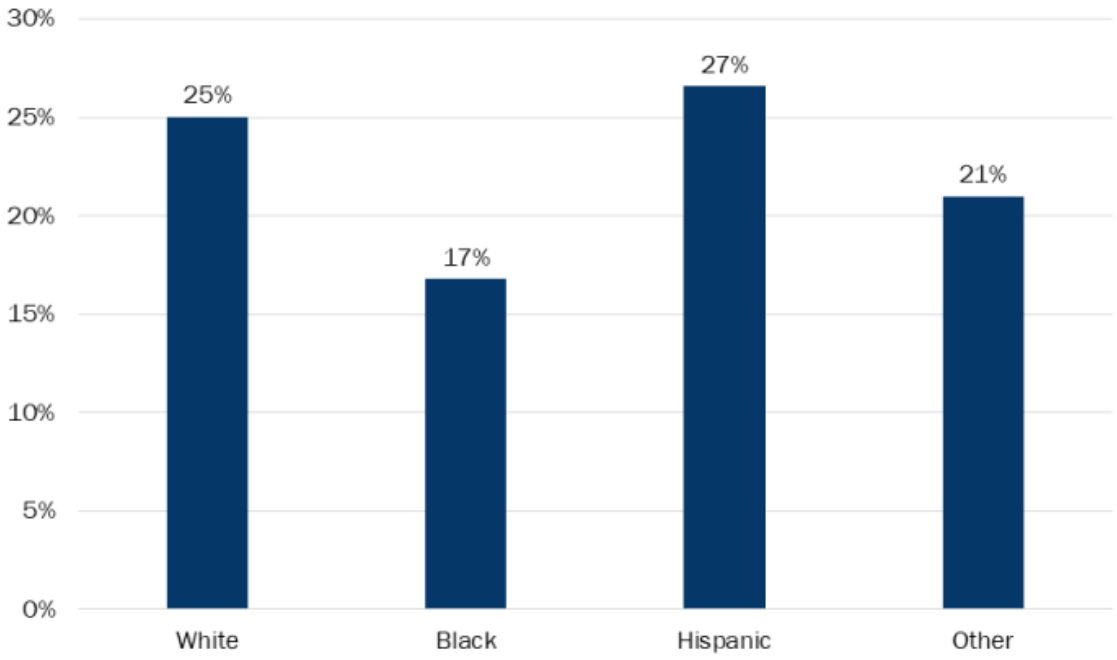
Figure 2. Percentage of respondents reporting COVID-19-related job or income loss, by income



Source: COVID-19 Survey, Wave 1 (April 22–May 12, 2020), Social Policy Institute. BROOKINGS

The disparate impact of these job losses by race and ethnicity are substantial, with Latinx workers hurt the most; and when one sums across age, wage and ethnicity, the conclusion is that young, low-wage Latinx workers have been hit extremely hard, most likely because of their dominance in the hospitality sector of the economy.[64]

Figure 1. Percentage of respondents reporting COVID-19-related job or income loss, by race/ethnicity



Source: COVID-19 Survey, Wave 1 (April 22–May 12, 2020), Social Policy Institute. BROOKINGS

Because of the linkage of health insurance to employment, this magnitude of job loss translates into millions of newly uninsured persons because when they lose their jobs they often also lose their employer-sponsored insurance ("ESI"). According to the latest pre-pandemic data available, the Census Bureau data for 2018, 8.5 percent of our population, some 27.5 million people were without health insurance.[65] In hindsight, those were the good old times. Although the number of persons who lost insurance due to the pandemic won't be known until sometime next year, when the Census Bureau's

[64] This conclusion and the figures are from Mathieu Despard et al., COVID-19 Job and Income Loss Leading to More Hunger and Financial Hardship, Brookings (July 13, 2020), https://www.brookings.edu/blog/up-front/2020/07/13/covid-19-job-and-income-loss-leading-to-more-hunger-and-financial-hardship/ (Accessed July 21, 2020).

[65] See Edward R. Berchick, Jessica C. Barnett & Rachel D. Upton, Health Insurance Coverage in the United States: 2018. United States Census Bureau (Nov. 2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf (Accessed May 28, 2020).

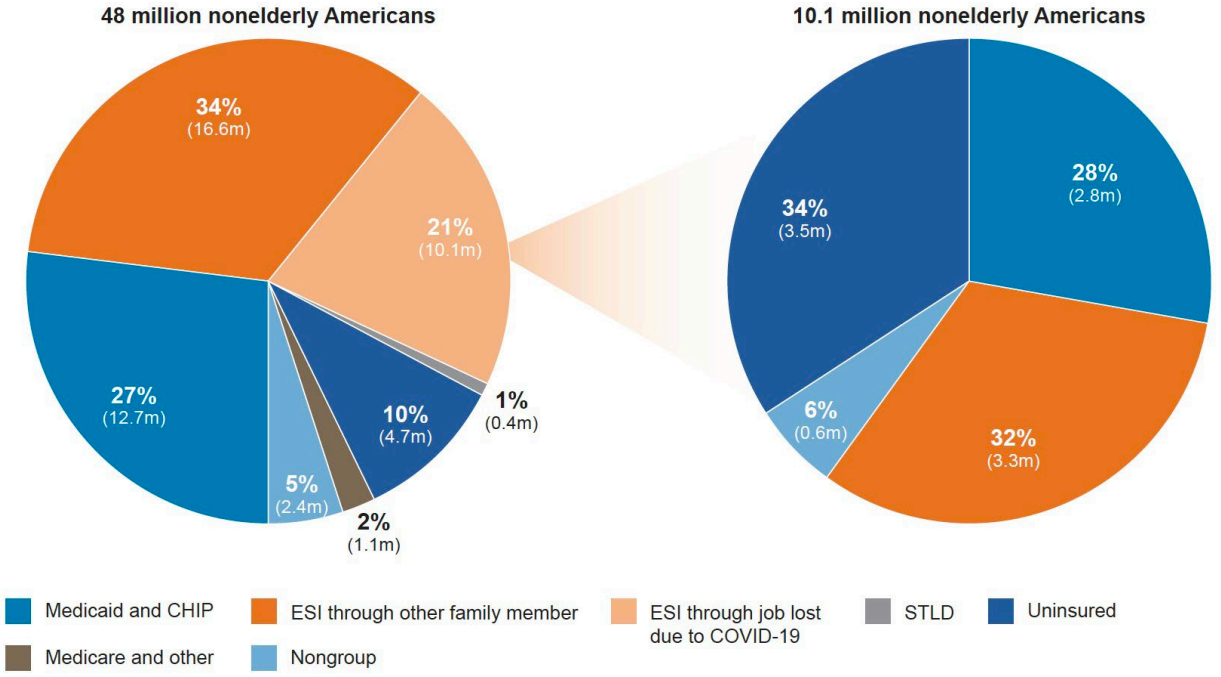
Household Survey is published, there are some recent, rigorous estimates. A Kaiser Family Foundation ("KFF") report[66] estimates that 27 million persons are in families which lost their ESI because the primary plan-holder lost his or her job, e.g., until she lost her job, a mother was insured under her employer's plan, which also covered her husband and children. The report goes on to estimate that 19 of those 27 million would retain ESI by switching the family's coverage to ESI offered to another family member—to carry the previous example forward, the family becomes covered under the husband-father's employer's plan.[67] That still yields about eight million people losing ESI. However, illustrating the fractured nature of alternative sources of coverage, something we discuss in a number of places in the book, many of those adults might be eligible for Medicaid, varying by state, or be eligible for subsidies to purchase an individual policy in the Marketplaces, created by the ACA, which we also discuss, while many children will be eligible for CHIP. To make the situation even more complicated, many persons who are eligible for these programs are not enrolled for a variety of reasons like lack of needed documentation. As a result, the so-called "take-up rate"—which too can vary from program to program and among the states—has to be estimated for each program in each state.

As you can see, then, the complications in making estimates makes one's head spin. A very fancy "microsimulation" by researchers at the Urban Institute projects that by the end of 2020, 10 million persons will have become uninsured because of loss of ESI, of which approximately 65 percent will pick up alternative coverage, yielding 3.5 million persons uninsured.[68] This result is illustrated by the following figure:[69]

[66] Rachel Garfield et al., Eligibility for ACA Coverage Following Job Loss, Kaiser Family Foundation (May 13, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/ (Accessed July 22, 2020).
[67] Id., Figure 1.
[68] Jessica Banthin et al., Changes in Health Insurance Coverage Due to the COVID-19 Recession: Preliminary Estimates Using Microsimulation, Urban Institute (July 13, 2020), https://www.urban.org/research/publication/changes-health-insurance-coverage-due-covid-19-recession (Accessed July 22, 2020).
[69] Id., Figure 1, at p. 3.

Figure 1. Health Insurance Coverage Prior to Pandemic Among Those with Subsequent Job Loss in Family, 2020

Figure 2. Post Job Loss Coverage Among Workers and Family Members Losing ESI Due to COVID-19 Recession, 2020

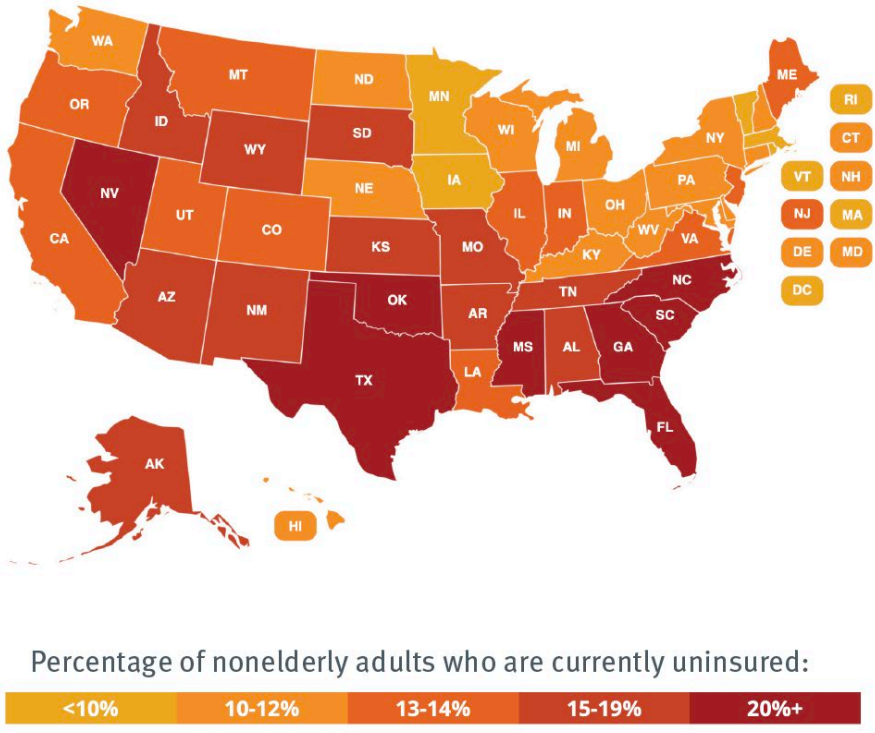


Source: Urban Institute's Health Insurance Policy Simulation Model
Notes: Estimates can be interpreted as applying to the average month in the last three quarters of 2020. ESI is employer-sponsored insurance, STLD is short-term limited duration plans, CHIP is Children's Health Insurance Program

By contrast, Families USA reported that as of May 2020, an historic 5.4 million workers have become uninsured because they had lost their ESI and were not picked up by another program, a figure 39% higher than the 3.9 nonelderly adults who became uninsured during the Great Recession because of job loss.[70] All studies concur that the greatest concentration of newly uninsured live in states that refused the Medicaid expansion, discussed above and in the book, as illustrated by the following figure:[71]

[70] Families USA, The COVID-19 Pandemic and Resulting Economic Crash Have Caused the Greatest Health Insurance Losses in American History (July 17, 2020), https://www.familiesusa.org/resources/the-covid-19-pandemic-and-resulting-economic-crash-have-caused-the-greatest-health-insurance-losses-in-american-history/ (Accessed July 22, 2020).
[71] Id., Figure 2, at p. 12.

Figure 2. Uninsured as of May 2020



There are five take-aways from these data and analyses. First, as you can tell, health insurance for millions of Americans hangs by a thread. Second, the sources of health insurance are spread across a multitude of different organizations and public programs. As you will see in the book, health insurance in the United States is simply ridiculously complicated. Third, the federal subsidies for individuals to buy insurance on the ACA Marketplaces, available for individuals whose income falls between 138 and 400 percent of the federal poverty limit ("FPL"), as discussed in the book, are crucial. The Trump administration has refused to reopen enrollment in the federal Marketplace, used by 38 states, by declaring a "special enrollment period" ("SEP"), something that would, among other effects, make it substantially easier for numerous people to enroll.[72] By contrast, the 12 of the 13 states that do not use the federal Marketplace but operate their own "state-based exchanges" have created SEPs, but, as always [!!!!!], there is

[72] See, e.g., Margot Sanger-Katz & Reed Abelson, Obamacare Markets Will Not Reopen, Trump Decides, New York Times (April 1, 2020), https://www.nytimes.com/2020/04/01/upshot/obamacare-markets-coronavirus-trump.html (Accessed July 24, 2020).

variation among them.[73] Fourth, likewise crucial is Medicaid, discussed too in the book, covering people whose income falls below 138 percent of FPL but with vast variation among states with regard to income caps for eligibility, e.g., in Louisiana eligibility is capped for a family of four whose income if their income for a month exceeds $3013,[74] and with 13 states still refusing to take the ACA's Medicaid expansion, including most of those with surging cases in late July 2020. Fifth, as also discussed in the book, funding for Medicaid in good times is fragile, and could become untenable in light of the pandemic. Medicaid is partly funded by the federal government and partly by states, and state budgets are now getting slammed because much of their revenue depends on the economy running at full tilt—unlike the federal government states cannot print money and run deficits—while simultaneously their Medicaid enrollment is increasing.[75] Therefore, state budgets are getting squeezed in both directions, with falling revenue and increasing Medicaid expenditures, not to mention the huge expenditures the states are incurring in so many other ways to deal with the pandemic. Ridiculously complicated and crucial to millions of people's lives.

4. Blacks, Latinx, Native Americans and other populations of color have suffered much greater health impacts from the pandemic due to the structural racism baked into the health care system and the social determinants of health.

Black, Latinx, Native Americans and other people of color in the United States are being hit much harder than whites. The data supporting this conclusion are absolutely stunning, showing much higher, age-adjusted rates of infection, hospitalization and death.[76] The following figure shows age-adjusted rates of infection:[77]

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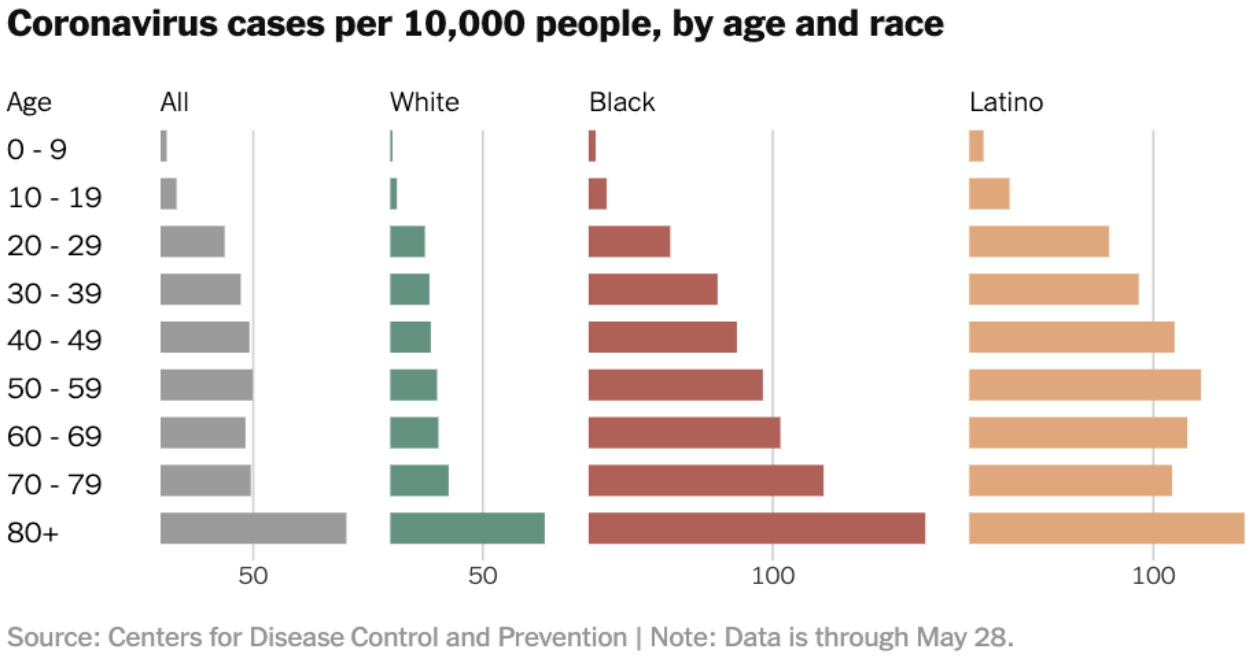
[73] See, e.g., Chad Brooker, Kate Sikora & Katie Patton, Exchanges May Add More than 1 Million New Enrollees Due to COVID-19, Avalere (July 8, 2020), https://avalere.com/insights/exchanges-may-add-more-than-1-million-new-enrollees-due-to-covid-19 (Accessed July 24, 2020); Rachel Schwad, Justin Giovannelli & Kevin Lucia, During the COVID-19 Crisis, State Health Insurance Marketplaces Are Working to Enroll the Uninsured, Commonwealth Fund (May 19, 2020), https://www.commonwealthfund.org/blog/2020/during-covid-19-crisis-state-health-insurance-marketplaces-are-working-enroll-uninsured (Accessed July 25, 2020).

[74] Monthly Income Limits for Medicaid Programs, https://ldh.la.gov/index.cfm/page/1371 (Accessed August 3, 2020).

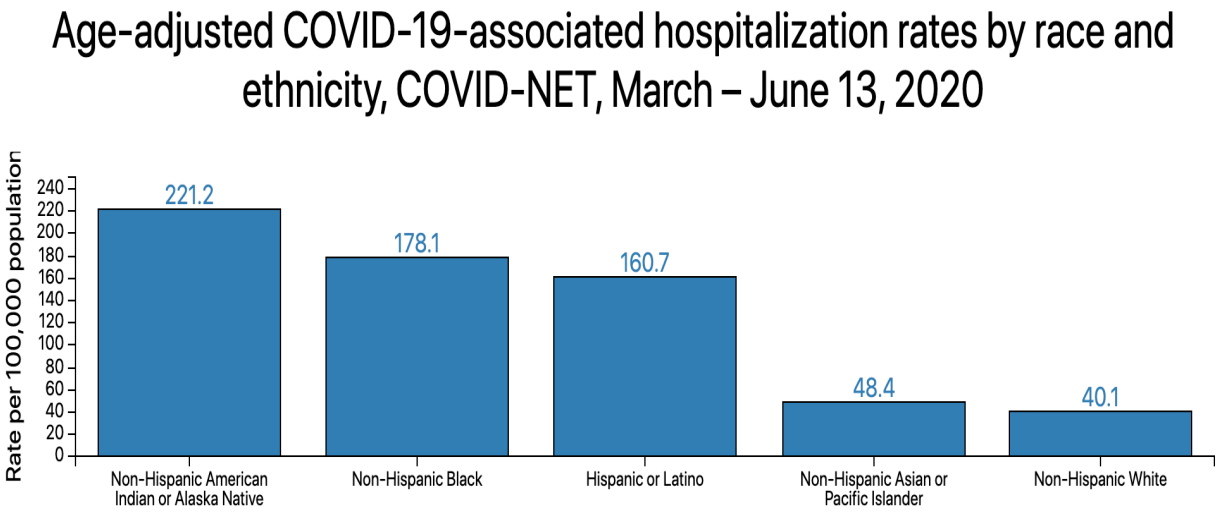
[75] Medicaid enrollment is increasing during the pandemic. See, e.g., Robin Rudowitz, Bradley Corallo and Samantha Artiga, Analysic of Recent National Trends in Medicaid and CHIP Enrollment, Kaiser Family Foundation (July 24, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/data-note-analysis-of-recent-national-trends-in-medicaid-and-chip-enrollment/ (Accessed July 24, 2020).

[76] Age-adjusted data are better than data that aren't adjusted for age because otherwise, in purporting to compare different racial or ethnic populations, one might instead be measuring age. Suppose for example that the sample for Caucasians has many more younger people, while that for Blacks is dominated by the elderly. Since there is variance by age groups, the results from such a comparison might reflect age rather than race.

[77] Richard A. Oppel Jr. et al., The Fullest Look Yet at the Racial Inequity of Coronavirus, New York Times (July 5, 2020), https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html (Accessed July 25, 2020).



The following figure shows age-adjusted rates of hospitalization by race and ethnicity:[78]



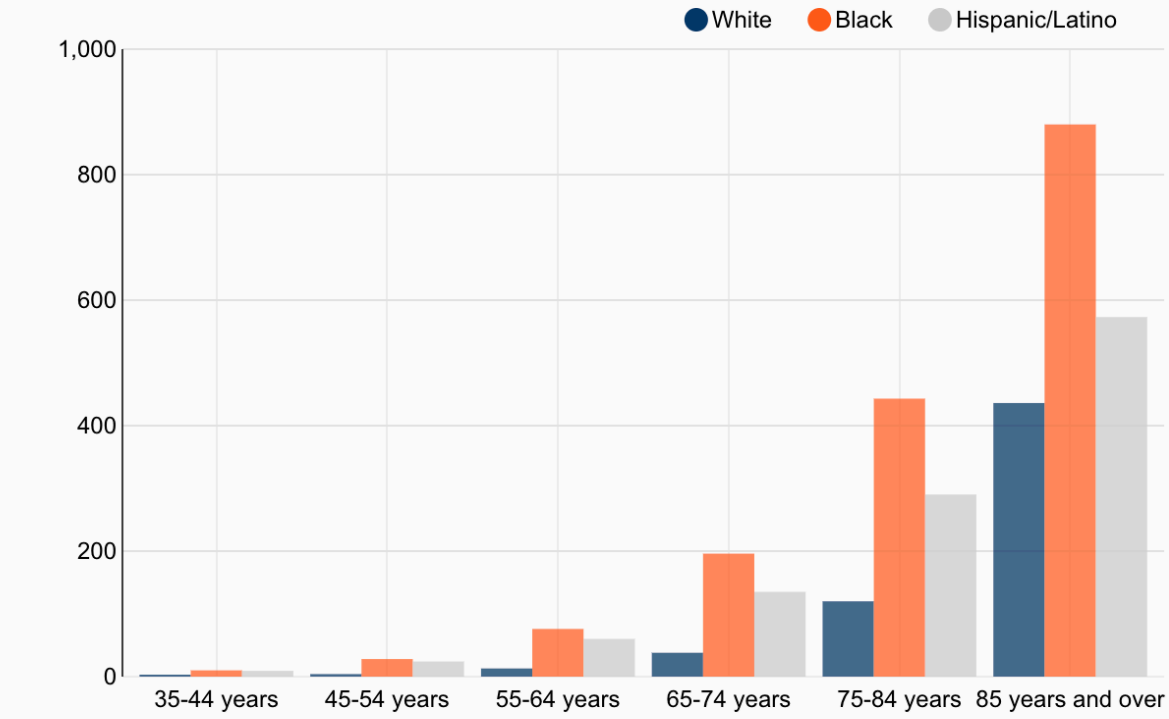
This translates to the following: "Non-Hispanic American Indian or Alaska Native persons have an age-adjusted hospitalization rate approximately 5.7 times that of non-Hispanic White persons, non-Hispanic Black persons have a rate approximately 4.7 times

[78] Centers for Disease Control & Prevention, COVID-19 in Racial and Ethnic Minority Groups at p. 9 (June 25, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html (Accessed July 25, 2020).

that of non-Hispanic White persons, and Hispanic or Latino persons have a rate approximately 4.5 times that of non-Hispanic White persons."[79]

The following figure shows age-adjusted mortality by race and ethnicity—and is simply shocking:[80]

Figure 1. COVID-19 death rates by age and race



Source: CDC data from 2/1/20-6/6/20 and 2018 Census Population Estimates for USA

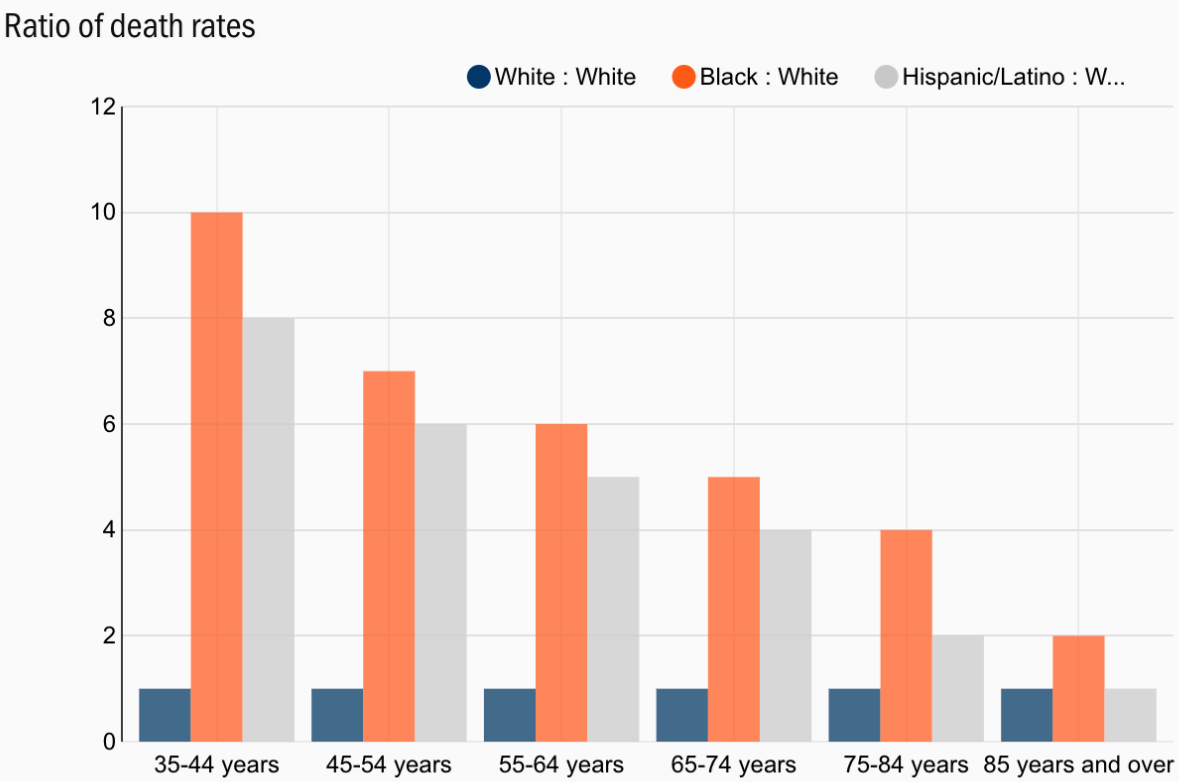
BROOKINGS

A number that is often used is that Blacks and Latinx are dying at a rate two times more than Whites.[81] However, without age adjustment, as stated above, to some extent those figures mix apples with oranges. With age-adjustment, the disparities are much

[79] Centers for Disease Control & Prevention, COVIDView for Week 26, ending June 27, 2020, at 9 (July 3, 2020), https://www.cdc.gov/coronavirus/2019-ncov/covid-data/pdf/covidview-07-03-2020.pdf (Accessed July 25, 2020).
[80] Tiffany Ford, Sarah Reber & Richard V. Reeves, Race Gaps in COVID-19 Are Even Bigger Than They Appear, Brookings (June 16, 2020), https://www.brookings.edu/blog/up-front/2020/06/16/race-gaps-in-covid-19-deaths-are-even-bigger-than-they-appear/ (Accessed July 25, 2020).
[81] See, e.g., Richard A. Oppel Jr. et al., supra note 76.

greater. "These disparities can be observed at all ages, but are especially marked in somewhat younger age groups. These disparities can be seen more clearly by comparing the ratio of death rates among Black and Hispanic/Latino people to the rate for white people in each age category. Among those aged 45-54, for example, Black and Hispanic/Latino death rates are at least six times higher than for whites":[82]

Figure 2. Huge race gaps in COVID-19 death rates, especially in middle age



Source: CDC data from 2/1/20-6/6/20 and 2018 Census Population Estimates for USA

BROOKINGS

Why do these disparities exist?

It is commonly noted that there might be implicit or overt bias in the system.[83] The latter is illustrated by the shocking manner in which hospital capacity was created

[82] Id.
[83] See, e.g., William J. Hall, Implicit Racial/Ethnic Bias Among Health Care Professionals and Its Influence on Health Care Outcomes: A Systematic Review, 105(12) Am. J. Pub. Health e60-e76 (Dec. 2015); David R. Williams & Ronald Wyatt, Racial Bias in Health Care and Health: Challenges and Opportunities, 314(6) JAMA 555 (2015); Diana Burgess et al., Reducing Racial Bias Among Health Care Providers: Lessons from Social-Cognitive Psychology, 22(6) J. Gen. Internal Med. 882 (2007).

and used in New York City during the peak of its surge in mid-April.[84] The City built a fully-staffed—and quite expensive—temporary hospital at the U.S.T.A Billie Jean King Tennis Center ("the Billie Jean King"). It cost 52 million dollars but served only 79 patients, most of which were transfers from private hospitals rather than the City's overwhelmed public hospitals. One of those hospitals, the Queens Hospital Center, located less than four miles from the Billie Jean King, was totally overwhelmed.

In the evening of April 9th, the night before the Billie Jean King opened, the Queens Hospital Center emergency department included 66 patients who were so sick that they had been admitted but were stacked up in the emergency department, waiting for inpatient beds. "In interviews, doctors at overwhelmed private hospitals said they were told they could not transfer to Billie Jean King because it was only for patients from public hospitals. . . . Several doctors at public hospitals said they believed their bosses did not want to transfer because the hospitals in the public system each had their own budgets, and they did not receive revenue from patients they sent away. Some said they were told Billie Jean King could treat only people with extremely mild symptoms." Other nearby hospitals were likewise overwhelmed, such as the Elmhurst Hospital Center. New York City had in fact set up this mess. "An aide to Mayor Bill de Blasio who helped oversee the site, Jackie Bray, said the city acted quickly to open it but ultimately concluded patients were best treated at existing hospitals, even if they were crowded."[85] The service area of the Queens Hospital Center has been described in the following way: "As of 2016, over 40 percent of the service area's population is Black, including African Americans and Afro-Caribbeans. Of the remaining population, 15 percent is Hispanic or Latino, 10 percent identifies as Asian or Pacific Islander, and 4 percent identifies as White. A significant portion of the service area consists of South Asian immigrants from nations such as India, Pakistan, and Bangladesh, as well as Guyanese. Much of the population is foreign-born and low income."[86] Therefore, the racial and ethnic groups who are dying much more than Caucasians from the pandemic were the ones impacted by the virtual inability of the public hospital system to transfer to the Billie Jean King.

This sequence of events also perfectly exemplifies the differential capacity available to Blacks, Latinx, Native Americans and other persons of color. Even obtaining a test is difficult for these populations, who then experience longer wait times and understaffed testing centers. In some major urbanized area—"from Dallas to Miami to San Diego and many places in between—majority-Black and majority-Hispanic neighborhoods faced far more competition for COVID-19 testing than their white neighbors. Disparities were also seen in some predominantly Asian or Pacific Islander communities, such as those in Washington, D.C., Minneapolis and Riverside, Calif., but

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[84] Unless otherwise noted, this paragraph derives from Brian M. Rosenthal, This Hospital Cost $52 Million. It treated 79 Virus Patients, New York Times (July 1, 2020), https://www.nytimes.com/2020/07/21/nyregion/coronavirus-hospital-usta-queens.html (Accessed July 26, 2020).
[85] Id.
[86] Wikipedia, Queens Hospital Center, https://en.wikipedia.org/wiki/Queens_Hospital_Center (Accessed

they weren't as widespread as those among Black and Hispanic communities."[87] One researcher who has examined these disparities summarized the impact in the following way: "'Testing site distribution and capacity is a direct reflection of the inequalities in our existing health care system,' said John Brownstein, a professor of epidemiology at Harvard Medical School whose team of researchers at Boston Children's Hospital's Computational Epidemiology Lab also looked into the health care disparities underlying geographic access to testing. "'The lack of access for those most vulnerable to infections will only serve to intensify the impact of this pandemic.'"[88]

The disparities are also commonly attributed to the fact that the non-White and non-Asian populations in the United States have a greater number of pre-existing health conditions, i.e., more comorbidities, such as obesity, hypertension, diabetes and cardiovascular disease, that have been correlated with more serious COVID-19 cases, hospitalizations and death. That is true but ultimately unsatisfying because one can then ask why those disparities exist.[89] The pandemic has brought into stark relief that structural racism drives these disparities.[90] The CDC has provided an excellent summary of the situation:[91]

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[87] FiveThirtyEight & ABC News, Want A COVID-19 Test? It's Much Easier To Get In Wealthier, Whiter Neighborhoods: But the disease is hitting Black and Hispanic communities hardest, https://fivethirtyeight.com/features/white-neighborhoods-have-more-access-to-covid-19-testing-sites/ (Accessed July 26, 2020). See also Benjamin Rader et al., Geographic Access to United States SARS-CoV-2 Testing Sites Highlights Healthcare Disparities and May Bias Transmission Estimates, J. of Travel Med. (May 15, 2020), https://academic.oup.com/jtm/article/doi/10.1093/jtm/taaa076/5837479 (Accessed July 26, 2020).

[88] Id.

[89] See, e.g., Chowkwanyun & Reed, Racial Health Disparities and Covid-19 — Caution and Context, New Eng. J. Med. (July 16, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2012910?query=featured_coronavirus (Accessed July 25, 2020); Alexander Bryan et al., Moving From The Five Whys To Five Hows: Addressing Racial Inequities In COVID-19 Infection And Death, Health Affairs Blog (July 2, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200625.389260/full/ (Accessed July 25, 2020); Clyde W. Yancy, COVID-19 and African Americans, 323(19) JAMA 1891 (April 15, 2020), https://jamanetwork.com/journals/jama/fullarticle/2764789 (Accessed July 25, 2020).

[90] See, e.g., id.; Leonard E. Egede & Rebekah J. Walker, Structural Racism, Social Risk Factors, and Covid-19 — A Dangerous Convergence for Black Americans, New Eng. J. Med. (July 22, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2023616 (Accessed July 25, 2020); David Blumenthal et al., Covid-19 — Implications for the Health Care System, New Eng. J. Med. (July 22, 2020), https://www.nejm.org/doi/full/10.1056/NEJMsb2021088 (Accessed July 25, 2020); Seth A. Berkowitz, Crystal Wiley Cené & Avik Chatterjee, Covid-19 and Health Equity—Time to Think Big, New Eng. J. Med. (July 22, 2020), https://www.nejm.org/doi/full/10.1056/NEJMp2021209?query=featured_coronavirus (Accessed July 25, 2020); Zinzi D. Baley & J. Robin Moon, Racism and the Political Economy of COVID-19: Will We Continue to Resurrect the Past, J. Health Pol., Pol'y & Law (May 28, 2020), https://read.dukeupress.edu/jhppl/article/doi/10.1215/03616878-8641481/165296/Racism-and-the-Political-Economy-of-COVID-19-Will (Accessed July 25, 2020).

[91] Centers for Disease Control & Prevention, Why Racial and Ethnic Minority Groups Are at Increased Risk During COVID-19 (June 25, 2020), https://www.cdc.gov/coronavirus/2019-ncov/need-extra-precautions/racial-ethnic-minorities.html (Accessed July 25, 2020).

Why Racial and Ethnic Minority Groups are at Increased Risk During COVID-19

Health differences between racial and ethnic groups result from inequities in living, working, health, and social conditions that have persisted across generations. In public health emergencies, such as the COVID-19 pandemic, these conditions can also isolate people from the resources they need to prepare for and respond to outbreaks.

Living conditions

For many people from racial and ethnic minority groups, living conditions can contribute to health conditions and make it harder to follow steps to prevent getting sick with COVID-19 or to seek care if they do get sick.

- Many members of racial and ethnic minorities may be more likely to live in **densely populated areas** because of institutional racism in the form of residential housing segregation. In addition, overcrowding is more likely in tribal reservation homes and Alaska Native villages, compared to the rest of the nation. People living in densely populated areas and homes may find it harder to practice social distancing.
- **Racial housing segregation** is linked to health conditions, such as asthma and other underlying medical conditions, that put people at increased risk of getting severely ill or dying from COVID-19. Some communities with higher numbers of racial and ethnic minorities have higher levels of exposure to pollution and other environmental hazards.
- **Reservation homes are more likely to lack complete plumbing** when compared to the rest of the nation. This may make handwashing and disinfection harder.
- Many members of racial and ethnic minority groups live in neighborhoods that are **farther from grocery stores and medical facilities**, or may **lack safe and reliable transportation**, making it harder to stock up on supplies that would allow them to stay home and to receive care if sick.
- Some members of racial and ethnic minority groups may be more likely to **rely on public transportation**, which may make it challenging to practice social distancing.
- People living in multigenerational households and multi-family households (which are more common among some racial and ethnic minority groups), may find it hard to protect older family members or isolate those who are sick if space in the household is limited.
- Some racial and ethnic minority groups are **over-represented in jails, prisons, homeless shelters, and detention centers**, where people live, work, eat, study,

and recreate within congregate environments, which can make it difficult to slow the spread of COVID-19.

Work circumstances

Some types of work and workplace policies can put workers at increased risk of getting COVID-19. Members of some racial and ethnic minority groups are more likely to work in these conditions. Examples include:

- **Being an essential worker**: The risk of infection may be greater for workers in essential industries, such as health care, meat-packing plants, grocery stores, and factories. These workers must be at the job site despite outbreaks in their communities, and some may need to continue working in these jobs because of their economic circumstances.
- **Not having sick leave**: Workers without paid sick leave may be more likely to keep working when they are sick.

- **Income, education, and joblessness**: On average, racial and ethnic minorities earn less than non-Hispanic whites, have less accumulated wealth, have lower levels of educational attainment, and have higher rates of joblessness. These factors can each affect the quality of the social and physical conditions in which people live, learn, work, and play, and can have an impact on health outcomes.

Health circumstances

Health and healthcare inequities affect many racial and ethnic minority groups. Some of these inequities can put people at increased risk of getting severely ill and dying from COVID-19.

- Compared to non-Hispanic whites, Hispanics are almost 3 times as likely to be **uninsured**, and non-Hispanic blacks are almost twice as likely to be uninsured. In all age groups, blacks are more likely than non-Hispanic whites to report not being able to see a doctor in the past year because of cost. In 2017, almost 3 times as many American Indians and Alaska Natives had no health insurance coverage compared to non-Hispanic whites.
- People may not receive care because of **distrust of the healthcare system, language barriers, or cost of missing work**.
- Compared to non-Hispanic whites, blacks experience **higher rates of chronic conditions at earlier ages and higher death rates**. Similarly, American Indian and Alaska Native adults are more likely to have obesity, have high blood pressure, and smoke cigarettes than non-Hispanic white adults. These underlying medical conditions may put people at increased risk for severe illness.

- **Racism, stigma, and systemic inequities** undermine prevention efforts, increase levels of chronic and toxic stress, and ultimately sustain health and healthcare inequities.

* * *

We can usefully categorize these factors into two categories, more serious risk of infection and more risk of serious illness or death. The factors that lead to a more serious risk of infection include: greater exposure due to greater housing density; higher number of front-line, "essential" jobs; lack of sick pay; greater use of public transportation; greater living in multi-generational or multi-family dwellings, or greater number of gatherings, or both due to economic or cultural reasons, or both; inadequate access to healthy food. The factors that lead to greater number of serious illnesses or deaths: higher rates of comorbidities; diminished access to care; inferior care; higher rate of uninsurance; existence of undocumented workers; lower income and assets, requiring continued working for income and insurance; immigration status; and inadequate access to healthy food.

We will see in the book that many anti-discrimination laws pertain to health care insurance and delivery. Is what the CDC describes "discrimination"? What would your definition of discrimination have to be if you deem these factors to be discrimination? What if your definition of discrimination requires that overt racial categories be drawn in the allegedly discriminatory practice? What if your definition of discrimination includes differential impact? What problems of administration would that definition entail? What if an employer-sponsored health insurance, offered to all employees, has a cap on expenditures for HIV-related illnesses? What are the results of applying different definitions of discrimination to that policy? What if that policy were offered only to employees who are HIV-positive?

If you deem this social structure to constitute discrimination, where would the remedy lie? In the judiciary? In the legislature? In the private section? In non-governmental organizations? Somewhere else?

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 *Obergfell*, 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

* 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.

question of whether the Administration even has the legal authority to extend existing 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—

[*] Note the agency's error on EMTALA's name—not a basis for a vote of confidence.

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:

> 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. 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

Table of Contents for Chapter 4 Inserts

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

[The Supreme Court's decision in Dobbs v. Jackson Women's Health Organization, reprinted in this Supplement immediately below, overruled part or all of what's below. We have retained it because it gives context to the decision in Dobbs and, moreover, because, as you will see in the Notes following Dobbs, the case's consequences are virtually unknown right now.]

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, "rais[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 *amici* 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' 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 speak in opposition to abortion, is at issue. As Justice ALITO observes, today's decision creates an abortion exception to ordinary rules of res judicata, ignores compelling evidence that Texas' law imposes no unconstitutional burden, and disregards basic principles of the severability doctrine. I write separately to emphasize how today's decision perpetuates the Court's habit of applying different rules to different constitutional rights—especially the putative right to abortion.

To begin, 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 "reasonabl[e] relat[ion] 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. Meanwhile, the majority's undue-burden balancing approach risks ruling out even minor, previously valid infringements on access to abortion. 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 new taxonomy of preferred rights. 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' filibuster 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 Women'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 State Constitution*, 61 UCLA L. Rev. Discourse 22, 29 (2013). Since then, California repealed its physician-only restriction.

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 1313 (M.D. Alabama, 2016), 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.

6. Texas and family planning. Abortion is not the only women's health care in Texas' crosshairs. The state's pursuit of abortion coincided with its aggressive actions to curb access to contraception by disadvantaged and medically underserved women. Under federal Medicaid law, states are barred from arbitrarily excluding qualified providers from their programs based on the fact that providers also furnish care not covered by Medicaid. https://www.medicaid.gov/federal-policy-guidance/downloads/smd16005.pdf (Accessed July 22, 2017). Planned Parenthood, the nation's most prominent abortion provider, also furnishes essential preventive care, including breast and cervical cancer screening and family planning services. Half of all U.S. pregnancies are unplanned, and unplanned pregnancy is the single most important determinant of the health of infants and their mothers and families. Brief of the Guttmacher Institute and Professor Sara Rosenbaum on behalf of the United States Government in *Zubik v Burwell* (United States Supreme Court, 2016), http://www.scotusblog.com/wp-content/uploads/2016/02/02.17.16_amicus_brief_in_support_of_respondents-_guttmacher.pdf (Accessed July 22, 2017).

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/ (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 (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 Health Centers, and Women's Health: Getting the Facts Right (Health Affairs Blog,

2015), http://healthaffairs.org/blog/2015/09/02/planned-parenthood-community-health-centers-and-womens-health-getting-the-facts-right/ (Accessed July 22, 2017).

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 abstention.

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).

Barring federal Medicaid payments to Planned Parenthood: Obamacare repeal and replace. In 2017, as part of its (ultimately failed) Obamacare repeal and replace effort, Congress attempted to block Planned Parenthood from receiving Medicaid payments for the covered family planning and preventive women's health services it furnishes. Margot Sanger-Katz, Who Wins and Who Loses in the Latest G.O.P. Health Care Bill, New York Times, May 4, 2017, available at https://www.nytimes.com/2017/05/04/upshot/who-wins-and-who-loses-in-the-latest-gop-health-care-bill.html. (Only 3 percent of all medical care furnished by Planned Parenthood clinics involve abortions. Planned Parenthood 100 Years, available at https://www.plannedparenthood.org/uploads/filer_public/71/53/7153464c-8f5d-4a26-bead-2a0dfe2b32ec/20171229_ar16-17_p01_lowres.pdf). Because the organization plays such an outsize role in health care for low-income women, Medicaid is a central source of funding, accounting for 75 percent of the federal funding Planned Parenthood receives. NPR, Fact Check: How Does Planned Parenthood Spend that Government Money? available at https://www.npr.org/sections/itsallpolitics/2015/08/05/429641062/fact-check-how-does-planned-parenthood-spend-that-government-money. The legislative effort

failed, but the cudgel has been taken up through a multi-faceted regulatory strategy to accomplish the same exclusionary results.

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 type of exclusionary state practice. In reversing its position, the agency suggested that it would proceed through a new formal rulemaking process aimed at expanding state powers to exclude certain providers under federal Medicaid law. See, Sara Rosenbaum, The Trump Administration's Newest Strategy For Excluding Planned Parenthood From Medicaid, Health Affairs Blog (January 25, 2018), available at https://www.healthaffairs.org/do/10.1377/hblog20180125.480978/full/.

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. https://www.hhs.gov/opa/title-x-family-planning/about-title-x-grants/index.html. 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 subsidized 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. . . . [H]ere 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.

Rust v. Sullivan, 500 U.S. at 192-205.

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.

45 C.F.R. § 59.14.

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.

8. *State admitting privilege laws redux.* Not deterred in the slightest, apparently, and hoping for a new day at the Supreme Court, abortion opponents once again made their way back to the Justices. The case that brought them there was *June Medical Services v Russo,* __ S.Ct. ___, 2020 WL 3492640. Focusing on Louisiana's hospital admitting privileges law, the law was a virtual carbon copy of the *Whole Woman's Health* decision only 4 years previously. The case resulted in a plurality vote to reinstate the permanent injunction against enforcement of the law that had been issued by the trial court and reversed by the Fifth Circuit Court of Appeals. Most important, however, was Chief Justice's concurrence on *stare decisis* grounds, that he also used to signal to abortion opponents and the dissent that in the future, he might be willing to make more of a move where state laws that are not 100-percent replicas of what came before are concerned.

The Fifth Circuit's ruling was based on its assertion that the Louisiana law was sufficiently different from that at issue in Texas and that it placed no unconstitutional undue burden on women. But in the plurality opinion for the Court, Justice Breyer essentially called out the lower court for engaging in a major case of judicial overreach. Chief Justice Roberts essentially concurred, going through a point-by-point refutation of the lower court's assertion that this law was different and emphasizing the principle of *stare decisis.* At the same time, his concurrence came at a cost whose exact price is yet to be determined.

Justice Breyer (who as you recall wrote the majority opinion in *Whole Woman's Health*) began for the plurality by observing that the Louisiana statute whose constitutionality at issue was "almost word-for-word identical" to the Texas law at issue in the Court's 2016 decision. Indeed, he noted, Louisiana began its process of enactment once it saw the success of the Texas law, which had caused the closure of half that state's clinics. Previously, as in Texas, Louisiana had required abortion providers to have either local hospital privileges or else a patient transfer arrangement with a physician with local

privileges. Also, as in Texas, the level of privileges required under Louisiana's new law were that the physician be "'a member in good standing' of the hospital's 'medical staff . . . with the ability to admit a patient and to provide diagnostic and surgical services to such patient.'"

Litigation ensued, with two separate cases involving 6 individual physicians from across the state. In the consolidated suits, the plaintiffs all claimed that like Texas, the new Louisiana law placed an unconstitutional undue burden on their patients' right to obtain abortions. The state did not challenge plaintiffs' standing (the question of whether physicians can raise claims on behalf of their patients is a recurring one in abortion cases) and both sides sought a preliminary decision on the legality of the law before it took effect. Instead, the judge issued a temporary restraining order and directed physicians to seek privileges as required under the statute and to "keep the court apprised of their progress."

Following a 6-day bench trial the court declared the law unconstitutional on its face and preliminarily enjoined its operation. The Fifth Circuit stayed the injunction and the Supreme Court intervened, reinstating the trial court's preliminary injunction for the time being. *June Medical Services L.L.C. v Gee,* 814 F. 3d 319 (5th Cir., 2016), *vacated* 136 S.Ct. 1354 (2016). Following its 2016 decision in *Whole Woman's Health* (also reversing the 5th Circuit), the Court remanded *June Medical Services* for reconsideration. The 5th Circuit in turn sent the case back to the trial court for further fact-finding.

The trial court ultimately permanently enjoined the Louisiana law from taking effect, entering findings that in tenor were a carbon copy of those in *Whole Woman's* Health—a procedure (abortion) that is extremely safe; no credible evidence in the legislative record of any woman's health problem that the law was needed to protect against; the law's massive impact on the approximately 10,000 Louisiana women who obtain abortions each year because of its impact on physicians' ability to practice, with 5 of the 6 named physicians unable to obtain privileges "for reasons related to [the] Act and not related to their competence"; a law that served no relevant credentialing function because it permitted physicians to be denied privileges for reasons unrelated to their clinical competency; hospital bylaws that barred or discouraged privileges for abortion providers; at most, two physicians left in the state (Shreveport and New Orleans) who might be able to satisfy the privileges rule, and one of whom indicated that he would no longer provide abortions if in the region he was the only physician left willing to perform the procedure; a statewide reduction in capacity of between 55% and 70%; and finally, a loss of access to "safe, legal abortion" among women in Louisiana. The trial court concluded that the act "does not advance Louisiana's legitimate interest in protecting the health of women seeking abortions. Instead [the] Act would increase the risk of harm to women's health by dramatically reducing the availability of safe abortion" in the state. The court further found "no legally significant distinction" between the Louisiana law and the Texas statute in *Whole Woman's Health,* and permanently enjoined its operation.

Back to the 5th Circuit, which again reversed. The court conducted its own, independent review of the evidence and concluded that the trial court had committed clear error and that the Louisiana statute, in its operation and impact, could be distinguished from the Texas law. Specifically, the appeals court found that the admitting privilege requirement "'performs a real, and previously unaddressed, credentialing function that promotes the wellbeing of women seeking abortion'" because "the process of obtaining privileges would help to 'verify an applicant's surgical ability, training, education, experience, practice record, and criminal history.'" The court also accepted the state's argument that the requirement served simply to bring its laws regarding abortion clinics "into conformity with the *preexisting* requirement that physicians at ambulatory surgical centers" have local hospital privileges. In terms of burden, the court further found that the doctors had not demonstrated sufficient problems with privileges. The court concluded that all but one physician had not made a good faith effort or because the choice, and furthermore, that it was not the state's fault if one of the physicians ceased performing abortions entirely as a result of the loss of colleagues. The majority concluded that "'there is no evidence that Louisiana facilities will close'" as a result of the Act and that in the one community where the clinic would close (Baton Rouge) the problem was not with the law but with the lack of a good-faith effort by that physician to obtain privileges. Based on all of this, the court concluded that the law would place "'no substantial burden at all'"—that it would merely lengthen waiting periods by 54 minutes for, at most, 30 percent of the state's women.

And then on to the Supreme Court, which reinstated the district court's injunction during the pendency of the litigation and handed down its decision at the end of June. After determining that the State had waived its ability to raise third-party standing issues (unlike Article Three standing, third-party standing is merely a prudential policy call and therefore can be waived), Justice Breyer turned to the merits. After reiterating that, as in *Whole Woman's Health, Casey* continues to guide the Court's abortion jurisprudence, he explained where and how the 5th Circuit went off the rails:

> In *Whole Woman's Health*, we quoted *Casey* in explaining 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. We added that *unnecessary* health regulations impose an unconstitutional undue burden if they have the purpose or effect of presenting a substantial obstacle to a woman seeking an abortion. We went on to explain that, in applying these standards, courts must consider the burdens a law imposes on abortion access together with the benefits those laws confer. We cautioned that courts must review legislative factfinding under a deferential standard. But they must not "'place dispositive weight on those findings,'" for the courts retain an independent constitutional duty to review factual findings where constitutional rights are at stake.

> We held in *Whole Woman's Health* that the trial court faithfully applied these standards. It considered the evidence in the record—including expert evidence, presented in stipulations, depositions, and testimony. It then weighed the asserted benefits of the law against the burdens it imposed on abortion access. And it concluded that the balance tipped against the statute's constitutionality. The District Court in this suit did the same.
>
> The Court of Appeals disagreed with the District Court, not so much in respect to the legal standards that we have just set forth, but because it did not agree with the factual findings on which the District Court relied in assessing both the burdens that Act 620 imposes and the health-related benefits it might bring. We have consequently reviewed the record in detail ourselves. In doing so, we have applied well-established legal standards.
>
> We start from the premise that a district court's findings of fact, whether based on oral or other evidence, must not be set aside unless clearly erroneous, and the reviewing court must give due regard to the trial court's opportunity to judge the witnesses' credibility. In applying this standard to the findings of a district court sitting without a jury, appellate courts must constantly have in mind that their function is not to decide factual issues *de novo.* Where the district court's account of the evidence is plausible in light of the record viewed in its entirety, the court of appeals may not reverse it even though convinced that had it been sitting as the trier of fact, it would have weighed the evidence differently.

To the dissent's argument that the appellate court owed less deference because the trial court's decision was issued before the law was permitted to take effect, Justice Breyer responded:

> We are aware of no authority suggesting that appellate scrutiny of factual determinations varies with the timing of a plaintiff's lawsuit or a trial court's decision. And, in any event, the record belies the dissents' claims that the District Court's findings in this case were "conjectural" or premature. As we have explained, the District Court's order on the plaintiffs' motion for a temporary restraining order suspended only Act 620's penalties. The plaintiffs were required to continue in their efforts to obtain admitting privileges. The District Court supervised those efforts through the trial and beyond. It based its findings on this real-world evidence, not speculative guesswork. Nor can we agree with the suggestion that the timing of the District Court's decision somehow prejudiced the State. From the start, the State urged that the District Court decide the merits of the plaintiffs' claims without awaiting a decision on their applications for admitting privileges. And, when this case returned to

> the District Court in August 2016, following our decision in *Whole Woman's Health*, the State stipulated that the case was ripe for decision on the record as it stood in June 2015. In short, we see no legal or practical basis to depart from the familiar standard that applies to all findings of fact.
>
> Under that familiar standard, we find that the testimony and other evidence contained in the extensive record developed over the 6-day trial support the District Court's ultimate conclusion that, even if Act 620 could be said to further women's health to some marginal degree, the burdens it imposes far outweigh any such benefit, and thus the Act imposes an unconstitutional undue burden.

Thus, the plurality decision became a lesson of sorts in what constitutes proper appellate practice, a Supreme Court spanking because of the 5th Circuit's decision to effectively reweigh the evidence and insert itself as a grand trier of fact.

But the Chief Justice did not merely concur, although much of his concurrence consisted of a point-by-point comparison of the Louisiana and Texas laws, thereby driving home the legal basis for his conclusion, namely the principle of *stare decisis.* Yet even as he made much of this principle and went out of his way to do a granular dive into the facts, he also noted along the way that under certain circumstances (different from what was the case here), admitting privileges have value, as argued by Justice Alito in his dissent. Furthermore, the Chief Justice also staked out new ground in relation to the proper scope of judicial inquiry under *Casey's* undue burden test:

> *Casey* reaffirmed the most central principle of *Roe v. Wade*, a woman's right to terminate her pregnancy before viability. At the same time, it recognized that the State has important and legitimate interests in [] protecting the health of the pregnant woman and in protecting the potentiality of human life. To serve the former interest, the State may, as with any medical procedure, enact regulations to further the health or safety of a woman seeking an abortion. To serve the latter interest, the State may, among other things, enact rules and regulations designed to encourage her to know that there are philosophic and social arguments of great weight that can be brought to bear in favor of continuing the pregnancy to full term. The State's freedom to enact such rules is consistent with *Roe*'s central premises, and indeed the inevitable consequence of our holding that the State has an interest in protecting the life of the unborn.
>
> Under *Casey*, the State may not impose an undue burden on the woman's ability to obtain an abortion. A finding of an undue burden is a shorthand for the conclusion that a state regulation has the purpose or effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. Laws that do not pose a substantial obstacle

> to abortion access are permissible, so long as they are "reasonably related" to a legitimate state interest. After faithfully reciting this standard, the Court in *Whole Woman's Health* added the following observation: "The rule announced in *Casey*... requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer." The plurality repeats today that the undue burden standard requires courts "to weigh the law's asserted benefits against the burdens it imposes on abortion access."

The Chief Justice then invoked Justice Scalia repeatedly:

> Read in isolation from *Casey*, such an inquiry could invite a grand "balancing test in which unweighted factors mysteriously are weighed." Under such tests, "equality of treatment is . . . impossible to achieve; predictability is destroyed; judicial arbitrariness is facilitated; judicial courage is impaired." Scalia, The Rule of Law as a Law of Rules, 56 U. Chi. L. Rev. 1175, 1182 (1989). In this context, courts applying a balancing test would be asked in essence to weigh the State's interests in protecting the potentiality of human life and the health of the woman, on the one hand, against the woman's liberty interest in defining her own concept of existence, of meaning, of the universe, and of the mystery of human life on the other. There is no plausible sense in which anyone, let alone this Court, could objectively assign weight to such imponderable values and no meaningful way to compare them if there were. Attempting to do so would be like "judging whether a particular line is longer than a particular rock is heavy," *Bendix Autolite Corp. v. Midwesco Enterprises, Inc.*, 486 U.S. 888, (1988) (Scalia, J., concurring in judgment). Pretending that we could pull that off would require us to act as legislators, not judges, and would result in nothing other than an "unanalyzed exercise of judicial will" in the guise of a neutral utilitarian calculus.
>
> Nothing about *Casey* suggested that a weighing of costs and benefits of an abortion regulation was a job for the courts. On the contrary, we have explained that the traditional rule that "state and federal legislatures have wide discretion to pass legislation in areas where there is medical and scientific uncertainty is consistent with *Casey*. *Casey* instead focuses on the existence of a substantial obstacle, the sort of inquiry familiar to judges across a variety of contexts. See, *e.g.*, *Burwell v. Hobby Lobby Stores, Inc.*, 573 U.S. 682 (2014) (asking whether the government "substantially burdens a person's exercise of religion" under the Religious Freedom Restoration Act).
>
> *Casey*'s analysis of the various restrictions that were at issue in that case is illustrative. For example, the opinion recognized that Pennsylvania's 24-hour waiting period for abortions has the effect of

increasing the cost and risk of delay of abortions, but observed that the District Court did not find that the increased costs and potential delays amount to substantial obstacles. The opinion concluded that given the statute's definition of medical emergency, the waiting period did not impose[ ] a real health risk . . . notwithstanding the District Court's finding that the law did not further the state interest in maternal health.

Turning to the State's various recordkeeping and reporting requirements, *Casey* found those requirements do not impose a substantial obstacle to a woman's choice" because "[a]t most they increase the cost of some abortions by a slight amount." The Court did not weigh this cost against the benefits of the law.

The same was true for Pennsylvania's parental consent requirement. *Casey* held that a State may require a minor seeking an abortion to obtain the consent of a parent or guardian, provided there is an adequate judicial bypass procedure. The opinion similarly looked to whether there was a substantial burden, not whether benefits outweighed burdens, in analyzing Pennsylvania's requirement that physicians provide certain "truthful, nonmisleading information" about the nature of the abortion procedure. The opinion concluded that the requirement "cannot be considered a substantial obstacle to obtaining an abortion, and, *it follows*," there is no undue burden. (emphasis added).

With regard to the State's requirement that a physician, as opposed to a qualified assistant, provide the woman this information, the opinion reasoned: "*Since* there is no evidence on this record that requiring a doctor to give the information as provided by the statute would amount in practical terms to a substantial obstacle to a woman seeking an abortion, we conclude that it is not an undue burden." (emphasis added). This was so "even if an objective assessment might suggest that those same tasks could be performed by others," meaning the law had little if any benefit.

The only restriction *Casey* found unconstitutional was Pennsylvania's spousal notification requirement. On that score, the Court recited a bevy of social science evidence demonstrating that "millions of women in this country . . . may have justifiable fears of physical abuse" or "devastating forms of psychological abuse from their husbands." In addition to "physical violence" and "child abuse," women justifiably feared "verbal harassment, threats of future violence, the destruction of possessions, physical confinement to the home, the withdrawal of financial support, or the disclosure of the abortion to family and friends." The spousal notification requirement was "thus likely to prevent a significant number of women from obtaining an abortion." *Ibid.* It did not "merely make abortions a little more difficult or expensive to obtain; for

many women, it [imposed] a substantial obstacle." The Court emphasized that it would not "blind [itself] to the fact that the significant number of women who fear for their safety and the safety of their children are likely to be deterred from procuring an abortion as surely as if the Commonwealth had outlawed abortion in all cases."

The upshot of *Casey* is clear: The several restrictions that did not impose a substantial obstacle were constitutional, while the restriction that did impose a substantial obstacle was unconstitutional.

To be sure, the Court at times discussed the benefits of the regulations, including when it distinguished spousal notification from parental consent. But in the context of *Casey*'s governing standard, these benefits were not placed on a scale opposite the law's burdens. Rather, *Casey* discussed benefits in considering the threshold requirement that the State have a legitimate purpose and that the law be reasonably related to that goal. So long as that showing is made, the only question for a court is whether a law has the effect of placing a substantial obstacle in the path of a woman seeking an abortion of a nonviable fetus. The only place a balancing test appears in *Casey* is in Justice Stevens's partial dissent. "Weighing the State's interest in potential life and the woman's liberty interest," Justice Stevens would have gone further than the plurality to strike down portions of the State's informed consent requirements and 24-hour waiting period. But that approach did not win the day.

Mazurek v. *Armstrong* [520 U.S. 968 (1997)] places this understanding of *Casey*'s undue burden standard beyond doubt. *Mazurek* involved a challenge to a Montana law restricting the performance of abortions to licensed physicians. It was uncontested that there was insufficient evidence of a 'substantial obstacle' to abortion. Therefore, once the Court found that the Montana Legislature had not acted with an unlawful motive, the Court's work was complete. In fact, the Court found the challengers' argument—that the law was invalid because all health evidence contradicts the [State's] claim that there is any health basis for the law"—to be "*squarely foreclosed* by *Casey* itself."

Here the plurality expressly acknowledges that we are not considering how to analyze an abortion regulation that does not present a substantial obstacle. "That," the plurality explains, "is not this case." *Casey*'s requirement of finding a substantial obstacle before invalidating an abortion regulation is therefore a sufficient basis for the decision, as it was in *Whole Woman's Health*. In neither case, nor in *Casey* itself, was there call for consideration of a regulation's benefits, and nothing in *Casey* commands such consideration. Under principles of *stare decisis*, I agree with the plurality that the determination in *Whole Woman's Health* that

> Texas's law imposed a substantial obstacle requires the same determination about Louisiana's law. Under those same principles, I would adhere to the holding of *Casey*, requiring a substantial obstacle before striking down an abortion regulation.
>
> * * *

So what does it mean, in the end, whether or not the judicial inquiry is strictly limited to measuring the presence of substantial burden and does *not* include a separate determination as to whether the law confers a benefit? In the end, what is the legal impact of the Chief Justice's effort to reframe *Casey,* other than barring courts from considering the benefits of a law into account and instead weighing its impact alone? What if a state enacted a law requiring all women seeking abortions to wear blue dresses for the procedure? Clearly such a law would be without any benefit at all. But isn't the Chief Justice saying that the basis for striking down a law is simply if it places undue burden on the right to obtain a legal abortion?

And yet, what can the word "undue" possibly mean other than balancing?

In her essay at *Scotusblog* following the ruling, https://www.scotusblog.com/2020/06/symposium-june-medical-services-v-russo-when-a-win-is-not-a-win/, Gretchen Borchelt, one of the nation's leading experts on reproductive law and abortion rights, reaches the opposite conclusion, viewing the Roberts concurrence as a very careful set of signals to both the dissenters and abortion opponents everywhere:

> On its face, *June Medical Services* has the makings of a significant win: Chief Justice John Roberts—who has previously voted against abortion access in the Supreme Court's major rulings—sided with Justices Stephen Breyer, Ruth Bader Ginsburg, Sonia Sotomayor and Elena Kagan to strike down an anti-abortion law and reject a challenge to abortion providers' standing. This decision will end Louisiana's pretense that this law does not burden people seeking abortion. And it will allow abortion providers to continue bringing legal challenges on behalf of their patients, as they have done for decades.
>
> But that is where the win ends. Roberts took pains to write an opinion that cabins the plurality. It is a concurrence that goes out of its way to find common ground with the dissenters, including disdain for the Supreme Court's most recent precedent. . . .
>
> Roberts spends the bulk of his concurrence on his disdain for *Whole Woman's Health*, a disdain he shares with the dissenters. In *Whole Woman's Health*, the court explained that the undue burden standard from *Planned Parenthood v. Casey* requires courts to balance the burdens a law

> imposes against any benefits it confers. If burdens outweigh benefits, the law is unconstitutional. Roberts instead wants to return to what he says is the correct analysis of undue burden from *Casey*. In his view, when considering an abortion restriction, courts should not balance burdens against benefits. Rather, a court need only consider whether the law imposes a substantial obstacle in the path of a person seeking abortion, and whether the restriction survives rational basis review. Only if there is a "substantial obstacle," or if the law somehow fails rational basis review, will it be invalidated.
>
> But this is a smoke screen. Roberts has never met an obstacle to abortion he actually believes is substantial. . . . In *Whole Woman's Health,* he did not believe the Texas law presented a substantial obstacle, despite its closing half of the state's abortion clinics. . . . Roberts does not mention that the decision in *Whole Woman's Health* was necessary in part because lower courts had been inconsistently and incorrectly applying the Casey undue burden standard. After *Casey*, numerous states passed hundreds of abortion restrictions—over 450 in the last decade alone—that led to a patchwork of abortion laws across the country that left far too many without abortion access. Courts ignored the harm of those restrictions to people seeking abortion, did not consider how multiple restrictions compounded to make abortion access all but impossible, and permitted anti-abortion politicians to pass medically unnecessary laws intended only to restrict abortion and shame those who sought abortion care. This is the standard to which Roberts wants to return.
>
> *Whole Woman's Health* clarified the undue burden standard established in *Casey* in order to eliminate confusion in abortion law, provide guidance to lower courts for analyzing abortion restrictions and halt the proliferation of laws that have made a person's right to abortion largely dependent on their zip code. But Roberts' concurrence in the current case and his wish to return to the previous norm of misinterpreting and incorrectly applying the undue burden standard established in *Casey* will lead to uncertainty and turmoil. It will effectively sanction anti-abortion laws enacted to test interpretations of "substantial obstacle," target individuals seeking abortion and the doctors who provide that care, and increase litigation. And make no mistake, increased litigation will yield more instances of judges upholding abortion restrictions that should be struck down, in defiance of *Whole Woman's Health,* because President Donald Trump has successfully filled the lower federal courts with judges hostile to abortion rights—200 and counting.

Putting aside the question of whether Chief Justice Roberts would find that any state law amounts to an undue burden, isn't her point critical? Doesn't the process of weighing the burdens of a law inevitably entail, at least contextually, an assessment of

whether the law has benefits? And could one go a bit further? Isn't it relevant that a law that either is aimed at curbing the exercise of constitutional rights, or else has such an effect, is at best silly and worthless and, at worst, of absolutely no value and potentially harmful? Doesn't that determination help shed light on where the balance should be struck when considering the constitutionality of state abortion laws?

* * *

On June 24th, 2022, the Supreme Court decided *Dobbs v Jackson Women's Health Organization* and ended the fundamental constitutional right to abortion. The decision expressly returns to states virtually unfettered power to define what is a lawful abortion, as well as the sanctions and penalties for unlawfully seeking, performing, or aiding in the receipt of, abortion. Stories now emerging in the news suggest that the Chief Justice tried to persuade members of the majority to change their vote, up to the end. Joan Biskupic, Sources: Roberts fought to the end to save Roe v Wade (CNN, July 26, 2022) https://www.cnn.com/videos/politics/2022/07/26/roe-v-wade-john-roberts-scotus-biskupic-newday-vpx.cnn. But once the actual decision leaked in early May, any chance of doing so was lost. Politico, Supreme Court has voted to overturn abortion rights, draft opinion shows (May 2, 2022) https://www.politico.com/news/2022/05/02/supreme-court-abortion-draft-opinion-00029473.

Despite the leak, when it finally came the decision struck with overwhelming force. Indeed, its legal, medical, and population health implications are virtually incalculable. Moreover—as you will see when you read the decision, Justice Thomas's concurrence, and the dissent—*Dobbs* may signal the Court's willingness to revisit other rights growing out of the same Fourteenth Amendment Due Process theory on which the right to abortion once rested. Where abortion is concerned, it took no time for about half the states to begin their task of banning pre-viability abortions, many with only the most limited exceptions.

To say that we have entered a period of profound legal uncertainty is the understatement of the century, and any thought the Court had that it was getting out of the abortion business will quickly be dashed. The coming years will see a host of new landmark abortion cases addressing federal law matters such as access to medication abortions, EMTALA protections for pregnancy-related emergencies that endanger health, and due process challenges to state statutes so vague or harmful to life, health, and the responsible practice of medicine that they imperil both pregnant people and the providers who serve them. This is probably just for starters since the decision also has implications for state laws regulating medical practice, in particular, state malpractice law. The edited decision is followed by Notes that only begin to scratch the surface of what lies ahead.

Dobbs v. Jackson Women's Health Organization

2022 WL 2276808

Supreme Court of the United States.
June 24, 2022

ALITO, J., delivered the opinion of the Court, in which THOMAS, GORSUCH, KAVANAUGH, and BARRETT, JJ., joined. THOMAS, J., and KAVANAUGH, J., filed concurring opinions. ROBERTS, C. J., filed an opinion concurring in the judgment. BREYER, SOTOMAYOR, and KAGAN, JJ., filed a dissenting opinion.

Justice ALITO delivered the opinion of the Court.

Abortion presents a profound moral issue on which Americans hold sharply conflicting views. Some believe fervently that a human person comes into being at conception and that abortion ends an innocent life. Others feel just as strongly that any regulation of abortion invades a woman's right to control her own body and prevents women from achieving full equality. Still others in a third group think that abortion should be allowed under some but not all circumstances, and those within this group hold a variety of views about the particular restrictions that should be imposed.

For the first 185 years after the adoption of the Constitution, each State was permitted to address this issue in accordance with the views of its citizens. Then, in 1973, this Court decided Roe v. Wade. Even though the Constitution makes no mention of abortion, the Court held that it confers a broad right to obtain one. It did not claim that American law or the common law had ever recognized such a right, and its survey of history ranged from the constitutionally irrelevant (*e.g.*, its discussion of abortion in antiquity) to the plainly incorrect (*e.g.*, its assertion that abortion was probably never a crime under the common law). After cataloging a wealth of other information having no bearing on the meaning of the Constitution, the opinion concluded with a numbered set of rules much like those that might be found in a statute enacted by a legislature.

Under this scheme, each trimester of pregnancy was regulated differently, but the most critical line was drawn at roughly the end of the second trimester, which, at the time, corresponded to the point at which a fetus was thought to achieve "viability," *i.e.*, the ability to survive outside the womb. Although the Court acknowledged that States had a legitimate interest in protecting "potential life," it found that this interest could not justify any restriction on pre-viability abortions. The Court did not explain the basis for this line, and even abortion supporters have found it hard to defend *Roe*'s reasoning. One prominent constitutional scholar wrote that he "would vote for a statute very much like the one the Court end[ed] up drafting" if he were "a legislator," but his assessment of *Roe*

was memorable and brutal: *Roe* was "not constitutional law" at all and gave "almost no sense of an obligation to try to be."[2]

At the time of *Roe*, 30 States still prohibited abortion at all stages. In the years prior to that decision, about a third of the States had liberalized their laws, but *Roe* abruptly ended that political process. It imposed the same highly restrictive regime on the entire Nation, and it effectively struck down the abortion laws of every single State. As Justice Byron White aptly put it in his dissent, the decision represented the "exercise of raw judicial power," and it sparked a national controversy that has embittered our political culture for a half century.

Eventually, in *Planned Parenthood of Southeastern Pa. v. Casey*, the Court revisited *Roe*, but the Members of the Court split three ways. Two Justices expressed no desire to change *Roe* in any way. Four others wanted to overrule the decision in its entirety. And the three remaining Justices, who jointly signed the controlling opinion, took a third position. Their opinion did not endorse *Roe*'s reasoning, and it even hinted that one or more of its authors might have "reservations" about whether the Constitution protects a right to abortion. But the opinion concluded that *stare decisis*, which calls for prior decisions to be followed in most instances, required adherence to what it called *Roe*'s "central holding"—that a State may not constitutionally protect fetal life before "viability"—even if that holding was wrong. Anything less, the opinion claimed, would undermine respect for this Court and the rule of law.

Paradoxically, the judgment in *Casey* did a fair amount of overruling. Several important abortion decisions were overruled *in toto*, and *Roe* itself was overruled in part. *Casey* threw out *Roe*'s trimester scheme and substituted a new rule of uncertain origin under which States were forbidden to adopt any regulation that imposed an "undue burden" on a woman's right to have an abortion. The decision provided no clear guidance about the difference between a "due" and an "undue" burden. But the three Justices who authored the controlling opinion "call[ed] the contending sides of a national controversy to end their national division" by treating the Court's decision as the final settlement of the question of the constitutional right to abortion.

As has become increasingly apparent in the intervening years, *Casey* did not achieve that goal. Americans continue to hold passionate and widely divergent views on abortion, and state legislatures have acted accordingly. Some have recently enacted laws allowing abortion, with few restrictions, at all stages of pregnancy. Others have tightly restricted abortion beginning well before viability. And in this case, 26 States have expressly asked this Court to overrule *Roe* and *Casey* and allow the States to regulate or prohibit pre-viability abortions.

Before us now is one such state law. The State of Mississippi asks us to uphold the constitutionality of a law that generally prohibits an abortion after the 15th week of

[2] J. Ely, The Wages of Crying Wolf: A Comment on Roe v. Wade, 82 Yale L. J. 920, 926, 947 (1973).

pregnancy—several weeks before the point at which a fetus is now regarded as "viable" outside the womb. In defending this law, the State's primary argument is that we should reconsider and overrule *Roe* and *Casey* and once again allow each State to regulate abortion as its citizens wish. On the other side, respondents and the Solicitor General ask us to reaffirm *Roe* and *Casey*, and they contend that the Mississippi law cannot stand if we do so. Allowing Mississippi to prohibit abortions after 15 weeks of pregnancy, they argue, would be no different than overruling *Casey* and *Roe* entirely. They contend that "no half-measures" are available and that we must either reaffirm or overrule *Roe* and *Casey*.

We hold that *Roe* and *Case*y must be overruled. The Constitution makes no reference to abortion, and no such right is implicitly protected by any constitutional provision, including the one on which the defenders of *Roe* and *Casey* now chiefly rely—the Due Process Clause of the Fourteenth Amendment. That provision has been held to guarantee some rights that are not mentioned in the Constitution, but any such right must be deeply rooted in this Nation's history and tradition and implicit in the concept of ordered liberty.

The right to abortion does not fall within this category. Until the latter part of the 20th century, such a right was entirely unknown in American law. Indeed, when the Fourteenth Amendment was adopted, three quarters of the States made abortion a crime at all stages of pregnancy. The abortion right is also critically different from any other right that this Court has held to fall within the Fourteenth Amendment's protection of "liberty." *Roe*'s defenders characterize the abortion right as similar to the rights recognized in past decisions involving matters such as intimate sexual relations, contraception, and marriage, but abortion is fundamentally different, as both *Roe* and *Casey* acknowledged, because it destroys what those decisions called "fetal life" and what the law now before us describes as an "unborn human being."

Stare decisis, the doctrine on which *Casey*'s controlling opinion was based, does not compel unending adherence to *Roe*'s abuse of judicial authority. *Roe* was egregiously wrong from the start. Its reasoning was exceptionally weak, and the decision has had damaging consequences. And far from bringing about a national settlement of the abortion issue, *Roe* and *Casey* have enflamed debate and deepened division. It is time to heed the Constitution and return the issue of abortion to the people's elected representatives. That is what the Constitution and the rule of law demand.

I

The law at issue in this case, Mississippi's Gestational Age Act (2018), contains this central provision: "Except in a medical emergency or in the case of a severe fetal abnormality, a person shall not intentionally or knowingly perform . . . or induce an abortion of an unborn human being if the probable gestational age of the unborn human being has been determined to be greater than fifteen (15) weeks."

To support this Act, the legislature made a series of factual findings. It began by noting that, at the time of enactment, only six countries besides the United States "permit[ted] nontherapeutic or elective abortion-on-demand after the twentieth week of gestation." The legislature then found that at 5 or 6 weeks' gestational age an "unborn human being's heart begins beating"; at 8 weeks the "unborn human being begins to move about in the womb"; at 9 weeks "all basic physiological functions are present"; at 10 weeks "vital organs begin to function," and "[h]air, fingernails, and toenails . . . begin to form"; at 11 weeks "an unborn human being's diaphragm is developing," and he or she may "move about freely in the womb"; and at 12 weeks the "unborn human being" has "taken on 'the human form' in all relevant respects." It found that most abortions after 15 weeks employ "dilation and evacuation procedures which involve the use of surgical instruments to crush and tear the unborn child," and it concluded that the "intentional commitment of such acts for nontherapeutic or elective reasons is a barbaric practice, dangerous for the maternal patient, and demeaning to the medical profession."

Respondents are an abortion clinic, Jackson Women's Health Organization, and one of its doctors. On the day the Gestational Age Act was enacted, respondents filed suit in Federal District Court against various Mississippi officials, alleging that the Act violated this Court's precedents establishing a constitutional right to abortion. The District Court granted summary judgment in favor of respondents and permanently enjoined enforcement of the Act, reasoning that "viability marks the earliest point at which the State's interest in fetal life is constitutionally adequate to justify a legislative ban on nontherapeutic abortions" and that 15 weeks' gestational age is "prior to viability." (2019)

We granted certiorari, to resolve the question whether "all pre-viability prohibitions on elective abortions are unconstitutional," Petitioners' primary defense of the Mississippi Gestational Age Act is that Roe and Casey were wrongly decided and that "the Act is constitutional because it satisfies rational-basis review." Respondents answer that allowing Mississippi to ban pre-viability abortions "would be no different than overruling Casey and Roe entirely." They tell us that "no half-measures" are available: We must either reaffirm or overrule Roe and Casey.

II

We begin by considering the critical question whether the Constitution, properly understood, confers a right to obtain an abortion. Skipping over that question, the controlling opinion in Casey reaffirmed Roe's "central holding" based solely on the doctrine of stare decisis, but as we will explain, proper application of stare decisis required an assessment of the strength of the grounds on which Roe was based.

We address that question in three steps. First, we explain the standard that our cases have used in determining whether the Fourteenth Amendment's reference to "liberty" protects a particular right. Second, we examine whether the right at issue in this case is rooted in our Nation's history and tradition and whether it is an essential

component of what we have described as "ordered liberty." Finally, we consider whether a right to obtain an abortion is part of a broader entrenched right that is supported by other precedents.

A
1

The Constitution makes no express reference to a right to obtain an abortion, and therefore those who claim that it protects such a right must show that the right is somehow implicit in the constitutional text.

Roe, however, was remarkably loose in its treatment of the constitutional text. It held that the abortion right, which is not mentioned in the Constitution, is part of a right to privacy, which is also not mentioned. And that privacy right, Roe observed, had been found to spring from no fewer than five different constitutional provisions—the First, Fourth, Fifth, Ninth, and Fourteenth Amendments.

The Court's discussion left open at least three ways in which some combination of these provisions could protect the abortion right. One possibility was that the right was "founded . . . in the Ninth Amendment's reservation of rights to the people." Another was that the right was rooted in the First, Fourth, or Fifth Amendment, or in some combination of those provisions, and that this right had been "incorporated" into the Due Process Clause of the Fourteenth Amendment just as many other Bill of Rights provisions had by then been incorporated. And a third path was that the First, Fourth, and Fifth Amendments played no role and that the right was simply a component of the "liberty" protected by the Fourteenth Amendment's Due Process Clause. The Casey Court did not defend this unfocused analysis and instead grounded its decision solely on the theory that the right to obtain an abortion is part of the "liberty" protected by the Fourteenth Amendment's Due Process Clause.

We discuss this theory in depth below, but before doing so, we briefly address one additional constitutional provision that some of respondents' amici have now offered as yet another potential home for the abortion right: the Fourteenth Amendment's Equal Protection Clause. Neither Roe nor Casey saw fit to invoke this theory, and it is squarely foreclosed by our precedents, which establish that a State's regulation of abortion is not a sex-based classification and is thus not subject to the "heightened scrutiny" that applies to such classifications. The regulation of a medical procedure that only one sex can undergo does not trigger heightened constitutional scrutiny unless the regulation is a mere pretext designed to effect an invidious discrimination against members of one sex or the other. Accordingly, laws regulating or prohibiting abortion are not subject to heightened scrutiny. Rather, they are governed by the same standard of review as other health and safety measures.

With this new theory addressed, we turn to Casey's bold assertion that the abortion right is an aspect of the "liberty" protected by the Due Process Clause of the Fourteenth Amendment.

2

[O]ur decisions have held that the Due Process Clause protects two categories of substantive rights. The first consists of rights guaranteed by the first eight Amendments. Those Amendments originally applied only to the Federal Government, but this Court has held that the Due Process Clause of the Fourteenth Amendment "incorporates" the great majority of those rights and thus makes them equally applicable to the States. The second category—which is the one in question here—comprises a select list of fundamental rights that are not mentioned anywhere in the Constitution.

In deciding whether a right falls into either of these categories, the Court has long asked whether the right is "deeply rooted in [our] history and tradition" and whether it is essential to our Nation's "scheme of ordered liberty." And in conducting this inquiry, we have engaged in a careful analysis of the history of the right at issue. A similar inquiry was undertaken in McDonald, which held that the Fourteenth Amendment protects the right to keep and bear arms. The lead opinion surveyed the origins of the Second Amendment, the debates in Congress about the adoption of the Fourteenth Amendment, the state constitutions in effect when that Amendment was ratified (at least 22 of the 37 States protected the right to keep and bear arms), federal laws enacted during the same period, and other relevant historical evidence. Only then did the opinion conclude that the Framers and ratifiers of the Fourteenth Amendment counted the right to keep and bear arms among those fundamental rights necessary to our system of ordered liberty.

McDonald concerned the question whether the Fourteenth Amendment protects rights that are expressly set out in the Bill of Rights, and it would be anomalous if similar historical support were not required when a putative right is not mentioned anywhere in the Constitution. Thus, in Washington v Glucksberg, which held that the Due Process Clause does not confer a right to assisted suicide, the Court surveyed more than 700 years of Anglo-American common law tradition and made clear that a fundamental right must be "objectively, deeply rooted in this Nation's history and tradition."

Historical inquiries of this nature are essential whenever we are asked to recognize a new component of the "liberty" protected by the Due Process Clause because the term "liberty" alone provides little guidance. "Liberty" is a capacious term. In interpreting what is meant by the Fourteenth Amendment's reference to "liberty," we must guard against the natural human tendency to confuse what that Amendment protects with our own ardent views about the liberty that Americans should enjoy.

On occasion, when the Court has ignored the "[a]ppropriate limits" imposed by "respect for the teachings of history," it has fallen into the freewheeling judicial policymaking that characterized discredited decisions such as Lochner v. New York

(1905). Instead, guided by the history and tradition that map the essential components of our Nation's concept of ordered liberty, we must ask what the Fourteenth Amendment means by the term "liberty." When we engage in that inquiry in the present case, the clear answer is that the Fourteenth Amendment does not protect the right to an abortion.

B
1

Until the latter part of the 20th century, there was no support in American law for a constitutional right to obtain an abortion. No state constitutional provision had recognized such a right. Until a few years before Roe was handed down, no federal or state court had recognized such a right. Not only was there no support for such a constitutional right until shortly before Roe, but abortion had long been a crime in every single State. At common law, abortion was criminal in at least some stages of pregnancy and was regarded as unlawful and could have very serious consequences at all stages. American law followed the common law until a wave of statutory restrictions in the 1800s expanded criminal liability for abortions. By the time of the adoption of the Fourteenth Amendment, three-quarters of the States had made abortion a crime at any stage of pregnancy, and the remaining States would soon follow.

Roe either ignored or misstated this history, and Casey declined to reconsider Roe's faulty historical analysis. It is therefore important to set the record straight.

2
a

We begin with the common law, under which abortion was a crime at least after "quickening"—*i.e.*, the first felt movement of the fetus in the womb, which usually occurs between the 16th and 18th week of pregnancy.

The eminent common-law authorities all describe abortion after quickening as criminal. Henry de Bracton's 13th-century treatise explained that if a person has "struck a pregnant woman, or has given her poison, whereby he has caused abortion, if the foetus be already formed and animated, and particularly if it be animated, he commits homicide."

Sir Edward Coke's 17th-century treatise likewise asserted that abortion of a quick child was "murder" if the "childe be born alive" and a "great misprision" if the "childe dieth in her body." Two treatises by Sir Matthew Hale likewise described abortion of a quick child who died in the womb as a "great crime" and a "great misprision." And writing near the time of the adoption of our Constitution, William Blackstone explained that abortion of a "quick" child was "by the ancient law homicide or manslaughter" and at least a very "heinous misdemeanor". English cases dating all the way back to the 13th century corroborate the treatises' statements that abortion was a crime.

Although a pre-quickening abortion was not itself considered homicide, it does not follow that abortion was permissible at common law—much less that abortion was a legal right. In sum, although common-law authorities differed on the severity of punishment for abortions committed at different points in pregnancy, none endorsed the practice. Moreover, we are aware of no common-law case or authority, and the parties have not pointed to any, that remotely suggests a positive right to procure an abortion at any stage of pregnancy.

b

In this country, the historical record is similar. The few cases available from the early colonial period corroborate that abortion was a crime.

c

The original ground for drawing a distinction between pre- and post-quickening abortions is not entirely clear, but some have attributed the rule to the difficulty of proving that a pre-quickening fetus was alive. At that time, there were no scientific methods for detecting pregnancy in its early stages[.]

The Solicitor General offers a different explanation of the basis for the quickening rule, namely, that before quickening the common law did not regard a fetus "as having a separate and independent existence. But the case on which the Solicitor General relies for this proposition also suggested that the criminal law's quickening rule was out of step with the treatment of prenatal life in other areas of law, noting that "to many purposes, in reference to civil rights, an infant in ventre sa mere is regarded as a person in being."

At any rate, the original ground for the quickening rule is of little importance for present purposes because the rule was abandoned in the 19th century. During that period, treatise writers and commentators criticized the quickening distinction as "neither in accordance with the result of medical experience, nor with the principles of the common law." In 1803, the British Parliament made abortion a crime at all stages of pregnancy and authorized the imposition of severe punishment. In this country during the 19th century, the vast majority of the States enacted statutes criminalizing abortion at all stages of pregnancy. By 1868, the year when the Fourteenth Amendment was ratified, three-quarters of the States, 28 out of 37, had enacted statutes making abortion a crime even if it was performed before quickening. By the end of the 1950s, according to the Roe Court's own count, statutes in all but four States and the District of Columbia prohibited abortion however and whenever performed, unless done to save or preserve the life of the mother.

This overwhelming consensus endured until the day Roe was decided. At that time, also by the Roe Court's own count, a substantial majority—30 States—still prohibited abortion at all stages except to save the life of the mother. In short, the Court's

opinion in Roe itself convincingly refutes the notion that the abortion liberty is deeply rooted in the history or tradition of our people.

d

The inescapable conclusion is that a right to abortion is not deeply rooted in the Nation's history and traditions. On the contrary, an unbroken tradition of prohibiting abortion on pain of criminal punishment persisted from the earliest days of the common law until 1973.

Respondents and their amici have no persuasive answer to this historical evidence. Neither respondents nor the Solicitor General disputes the fact that by 1868 the vast majority of States criminalized abortion at all stages of pregnancy. Instead, respondents are forced to argue that it does [not] matter that some States prohibited abortion at the time Roe was decided or when the Fourteenth Amendment was adopted. But that argument flies in the face of the standard we have applied in determining whether an asserted right that is nowhere mentioned in the Constitution is nevertheless protected by the Fourteenth Amendment.

Not only are respondents and their amici unable to show that a constitutional right to abortion was established when the Fourteenth Amendment was adopted, but they have found no support for the existence of an abortion right that predates the latter part of the 20th century—no state constitutional provision, no statute, no judicial decision, no learned treatise. The earliest sources called to our attention are a few district court and state court decisions decided shortly before Roe and a small number of law review articles from the same time period.

Instead of following these authorities, Roe relied largely on two articles by a pro-abortion advocate who claimed that Coke had intentionally misstated the common law because of his strong anti-abortion views. These articles have been discredited, and it has come to light that even members of Jane Roe's legal team did not regard them as serious scholarship.

The Solicitor General next suggests that history supports an abortion right because the common law's failure to criminalize abortion before quickening means that "at the Founding and for decades thereafter, women generally could terminate a pregnancy, at least in its early stages." But the insistence on quickening was not universal, and regardless, the fact that many States in the late 18th and early 19th century did not criminalize pre-quickening abortions does not mean that anyone thought the States lacked the authority to do so. When legislatures began to exercise that authority as the century wore on, no one, as far as we are aware, argued that the laws they enacted violated a fundamental right.

Another amicus brief relied upon by respondents tries to dismiss the significance of the state criminal statutes that were in effect when the Fourteenth Amendment was

adopted by suggesting that they were enacted for illegitimate reasons. According to this account, which is based almost entirely on statements made by one prominent proponent of the statutes, important motives for the laws were the fear that Catholic immigrants were having more babies than Protestants and that the availability of abortion was leading White Protestant women to shirk their maternal duties.

Resort to this argument is a testament to the lack of any real historical support for the right that Roe and Casey recognized. This Court has long disfavored arguments based on alleged legislative motives.

Here, the argument about legislative motive is not even based on statements by legislators, but on statements made by a few supporters of the new 19th-century abortion laws, and it is quite a leap to attribute these motives to all the legislators whose votes were responsible for the enactment of those laws. Recall that at the time of the adoption of the Fourteenth Amendment, over three-quarters of the States had adopted statutes criminalizing abortion (usually at all stages of pregnancy), and that from the early 20th century until the day Roe was handed down, every single State had such a law on its books. Are we to believe that the hundreds of lawmakers whose votes were needed to enact these laws were motivated by hostility to Catholics and women? There is ample evidence that the passage of these laws was instead spurred by a sincere belief that abortion kills a human being. One may disagree with this belief (and our decision is not based on any view about when a State should regard prenatal life as having rights or legally cognizable interests), but even Roe and Casey did not question the good faith of abortion opponents.

C
1

Instead of seriously pressing the argument that the abortion right itself has deep roots, supporters of Roe and Casey contend that the abortion right is an integral part of a broader entrenched right. Roe termed this a right to privacy, and Casey described it as the freedom to make "intimate and personal choices" that are "central to personal dignity and autonomy."

The Court did not claim that this broadly framed right is absolute, and no such claim would be plausible. While individuals are certainly free to think and to say what they wish about "existence," "meaning," the "universe," and "the mystery of human life," they are not always free to act in accordance with those thoughts. License to act on the basis of such beliefs may correspond to one of the many understandings of "liberty," but it is certainly not "ordered liberty."

Ordered liberty sets limits and defines the boundary between competing interests. Roe and Casey each struck a particular balance between the interests of a woman who wants an abortion and the interests of what they termed "potential life." But the people of the various States may evaluate those interests differently. In some States, voters may

believe that the abortion right should be even more extensive than the right that Roe and Casey recognized. Voters in other States may wish to impose tight restrictions based on their belief that abortion destroys an "unborn human being." Our Nation's historical understanding of ordered liberty does not prevent the people's elected representatives from deciding how abortion should be regulated.

Nor does the right to obtain an abortion have a sound basis in precedent. Casey relied on cases involving the right to marry a person of a different race, Loving v. Virginia (1967); the right to marry while in prison, Turner v. Safley (1987); the right to obtain contraceptives, Griswold v. Connecticut (1965), Eisenstadt v. Baird (1972), Carey v. Population Services Int'l (1977); the right to reside with relatives, Moore v. East Cleveland (1977); the right to make decisions about the education of one's children, Pierce v. Society of Sisters (1925), Meyer v. Nebraska (1923); the right not to be sterilized without consent, Skinner v. Oklahoma ex rel. Williamson (1942); and the right in certain circumstances not to undergo involuntary surgery, forced administration of drugs, or other substantially similar procedures, Winston v. Lee (1985), Washington v. Harper (1990), Rochin v. California (1952). Respondents and the Solicitor General also rely on post-Casey decisions like Lawrence v. Texas (2003) (right to engage in private, consensual sexual acts), and Obergefell v. Hodges (2015) (right to marry a person of the same sex).

These attempts to justify abortion through appeals to a broader right to autonomy and to define one's "concept of existence" prove too much. Those criteria, at a high level of generality, could license fundamental rights to illicit drug use, prostitution, and the like. None of these rights has any claim to being deeply rooted in history. What sharply distinguishes the abortion right from the rights recognized in the cases on which Roe and Casey rely is something that both those decisions acknowledged: Abortion destroys what those decisions call potential life and what the law at issue in this case regards as the life of an "unborn human being." None of the other decisions cited by Roe and Casey involved the critical moral question posed by abortion. They are therefore inapposite. They do not support the right to obtain an abortion, and by the same token, our conclusion that the Constitution does not confer such a right does not undermine them in any way.

2

In drawing this critical distinction between the abortion right and other rights, it is not necessary to dispute Casey's claim (which we accept for the sake of argument) that "the specific practices of States at the time of the adoption of the Fourteenth Amendment" do not "mar[k] the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." Abortion is nothing new. It has been addressed by lawmakers for centuries, and the fundamental moral question that it poses is ageless.

Defenders of Roe and Casey do not claim that any new scientific learning calls for a different answer to the underlying moral question, but they do contend that changes in

society require the recognition of a constitutional right to obtain an abortion. Without the availability of abortion, they maintain, people will be inhibited from exercising their freedom to choose the types of relationships they desire, and women will be unable to compete with men in the workplace and in other endeavors.

Americans who believe that abortion should be restricted press countervailing arguments about modern developments. They note that attitudes about the pregnancy of unmarried women have changed drastically; that federal and state laws ban discrimination on the basis of pregnancy; that leave for pregnancy and childbirth are now guaranteed by law in many cases; that the costs of medical care associated with pregnancy are covered by insurance or government assistance; that States have increasingly adopted "safe haven" laws, which generally allow women to drop off babies anonymously; and that a woman who puts her newborn up for adoption today has little reason to fear that the baby will not find a suitable home. They also claim that many people now have a new appreciation of fetal life and that when prospective parents who want to have a child view a sonogram, they typically have no doubt that what they see is their daughter or son.

Both sides make important policy arguments, but supporters of Roe and Casey must show that this Court has the authority to weigh those arguments and decide how abortion may be regulated in the States. They have failed to make that showing, and we thus return the power to weigh those arguments to the people and their elected representatives.

D

1

The dissent is very candid that it cannot show that a constitutional right to abortion has any foundation, let alone a "deeply rooted" one, "in this Nation's history and tradition." The dissent's failure to engage with this long tradition is devastating to its position. The dissent attempts to obscure this failure by misrepresenting our application of Glucksberg. The dissent suggests that we have focused only on the legal status of abortion in the 19th century, post, at ——, but our review of this Nation's tradition extends well past that period. As explained, for more than a century after 1868—including "another half-century" after women gained the constitutional right to vote in 1920—it was firmly established that laws prohibiting abortion like the Texas law at issue in Roe were permissible exercises of state regulatory authority. And today, another half century later, more than half of the States have asked us to overrule Roe and Casey. The dissent cannot establish that a right to abortion has ever been part of this Nation's tradition.

2

Because the dissent cannot argue that the abortion right is rooted in this Nation's history and tradition, it contends that the "constitutional tradition" is "not captured whole

at a single moment," and that its "meaning gains content from the long sweep of our history and from successive judicial precedents." This vague formulation imposes no clear restraints on what Justice White called the "exercise of raw judicial power," and while the dissent claims that its standard "does not mean anything goes," post, at ——, any real restraints are hard to discern.

The largely limitless reach of the dissenters' standard is illustrated by the way they apply it here. First, if the "long sweep of history" imposes any restraint on the recognition of unenumerated rights, then Roe was surely wrong, since abortion was never allowed (except to save the life of the mother) in a majority of States for over 100 years before that decision was handed down. Second, it is impossible to defend Roe based on prior precedent because all of the precedents Roe cited, including Griswold and Eisenstadt, were critically different for a reason that we have explained: None of those cases involved the destruction of what Roe called "potential life."

So without support in history or relevant precedent, Roe's reasoning cannot be defended even under the dissent's proposed test, and the dissent is forced to rely solely on the fact that a constitutional right to abortion was recognized in Roe and later decisions that accepted Roe's interpretation. Under the doctrine of stare decisis, those precedents are entitled to careful and respectful consideration, and we engage in that analysis below. But as the Court has reiterated time and time again, adherence to precedent is not "an inexorable command. There are occasions when past decisions should be overruled, and as we will explain, this is one of them.

3

The most striking feature of the dissent is the absence of any serious discussion of the legitimacy of the States' interest in protecting fetal life. That view is evident throughout the dissent. The dissent has much to say about the effects of pregnancy on women, the burdens of motherhood, and the difficulties faced by poor women. These are important concerns. However, the dissent evinces no similar regard for a State's interest in protecting prenatal life. But for reasons we discuss later, the viability line makes no sense. It was not adequately justified in Roe, and the dissent does not even try to defend it today. Nor does it identify any other point in a pregnancy after which a State is permitted to prohibit the destruction of a fetus.

Our opinion is not based on any view about if and when prenatal life is entitled to any of the rights enjoyed after birth. The dissent, by contrast, would impose on the people a particular theory about when the rights of personhood begin. According to the dissent, the Constitution requires the States to regard a fetus as lacking even the most basic human right—to live—at least until an arbitrary point in a pregnancy has passed. Nothing in the Constitution or in our Nation's legal traditions authorizes the Court to adopt that theory of life.

III

We next consider whether the doctrine of stare decisis counsels continued acceptance of Roe and Casey. Stare decisis plays an important role in our case law, and we have explained that it serves many valuable ends. It protects the interests of those who have taken action in reliance on a past decision. It "contributes to the actual and perceived integrity of the judicial process." And it restrains judicial hubris and reminds us to respect the judgment of those who have grappled with important questions in the past.

We have long recognized, however, that stare decisis is "not an inexorable command," and it is at its weakest when we interpret the Constitution. In addition, when one of our constitutional decisions goes astray, the country is usually stuck with the bad decision unless we correct our own mistake. Some of our most important constitutional decisions have overruled prior precedents. We mention three. In Brown v. Board of Education, (1954), the Court repudiated the "separate but equal" doctrine, which had allowed States to maintain racially segregated schools and other facilities. In so doing, the Court overruled the infamous decision in Plessy v. Ferguson (1896) along with six other Supreme Court precedents that had applied the separate-but-equal rule.

In West Coast Hotel Co. v. Parrish (1937), the Court overruled Adkins v. Children's Hospital of D. C., (1923), which had held that a law setting minimum wages for women violated the "liberty" protected by the Fifth Amendment's Due Process Clause. West Coast Hotel signaled the demise of an entire line of important precedents that had protected an individual liberty right against state and federal health and welfare legislation. See Lochner v. New York (1905).

Finally, in West Virginia Bd. of Ed. v. Barnette (1943), after the lapse of only three years, the Court overruled Minersville School Dist. v. Gobitis (1940), and held that public school students could not be compelled to salute the flag in violation of their sincere beliefs. Barnette stands out because nothing had changed during the intervening period other than the Court's belated recognition that its earlier decision had been seriously wrong.

No Justice of this Court has ever argued that the Court should never overrule a constitutional decision, but overruling a precedent is a serious matter. It is not a step that should be taken lightly. Our cases have attempted to provide a framework for deciding when a precedent should be overruled, and they have identified factors that should be considered in making such a decision. In this case, five factors weigh strongly in favor of overruling Roe and Casey: the nature of their error, the quality of their reasoning, the "workability" of the rules they imposed on the country, their disruptive effect on other areas of the law, and the absence of concrete reliance.

A

The nature of the Court's error. An erroneous interpretation of the Constitution is always important, but some are more damaging than others. The infamous decision in Plessy v. Ferguson, was one such decision.

Roe was also egregiously wrong and deeply damaging. For reasons already explained, Roe's constitutional analysis was far outside the bounds of any reasonable interpretation of the various constitutional provisions to which it vaguely pointed.

[T]he Court usurped the power to address a question of profound moral and social importance that the Constitution unequivocally leaves for the people. Those on the losing side—those who sought to advance the State's interest in fetal life—could no longer seek to persuade their elected representatives to adopt policies consistent with their views. As the Court's landmark decision in West Coast Hotel illustrates, the Court has previously overruled decisions that wrongly removed an issue from the people and the democratic process.

B

The quality of the reasoning. Under our precedents, the quality of the reasoning in a prior case has an important bearing on whether it should be reconsidered. In Part II, supra, we explained why Roe was incorrectly decided, but that decision was more than just wrong. It stood on exceptionally weak grounds.

Roe found that the Constitution implicitly conferred a right to obtain an abortion, but it failed to ground its decision in text, history, or precedent. It relied on an erroneous historical narrative; it devoted great attention to and presumably relied on matters that have no bearing on the meaning of the Constitution; it disregarded the fundamental difference between the precedents on which it relied and the question before the Court; it concocted an elaborate set of rules, with different restrictions for each trimester of pregnancy, but it did not explain how this veritable code could be teased out of anything in the Constitution, the history of abortion laws, prior precedent, or any other cited source; and its most important rule (that States cannot protect fetal life prior to "viability") was never raised by any party and has never been plausibly explained. Roe's reasoning quickly drew scathing scholarly criticism, even from supporters of broad access to abortion.

The Casey plurality, while reaffirming Roe's central holding, pointedly refrained from endorsing most of its reasoning. It revised the textual basis for the abortion right, silently abandoned Roe's erroneous historical narrative, and jettisoned the trimester framework. But it replaced that scheme with an arbitrary "undue burden" test and relied on an exceptional version of stare decisis that, as explained below, this Court had never before applied and has never invoked since.

1
a

The weaknesses in Roe's reasoning are well-known. Without any grounding in the constitutional text, history, or precedent, it imposed on the entire country a detailed set of rules much like those that one might expect to find in a statute or regulation. Dividing pregnancy into three trimesters, the Court imposed special rules for each. During the first trimester, the Court announced, "the abortion decision and its effectuation must be left to the medical judgment of the pregnant woman's attending physician." After that point, a State's interest in regulating abortion for the sake of a woman's health became compelling, and accordingly, a State could "regulate the abortion procedure in ways that are reasonably related to maternal health." Finally, in "the stage subsequent to viability," which in 1973 roughly coincided with the beginning of the third trimester, the State's interest in "the potentiality of human life" became compelling, and therefore a State could "regulate, and even proscribe, abortion except where it is necessary, in appropriate medical judgment, for the preservation of the life or health of the mother."

This elaborate scheme was the Court's own brainchild. Neither party advocated the trimester framework; nor did either party or any amicus argue that "viability" should mark the point at which the scope of the abortion right and a State's regulatory authority should be substantially transformed.

b

Not only did this scheme resemble the work of a legislature, but the Court made little effort to explain how these rules could be deduced from any of the sources on which constitutional decisions are usually based.

Roe featured a lengthy survey of history, but much of its discussion was irrelevant, and the Court made no effort to explain why it was included. When it came to the most important historical fact—how the States regulated abortion when the Fourteenth Amendment was adopted—the Court said almost nothing. It allowed that States had tightened their abortion laws "in the middle and late 19th century," but it implied that these laws might have been enacted not to protect fetal life but to further "a Victorian social concern" about "illicit sexual conduct."

Roe's failure even to note the overwhelming consensus of state laws in effect in 1868 is striking, and what it said about the common law was simply wrong. This erroneous understanding appears to have played an important part in the Court's thinking because the opinion cited "the lenity of the common law" as one of the four factors that informed its decision.

After surveying history, the opinion spent many paragraphs conducting the sort of fact-finding that might be undertaken by a legislative committee. The Court did not

explain why these sources shed light on the meaning of the Constitution, and not one of them adopted or advocated anything like the scheme that Roe imposed on the country.

Finally, after all this, the Court turned to precedent. Citing a broad array of cases, the Court found support for a constitutional "right of personal privacy," but it conflated two very different meanings of the term: the right to shield information from disclosure and the right to make and implement important personal decisions without governmental interference. Only the cases involving this second sense of the term could have any possible relevance to the abortion issue, and some of the cases in that category involved personal decisions that were obviously very, very far afield.

What remained was a handful of cases having something to do with marriage, or procreation. But none of these decisions involved what is distinctive about abortion: its effect on what Roe termed "potential life."

When the Court summarized the basis for the scheme it imposed on the country, it asserted that its rules were "consistent with" the following: (1) "the relative weights of the respective interests involved," (2) "the lessons and examples of medical and legal history," (3) "the lenity of the common law," and (4) "the demands of the profound problems of the present day." Put aside the second and third factors, which were based on the Court's flawed account of history, and what remains are precisely the sort of considerations that legislative bodies often take into account when they draw lines that accommodate competing interests.

c

What Roe did not provide was any cogent justification for the lines it drew. Why, for example, does a State have no authority to regulate first trimester abortions for the purpose of protecting a woman's health? The Court's only explanation was that mortality rates for abortion at that stage were lower than the mortality rates for childbirth. But the Court did not explain why mortality rates were the only factor that a State could legitimately consider. Many health and safety regulations aim to avoid adverse health consequences short of death. And the Court did not explain why it departed from the normal rule that courts defer to the judgments of legislatures in areas fraught with medical and scientific uncertainties.

An even more glaring deficiency was Roe's failure to justify the critical distinction it drew between pre- and post-viability abortions. The definition of a "viable" fetus is one that is capable of surviving outside the womb, but why is this the point at which the State's interest becomes compelling? If, as Roe held, a State's interest in protecting prenatal life is compelling after viability, why isn't that interest equally compelling before viability?

This arbitrary line has not found much support among philosophers and ethicists who have attempted to justify a right to abortion. Some have argued that a fetus should

not be entitled to legal protection until it acquires the characteristics that they regard as defining what it means to be a person. Among the characteristics that have been offered as essential attributes of personhood are sentience, self-awareness, the ability to reason, or some combination thereof. By this logic, it would be an open question whether even born individuals, including young children or those afflicted with certain developmental or medical conditions, merit protection as persons. But even if one takes the view that "personhood" begins when a certain attribute or combination of attributes is acquired, it is very hard to see why viability should mark the point where "personhood" begins.

The most obvious problem with any such argument is that viability is heavily dependent on factors that have nothing to do with the characteristics of a fetus. One is the state of neonatal care at a particular point in time. Due to the development of new equipment and improved practices, the viability line has changed over the years. In the 19th century, a fetus may not have been viable until the 32d or 33d week of pregnancy or even later. When Roe was decided, viability was gauged at roughly 28 weeks. Today, respondents draw the line at 23 or 24 weeks. So, according to Roe's logic, States now have a compelling interest in protecting a fetus with a gestational age of, say, 26 weeks, but in 1973 States did not have an interest in protecting an identical fetus. How can that be?

Viability also depends on the "quality of the available medical facilities." Thus, a 24-week-old fetus may be viable if a woman gives birth in a city with hospitals that provide advanced care for very premature babies, but if the woman travels to a remote area far from any such hospital, the fetus may no longer be viable. On what ground could the constitutional status of a fetus depend on the pregnant woman's location? And if viability is meant to mark a line having universal moral significance, can it be that a fetus that is viable in a big city in the United States has a privileged moral status not enjoyed by an identical fetus in a remote area of a poor country?

In addition, as the Court once explained, viability is not really a hard-and-fast line. It is thus "only with difficulty" that a physician can estimate the "probability" of a particular fetus's survival. And even if each fetus's probability of survival could be ascertained with certainty, settling on a probability of survival that should count as viability is another matter. Is a fetus viable with a 10 percent chance of survival? 25 percent? 50 percent? Can such a judgment be made by a State? And can a State specify a gestational age limit that applies in all cases? Or must these difficult questions be left entirely to the individual attending physician on the particular facts of the case before him?

The viability line, which Casey termed Roe's central rule, makes no sense, and it is telling that other countries almost uniformly eschew such a line. The Court thus asserted raw judicial power to impose, as a matter of constitutional law, a uniform viability rule that allowed the States less freedom to regulate abortion than the majority of western democracies enjoy.

d

All in all, Roe‘s reasoning was exceedingly weak, and academic commentators, including those who agreed with the decision as a matter of policy, were unsparing in their criticism.

Despite Roe‘s weaknesses, its reach was steadily extended in the years that followed. The Court struck down laws requiring that second-trimester abortions be performed only in hospitals; that minors obtain parental consent; that women give written consent after being informed of the status of the developing prenatal life and the risks of abortion; that women wait 24 hours for an abortion; that a physician determine viability in a particular manner; that a physician performing a post-viability abortion use the technique most likely to preserve the life of the fetus; and that fetal remains be treated in a humane and sanitary manner.

2

When Casey revisited Roe almost 20 years later, very little of Roe’s reasoning was defended or preserved. The Court abandoned any reliance on a privacy right and instead grounded the abortion right entirely on the Fourteenth Amendment’s Due Process Clause. The Court did not reaffirm Roe’s erroneous account of abortion history. In fact, none of the Justices in the majority said anything about the history of the abortion right. And as for precedent, the Court relied on essentially the same body of cases that Roe had cited. Thus, with respect to the standard grounds for constitutional decisionmaking—text, history, and precedent—Casey did not attempt to bolster Roe’s reasoning.

The Court also made no real effort to remedy one of the greatest weaknesses in Roe‘s analysis: its much-criticized discussion of viability. The Court retained what it called Roe’s “central holding”—that a State may not regulate pre-viability abortions for the purpose of protecting fetal life—but it provided no principled defense of the viability line.

The controlling opinion criticized and rejected Roe‘s trimester scheme, and substituted a new “undue burden” test, but the basis for this test was obscure. And as we will explain, the test is full of ambiguities and is difficult to apply. Casey, in short, either refused to reaffirm or rejected important aspects of Roe‘s analysis, failed to remedy glaring deficiencies in Roe’s reasoning, endorsed what it termed Roe’s central holding while suggesting that a majority might not have thought it was correct, provided no new support for the abortion right other than Roe’s status as precedent, and imposed a new and problematic test with no firm grounding in constitutional text, history, or precedent.

As discussed below, Casey also deployed a novel version of the doctrine of stare decisis. This new doctrine did not account for the profound wrongness of the decision in Roe, and placed great weight on an intangible form of reliance with little if any basis in prior case law.

C

Workability. Our precedents counsel that another important consideration in deciding whether a precedent should be overruled is whether the rule it imposes is workable—that is, whether it can be understood and applied in a consistent and predictable manner. Casey's "undue burden" test has scored poorly on the workability scale.

1

Problems begin with the very concept of an "undue burden." [D]etermining whether a burden is "due" or "undue" is inherently standardless. The Casey plurality tried to put meaning into the "undue burden" test by setting out three subsidiary rules, but these rules created their own problems. The first rule is that "a provision of law is invalid, if its purpose or effect is to place a substantial obstacle in the path of a woman seeking an abortion before the fetus attains viability." But whether a particular obstacle qualifies as "substantial" is often open to reasonable debate.

This ambiguity is a problem, and the second rule, which applies at all stages of a pregnancy, muddies things further. It states that measures designed "to ensure that the woman's choice is informed" are constitutional so long as they do not impose "an undue burden on the right." To the extent that this rule applies to pre-viability abortions, it overlaps with the first rule and appears to impose a different standard. Consider a law that imposes an insubstantial obstacle but serves little purpose. As applied to a pre-viability abortion, would such a regulation be constitutional on the ground that it does not impose a "substantial obstacle"? Or would it be unconstitutional on the ground that it creates an "undue burden" because the burden it imposes, though slight, outweighs its negligible benefits? Casey does not say, and this ambiguity would lead to confusion down the line.

The third rule complicates the picture even more. Under that rule, "[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. This rule contains no fewer than three vague terms. It includes the two already discussed—"undue burden" and "substantial obstacle"—even though they are inconsistent. And it adds a third ambiguous term when it refers to "unnecessary health regulations." Casey did not explain the sense in which the term is used in this rule.

In addition to these problems, one more applies to all three rules. They all call on courts to examine a law's effect on women, but a regulation may have a very different impact on different women for a variety of reasons, including their places of residence, financial resources, family situations, work and personal obligations, knowledge about fetal development and abortion, psychological and emotional disposition and condition, and the firmness of their desire to obtain abortions. In order to determine whether a regulation presents a substantial obstacle to women, a court needs to know which set of

women it should have in mind and how many of the women in this set must find that an obstacle is "substantial."

Casey provided no clear answer to these questions. It said that a regulation is unconstitutional if it imposes a substantial obstacle in a large fraction of cases in which [it] is relevant, but there is obviously no clear line between a fraction that is "large" and one that is not. Nor is it clear what the Court meant by "cases in which" a regulation is "relevant."

2

The difficulty of applying Casey's new rules surfaced in that very case. The controlling opinion found that Pennsylvania's 24-hour waiting period requirement and its informed-consent provision did not impose undue burden[s], but Justice Stevens, applying the same test, reached the opposite result. That did not bode well.

The ambiguity of the "undue burden" test also produced disagreement in later cases. In Whole Woman's Health, the Court adopted the cost-benefit interpretation of the test, stating that "[t]he rule announced in Casey . . . requires that courts consider the burdens a law imposes on abortion access together with the benefits those laws confer. But five years later, a majority of the Justices rejected that interpretation. Four Justices reaffirmed Whole Woman's Health's instruction to weigh a law's benefits against the burdens it imposes on abortion access. But THE CHIEF JUSTICE—who cast the deciding vote—argued that "[n]othing about Casey suggested that a weighing of costs and benefits of an abortion regulation was a job for the courts." This Court's experience applying Casey has confirmed Chief Justice Rehnquist's prescient diagnosis that the undue-burden standard was "not built to last."

3

The experience of the Courts of Appeals provides further evidence that Casey's "line between" permissible and unconstitutional restrictions "has proved to be impossible to draw with precision." Casey has generated a long list of Circuit conflicts. The Courts of Appeals have experienced particular difficulty in applying the large-fraction-of-relevant-cases test. They have criticized the assignment while reaching unpredictable results. And they have candidly outlined Casey's many other problems.

D

Effect on other areas of law. Roe and Casey have led to the distortion of many important but unrelated legal doctrines, and that effect provides further support for overruling those decisions. Members of this Court have repeatedly lamented that "no legal rule or doctrine is safe from ad hoc nullification by this Court when an occasion for its application arises in a case involving state regulation of abortion." The Court's abortion cases have diluted the strict standard for facial constitutional challenges. They have ignored the Court's third-party standing doctrine. They have disregarded standard

res judicata principles. They have flouted the ordinary rules on the severability of unconstitutional provisions, as well as the rule that statutes should be read where possible to avoid unconstitutionality. And they have distorted First Amendment doctrines.

E

Reliance interests. We last consider whether overruling Roe and Casey will upend substantial reliance interests.

1

Traditional reliance interests arise "where advance planning of great precision is most obviously a necessity." In Casey, the controlling opinion conceded that those traditional reliance interests were not implicated because getting an abortion is generally "unplanned activity," and "reproductive planning could take virtually immediate account of any sudden restoration of state authority to ban abortions." For these reasons, we agree with the Casey plurality that conventional, concrete reliance interests are not present here.

2

Unable to find reliance in the conventional sense, the controlling opinion in Casey perceived a more intangible form of reliance. It wrote that "people [had] organized intimate relationships and made choices that define their views of themselves and their places in society . . . in reliance on the availability of abortion in the event that contraception should fail" and that "[t]he 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." But this Court is ill-equipped to assess "generalized assertions about the national psyche." Casey's notion of reliance thus finds little support in our cases, which instead emphasize very concrete reliance interests, like those that develop in "cases involving property and contract rights."

When a concrete reliance interest is asserted, courts are equipped to evaluate the claim, but assessing the novel and intangible form of reliance endorsed by the Casey plurality is another matter. That form of reliance depends on an empirical question that is hard for anyone—and in particular, for a court—to assess, namely, the effect of the abortion right on society and in particular on the lives of women. The contending sides in this case make impassioned and conflicting arguments about the effects of the abortion right on the lives of women. The contending sides also make conflicting arguments about the status of the fetus. This Court has neither the authority nor the expertise to adjudicate those disputes, and the Casey plurality's speculations and weighing of the relative importance of the fetus and mother represent a departure from the "original constitutional proposition that courts do not substitute their social and economic beliefs for the judgment of legislative bodies."

Our decision returns the issue of abortion to those legislative bodies, and it allows women on both sides of the abortion issue to seek to affect the legislative process by influencing public opinion, lobbying legislators, voting, and running for office. Women are not without electoral or political power. It is noteworthy that the percentage of women who register to vote and cast ballots is consistently higher than the percentage of men who do so. In the last election in November 2020, women, who make up around 51.5 percent of the population of Mississippi, constituted 55.5 percent of the voters who cast ballots.

3

Unable to show concrete reliance on *Roe* and *Casey* themselves, the Solicitor General suggests that overruling those decisions would "threaten the Court's precedents holding that the Due Process Clause protects other rights." Brief for United States 26 (citing *Obergefell*, *Lawrence*, *Griswold*). That is not correct for reasons we have already discussed. As even the Casey plurality recognized, abortion is a unique act because it terminates life or potential life. And to ensure that our decision is not misunderstood or mischaracterized, we emphasize that our decision concerns the constitutional right to abortion and no other right. Nothing in this opinion should be understood to cast doubt on precedents that do not concern abortion.

IV

Having shown that traditional stare decisis factors do not weigh in favor of retaining Roe or Casey, we must address one final argument that featured prominently in the Casey plurality opinion. The argument was cast in different terms, but stated simply, it was essentially as follows. The American people's belief in the rule of law would be shaken if they lost respect for this Court as an institution that decides important cases based on principle, not "social and political pressures." There is a special danger that the public will perceive a decision as having been made for unprincipled reasons when the Court overrules a controversial "watershed" decision, such as Roe.

This analysis starts out on the right foot but ultimately veers off course. [I]t is important for the public to perceive that our decisions are based on principle, and we should make every effort to achieve that objective by issuing opinions that carefully show how a proper understanding of the law leads to the results we reach. But we cannot exceed the scope of our authority under the Constitution, and we cannot allow our decisions to be affected by any extraneous influences such as concern about the public's reaction to our work. That is true both when we initially decide a constitutional issue and when we consider whether to overrule a prior decision. The doctrine of stare decisis is an adjunct of this duty, and should be no more subject to the vagaries of public opinion than is the basic judicial task. In suggesting otherwise, the Casey plurality went beyond this Court's role in our constitutional system.

The Casey plurality "call[ed] the contending sides of a national controversy to end their national division," and claimed the authority to impose a permanent settlement of the issue of a constitutional abortion right simply by saying that the matter was closed. That unprecedented claim exceeded the power vested in us by the Constitution. Our sole authority is to exercise "judgment"—which is to say, the authority to judge what the law means and how it should apply to the case at hand. The Court has no authority to decree that an erroneous precedent is permanently exempt from evaluation under traditional stare decisis principles. A precedent of this Court is subject to the usual principles of stare decisis under which adherence to precedent is the norm but not an inexorable command. If the rule were otherwise, erroneous decisions like Plessy and Lochner would still be the law. That is not how stare decisis operates.

The Casey plurality also misjudged the practical limits of this Court's influence. Roe certainly did not succeed in ending division on the issue of abortion. On the contrary, Roe "inflamed" a national issue that has remained bitterly divisive for the past half century. Neither decision has ended debate over the issue of a constitutional right to obtain an abortion. Indeed, in this case, 26 States expressly ask us to overrule Roe and Casey and to return the issue of abortion to the people and their elected representatives. This Court's inability to end debate on the issue should not have been surprising. This Court cannot bring about the permanent resolution of a rancorous national controversy simply by dictating a settlement and telling the people to move on. Whatever influence the Court may have on public attitudes must stem from the strength of our opinions, not an attempt to exercise "raw judicial power."

We do not pretend to know how our political system or society will respond to today's decision overruling Roe and Casey. And even if we could foresee what will happen, we would have no authority to let that knowledge influence our decision. We can only do our job, which is to interpret the law, apply longstanding principles of stare decisis, and decide this case accordingly. We therefore hold that the Constitution does not confer a right to abortion. Roe and Casey must be overruled, and the authority to regulate abortion must be returned to the people and their elected representatives.

V
A
1

The dissent argues that we have "abandon[ed]" stare decisis, but we have done no such thing, and it is the dissent's understanding of stare decisis that breaks with tradition. The dissent's foundational contention is that the Court should never (or perhaps almost never) overrule an egregiously wrong constitutional precedent unless the Court can "poin[t] to major legal or factual changes undermining [the] decision's original basis." To support this contention, the dissent claims that Brown v. Board of Education and other landmark cases overruling prior precedents "responded to changed law and to changed facts and attitudes that had taken hold throughout society." The unmistakable implication of this argument is that only the passage of time and new developments justified those

decisions. Recognition that the cases they overruled were egregiously wrong on the day they were handed down was not enough. The Court has never adopted this strange new version of stare decisis—and with good reason. Does the dissent really maintain that overruling Plessy was not justified until the country had experienced more than a half-century of state-sanctioned segregation and generations of Black school children had suffered all its effects?

Precedents should be respected, but sometimes the Court errs, and occasionally the Court issues an important decision that is egregiously wrong. When that happens, stare decisis is not a straitjacket. And indeed, the dissent eventually admits that a decision could "be overruled just because it is terribly wrong," though the dissent does not explain when that would be so.

2

Even if the dissent were correct in arguing that an egregiously wrong decision should (almost) never be overruled unless its mistake is later highlighted by "major legal or factual changes," reexamination of Roe and Casey would be amply justified. We have already mentioned a number of post-Casey developments, but the most profound change may be the failure of the Casey plurality's call for "the contending sides" in the controversy about abortion "to end their national division." That has not happened, and there is no reason to think that another decision sticking with Roe would achieve what Casey could not.

The dissent, however, is undeterred. It contends that the "very controversy surrounding Roe and Casey" is an important stare decisis consideration that requires upholding those precedents. The dissent characterizes Casey as a "precedent about precedent" that is permanently shielded from further evaluation under traditional stare decisis principles. But as we have explained, Casey broke new ground when it treated the national controversy provoked by Roe as a ground for refusing to reconsider that decision, and no subsequent case has relied on that factor. Our decision today simply applies longstanding stare decisis factors instead of applying a version of the doctrine that seems to apply only in abortion cases.

3

Finally, the dissent suggests that our decision calls into question Griswold, Eisenstadt, Lawrence, and Obergefell. But we have stated unequivocally that "[n]othing in this opinion should be understood to cast doubt on precedents that do not concern abortion." We have also explained why that is so: rights regarding contraception and same-sex relationships are inherently different from the right to abortion because the latter (as we have stressed) uniquely involves what Roe and Casey termed "potential life." Moreover, even putting aside that these cases are distinguishable, there is a further point that the dissent ignores: Each precedent is subject to its own stare decisis analysis,

and the factors that our doctrine instructs us to consider like reliance and workability are different for these cases than for our abortion jurisprudence.

B
1

We now turn to the concurrence in the judgment, which reproves us for deciding whether Roe and Casey should be retained or overruled. That opinion (which for convenience we will call simply "the concurrence") recommends a "more measured course," which it defends based on what it claims is "a straightforward stare decisis analysis." (opinion of ROBERTS, C. J.). The concurrence would "leave for another day whether to reject any right to an abortion at all,". and would hold only that if the Constitution protects any such right, the right ends once women have had "a reasonable opportunity" to obtain an abortion The concurrence does not specify what period of time is sufficient to provide such an opportunity, but it would hold that 15 weeks, the period allowed under Mississippi's law, is enough—at least "absent rare circumstances."

There are serious problems with this approach, and it is revealing that nothing like it was recommended by either party. What is more, the concurrence has not identified any of the more than 130 amicus briefs filed in this case that advocated its approach. The concurrence would do exactly what it criticizes Roe for doing: pulling "out of thin air" a test that "[n]o party or amicus asked the Court to adopt."

2

The concurrence's most fundamental defect is its failure to offer any principled basis for its approach. The concurrence would "discar[d]" "the rule from Roe and Casey that a woman's right to terminate her pregnancy extends up to the point that the fetus is regarded as 'viable' outside the womb." But this rule was a critical component of the holdings in Roe and Casey, and stare decisis is a "doctrine of preservation, not transformation." Therefore, a new rule that discards the viability rule cannot be defended on stare decisis grounds.

The concurrence concedes that its approach would "not be available" if "the rationale of Roe and Casey were inextricably entangled with and dependent upon the viability standard." But the concurrence asserts that the viability line is separable from the constitutional right they recognized, and can therefore be "discarded" without disturbing any past precedent. That is simply incorrect. Roe's trimester rule was expressly tied to viability, and viability played a critical role in later abortion decisions.

When the Court reconsidered Roe in Casey, it left no doubt about the importance of the viability rule. It described the rule as Roe's "central holding," and repeatedly stated that the right it reaffirmed was the right of the woman to choose to have an abortion before viability. Not only is the new rule proposed by the concurrence inconsistent with

Casey's unambiguous "language," it is also contrary to the judgment in that case and later abortion cases.

For all these reasons, stare decisis cannot justify the new "reasonable opportunity" rule propounded by the concurrence. If that rule is to become the law of the land, it must stand on its own, but the concurrence makes no attempt to show that this rule represents a correct interpretation of the Constitution. The concurrence does not claim that the right to a reasonable opportunity to obtain an abortion is "deeply rooted in this Nation's history and tradition" and "implicit in the concept of ordered liberty." Nor does it propound any other theory that could show that the Constitution supports its new rule. And if the Constitution protects a woman's right to obtain an abortion, the opinion does not explain why that right should end after the point at which all "reasonable" women will have decided whether to seek an abortion. While the concurrence is moved by a desire for judicial minimalism, "we cannot embrace a narrow ground of decision simply because it is narrow; it must also be right."

3

The concurrence would "leave for another day whether to reject any right to an abortion at all," but "another day" would not be long in coming. Some States have set deadlines for obtaining an abortion that are shorter than Mississippi's. If we held only that Mississippi's 15-week rule is constitutional, we would soon be called upon to pass on the constitutionality of a panoply of laws with shorter deadlines or no deadline at all. The "measured course" charted by the concurrence would be fraught with turmoil until the Court answered the question that the concurrence seeks to defer.

Even if the Court ultimately adopted the new rule suggested by the concurrence, we would be faced with the difficult problem of spelling out what it means. For example, if the period required to give women a "reasonable" opportunity to obtain an abortion were pegged, as the concurrence seems to suggest, at the point when a certain percentage of women make that choice, we would have to identify the relevant percentage. It would also be necessary to explain what the concurrence means when it refers to "rare circumstances" that might justify an exception. And if this new right aims to give women a reasonable opportunity to get an abortion, it would be necessary to decide whether factors other than promptness in deciding might have a bearing on whether such an opportunity was available.

In sum, the concurrence's quest for a middle way would only put off the day when we would be forced to confront the question we now decide. The turmoil wrought by Roe and Casey would be prolonged. It is far better—for this Court and the country—to face up to the real issue without further delay.

VI

We must now decide what standard will govern if state abortion regulations undergo constitutional challenge and whether the law before us satisfies the appropriate standard.

A

Under our precedents, rational-basis review is the appropriate standard for such challenges. As we have explained, procuring an abortion is not a fundamental constitutional right because such a right has no basis in the Constitution's text or in our Nation's history. It follows that the States may regulate abortion for legitimate reasons, and when such regulations are challenged under the Constitution, courts cannot "substitute their social and economic beliefs for the judgment of legislative bodies." United States v. Carolene Products Co., 304 U.S. 144 (1938). That respect for a legislature's judgment applies even when the laws at issue concern matters of great social significance and moral substance.

A law regulating abortion, like other health and welfare laws, is entitled to a "strong presumption of validity." It must be sustained if there is a rational basis on which the legislature could have thought that it would serve legitimate state interests. Williamson v. Lee Optical of Okla., Inc., 348 U.S. 483 (1955). These legitimate interests include respect for and preservation of prenatal life at all stages of development, Gonzales v Carhart; the protection of maternal health and safety; the elimination of particularly gruesome or barbaric medical procedures; the preservation of the integrity of the medical profession; the mitigation of fetal pain; and the prevention of discrimination on the basis of race, sex, or disability.

B

These legitimate interests justify Mississippi's Gestational Age Act. Except "in a medical emergency or in the case of a severe fetal abnormality," the statute prohibits abortion "if the probable gestational age of the unborn human being has been determined to be greater than fifteen (15) weeks." The Mississippi Legislature's findings recount the stages of "human prenatal development" and assert the State's interest in "protecting the life of the unborn." The legislature also found that abortions performed after 15 weeks typically use the dilation and evacuation procedure, and the legislature found the use of this procedure "for nontherapeutic or elective reasons [to be] a barbaric practice, dangerous for the maternal patient, and demeaning to the medical profession." These legitimate interests provide a rational basis for the Gestational Age Act, and it follows that respondents' constitutional challenge must fail.

VII

We end this opinion where we began. Abortion presents a profound moral question. The Constitution does not prohibit the citizens of each State from regulating or

prohibiting abortion. Roe and Casey arrogated that authority. We now overrule those decisions and return that authority to the people and their elected representatives.

The judgment of the Fifth Circuit is reversed, and the case is remanded for further proceedings consistent with this opinion.

Justice THOMAS, concurring.

I join the opinion of the Court because it correctly holds that there is no constitutional right to abortion. The idea that the Framers of the Fourteenth Amendment understood the Due Process Clause to protect a right to abortion is farcical.

I write separately to emphasize a second, more fundamental reason why there is no abortion guarantee lurking in the Due Process Clause. Considerable historical evidence indicates that "due process of law" merely required executive and judicial actors to comply with legislative enactments and the common law when depriving a person of life, liberty, or property. [T]he Due Process Clause at most guarantees process. It does not, as the Court's substantive due process cases suppose, "forbi[d] the government to infringe certain 'fundamental' liberty interests at all, no matter what process is provided."

As I have previously explained, "substantive due process" is an oxymoron that "lack[s] any basis in the Constitution." The resolution of this case is thus straightforward. Because the Due Process Clause does not secure any substantive rights, it does not secure a right to abortion.

The Court today declines to disturb substantive due process jurisprudence generally or the doctrine's application in other, specific contexts. Cases like Griswold v. Connecticut, (1965) (right of married persons to obtain contraceptives); Lawrence v. Texas (2003) (right to engage in private, consensual sexual acts); and Obergefell v. Hodges (2015) (right to same-sex marriage), are not at issue. The Court's abortion cases are unique, and no party has asked us to decide "whether our entire Fourteenth Amendment jurisprudence must be preserved or revised."

For that reason, in future cases, we should reconsider all of this Court's substantive due process precedents, including Griswold, Lawrence, and Obergefell. [A]ny substantive due process decision is "demonstrably erroneous." Moreover, apart from being a demonstrably incorrect reading of the Due Process Clause, the "legal fiction" of substantive due process is "particularly dangerous." At least three dangers favor jettisoning the doctrine entirely.

First, "substantive due process exalts judges at the expense of the People from whom they derive their authority." Because the Due Process Clause "speaks only to 'process,' the Court has long struggled to define what substantive rights it protects." In practice, the Court's approach for identifying those "fundamental" rights "unquestionably involves policymaking rather than neutral legal analysis."

Nowhere is this exaltation of judicial policymaking clearer than this Court's abortion jurisprudence. In Roe v. Wade, the Court divined a right to abortion because it "fel[t]" that "the Fourteenth Amendment's concept of personal liberty included a right of privacy" that "is broad enough to encompass a woman's decision whether or not to terminate her pregnancy." In Planned Parenthood of Southeastern Pa. v. Casey, the Court likewise identified an abortion guarantee in "the liberty protected by the Fourteenth Amendment," but, rather than a "right of privacy," it invoked an ethereal "right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life." As the Court's preferred manifestation of "liberty" changed, so, too, did the test used to protect it, as Roe's author lamented.

Now, in this case, the nature of the purported "liberty" supporting the abortion right has shifted yet again. Respondents and the United States propose no fewer than three different interests that supposedly spring from the Due Process Clause. They include "bodily integrity," "personal autonomy in matters of family, medical care, and faith," That 50 years have passed since Roe and abortion advocates still cannot coherently articulate the right (or rights) at stake proves the obvious: The right to abortion is ultimately a policy goal in desperate search of a constitutional justification.

Second, substantive due process distorts other areas of constitutional law. For example, once this Court identifies a "fundamental" right for one class of individuals, it invokes the Equal Protection Clause to demand exacting scrutiny of statutes that deny the right to others. Statutory classifications implicating certain "nonfundamental" rights, meanwhile, receive only cursory review. [R]egardless of the doctrinal context, the Court often demands extra justifications for encroachments on "preferred rights" while "relax[ing] purportedly higher standards of review for less preferred rights." Substantive due process is the core inspiration for many of the Court's constitutionally unmoored policy judgments.

Third, substantive due process is often wielded to "disastrous ends." For instance, in Dred Scott v. Sandford (1857), the Court invoked a species of substantive due process to announce that Congress was powerless to emancipate slaves brought into the federal territories. While Dred Scott was "overruled on the battlefields of the Civil War and by constitutional amendment after Appomattox," Obergefell, that overruling was "[p]urchased at the price of immeasurable human suffering," Now today, the Court rightly overrules Roe and Casey—two of this Court's "most notoriously incorrect" substantive due process decisions—after more than 63 million abortions have been performed. The harm caused by this Court's forays into substantive due process remains immeasurable.

Because the Court properly applies our substantive due process precedents to reject the fabrication of a constitutional right to abortion, and because this case does not present the opportunity to reject substantive due process entirely, I join the Court's opinion. But, in future cases, we should "follow the text of the Constitution, which sets

forth certain substantive rights that cannot be taken away, and adds, beyond that, a right to due process when life, liberty, or property is to be taken away." Substantive due process conflicts with that textual command and has harmed our country in many ways. Accordingly, we should eliminate it from our jurisprudence at the earliest opportunity.

Justice KAVANAUGH, concurring.

I write separately to explain my additional views about why Roe was wrongly decided, why Roe should be overruled at this time, and the future implications of today's decision.

I

Abortion is a profoundly difficult and contentious issue because it presents an irreconcilable conflict between the interests of a pregnant woman who seeks an abortion and the interests in protecting fetal life. The interests on both sides of the abortion issue are extraordinarily weighty. When it comes to abortion, one interest must prevail over the other at any given point in a pregnancy. Many Americans of good faith would prioritize the interests of the pregnant woman. Many other Americans of good faith instead would prioritize the interests in protecting fetal life—at least unless, for example, an abortion is necessary to save the life of the mother. Of course, many Americans are conflicted or have nuanced views that may vary depending on the particular time in pregnancy, or the particular circumstances of a pregnancy.

The issue before this Court, however, is not the policy or morality of abortion. The issue before this Court is what the Constitution says about abortion. The Constitution does not take sides on the issue of abortion. The text of the Constitution does not refer to or encompass abortion. To be sure, this Court has held that the Constitution protects unenumerated rights that are deeply rooted in this Nation's history and tradition, and implicit in the concept of ordered liberty. But a right to abortion is not deeply rooted in American history and tradition, as the Court today thoroughly explains.

On the question of abortion, the Constitution is therefore neither pro-life nor pro-choice. The Constitution is neutral and leaves the issue for the people and their elected representatives to resolve through the democratic process in the States or Congress—like the numerous other difficult questions of American social and economic policy that the Constitution does not address. Because the Constitution is neutral on the issue of abortion, this Court also must be scrupulously neutral. Instead of adhering to the Constitution's neutrality, the Court in Roe took sides on the issue and unilaterally decreed that abortion was legal throughout the United States up to the point of viability (about 24 weeks of pregnancy). The Court's decision today properly returns the Court to a position of neutrality and restores the people's authority to address the issue of abortion through the processes of democratic self-government established by the Constitution.

Some amicus briefs argue that the Court today should not only overrule Roe and return to a position of judicial neutrality on abortion, but should go further and hold that the Constitution outlaws abortion throughout the United States. No Justice of this Court has ever advanced that position. I respect those who advocate for that position, just as I respect those who argue that this Court should hold that the Constitution legalizes pre-viability abortion throughout the United States. But both positions are wrong as a constitutional matter, in my view. The Constitution neither outlaws abortion nor legalizes abortion.

To be clear, then, the Court's decision today does not outlaw abortion throughout the United States. On the contrary, the Court's decision properly leaves the question of abortion for the people and their elected representatives in the democratic process. Through that democratic process, the people and their representatives may decide to allow or limit abortion.

Today's decision therefore does not prevent the numerous States that readily allow abortion from continuing to readily allow abortion. By contrast, other States may maintain laws that more strictly limit abortion. After today's decision, all of the States may evaluate the competing interests and decide how to address this consequential issue.

In arguing for a constitutional right to abortion that would override the people's choices in the democratic process, the plaintiff Jackson Women's Health Organization and its amici emphasize that the Constitution does not freeze the American people's rights as of 1791 or 1868. I fully agree. But when it comes to creating new rights, the Constitution directs the people to the various processes of democratic self-government contemplated by the Constitution—state legislation, state constitutional amendments, federal legislation, and federal constitutional amendments. This Court therefore does not possess the authority either to declare a constitutional right to abortion or to declare a constitutional prohibition of abortion.

In sum, the Constitution is neutral on the issue of abortion and allows the people and their elected representatives to address the issue through the democratic process. In my respectful view, the Court in Roe therefore erred by taking sides on the issue of abortion.

II

The more difficult question in this case is stare decisis—that is, whether to overrule the Roe decision. The principle of stare decisis requires respect for the Court's precedents and for the accumulated wisdom of the judges who have previously addressed the same issue. Stare decisis is rooted in Article III of the Constitution and is fundamental to the American judicial system and to the stability of American law. Adherence to precedent is the norm, and stare decisis imposes a high bar before this Court may overrule a precedent. This Court's history shows, however, that stare decisis is not

absolute, and indeed cannot be absolute. Otherwise, as the Court today explains, many long-since-overruled cases would never have been overruled and would still be the law.

But that history alone does not answer the critical question: When precisely should the Court overrule an erroneous constitutional precedent? The history of stare decisis in this Court establishes that a constitutional precedent may be overruled only when (i) the prior decision is not just wrong, but is egregiously wrong, (ii) the prior decision has caused significant negative jurisprudential or real-world consequences, and (iii) overruling the prior decision would not unduly upset legitimate reliance interests.

Applying those factors, I agree with the Court today that Roe should be overruled.

Of course, the fact that a precedent is wrong, even egregiously wrong, does not alone mean that the precedent should be overruled. But as the Court today explains, Roe has caused significant negative jurisprudential and real-world consequences. By taking sides on a difficult and contentious issue on which the Constitution is neutral, Roe overreached and exceeded this Court's constitutional authority; gravely distorted the Nation's understanding of this Court's proper constitutional role; and caused significant harm to what Roe itself recognized as the State's "important and legitimate interest" in protecting fetal life. All of that explains why tens of millions of Americans—and the 26 States that explicitly ask the Court to overrule Roe—do not accept Roe even 49 years later. Under the Court's longstanding stare decisis principles, Roe should be overruled.

But the stare decisis analysis here is somewhat more complicated because of Casey. I have deep and unyielding respect for the Justices who wrote the Casey plurality opinion. And I respect the Casey plurality's good-faith effort to locate some middle ground or compromise that could resolve this controversy for America. But as has become increasingly evident over time, Casey's well-intentioned effort did not resolve the abortion debate. The national division has not ended. In recent years, a significant number of States have enacted abortion restrictions that directly conflict with Roe. Those laws cannot be dismissed as political stunts or as outlier laws. Those numerous state laws collectively represent the sincere and deeply held views of tens of millions of Americans who continue to fervently believe that allowing abortions up to 24 weeks is far too radical and far too extreme, and does not sufficiently account for what Roe itself recognized as the State's "important and legitimate interest" in protecting fetal life.

In short, Casey's stare decisis analysis rested in part on a predictive judgment about the future development of state laws and of the people's views on the abortion issue. But that predictive judgment has not borne out. As the Court today explains, the experience over the last 30 years conflicts with Casey's predictive judgment and therefore undermines Casey's precedential force.

III

After today's decision, the nine Members of this Court will no longer decide the basic legality of pre-viability abortion for all 330 million Americans. That issue will be resolved by the people and their representatives in the democratic process in the States or Congress. But the parties' arguments have raised other related questions, and I address some of them here.

First is the question of how this decision will affect other precedents involving issues such as contraception and marriage. I emphasize what the Court today states: Overruling Roe does not mean the overruling of those precedents, and does not threaten or cast doubt on those precedents.

Second, as I see it, some of the other abortion-related legal questions raised by today's decision are not especially difficult as a constitutional matter. For example, may a State bar a resident of that State from traveling to another State to obtain an abortion? In my view, the answer is no based on the constitutional right to interstate travel. May a State retroactively impose liability or punishment for an abortion that occurred before today's decision takes effect? In my view, the answer is no based on the Due Process Clause or the Ex Post Facto Clause.

Other abortion-related legal questions may emerge in the future. But this Court will no longer decide the fundamental question of whether abortion must be allowed throughout the United States through 6 weeks, or 12 weeks, or 15 weeks, or 24 weeks, or some other line. The Court will no longer decide how to evaluate the interests of the pregnant woman and the interests in protecting fetal life throughout pregnancy. Instead, those difficult moral and policy questions will be decided, as the Constitution dictates, by the people and their elected representatives through the constitutional processes of democratic self-government.

The Court's decision today properly returns the Court to a position of judicial neutrality on the issue of abortion, and properly restores the people's authority to resolve the issue of abortion through the processes of democratic self government established by the Constitution. To be sure, many Americans will disagree with the Court's decision today. That would be true no matter how the Court decided this case. Both sides on the abortion issue believe sincerely and passionately in the rightness of their cause. Especially in those difficult and fraught circumstances, the Court must scrupulously adhere to the Constitution's neutral position on the issue of abortion.

In my judgment, on the issue of abortion, the Constitution is neither pro-life nor pro-choice. The Constitution is neutral, and this Court likewise must be scrupulously neutral. The Court today properly heeds the constitutional principle of judicial neutrality and returns the issue of abortion to the people and their elected representatives in the democratic process.

Chief Justice ROBERTS, concurring in the judgment.

We granted certiorari to decide one question: "Whether all pre-viability prohibitions on elective abortions are unconstitutional." Pet. for Cert. i. That question is directly implicated here: Mississippi's Gestational Age Act generally prohibits abortion after the fifteenth week of pregnancy—several weeks before a fetus is regarded as "viable" outside the womb. In urging our review, Mississippi stated that its case was "an ideal vehicle" to "reconsider the bright-line viability rule," and that a judgment in its favor would "not require the Court to overturn" Roe v. Wade and Planned Parenthood of Southeastern Pa. v. Casey.

Today, the Court nonetheless rules for Mississippi by doing just that. I would take a more measured course. I agree with the Court that the viability line established by Roe and Casey should be discarded under a straightforward stare decisis analysis. That line never made any sense. Our abortion precedents describe the right at issue as a woman's right to choose to terminate her pregnancy. That right should therefore extend far enough to ensure a reasonable opportunity to choose, but need not extend any further—certainly not all the way to viability. Mississippi's law allows a woman three months to obtain an abortion, well beyond the point at which it is considered "late" to discover a pregnancy. I see no sound basis for questioning the adequacy of that opportunity.

But that is all I would say, out of adherence to a simple yet fundamental principle of judicial restraint: If it is not necessary to decide more to dispose of a case, then it is necessary not to decide more. Perhaps we are not always perfect in following that command, and certainly there are cases that warrant an exception. But this is not one of them. Surely we should adhere closely to principles of judicial restraint here, where the broader path the Court chooses entails repudiating a constitutional right we have not only previously recognized, but also expressly reaffirmed applying the doctrine of stare decisis. The Court's opinion is thoughtful and thorough, but those virtues cannot compensate for the fact that its dramatic and consequential ruling is unnecessary to decide the case before us.

I

Let me begin with my agreement with the Court, on the only question we need decide here: whether to retain the rule from Roe and Casey that a woman's right to terminate her pregnancy extends up to the point that the fetus is regarded as "viable" outside the womb. I agree that this rule should be discarded.

First, this Court seriously erred in Roe in adopting viability as the earliest point at which a State may legislate to advance its substantial interests in the area of abortion. Roe set forth a rigid three-part framework anchored to viability[.] That framework, moreover, came out of thin air. Neither the Texas statute challenged in Roe nor the Georgia statute at issue in its companion case, Doe v. Bolton, (1973) included any gestational age limit.

No party or amicus asked the Court to adopt a bright line viability rule. And as for Casey, arguments for or against the viability rule played only a de minimis role in the parties' briefing and in the oral argument.

It is thus hardly surprising that neither Roe nor Casey made a persuasive or even colorable argument for why the time for terminating a pregnancy must extend to viability. The Court's jurisprudence on this issue is a textbook illustration of the perils of deciding a question neither presented nor briefed. As has been often noted, Roe's defense of the line boiled down to the circular assertion that the State's interest is compelling only when an unborn child can live outside the womb, because that is when the unborn child can live outside the womb.

Twenty years later, the best defense of the viability line the Casey plurality could conjure up was workability. Although the plurality attempted to add more content by opining that "it might be said that a woman who fails to act before viability has consented to the State's intervention on behalf of the developing child," that mere suggestion provides no basis for choosing viability as the critical tipping point. A similar implied consent argument could be made with respect to a law banning abortions after fifteen weeks, well beyond the point at which nearly all women are aware that they are pregnant. The dissent, which would retain the viability line, offers no justification for it either.

This Court's jurisprudence since Casey, moreover, has "eroded" the "underpinnings" of the viability line, such as they were. The viability line is a relic of a time when we recognized only two state interests warranting regulation of abortion: maternal health and protection of "potential life." That changed with Gonzales v. Carhart. There, we recognized a broader array of interests, such as drawing "a bright line that clearly distinguishes abortion and infanticide," maintaining societal ethics, and preserving the integrity of the medical profession. The viability line has nothing to do with advancing such permissible goals.

Consider, for example, statutes passed in a number of jurisdictions that forbid abortions after twenty weeks of pregnancy, premised on the theory that a fetus can feel pain at that stage of development. Assuming that prevention of fetal pain is a legitimate state interest after Gonzales, there seems to be no reason why viability would be relevant to the permissibility of such laws. The same is true of laws designed to "protect the integrity and ethics of the medical profession" and restrict procedures likely to "coarsen society" to the "dignity of human life." Mississippi's law, for instance, was premised in part on the legislature's finding that the "dilation and evacuation" procedure is a "barbaric practice, dangerous for the maternal patient, and demeaning to the medical profession." That procedure accounts for most abortions performed after the first trimester—two weeks before the period at issue in this case[.]

In short, the viability rule was created outside the ordinary course of litigation, is and always has been completely unreasoned, and fails to take account of state interests

since recognized as legitimate. It is indeed telling that other countries almost uniformly eschew a viability line.

II

None of this, however, requires that we also take the dramatic step of altogether eliminating the abortion right first recognized in Roe. Mississippi itself previously argued as much to this Court in this litigation. When the State petitioned for our review, its basic request was straightforward: "clarify whether abortion prohibitions before viability are always unconstitutional." The State made a number of strong arguments that the answer is no, id., at 15-26—arguments that, as discussed, I find persuasive. And it went out of its way to make clear that it was not asking the Court to repudiate entirely the right to choose whether to terminate a pregnancy[.] Mississippi tempered that statement with an oblique one-sentence footnote intimating that, if the Court could not reconcile Roe and Casey with current facts or other cases, it "should not retain erroneous precedent." But the State never argued that we should grant review for that purpose.

After we granted certiorari, however, Mississippi changed course. In its principal brief, the State bluntly announced that the Court should overrule Roe and Casey. The Court now rewards that gambit, noting three times that the parties presented "no half-measures" and argued that we must either reaffirm or overrule Roe and Casey. Given those two options, the majority picks the latter.

This framing is not accurate. In its brief on the merits, Mississippi in fact argued at length that a decision simply rejecting the viability rule would result in a judgment in its favor. But even if the State had not argued as much, it would not matter. There is no rule that parties can confine this Court to disposing of their case on a particular ground—let alone when review was sought and granted on a different one. Our established practice is instead not to "formulate a rule of constitutional law broader than is required by the precise facts to which it is to be applied."

Following that "fundamental principle of judicial restraint," we should begin with the narrowest basis for disposition, proceeding to consider a broader one only if necessary to resolve the case at hand.

Here, there is a clear path to deciding this case correctly without overruling Roe all the way down to the studs: recognize that the viability line must be discarded, as the majority rightly does, and leave for another day whether to reject any right to an abortion at all.

Of course, such an approach would not be available if the rationale of Roe and Casey was inextricably entangled with and dependent upon the viability standard. It is not. Our precedents in this area ground the abortion right in a woman's "right to choose." If that is the basis for Roe, Roe's viability line should be scrutinized from the same

perspective. And there is nothing inherent in the right to choose that requires it to extend to viability or any other point, so long as a real choice is provided.

To be sure, in reaffirming the right to an abortion, Casey termed the viability rule Roe's "central holding." Other cases of ours have repeated that language. But simply declaring it does not make it so. The question in Roe was whether there was any right to abortion in the Constitution.

The Court in Roe just chose to address both issues in one opinion: It first recognized a right to "choose to terminate [a] pregnancy" under the Constitution, and then, having done so, explained that a line should be drawn at viability such that a State could not proscribe abortion before that period[.] The viability line is a separate rule fleshing out the metes and bounds of Roe's core holding. Applying principles of stare decisis, I would excise that additional rule—and only that rule—from our jurisprudence.

Roe adopted two distinct rules of constitutional law: one, that a woman has the right to choose to terminate a pregnancy; two, that such right may be overridden by the State's legitimate interests when the fetus is viable outside the womb. The latter is obviously distinct from the former. I would abandon that timing rule, but see no need in this case to consider the basic right.

The Court contends that it is impossible to address Roe's conclusion that the Constitution protects the woman's right to abortion, without also addressing Roe's rule that the State's interests are not constitutionally adequate to justify a ban on abortion until viability. But we have partially overruled precedents before and certainly have never held that a distinct holding defining the contours of a constitutional right must be treated as part and parcel of the right itself.

Overruling the subsidiary rule is sufficient to resolve this case in Mississippi's favor. The law at issue allows abortions up through fifteen weeks, providing an adequate opportunity to exercise the right Roe protects. By the time a pregnant woman has reached that point, her pregnancy is well into the second trimester. Pregnancy tests are now inexpensive and accurate, and a woman ordinarily discovers she is pregnant by six weeks of gestation. Given all this, it is no surprise that the vast majority of abortions happen in the first trimester. Presumably most of the remainder would also take place earlier if later abortions were not a legal option. Ample evidence thus suggests that a 15-week ban provides sufficient time, absent rare circumstances, for a woman to decide for herself whether to terminate her pregnancy.

III

Whether a precedent should be overruled is a question "entirely within the discretion of the court." In my respectful view, the sound exercise of that discretion should have led the Court to resolve the case on the narrower grounds set forth above, rather than overruling Roe and Casey entirely. The Court says there is no "principled

basis" for this approach, but in fact it is firmly grounded in basic principles of stare decisis and judicial restraint.

The Court's decision to overrule Roe and Casey is a serious jolt to the legal system—regardless of how you view those cases. A narrower decision rejecting the misguided viability line would be markedly less unsettling, and nothing more is needed to decide this case.

Our cases say that the effect of overruling a precedent on reliance interests is a factor to consider in deciding whether to take such a step, and respondents argue that generations of women have relied on the right to an abortion in organizing their relationships and planning their futures. The Court questions whether these concerns are pertinent under our precedents, but the issue would not even arise with a decision rejecting only the viability line: It cannot reasonably be argued that women have shaped their lives in part on the assumption that they would be able to abort up to viability, as opposed to fifteen weeks.

In support of its holding, the Court cites three seminal constitutional decisions that involved overruling prior precedents: Brown v. Board of Education, West Virginia Bd. of Ed. v. Barnette, and West Coast Hotel Co. v. Parrish. The opinion in Brown was unanimous and eleven pages long; this one is neither. Barnette was decided only three years after the decision it overruled, three Justices having had second thoughts. And West Coast Hotel was issued against a backdrop of unprecedented economic despair that focused attention on the fundamental flaws of existing precedent. It also was part of a sea change in this Court's interpretation of the Constitution, "signal[ing] the demise of an entire line of important precedents"—a feature the Court expressly disclaims in today's decision. None of these leading cases, in short, provides a template for what the Court does today.

The Court says we should consider whether to overrule Roe and Casey now, because if we delay we would be forced to consider the issue again in short order. There would be "turmoil" until we did so, according to the Court, because of existing state laws with "shorter deadlines or no deadline at all." But under the narrower approach proposed here, state laws outlawing abortion altogether would still violate binding precedent. And to the extent States have laws that set the cutoff date earlier than fifteen weeks, any litigation over that timeframe would proceed free of the distorting effect that the viability rule has had on our constitutional debate. The same could be true, for that matter, with respect to legislative consideration in the States. We would then be free to exercise our discretion in deciding whether and when to take up the issue, from a more informed perspective.

* * *

Both the Court's opinion and the dissent display a relentless freedom from doubt on the legal issue that I cannot share. I am not sure, for example, that a ban on

terminating a pregnancy from the moment of conception must be treated the same under the Constitution as a ban after fifteen weeks. I would decide the question we granted review to answer—whether the previously recognized abortion right bars all abortion restrictions prior to viability, such that a ban on abortions after fifteen weeks of pregnancy is necessarily unlawful. The answer to that question is no, and there is no need to go further to decide this case.

I therefore concur only in the judgment.

Justice BREYER, Justice SOTOMAYOR, and Justice KAGAN, dissenting.

For half a century, Roe v. Wade and Planned Parenthood of Southeastern Pa. v. Casey have protected the liberty and equality of women. Roe held, and Casey reaffirmed, that the Constitution safeguards a woman's right to decide for herself whether to bear a child. Roe held, and Casey reaffirmed, that in the first stages of pregnancy, the government could not make that choice for women. The government could not control a woman's body or the course of a woman's life: It could not determine what the woman's future would be. Respecting a woman as an autonomous being, and granting her full equality, meant giving her substantial choice over this most personal and most consequential of all life decisions.

Roe and Casey well understood the difficulty and divisiveness of the abortion issue. The Court knew that Americans hold profoundly different views about the "mora[lity'" of "terminating a pregnancy, even in its earliest stage." And the Court recognized that "the State has legitimate interests from the outset of the pregnancy in protecting" the "life of the fetus that may become a child." So the Court struck a balance, as it often does when values and goals compete. It held that the State could prohibit abortions after fetal viability, so long as the ban contained exceptions to safeguard a woman's life or health. It held that even before viability, the State could regulate the abortion procedure in multiple and meaningful ways. But until the viability line was crossed, the Court held, a State could not impose a "substantial obstacle" on a woman's "right to elect the procedure" as she (not the government) thought proper, in light of all the circumstances and complexities of her own life.

Today, the Court discards that balance. It says that from the very moment of fertilization, a woman has no rights to speak of. A State can force her to bring a pregnancy to term, even at the steepest personal and familial costs. An abortion restriction, the majority holds, is permissible whenever rational, the lowest level of scrutiny known to the law. And because, as the Court has often stated, protecting fetal life is rational, States will feel free to enact all manner of restrictions. The Mississippi law at issue here bars abortions after the 15th week of pregnancy. Under the majority's ruling, though, another State's law could do so after ten weeks, or five or three or one—or, again, from the moment of fertilization. States have already passed such laws, in anticipation of today's ruling. More will follow. Some States have enacted laws

extending to all forms of abortion procedure, including taking medication in one's own home. They have passed laws without any exceptions for when the woman is the victim of rape or incest. Under those laws, a woman will have to bear her rapist's child or a young girl her father's—no matter if doing so will destroy her life. So too, after today's ruling, some States may compel women to carry to term a fetus with severe physical anomalies—for example, one afflicted with Tay-Sachs disease, sure to die within a few years of birth. States may even argue that a prohibition on abortion need make no provision for protecting a woman from risk of death or physical harm. Across a vast array of circumstances, a State will be able to impose its moral choice on a woman and coerce her to give birth to a child.

Enforcement of all these draconian restrictions will also be left largely to the States' devices. A State can of course impose criminal penalties on abortion providers, including lengthy prison sentences. But some States will not stop there. Perhaps, in the wake of today's decision, a state law will criminalize the woman's conduct too, incarcerating or fining her for daring to seek or obtain an abortion. And as Texas has recently shown, a State can turn neighbor against neighbor, enlisting fellow citizens in the effort to root out anyone who tries to get an abortion, or to assist another in doing so.

The majority tries to hide the geographically expansive effects of its holding. Today's decision, the majority says, permits "each State" to address abortion as it pleases. That is cold comfort, of course, for the poor woman who cannot get the money to fly to a distant State for a procedure. Above all others, women lacking financial resources will suffer from today's decision. In any event, interstate restrictions will also soon be in the offing. After this decision, some States may block women from traveling out of State to obtain abortions, or even from receiving abortion medications from out of State. Some may criminalize efforts, including the provision of information or funding, to help women gain access to other States' abortion services. Most threatening of all, no language in today's decision stops the Federal Government from prohibiting abortions nationwide, once again from the moment of conception and without exceptions for rape or incest. If that happens, "the views of [an individual State's] citizens" will not matter. The challenge for a woman will be to finance a trip not to New York or California but to Toronto.

Whatever the exact scope of the coming laws, one result of today's decision is certain: the curtailment of women's rights, and of their status as free and equal citizens. Yesterday, the Constitution guaranteed that a woman confronted with an unplanned pregnancy could (within reasonable limits) make her own decision about whether to bear a child, with all the life-transforming consequences that act involves. But no longer. As of today, this Court holds, a State can always force a woman to give birth, prohibiting even the earliest abortions. A State can thus transform what, when freely undertaken, is a wonder into what, when forced, may be a nightmare. Some women, especially women of means, will find ways around the State's assertion of power. Others—those without money or childcare or the ability to take time off from work—will not be so fortunate. Maybe they will try an unsafe method of abortion, and come to physical harm, or even

die. Maybe they will undergo pregnancy and have a child, but at significant personal or familial cost. At the least, they will incur the cost of losing control of their lives. The Constitution will, today's majority holds, provide no shield, despite its guarantees of liberty and equality for all.

And no one should be confident that this majority is done with its work. The right Roe and Casey recognized does not stand alone. To the contrary, the Court has linked it for decades to other settled freedoms involving bodily integrity, familial relationships, and procreation. Most obviously, the right to terminate a pregnancy arose straight out of the right to purchase and use contraception. In turn, those rights led, more recently, to rights of same-sex intimacy and marriage. They are all part of the same constitutional fabric, protecting autonomous decisionmaking over the most personal of life decisions. The majority (or to be more accurate, most of it) is eager to tell us today that nothing it does "cast[s] doubt on precedents that do not concern abortion." But how could that be? The lone rationale for what the majority does today is that the right to elect an abortion is not "deeply rooted in history": Not until Roe, the majority argues, did people think abortion fell within the Constitution's guarantee of liberty. The same could be said, though, of most of the rights the majority claims it is not tampering with. The majority could write just as long an opinion showing, for example, that until the mid-20th century, there was no support in American law for a constitutional right to obtain [contraceptives]. So one of two things must be true. Either the majority does not really believe in its own reasoning. Or if it does, all rights that have no history stretching back to the mid-19th century are insecure. Either the mass of the majority's opinion is hypocrisy, or additional constitutional rights are under threat. It is one or the other.

One piece of evidence on that score seems especially salient: The majority's cavalier approach to overturning this Court's precedents. Stare decisis is the Latin phrase for a foundation stone of the rule of law: that things decided should stay decided unless there is a very good reason for change. It is a doctrine of judicial modesty and humility. Those qualities are not evident in today's opinion. The majority has no good reason for the upheaval in law and society it sets off. Roe and Casey have been the law of the land for decades, shaping women's expectations of their choices when an unplanned pregnancy occurs. Women have relied on the availability of abortion both in structuring their relationships and in planning their lives. The legal framework Roe and Casey developed to balance the competing interests in this sphere has proved workable in courts across the country. No recent developments, in either law or fact, have eroded or cast doubt on those precedents. Nothing, in short, has changed. Indeed, the Court in Casey already found all of that to be true. Casey is a precedent about precedent. It reviewed the same arguments made here in support of overruling Roe, and it found that doing so was not warranted. The Court reverses course today for one reason and one reason only: because the composition of this Court has changed. Stare decisis "contributes to the actual and perceived integrity of the judicial process" by ensuring that decisions are "founded in the law rather than in the proclivities of individuals." Today, the proclivities of individuals rule. The Court departs from its obligation to faithfully and impartially apply the law. We dissent.

I

We start with Roe and Casey, and with their deep connections to a broad swath of this Court's precedents. To hear the majority tell the tale, Roe and Casey are aberrations: They came from nowhere, went nowhere—and so are easy to excise from this Nation's constitutional law. That is not true. After describing the decisions themselves, we explain how they are rooted in—and themselves led to—other rights giving individuals control over their bodies and their most personal and intimate associations. The majority does not wish to talk about these matters for obvious reasons; to do so would both ground Roe and Casey in this Court's precedents and reveal the broad implications of today's decision. But the facts will not so handily disappear. Roe and Casey were from the beginning, and are even more now, embedded in core constitutional concepts of individual freedom, and of the equal rights of citizens to decide on the shape of their lives. Those legal concepts, one might even say, have gone far toward defining what it means to be an American. For in this Nation, we do not believe that a government controlling all private choices is compatible with a free people. So we do not (as the majority insists today) place everything within "the reach of majorities and [government] officials." We believe in a Constitution that puts some issues off limits to majority rule. Even in the face of public opposition, we uphold the right of individuals—yes, including women—to make their own choices and chart their own futures. Or at least, we did once.

A

Some half-century ago, Roe struck down a state law making it a crime to perform an abortion unless its purpose was to save a woman's life. The Roe Court knew it was treading on difficult and disputed ground. But by a 7-to-2 vote, the Court held that in the earlier stages of pregnancy, that contested and contestable choice must belong to a woman, in consultation with her family and doctor. The Court explained that a long line of precedents, "founded in the Fourteenth Amendment's concept of personal liberty," protected individual decisionmaking related to "marriage, procreation, contraception, family relationships, and child rearing and education." For the same reasons, the Court held, the Constitution must protect "a woman's decision whether or not to terminate her pregnancy." The Court recognized the myriad ways bearing a child can alter the "life and future" of a woman and other members of her family. A State could not, "by adopting one theory of life, override all rights of the pregnant woman."

At the same time, though, the Court recognized "valid interest[s]" of the State "in regulating the abortion decision." The Court noted in particular "important interests" in "protecting potential life," "maintaining medical standards," and "safeguarding [the] health" of the woman.

The Court therefore struck a balance, turning on the stage of the pregnancy at which the abortion would occur. The Court explained that early on, a woman's choice must prevail, but that "at some point the state interests" become "dominant." It then set

some guideposts. In the first trimester of pregnancy, the State could not interfere at all with the decision to terminate a pregnancy. At any time after that point, the State could regulate to protect the pregnant woman's health, such as by insisting that abortion providers and facilities meet safety requirements. And after the fetus's viability—the point when the fetus "has the capability of meaningful life outside the mother's womb"—the State could ban abortions, except when necessary to preserve the woman's life or health.

In the 20 years between Roe and Casey, the Court expressly reaffirmed Roe on two occasions, and applied it on many more. Then, in Casey, the Court considered the matter anew, and again upheld Roe's core precepts. Casey is in significant measure a precedent about the doctrine of precedent—until today, one of the Court's most important. But we leave for later that aspect of the Court's decision. The key thing now is the substantive aspect of the Court's considered conclusion that "the essential holding of Roe v. Wade should be retained and once again reaffirmed."

Central to that conclusion was a full-throated restatement of a woman's right to choose. Like Roe, Casey grounded that right in the Fourteenth Amendment's guarantee of "liberty." And the guarantee of liberty encompasses conduct today that was not protected at the time of the Fourteenth Amendment. Especially important in this web of precedents protecting an individual's most "personal choices" were those guaranteeing the right to contraception. So too, Casey reasoned, the liberty clause protects the decision of a woman confronting an unplanned pregnancy. Her decision about abortion was central, in the same way, to her capacity to chart her life's course.

In reaffirming the right Roe recognized, the Court took full account of the diversity of views on abortion, and the importance of various competing state interests.

So Casey again struck a balance, differing from Roe's in only incremental ways. It retained Roe's "central holding" that the State could bar abortion only after viability. The viability line, Casey thought, was "more workable" than any other in marking the place where the woman's liberty interest gave way to a State's efforts to preserve potential life. At the same time, Casey decided, based on two decades of experience, that the Roe framework did not give States sufficient ability to regulate abortion prior to viability. In that period, Casey now made clear, the State could regulate not only to protect the woman's health but also to promote prenatal life. In particular, the State could ensure informed choice and could try to promote childbirth. But the State still could not place an "undue burden"—or "substantial obstacle"—in the path of a woman seeking an abortion. Prior to viability, the woman, consistent with the constitutional "meaning of liberty," must "retain the ultimate control over her destiny and her body."

We make one initial point about this analysis in light of the majority's insistence that Roe and Casey, and we in defending them, are dismissive of a "State's interest in protecting prenatal life." Nothing could get those decisions more wrong. As just described, Roe and Casey invoked powerful state interests in that protection, operative at

every stage of the pregnancy and overriding the woman's liberty after viability. The strength of those state interests is exactly why the Court allowed greater restrictions on the abortion right than on other rights deriving from the Fourteenth Amendment. But what Roe and Casey also recognized—which today's majority does not—is that a woman's freedom and equality are likewise involved. That fact—the presence of countervailing interests—is what made the abortion question hard, and what necessitated balancing. To the majority "balance" is a dirty word, as moderation is a foreign concept. The majority would allow States to ban abortion from conception onward because it does not think forced childbirth at all implicates a woman's rights to equality and freedom. Roe and Casey thought that one-sided view misguided. In some sense, that is the difference in a nutshell between our precedents and the majority opinion. The constitutional regime we have lived in for the last 50 years recognized competing interests, and sought a balance between them. The constitutional regime we enter today erases the woman's interest and recognizes only the State's (or the Federal Government's).

B

The majority makes this change based on a single question: Did the reproductive right recognized in Roe and Casey exist in "1868, the year when the Fourteenth Amendment was ratified"? The majority says (and with this much we agree) that the answer to this question is no: In 1868, there was no nationwide right to end a pregnancy, and no thought that the Fourteenth Amendment provided one.

Of course, the majority opinion refers as well to some later and earlier history. On the one side of 1868, it goes back as far as the 13th (the 13th!) century. But that turns out to be wheel-spinning. First, it is not clear what relevance such early history should have, even to the majority. See New York State Rifle & Pistol Assn., Inc. v. Bruen, ("Historical evidence that long predates [ratification] may not illuminate the scope of the right"). If the early history obviously supported abortion rights, the majority would no doubt say that only the views of the Fourteenth Amendment's ratifiers are germane. Second—and embarrassingly for the majority—early law in fact does provide some support for abortion rights. Common-law authorities did not treat abortion as a crime before "quickening"—the point when the fetus moved in the womb. And early American law followed the common-law rule. So the criminal law of that early time might be taken as roughly consonant with Roe's and Casey's different treatment of early and late abortions. Better, then, to move forward in time. On the other side of 1868, the majority occasionally notes that many States barred abortion up to the time of Roe. That is convenient for the majority, but it is window dressing. As the same majority (plus one) just informed us, "post-ratification adoption or acceptance of laws that are inconsistent with the original meaning of the constitutional text obviously cannot overcome or alter that text." New York State Rifle & Pistol Assn., Inc.. Had the pre-Roe liberalization of abortion laws occurred more quickly and more widely in the 20th century, the majority would say (once again) that only the ratifiers' views are germane.

The majority's core legal postulate, then, is that we in the 21st century must read the Fourteenth Amendment just as its ratifiers did. If the ratifiers did not understand something as central to freedom, then neither can we. Or said more particularly: If those people did not understand reproductive rights as part of the guarantee of liberty conferred in the Fourteenth Amendment, then those rights do not exist.

As an initial matter, note a mistake in the just preceding sentence. We referred there to the "people" who ratified the Fourteenth Amendment: What rights did those "people" have in their heads at the time? But, of course, "people" did not ratify the Fourteenth Amendment. Men did. So it is perhaps not so surprising that the ratifiers were not perfectly attuned to the importance of reproductive rights for women's liberty, or for their capacity to participate as equal members of our Nation. Indeed, the ratifiers—both in 1868 and when the original Constitution was approved in 1788—did not understand women as full members of the community embraced by the phrase "We the People." In 1868, the first wave of American feminists were explicitly told—of course by men—that it was not their time to seek constitutional protections. (Women would not get even the vote for another half-century.) To be sure, most women in 1868 also had a foreshortened view of their rights: If most men could not then imagine giving women control over their bodies, most women could not imagine having that kind of autonomy. But that takes away nothing from the core point. Those responsible for the original Constitution, including the Fourteenth Amendment, did not perceive women as equals, and did not recognize women's rights. When the majority says that we must read our foundational charter as viewed at the time of ratification (except that we may also check it against the Dark Ages), it consigns women to second-class citizenship.

Casey itself understood this point, as will become clear. "There was a time," Casey explained, when the Constitution did not protect "men and women alike." But times had changed. A woman's place in society had changed, and constitutional law had changed along with it. The relegation of women to inferior status in either the public sphere or the family was "no longer consistent with our understanding" of the Constitution.

So how is it that, as Casey said, our Constitution, read now, grants rights to women, though it did not in 1868? How is it that our Constitution subjects discrimination against them to heightened judicial scrutiny? How is it that our Constitution, through the Fourteenth Amendment's liberty clause, guarantees access to contraception (also not legally protected in 1868) so that women can decide for themselves whether and when to bear a child? How is it that until today, that same constitutional clause protected a woman's right, in the event contraception failed, to end a pregnancy in its earlier stages?

The answer is that this Court has rejected the majority's pinched view of how to read our Constitution. [I]n the words of the great Chief Justice John Marshall, our Constitution is "intended to endure for ages to come," and must adapt itself to a future "seen dimly," if at all. McCulloch v. Maryland (1819). That is indeed why our Constitution is written as it is. The Framers (both in 1788 and 1868) understood that the

world changes. So they did not define rights by reference to the specific practices existing at the time. Instead, the Framers defined rights in general terms, to permit future evolution in their scope and meaning. And over the course of our history, this Court has taken up the Framers' invitation. It has kept true to the Framers' principles by applying them in new ways, responsive to new societal understandings and conditions.

Nowhere has that approach been more prevalent than in construing the majestic but open-ended words of the Fourteenth Amendment—the guarantees of "liberty" and "equality" for all. And nowhere has that approach produced prouder moments, for this country and the Court. The Constitution does not freeze for all time the original view of what those rights guarantee, or how they apply.

That does not mean anything goes. The majority wishes people to think there are but two alternatives: (1) accept the original applications of the Fourteenth Amendment and no others, or (2) surrender to judges' "own ardent views," ungrounded in law, about the "liberty that Americans should enjoy." At least, that idea is what the majority sometimes tries to convey. At other times, the majority (or, rather, most of it) tries to assure the public that it has no designs on rights (for example, to contraception) that arose only in the back half of the 20th century—in other words, that it is happy to pick and choose, in accord with individual preferences. [O]ur point is . . . that applications of liberty and equality can evolve while remaining grounded in constitutional principles, constitutional history, and constitutional precedents. The . . . constitutional "tradition" of this country is not captured whole at a single moment. Ibid. Rather, its meaning gains content from the long sweep of our history and from successive judicial precedents—each looking to the last and each seeking to apply the Constitution's most fundamental commitments to new conditions. That is why Americans . . . have a right to marry across racial lines. And it is why . . . Americans have a right to use contraceptives so they can choose for themselves whether to have children.

All that is what Casey understood. Casey explicitly rejected the present majority's method. "[T]he specific practices of States at the time of the adoption of the Fourteenth Amendment," Casey stated, do not "mark[ ] the outer limits of the substantive sphere of liberty which the Fourteenth Amendment protects." To hold otherwise—as the majority does today—"would be inconsistent with our law." Why? Because the Court has vindicated the principle" over and over that (no matter the sentiment in 1868) there is a realm of personal liberty which the government may not enter—especially relating to bodily integrity and family life. described in detail the Court's contraception cases. It noted decisions protecting the right to marry, including to someone of another race. In reviewing decades and decades of constitutional law, Casey could draw but one conclusion: Whatever was true in 1868, "[i]t is settled now, as it was when the Court heard arguments in Roe v. Wade, that the Constitution places limits on a State's right to interfere with a person's most basic decisions about family and parenthood."

And that conclusion still held good, until the Court's intervention here. The Court's precedents about bodily autonomy, sexual and familial relations, and procreation

are all interwoven—all part of the fabric of our constitutional law, and because that is so, of our lives. Especially women's lives, where they safeguard a right to self-determination.

And eliminating that right, we need to say before further describing our precedents, is not taking a "neutral" position, as Justice KAVANAUGH tries to argue. His idea is that neutrality lies in giving the abortion issue to the States, where some can go one way and some another. But would he say that the Court is being "scrupulously neutral" if it allowed New York and California to ban all the guns they want? If the Court allowed some States to use unanimous juries and others not? If the Court told the States: Decide for yourselves whether to put restrictions on church attendance? We could go on—and in fact we will. Suppose Justice KAVANAUGH were to say (in line with the majority opinion) that the rights we just listed are more textually or historically grounded than the right to choose. What, then, of the right to contraception or same-sex marriage? Would it be "scrupulously neutral" for the Court to eliminate those rights too? The point of all these examples is that when it comes to rights, the Court does not act "neutrally" when it leaves everything up to the States. Rather, the Court acts neutrally when it protects the right against all comers. And to apply that point to the case here: When the Court decimates a right women have held for 50 years, the Court is not being "scrupulously neutral." It is instead taking sides: against women who wish to exercise the right, and for States (like Mississippi) that want to bar them from doing so.

Consider first, then, the line of this Court's cases protecting "bodily integrity." "No right," in this Court's time-honored view, "is held more sacred, or is more carefully guarded," than "the right of every individual to the possession and control of his own person. [S]ee Cruzan v. Director, Mo. Dept. of Health (1990) (Every adult "has a right to determine what shall be done with his own body"). Or to put it more simply: Everyone, including women, owns their own bodies. So the Court has restricted the power of government to interfere with a person's medical decisions or compel her to undergo medical procedures or treatments.

Casey recognized the "doctrinal affinity" between those precedents and Roe. And that doctrinal affinity is born of a factual likeness. There are few greater incursions on a body than forcing a woman to complete a pregnancy and give birth. That women happily undergo those burdens and hazards of their own accord does not lessen how far a State impinges on a woman's body when it compels her to bring a pregnancy to term. And for some women, as Roe recognized, abortions are medically necessary to prevent harm. The majority does not say—which is itself ominous—whether a State may prevent a woman from obtaining an abortion when she and her doctor have determined it is a needed medical treatment.

So too, Roe and Casey fit neatly into a long line of decisions protecting from government intrusion a wealth of private choices about family matters, child rearing, intimate relationships, and procreation. Those cases safeguard particular choices about whom to marry; whom to have sex with; what family members to live with; how to raise

children—and crucially, whether and when to have children. In varied cases, the Court explained that those choices—"the most intimate and personal" a person can make—reflect fundamental aspects of personal identity; they define the very "attributes of personhood." And they inevitably shape the nature and future course of a person's life (and often the lives of those closest to her). So, the Court held, those choices belong to the individual, and not the government. That is the essence of what liberty requires.

And liberty may require it, this Court has repeatedly said, even when those living in 1868 would not have recognized the claim—because they would not have seen the person making it as a full-fledged member of the community. And after Roe and Casey, of course, the Court continued in that vein. With a critical stop to hold that the Fourteenth Amendment protected same-sex intimacy, the Court resolved that the Amendment also conferred on same-sex couples the right to marry. In considering that question, the Court held, history and tradition, especially as reflected in the course of our precedent, guide and discipline the inquiry. But the sentiments of 1868 alone do not and cannot rule the present.

Casey similarly recognized the need to extend the constitutional sphere of liberty to a previously excluded group. The Court then understood, as the majority today does not, that the men who ratified the Fourteenth Amendment and wrote the state laws of the time did not view women as full and equal citizens. A woman then, Casey wrote, "had no legal existence separate from her husband." But that could not be true any longer: The State could not now insist on the historically dominant "vision of the woman's role." And equal citizenship, Casey realized, was inescapably connected to reproductive rights.

For much that reason, Casey made clear that the precedents Roe most closely tracked were those involving contraception. Reasonable people could also oppose contraception; and indeed, they could believe that some forms of contraception similarly implicate a concern with potential life. Yet the views of others could not automatically prevail against a woman's right to control her own body and make her own choice about whether to bear, and probably to raise, a child. No State could undertake to resolve the moral questions raised in such a definitive way as to deprive a woman of all choice.

Faced with all these connections between Roe/Casey and judicial decisions recognizing other constitutional rights, the majority tells everyone not to worry. It can (so it says) neatly extract the right to choose from the constitutional edifice without affecting any associated rights. (Think of someone telling you that the Jenga tower simply will not collapse.) Today's decision, the majority first says, "does not undermine" the decisions cited by Roe and Casey—the ones involving "marriage, procreation, contraception, [and] family relationships"—"in any way." Note that this first assurance does not extend to rights recognized after Roe and Casey, and partly based on them—in particular, rights to same-sex intimacy and marriage. On its later tries, though, the majority includes those too: "Nothing in this opinion should be understood to cast doubt on precedents that do not concern abortion." That right is unique, the majority asserts, "because [abortion] terminates life or potential life." So the majority depicts today's decision as "a restricted

railroad ticket, good for this day and train only." Should the audience for these too-much-repeated protestations be duly satisfied? We think not.

The first problem with the majority's account comes from Justice THOMAS's concurrence—which makes clear he is not with the program. In saying that nothing in today's opinion casts doubt on non-abortion precedents, Justice THOMAS explains, he means only that they are not at issue in this very case. But he lets us know what he wants to do when they are. So at least one Justice is planning to use the ticket of today's decision again and again and again.

Even placing the concurrence to the side, the assurance in today's opinion still does not work. Or at least that is so if the majority is serious about its sole reason for overturning Roe and Casey: the legal status of abortion in the 19th century. Except in the places quoted above, the state interest in protecting fetal life plays no part in the majority's analysis. To the contrary, the majority takes pride in not expressing a view "about the status of the fetus." The majority's departure from Roe and Casey rests instead—and only—on whether a woman's decision to end a pregnancy involves any Fourteenth Amendment liberty interest (against which Roe and Casey balanced the state interest in preserving fetal life).

According to the majority, no liberty interest is present—because (and only because) the law offered no protection to the woman's choice in the 19th century. But here is the rub. The law also did not then (and would not for ages) protect a wealth of other things. It did not protect the rights recognized in Lawrence and Obergefell to same-sex intimacy and marriage. It did not protect the right recognized in Loving to marry across racial lines. It did not protect the right recognized in Griswold to contraceptive use. For that matter, it did not protect the right recognized in Skinner v. Oklahoma ex rel. Williamson not to be sterilized without consent. So if the majority is right in its legal analysis, all those decisions were wrong, and all those matters properly belong to the States too—whatever the particular state interests involved. And if that is true, it is impossible to understand (as a matter of logic and principle) how the majority can say that its opinion today does not threaten—does not even "undermine"—any number of other constitutional rights.

Nor does it even help just to take the majority at its word. Assume the majority is sincere in saying, for whatever reason, that it will go so far and no further. Scout's honor. Still, the future significance of today's opinion will be decided in the future. And law often has a way of evolving without regard to original intentions—a way of actually following where logic leads, rather than tolerating hard-to-explain lines. Rights can expand in that way. Dissenting in Lawrence, Justice Scalia explained why he took no comfort in the Court's statement that a decision recognizing the right to same-sex intimacy did "not involve" same-sex marriage. That could be true, he wrote, "only if one entertains the belief that principle and logic have nothing to do with the decisions of this Court." Score one for the dissent, as a matter of prophecy. And logic and principle are not one-way ratchets. Rights can contract in the same way and for the same reason—because

whatever today's majority might say, one thing really does lead to another. We fervently hope that does not happen because of today's decision. We hope that we will not join Justice Scalia in the book of prophets. But we cannot understand how anyone can be confident that today's opinion will be the last of its kind.

Consider, as our last word on this issue, contraception. The Constitution, of course, does not mention that word. And there is no historical right to contraception, of the kind the majority insists on. To the contrary, the American legal landscape in the decades after the Civil War was littered with bans on the sale of contraceptive devices. So again, there seem to be two choices. If the majority is serious about its historical approach, then Griswold and its progeny are in the line of fire too. Or if it is not serious, then . . . what is the basis of today's decision? If we had to guess, we suspect the prospects of this Court approving bans on contraception are low. But once again, the future significance of today's opinion will be decided in the future. At the least, today's opinion will fuel the fight to get contraception, and any other issues with a moral dimension, out of the Fourteenth Amendment and into state legislatures.

Anyway, today's decision, taken on its own, is catastrophic enough. As a matter of constitutional method, the majority's commitment to replicate in 2022 every view about the meaning of liberty held in 1868 has precious little to recommend it. Our law in this constitutional sphere, as in most, has for decades upon decades proceeded differently. It has considered fundamental constitutional principles, the whole course of the Nation's history and traditions, and the step-by-step evolution of the Court's precedents.

As a matter of constitutional substance, the majority's opinion has all the flaws its method would suggest. Because laws in 1868 deprived women of any control over their bodies, the majority approves States doing so today. Because those laws prevented women from charting the course of their own lives, the majority says States can do the same again. Because in 1868, the government could tell a pregnant woman—even in the first days of her pregnancy—that she could do nothing but bear a child, it can once more impose that command. Today's decision strips women of agency over what even the majority agrees is a contested and contestable moral issue. It forces her to carry out the State's will, whatever the circumstances and whatever the harm it will wreak on her and her family. In the Fourteenth Amendment's terms, it takes away her liberty. Even before we get to stare decisis, we dissent.

II

By overruling Roe, Casey, and more than 20 cases reaffirming or applying the constitutional right to abortion, the majority abandons stare decisis, a principle central to the rule of law. "Stare decisis" means to stand by things decided. Stare decisis promotes the evenhanded, predictable, and consistent development of legal principles. It maintains a stability that allows people to order their lives under the law.

Stare decisis also "contributes to the integrity of our constitutional system of government" by ensuring that decisions are founded in the law rather than in the proclivities of individuals. That is why, the story goes, Chief Justice John Marshall donned a plain black robe when he swore the oath of office. That act personified an American tradition. Judges' personal preferences do not make law; rather, the law speaks through them.

That means the Court may not overrule a decision, even a constitutional one, without a "special justification."

The majority today lists some 30 of our cases as overruling precedent, and argues that they support overruling Roe and Casey. But none does[.] In some, the Court only partially modified or clarified a precedent. And in the rest, the Court relied on one or more of the traditional stare decisis factors in reaching its conclusion. The Court found, for example, (1) a change in legal doctrine that undermined or made obsolete the earlier decision; (2) a factual change that had the same effect; or (3) an absence of reliance because the earlier decision was less than a decade old. None of those factors apply here: Nothing—and in particular, no significant legal or factual change—supports overturning a half-century of settled law giving women control over their reproductive lives.

First, for all the reasons we have given, Roe and Casey were correct. In holding that a State could not "resolve" the debate about abortion "in such a definitive way that a woman lacks all choice in the matter," the Court protected women's liberty and women's equality in a way comporting with our Fourteenth Amendment precedents. Contrary to the majority's view, the legal status of abortion in the 19th century does not weaken those decisions. And the majority's repeated refrain about "usurp[ing]" state legislatures' "power to address" a publicly contested question does not help it on the key issue here. To repeat: The point of a right is to shield individual actions and decisions from the vicissitudes of political controversy, to place them beyond the reach of majorities and officials and to establish them as legal principles to be applied by the courts. However divisive, a right is not at the people's mercy.

In any event "[w]hether or not we . . . agree" with a prior precedent is the beginning, not the end, of our analysis—and the remaining principles of stare decisis weigh heavily against overruling. Casey itself applied those principles, in one of this Court's most important precedents about precedent. The standards Roe and Casey set out are perfectly workable. No changes in either law or fact have eroded the two decisions. And tens of millions of American women have relied, and continue to rely, on the right to choose. So under traditional stare decisis principles, the majority has no special justification for the harm it causes.

And indeed, the majority comes close to conceding that point. The majority barely mentions any legal or factual changes that have occurred since Roe and Casey. It suggests that the two decisions are hard for courts to implement, but cannot prove its case. In the end, the majority says, all it must say to override stare decisis is one thing:

that it believes Roe and Casey "egregiously wrong." That rule could equally spell the end of any precedent with which a bare majority of the present Court disagrees.

So how does that approach prevent the "scale of justice" from "waver[ing] with every new judge's opinion?" It does not. It makes radical change too easy and too fast, based on nothing more than the new views of new judges. The majority has overruled Roe and Casey for one and only one reason: because it has always despised them, and now it has the votes to discard them. The majority thereby substitutes a rule by judges for the rule of law.

A

Contrary to the majority's view, there is nothing unworkable about Casey's "undue burden" standard. Its primary focus on whether a State has placed a "substantial obstacle" on a woman seeking an abortion is "the sort of inquiry familiar to judges across a variety of contexts." And it has given rise to no more conflict in application than many standards this Court and others unhesitatingly apply every day.

General standards, like the undue burden standard, are ubiquitous in the law, and particularly in constitutional adjudication. When called on to give effect to the Constitution's broad principles, this Court often crafts flexible standards that can be applied case-by-case to a myriad of unforeseeable circumstances. So, for example, the Court asks about undue or substantial burdens on speech, on voting, and on interstate commerce. The Casey undue burden standard is the same. It also resembles general standards that courts work with daily in other legal spheres—like the "rule of reason" in antitrust law or the "arbitrary and capricious" standard for agency decisionmaking. Applying general standards to particular cases is, in many contexts, just what it means to do law.

And the undue burden standard has given rise to no unusual difficulties. Of course, it has provoked some disagreement among judges. Casey knew it would: That much is "to be expected in the application of any legal standard which must accommodate life's complexity." Which is to say: That much is to be expected in the application of any legal standard. But the majority vastly overstates the divisions among judges applying the standard. We count essentially two. THE CHIEF JUSTICE disagreed with other Justices in the June Medical majority about whether Casey called for weighing the benefits of an abortion regulation against its burdens. As for lower courts, there is now a one-year-old, one-to-one Circuit split about how the undue burden standard applies to state laws that ban abortions for certain reasons, like fetal abnormality. That is about it, as far as we can see. And that is not much. This Court mostly does not even grant certiorari on one-year-old, one-to-one Circuit splits, because we know that a bit of disagreement is an inevitable part of our legal system. To borrow an old saying that might apply here: Not one or even a couple of swallows can make the majority's summer.

Anyone concerned about workability should consider the majority's substitute standard. The majority says a law regulating or banning abortion "must be sustained if there is a rational basis on which the legislature could have thought that it would serve legitimate state interests." And the majority lists interests like "respect for and preservation of prenatal life," "protection of maternal health," elimination of certain "medical procedures," "mitigation of fetal pain," and others. This Court will surely face critical questions about how that test applies. Must a state law allow abortions when necessary to protect a woman's life and health? And if so, exactly when? How much risk to a woman's life can a State force her to incur, before the Fourteenth Amendment's protection of life kicks in? Suppose a patient with pulmonary hypertension has a 30-to-50 percent risk of dying with ongoing pregnancy; is that enough? And short of death, how much illness or injury can the State require her to accept, consistent with the Amendment's protection of liberty and equality? Further, the Court may face questions about the application of abortion regulations to medical care most people view as quite different from abortion. What about the morning-after pill? IUDs? In vitro fertilization? And how about the use of dilation and evacuation or medication for miscarriage management?

Finally, the majority's ruling today invites a host of questions about interstate conflicts. Can a State bar women from traveling to another State to obtain an abortion? Can a State prohibit advertising out-of-state abortions or helping women get to out-of-state providers? Can a State interfere with the mailing of drugs used for medication abortions? The Constitution protects travel and speech and interstate commerce, so today's ruling will give rise to a host of new constitutional questions. Far from removing the Court from the abortion issue, the majority puts the Court at the center of the coming "interjurisdictional abortion wars."

In short, the majority does not save judges from unwieldy tests or extricate them from the sphere of controversy. To the contrary, it discards a known, workable, and predictable standard in favor of something novel and probably far more complicated. It forces the Court to wade further into hotly contested issues, including moral and philosophical ones, that the majority criticizes Roe and Casey for addressing.

B

When overruling constitutional precedent, the Court has almost always pointed to major legal or factual changes undermining a decision's original basis. A review of the Appendix to this dissent proves the point. See infra, at ————. Most "successful proponent[s] of overruling precedent," this Court once said, have carried "the heavy burden of persuading the Court that changes in society or in the law dictate that the values served by stare decisis yield in favor of a greater objective." But it is not so today. Although nodding to some arguments others have made about "modern developments," the majority does not really rely on them, no doubt seeing their slimness. The majority briefly invokes the current controversy over abortion. But it has to acknowledge that the same dispute has existed for decades: Conflict over abortion is not a change but a

constant. (And as we will later discuss, the presence of that continuing division provides more of a reason to stick with, than to jettison, existing precedent.) In the end, the majority throws longstanding precedent to the winds without showing that anything significant has changed to justify its radical reshaping of the law.

1

Subsequent legal developments have only reinforced Roe and Casey. The Court has continued to embrace all the decisions Roe and Casey cited, decisions which recognize a constitutional right for an individual to make her own choices about "intimate relationships, the family," and contraception. Roe and Casey have themselves formed the legal foundation for subsequent decisions protecting these profoundly personal choices. In sum, Roe and Casey are inextricably interwoven with decades of precedent about the meaning of the Fourteenth Amendment. While the majority might wish it otherwise, Roe and Casey are the very opposite of "obsolete constitutional thinking."

Moreover, no subsequent factual developments have undermined Roe and Casey. Women continue to experience unplanned pregnancies and unexpected developments in pregnancies. Pregnancies continue to have enormous physical, social, and economic consequences. Even an uncomplicated pregnancy imposes significant strain on the body, unavoidably involving significant physiological change and excruciating pain. For some women, pregnancy and childbirth can mean life-altering physical ailments or even death. Today, as noted earlier, the risks of carrying a pregnancy to term dwarf those of having an abortion. Experts estimate that a ban on abortions increases maternal mortality by 21 percent, with white women facing a 13 percent increase in maternal mortality while black women face a 33 percent increase. Pregnancy and childbirth may also impose large-scale financial costs. The majority briefly refers to arguments about changes in laws relating to healthcare coverage, pregnancy discrimination, and family leave. Many women, however, still do not have adequate healthcare coverage before and after pregnancy; and, even when insurance coverage is available, healthcare services may be far away. Women also continue to face pregnancy discrimination that interferes with their ability to earn a living. Paid family leave remains inaccessible to many who need it most. Only 20 percent of private-sector workers have access to paid family leave, including a mere 8 percent of workers in the bottom quartile of wage earners.

The majority briefly notes the growing prevalence of safe haven laws and demand for adoption, but, to the degree that these are changes at all, they too are irrelevant. Neither reduces the health risks or financial costs of going through pregnancy and childbirth. Moreover, the choice to give up parental rights after giving birth is altogether different from the choice not to carry a pregnancy to term. The reality is that few women denied an abortion will choose adoption. The vast majority will continue, just as in Roe and Casey's time, to shoulder the costs of childrearing. Whether or not they choose to parent, they will experience the profound loss of autonomy and dignity that coerced pregnancy and birth always impose.

Mississippi's own record illustrates how little facts on the ground have changed since Roe and Casey, notwithstanding the majority's supposed "modern developments." Sixty-two percent of pregnancies in Mississippi are unplanned, yet Mississippi does not require insurance to cover contraceptives and prohibits educators from demonstrating proper contraceptive use. The State neither bans pregnancy discrimination nor requires provision of paid parental leave. It has strict eligibility requirements for Medicaid and nutrition assistance, leaving many women and families without basic medical care or enough food. Although 86 percent of pregnancy-related deaths in the State are due to postpartum complications, Mississippi rejected federal funding to provide a year's worth of Medicaid coverage to women after giving birth. Perhaps unsurprisingly, health outcomes in Mississippi are abysmal for both women and children. Mississippi has the highest infant mortality rate in the country, and some of the highest rates for preterm birth, low birthweight, cesarean section, and maternal death. It is approximately 75 times more dangerous for a woman in the State to carry a pregnancy to term than to have an abortion. We do not say that every State is Mississippi, and we are sure some have made gains since Roe and Casey in providing support for women and children. But a state-by-state analysis by public health professionals shows that States with the most restrictive abortion policies also continue to invest the least in women's and children's health.

The only notable change we can see since Roe and Casey cuts in favor of adhering to precedent: It is that American abortion law has become more and more aligned with other nations. The majority, like the Mississippi Legislature, claims that the United States is an extreme outlier when it comes to abortion regulation. The global trend, however, has been toward increased provision of legal and safe abortion care. A number of countries, including New Zealand, the Netherlands, and Iceland, permit abortions up to a roughly similar time as Roe and Casey set. Canada has decriminalized abortion at any point in a pregnancy. Most Western European countries impose restrictions on abortion after 12 to 14 weeks, but they often have liberal exceptions to those time limits, including to prevent harm to a woman's physical or mental health. They also typically make access to early abortion easier, for example, by helping cover its cost. Perhaps most notable, more than 50 countries around the world—in Asia, Latin America, Africa, and Europe—have expanded access to abortion in the past 25 years. In light of that worldwide liberalization of abortion laws, it is American States that will become international outliers after today.

In sum, the majority can point to neither legal nor factual developments in support of its decision. Nothing that has happened in this country or the world in recent decades undermines the core insight of Roe and Casey. It continues to be true that, within the constraints those decisions established, a woman, not the government, should choose whether she will bear the burdens of pregnancy, childbirth, and parenting.

2

In support of its holding, the majority invokes two watershed cases overruling prior constitutional precedents: West Coast Hotel Co. v. Parrish and Brown v. Board of

Education. But those decisions, unlike today's, responded to changed law and to changed facts and attitudes that had taken hold throughout society. As Casey recognized, the two cases are relevant only to show—by stark contrast—how unjustified overturning the right to choose is.

West Coast Hotel overruled Adkins v. Children's Hospital of D. C., and a whole line of cases beginning with Lochner v. New York. Adkins had found a state minimum-wage law unconstitutional because, in the Court's view, the law interfered with a constitutional right to contract. But then the Great Depression hit, bringing with it unparalleled economic despair. The experience undermined—in fact, it disproved—Adkins's assumption that a wholly unregulated market could meet basic human needs. And since Adkins was decided, the law had also changed. In several decisions, the Court had started to recognize the power of States to implement economic policies designed to enhance their citizens' economic well-being. There was no escaping the need for Adkins to go.

Brown v. Board of Education overruled Plessy v. Ferguson, along with its doctrine of "separate but equal." Segregation was not, and could not ever be, consistent with the Reconstruction Amendments, ratified to give the former slaves full citizenship. Whatever might have been thought in Plessy's time, the Brown Court explained, both experience and modern authority showed the detrimental effects of state-sanctioned segregation: It affected children's hearts and minds in a way unlikely ever to be undone. By that point, too, the law had begun to reflect that understanding. In a series of decisions, the Court had held unconstitutional public graduate schools' exclusion of black students. The logic of those cases, Brown held, applied with added force to children in grade and high schools. Changed facts and changed law required Plessy's end.

The majority says that in recognizing those changes, we are implicitly supporting the half-century interlude between Plessy and Brown. That is not so. First, if the Brown Court had used the majority's method of constitutional construction, it might not ever have overruled Plessy, whether 5 or 50 or 500 years later. Brown thought that whether the ratification-era history supported desegregation was "[a]t best . . . inconclusive." But even setting that aside, we are not saying that a decision can never be overruled just because it is terribly wrong. Both Barnette and Brown, moreover, share another feature setting them apart from the Court's ruling today. They protected individual rights with a strong basis in the Constitution's most fundamental commitments; they did not, as the majority does here, take away a right that individuals have held, and relied on, for 50 years. To take that action based on a new and bare majority's declaration that two Courts got the result egregiously wrong? And to justify that action by reference to . . . Brown—a case in which the Chief Justice also wrote an (11-page) opinion in which the entire Court could speak with one voice? These questions answer themselves. Casey itself addressed both West Coast Hotel and Brown, and found that neither supported Roe's overruling.

Roe and Casey continue to reflect, not diverge from, broad trends in American society. It is, of course, true that many Americans, including many women, opposed

those decisions when issued and do so now as well. Yet the fact remains: Roe and Casey were the product of a profound and ongoing change in women's roles in the latter part of the 20th century. By 1973, when the Court decided Roe, fundamental social change was underway regarding the place of women—and the law had begun to follow. See Reed v. Reed (1971) (recognizing that the Equal Protection Clause prohibits sex-based discrimination). By 1992, when the Court decided Casey, the traditional view of a woman's role as only a wife and mother was "no longer consistent with our understanding of the family, the individual, or the Constitution." Under that charter, Casey understood, women must take their place as full and equal citizens. And for that to happen, women must have control over their reproductive decisions. Nothing since Casey—no changed law, no changed fact—has undermined that promise.

C

The reasons for retaining Roe and Casey gain further strength from the overwhelming reliance interests those decisions have created. Casey understood that to deny individuals' reliance on Roe was to refuse to face the facts. Today the majority refuses to face the facts. The most striking feature of the [majority] is the absence of any serious discussion" of how its ruling will affect women. By characterizing Casey's reliance arguments as "generalized assertions about the national psyche," it reveals how little it knows or cares about women's lives or about the suffering its decision will cause.

In Casey, the Court observed that for two decades individuals have organized intimate relationships and made significant life choices "in reliance on the availability of abortion in the event that contraception should fail." Over another 30 years, that reliance has solidified. Indeed, all women now of childbearing age have grown up expecting that they would be able to avail themselves of Roe's and Casey's protections.

The disruption of overturning Roe and Casey will therefore be profound. Abortion is a common medical procedure and a familiar experience in women's lives. About 18 percent of pregnancies in this country end in abortion, and about one quarter of American women will have an abortion before the age of 45. Those numbers reflect the predictable and life-changing effects of carrying a pregnancy, giving birth, and becoming a parent. Women may count on abortion access for when contraception fails. They may count on abortion access for when contraception cannot be used, for example, if they were raped. They may count on abortion for when something changes in the midst of a pregnancy, whether it involves family or financial circumstances, unanticipated medical complications, or heartbreaking fetal diagnoses. Taking away the right to abortion, as the majority does today, destroys all those individual plans and expectations. In so doing, it diminishes women's opportunities to participate fully and equally in the Nation's political, social, and economic life.

The majority's response to these obvious points exists far from the reality American women actually live. The majority proclaims that "reproductive planning could take virtually immediate account of any sudden restoration of state authority to ban

abortions." The facts are: 45 percent of pregnancies in the United States are unplanned. Even the most effective contraceptives fail, and effective contraceptives are not universally accessible. Not all sexual activity is consensual and not all contraceptive choices are made by the party who risks pregnancy. The Mississippi law at issue here, for example, has no exception for rape or incest, even for underage women. Finally, the majority ignores, as explained above, that some women decide to have an abortion because their circumstances change during a pregnancy. Human bodies care little for hopes and plans. Events can occur after conception, from unexpected medical risks to changes in family circumstances, which profoundly alter what it means to carry a pregnancy to term. In all these situations, women have expected that they will get to decide, perhaps in consultation with their families or doctors but free from state interference, whether to continue a pregnancy. For those who will now have to undergo that pregnancy, the loss of Roe and Casey could be disastrous.

That is especially so for women without money. In States that bar abortion, women of means will still be able to travel to obtain the services they need. It is women who cannot afford to do so who will suffer most. These are the women most likely to seek abortion care in the first place. Women living below the federal poverty line experience unintended pregnancies at rates five times higher than higher income women do, and nearly half of women who seek abortion care live in households below the poverty line. Even with Roe's protection, these women face immense obstacles to raising the money needed to obtain abortion care early in their pregnancy. After today, in States where legal abortions are not available, they will lose any ability to obtain safe, legal abortion care. They will not have the money to make the trip necessary; or to obtain childcare for that time; or to take time off work. Many will endure the costs and risks of pregnancy and giving birth against their wishes. Others will turn in desperation to illegal and unsafe abortions. They may lose not just their freedom, but their lives.

Finally, the expectation of reproductive control is integral to many women's identity and their place in the Nation. It reflects that she is an autonomous person, and that society and the law recognize her as such. Like many constitutional rights, the right to choose situates a woman in relationship to others and to the government. It helps define a sphere of freedom, in which a person has the capacity to make choices free of government control. As Casey recognized, the right "order[s]" her "thinking" as well as her "living." Beyond any individual choice about residence, or education, or career, her whole life reflects the control and authority that the right grants.

Withdrawing a woman's right to choose whether to continue a pregnancy does not mean that no choice is being made. It means that a majority of today's Court has wrenched this choice from women and given it to the States. Women have relied on Roe and Casey in this way for 50 years. Many have never known anything else. When Roe and Casey disappear, the loss of power, control, and dignity will be immense.

The Court's failure to perceive the whole swath of expectations Roe and Casey created reflects an impoverished view of reliance. According to the majority, a reliance

interest must be "very concrete," like those involving "property" or "contract." While many of this Court's cases addressing reliance have been in the commercial context, none holds that interests must be analogous to commercial ones to warrant stare decisis protection. This unprecedented assertion is, at bottom, a radical claim to power. By disclaiming any need to consider broad swaths of individuals' interests, the Court arrogates to itself the authority to overrule established legal principles without even acknowledging the costs of its decisions for the individuals who live under the law, costs that this Court's stare decisis doctrine instructs us to privilege when deciding whether to change course.

The majority claims that the reliance interests women have in Roe and Casey are too "intangible" for the Court to consider, even if it were inclined to do so. This is to ignore as judges what we know as men and women. The interests women have in Roe and Casey are perfectly, viscerally concrete. Countless women will now make different decisions about careers, education, relationships, and whether to try to become pregnant than they would have when Roe served as a backstop. Other women will carry pregnancies to term, with all the costs and risk of harm that involves, when they would previously have chosen to obtain an abortion. For millions of women, Roe and Casey have been critical in giving them control of their bodies and their lives. Closing our eyes to the suffering today's decision will impose will not make that suffering disappear.

More broadly, the majority's approach to reliance cannot be reconciled with our Nation's understanding of constitutional rights. The majority's insistence on a "concrete," economic showing would preclude a finding of reliance on a wide variety of decisions recognizing constitutional rights—such as the right to express opinions, or choose whom to marry, or decide how to educate children. To recognize that people have relied on these rights is not to dabble in abstractions, but to acknowledge some of the most "concrete" and familiar aspects of human life and liberty.

All those rights, like the one here, also have a societal dimension, because of the role constitutional liberties play in our structure of government. Rescinding an individual right in its entirety and conferring it on the State, an action the Court takes today for the first time in history, affects all who have relied on our constitutional system of government and its structure of individual liberties protected from state oversight. Roe and Casey have of course aroused controversy and provoked disagreement. But the right those decisions conferred and reaffirmed is part of society's understanding of constitutional law and of how the Court has defined the liberty and equality that women are entitled to claim.

After today, young women will come of age with fewer rights than their mothers and grandmothers had. The majority accomplishes that result without so much as considering how women have relied on the right to choose or what it means to take that right away. The majority's refusal even to consider the life-altering consequences of reversing Roe and Casey is a stunning indictment of its decision.

D

One last consideration counsels against the majority's ruling: the very controversy surrounding Roe and Casey. The majority accuses Casey of acting outside the bounds of the law to quell the conflict over abortion—of imposing an unprincipled "settlement" of the issue in an effort to end "national division." But that is not what Casey did. As shown above, Casey applied traditional principles of stare decisis—which the majority today ignores—in reaffirming Roe. Casey carefully assessed changed circumstances (none) and reliance interests (profound). It considered every aspect of how Roe's framework operated. It adhered to the law in its analysis, and it reached the conclusion that the law required. True enough that Casey took notice of the "national controversy" about abortion: The Court knew in 1992, as it did in 1973, that abortion was a "divisive issue." But Casey's reason for acknowledging public conflict was the exact opposite of what the majority insinuates. Casey addressed the national controversy in order to emphasize how important it was, in that case of all cases, for the Court to stick to the law. Would that today's majority had done likewise.

Here, more than anywhere, the Court needs to apply the law—particularly the law of stare decisis. Here, we know that citizens will continue to contest the Court's decision, because "[m]en and women of good conscience" deeply disagree about abortion. When that contestation takes place—but when there is no legal basis for reversing course—the Court needs to be steadfast, to stand its ground. That is what the rule of law requires. And that is what respect for this Court depends on.

Justice Jackson once called a decision he dissented from a "loaded weapon," ready to hand for improper uses. Korematsu v. United States (1944). We fear that today's decision, departing from stare decisis for no legitimate reason, is its own loaded weapon. Weakening stare decisis threatens to upend bedrock legal doctrines, far beyond any single decision. Weakening stare decisis creates profound legal instability. And as Casey recognized, weakening stare decisis in a hotly contested case like this one calls into question this Court's commitment to legal principle. It makes the Court appear not restrained but aggressive, not modest but grasping. In all those ways, today's decision takes aim, we fear, at the rule of law.

III

"Power, not reason, is the new currency of this Court's decisionmaking." Roe has stood for fifty years. Casey, a precedent about precedent specifically confirming Roe, has stood for thirty. And the doctrine of stare decisis—a critical element of the rule of law—stands foursquare behind their continued existence. The right those decisions established and preserved is embedded in our constitutional law, both originating in and leading to other rights protecting bodily integrity, personal autonomy, and family relationships. The abortion right is also embedded in the lives of women—shaping their expectations, influencing their choices about relationships and work, supporting (as all reproductive rights do) their social and economic equality. Since the right's recognition (and

affirmation), nothing has changed to support what the majority does today. Neither law nor facts nor attitudes have provided any new reasons to reach a different result than Roe and Casey did. All that has changed is this Court.

Mississippi—and other States too—knew exactly what they were doing in ginning up new legal challenges to Roe and Casey. The 15-week ban at issue here was enacted in 2018. Other States quickly followed: Between 2019 and 2021, eight States banned abortion procedures after six to eight weeks of pregnancy, and three States enacted all-out bans. Mississippi itself decided in 2019 that it had not gone far enough: The year after enacting the law under review, the State passed a 6-week restriction. A state senator who championed both Mississippi laws said the obvious out loud. "[A] lot of people thought," he explained, that "finally, we have" a conservative Court "and so now would be a good time to start testing the limits of Roe." In its petition for certiorari, the State had exercised a smidgen of restraint. But as Mississippi grew ever more confident in its prospects, it resolved to go all in. It urged the Court to overrule Roe and Casey. Nothing but everything would be enough.

Earlier this Term, this Court signaled that Mississippi's stratagem would succeed. Texas was one of the fistful of States to have recently banned abortions after six weeks of pregnancy. It added to that "flagrantly unconstitutional" restriction an unprecedented scheme to "evade judicial scrutiny." And five Justices acceded to that cynical maneuver. They let Texas defy this Court's constitutional rulings, nullifying Roe and Casey ahead of schedule in the Nation's second largest State.

And now the other shoe drops, courtesy of that same five-person majority. (We believe that THE CHIEF JUSTICE's opinion is wrong too, but no one should think that there is not a large difference between upholding a 15-week ban on the grounds he does and allowing States to prohibit abortion from the time of conception.) Now a new and bare majority of this Court—acting at practically the first moment possible—overrules Roe and Casey. It converts a series of dissenting opinions expressing antipathy toward Roe and Casey into a decision greenlighting even total abortion bans. It eliminates a 50-year-old constitutional right that safeguards women's freedom and equal station. It breaches a core rule-of-law principle, designed to promote constancy in the law. In doing all of that, it places in jeopardy other rights, from contraception to same-sex intimacy and marriage. And finally, it undermines the Court's legitimacy.

Casey itself made the last point in explaining why it would not overrule Roe—though some members of its majority might not have joined Roe in the first instance. O'Connor, Kennedy, and Souter were judges of wisdom. They would not have won any contests for the kind of ideological purity some court watchers want Justices to deliver. But if there were awards for Justices who left this Court better than they found it? And who for that reason left this country better? And the rule of law stronger? Sign those Justices up.

They knew that "the legitimacy of the Court [is] earned over time." They also would have recognized that it can be destroyed much more quickly. They worked hard to avert that outcome in Casey. The American public, they thought, should never conclude that its constitutional protections hung by a thread—that a new majority, adhering to a new doctrinal school, could by dint of numbers alone expunge their rights. It is hard—no, it is impossible—to conclude that anything else has happened here. In overruling Roe and Casey, this Court betrays its guiding principles.

With sorrow—for this Court, but more, for the many millions of American women who have today lost a fundamental constitutional protection—we dissent.

Notes

1. *Mapping the opinions.* When one deals with a decision this profound from both a legal and health perspective, the first step may be simply to map the opinions in one's brain to understand the theory of each argument being made.

- The majority opinion seems to be saying something like this: Abortion presents an immense moral dilemma that society must grapple with, but it will not do so until the Court takes its thumb off the scales, excises abortion from the Constitution as a protected right, and throws abortion—like any medical care matter—back to state regulation and the democratic process, where it can be resolved through political processes. It's not the Court's role to choose the winner, and nothing about *stare decisis* compels the opposite conclusion; indeed (according to the majority) one can point to many precedents in which the Court correctly abandoned *stare decisis* to correct a prior error in judgment (such as *Plessy*) that had triggered terrible legal and social consequences.

- Justice Thomas seems to argue for a complete rethinking of the legal doctrine of substantive due process that, according to him, had gotten the Court into such hot water, to begin with.

- Justice Kavanaugh (rumored to be under the most intense pressure to join the members of the Court who would maintain some level of abortion rights) seemingly wants to throw up some guardrails for the epic battles that are destined to follow the decision to overrule Roe and Casey. He does this by signaling those situations in which he would oppose legislative efforts to bar certain types of personal conduct such as interstate travel. If a certain type of medical care is legal in one state but not in another, for example, people should be able to travel to a state where the care is available in order to obtain it—sort of like being able to get eyeglasses cheaply because opticians are permitted to do simple prescribing in a different state, versus having to deal with the exorbitant cost of eyeglasses in one's home state because prescribing is restricted to ophthalmologists.

- For his part, Chief Justice Roberts is searching for a compromise that can hold the Court—not to mention society—together. To this end, he seems to recognize that abortion is, in fact, different from prescribing eyeglasses and that, as a result, the better course is to update *Casey* with a newer, less protective "reasonable opportunity" standard that nevertheless provides a more modern and more workable middle ground that affords greater legislative action to protect State interests, as he defines them, while preserving a woman's freedom to choose.

- The dissent argues that the majority has exercised its raw power to simply rip away a right that it despises, that the decision should be understood for what it is (a teeing up of a whole series of decisions previewed in opinions by Justice Thomas), and that the majority decision violates every principle of judicial humility and prudence, not to mention public acceptance of the Court's use of its immense power to reshape society through legal rulings that are the supreme law of the land.

During oral argument, the Chief Justice attempted to road test his idea and got absolutely no takers. This is something that proponents of protecting abortion rights (both on and off the Court) may now regret, although they may have concluded that Justice Kavanaugh, perceived as a swing vote, already was lost and that there was no reason to give ground. Potentially they believed that ultimately a majority of the Justices would respect the doctrine of *stare decisis* sufficiently to preserve *Casey* albeit with certain limitations to be determined. We will never know.

2. *Putting the genie back in the bottle: will the Court be forced to revisit its own radical step?* Of course, were Congress to enact a constitutional amendment restoring rights conferred by *Casey and* were a sufficient number of states to ratify such an amendment, a federal constitutional protection of abortion would be restored. Obviously, this is not likely to happen any time soon.

A state could add such an amendment to its own state constitution, although as of July 1, 2022, it appears that only four states have acted at the state constitutional level. In these four states, the constitutional provision in question explicitly provides that nothing in the constitution secures or protects abortion rights nor permits public funds to be used for abortion. Guttmacher Institute, Abortion Policy in the Absence of Roe (July 1, 2022), https://www.guttmacher.org/state-policy/explore/abortion-policy-absence-roe. At the same time, in numerous states, abortion rights advocates are mounting challenges to state bans, asserting that the state's constitution's guarantees of privacy and liberty are broad enough to protect abortion. Cheryl Saenz, Abortion Rights War Shifts to Battles Over State Constitutions, Bloomberg News (June 29, 2022) https://news.bloomberglaw.com/litigation/abortion-rights-war-shifts-to-battles-over-state-constitutions.

Another question is whether, over time, the Court might find itself under immense pressure to mitigate the impact of its decision, perhaps moving toward the Chief Justice's "reasonable opportunity" standard. This could happen if federal constitutional challenges to some of the most extreme state measures begin to move forward; indeed, to the extent that the majority hoped that its decision would allow the Court to wash its hands of abortion, current litigation either underway or under preparation by the latter part of July 2022 is most likely to dash that hope. Indeed, as described below, the Court may soon be confronting crucial questions regarding the conflict between federal statutes regulating hospital emergency care, protective of, among other medical conditions, women in labor, or FDA approval of prescribed drugs and state anti-abortion policies seeking to limit or prevent access to those drugs.

Evidence is mounting regarding the extreme degree to which some states will go in their quest to end abortion. The New York Times offers a daily abortion ban tracker and shows that as of July 22, 2022, 8 states have pre-viability abortion bans in effect with another 5 states having enacted bans blocked by courts. Many of these states appear to be pursuing a total-ban policy—in the case of Oklahoma, from the moment of fertilization—with no exception for rape or incest. In these states, the only surviving exception is to protect the life of pregnant woman; and early signs are that in practice there may be no exception at all given how hard it is to predict medically when "mere" health endangerment becomes life endangerment, and when intervention will be permissible without fear of criminal sanction. J. David Goodman & Azeen Ghorayshi, *Women Face Risks as Doctors Struggle With Medical Exceptions on Abortion*, New York Times (July 20, 2022), https://www.nytimes.com/2022/07/20/us/abortion-save-mothers-life.html?referringSource=articleShare. Some of the state laws attempting to end all abortions may fail to meet even a minimum rationality test because they so endanger health during pregnancy and represent such a fundamental threat to the reasonable practice of medicine. This is especially true for state laws that limit exceptions to life endangerment, impose insurmountable tests on health care providers to prove life endangerment, and allow the state to interfere in the types of basic, rapid medical judgments that pregnancy-related emergencies can demand. State laws may be nothing more than efforts to substitute raw ideology for sensible clinical judgments regarding life, health and when to intervene. Take, for example, a life-endangerment statute that lacks any measure of deference to medical judgment, situations in which health care providers are made to jump through endless levels of justification or where a fetus is judged to be fatally or grievously compromised and evidence drawn from patient care is simply not accepted as final. In short, it may be that in not too long, assertions by Dobb's majority to the contrary, the Court will face a reckoning with the consequences of its decision to equate state regulation of abortion with regulation of eyeglass prescribing.

3. *The absence of a maternity and infant health safety net.* People who become pregnant in the United States face particularly stark consequences. There is no universal right to maternity and infant care; instead, a patchwork of federal and state laws offers highly unstable and imperfect coverage, riddled with limitations and gaps. Nearly 12 percent of women of childbearing age were completely uninsured in 2020. March of

Dimes, Peristats (2020) https://www.marchofdimes.org/peristats/data?reg=99&top=11&stop=154&lev=1&slev=1&obj=18. In some states the proportion of uninsured women is far higher, especially states that either have or else intend to impose a strict ban. As examples, in South Caroline and Georgia, 21 and 20 percent, respectively, of women of reproductive age are uninsured. Robert Wood Johnson Foundation, Marketplace Pulse: The Importance of Coverage in a Post-Dobbs World (2022), https://www.rwjf.org/en/library/research/2022/07/marketplace-pulse-the-importance-of-coverage-in-a-post-dobbs-world.html?rid=003E000001Fd11jIAB&et_cid=2553097.

Given the enormous cost of U.S. medical care, there simply is no way to afford pregnancy without health insurance. In 2022, the average price of maternity care and a simple vaginal delivery ranges from $5000 to $11,000 across states. A cesarean section raises the price to between $7500 and $14,500. Addition Financial, The Average Cost of Having a Baby, https://resources.additionfi.com/average-cost-of-having-a-baby.

And all this assumes that nothing goes wrong during pregnancy, delivery, and what is termed the postpartum period, considered by experts to last many months following delivery. Given the number of underlying health conditions that can arise during pregnancy (or be exacerbated by pregnancy) or the serious (and indeed, life-threatening) complications that pregnancy can trigger, uninsured, pregnant women face much higher exposure. Mattea Romano et al., Postpartum period: Three Distinct but Continuous Phases, J. Perinatal Med. (2010), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3279173/. Indeed, pregnancy carries health risks exponentially greater than abortion. Adebayo Adesomo, Pregnancy is Far More Dangerous Than Abortion, Scientific American, May 2022, https://www.scientificamerican.com/article/pregnancy-is-far-more-dangerous-to-women-than-abortion/ (expert projections regarding the impact on abortion bans on U.S. mortality rates, already the highest among wealthy nations). A report commissioned by Blue Cross Blue Shield of America that examined more than 18 million claims from privately insured births found that between 2014 and 2018, a growing proportion of women were entering pregnancy with preexisting health conditions, the number of women experiencing complications of pregnancy and childbirth rose by over 31 percent, and the number of women diagnosed with postpartum depression rose by nearly 30 percent. Blue Cross and Blue Shield, Trends in Pregnancy and Childbirth Complications in the U.S. https://www.bcbs.com/the-health-of-america/reports/trends-in-pregnancy-and-childbirth-complications-in-the-us#key-findings. Imagine if the study had examined claims involving births insured by Medicaid—the poorest births.

In a nation with exceptionally expensive health care, elevated health risks during pregnancy, and a ferociously restrictive approach to abortion in at least half of the country now—the half, we might add, where people are poorest and the low-income population is disproportionately represented by Black people and other people of color who experience the worst health inequities—a crucial question becomes the quality and reliability of the nation's maternity and infant care system.

Guess what. We don't have a quality, reliable maternity, and infant care system.

The problem starts with insurance coverage. No condition better exemplifies the chaotic nature of the U.S. insurance system than maternity care. The Affordable Care Act mandates that most (but not all) employer plans cover maternity care—employer plans with fewer than 15 full-time employees are not required to do so under the 1978 Pregnancy Discrimination Act. EEOC, 2014, Fact Sheet for Small Businesses, Pregnancy Discrimination, https://www.eeoc.gov/laws/guidance/fact-sheet-small-businesses-pregnancy-discrimination#:~:text=The%20PDA%20and%20ADA%20apply%20to%20employers%20with%2015%20or%20more%20employees. Maternity coverage is required for ACA-compliant individual policies sold on or off the health insurance marketplace, but short-term plans that are not ACA-compliant are not required to do so, and several million people use these short-term plans for their coverage. Kaiser Family Foundation, What services do plans have to cover for pregnancy?, https://www.kff.org/faqs/faqs-health-insurance-marketplace-and-the-aca/what-services-do-plans-have-to-cover-for-pregnant-women/#:~:text=Federal%20law%20requires%20most%20employer,child%20birth%20and%20newborn%20care.

Medicaid paid for 43 percent of all deliveries in 2018, a figure that likely was higher in later years during the pandemic because Medicaid rolls swelled as people lost other forms of health insurance. Medicaid and CHIP Access and Payment Commission, Medicaid's Role in Financing Maternity Care (2020), https://www.macpac.gov/wp-content/uploads/2020/01/Medicaid%E2%80%99s-Role-in-Financing-Maternity-Care.pdf. Federal law requires State Medicaid programs to cover pregnancy-related care for all people with incomes up to 138 percent of the federal poverty level, from the time at which pregnancy is determined through the end of the month in which the 60th postpartum day occurs; the 2021 American Rescue Plan Act provides federal funding for states that extend postpartum coverage for up to 12 months. As of 2022, only 20 states plus the District of Columbia have taken this option. Another 14 have plans to do so or are considering it, leaving one-third of all states with no postpartum coverage after 60 days. Kaiser Family Foundation, Medicaid Postpartum Coverage Extensions: Approved and Pending State Action as of July 21, 2022, https://www.kff.org/medicaid/issue-brief/medicaid-postpartum-coverage-extension-tracker/. Mississippi, where *Dobbs* originated, is one of the states with no plans to extend coverage during the postpartum period although it has the worst poverty and the nation's highest infant mortality rate.

States can extend pregnancy-related income eligibility far higher than the 138 percent threshold to well over 300 percent of poverty ($69,090 in 2022). Yet many states limit pregnancy coverage to an income threshold well below this level; in South Dakota, for example, where the Native Americans rely disproportionately on Medicaid and maternal mortality rates are seriously elevated, eligibility is restricted to the federal minimum. Kaiser Family Foundation, Medicaid and CHIP Income Eligibility Levels for Pregnant Women 2003-2022, https://www.kff.org/medicaid/state-indicator/medicaid-and-chip-income-eligibility-limits-for-pregnant-women/?currentTimeframe=0&selectedDistributions=january-

2022&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. States with abortion bans are more likely to maintain upper-income eligibility thresholds below 200 percent of poverty. Furthermore, although states may extend pregnancy-related Medicaid to recently arrived legal immigrants, only half do so. Kaiser Family Foundation, Medicaid/CHIP Coverage of Lawfully-Residing Immigrant Children and Pregnant Women, https://www.kff.org/health-reform/state-indicator/medicaid-chip-coverage-of-lawfully-residing-immigrant-children-and-pregnant-women/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D. As of 2016, only 16 states funded any level of care for undocumented pregnant women. Jesse Kemmick Pintor & Kathleen Thiede Call, State-Level Immigrant Prenatal Health Care Policy and Inequities in Health Insurance Among Children in Mixed-Status Families, Global Pediatric Health (2019) https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6764026/#:~:text=Despite%20the%20federal%20match%20and,has%20expanded%20access%20since%202008).&text=Figure%201.

Even when pregnant women are insured, care may be impossible to find because severe obstetrical care shortages exist across the entire nation. According to the American College of Obstetricians and Gynecologists (ACOG), in 2020 the nation needed as many as 8,800 more OB-GYNs by 2020, a shortfall predicted to increase to 22,000 by 2050. In 2017, ACOG estimated that half of the U.S. counties lacked any OB-GYN. Joanna Finnegan, Millennial Women Expected To Be Most Impacted by OB-GYN Shortage, Report Says, Fierce Healthcare (2019), https://www.fiercehealthcare.com/practices/millennial-women-expected-to-be-most-impacted-by-ob-gyn-shortage-report-says. The *Dobbs* decision is likely to worsen the existing obstetric workforce shortage by impacting the education of the next generation of physicians who would otherwise provide essential abortion care services.

Dobbs ultimately will affect access for all people who need abortion and pregnancy termination care. In states where abortion bans are in place or soon to emerge, graduate medical education training programs are struggling to navigate if and how to teach these skills, essential for accrediting rising OB-GYN physicians, with the limitations they face. Emory University, for example, is exploring contingency plans to ensure that students, residents, fellows, and providers can train and practice in obstetric care, given Georgia's six-week abortion ban that is scheduled to take effect soon. It is a real possibility that OB-GYN trainees will be required to travel out-of-state for abortion training or that programs will be forced to offer "didactic activities, including simulation," to enable trainees to learn skills and procedures necessary for terminating a pregnancy. Nick Anderson, The fall of Roe Scrambles Abortion Training for University Hospitals, The Washington Post (2022), https://www.washingtonpost.com/education/2022/06/30/abortion-training-upheaval-dobbs/. Approximately 44% of OB-GYN residents are based in states where abortion—and therefore abortion training—is likely to be restricted. Laura Kurtzman, Many Residents Won't Get Abortion Training if Roe Is Overturned, University of California San Francisco (2022), https://www.ucsf.edu/news/2022/04/422741/many-residents-wont-get-abortion-training-if-roe-overturned.

This is the national estimate. Things are much worse for the millions of residents of underserved urban and rural communities, where healthcare shortages are extreme. Many of these communities rely on federally funded community health centers, a major public health investment more than a half century old whose purpose is to make comprehensive primary health care accessible to medically underserved communities and populations. Sara Rosenbaum et al., Community Health Centers: Growing Importance in a Changing Health Care System (Kaiser Family Foundation, 2018) https://www.kff.org/medicaid/issue-brief/community-health-centers-growing-importance-in-a-changing-health-care-system/. Health centers are a major source of maternity care. In 2020, health centers nationwide cared for 1 in 10 low-income births. In the 26 states that either ban pre-viability abortion or are likely to do so, maternity patients are overwhelmingly people of color, who already face disproportionate risks for maternal mortality. One recent analysis finds that health centers are facing critical staffing shortages and that in no state that bans abortion does health center maternity staffing meet minimally accepted provider-to-patient health workforce ratios. Peter Shin et al., In *Dobbs'* Aftermath Are Community Health Centers Prepared To Respond To Rising Maternal and Infant Care Needs? (Milken Institute School of Public Health, July 21, 2022), https://publichealth.gwu.edu/content/dobbs%E2%80%99-aftermath-new-report-examines-maternity-and-infant-care-capacity-community-health.

Beyond health care, pregnant people need nutrition, a safe place to live, basic income support, and other services essential to the health of women and infants. The U.S. provides none of these minimums according to a public health brief heavily cited by the *Dobbs* dissent. The majority opinion, as you may have noticed, fails utterly to acknowledge the health threats flowing from unplanned pregnancy to populations at high risk for underlying health inequalities. Indeed, the issue of women's health simply seemed not to exist as a consideration other than the majority's assertion that times have changed, that women have choices, access to family planning, health insurance when pregnant, and childcare. Of course, for many women, these assertions simply are not true. The public health brief set forth extensive evidence regarding elevated reproductive, maternal, and infant health risks, especially in states that extensively restrict abortion, along with data on the lack of basic supports for the poorest families and children. https://www.supremecourt.gov/DocketPDF/19/19-1392/193302/20210921172339465_19-1392%20Brief.pdf. None of these facts were relevant to the Justices in the majority for whom constitutional analysis turned solely on the nation's history and tradition in the mid-19th Century—or at least their (much refuted) version of that history and tradition.

4. *EMTALA emergency hospital care protections under threat.* The textbook (Part One) reviews the Emergency Medical Treatment and Labor Act (EMTALA), arguably the nation's single most important health care law in protection of access to care for pregnant women. Enacted in 1986 with broad bipartisan support, EMTALA, 42 U.S.C. § 1395dd, aims to ensure that people who seek hospital emergency care will receive an exam and stabilizing treatment prior to discharge or transfer to another facility. The duty imposed on hospitals by EMTALA is tied to hospital participation in Medicare, the single

biggest source of hospital financing; thus, it is uniform and nationwide. Stories of some hospitals' refusal to treat pregnant women experiencing pregnancy-related emergencies contributed to EMTALA's passage, as did a 1984 Texas law tying emergency care to licensure. EMTALA explicitly references emergency care for pregnant women—the only population to hold that distinction. 42 U.S.C. § 1395dd(a)-(c). The United States Department of Health and Human Services is responsible for enforcing EMTALA, which it has elected to do only by means of investigating complaints rather than engaging in active oversight of compliance, meaning that enforcement is driven only by incidents that are reported not by the much larger number of violations that occur but remain unreported.

You should recall from Part One that EMTALA spells out in detail the scope of hospitals' duties. First, a Medicare hospital with an emergency department must screen "any" individual who comes to the hospital and requests care (or a request is made on the individual's behalf). 42 U.S.C. § 1395dd(a) As Part One describes, the purpose of the screening exam is to determine whether an "emergency medical condition" exists. If a mandatory screening exam uncovers an emergency medical condition, then the hospital must stabilize the patient and is barred from transferring an unstable patient unless the transfer is medically appropriate as defined by the law. 42 U.S.C. §§ 1395dd(b) and (c).

An "emergency medical condition" is a condition that in the "absence of immediate medical attention could reasonably be expected to result in placing *the health* of the individual (or, with respect to a pregnant woman, *the health of the woman* or her unborn child) in serious jeopardy" (emphasis added) 42 U.S.C. sec. 1395dd(e). This definition reflects an express rejection of earlier state laws that had confined hospitals' duty to provide emergency care to situations in which life, but not just health, is endangered. The term "stabilize" means that "no material deterioration of the condition is likely, within reasonable medical probability" to occur during transfer. In short, EMTALA commands hospitals to make reasonable efforts to avert morbidity even when mortality is not threatened.

By September 2021 it had become clear that if Roe were repealed some states would prohibit abortion even if a pregnant woman's health was threatened if that abortion were not to be provided. In that context, HHS issued new instructions under EMTALA, https://www.cms.gov/files/document/qso-21-22-hospital.pdf, reminding hospitals of their duty to protect the health of a woman in an emergent situation even if her life was not endangered, as well as notifying them that termination of pregnancy could be the medically reasonable means to stabilize her condition. The September notice attracted little attention—after all, the matter was still academic as of September 2021.

Nine months later, after Dobbs had been decided, the conflict EMTALA's health-protection rule and state laws requiring treatment only if a pregnant woman's life is endangered was no longer just an academic matter. Consequently, on July 8th President Biden issued an Executive Order. https://www.whitehouse.gov/briefing-room/statements-releases/2022/07/08/fact-sheet-president-biden-to-sign-executive-order-protecting-access-to-reproductive-health-care-services/, that, among other matters, directed HHS to

clarify EMTALA's protections for pregnant women. On July 11th, HHS reissued the September 2021 guidance in strengthened form, clarifying that the health-emergency standard under EMTALA is mandatory in all states, https://www.cms.gov/files/document/qso-22-22-hospitals.pdf; HHS also sent a letter to all hospitals participating in Medicare—effectively, all hospitals—explicitly stating that an abortion procedure could be medically necessary to stabilize a pregnant woman in an emergent condition, https://www.hhs.gov/sites/default/files/emergency-medical-care-letter-to-health-care-providers.pdf.

This time the CMS notice did not go unnoticed. On July 14th, obviously anticipating the CMS policy, the state of Texas sued to halt its application. SeeTexas, State of Texas v Becerra, Civ. Act. No 5.22-CV-185 (N.D.Tex). Because the suit was filed in Texas, any appeal, which is all-but guaranteed, of the lower court's decision will be taken to the Fifth Circuit Court of Appeals, perhaps the nation's most conservative and anti-abortion appellate court. Thus far no other state has joined Texas, but intervention by other states is possible.

In its suit, Texas claims that EMTALA's duty is limited by a separate provision of the Social Security Act, 42 U.S.C. § 1395, which states that "[n]othing in this subchapter shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided . . . or to exercise any supervision or control over the administration or operation of any such institution, agency, or person." This provision, titled "Prohibition against any Federal interference," clarifies that Medicare's terms of coverage do not define lawful health care in a state. Thus, for example, the fact that Medicare might permit coverage of in-home rehabilitation care does not mean that rehabilitation therapy in a particular state can be furnished at home, rather than a clinical setting. This general Medicare provision preserving state laws regulating underlying medical practice has no bearing on EMTALA's duty to protect patients' health as an express condition of Medicare participation. Indeed, in Biden v Missouri, 142 S. Ct. 647 (2022), the Supreme Court reiterated the authority of the HHS Secretary to set conditions of Medicare participation for hospitals and health care workers even when state law differs on underlying institutional qualifications. Indeed, the language of EMTALA gives the Secretary no discretion to set an alternative to the health-protection standard.

Think about it: Were the language relied on by Texas construed to give states *carte blanche* to differentiate among types of medical emergencies, applying the health-endangerment to some but denying it to others, such as pregnancy, effectively EMTALA would in this regard be repealed, returning to state law the duties applying to emergent care. EMTALA, however, was passed *precisely* because Congress found that state law needed to be supplanted by federal law. Courts already have held that EMTALA's duty is the supreme law of the land, superseding conflicting federal law without regard to what might be considered as falling within the bounds of standard medical practice in a particular state. See, Main Text, Matter of Baby K, 16 F. 3d 590 (4th Cir. 1994). No state can pick and choose which medical conditions constitute an emergent medical condition, nor can any state dictate the medically appropriate response.

Given that the Fifth Circuit Court of Appeals is known for the wide berth it gives states that seek to nullify federal safeguards for public health, particularly those pertaining to abortion, it is a safe bet that the Supreme Court, which thought it had washed its hands of abortion, might soon find itself embroiled in a life-and-death confrontation over emergency care for pregnant women. As we stated at the outset of this section, this controversy is but one of many that is likely to land at the Court's door.

5. *Dobbs' impact on medical liability for death or injury as a result of failure to act in a medically reasonable fashion.* Under normal principles of medical negligence, a hospital or clinical practice's failure to adhere to reasonable standards of clinical practice in managing pregnancy would result in liability. But what happens when the reasonable medical response is outlawed by a state? Currently, all states banning abortion provide an exception when a pregnant woman's life is endangered. Would a provider be liable for negligence if it failed to follow professional standards of care that require an abortion when the woman's health but not life is endangered? Suppose that a pregnant woman is bleeding from her vagina but is told to go home and return only if she has lost a liter of blood? Is that malpractice? Clinicians are reporting that they already have been forced to significantly change how they practice health care. Women Face Risks as Doctors Struggle With Medical Exceptions on Abortion, op. cit. Can you think of a comparable situation where a state law actually could be read as commanding physicians to behave in a negligent fashion toward their patients or to abandon their proper care? Is such a state law even minimally rational in situations in which there is zero chance of viability and the only life on the line is that of the pregnant woman? Does this type of law pass the Supreme Court's test that state law is constitutional if the state law "could have had a legitimate reason"?

6. *Implications regarding the provision of information regarding abortion.* In the wake of Dobbs may a state constitutionally forbid health care providers or organizations counseling pregnant women regarding their options from providing information about where and how to obtain a legal abortion in another state? Is this aiding and abetting abortion, which is criminal under the some state laws? Can a state outlaw websites that provide general information about where and how to obtain abortions? Legislation introduced in South Carolina would do precisely that, and its pending legislation is considered to be a signal of what other states may attempt. Cat Zakrewski, South Carolina Bill Outlaws Websites That Tell How To Get an Abortion, Washington Post (July 22, 2022), https://www.washingtonpost.com/technology/2022/07/22/south-carolina-bill-abortion-websites/. Is the provision of such information not protected speech under the First Amendment?

How about federally funded family planning clinics, which are obligated as a condition of receiving funding under Title X of the Public Health Service Act, to provide pregnant women with nondirective counseling regarding their options? In Rust v Sullivan, 500 U.S. 173 (1991), the Supreme Court upheld as lawful a condition imposed by the Bush administration on receipt of a federal grant that instituted a "gag rule" barring nondirective counseling. Following the Clinton administration's reversal of this

gag rule, the Trump administration reinstated it. Sara Rosenbaum, The Assault on Family Planning Redux, Milbank Quarterly (May 29, 1918), https://www.milbank.org/quarterly/articles/assault-family-planning-redux/. Following extensive litigation aimed at nullifying the newest version of the gag rule, the Biden administration in late 2021 issued rules repealing the Trump-era iteration and replacing it with regulations that re-establish non-directive counseling as a basic requirement for receipt of federal funding. 86 Fed. Reg. 56144 (October 7, 2021). What happens now in states that prohibit abortion? The clinics' federal grants require that they provide nondirective counseling, which presumably would include information how and where to obtain an abortion legally in another state. Complying with the federal requirement would result in criminal liability in a state that criminalizes the provision of such information as aiding and abetting. Grants under Title X are vital to the survival of such clinics, which are located in medically underserved communities, and the denial of federal funding would obliterate them at a time when access to effective birth control never has been more important to residents of these communities, given that pregnancy can no longer be terminated in their states by abortion. What do you think the federal government will do under these circumstances? Insist on compliance? Waive compliance? As of late July 2022, the Biden administration has yet to provide a formal answer. It is possible that the Biden administration will waive compliance after having worked hard to get the Title X program functional again—thousands of clinics actually did forgo their federal grants in response to the Trump gag rule and the size of the federal network fell by half. Guttmacher Institute, Trump Administration's Domestic Gag Rule has Slashed the Title X Network's Capacity by Half (February 2020), https://www.guttmacher.org/article/2020/02/trump-administrations-domestic-gag-rule-has-slashed-title-x-networks-capacity-half, but no formal answer has been given.

7. *Access to family planning services.* As the dissent in Dobbs emphasizes, and Justice Thomas actually makes explicit, the right to abortion is part of a suite of rights recognized by the Court over decades as integral to the Fourteenth Amendment Due Process guarantee. Chief among these rights is the right to obtain contraception. Because these rights are so inextricably bound together, on July 21, 2022, the House of Representatives passed a bill, H.R. 8373, The Right to Contraception Act (117th Cong., 2d Sess), https://www.congress.gov/117/bills/hr8373/BILLS-117hr8373eh.pdf, that would make use of contraceptives, as well as family-planning counseling, a right under federal statutory law. Annie Karni, *House Passes Bill to Ensure Contraception Rights After Dobbs,* New York Times (July 21, 2022), https://www.nytimes.com/2022/07/21/us/politics/house-contraception.html. The measure garnered only *eight* Republican votes in support and is deemed dead on arrival in the Senate without the support of a filibuster-proof majority. It followed the House's passage of bills protecting same-sex marriage and the right to an abortion, likewise deemed to have no chance of passage in the Senate, although in the House the bill protecting same-sex marriage bill drew significantly more Republican support (47 voted for it) than did the bill protecting access to contraception. Contraception is defined as any drug, device, or biological product "intended for use in the prevention of pregnancy" and includes the full range of FDA-approved methods, including methods that have been labeled as

abortifacients by opponents of abortions because they work by preventing implantation of a fertilized egg. (Oklahoma's abortion ban, the nation's most extreme to date, defines pregnancy as occurring at the time of fertilization). The law establishes a statutory right to seek and provide contraception and authorizes the Attorney General to bring a civil action against any state official or government that violates the provisions of the law.

As you will recall from a description of the Affordable Care Act in Part Two, and as discussed in other parts of this Supplement, the ACA requires qualified health plans to cover all FDA-approved contraceptive methods without cost-sharing. Years of litigation, described elsewhere in this Supplement, have surrounded the question of whether employers can claim a religious exemption from the coverage guarantee; the most recent pronouncement from the Supreme Court is a decision, Little Sisters of the Poor v Pennsylvania, 140 S. Ct. 2367 (2020), which upheld Trump-era rules (still in force) that grant an exemption from the guarantee to any employer that asserts religious or moral opposition to such coverage. People insured through Medicaid, the nation's single largest public insurer, are also entitled to the coverage of comprehensive family planning. Sara Rosenbaum et al., Family Planning and Medicaid Managed Care: Improving Access and Quality Through Integration (George Washington University, 2021), https://publichealth.gwu.edu/sites/default/files/GW-AV%20Family%20Planning%20and%20Medicaid%20Managed%20Care%20Phase%20One%20Report%20Final%20June%202021.pdf. But financial access is, of course, only part of access. If physicians refuse to prescribe certain methods or if pharmacies refuse to stock them, family planning services as a practical matter may then be inaccessible. The network of publicly supported family planning clinics is, as noted, very limited, and in a nation that now authorizes states to ban abortion, obtaining safe, effective, and timely family planning services in those states may be difficult at best.

8. *Abortions by use of medications.* FDA guidelines permit the use of medications to abort pregnancies so long as they are used during the first 10 weeks of pregnancy. Guttmacher Institute, Medication Abortion (July 11, 2022), https://www.guttmacher.org/state-policy/explore/medication-abortion. Many of these medications are also used after miscarriage , when fetal remains must be removed to protect the health and life of the pregnant woman. Before Dobbs, A states total ban on the use of these medications to obtain and abortion has been ruled unconstitutional, but states still impose many restrictions, such as requiring multiple visits and that the medication be used only in the presence of a physician. Some states now allow abortion only if accomplished within 6 weeks of pregnancy, far shorter than the 10-week window specified by the FDA. Litigation in Mississippi, brought by one of the manufacturers of the drug mifepristone, is expected to lead to a ruling on whether states can outlaw the use of an FDA-approved drug within their borders. Genbiopro v Dobbs, S. D. Miss. No. 3:20-cv-00652 (S.D. Miss., 2021).

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 Supplement 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.

* * *

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.

* * *

Insert at textbook, p. 383 following "Notes" and prior to "Note: ERISA Preemption and State Health Reform Efforts":

Rutledge v Pharmaceutical Care Management Association
141 S.Ct. 474 (2020)

Justice Sotomayor delivered the opinion of the Court.

Arkansas' Act 900 regulates the price at which pharmacy benefit managers reimburse pharmacies for the cost of drugs covered by prescription-drug plans. The question presented in this case is whether the Employee Retirement Income Security Act of 1974 (ERISA) pre-empts Act 900. The Court holds that the Act has neither an impermissible connection with nor reference to ERISA and is therefore not pre-empted.

I
A

Pharmacy benefit managers (PBMs) are a little-known but important part of the process by which many Americans get their prescription drugs. Generally speaking, PBMs serve as intermediaries between prescription-drug plans and the pharmacies that beneficiaries use. When a beneficiary of a prescription-drug plan goes to a pharmacy to fill a prescription, the pharmacy checks with a PBM to determine that person's coverage and copayment information. After the beneficiary leaves with his or her prescription, the PBM reimburses the pharmacy for the prescription, less the amount of the beneficiary's copayment. The prescription-drug plan, in turn, reimburses the PBM.

The amount a PBM "reimburses" a pharmacy for a drug is not necessarily tied to how much the pharmacy paid to purchase that drug from a wholesaler. Instead, PBMs' contracts with pharmacies typically set reimbursement rates according to a list specifying the maximum allowable cost (MAC) for each drug. PBMs normally develop and administer their own unique MAC lists. Likewise, the amount that prescription-drug plans reimburse PBMs is a matter of contract between a given plan and a PBM. A PBM's reimbursement from a plan often differs from and exceeds a PBM's reimbursement to a pharmacy. That difference generates a profit for PBMs.

In 2015, Arkansas adopted Act 900 in response to concerns that the reimbursement rates set by PBMs were often too low to cover pharmacies' costs, and that many pharmacies, particularly rural and independent ones, were at risk of losing money and closing. 2015 Ark. Acts no. 900. In effect, Act 900 requires PBMs to reimburse Arkansas pharmacies at a price equal to or higher than that which the pharmacy paid to buy the drug from a wholesaler.

Act 900 accomplishes this result through three key enforcement mechanisms. First, the Act requires PBMs to tether reimbursement rates to pharmacies' acquisition costs by timely updating their MAC lists when drug wholesale prices increase. Second, PBMs must provide administrative appeal procedures for pharmacies to challenge MAC reimbursement prices that are below the pharmacies' acquisition costs. If a pharmacy could not have acquired the drug at a lower price from its typical wholesaler, a PBM must increase its reimbursement rate to cover the pharmacy's acquisition cost. PBMs must also allow pharmacies to "reverse and rebill" each reimbursement claim affected by the pharmacy's inability to procure the drug from its typical wholesaler at a price equal to or less than the MAC reimbursement price. Third, and finally, the Act permits a pharmacy to decline to sell a drug to a beneficiary if the relevant PBM will reimburse the pharmacy at less than its acquisition cost.

B

Respondent Pharmaceutical Care Management Association (PCMA) is a national trade association representing the 11 largest PBMs in the country. After the enactment of Act 900, PCMA filed suit in the Eastern District of Arkansas, alleging, as relevant here, that Act 900 is pre-empted by ERISA.

Before the District Court issued its opinion in response to the parties' cross-motions for summary judgment, the Court of Appeals for the Eighth Circuit decided, in a different case, that ERISA pre-empts a similar Iowa statute. The Eighth Circuit concluded that the Iowa statute was pre-empted for two reasons. First, it made "implicit reference" to ERISA by regulating PBMs that administer benefits for ERISA plans. Second, it was impermissibly "connected with" an ERISA plan because, by requiring an appeal process for pharmacies to challenge PBM reimbursement rates and restricting the sources from which PBMs could determine pricing, the law limited a plan administrator's ability to control the calculation of drug benefits. Concluding that Arkansas' Act 900 contains similar features, the District Court held that ERISA likewise pre-empts Act 900. The Eighth Circuit affirmed. This Court granted certiorari.

II

ERISA pre-empts "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). [A] state law relates to an ERISA plan if it has a connection with or reference to such a plan. Because Act 900 has neither of those impermissible relationships with an ERISA plan, ERISA does not pre-empt it.

A

To determine whether a state law has an "impermissible connection" with an ERISA plan, this Court considers ERISA's objectives as a guide to the scope of the state law that Congress understood would survive. ERISA was enacted to make the benefits

promised by an employer more secure by mandating certain oversight systems and other standard procedures. *Gobeille* v. *Liberty Mut. Ins. Co.*, 577 U. S. 312, 320–321 (2016) [this Supplement, infra]. In pursuit of that goal, Congress sought to ensure that plans and plan sponsors would be subject to a uniform body of benefits law, thereby minimiz[ing] the administrative and financial burden of complying with conflicting directives and ensuring that plans do not have to tailor substantive benefits to the particularities of multiple jurisdictions.

ERISA is therefore primarily concerned with pre-empting laws that require providers to structure benefit plans in particular ways, such as by requiring payment of specific benefits, *Shaw v. Delta Air Lines, Inc.*, or by binding plan administrators to specific rules for determining beneficiary status. *Egelhoff v Egelhoff.* A state law may also be subject to pre-emption if "acute, albeit indirect, economic effects of the state law force an ERISA plan to adopt a certain scheme of substantive coverage." *Gobeille* As a shorthand for these considerations, this Court asks whether a state law governs a central matter of plan administration or interferes with nationally uniform plan administration. If it does, it is pre-empted.

Crucially, not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan. That is especially so if a law merely affects costs. In *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*(1995), this Court addressed a New York law that imposed surcharges of up to 13% on hospital billing rates for patients covered by insurers other than Blue Cross/Blue Shield (Blues). Plans that bought insurance from the Blues therefore paid less for New York hospital services than plans that did not. This Court presumed that the surcharges would be passed on to insurance buyers, including ERISA plans, which in turn would incentivize ERISA plans to choose the Blues over other alternatives in New York. Nevertheless, the Court held that such an "indirect economic influence" did not create an impermissible connection between the New York law and ERISA plans because it did not "bind plan administrators to any particular choice." The law might "affect a plan's shopping decisions, but it [did] not affect the fact that any plan will shop for the best deal it can get." If a plan wished, it could still provide a uniform interstate benefit package.

In short, ERISA does not pre-empt state rate regulations that merely increase costs or alter incentives for ERISA plans without forcing plans to adopt any particular scheme of substantive coverage.

The logic of *Travelers* decides this case. Like the New York surcharge law in *Travelers*, Act 900 is merely a form of cost regulation. It requires PBMs to reimburse pharmacies for prescription drugs at a rate equal to or higher than the pharmacy's acquisition cost. PBMs may well pass those increased costs on to plans, meaning that ERISA plans may pay more for prescription-drug benefits in Arkansas than in, say, Arizona. But cost uniformity was almost certainly not an object of pre-emption. Nor is the effect of Act 900 so acute that it will effectively dictate plan choices. Indeed, Act 900

is less intrusive than the law at issue in *Travelers,* which created a compelling incentive for plans to buy insurance from the Blues instead of other insurers. Act 900, by contrast, applies equally to all PBMs and pharmacies in Arkansas. As a result, Act 900 does not have an impermissible connection with an ERISA plan.

B

Act 900 also does not "refer to" ERISA. A law refers to ERISA if it "acts immediately and exclusively upon ERISA plans or where the existence of ERISA plans is essential to the law's operation." *Gobeille*. Act 900 does not act immediately and exclusively upon ERISA plans because it applies to PBMs whether or not they manage an ERISA plan. Indeed, the Act does not directly regulate health benefit plans at all, ERISA or otherwise. It affects plans only insofar as PBMs may pass along higher pharmacy rates to plans with which they contract.

ERISA plans are likewise not essential to Act 900's operation. Act 900 defines a PBM as any "entity that administers or manages a pharmacy benefits plan or program," and it defines a "pharmacy benefits plan or program," in turn, as any "plan or program that pays for, reimburses, covers the cost of, or otherwise provides for pharmacist services to individuals who reside in or are employed in [Arkansas]." Under those provisions, Act 900 regulates PBMs whether or not the plans they service fall within ERISA's coverage.[92] Act 900 is therefore analogous to the law in *Travelers*, which did not refer to ERISA plans because it imposed surcharges regardless of whether the commercial coverage [was] ultimately secured by an ERISA plan, private purchase, or otherwise.

III

PCMA disagrees that Act 900 amounts to nothing more than cost regulation. It contends that Act 900 has an impermissible connection with an ERISA plan because its enforcement mechanisms both directly affect central matters of plan administration and interfere with nationally uniform plan administration. The mechanisms that PCMA identifies, however, do not require plan administrators to structure their benefit plans in any particular manner, nor do they lead to anything more than potential operational inefficiencies.[93]

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[92] PBMs contract with a variety of healthcare plans and programs that are not covered by ERISA, including Medicaid, Medicare, military, and market place plans.

[93] The Court has found something to be "a central matter of plan administration" only when the matter is addressed by ERISA's text. *Gobeille* v. *Liberty Mut. Ins. Co.* And if the state law interferes with national uniformity but ERISA does not address the matter, we have held that the matter in question does not require uniformity. *Travelers.* We have also held that ERISA does not pre-empt state laws regulating ERISA plans engaging in activity not regulated by ERISA, like running a hospital. *De Buono v. NYSA–ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997). That makes sense because ERISA has nothing to say about those activities.

PCMA first claims that Act 900 affects plan design by mandating a particular pricing methodology for pharmacy benefits. As PCMA reasons, while a plan might prefer that PBMs reimburse pharmacies using a MAC list constructed with an eye toward containing costs and ensuring predictability, Act 900 ignores that preference and instead requires PBMs to reimburse pharmacies based on acquisition costs. But that argument is just a long way of saying that Act 900 regulates reimbursement rates. Requiring PBMs to reimburse pharmacies at or above their acquisition costs does not require plans to provide any particular benefit to any particular beneficiary in any particular way. It simply establishes a floor for the cost of the benefits that plans choose to provide. The plans in *Travelers* might likewise have preferred that their insurers reimburse hospital services without paying an additional surcharge, but that did not transform New York's cost regulation into central plan administration.[94]

Act 900's appeal procedure likewise does not govern central matters of plan administration. True, plan administrators must "comply with a particular process, subject to state-specific deadlines, and [Act 900] dictates the substantive standard governing the resolution of [an] appeal." Moreover, if a pharmacy wins its appeal, a plan, depending on the terms of its contract with a PBM, may need to recalculate and reprocess how much it (and its beneficiary) owes. But any contract dispute implicating the cost of a medical benefit would involve similar demands and could lead to similar results. Taken to its logical endpoint, PCMA's argument would pre-empt any suits under state law that could affect the price or provision of benefits. Yet this Court has held that ERISA does not pre-empt "state-law mechanisms of executing judgments against ERISA welfare benefit plans, even when those mechanisms prevent plan participants from receiving their benefits." *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988).

PCMA also argues that Act 900 interferes with central matters of plan administration by allowing pharmacies to decline to dispense a prescription if the PBM's reimbursement will be less than the pharmacy's cost of acquisition. PCMA contends that such a refusal effectively denies plan beneficiaries their benefits, but that argument misunderstands the statutory scheme. Act 900 requires PBMs to compensate pharmacies at or above their acquisition costs. When a pharmacy declines to dispense a prescription, the responsibility lies first with the PBM for offering the pharmacy a below-acquisition reimbursement.

Finally, PCMA argues that Act 900's enforcement mechanisms interfere with nationally uniform plan administration by creating "operational inefficiencies." But creating inefficiencies alone is not enough to trigger ERISA pre-emption. See, *e.g., Mackey* (holding that ERISA did not pre-empt a state garnishment procedure despite petitioners' contention that such actions would impose "substantial administrative

[94] PCMA also points to Act 900's requirement that PBMs update their MAC lists to reflect statutorily mandated prices. But that obligation does not affect plan design for the same reasons. Moreover, if PBMs were not required to update their MAC lists, they would be in constant non-compliance with Act 900's cost regulation.

burdens and costs" on plans). PCMA argues that those operational inefficiencies will lead to increased costs and, potentially, decreased benefits. ERISA does not pre-empt a state law that merely increases costs, however, even if plans decide to limit benefits or charge plan members higher rates as a result.

* * *

In sum, Act 900 amounts to cost regulation that does not bear an impermissible connection with or reference to ERISA. The judgment of the Eighth Circuit is therefore reversed, and the case is remanded for further proceedings consistent with this opinion.

It is so ordered.

Justice BARRETT took no part in the consideration or decision of this case.

Justice THOMAS, concurring.

I join the Court's opinion in full because it properly applies our precedents interpreting the pre-emptive effect of ERISA.

I write separately because I continue to doubt our ERISA pre-emption jurisprudence. The plain text of ERISA suggests a two-part pre-emption test: (1) do any ERISA provisions govern the same matter as the state law at issue, and (2) does that state law have a meaningful relationship to ERISA plans? Only if the answers to both are in the affirmative does ERISA displace state law. But our precedents have veered from the text, transforming § 1144 into a vague and potentially boundless purposes and objectives pre-emption clause that relies on generalized notions of congressional purposes. Although that approach may allow courts to arrive at the correct result in individual cases, it offers little guidance or predictability. We should instead apply the law as written.

I

When construing a statutory provision, we begin with the text. Section 1144(a) provides that certain of ERISA's provisions "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" with certain exceptions not relevant in this case.

The term "supersede" precludes reading the statute as categorically pre-empting any state law related to employee benefit plans. Rather, it suggests a replacement or substitution instead of a blanket pre-emption. See Webster's Third New International Dictionary 2295 (1976) (defining "supersede" to mean, among other things, "to take the place of and outmode by superiority").

Where Congress seeks to pre-empt state laws *without* replacing them, it typically uses different words. Congress knows how to write sweeping pre-emption statutes. But it did not do so here. Applying the statutory text, the first step is to ask whether a provision in ERISA governs the same matter as the disputed state law, and thus could replace it.

The next step is to determine whether the state law "relate[s] to" employee benefit plans. 29 U.S.C. § 1144(a). The Court has expressed concern that a *literal* reading of this phrase is so broad that it is meaningless.

II

Here, the parties have not pointed to any ERISA provision that governs the same matter as Act 900. That alone should resolve the case. But the parties certainly cannot be faulted for not raising this argument. Our amorphous precedents have largely ignored this step. Instead, we have asked only if the state law relate[d] to ERISA plans. Instead of reverting to the text, however, we decided that "relate to" is so indetermina[te] that it cannot give us much help drawing the line.

Having paid little attention to the actual statutory test, we crafted our own, asking whether the challenged state law frustrates the "objectives" of ERISA. *Gobeille*. Under this approach, the Court will declare as pre-empted "state laws based on perceived conflicts with broad federal policy objectives, legislative history, or generalized notions of congressional purposes that are not embodied within the text of federal law." Our case law states that under an objectives and purposes pre-emption approach, a state law is pre-empted if it has a "reference to" or an "impermissible connection with" ERISA plans. *Gobeille*. But this vague test offered "no more help than" the "relate to" one.

Our more recent efforts to further narrow the test have just yielded more confusion. A state law references ERISA only if it "acts immediately and exclusively upon ERISA plans . . . or where the existence of ERISA plans is essential to the law's operation." *Gobeille.* A connection with ERISA plans is impermissible only if it "governs . . . a central matter of plan administration" or "interferes with nationally uniform plan administration." Although, at first blush, that may seem more precise than asking if a law "relates to" ERISA, it has proven just as difficult to apply consistently, leading many members of the Court to suggest still other methods. Instead of relying on this "accordion-like" test that seems to expand or contract depending on the year, Reece, The Accordion Type Jurisprudence of ERISA Preemption Creates Unnecessary Uncertainty, 88 UMKC L. Rev. 115, 124, n. 71 (2019), perhaps we should just interpret the text as written.

III

Stare decisis concerns need not caution against a return to the text because the outcomes of our recent cases—if not the reasoning— are generally consistent with a text-based approach. Indeed, since *Travelers* every state law this Court has held pre-empted involved a matter explicitly addressed by ERISA provisions. See, *e.g.*, *Aetna Health*, 542

U.S. at 204 (2005) (holding that states cannot create new causes of action that conflict with ERISA's "'interlocking, interrelated, and interdependent remedial scheme,'" located in § 502(a) of ERISA).

But it is not enough for this Court to reach the right conclusions. We should do so in the way Congress instructed. Indeed, although we have generally arrived at the conclusions we would arrive at under a text-based approach, our capacious, nontextual test encourages departure from the text. The decision below is testament to that problem. We unanimously reverse that decision today, but we can hardly fault judges when they apply the amorphous test that we gave them. We can and should do better.

Notes

1. *Do you agree with Justice Thomas that the Court has confused matters still further?* Justice Thomas takes the time to write a concurrence complaining about the Court's fuzzy "accordion" ERISA jurisprudence. Is this fair?

In fact, the Court's decision—in Justice Sotomayor's succinct, crisp writing style—seems pretty straightforward. To boil it down, the Court makes it clear that in its view Arkansas Act 900 has nothing to do with regulating ERISA plans. Its focus, instead, is regulating the *companies that do business with* insurers, whether those insurers are insuring a plan or administering a self insured plan and regardless of who the plan sponsor is—an ERISA employer, a public employer, Medicaid, Medicare, or an individual policyholder.

The regulated companies in question here are known as pharmaceutical benefit management (PBM) companies. According to *Becker's Hospital Review* https://www.beckershospitalreview.com/pharmacy/the-top-insurers-all-have-pbms-here-s-who-they-are.html, many are owned by the nation's biggest insurers, while others are owned by major drugstore chains such as Walgreens. The job of PBMs is to manage drug coverage across plan types, whether derived through an ERISA plan, a health plan sold in the individual market, a state employee benefit plan, a Medicaid managed care plan, a Medicare Advantage plan or perhaps a plan sponsored by the federal government for the military or civilian workforce. To do their work, PBMs contract with plan administrators to perform a bunch of tasks: assemble provider networks; set up drug formularies and negotiate the rates manufacturers will charge; set up pharmacy payment rates for getting and dispensing the drugs (the acquisition cost plus a dispensing fee); make individual coverage determinations; and so forth. As Justice Sotomayor notes, this is a big business in its own right, quite apart from which plan happens to be purchasing its services, and Act 900 is aimed at regulating these companies without regard to the particular type of coverage they are administering.

Sure, PBMs administer ERISA plans. But they also provide services to individual policyholders, public teachers plans, Medicare Advantage customers, and so forth. Just because ERISA plans are one of their customers, should they get the benefit of some

magical ERISA preemption shield when they work for these clients? If so, then, as you should know by now, Act 900 would lose its power to save community pharmacies—going under as a result of cut-rate payments—since such a high proportion of the insured population is covered by an ERISA plan. Even if Act 900 can be saved as a law that regulates insurance in the case of insured plans (which is discussed in the section that follows), the loss of the self-insured market is enough to render Act 900 toothless. Furthermore, since this law regulates PBMs and *not* insurers, whether the law even could be saved is open to question.

Thus, even though PBMs that work for ERISA plans certainly allow the plan to operate, from the legal perspective they are not part of plan administration, and thus, regulating them does not amount to binding the plan administrator, as in, say *Shaw v Delta Airlines.* No one is telling the plan what it can cover. No one is even telling the plan what to pay for drug coverage. The PBMs can decide to absorb the cost of the higher rates they pay. Just as hospitals sold their services to ERISA plans for a slightly higher fee under *Travelers,* here, PBMs are selling a service to an ERISA plan and setting the rate. A hospital could have discounted its fees to its ERISA customers in *Travelers* to keep the net cost down. Here, the PBMs can do the same. It doesn't make any difference to the Court apparently that the drug stores can retaliate for low fees by refusing to dispense drugs to covered customers. This, the Court says, is the PBM's problem to solve. If the PBM doesn't want to lose its contracts with its ERISA customers, it won't let anything of the sort happen—just like if hospitals want to be in plan networks, they will try to moderate the rates they charge their best customers.

What the Court seems to be doing is writing the next installment of *ERISA, The Continuing Saga*. This installment involves the middlemen that make big bucks working as contractors to plans and that then turn around trying to claim an ERISA preemption shield. True, this shield only works for ERISA plans, but of course given the size of the ERISA market, if preemption applies, states lose the biggest part of their clout as insurance regulators. The Court is simply not going to let this happen and seemingly has drawn the line around this vast middleman industry. Thus, Act 900 is recast as a law regulating market conduct by health benefits industry business consultants, not a law that has a connection with or reference to an ERISA plan. As such, the PBM industry is free to jack up the rates to its customers and pass higher fees along (probably a wise move rather than letting plan members leave a drug store without their prescription) or hold the line, absorb the bigger fees, and make a bit less money. End of story. But just the opening gambit for other middlemen regulatory laws such as laws aimed at the sea of businesses found in this vast industry—companies that assemble medical and surgical practice networks, companies that sell behavioral health services to plans, or companies that sell dialysis management services to plans. We could go on and on.

Viewed this way, do you buy Justice Thomas's somewhat whiny concurrence that the Court is being sloppy and providing insufficient guidance to the health benefits/health care industry regarding when ERISA preemption does or does not come into play? In fact,

doesn't Justice Sotomayor do a perfectly good job of giving us some guideposts going forward?

2. The opinions in the case state that they are applying preemption only to the subject matters governed by ERISA. Seriously? What about the legislative history discussed above and the explicit statement in *Travelers* that because of this history preemption extends beyond ERISA's core subject matters? When you read *Gobeille* in this Supplement infra, ask yourselves the same question in light of the fact that in the law at issue in that case Vermont regulated absolutely nothing within the purview of ERISA regulation and enforcement thereof by the Department of Labor. What about the thousands of cases in which courts have held preempted state laws that have nothing to do with the actual subject matters of ERISA? After you read about *Pilot Life* and complete preemption, ask yourselves again if the cases stand for the proposition that preemption ends where federal regulation ends. Ditto the cases involving preemption of state malpractice law. Can one know whether *Rutledge* signals a new approach when it flies in the face of so much precedent without any discussion?

3. Justice Thomas claims to apply his usual textualist arguments while simultaneously stating that the relate-to clause, if applied literally, has no meaning. Can one logically maintain both positions at once? If the relate-to clause is meaningless, how can it be construed without reference to extra-textual authority? How can he possibly criticize the majority for doing precisely that?

Insert at page 425 at the end of Chapter 8:

Note on "Surprise Medical Billing"

By the summer of 2019 one of the hottest areas in health law and policy concerned 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—the so-called "greatest of three." 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), https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them/ (Accessed July 29, 2021). 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), https://www.healthaffairs.org/do/10.1377/hblog20190603.704918/full/ (Accessed July 29, 2021). 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 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.**

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* 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.

** One conservative commentator gained attention by claiming that legislation to ban balance billing would be unconstitutional. See Paul D. Clement, Federal "Balance Billing" Legislation: Constitutional Implications, Kirkland & Ellis (June 19, 2019), https://www.scribd.com/document/414001118/Paul-Clement-Balance-Billing-Constitutional-Implications-June-2019 (Accessed July 29, 2021). We agree with Professor Jost that these arguments were a "'real stretch,'" Harris Meyer, Conservative Legal Expert Calls Surprise Bill Proposals Unconstitutional, Modern Healthcare, June 21, 2019, https://www.modernhealthcare.com/politics-policy/conservative-legal-expert-calls-surprise-bill-proposals-unconstitutional(Accessed July 29, 2021), although we would less politely characterize them as absurd.

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., hospitals, ambulatory surgery centers, free-standing emergency centers), whether the laws apply to both emergent and nonemergent care, the type of providers included (e.g., assistant surgeons, anesthesiologists, air ambulances) and the degree to which balance-billing is allowed and in what circumstances. See generally, e.g., Christina Cousart, States Continue to Implement Surprise Medical Billing Protections, National Academy for State Health Policy (June 24, 2019), https://nashp.org/states-continue-to-implement-surprise-medical-bill-protections/ (Accessed July 29, 2021); Loren Adler et al., State Approaches to Mitigating Surprise Out-of-Network Billing, USC-Brookings Schaeffer Initiative for Health Policy (Feb. 2019), https://www.brookings.edu/wp-content/uploads/2019/02/State-Approaches-to-Mitigate-Surprise-Billing-February-2019.pdf (Accessed July 29, 2021); Jack Hoadley, Kevin Lucia & Maanasa Kona, State

[*] 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.

Efforts to Protect Consumers from Balance Billing, Commonwealth Foundation (Jan. 18, 2019), https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing (Accessed July 29, 2021).

The problem long cried out for federal solution. Hopes were high two years ago, July 2019, and some commentators, enamored of the "bipartisanship" and "comity" that supposedly existed around the need to protect patients, thought that the much needed federal intervention was finally at hand. 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 29, 2021); 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 29, 2021). Bills then pending in Congress generally reflected the variation in state law. See, e.g., Loren Adler et al., Analyzing The House E & C Committee's Bipartisan Surprise Out-Of-Network Billing Proposal, Health Affairs Blog (May 14, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190514.695693/full/ (Accessed July 29, 2021); Mihir Dekhne et al., Federal Policy to End Surprise Billing: Building on Prior Approaches, Health Affairs Blog (Feb. 22, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190221.859328/full/ (Accessed July 29, 2021). Some embodied the position, favored by many academics, that the proper solution is to require all providers to be in the same network as the facilities in which they work—variously called, and somewhat differently implemented as, "network matching," an "in-network guarantee" or "bundled billing." Purportedly this solution would be administratively simple, economically efficient and transparent to patients. See, e.g., Loren Adler, Matthew Fiedler & Benedic Ippolito, Network Matching: An Attractive Solution to Surprise Billing, Health Affairs Blog (May 23, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190523.737937/full/ (Accessed July 29, 2021); Benedic N. Ippolito & David A. Hyman, Solving Surprise Medical Billing. AEI Economic Perspectives (March 2019), https://www.aei.org/wp-content/uploads/2019/03/Solving-Surprise-Medical-Billing.pdf (Accessed July 29, 2021); Zack Cooper, Fiona Scott Morton & Nathan Shekita, Surprise! Out-of-Network Billing 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 29, 2021). 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, these proposals had little chance of passage because virtually all stakeholders opposed forcing all providers effectively into a single network in order to protect patients. The only point on which all stakeholders could agree is that they uniformly wished to preserve their freedom to design networks as they pleased.

Short of coercing the creation of a single network, protection of all patients, regardless of the contours of their networks, requires that some form of payment 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 lined up on one of two sides. Most hospital and doctor groups opposed any form of benchmark pricing, because they wished to preserve their power to obtain higher payments from insurers; they particularly dreaded 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 prefer that more open-ended processes like arbitration and mediation be used, in part because conflict-resolution systems allows them to gain leverage because such a system uses 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 29, 2021); 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 29, 2021). By contrast, employer groups and insurers hoped 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.*

Quite simply, the fight has always been about money; and for two years, despite the fact that many compromises were floated, refloated, cycled and recycled, nothing seemed capable of breaking the logjam. However, finally a "solution" was found, similar to the numerous "solutions" to the problems created by a system characterized by

* 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 Federal Balance Billing Legislation, Health Affairs Blog, July 15, 2019, https://www.healthaffairs.org/do/10.1377/hblog20190708.627390/full/?utm_source=Newsletter&utm_medium=email&utm_content=Federal+Balance+Billing+Legislation%3B++Value-Based+Insurance+Design%3B+Social+Risk+Factors+And+Dialysis+Facility+Ratings%3B+Disparities. Space precludes further discussion here.

fragmentation all around—pile even greater complexity on top of the massive complexity that already exists, and effectively kick the can down the road. In this case, this "solution," enacted as the sun set on 2020, as part of the massive COVID-19 stimulus package and government funding for fiscal year 2021, is "The No Surprises Act" ("the NSA"), H.R. 133, P.L. 116-260.*

The NSA does build significantly on the ACA reforms regarding out-of-network emergency services, including out-of-network post-stabilization care, in that it holds patients harmless against balance billing, and also explicitly prohibits providers from actually sending bills to patients, an important prohibition because patients, not knowing their rights, might pay and then have to get their money back. The services of air ambulances, a particular, expensive problem, were included, in fact whether the transport was emergent or not.** However, the services of ground ambulances were omitted, a problem not as expensive as air transport but much more common and hugely complicated because two in three rides were provided by ones run by local governments subject to diverse state and local law.*** These protections alone constitute major reform.****

For non-emergent professional services provided at in-network facilities, hold-harmless protection is again provided to patients, as is the ban against actual billing, for services in emergency medicine, anesthesiology, pathology, neonatology, and diagnostic testing, as well as the services of assistant surgeons, hospitalists and intensivists, generally instances of ancillary or unanticipated services in which patients generally have no ability to exercise choice. By contrast, other out-of-network providers are permitted to notify patients of their out-of-network status and obtain written consent to their estimated prices from patients 72 hours in advance of treatment.

From there, however, things get much more muddy because now we're into the money. Congress, first, provided for the sunset of the ACA's "greatest of three" provision—again, the greatest of in-network rates, out-of-network rates or Medicare's

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* Summaries of the NSA, more detailed than that provided here, include Loren Adler et al., Understanding the No Surprises Act, USC-Brookings Schaeffer on Health Policy, Feb. 4, 2021, https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2021/02/04/understanding-the-no-surprises-act/ (Accessed July 29, 2021); Surprise Medical Bills: New Protections for Consumers Take Effect in 2022, Kaiser Family Foundation, Feb. 4, 2021, https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/# (Accessed July 29, 2021).

** A recent study found that charges for air ambulance services were 4.1–9.5 times higher than what Medicare paid for the same services in 2016. The median charge ratios (the charge divided by the Medicare rate) for the services increased by 46–61 percent in 2012–16. Ge Bai et al., Air Ambulances with Sky-High Charges. 38(7) Health Affairs 1195 (2019), https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2018.05375 (Accessed July 29, 2021).

*** See, e.g., Amin Krutika et al., Ground Ambulance Rides and Potential for Surprise Billing (June 24, 2021), https://www.healthsystemtracker.org/brief/ground-ambulance-rides-and-potential-for-surprise-billing/ (Accessed July 28, 2021).

**** The NSA also provides greater clarity regarding patients' cost-sharing obligations than did the ACA reforms, as explicated in the textbook at page 304, to ensure that cost sharing does not exceed what state law allows. Because our focus is on balance-billing, we do not here provide any detail.

payment—as the manner of calculating payment to out-of-network providers by patients' insurers. Second, Congress categorically rejected the use of *any* benchmark—the major and key victory obtained providers. Third, instead of mandating use of a benchmark, Congress substituted a mind-boggling complex process—one that is potentially enormously expensive and possibly completely unworkable—for the derivation of those payments—to derive a result that is independent of any payment that would have obtained under the ACA's "greatest of three" provision, or under Medicare, Tricare, Medicaid or the Children's Health Insurance Program. A cynic might observe that out-of-network payment is to be cleaved apart from the reality of any extant payment system. Such is the nature of "reform" in the U.S. of A.

Still, payment must be based on something that actually exists. The NSR provides that establishing out-of-network payment begins with an initial payment by the insurer to the out-of-network provider, which, if it is dissatisfied with that amount, can invoke a 30-day period of negotiation. At the end of that period, either party can initiate binding, "final offer" arbitration, also known as "baseball-style" arbitration, in which the arbitration entity is to choose between the two offers but is not authorized to deviate from those offers in order to determine a payment amount in any independent fashion.

A central factor in the arbitration entity's choice among the two, competing offers is for the arbitrator to take into account the "qualifying payment amount," which the NSA defines as the median of contracted rates for a given service in the same geographic region within the same type of insurance market—individual, fully insured large or small group, or self-insured group—across all of an insurer's plans as of January 31, 2019, inflated forward by the Consumer Price Index for All Urban Consumers ("CPI"). This stipulation actually represents a partial victory for insurers—and for payers, to the extent that lower prices paid by insurers are reflected in the prices to payers for insurance or for administrative services[*]—because providers would prefer that arbitration awards be based on charges rather than actual prices. The arbitration entity is also directed to consider factors like the provider's level of training, experience, quality and outcomes, the provider's or plan's market share, patient acuity, the provider's case mix, and the teaching status of the provider (e.g., teaching hospital or academic medical center), past network agreements between the parties and the amounts paid, and whether there have been good-faith efforts to obtain network status. How this hopper of factors is supposed to shake out is left entirely unclear although it is clear that the qualifying payment amount is a thumb on the scale toward payment based on contracted rates—the prices actually prevailing on January 31, 2019, escalated by use of the CPI.

How the NSR will affect health care expenditures is for that reason among a host of other reasons entirely unclear. Arbitration systems in New York and New Jersey led to increased prices, but those systems tied arbitration awards to 80 percent of charges rather

[*] In numerous places in the textbook but in particular in the chapter on antitrust, we discuss the fact that there is little evidence that bargaining power asserted by insurers against providers, leading to lower prices, results in lower premiums to payers.

than to negotiated rates, as does the system established by the NSR. Benchmark pricing was opposed tooth and nail by providers because of its potential to ratchet prices downward, while the NSR appears to lock in already inflated prices, particularly favoring insurers or providers already possessing market power. Additionally, the NSR's effect on prices and expenditures will very much depend on the details to be fought out in the massive implementation process that has only recently begun with the first set of interim final regulations issued on July 1, 2021.[*] However, given the history of the battle for passage and the structure created by that Act, there is little reason to expect prices to be driven downwards. Essentially doctors, hospitals, and big equity investors traded protections for *individual* patients—under the NSA individual patients are, finally, held harmless in the struggle over payment in individual episodes of care—while they staved off the assertion of *aggregated* payer power through stronger systemwide controls over expenditures. In this regard, there is absolutely no "reform." It is an old story in the United States, repeated yet again.

* * *

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),[**]

[*] Requirements Related to Surprise Billing; Part I, Interim Final Rules with Request for Comments, 86 Fed. Reg. 36,872 (July 13, 2021).

[**] 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 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 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

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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.

"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).[11]

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 Amended Complaint cites Agency decisions that are arguably consistent with the imposition of an Improvement Standard because adjudicators

[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.

> 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.
>
> [T]he 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.

2011 WL 5104355, at 18-21.

In the wake of *Jimmo,* rather than continuing to fight over the existence of the so-called Improvement Standard, the Secretary entered into a nationwide settlement, announced with much publicity in October, 2012. Robert Pear, Settlement Eases Rules for Some Medicare Patients, NEW YORK TIMES (October 22, 2012) http://www.nytimes.com/2012/10/23/us/politics/settlement-eases-rules-for-some-medicare-patients.html?pagewanted=all&_r=0 (Accessed online July 13, 2013) (reporting on the potential national reach of the decision). See also Susan Jaffe, Therapy Plateau No Longer Ends Coverage, NEW YORK TIMES (February 13, 2013). http://newoldage.blogs.nytimes.com/2013/02/04/therapy-plateau-no-longer-ends-coverage/ (Accessed online, July 13, 2013), describing the enormous significance of the settlement in terms of health care practice, with extensive discussion by health care providers regarding the importance of not ending therapy simply because patients do not show actual improvement because of the value of preventing conditions from getting worse.

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?

* * *

Chapter 11 Medicaid

Table of Contents for Chapter 11 Inserts

Insert at textbook, page 232 before subheading c:

Note: The Supreme Court's Latest Word on Medicaid and Private Enforcement

In Health & Hospital Corporation of Marion County v. Talevski, 143 S. Ct. 1444 (2023), the Supreme Court reaffirmed that 42 U.S.C. § 1983 allows private individuals to sue state officials engaged in violations of law when the Medicaid violation that gives rise to the suit involves a statutory right, as opposed to a general command to state administrators. As you will see in *Armstrong v Exceptional Child Ctr.,* infra, many of Medicaid's most vital provisions are viewed by the Court simply as general rules of operation, to be enforced solely by the HHS Secretary. When the language in one of Medicaid's hundreds of commands is considered by the Court to expressly and unambiguously confer a statutory right, however, the full power of section 1983 becomes available to private individuals who could suffer irreparable harm without direct judicial intervention.

As discussed in the main text, this rule of thumb stems from *Gonzaga*. It may be easy to state, but it is much harder to know when, exactly, the rights-creating language actually exists. In *Talevski* the Court concluded that the provision at issue was, in fact, rights-conferring. However, the opinions in *Talevski* also make it clear that similar holdings could be few and far between (if not approaching nil).

Talevski involved a suit brought under section 1983 against a nursing home owned and operated by Marion County, Indiana because of the facility's failure to comply with the Federal Nursing Home Reform Act's ("FNHRA") prohibitions against, first, the use of unnecessary chemical restraints and, second, discharge or transfer in the absence of particular safeguards, including advance notice to the beneficiary and his or her family. Indeed, the facts show that the violations were repeated, that family members had made numerous efforts to obtain relief from state officials and that Indiana's officials' responses were ineffective at best.

Gorgi Talevski had entered the nursing home with dementia but was still able to talk, feed himself, walk, socialize and recognize his family. However, shortly thereafter his family found that suddenly he could no longer eat by himself or communicate. An outside physician confirmed that Talevski had been given six powerful psychotropic medications as chemical restraints. Later, the nursing home claimed that Talevski was harassing female residents and staff, transferred him twice to a psychiatric hospital and then after a third transfer refused to readmit him. Talevski's family had invoked the state's grievance process and then filed a formal complaint with the Indiana State Department of Health. Even after an administrative law judge nullified Talevski's transfer, the nursing home refused to comply by readmitting him. After another formal complaint and the issuance of a report by the state agency, a nursing home official contacted Talevski's wife to discuss his possible return but by then the family was afraid of retaliation should he be readmitted and instead filed the lawsuit under section 1983.

The Seventh Circuit reversed the trial court's dismissal for failure to state a claim, and it is this ruling that the Supreme Court affirmed. In doing so, the Court first brushed aside any claim that section 1983 could not be used to enforce any section of the Medicaid Act because Medicaid represents a contract only between a state and the federal government, unenforceable by third-party beneficiaries, or more broadly because no legislation enacted pursuant to the Spending Power creates private rights. While Justice Gorsuch in concurrence indicated his willingness to entertain such a claim when properly presented—this issue was not the basis on which cert was granted—only Justice Thomas stood by the third-party beneficiary argument in an opinion that, purporting to be a deep dive into constitutional history and interpretation, would have jettisoned four decades of precedent reaching back to Maine v. Thiboutot, 448 U.S. 1, decided in 1980. It is thus clear that at least seven justices of the current Court maintain that section 1983 can be used to enforce Medicaid when the focus of the action involves a provision that expressly and unambiguously confers a right.*

The Court then found such rights-conferring language in the FNHRA. It wrote:

> The FNHRA is largely composed of a litany of statutory requirements that Congress laid out for Medicaid-participant States and "nursing facilities." §1396a(a)(28).11 Those include "[r]equirements relating to residents' rights," §1396r(c) (boldface deleted), two of which Talevski's complaint invoked.
>
> The first requires nursing facilities to "protect and promote" residents' "right to be free from . . . any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." §1396r(c)(1)(A)(ii) (referred to

* Justice Alito dissented on the ground that the Court was wrong in finding rights-conferring language in the FNHRA but he indicated his disagreement with Justice Thomas that the Constitution precludes the existence of such private rights.

herein as "the unnecessary-restraint provision"). The second appears in a subparagraph concerning "[t]ransfer and discharge rights," §1396r(c)(2)(A) (boldface deleted), and tells nursing facilities that they "must not transfer or discharge [a] resident" unless certain enumerated preconditions, including advance notice of such a transfer or discharge, are met. E.g., §§1396r(c)(2)(A)–(B) (referred to herein as "the predischarge-notice provision").

* * *

To start, we note that both reside in 42 U. S. C. §1396r(c), which expressly concerns "[r]equirements *relating to residents' rights*." *Ibid.* (emphasis added; boldface deleted). This framing is indicative of an individual "rights-creating" focus. *Gonzaga*, 536 U. S., at 284. Examined further, the text of the unnecessary-restraint and predischarge-notice provisions unambiguously confers rights upon the residents of nursing-home facilities.

The unnecessary-restraint provision requires nursing homes to "protect and promote . . . *[t]he right* to be free from . . . any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat *the resident's* medical symptoms." §1396r(c)(1)(A)(ii) (emphasis added). The provision's enumerated exceptions further sustain the focus on individual residents. For example, nursing homes may use restraints "to ensure the physical safety *of the resident or other residents*," but "only upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used" (absent emergency circumstances specified by the HHS Secretary). §§1396r(c)(1)(A)(ii)(I)–(II) (emphasis added).

The predischarge-notice provision is more of the same. Nestled in a paragraph concerning "transfer and discharge *rights*," §1396r(c)(2) (emphasis added; boldface deleted), that provision tells nursing facilities that they "must not transfer or discharge [a] *resident*" unless certain preconditions are met, including advance notice of the transfer or discharge to the resident and his or her family. §§1396r(c)(2)(A)–(B) (emphasis added). And, again, the statute's caveats remain focused on individual residents: A nursing home may transfer or discharge such an individual if, among other things, the transfer is "necessary to meet *the resident's* welfare"; or if the resident's health has improved so much that the facility is no longer necessary; or if the safety or health of other individuals would be endangered. §1396r(c)(2)(A) (emphasis added). The exceptions to the advance-notice requirement, too, turn (*inter alia*) on the "*resident's* health," the "*resident's* urgent medical needs," or the existence

> of threats to the safety or health of other individuals in the nursing home. §§1396r(c)(2)(B)(ii)(I)–(III)n (emphasis added).

143 S.Ct. at 1456-58.

Finally, the Court concluded that nothing regarding the FNHR's special obligations to safeguard beneficiaries amounted to the type of comprehensive remedial scheme that under the Court's precedents would be incompatible with a private section 1983 enforcement action by beneficiaries. Such a conflict would exist, in the Court's view, if the FNHR itself explicitly substituted for section 1983 a separate system for beneficiaries to vindicate their rights. No such explicit, alternative, comprehensive remedial scheme exists. The Court therefore concluded that there was no evidence that Congress intended to foreclose a cause of action under section 1983.

Notice that all the weight of the conclusion is on the express use of the word "right" in two places. Fine. So in the case of the FNHR the statutory text expressly uses the word "right." Therefore, the language expressing and unambiguously confers a right. How about the reverse inference, that if Congress passes a law omitting the word "right," it intended that there be no right?

Compare four possible provisions in the Medicaid Statute:

(1) State plans shall ensure that nursing homes are precluded from using chemical restraints on a resident unless such restraints are appropriate.

(2) State plans shall ensure that nursing homes protect a resident's right to be free from the use of chemical restraints unless such restraints are appropriate.

(3) Providers receiving funds under this Act are precluded from using chemical restraints on a resident unless such restraints are appropriate.

(4) Providers receiving funds under this Act shall protect a resident's right to be free from the use of chemical restraints unless such restraints are appropriate.

Substantively, are they any different? Do you think it a fair inference to conclude that number (2) confers a right while number (1) does not? Ditto numbers (4) and (3)? We are making inferences from silence; and we continue this discussion in the Notes following *Armstrong* in the next subsection.

What do we mean by "Congressional intent" anyway? If we see you walking down the street with an umbrella, we might reasonably infer that you intend not to get wet if it rains. Does Congress walk down the street?

If not, then isn't "Congressional intent" a legal construct informed by certain rules of construction? When justices write that "[t]he bar is high" against finding a right in Medicaid, is that statement a conclusion relying on rules of construction or is the statement part of a process of establishing what the rules of construction are? Could the Supreme Court, then, rule that number (1) above substantively is the same as number (2) above and therefore *both* are rights-conferring even though only number (2) expressly uses the word "right"? Ditto numbers (3) and (4)?

As we described in the book, the Rehnquist Court retreated from a line of cases leading to *Wilder*, and created a line of cases leading to *Gonzaga* such that the "bar" is set high against any inference that Congress created a private right in Medicaid. Could *Talevski* be the leading edge of a line of cases supporting a greater willingness to infer private rights? Alternatively, do you think that the prevailing winds are blowing in the opposite direction? Isn't the Court, then, inching closer and closer to the position taken by Justice Thomas every time it sets the bar higher and higher against the inference that Medicaid confers individual rights, to the point that no Act of Congress passed under the Spending Power confers private rights?

Delete the material beginning on textbook, page 532 at subheading (c) and running through textbook, page 552, up to note "8."; and insert the following material:

c. Can Private Parties Use the Supremacy Clause to Enforce States' Federal Medicaid Obligations? Medicaid's "Equal Access" Statute

(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, display[s] a[n] 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.

I
A

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).*

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,

* [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 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.

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.

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

Table of Contents for Chapter 12 Inserts

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 payed 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.

CMS, Medicare Benefit Policy Manual: Chapter 6—Hospital Service Covered under Part B, at §20.6, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c06.pdf (Accessed July 17, 2015).

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, or11:59 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 is still on observation status. Suppose then that the patient stays yet another midnight. We now have three midnights but the patient still 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).

TABLE 7–3 **Average Medicare total payments for inpatient stays are higher than for similar outpatient observation stays, 2012**

MS-DRG	MS-DRG description	Average Medicare inpatient payment (one-day stay)	Average Medicare outpatient observation payment
313	Chest pain	$3,716	$1,655
310	Cardiac arrhythmia & conductive disorders	3,677	1,420
392	Esophagitis, gastroenteritis & miscellaneous digestive disorders	4,953	1,526
312	Syncope & collapse	4,972	1,689
287	Circulatory disorders except AMI, with cardiac catheterization without MCC	7,064	3,998
641	Disorders of nutrition, metabolism, fluid/electrolytes without MCC	4,467	1,341

Note: MS–DRG (Medicare severity–diagnosis related group), AMI (acute myocardial infarction), MCC (major complication or comorbidity). Payments reflect actual program payments (including indirect medical education and disproportionate share hospital add-ons) and beneficiary cost sharing. Data exclude Maryland and critical access hospitals. The observation data are for beneficiaries whose observation care meets the criteria for composite ambulatory payment classification payment for extended evaluation and management. Claims for outpatients are compared with inpatient claims for MS–DRGs that include patients with similar diagnoses and procedures. The bundle of services covered by the inpatient payments and outpatient payments are not entirely comparable in part because of the inpatient 72-hour rule and outpatient payments not covering self-administered drugs.

Source: MedPAC analysis of Medicare standard analytic file of inpatient and outpatient hospital claims.

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.

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

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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 (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. Burwell, 68 F. Supp.3d 54 (2014).

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 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

* 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).

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*"], http://oig.hhs.gov/oei/reports/oei-02-12-00040.pdf (Accessed July 18, 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 (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).* Baugh and Schuur summarized the effect of this

* 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,

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

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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 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.

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 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.

CMS, Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Proposed Fiscal Year 2014 Rates, 78 Fed. Reg. 27,486, 27,645-46 (May 10, 2013) [hereinafter "*FY 2014 Inpatient Rates Proposed Rule*"].*

* 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/Medical-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

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 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

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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).

* 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 Care Hospitals and Proposed Fiscal Year 2014 Rates, 78 Fed. Reg. 27,486, 27,649-50 (May 10, 2013). 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).

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:

> 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 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, MedPACs 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.

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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 Hospital Stays; Proposed Rule for CY 2016, 130 Fed. Reg. 39, 39,200, 39,348-50 [hereinafter "*CMS, Proposed Rule for Short Inpatient Stays*"].

[***] 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.

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:

> 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.[*]

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[*] 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-there's-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).

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 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

[*] 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 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.

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

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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."

> 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.

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.**

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* 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.

** At least one bill is currently pending in Congress to extend even greater protection to hospitals. See Medicare Audit Improvement Act of 2015, H.R. 2156, 114th Cong., 1st Sess.,

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-opps.shtml. (Accessed July 20, 2015); AHA, Special Bulletin, CMS Releases Two Proposed Rules for CY 2016 (July 2, 2015), http://www.scha.org/tools/files/ahaspecialbulletincy2016_opps-esrd-pps-prule_070215-55a42643.pdf (Accessed July 20, 2015). By contrast, because the proposed reformulated rule gives *no relief* to the plight of beneficiaries, stuck in the limbo of observation status (and possibly denied the quality of care possible in dedicated, well-run observation units), the reactions have been negative. See Center for Medicare Advocacy, Proposed Revisions to "Two-Midnight" Rule Provide Little, If Any, Relief for Medicare Beneficiaries Stuck in the Hospital in Observation Status (July 8, 2015), http://www.medicareadvocacy.org/proposed-revisions-to-two-midnight-rule-provide-little-if-any-relief-for-medicare-beneficiaries-stuck-in-the-hospital-in-observation-status/ (Accessed July 20, 2015).

Relief for beneficiaries has to happen, if at all, in Congress and state legislatures, and to some extent it has happened already or is currently happening. As of July 20, 2015, five states have passed laws to ensure that persons on observation status are informed that they are not inpatients. With great variation among the laws concerning the who, how and when of notification, as well as consequences of failure to comply, these states are Connecticut, Maryland, New York, Pennsylvania and most recently Virginia. See, e.g., Center for Medicare Advocacy, Observation Status: Virginia Requires Hospitals to Notify Patients of Their Observation Status, http://www.medicareadvocacy.org/observation-status-virginia-requires-hospitals-to-notify-patients-of-their-observation-status/ (Accessed July 20, 2015). In the Congress, the Notice of Observation Treatment and Implications for Care Eligibility (NOTICE) Act has unanimously passed the House, H.R. 876, 114th Cong., 1st Sess., https://www.congress.gov/bill/114th-congress/house-bill/876 (Accessed July 20, 2015), and, as of July 20, 2015, has cleared the Senate Finance Committee. S. 1349, 114th Cong., 1st Sess., https://www.congress.gov/bill/114th-congress/senate-bill/1349 (Accessed July

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https://www.congress.gov/114/bills/hr2156/BILLS-114hr2156ih.pdf (Accessed July 20, 2015). Regardless of any pending changes, the process to contract with RACs for 2015 is now stalled because, at the behest of a potential bidder seeking to renew its contract, in CGI Federal Inc. v. United States, 779 F.3d 1346 (2015), the Court of Appeals for the Federal Circuit held that the request for bids with the modified contingency fee violates statutory requirements related to the procurement process. Following the issuance of an injunction enjoining use of the request for bids that CMS had already issued, on July 10, 2015, CMS withdrew its request for bids to hire the RACs for 2015. See CMS, Recent Updates, http://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Recovery-Audit-Program/Recent_Updates.html (Accessed July 20, 2015); CMS Withdraws Request for Quotes for Next Round of RAC Contracts, AHA NEWS (July 14, 2015), http://news.aha.org/article/150714-cms-withdraws-request-for-quotes-for-next-round-of-rac-contracts (Accessed July 20, 2015).

20, 2015). Additionally, in both chambers there has been bipartisan support for the Improving Access to Medicare Coverage Act of 2015, which would count observation status for the three-day-stay requirement for SNF coverage, and which, as of July 20, 2015, has been referred to committee. See H.R. 1571, 114th Cong., 1st Sess., https://www.congress.gov/bill/114th-congress/house-bill/1571 (Accessed July 20, 2015); S. 843, 114th Cong., 1st Sess., https://www.congress.gov/bill/114th-congress/senate-bill/843 (Accessed July 20, 2015).

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.

[*] http://www.lyricsfreak.com/b/burt+bacharach/alfie_20025979.html (Accessed July 20, 2015).

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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.

CMS, Hospital Inpatient Prospective Payment Systems for Acute Care Hospitals and Proposed FY 2015 Rates, 79 Fed. Reg. 27,978, 28,169 (May 15, 2014).

With regard to prices paid by private payers, a survey by the American Hospital Association released in March 2014 found that 42 states report hospital charges or prices, to some degree. See American Hospital Association, Advocacy Issue Paper: Hospital Price Transparency, http://www.aha.org/content/14/14pricetransparency.pdf (Accessed June 29, 2016); see also National Conference of State Legislatures, Transparency and Disclosure of Health Costs and Provider Payments: State Actions (Aug. 2015), http://www.ncsl.org/research/health/transparency-and-disclosure-health-costs.aspx (Accessed June 29, 2016). Additionally, private organizations are now collecting and making available data concerning provider prices. See, e.g., Health Care Cost Institute ("HCCI"), FAQ: Health Price and Quality Transparency Project (May 14, 2014) (HCCI will collect and make available price data obtained from Aetna, Humana and UnitedHealthcare), http://www.healthcostinstitute.org/files/Final%205-19-14%20FAQs.pdf (Accessed June 29, 2016); cf. Clear Choices: A Movement for Informed Health Care, http://www.clearchoicescampaign.org/ (Accessed June 29, 2016); Joel White, Promoting Transparency and Clear Choices in Health Care, HEALTH AFFAIRS (BLOG) (June 9, 2015) (describing Clear Choices, a coalition of activists, advocates, businesses, consumer groups to promote transparency).

Further, a number of organizations have started websites containing shopping tools. For example, the Health Care Cost Institute (HCCI) recently announced its launch of "GUROO," one of the new websites. See Health Care Cost Institute (HCCI) Launches GUROO—To Provide Consumers with Free Access to a Health Care Transparency Tool (Feb. 25, 2015), http://www.healthcostinstitute.org/files/Guroo%20Press%20Release.pdf (Accessed June 29, 2016); see also Eric Barrette & David Newman, Price Transparency: Removing the Blindfold, HEALTH AFFAIRS (BLOG) (March 11, 2015), http://healthaffairs.org/blog/2015/03/11/price-transparency-removing-the-blindfold/ (Accessed June 29, 2016). The site declares that it has "[n]umbers no one else has," and its promise is that users can "[g]et details on the real steps and costs of health care." http://www.guroo.com/ (Accessed June 29, 2016). A number of new websites, like "PriceCheck," use crowdsourcing to collect amounts paid by patients. See, e.g., Aliferis, Variation in Prices for Common Medical Tests and Procedures, 175(1) JAMA INTERNAL MED. 11 (2015). Even some providers are getting into the business of being "transparent," see, e.g., American Hospital Association, Achieving Price Transparency for Consumers: A Toolkit for Hospitals, http://www.ahacommunityconnections.org/tools-resources/transparency.shtml (Accessed June 29, 2016), if only as a marketing tool to attract customers and as a salve to appease politicians.

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

* 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).

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 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-

* Researchers likewise are paying attention to see how they might mine the data for their purposes—potentially prosecutors too, looking for patterns of fraud. See, e.g., Kavita Patel et al., How Open Data Can Reveal—and Correct—The Faults in Our Health System, HEALTH AFFAIRS (BLOG) (Feb. 18, 2015), http://healthaffairs.org/blog/2015/02/18/how-open-data-can-reveal-and-correct-the-faults-in-our-health-system/ (Accessed June 29, 2016); Kavita Patel et al., Making Sense of the Medicare Physician Payment Data Release: Uses, Limitations, and Potential, Commonwealth Fund Issue Brief (Nov. 2014),

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).

Similarly, the release of the physician-payment data has led to eye-opening articles about the level of revenue earned by some physicians from Medicare (as well as some sensible coverage regarding the limitations of the data). See, e.g., Christopher Weaver et al., Cancer Doctors Ring Up Big Medicare Bills for Tarnished Drug Procrit, 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.

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http://www.commonwealthfund.org/publications/issue-briefs/2014/nov/making-sense-of-the-medicare-physician-payment-data-release (Accessed June 29, 2016).

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.

Eighth, any data on prices must be matched up with data on quality—something that is monstrously complicated and difficult (and we leave to Chapter 20 (Payers and Health Care Quality))—because price without quality has little meaning. See generally François de Brantes & Suzanne Delbanco, Getting Accurate Price Estimates from Price Transparency Tools (Feb. 2015), http://www.hci3.org/content/getting-accurate-price-estimates-price-transparency-tools (Accessed June 29, 2016); Kavita Patel et al., Recommendations to Achieve a More Transparent Health Care System for Consumers, BROOKINGS HEALTH POLICY ISSUE BRIEF (Feb. 2015), http://www.brookings.edu/~/media/research/files/papers/2015/02/03-medicare-physician-payment-data/health-policy-brief--recs-for-transparent-health-system.pdf (Accessed June 29, 2016); Healthcare Financial Management Association, Price Transparency in Health Care: Report from the HFMA Transparency Task Force (2014), http://www.hfma.org/Content.aspx?id=22274 (Accessed June 29, 2016); Jo Porter et al., The Basics of All-Payer Claims Database: A Primer for States, ROBERT WOOD JOHNSON FOUNDATION ISSUE BRIEF (Jan. 2014), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2014/rwjf409988 (Accessed June 29, 2016); GAO, Health Care Transparency: Actions Needed to Improve Cost and Quality Information for Consumers, at 11 n.21 [hereinafter "*GAO 2014 Transparency Report*"], http://www.gao.gov/products/GAO-15-11 (Accessed June 29, 2016).

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/collecting-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.catalyzepaymentreform.org/images/documents/2015_Report_PriceTransLaws_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.

Gobeille 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 (ERISA). The question before the Court is whether ERISA pre-empts the Vermont statute as it applies to ERISA plans.

I
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

* 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.

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.

B

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.

I

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."[1] 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 "identif[y] health care needs and infor[m] health care policy," "evaluat[e] the effectiveness of intervention programs on improving patient outcomes," "compar [e] costs between various treatment settings and approaches,"

[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.

"determin[e] the capacity and distribution of existing resources," and "provid[e] information to ... purchasers of health care").[2]

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.,* ollecting data on numerous beneficiaries from each of several major segments of the health care market.[4] 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.

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[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.

[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.

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 functio[n]" 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 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]

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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

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 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"

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measured against ordinary preemption principles or this Court's ERISA-specific precedent, Vermont's data-collection law should survive inspection.

to protect against "the mismanagement of funds accumulated to finance employee benefits and the failure to pay employees' benefits from accumulated funds."[6]

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 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.

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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).

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).[7] 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.[8]

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[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 finder of fact would reasonably ask, for example: Do Blue Cross's existing technologies for data storage already have capacity to store and report the data sought by Vermont? And is compliance with Vermont's reporting rules any more burdensome than compliance with other state reporting laws with which the plan already complies?

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.[9]

Liberty points to *Egelhoff* as exemplary. In *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 *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.[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, *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, does not fit the bill any more than reporting relating to a plan's taxes or wage payments does.

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[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.

[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." *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?

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 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

[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.

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

[*] 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

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"?

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

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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.

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 the 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 (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 (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

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Key Tools for Health Reform?, National Academy for State Health Policy, April 5, 2016, http://nashp.org/are-states-losing-key-tools-for-health-reform/ (Accessed June 29, 2016).

maintained that "reporting" under ERISA is the same as "reporting" under Vermont's law simply because one uses the same word to encompass both?

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 'identif[y] health care needs and infor[m] health care policy,' 'evaluat[e] the effectiveness of intervention programs on improving patient outcomes,' 'compar[e] costs between various treatment settings and approaches,' 'determin[e] the capacity and distribution of existing resources,' and 'provid[e] 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-

* In his concurring opinion joined by Justice Ginsburg, mentioned above, Justice Scalia found that the Washington law directly conflicted with ERISA.

insured plans significantly impairs, if not eliminates, the laws' efficacy.* As Justice 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/ (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 (Accessed June 29, 2016). States might attempt to obtain data from providers, which

* 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), https://www.apcdcouncil.org/publication/key-regulatory-issues-facing-apcd-states-post-gobeille-v-liberty-mutual (Accessed June 29, 2016).

** 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 (Accessed June 29, 2016).

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 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?

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[*] 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 (Accessed June 29, 2016).

[**] 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).

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 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 spite 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?

[*] 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*.

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.

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

* 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.

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 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.RefPrcng.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-non-

group-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 Princing 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-reform-landscape-benefit-and-network-design-strategies-to-complement-payment-reform/ (Accessed July 24, 2015).*

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),

* 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.

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).

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?

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* 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.

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 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 Melton, et al., Reference-Based Pricing: An Evidence-Based Solution for Lab Services Shopping, AMERICAN J. MANAGED CARE (Dec. 12, 2014), http://www.ajmc.com/journals/issue/2014/2014-vol20-n12/reference-based-pricing-an-evidence-based-solution-for-lab-services-shopping (Accessed July 24, 2015). Another recent study conservatively estimated that the widest possible use of reference pricing across all "shoppable" services would reduce total national health expenditures only by roughly 5%. See Chapin White & Megan Eguchi, Reference Pricing: A Small Piece of the Health Care Price and Quality, NIHCR RESEARCH BRIF, No. 18 (2014), http://www.nihcr.org/Reference-Pricing2 (Accessed July 24, 2015).

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 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

* 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.

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 levels? As Professor Tim Jost notes, the actuarial value of a plan using reference pricing depends on the choices made by plan members whether to use the services of the designated provider, something that is unknowable in advance. See Implementing Health Reform: Third-Party Payments and Reference Pricing, HEALTH AFFAIRS BLOG, May 22, 2014, http://healthaffairs.org/blog/2014/05/22/implementing-health-reform-third-party-payments-and-reference-pricing/ (Accessed July 24, 2015).

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?

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

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 Supplement 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--6UP1qu79FoUkdcBigadASnd7hxgNWNwJeNaL5irQgNPNjjf4naizzGuOa54Z0HEt0u6hUrnDN7zMyhQD6aqU8gUHBhO7ZShrZZJ7hcIu7LE8DObM&_hsmi=13402390 (Accessed July 24, 2015). Also, there are reports that plans or insurers are attempting to discourage enrollment by persons with cancer by excluding leading cancer centers from their networks. See, e.g., Ricardo Alonso Zaldiver, Health Law Concerns for Cancer Centers, March 19, 2014, http://www.usnews.com/news/articles/2014/03/19/concerns-about-cancer-centers-under-health-law (Accessed July 24, 2015). Couldn't a system of reference pricing similarly discourage enrollment of persons with some illnesses or deny services based on a particular condition?

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.

States vary greatly in their definitions of network adequacy, see, e.g., Justin Giovannelli et al., Implementing the Affordable Care Act: State Regulation of

Marketplace Plan Provider Networks, Commonwealth Fund (May 2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1758_giovannelli_implementing_aca_state_reform_individual_market_rb.pdf (Accessed July 24, 2015); Sally McCarty & Max Ferris, ACA Implications for State Network Adequacy Standards, ROBERT WOOD JOHNSON FOUNDATION ISSUE BRIEF (August 2013), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2013/rwjf407486 (Accessed July 24, 2015).* Moreover, state requirements are often weak to nonexistent. See, e.g., Sabrina Corlette et al., Implementation of the Affordable Care Act: Cross-Cutting Issues Six-State Case Study on Network Adequacy, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413240-Implementation-of-the-Affordable-Care-Act-Cross-Cutting-Issues.PDF (Accessed July 24, 2015); Sabrina Corlette et al., Narrow Provider Networks in New Health Plans: Balancing Affordability with Access to Quality, Georgetown University Center on Health Insurance Reforms & Urban Institute, May 2014, http://www.urban.org/sites/default/files/alfresco/publication-pdfs/413135-Narrow-Provider-Networks-in-New-Health-Plans.PDF (Accessed July 24, 2015). Some states impose standards of reasonableness; and some impose quantified requirements like time 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*

* For a very recent, exhaustive compilation of state law related to network adequacy, see National Conference of State Legislatures, Insurance Carriers and Access to Healthcare Providers, Network Adequacy (July23, 2015), http://www.ncsl.org/research/health/insurance-carriers-and-access-to-healthcare-providers-network-adequacy.aspx (Accessed July 24, 2015).

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

We posted some of the content of this note online, although due to space limitations the online version is not as flush as this note. See David Frankford & Sara Rosenbaum, Go Slow on Reference Pricing: Not Ready for Prime Time, HEALTH AFFAIRS (BLOG) (March 9, 2007), http://healthaffairs.org/blog/2015/03/09/go-slow-on-reference-pricing-not-ready-for-prime-time/ (Accessed July 15, 2015); David Frankford & Sara Rosenbaum, Go Slow On Reference Pricing: Why The Federal Agencies Have It Wrong On Regulations, HEALTH AFFAIRS (BLOG) (March 9, 2015),

http://healthaffairs.org/blog/2015/03/09/go-slow-on-reference-pricing-why-the-federal-agencies-have-it-wrong-on-regulations/ (Accessed July 12, 2015). For fairly flush defense of reference pricing, see Ann Boynton & James C. Robinson, Appropriate Use of Reference Pricing Can Increase Value, HEALTH AFFAIRS (BLOG) (May 7, 2015), http://healthaffairs.org/blog/2015/07/07/appropriate-use-of-reference-pricing-can-increase-value/ (Accessed July 24, 2015). If you read the latter, ask yourselves if the authors engage with the issues we have raised.

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

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

III
A

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.

1

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.,* cls. 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 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"); *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]

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[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] in the self-insurance market" when they fail to purchase insurance, than they are active in the "rest" market when doing nothing.

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.*

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."

2

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 "'protec[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 caseheld 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 "consist[ent] 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 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 "fai[l] 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).

C

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 "compe[l] individuals to become active in commerce by purchasing a product."

1
a

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)).[5]

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

[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.

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 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.

b

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, 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

[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.

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]

2

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 else—where, substantially affect any sort of interstate commerce." 514 U.S., at 567; *ibid.* (noting that the Court 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.

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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.

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 "pil[ing 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").

3

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] powe[r] 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 par[t] 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 par[t] 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 disserves 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] are[a] 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. 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.

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[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.

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.[*] His 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 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

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[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)."

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.offthechartsblog.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.[8] 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

[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).

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 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 "[i]mpos[e] 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 capitation, 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 (1861). 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(b) 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 rende[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.

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* 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.

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 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] influenc[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.

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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.

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 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

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[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.

[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.

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.

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

[*] 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?

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 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.[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. *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 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 "conscript[ing] state

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[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, *e.g.,* participating States were obliged to offer minimum coverage for hospitalization and physician services. See Huberfeld, *supra,* at 443–444.

[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.

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] 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.

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[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 "threa[t]" to "political accountability." By that, they mean voter confusion: Citizens upset by unpopular government action, they posit, may ascribe to state officials blame more appropriately laid at Congress' door. But no such confusion is apparent in this case: Medicaid's status as a federally funded, state-administered program is hardly hidden from view.

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 "threa[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.[20] The level of benefits offered therefore does not set apart post-ACA Medicaid recipients from all those entitled to benefits pre-ACA.

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?

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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).

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 accep[t]." *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

[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).

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 "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 alte[r] and expan[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," *Steward Machine,* 301 U.S., at 591, "where persuasion gives way to coercion." Neither do the joint dissenters.[25] 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,

[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.

[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.

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?[26] 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.[27] THE CHIEF JUSTICE, however, holds that the Constitution precludes 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

[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 experience political pressures, which would make her all the more reluctant to cut off funds Congress has appropriated for a State's needy citizens.

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.[7] 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.

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

[7] "State expenditures" is used here to mean annual expenditures from the States' own funding sources, and it excludes federal grants unless otherwise noted.

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[l] 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
1

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.

2

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 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

[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.

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.[14] *This amount equals nearly 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

[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.

$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 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

[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.

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.

2

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.

F

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). http://www.gwumc.edu/sphhs/departments/healthpolicy/dhp_publications/pub_uploads/dhpPublication_9BB1853A-5056-9D20-3D3DCBB99318306E.pdf.

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 (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?[26] 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

[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.

unprecedented holding? The fact that the ACA provides no mechanism (other than Medicaid) to finance health care for the poor, thereby presuming universal 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-conferred 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 significant difference among adults (particularly those living in the poorest communities) not only in access to care but also in self-reported health and measurable health outcomes in states that expanded Medicaid to cover low-income adults (the group aided by the ACA Medicaid expansion), compared to persons in states that had not so expanded their programs. Benjamin Sommers, Katherine Baicker, & Arnold Epstein, Mortality and Access to Care Among Adults after State Medicaid Expansions, *New Eng. J. Med.* [Online First] 10.1056/NEJMsa1202099 (July 25, 2012) http://www.nejm.org/doi/full/10.1056/NEJMsa1202099 (Accessed online, July 29, 2012). These results tell us that how state response to the decision is not just about money; it is about life and health as well. Timothy Jost & Sara Rosenbaum, The Supreme Court and the Future of Medicaid, *New Eng. J. Med.* [Online First] (10.1056/NEJMp1208219) http://www.nejm.org/doi/full/10.1056/NEJMp1208219?query=featured_home (Accessed July 29, 2012).

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.*

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

* 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 coverage for the group at any time. https://www.cms.gov/CCIIO/Resources/Files/Downloads/exchanges-faqs-12-10-2012.pdf (Accessed July 10, 2015).

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: *California v. Texas*, A Constitutional Attack on the ACA, Redux, and the Supreme Court Speaks Again

On June 17, 2021, in what Justice Alito termed "the third installment in our epic Affordable Care Act trilogy," the United States Supreme Court once again upheld the ACA in the latest challenge to its constitutionality. The origins of *California v Texas,* Slip op., https://www.supremecourt.gov/opinions/20pdf/19-840_6jfm.pdf , a case designed to tank the law in its entirety, began with the Tax Cuts and Jobs Act of 2017, P. L. 115-97, §11081, 131 Stat. 2092. Among numerous other provisions, the law reset to $0 the ACA's tax for failing to purchase what the ACA defines as affordable health insurance. (codified at 26 U.S.C. § 5000A). Previously the tax had been set at an amount deemed sufficient to act as a financial incentive to purchase affordable coverage rather than raise revenue (like, for example, taxation on earned income). In this sense, the law worked like a zillion other Internal Revenue Code provisions aimed at nudging people into certain types of socially desirable behaviors. The 2017 $0 reset, however, made the tax meaningless and therefore effectively made the "mandate" unenforceable.

Despite the total lack of any consequences for failing to purchase affordable coverage in the wake of the tax law (the zeroing out of the tax took effect in 2019), a group of states, along with several individuals, argued that the mandate remained a legal threat. As a result, for purposes of standing, the argument ran, people who refused to purchase coverage, and, for reasons delineated below, states in which such people reside, faced actual consequences that only the courts could cure by declaring the mandate unconstitutional. The plaintiffs further argued that given the unconstitutionality of a $0 tax (in *NFIB* the Court stated that a tax had to raise revenue to be constitutional, and thus, the penalty qualified as a tax no matter how small the actual amount), then the constitutional basis for the entire ACA evaporated. At this point, plaintiffs argued, the entire law was rendered unconstitutional since its thousands of other provisions were tied to the mandate and thus were constitutionally inseverable from the mandate itself.

Thus, the lawsuit, no matter how far-fetched, put everything in the ACA at risk—the market reforms, the marketplace subsidies, the exchanges, the Medicaid expansion funding, and a vast array of reforms to Medicare, Medicaid, other federal health care programs, the law's tax code provisions (such as additional duties for nonprofit hospitals claiming tax-exempt status), food labeling laws—in short, everything. Panic ensued. Briefs flew. Intervenors and amici stepped forward (the Trump administration ultimately took the side of the challengers, leaving no one to defend the law). Impact estimates abounded showing the magnitude of the damage flowing from striking down the ACA, since the ACA has affected virtually the entire health care system, from coverage, to health care financing, to public health regulation.

Initially, a federal district court agreed with the states and individual plaintiffs, concluding that constitutional standing existed, that the $0 penalty rendered the mandate unconstitutional, and that the entire law was inseverable. An appeals court affirmed on

the first two counts (standing and constitutionality) but remanded the case to the trial court to, in essence, conduct a section-by-section review of the massive law in order to determine which provisions could not survive the loss of the mandate. (For example, the mandate might fall, but the health insurance reforms might have survived as a valid exercise of Congress's Commerce Clause powers. Similarly, the Medicaid expansions and marketplace subsidies might have survived under Congress's Spending Clause powers). In short, the appellate court treated the severability question as one tied to the requested relief—that is, a question to be answered through a detailed analysis aimed at determining the scope of the remedy. Even this analysis, aimed divining what Congress would have intended when the ACA was passed, strained credulity, ignoring the fact that, first, the disastrous 2017 ACA "repeal and replace" effort had effectively ended at 1:30 in the morning of July 28th with a thumbs down from Senator John McCain on the pivotal vote, and second, in the 2017 tax law no one—not the Republicans supporting the tax law and not the Trump White House—intended to do more at that point than zero out the tax and take a minor victory lap.

During the Supreme Court argument, which took place on November 10, 2020, 2 days after the Presidential election, the Court's clear focus was on both standing and severability. Observers dismissed assertions of a total win for the challengers and predicted the law's survival on one ground or another. See Amy Howe, Argument analysis: ACA seems likely to survive, but on what ground?, *Scotusblog,* https://www.scotusblog.com/2020/11/argument-analysis-aca-seems-likely-to-survive-but-on-what-ground/.

When the decision finally came, it was anticlimactic, although it still was covered in the same breathless tones (justifiably) used when *NFIB* upheld the Act in 2012. The Chief Justice, who was in the 7-2 majority (Justice Thomas concurring; Justices Alito and Gorsuch dissenting), chose Justice Breyer to write the opinion for the Court, a nod to, perhaps, Justice Breyer's low-key writing style and to the fact that the longest-serving Justice, now 82, has been the subject of much resignation chatter and so was perhaps viewed as deserving to write the opinion as a sort of valedictory address. (There is no sign, as of July 2021, that Justice Breyer in fact is going anywhere soon). In his straightforward opinion, Justice Breyer made clear that the plaintiffs—both the states and the individuals—lacked standing. With the "mandate" now reduced to an unenforceable law, the constitutional basis for standing—a concrete and particularized injury, traceable to the defendant's unlawful action (i.e., the mandate), that could be remedied by judicial intervention—did not exist. No one—not the states, and not the plaintiffs—would face any consequences from anyone's failure to buy affordable coverage.

The states (many of them nonexpansion states but nonetheless affected by other ACA Medicaid reforms such as reforms to streamline enrollment and renewal and to make the process work for more people) tried to argue that the mere continued existence of the mandate forced them to spend more money on Medicaid, because even though it has always exempted people with incomes below the federal taxable threshold, the mandate would lead more people to enroll and renew their Medicaid coverage, whether

under the expansion eligibility category or under a traditional category. In effect, the plaintiffs argued, the mandate's inextricable linkage to all other ACA reforms meant that they could point to these other "injuries" (e.g., more enrollment) as a justification for finding not only remediable harm, but standing itself. In other words, the plaintiffs attempted to bootstrap inseverability into the standing domain – a "novel" theory according to the Court but one that it swatted away. The majority did not bite, instead viewing inseverability as a question that goes to the scope of relief—which provisions must fall—not to the threshold question of standing itself.

In his angry dissent, Justice Alito did take the bait, agreeing that severability implicates standing itself. However, in his opinion, Justice Alito seemingly, at least indirectly, gave away the store by declaring that "*to the extent* that the provisions of the ACA that burden the States are inextricably linked to the individual mandate, they too are unenforceable." [Alito dissent, *Slip. Op.*] at 4 [emphasis added]. The critical words are "to the extent" since they signify that the question of severability comes at the remedial stage, not the standing stage, and goes to which provisions have an independent constitutional basis. There seems to be no escaping the fact that it is the mandate that provides the focus of constitutional inquiry and that standing therefore is tied to the impact of the mandate itself.

So the ACA survived again. Commentators appear dubious as to whether it is possible that opponents of the ACA could manufacture another lawsuit that poses an existential threat to the law. The time may have come, in short, to move on. See, e.g., Adam Liptak, Affordable Care Act Survives Latest Supreme Court Challenge (New York Times, June 8, 2021).

One other fascinating aspect of the decision is our old friend Medicaid. Again and again, whether the question is legal harm or some states' refusal to adopt expansion, Medicaid emerges as the Great Satan to a number of states. Despite the good it does and despite the "boatload" of federal funding (in the words of Justice Kagan during the *NFIB* oral argument) it gives states, Medicaid, as the largest and most potent legal entitlement for the poor, looms over seemingly every federalism debate of consequence. With total enrollment now surpassing 74 million as a result of the pandemic—underscoring both the program's achievement as the largest public health safety net this nation has, as well as its astounding size—expect Medicaid's future to be at the core of every health reform debate for years to come. Amy Goldstein, Medicaid enrollment swells during the pandemic, reaching a new high. *Washington Post* (June 21, 2021).

Third Postscript to Part Two: *King v. Burwell*, the ongoing saga over contraception coverage, and federalism in enforcement

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]

[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

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.

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

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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.

more affordable by providing billions of dollars to the States' citizens; the other type of Exchange would not.[2]

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

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[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 precisely define what an Exchange must look like, however, so a Federal Exchange cannot differ from a State Exchange

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 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.[4]

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.

C

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"

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[4] 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).

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

[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.

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.

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 "*[f]ailure* 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.

V

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 responsib[ility] 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 *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-*King* all the time. After a slow start, popular and specialty media outlets flooded the news with stories (Googling *King v Burwell* on July 2, 2015 returned over 1.6 million hits). The arguments that ultimately led to *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 *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. *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, Doom for a Cynical Assault on Obamacare, http://www.newyorker.com/news/daily-comment/doom-for-a-cynical-assault-on-obamacare See also, Robert Pear, Four Words That Imperil Health Care Law Were All a Mistake, Writers Now Say, New York Times (May 25,

2015) 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 subsides 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 restructured 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,* Akiro 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 proceed. Abbe Gluck, *Symposium: Congress has a "plan" and the Court can understand it – The Court rises to the challenge of statutory complexity in King v. Burwell* http://www.scotusblog.com/2015/06/symposium-congress-has-a-plan-and-the-court-can-understand-it-the-court-rises-to-the-challenge-of-statutory-complexity-in-king-v-burwell/ (accessed July 8, 2015).

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 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 (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/ (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,

[*] 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.

Budgetary and Economic Effects of Repealing the Affordable Care Act (June 19, 2015) 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/* (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/ (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 Supplement, 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, Exemptions, and Religious Accommodation: The Unending Saga of the ACA's Women's Preventive Services Benefit

The Affordable Care Act requires health insurance plans sold in the individual and group markets, as well as self-insured employer plans, to cover, without cost-sharing, a range of preventive health services set forth in implementing regulations and guidance. The preventive services requirement exempts "grandfathered" health plans purchased on

or before March 23, 2010 (the date of final ACA passage) whose coverage and cost-sharing terms have not changed significantly since this date, as defined in federal rules. 45 C.F.R. § 147.140. Also unaffected are short term, limited duration insurance plans that exist outside the scope of the ACA's market reforms. Katie Keith, The Short-Term Limited Duration Coverage Final Rule: The Background, the Content, and What Could Come Next, *Health Affairs Blog,* https://www.healthaffairs.org/do/10.1377/hblog20180801.169759/full/ (Accessed August 1 2018).*

Among the types of preventive services subject to the requirement are women's preventive health services. Specifically 42 U.S.C. § 300gg-13, added to the Public Health Service Act by the ACA** provides as follows:

> **(a) In general.** 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—
>
> **(1)** evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force;
>
> **(2)** immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; and
>
> **(3)** with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.
>
> **(4)** with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.

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* (In July 2020, the United States Court of Appeals for the D.C. Circuit rejected a challenge to regulations issued by the Trump administration that vastly expand the size of the short-term plan market by allowing issuers to sell virtually unregulated plans with year-long coverage periods (rather than limited to a few months to enable people to bridge short breaks in coverage), span multiple years and can be repeatedly renewed. Association for Community Affiliated Plans v. United States Department of the Treasury (D.C. Cir., No. 19-5212, 2020).

** As with all of the ACA's market regulation rules, this amendment is written as a trifecta, with parallel amendments found under the Public Health Service Act, the Internal Revenue Code, and ERISA's Labor Code provisions. The most typical reference in cases that address the ACA's health insurance market regulations is to the PHS Act version.

The women's health provision was a compromise; rather than including language explicitly covering all FDA-approved contraceptive methods, the Senate (whose bill ultimately became law) adopted directed the Health Resources and Services Administration (HRSA), an agency that, among other activities, sets clinical practice protocols, the task of creating guidelines spelling out coverage. Following a report commissioned from the Institute of Medicine (now the National Academy of Medicine), HRSA issued its guidelines and the Obama administration issued accompanying regulations.

The fight over which ACA-regulated employer health plans should be subject to these standards effectively prevented Senate passage of detailed standards and continues to this day. The regulatory phase of the fight began with the Obama administration's initial 2011 rules implementing the HRSA guidelines. Ultimately the rules contained a narrow exemption for houses of worship, i.e., churches, and an "accommodation" covering nonprofit religious employers under which they could self-certify their objection to contraceptive coverage, in which case their insurer or plan administrator (in the case of self-insured plans) would keep the benefit in the plan but would itself pay that portion of the premium attributable to contraceptive coverage.

The rules spawned two distinct but related sets of legal challenges, one brought by religious nonprofit organizations that objected to the accommodation on the ground that the accommodation makes them "complicit" in giving their employees access to coverage through their employer plan. The second line of challenges was brought by for-profit employers that objected to the contraceptive mandate itself. In the end, however, both nonprofit and for-profit employers wanted the same thing—not an accommodation but a complete exemption from the coverage rules.

Following years of litigation over the narrowness of the Obama administration's exemption and its self-certification accommodation, the Trump administration granted the challengers' wishes in regulations published later in 2017 that create sweeping religious and moral exemptions estimated to affect as many as 120,000 women. These regulations were immediately challenged on both substantive and procedural grounds. Following a nationwide preliminary injunction issued in 2019, the Supreme Court agreed to hear the appeal.

Below is the 2020 installment of the ongoing legal battle. As you will see, this care really is just the latest chapter, not the final word on the subject. But this time, tens of thousands of women stand to lose some or all contraceptive coverage under their employer plans while we all wait for the next chapter to be written.

Little Sisters of the Poor Saints Peter and Paul Home v Pennsylvania

140 S. Ct. 2367
2020 WL 3808424
July 8, 2020

Justice THOMAS delivered the opinion of the Court.

In these consolidated cases, we decide whether the Government created lawful exemptions from a regulatory requirement implementing the Patient Protection and Affordable Care Act of 2010 (ACA). The requirement at issue obligates certain employers to provide contraceptive coverage to their employees through their group health plans. Though contraceptive coverage is not required by (or even mentioned in) the ACA provision at issue, the Government mandated such coverage by promulgating interim final rules (IFRs) shortly after the ACA's passage. This requirement is known as the contraceptive mandate.

After six years of protracted litigation, the Departments of Health and Human Services, Labor, and the Treasury (Departments)—which jointly administer the relevant ACA provision—exempted certain employers who have religious and conscientious objections from this agency-created mandate. The Third Circuit concluded that the Departments lacked statutory authority to promulgate these exemptions and affirmed the District Court's nationwide preliminary injunction. This decision was erroneous. We hold that the Departments had the authority to provide exemptions from the regulatory contraceptive requirements for employers with religious and conscientious objections. We accordingly reverse the Third Circuit's judgment and remand with instructions to dissolve the nationwide preliminary injunction.

I

The ACA's contraceptive mandate—a product of agency regulation—has existed for approximately nine years. Litigation surrounding that requirement has lasted nearly as long. In light of this extensive history, we begin by summarizing the relevant background.

The ACA requires covered employers to offer "a group health plan or group health insurance coverage" that provides certain "minimum essential coverage." 26 U.S.C. § 5000A(f)(2); §§ 4980H(a), (c)(2). Employers who do not comply face hefty penalties, including potential fines of $100 per day for each affected employee. These cases concern regulations promulgated under a provision of the ACA that requires covered employers to provide women with "preventive care and screenings" without "any cost sharing requirements." 42 U.S.C. § 300gg–13(a)(4).[2]

[2] The ACA exempts "grandfathered" plans from [the mandate]—*i.e.*, "those [plans] that existed prior to March 23, 2010, and that have not made specified changes after that date." As of 2018, an estimated 16

The statute does not define "preventive care and screenings," nor does it include an exhaustive or illustrative list of such services. Thus, the statute itself does not explicitly require coverage for any specific form of "preventive care." Instead, Congress stated that coverage must include "such additional preventive care and screenings . . . as provided for in comprehensive guidelines supported by the Health Resources and Services Administration" (HRSA), an agency of the Department of Health and Human Services (HHS). At the time of the ACA's enactment, these guidelines were not yet written. As a result, no specific forms of preventive care or screenings were (or could be) referred to or incorporated by reference.

Soon after the ACA's passage, the Departments began promulgating rules related to § 300gg–13(a)(4). But in doing so, the Departments did not proceed through the notice and comment rulemaking process, which the Administrative Procedure Act (APA) often requires before an agency's regulation can have the force and effect of law. Instead, the Departments invoked the APA's good cause exception, which permits an agency to dispense with notice and comment and promulgate an IFR that carries immediate legal force.

The first relevant IFR, promulgated in July 2010, primarily focused on implementing other aspects of § 300gg–13. The IFR indicated that HRSA planned to develop its Preventive Care Guidelines (Guidelines) by August 2011. However, it did not mention religious exemptions or accommodations of any kind. As anticipated, HRSA released its first set of Guidelines in August 2011. The Guidelines required health plans to provide coverage for all contraceptive methods and sterilization procedures approved by the Food and Drug Administration as well as related education and counseling.

The same day the Guidelines were issued, the Departments amended the 2010 IFR. When the 2010 IFR was originally published, the Departments began receiving comments from numerous religious employers expressing concern that the Guidelines would "impinge upon their religious freedom" if they included contraception. In the amended IFR, the Departments determined that "it [was] appropriate that HRSA . . . tak[e] into account the [mandate's] effect on certain religious employers" and concluded that HRSA had the discretion to do so through the creation of an exemption. The Departments then determined that the exemption should cover religious employers, and they set out a four-part test to identify which employers qualified. The last criterion required the entity to be a church, an integrated auxiliary, a convention or association of churches, or "the exclusively religious activities of any religious order." Because of the narrow focus on churches, this first exemption is known as the church exemption.

The Guidelines were scheduled to go into effect for plan years beginning on August 1, 2012. But in February 2012, before the Guidelines took effect, the Departments

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percent of employees with employer-sponsored coverage were enrolled in a grandfathered group health plan.

promulgated a final rule that temporarily prevented the Guidelines from applying to certain religious nonprofits. Specifically, the Departments stated their intent to promulgate additional rules to "accommodat[e] non-exempted, non-profit organizations' religious objections to covering contraceptive services." Until that rulemaking occurred, the 2012 rule also provided a temporary safe harbor to protect such employers. The safe harbor covered nonprofits "whose plans have consistently not covered all or the same subset of contraceptive services for religious reasons." Thus, the nonprofits who availed themselves of this safe harbor were not subject to the contraceptive mandate when it first became effective.

The Departments promulgated another final rule in 2013 that is relevant to these cases in two ways. First, after reiterating that § 300gg–13(a)(4) authorizes HRSA "to issue guidelines in a manner that exempts group health plans established or maintained by religious employers," the Departments "simplif[ied]" and "clarif[ied]" the definition of a religious employer. Second, pursuant to that same authority, the Departments provided the anticipated accommodation for eligible religious organizations, which the regulation defined as organizations that "(1) [o]ppos[e] providing coverage for some or all of the contraceptive services . . . on account of religious objections; (2) [are] organized and operat[e] as . . . nonprofit entit[ies]; (3) hol[d] [themselves] out as . . . religious organization[s]; and (4) self-certif[y] that [they] satisf[y] the first three criteria." The accommodation required an eligible organization to provide a copy of the self-certification form to its health insurance issuer, which in turn would exclude contraceptive coverage from the group health plan and provide payments to beneficiaries for contraceptive services separate from the health plan. The Departments stated that the accommodation aimed to "protec[t]" religious organizations "from having to contract, arrange, pay, or refer for [contraceptive] coverage" in a way that was consistent with and did not violate the Religious Freedom Restoration Act of 1993 (RFRA). This accommodation is referred to as the self-certification accommodation.

B

Shortly after the Departments promulgated the 2013 final rule, two religious nonprofits run by the Little Sisters of the Poor (Little Sisters) challenged the self-certification accommodation. They challenged the self-certification accommodation, claiming that completing the certification form would force them to violate their religious beliefs by "tak[ing] actions that directly cause others to provide contraception or appear to participate in the Departments' delivery scheme." As a result, they alleged that the self-certification accommodation violated RFRA. Under RFRA, a law that substantially burdens the exercise of religion must serve "a compelling governmental interest" and be "the least restrictive means of furthering that compelling governmental interest." The Court of Appeals disagreed that the self-certification accommodation substantially burdened the Little Sisters' free exercise rights and thus rejected their RFRA claim.

The Little Sisters were far from alone in raising RFRA challenges to the self-certification accommodation. Religious nonprofit organizations and educational

institutions across the country filed a spate of similar lawsuits, most resulting in rulings that the accommodation did not violate RFRA. We granted certiorari in cases from four Courts of Appeals to decide the RFRA question. (per curiam). Ultimately, however, we opted to remand the cases without deciding that question. In supplemental briefing, the Government had confirm[ed] that contraceptive coverage could be provided to petitioners' employees, through petitioners' insurance companies, without any . . . notice from petitioners. Petitioners, for their part, had agreed that such an approach would not violate their free exercise rights. Accordingly, because all parties had accepted that an alternative approach was "feasible," we directed the Government to accommodat[e] 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.

C

Zubik was not the only relevant ruling from this Court about the contraceptive mandate. As the Little Sisters and numerous others mounted their challenges to the self-certification accommodation, a host of other entities challenged the contraceptive mandate itself as a violation of RFRA. This Court granted certiorari in two cases involving three closely held corporations to decide whether the mandate violated RFRA.

The individual respondents in *Hobby Lobby* opposed four methods of contraception covered by the mandate. They sincerely believed that human life begins at conception and that, because the challenged methods of contraception risked causing the death of a human embryo, providing those methods of contraception to employees would make the employers complicit in abortion. We held that the mandate substantially burdened respondents' free exercise, explaining that "[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." We also held that the mandate did not utilize the least restrictive means, citing the self-certification accommodation as a less burdensome alternative. Thus, as the Departments began the task of reformulating rules related to the contraceptive mandate, they did so not only under *Zubik*'s direction to accommodate religious exercise, but also against the backdrop of *Hobby Lobby*'s pronouncement that the mandate, standing alone, violated RFRA as applied to religious entities with complicity-based objections.

D

In 2016, the Departments attempted to strike the proper balance a third time, publishing a request for information on ways to comply with *Zubik*. This attempt proved futile, as the Departments ultimately concluded that "no feasible approach" had been identified. Dept. of Labor, FAQs About Affordable Care Act Implementation Part 36, p.

4 (2017).* The Departments maintained their position that the self-certification accommodation was consistent with RFRA because it did not impose a substantial burden and, even if it did, it utilized the least restrictive means of achieving the Government's interests.

In 2017, the Departments tried yet again** to comply with *Zubik*, this time by promulgating the two IFRs that served as the impetus for this litigation. The first IFR significantly broadened the definition of an exempt religious employer to encompass an employer that "objects . . . based on its sincerely held religious beliefs," "to its establishing, maintaining, providing, offering, or arranging [for] coverage or payments for some or all contraceptive services." Among other things, this definition included for-profit and publicly traded entities. Because they were exempt, these employers did not need to participate in the accommodation process, which nevertheless remained available under the IFR.

As with their previous regulations, the Departments once again invoked § 300gg–13(a)(4) as authority to promulgate this "religious exemption," stating that it "include[d] the ability to exempt entities from coverage requirements announced in HRSA's Guidelines." Additionally, the Departments announced for the first time that RFRA compelled the creation of, or at least provided the discretion to create, the religious exemption. As the Departments explained: "We know from *Hobby Lobby* that, in the absence of any accommodation, the contraceptive-coverage requirement imposes a substantial burden on certain objecting employers. We know from other lawsuits and public comments that many religious entities have objections to complying with the [self-certification] accommodation based on their sincerely held religious beliefs." The Departments "believe[d] that the Court's analysis in *Hobby Lobby* extends, for the purposes of analyzing a substantial burden, to the burdens that an entity faces when it religiously opposes participating in the [self-certification] accommodation process." They thus "conclude[d] that it [was] appropriate to expand the exemption to other . . . organizations with sincerely held religious beliefs opposed to contraceptive coverage."

The second IFR created a similar "moral exemption" for employers—including nonprofits and for-profits with no publicly traded components—with "sincerely held moral" objections to providing some or all forms of contraceptive coverage. Citing congressional enactments, precedents from this Court, agency practice, and state laws that provided for conscience protections, the Departments invoked their authority under the ACA to create this exemption. The Departments requested post-promulgation comments on both IFRs.

E

* This Department of Labor communication came on January 9, 2017, before the Obama administration left office. See https://www.dol.gov/sites/dolgov/files/EBSA/about-ebsa/our-activities/resource-center/faqs/aca-part-36.pdf.

** By this time, the Trump administration was in charge; hence, the 180-degree turn.

Within a week of the 2017 IFRs' promulgation, the Commonwealth of Pennsylvania filed an action seeking declaratory and injunctive relief. Among other claims, it alleged that the IFRs were procedurally and substantively invalid under the APA. The District Court held that the Commonwealth was likely to succeed on both claims and granted a preliminary nationwide injunction against the IFRs. The Federal Government appealed.

While that appeal was pending, the Departments issued rules finalizing the 2017 IFRs. Though the final rules left the exemptions largely intact, they also responded to post-promulgation comments, explaining their reasons for neither narrowing nor expanding the exemptions beyond what was provided for in the IFRs. The final rule creating the religious exemption also contained a lengthy analysis of the Departments' changed position regarding whether the self-certification process violated RFRA. And the Departments explained that, in the wake of the numerous lawsuits challenging the self-certification accommodation and the failed attempt to identify alternative accommodations after the 2016 request for information, "an expanded exemption rather than the existing accommodation is the most appropriate administrative response to the substantial burden identified by the Supreme Court in *Hobby Lobby*."

After the final rules were promulgated, the State of New Jersey joined Pennsylvania's suit and, together, they filed an amended complaint. As relevant, the States—respondents here—once again challenged the rules as substantively and procedurally invalid under the APA. They alleged that the rules were substantively unlawful because the Departments lacked statutory authority under either the ACA or RFRA to promulgate the exemptions. Respondents also asserted that the IFRs were not adequately justified by good cause, meaning that the Departments impermissibly used the IFR procedure to bypass the APA's notice and comment procedures. Finally, respondents argued that the purported procedural defects of the IFRs likewise infected the final rules.

The District Court issued a nationwide preliminary injunction against the implementation of the final rules the same day the rules were scheduled to take effect. The Federal Government appealed, as did one of the homes operated by the Little Sisters, which had in the meantime intervened in the suit to defend the religious exemption. The appeals were consolidated with the previous appeal, which had been stayed.

The Third Circuit affirmed. In its view, the Departments lacked authority to craft the exemptions under either statute. The Third Circuit read 42 U.S.C. § 300gg–13(a)(4) as empowering HRSA to determine which services should be included as preventive care and screenings, but not to carve out exemptions from those requirements. It also concluded that RFRA did not compel or permit the religious exemption because the self-certification accommodation did not impose a substantial burden on free exercise. As for respondents' procedural claim, the court held that the Departments lacked good cause to bypass notice and comment when promulgating the 2017 IFRs. In addition, the court determined that, because the IFRs and final rules were "virtually identical," "[t]he notice

and comment exercise surrounding the Final Rules [did] not reflect any real open-mindedness." Though it rebuked the Departments for their purported attitudinal deficiencies, the Third Circuit did not identify any specific public comments to which the agency did not appropriately respond. We granted certiorari.

II

Respondents contend that the 2018 final rules providing religious and moral exemptions to the contraceptive mandate are both substantively and procedurally invalid. We begin with their substantive argument that the Departments lacked statutory authority to promulgate the rules.

A

The Departments invoke 42 U.S.C. § 300gg–13(a)(4) as legal authority for both exemptions. This provision of the ACA states that, "with respect to women," "[a] group health plan and a health insurance issuer offering group or individual health insurance coverage shall, at a minimum provide . . . such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by [HRSA]." The Departments maintain, as they have since 2011, that the phrase "as provided for" allows HRSA both to identify what preventive care and screenings must be covered and to exempt or accommodate certain employers' religious objections. They also argue that, as with the church exemption, their role as the administering agencies permits them to guide HRSA in its discretion by "defining the scope of permissible exemptions and accommodations for such guidelines." Respondents, on the other hand, contend that § 300gg–13(a)(4) permits HRSA to only list the preventive care and screenings that health plans "shall . . . provide," not to exempt entities from covering those identified services. Because that asserted limitation is found nowhere in the statute, we agree with the Departments.

Our analysis begins and ends with the text. Here, the pivotal phrase is "as provided for." To "provide" means to supply, furnish, or make available. See Webster's Third New International Dictionary 1827 (2002) (Webster's Third); American Heritage Dictionary 1411 (4th ed. 2000); 12 Oxford English Dictionary 713 (2d ed. 1989). And, as the Departments explained, the word "as" functions as an adverb modifying "provided," indicating "the manner in which" something is done. See also Webster's Third 125; 1 Oxford English Dictionary, at 673; American Heritage Dictionary 102 (5th ed. 2011).

On its face, then, the provision grants sweeping authority to HRSA to craft a set of standards defining the preventive care that applicable health plans must cover. But the statute is completely silent as to what those "comprehensive guidelines" must contain, or how HRSA must go about creating them. The statute does not, as Congress has done in other statutes, provide an exhaustive or illustrative list of the preventive care and screenings that must be included. It does not, as Congress did elsewhere in the same section of the ACA, set forth any criteria or standards to guide HRSA's selections. See,

e.g., 42 U.S.C. § 300gg–13(a)(3) (requiring "*evidence-informed* preventive care and screenings" (emphasis added)); § 300gg–13(a)(1) ("evidence-based items or services"). It does not, as Congress has done in other contexts, require that HRSA consult with or refrain from consulting with any party in the formulation of the Guidelines. This means that HRSA has virtually unbridled discretion to decide what counts as preventive care and screenings. But the same capacious grant of authority that empowers HRSA to make these determinations leaves its discretion equally unchecked in other areas, including the ability to identify and create exemptions from its own Guidelines.

Congress could have limited HRSA's discretion in any number of ways, but it chose not to do so. Instead, it enacted expansive language offer[ing] no indication whatever that the statute limits what HRSA can designate as preventive care and screenings or who must provide that coverage. This principle applies not only to adding terms not found in the statute, but also to imposing limits on an agency's discretion that are not supported by the text. By introducing a limitation not found in the statute, respondents ask us to alter, rather than to interpret, the ACA. By its terms, the ACA leaves the Guidelines' content to the exclusive discretion of HRSA. Under a plain reading of the statute, then, we conclude that the ACA gives HRSA broad discretion to define preventive care and screenings and to create the religious and moral exemptions.[7]

The dissent resists this conclusion, asserting that the Departments' interpretation thwarts Congress' intent to provide contraceptive coverage to the women who are interested in receiving such coverage. It also argues that the exemptions will make it significantly harder for interested women to obtain seamless access to contraception without cost sharing, which we have previously "assume[d]" is a compelling governmental interest, *Hobby Lobby*. The Departments dispute that women will be adversely impacted by the 2018 exemptions. Though we express no view on this disagreement, it bears noting that such a policy concern cannot justify supplanting the text's plain meaning. Moreover, even assuming that the dissent is correct as an empirical matter, its concerns are more properly directed at the regulatory mechanism that Congress put in place to protect this assumed governmental interest. As even the dissent recognizes, contraceptive coverage is mentioned nowhere in § 300gg–13(a)(4), and no language in the statute itself even hints that Congress intended that contraception should or must be covered. Thus, contrary to the dissent's protestations, it was Congress, not the

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[7] Though not necessary for this analysis, our decisions in *Zubik* v. *Burwell* and *Hobby Lobby* implicitly support the conclusion that § 300gg–13(a)(4) empowered HRSA to create the exemptions. As respondents acknowledged at oral argument, accepting their interpretation of the ACA would require us to conclude that the Departments had no authority under the ACA to promulgate the initial church exemption, which by extension would mean that the Departments lacked authority for the 2013 self-certification accommodation. That reading of the ACA would create serious tension with *Hobby Lobby*, which pointed to the self-certification accommodation as an example of a less restrictive means available to the Government, and which expressly directed the Departments to "accommodat[e]" petitioners' religious exercise. It would be passing strange for this Court to direct the Departments to make such an accommodation if it thought the ACA did not authorize one. In addition, we are not aware of, and the dissent does not point to, a single case predating or in which the Departments took the position that they could not adopt a different approach because they lacked the statutory authority under the ACA to do so.

Departments, that declined to expressly require contraceptive coverage in the ACA itself. And, it was Congress' deliberate choice to issue an extraordinarily "broad general directiv[e]" to HRSA to craft the Guidelines, without any qualifications as to the substance of the Guidelines or whether exemptions were permissible. Thus, it is Congress, not the Departments, that has failed to provide the protection for contraceptive coverage that the dissent seeks. [8]

No party has pressed a constitutional challenge to the breadth of the delegation involved here. The only question we face today is what the plain language of the statute authorizes. And the plain language of the statute clearly allows the Departments to create the preventive care standards as well as the religious and moral exemptions.

B

The Departments also contend, consistent with the reasoning in the 2017 IFR and the 2018 final rule establishing the religious exemption, that RFRA independently compelled the Departments' solution or that it at least authorized it. In light of our holding that the ACA provided a basis for both exemptions, we need not reach these arguments. We do, however, address respondents' argument that the Departments could not even consider RFRA as they formulated the religious exemption from the contraceptive mandate. Particularly in the context of these cases, it was appropriate for the Departments to consider RFRA.

As we have explained, RFRA "provide[s] very broad protection for religious liberty. *Hobby Lobby*. In RFRA's congressional findings, Congress stated that "governments should not substantially burden religious exercise," a right described by RFRA as "unalienable." To protect this right, Congress provided that the "[g]overnment shall not substantially burden a person's exercise of religion even if the burden results from a rule of general applicability" unless "it demonstrates that application of the burden . . . is in furtherance of a compelling governmental interest; and . . . is the least restrictive means of furthering that compelling governmental interest." Placing Congress' intent beyond dispute, RFRA specifies that it applies to all Federal law, and the implementation of that law, whether statutory or otherwise.

It is clear from the face of the statute that the contraceptive mandate is capable of violating RFRA. The ACA does not explicitly exempt RFRA, and the regulations implementing the contraceptive mandate qualify as "Federal law" or "the implementation of [Federal] law." Additionally, we expressly stated in that the contraceptive mandate

[8] HRSA has altered its Guidelines multiple times since 2011, always proceeding without notice and comment. Accordingly, if HRSA chose to exercise that discretion to remove contraception coverage from the next iteration of its Guidelines, it would arguably nullify the contraceptive mandate altogether without proceeding through notice and comment. The combination of the agency practice of proceeding without notice and comment and HRSA's discretion to alter the Guidelines, though not necessary for our analysis, provides yet another indication of Congress' failure to provide strong protections for contraceptive coverage.

violated RFRA as applied to entities with complicity-based objections. Thus, the potential for conflict between the contraceptive mandate and RFRA is well settled. Against this backdrop, it is unsurprising that RFRA would feature prominently in the Departments' discussion of exemptions that would not pose similar legal problems. Moreover, our decisions all but instructed the Departments to consider RFRA going forward. It is hard to see how the Departments could promulgate rules consistent with these decisions if they did not overtly consider these entities' rights under RFRA.

This is especially true in light of the basic requirements of the rulemaking process. Our precedents require final rules to "articulate a satisfactory explanation for [the] action including a rational connection between the facts found and the choice made." This requirement allows courts to assess whether the agency has promulgated an arbitrary and capricious rule by entirely fail[ing] to consider an important aspect of the problem [or] offer[ing] an explanation for its decision that runs counter to the evidence before [it]. Here, the Departments were aware that held the mandate unlawful as applied to religious entities with complicity-based objections. They were also aware of *Zubik*'s instructions. And, aside from our own decisions, the Departments were mindful of the RFRA concerns raised in "public comments and . . . court filings in dozens of cases—encompassing hundreds of organizations." If the Departments did not look to RFRA's requirements or discuss RFRA at all when formulating their solution, they would certainly be susceptible to claims that the rules were arbitrary and capricious for failing to consider an important aspect of the problem. Thus, respondents' argument that the Departments erred by looking to RFRA as a guide when framing the religious exemption is without merit.

III

Because we hold that the Departments had authority to promulgate the exemptions, we must next decide whether the 2018 final rules are procedurally invalid. Respondents present two arguments on this score. Neither is persuasive.

A

Unless a statutory exception applies, the APA requires agencies to publish a notice of proposed rulemaking in the Federal Register before promulgating a rule that has legal force. Respondents point to the fact that the 2018 final rules were preceded by a document entitled "Interim Final Rules with Request for Comments," not a document entitled "General Notice of Proposed Rulemaking." They claim that since this was insufficient to satisfy [the APA] requirement, the final rules were procedurally invalid. Respondents are incorrect. Formal labels aside, the rules contained all of the elements of a notice of proposed rulemaking as required by the APA.

The APA requires that the notice of proposed rulemaking contain "reference to the legal authority under which the rule is proposed" and "either the terms or substance of the proposed rule or a description of the subjects and issues involved." The request for comments in the 2017 IFRs readily satisfies these requirements. That request detailed the

Departments' view that they had legal authority under the ACA to promulgate both exemptions, as well as authority under RFRA to promulgate the religious exemption, And respondents do not—and cannot—argue that the IFRs failed to air the relevant issues with sufficient detail for respondents to understand the Departments' position. Thus, the APA notice requirements were satisfied.

Even assuming that the APA requires an agency to publish a document entitled "notice of proposed rulemaking" when the agency moves from an IFR to a final rule, there was no "prejudicial error" here. We have previously noted that the rule of prejudicial error is treated as an administrative law . . . harmless error rule. Respondents thus do not come close to demonstrating that they experienced any harm from the title of the document, let alone that they have satisfied this harmless error rule. The object [of notice and comment], in short, is one of fair notice, and respondents certainly had such notice here. Because the IFR complied with the APA's requirements, this claim fails.

B

Next, respondents contend that the 2018 final rules are procedurally invalid because "nothing in the record signal[s]" that the Departments "maintained an open mind throughout the [post-promulgation] process." As evidence for this claim, respondents point to the fact that the final rules made only minor alterations to the IFRs, leaving their substance unchanged. The Third Circuit applied this "open-mindedness" test, concluding that because the final rules were "virtually identical" to the IFRs, the Departments lacked the requisite "flexible and open-minded attitude" when they promulgated the final rules.

We decline to evaluate the final rules under the open-mindedness test. We have repeatedly stated that the text of the APA provides the maximum procedural requirements that an agency must follow in order to promulgate a rule. Because the APA sets forth the full extent of judicial authority to review executive agency action for procedural correctness, we have repeatedly rejected courts' attempts to impose judge-made procedur[es] in addition to the APA's mandates. And like the procedures that we have held invalid, the open-mindedness test violates the general proposition that courts are not free to impose upon agencies specific procedural requirements that have no basis in the APA. Rather than adopting this test, we focus our inquiry on whether the Departments satisfied the APA's objective criteria, just as we have in previous cases. We conclude that they did.

[APA requirements] obligated the Departments to provide adequate notice before promulgating a rule that has legal force. [T]he IFRs provided sufficient notice. Aside from these notice requirements, the APA mandates that agencies give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments; states that the final rules must include "a concise general statement of their basis and purpose[ ]"; and requires that final rules must be published 30 days before they become effective.

The Departments complied with each of these statutory procedures. They "request[ed] and encourag[ed] public comments on all matters addressed" in the rules—i.e., the basis for the Departments' legal authority, the rationales for the exemptions, and the detailed discussion of the exemptions' scope. They also gave interested parties 60 days to submit comments. The final rules included a concise statement of their basis and purpose, explaining that the rules were "necessary to protect sincerely held" moral and religious objections and summarizing the legal analysis supporting the exemptions. Lastly, the final rules were published on November 15, 2018, but did not become effective until January 14, 2019—more than 30 days after being published. In sum, the rules fully complied with the maximum procedural requirements [that] Congress was willing to have the courts impose upon agencies in conducting rulemaking procedures. Accordingly, respondents' second procedural challenge also fails.

* * *

For over 150 years, the Little Sisters have engaged in faithful service and sacrifice, motivated by a religious calling to surrender all for the sake of their brother. But for the past seven years, they—like many other religious objectors who have participated in the litigation and rulemakings leading up to today's decision—have had to fight for the ability to continue in their noble work without violating their sincerely held religious beliefs. After two decisions from this Court and multiple failed regulatory attempts, the Federal Government has arrived at a solution that exempts the Little Sisters from the source of their complicity-based concerns—the administratively imposed contraceptive mandate.

We hold today that the Departments had the statutory authority to craft that exemption, as well as the contemporaneously issued moral exemption. We further hold that the rules promulgating these exemptions are free from procedural defects. Therefore, we reverse the judgment of the Court of Appeals and remand the cases for further proceedings consistent with this opinion.

It is so ordered.

Justice ALITO, with whom Justice GORSUCH joins, concurring.

In these cases, the Court of Appeals held, among other things, (1) that the Little Sisters of the Poor lacked standing to appeal, (2) that the Affordable Care Act (ACA) does not permit any exemptions from the so-called contraceptive mandate, (3) that the Departments responsible for issuing the challenged rule violated the Administrative Procedure Act (APA) by failing to provide notice of proposed rulemaking, and (4) that the final rule creating the current exemptions is invalid because the Departments did not have an open mind when they considered comments to the rule. Based on this analysis, the Court of Appeals affirmed the nationwide injunction issued by the District Court.

This Court now concludes that all the holdings listed above were erroneous, and I join the opinion of the Court in full. We now send these cases back to the lower courts, where the Commonwealth of Pennsylvania and the State of New Jersey are all but certain to pursue their argument that the current rule is flawed on yet another ground, namely, that it is arbitrary and capricious and thus violates the APA. This will prolong the legal battle in which the Little Sisters have now been engaged for seven years—even though during all this time no employee of the Little Sisters has come forward with an objection to the Little Sisters' conduct.

I understand the Court's desire to decide no more than is strictly necessary, but under the circumstances here, I would decide one additional question: whether the Court of Appeals erred in holding that the Religious Freedom Restoration Act (RFRA) does not compel the religious exemption granted by the current rule. If RFRA requires this exemption, the Departments did not act in an arbitrary and capricious manner in granting it. And in my judgment, RFRA compels an exemption for the Little Sisters and any other employer with a similar objection to what has been called the accommodation to the contraceptive mandate.

[Justice Alito's extended analysis of why RFRA also would be violated in the absence if exemptions is omitted].

Justice KAGAN, with whom Justice BREYER joins, concurring in the judgment.

I would uphold HRSA's statutory authority to exempt certain employers from the contraceptive-coverage mandate, but for different reasons than the Court gives. I also write separately because I question whether the exemptions can survive administrative law's demand for reasoned decisionmaking. That issue remains open for the lower courts to address.

The majority and dissent dispute the breadth of the delegation in the Women's Health Amendment to the ACA. The Amendment states that a health plan or insurer must offer coverage for "preventive care and screenings . . . as provided for in comprehensive guidelines supported by [HRSA] for purposes of this paragraph." The disputed question is just what HRSA can "provide for." Both the majority and the dissent agree that HRSA's guidelines can differentiate among preventive services, mandating coverage of some but not others. The opinions disagree about whether those guidelines can also differentiate among health plans, exempting some but not others from the contraceptive-coverage requirement. On that question, all the two opinions have in common is equal certainty they are right. Compare ante, at —— (majority opinion) (Congress "enacted expansive language offer[ing] no indication whatever that the statute limits what HRSA can designate as preventive care and screenings or who must provide that coverage" (internal quotation marks omitted)), with post, at —— (GINSBURG, J., dissenting) ("Nothing in [the statute] accord[s] HRSA authority" to decide "who must provide coverage" (internal quotation marks omitted; emphasis in original)).

Try as I might, I do not find that kind of clarity in the statute. Sometimes when I squint, I read the law as giving HRSA discretion over all coverage issues: The agency gets to decide who needs to provide what services to women. At other times, I see the statute as putting the agency in charge of only the "what" question, and not the "who." If I had to, I would of course decide which is the marginally better reading. But deference was built for cases like these. *Chevron* instructs that a court facing statutory ambiguity should accede to a reasonable interpretation by the implementing agency. The court should do so because the agency is the more politically accountable actor. And it should do so because the agency's expertise often enables a sounder assessment of which reading best fits the statutory scheme.

Here, the Departments have adopted the majority's reading of the statutory delegation ever since its enactment. Over the course of two administrations, the Departments have shifted positions on many questions involving the Women's Health Amendment and the ACA more broadly. But not on whether the Amendment gives HRSA the ability to create exemptions to the contraceptive-coverage mandate. HRSA adopted the original church exemption on the same capacious understanding of its statutory authority as the Departments endorse today. While the exemption itself has expanded, the Departments' reading of the statutory delegation—that the law gives HRSA discretion over the "who" question—has remained the same. I would defer to that longstanding and reasonable interpretation.

But that does not mean the Departments should prevail when these cases return to the lower courts. The States challenged the exemptions not only as outside HRSA's statutory authority, but also as arbitrary [and] capricious. Because the courts below found for the States on the first question, they declined to reach the second. That issue is now ready for resolution, unaffected by today's decision. An agency acting within its sphere of delegated authority can of course flunk the test of reasoned decisionmaking. The agency does so when it has not given "a satisfactory explanation for its action"—when it has failed to draw a "rational connection" between the problem it has identified and the solution it has chosen, or when its thought process reveals "a clear error of judgment." Assessed against that standard of reasonableness, the exemptions HRSA and the Departments issued give every appearance of coming up short.[2]

Most striking is a mismatch between the scope of the religious exemption and the problem the agencies set out to address. In the Departments' view, the exemption was "necessary to expand the protections" for "certain entities and individuals" with "religious objections" to contraception. Recall that under the old system, an employer objecting to the contraceptive mandate for religious reasons could avail itself of the "self-certification accommodation." Upon making the certification, the employer no longer had "to contract, arrange, [or] pay" for contraceptive coverage; instead, its insurer would bear the services' cost. That device dispelled some employers' objections—but not all. The

[2] I speak here only of the substantive validity of the exemptions. I agree with the Court that the final rules issuing the exemptions were procedurally valid.

Little Sisters, among others, maintained that the accommodation itself made them complicit in providing contraception. The measure thus failed to "assuage[ ]" their "sincere religious objections." Given that fact, the Departments might have chosen to exempt the Little Sisters and other still-objecting groups from the mandate. But the Departments went further still. Their rule exempted all employers with objections to the mandate, even if the accommodation met their religious needs. In other words, the Departments exempted employers who had no religious objection to the status quo (because they did not share the Little Sisters' views about complicity). The rule thus went beyond what the Departments' justification supported—raising doubts about whether the solution lacks a "rational connection" to the problem described.[3]

And the rule's overbreadth causes serious harm, by the Departments' own lights. In issuing the rule, the Departments chose to retain the contraceptive mandate itself. Rather than dispute HRSA's prior finding that the mandate is "necessary for women's health and well-being," the Departments left that determination in place. The Departments thus committed themselves to minimizing the impact on contraceptive coverage, even as they sought to protect employers with continuing religious objections. But they failed to fulfill that commitment to women. Remember that the accommodation preserves employees' access to cost-free contraceptive coverage, while the exemption does not. So the Departments (again, according to their own priorities) should have exempted only employers who had religious objections to the accommodation—not those who viewed it as a religiously acceptable device for complying with the mandate. The Departments' contrary decision to extend the exemption to those without any religious need for it yielded all costs and no benefits. Once again, that outcome is hard to see as consistent with reasoned judgment.[4]

Other aspects of the Departments' handiwork may also prove arbitrary and capricious. For example, the Departments allow even publicly traded corporations to claim a religious exemption. That option is unusual enough to raise a serious question about whether the Departments adequately supported their choice. Cf. *Burwell v. Hobby Lobby Stores, Inc*., (noting the oddity of "a publicly traded corporation asserting RFRA

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[3] At oral argument, the Solicitor General argued that the rule's overinclusion is harmless because the accommodation remains available to all employers who qualify for the exemption. But in their final rule, the Departments themselves acknowledged the prospect that some employers without a religious objection to the accommodation would switch to the exemption. See 83 Fed. Reg. 57576–57577 ("Of course, some of the[ ] religious" institutions that "do not conscientiously oppose participating" in the accommodation "may opt for the expanded exemption[,] but others might not"); ("[I]t is not clear to the Departments" how many of the religious employers who had used the accommodation without objection "will choose to use the expanded exemption instead"). And the Solicitor General, when pressed at argument, could offer no evidence that, since the rule took effect, employers without the Little Sisters' complicity beliefs had declined to avail themselves of the new exemption.

[4] In a brief passage in the interim final rule, the Departments suggested that an exemption is "more workable" than the accommodation in addressing religious objections to the mandate. But the Departments continue to provide the accommodation to any religious employers who request that option, thus maintaining a two-track system. So ease of administration cannot support, at least without more explanation, the Departments' decision to offer the exemption more broadly than needed.

rights"). Similarly, the Departments offer an exemption to employers who have moral, rather than religious, objections to the contraceptive mandate. Perhaps there are sufficient reasons for that decision—for example, a desire to stay neutral between religion and non-religion. But RFRA cast a long shadow over the Departments' rulemaking, and that statute does not apply to those with only moral scruples. So a careful agency would have weighed anew, in this different context, the benefits of exempting more employers from the mandate against the harms of depriving more women of contraceptive coverage. In the absence of such a reassessment, it seems a close call whether the moral exemption can survive.

None of this is to say that the Departments could not issue a valid rule expanding exemptions from the contraceptive mandate. As noted earlier, I would defer to the Departments' view of the scope of Congress's delegation. That means the Departments (assuming they act hand-in-hand with HRSA) have wide latitude over exemptions, so long as they satisfy the requirements of reasoned decisionmaking. But that "so long as" is hardly nothing. Even in an area of broad statutory authority—maybe especially there—agencies must rationally account for their judgments.

Justice GINSBURG, with whom Justice SOTOMAYOR joins, dissenting.

In accommodating claims of religious freedom, this Court has taken a balanced approach, one that does not allow the religious beliefs of some to overwhelm the rights and interests of others who do not share those beliefs. Today, for the first time, the Court casts totally aside countervailing rights and interests in its zeal to secure religious rights to the nth degree. Specifically, in the Women's Health Amendment to the Patient Protection and Affordable Care Act (ACA), Congress undertook to afford gainfully employed women comprehensive, seamless, no-cost insurance coverage for preventive care protective of their health and well-being. Congress delegated to a particular agency, the Health Resources and Services Administration (HRSA), authority to designate the preventive care insurance should cover. HRSA included in its designation all contraceptives approved by the Food and Drug Administration (FDA).

Destructive of the Women's Health Amendment, this Court leaves women workers to fend for themselves, to seek contraceptive coverage from sources other than their employer's insurer, and, absent another available source of funding, to pay for contraceptive services out of their own pockets. The Constitution's Free Exercise Clause, all agree, does not call for that imbalanced result.[1] Nor does the Religious Freedom Restoration Act (RFRA) condone harm to third parties occasioned by entire disregard of

[1] In *Employment Div., Dept. of Human Resources of Ore. v. Smith*, 494 U.S. 872 (1990), the Court explained that "the right of free exercise does not relieve an individual of the obligation to comply with a valid and neutral law of general applicability on the ground that the law proscribes (or prescribes) conduct that his religion prescribes (or proscribes)." The requirement that insurers cover FDA-approved methods of contraception "applies generally, . . . trains on women's well-being, not on the exercise of religion, and any effect it has on such exercise is incidental." (GINSBURG, J., dissenting). forecloses "[a]ny First Amendment Free Exercise Clause claim [one] might assert" in opposition to that requirement.

their needs. I therefore dissent from the Court's judgment, under which, as the Government estimates, between 70,500 and 126,400 women would immediately lose access to no-cost contraceptive services. On the merits, I would affirm the judgment of the U. S. Court of Appeals for the Third Circuit.

I
A

Under the ACA, an employer-sponsored "group health plan" must cover specified "preventive health services" without "cost sharing," 42 U.S.C. § 300gg–13, i.e., without such out-of-pocket costs as copays or deductibles. Those enumerated services did not, in the original draft bill, include preventive care specific to women.[2] "To correct this oversight, Senator Barbara Mikulski introduced the Women's Health Amendment. This provision was designed "to promote equality in women's access to health care," countering gender-based discrimination and disparities in such access. Brief for 186 Members of the United States Congress as Amici Curiae 6. Its proponents noted, inter alia, that "[w]omen paid significantly more than men for preventive care," and that "cost barriers operated to block many women from obtaining needed care at all."

Due to the Women's Health Amendment, the preventive health services that group health plans must cover include, "with respect to women," "preventive care and screenings . . . provided for in comprehensive guidelines supported by [HRSA]." § 300gg–13(a)(4). Pursuant to this instruction, HRSA undertook, after consulting the Institute of Medicine, to state "what preventive services are necessary for women's health and well-being and therefore should be considered in the development of comprehensive guidelines for preventive services for women." The resulting "Women's Preventive Services Guidelines" issued in August 2011. Under these guidelines, millions of women who previously had no, or poor quality, health insurance gained cost-free access, not only to contraceptive services but as well to, inter alia, annual checkups and screenings for breast cancer, cervical cancer, postpartum depression, and gestational diabetes. As to contraceptive services, HRSA directed that, to implement § 300gg–13(a)(4), women's preventive services encompass "all [FDA] approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity."[7]

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[2] This requirement does not apply to employers with fewer than 50 employees, 26 U.S.C. § 4980H(c)(2), or "grandfathered health plans"—plans in existence on March 23, 2010 that have not thereafter made specified changes in coverage, 42 U.S.C. § 18011(a), (e); 45 C.F.R. § 147.140(g) (2018). "Federal statutes often include exemptions for small employers, and such provisions have never been held to undermine the interests served by these statutes." (GINSBURG, J., dissenting). "[T]he grandfathering provision," "far from ranking as a categorical exemption, . . . is temporary, intended to be a means for gradually transitioning employers into mandatory coverage."

[7] Proponents of the Women's Health Amendment specifically anticipated that HRSA would require coverage of family planning services. See, *e.g.*, 155 Cong. Rec. 28841 (2009) (statement of Sen. Boxer); *id.*, at 28843 (statement of Sen. Gillibrand); *id.*, at 28844 (statement of Sen. Mikulski); *id.*, at 28869 (statement of Sen. Franken); *id.*, at 28876 (statement of Sen. Cardin); (statement of Sen. Feinstein); *id.*, at 29307 (statement of Sen. Murray).

Ready access to contraceptives and other preventive measures for which Congress set the stage in § 300gg–13(a)(4) both safeguards women's health and enables women to chart their own life's course. Effective contraception, it bears particular emphasis, improves health outcomes for women and [their] children," as "women with unintended pregnancies are more likely to receive delayed or no prenatal care than women with planned pregnancies. Contraception is also critical for individuals with underlying medical conditions that would be further complicated by pregnancy," "has . . . health benefits unrelated to preventing pregnancy, (e.g., it can reduce the risk of endometrial and ovarian cancer), and improves women's social and economic status, by allow[ing] [them] to invest in higher education and a career with far less risk of an unplanned pregnancy.

B

For six years, the Government took care to protect women employees' access to critical preventive health services while accommodating the diversity of religious opinion on contraception. The Internal Revenue Service (IRS), the Employee Benefits Security Administration (EBSA), and the Center for Medicare and Medicaid Services (CMS) crafted a narrow exemption relieving houses of worship, "their integrated auxiliaries," "conventions or associations of churches," and "religious order[s]" from the contraceptive-coverage requirement. For other nonprofit and closely held for-profit organizations opposed to contraception on religious grounds, the agencies made available an accommodation rather than an exemption.

Under th[e] accommodation, [an employer] can self-certify that it opposes providing coverage for particular contraceptive services. If [an employer] makes such a certification, the [employer's] insurance issuer or third-party administrator must expressly exclude contraceptive coverage from the group health insurance coverage provided in connection with the group health plan and provide separate payments for any contraceptive services required to be covered' without imposing any cost-sharing requirements on the [employer], the group health plan, or plan participants or beneficiaries.

The self-certification accommodation, the Court observed in *Hobby Lobby*, does not impinge on [an employer's] belief that providing insurance coverage for contraceptives violates [its] religion. It serves a Government interest of the highest order, i.e., providing women employees with cost-free access to all FDA-approved methods of contraception.

II

Despite Congress' endeavor, in the Women's Health Amendment to the ACA, to redress discrimination against women in the provision of healthcare, the exemption the Court today approves would leave many employed women just where they were before

insurance issuers were obliged to cover preventive services for them, cost free. The Government urges that the ACA itself authorizes this result, by delegating to HRSA authority to exempt employers from the contraceptive-coverage requirement. This argument gains the Court's approbation. It should not.

A

I begin with the statute's text. The ACA's preventive-care provision, 42 U.S.C. § 300gg–13(a), reads in full:

> "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—
>
> "(1) evidence-based items or services that have in effect a rating of 'A' or 'B' in the current recommendations of the United States Preventive Services Task Force;
>
> "(2) immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved; . . .
>
> "(3) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by [HRSA; and]
>
> "(4) with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by [HRSA] for purposes of this paragraph."

At the start of this provision, Congress instructed who is to "provide coverage for" the specified preventive health services: "group health plan[s]" and "health insurance issuer[s]." § 300gg–13(a). As the Court of Appeals explained, paragraph (a)(4), added by the Women's Health Amendment, granted HRSA "authority to issue 'comprehensive guidelines' concern[ing] the *type* of services" group health plans and health insurance issuers must cover with respect to women. Nothing in paragraph (a)(4) accorded HRSA "authority to undermine Congress's [initial] directive," stated in subsection (a), "concerning who must provide coverage for these services." (emphasis added).

The Government argues otherwise, asserting that "[t]he sweeping authorization for HRSA to 'provide[ ] for' and 'support[ ]' guidelines 'for purposes of' the women's preventive-services mandate clearly grants HRSA the power not just to specify what services should be covered, but also to provide appropriate exemptions." This terse statement—the entirety of the Government's textual case—slights the language Congress employed. Most visibly, the Government does not endeavor to explain how any language

in paragraph (a)(4) counteracts Congress' opening instruction in § 300gg–13(a) that group health plans "shall . . . provide" specified services.

The Court embraces, and the opinion concurring in the judgment adopts, the Government's argument. The Court correctly acknowledges that HRSA has broad discretion to determine what preventive services insurers should provide for women. But it restates that HRSA's "discretion [is] equally unchecked in other areas, including the ability to identify and create exemptions from its own Guidelines." See also ante, at ——– —— (KAGAN, J., concurring in judgment) (agreeing with this interpretation). Like the Government, the Court and the opinion concurring in the judgment shut from sight § 300gg–13(a)'s overarching direction that group health plans and health insurance issuers "shall" cover the specified services. Where Congress wanted to exempt certain employers from the ACA's requirements, it said so expressly.

B

The position advocated by the Government and endorsed by the Court and the opinion concurring in the judgment encounters further obstacles.

Most saliently, the language in § 300gg–13(a)(4) mirrors that in § 300gg–13(a)(3), the provision addressing children's preventive health services. Not contesting here that HRSA lacks authority to exempt group health plans from the children's preventive-care guidelines, the Government attempts to distinguish paragraph (a)(3) from paragraph (a)(4). The attempt does not withstand inspection.

The Government first observes that (a)(4), unlike (a)(3), contemplates guidelines created "for purposes of this paragraph." (Emphasis added.) This language does not speak to the scope of the guidelines HRSA is charged to create. Moreover, the Government itself accounts for this textual difference: The children's preventive-care guidelines described in paragraph (a)(3) were preexisting guidelines . . . developed for purposes unrelated to the ACA. The guidelines on women's preventive care, by contrast, did not exist before the ACA; they had to be created for purposes of the preventive-care mandate. § 300gg–13(a)(4). The Government next points to the modifier "evidence-informed" placed in (a)(3), but absent in (a)(4). This omission, however it may bear on the kind of preventive services for women HRSA can require group health insurance to cover, does not touch or concern who is required to cover those services.

HRSA's role within HHS also tugs against the Government's, the Court's, and the opinion concurring in the judgment's construction of § 300gg–13(a)(4). That agency was a logical choice to determine what women's preventive services should be covered, as its mission is to improve health care access and eliminate health disparities. First and foremost, § 300gg–13(a)(4) is directed at eradicating gender-based disparities in access to preventive care. Overlooked by the Court, and the opinion concurring in the judgment, HRSA's expertise does not include any proficiency in delineating religious and moral exemptions. One would not, therefore, expect Congress to delegate to HRSA the task of

crafting such exemptions. See *King v. Burwell*, 576 U. S. 473, (2015) ("It is especially unlikely that Congress would have delegated this decision to [an agency] which has no expertise in . . . policy of this sort.").

In fact, HRSA did not craft the blanket exemption. [T]hat task was undertaken by the IRS, EBSA, and CMS. Nowhere in 42 U.S.C. § 300gg–13(a)(4) are those agencies named, as earlier observed, an absence the Government, the Court, and the opinion concurring in the judgment do not deign to acknowledge.

C

If the ACA does not authorize the blanket exemption, the Government urges, then the exemption granted to houses of worship in 2011 must also be invalid. provide coverage for these services As the Court of Appeals explained, however, the latter exemption is not attributable to the ACA's text; it was justified on First Amendment grounds. Even if the house-of-worship exemption extends beyond what the First Amendment would require, that extension, as just explained, cannot be extracted from the ACA's text.[16]

III

Because I conclude that the blanket exemption gains no aid from the ACA, I turn to the Government's alternative argument. The religious exemption, if not the moral exemption, the Government urges, is necessary to protect religious freedom. The Government does not press a free exercise argument, instead invoking RFRA. That statute instructs 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 doing so "is the least restrictive means of furthering [a] compelling governmental interest."

A

1

The parties here agree that federal agencies may craft accommodations and exemptions to cure violations of RFRA. But that authority is not unbounded. In this light, the Court has repeatedly assumed that any religious accommodation to the contraceptive-coverage requirement would preserve women's continued access to seamless, no-cost contraceptive coverage. ("[T]he parties on remand should be afforded an opportunity to arrive at an approach . . . that accommodates petitioners' religious exercise while . . . ensuring that women covered by petitioners' health plans receive full and equal health coverage, including contraceptive coverage." (internal quotation marks omitted));

[16] The Government does not argue that my view of the limited compass of § 300gg–13(a)(4) imperils the self-certification accommodation. That accommodation aligns with the Court's decisions under RFRA. It strikes a balance between women's health and religious opposition to contraception, preserving women's access to seamless, no-cost contraceptive coverage, but imposing the obligation to provide such coverage directly on insurers, rather than on the objecting employer. The blanket exemption, in contrast, entirely disregards women employees' preventive care needs.

("Nothing in this interim order affects the ability of applicant's employees and students to obtain, without cost, the full range of [FDA] approved contraceptives."); ("There are other ways in which Congress or HHS could equally ensure that every woman has cost-free access 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 [other] companies.").

The assumption made in the above-cited cases rests on the basic principle just stated, one on which this dissent relies: While the Government may accommodate religion beyond free exercise requirements, when it does so, it may not benefit religious adherents at the expense of the rights of third parties.

2

The expansive religious exemption at issue here imposes significant burdens on women employees. Between 70,500 and 126,400 women of childbearing age, the Government estimates, will experience the disappearance of the contraceptive coverage formerly available to them.[18] Lacking any alternative insurance coverage mechanism, the exemption leaves women two options, neither satisfactory.

The first option—the one suggested by the Government in its most recent rulemaking,—is for women to seek contraceptive care from existing government-funded programs. Such programs, serving primarily low-income individuals, are not designed to handle an influx of tens of thousands of previously insured women.[19] Moreover, as the Government has acknowledged, requiring women "to take steps to learn about, and to sign up for, a new health benefit" imposes "additional barriers," "mak[ing] that coverage accessible to fewer women." Finally, obtaining care from a government-funded program instead of one's regular care provider creates a continuity-of-care problem[.]

The second option for women losing insurance coverage for contraceptives is to pay for contraceptive counseling and devices out of their own pockets. Notably, however, the most effective contraception is also the most expensive. [T]he cost of an IUD [intrauterine device]," for example, "is nearly equivalent to a month's full-time pay for

[18] The Government notes that 2.9 million people were covered by the 209 plans that previously utilized the self-certification accommodation. One hundred nine of those plans covering 727,000 people, the Government estimates, will use the religious exemption, while 100 plans covering more than 2.1 million people will continue to use the self-certification accommodation. If more plans, or plans covering more people, use the new exemption, more women than the Government estimates will be affected.

[19] Title X is the only federal grant program dedicated solely to providing individuals with comprehensive family planning and related preventive health services. A recent rule makes women who lose contraceptive coverage due to the religious exemption eligible for Title X services. Expanding *eligibility*, however, "does nothing to ensure Title X providers actually have capacity to meet the expanded client population. Moreover, that same rule forced 1,041 health providers, serving more than 41% of Title X patients, out of the Title X provider network due to their affiliation with abortion providers.

workers earning the minimum wage. Faced with high out-of-pocket costs, many women will forgo contraception, or resort to less effective contraceptive methods.

As the foregoing indicates, the religious exemption reintroduce[s] the very health inequities and barriers to care that Congress intended to eliminate when it enacted the women's preventive services provision of the ACA. I would therefore hold the religious exemption neither required nor permitted by RFRA.

B

Pennsylvania and New Jersey advance an additional argument: The exemption is not authorized by RFRA, they maintain, because the self-certification accommodation it replaced was sufficient to alleviate any substantial burden on religious exercise. That accommodation, I agree, further indicates the religious exemption's flaws.

1

For years, religious organizations have challenged the self-certification accommodation as insufficiently protective of their religious rights. I agree with Pennsylvania and New Jersey that the accommodation does not substantially burden objectors' religious exercise. A religious adherent may be entitled to religious accommodation with regard to her own conduct, but she is not entitled to insist that . . . others must conform their conduct to [her] own religious necessities.

As the Court recognized in *Hobby Lobby*: "When a group-health-insurance issuer receives notice that [an employer opposes coverage for some or all contraceptive services for religious reasons], the issuer must then exclude [that] coverage from the employer's plan and provide separate payments for contraceptive services for plan participants." The accommodation works by requiring insurance companies to cover . . . contraceptive coverage for female employees who wish it. Under the self-certification accommodation, then, the objecting employer is absolved of any obligation to provide the contraceptive coverage to which it objects; that obligation is transferred to the insurer.

2

The Little Sisters resist this conclusion in two ways. First, they urge that contraceptive coverage provided by an insurer under the self-certification accommodation forms part of the same plan as the coverage provided by the employer. This contention is contradicted by the plain terms of the regulation establishing that accommodation.

Second, the Little Sisters assert that "tak[ing] affirmative steps to execute paperwork . . . necessary for the provision of 'seamless' contraceptive coverage to their employees" implicates them in providing contraceptive services to women in violation of their religious beliefs. [T]he Little Sisters do not object to what the self-certification

accommodation asks of them, namely, attesting to their religious objection to contraception. They object, instead, to the particular use insurance issuers make of that attestation.

* * *

The blanket exemption for religious and moral objectors to contraception formulated by the IRS, EBSA, and CMS is inconsistent with the text of, and Congress' intent for, both the ACA and RFRA. Neither law authorizes it. The original administrative regulation accommodating religious objections to contraception appropriately implemented the ACA and RFRA consistent with Congress' staunch determination to afford women employees equal access to preventive services, thereby advancing public health and welfare and women's well-being. I would therefore affirm the judgment of the Court of Appeals.

Notes

1. Where does this go next? As Justices Kagan and Breyer point out in their concurrence, the case now returns to Third Circuit where presumably litigation will continue. Still on the table, in their view, is the question whether, in exempting all employers, including those for whom the accommodation is sufficient, the rule is arbitrary and capricious because it fails to meet the APA's "reasoned decisionmaking" test. Of course, in the interim, the nation could undergo a change in Presidential administrations. A Biden administration could decide that the decisionmaking was not in fact reasoned and could, on an emergency basis (given the number of women whose coverage is compromised) suspend the rule and reinstate a narrower exemption along with the self-certification accommodation. Alternatively, the administration could work with Congress to create supplemental "contraceptive only" insurance plans that issuers and plan administrators could purchase for affected women. Technically, such a strategy would avoid the "complicit" test, since coverage would be independent of their employer plan. At the same time, since the contraceptive plans would be provided as a supplement to plan participants and beneficiaries insured through their objecting employers, employers would continue to view themselves as complicit because their plan structure becomes the conduit for targeting this new coverage.

Another option would be to create a new, fully-federally-funded Medicaid eligibility category consisting of any person insured through an employer plan that excludes contraceptives. Medicaid historically has played a central role in insuring people whose health needs are not met by their primary insurer. Examples include children and adults with severe disabilities whose employer plans fall short in coverage of long-term services and supports, as well as low-income Medicare beneficiaries for whom Medicaid covers premiums, deductibles, cost-sharing, and benefits not covered by Medicare, such as eyeglasses, hearing aids, and long term care. Family planning is a required Medicaid benefit, and many states offer supplemental family planning coverage for women who do not qualify for full Medicaid coverage. Jenna Walls et al., Medicaid Coverage of Family

Planning Benefits: Results from a State Survey (Kaiser Family Foundation, 2016), https://www.kff.org/womens-health-policy/report/medicaid-coverage-of-family-planning-benefits-results-from-a-state-survey/ (Accessed August 1, 2020). At the same time, states would be expected to establish enrollment and coverage systems, and people would have to enroll and comply with Medicaid rules as well as the rules applicable to their employer plans. The gynecological providers that participate in their employer plans might refuse to participate in Medicaid, a not uncommon problem.

All in all, supplementary insurance coverage, public or private, is plausible in theory but hard to implement. This is basically what the Obama administration decided when officials concluded, on January 9, 2017, that there was no decent alternative to including "seamless" coverage under an employer plan, with an accommodation that would protect employers from having to pay for this coverage.

2. Religion versus public health and health equity. In the end, the contraception battle is what comes of a nation like ours—with multiple forms of insurance each governed by its own rules, without a basic public health system that simply makes health care such as contraception, immunizations, cancer screenings, and certain other preventive treatments universally available, and whose social and cultural norms are willing to accommodate behaviors that fundamentally conflate individual religious freedoms with a universal health care financing mechanism grounded in basic public health principles. This same tension between religion and health is now playing itself out in regulations governing civil rights and health care. The ACA contains a sweeping provision, codified at § 1557, that modernizes civil rights law and expands the reach of civil rights statutes to all federally funded health programs. This modernization includes expanding the protected classes in health care that previously were recognized under federal law (race, color, national origin, age, and disability) to include sex, as the term is used under Title IX of the 1972 Education amendments, which derives its meaning from Title VII of the 1964 Civil Rights Act, barring employment discrimination based on sex.

Regulations published in 2016 by the Obama administration defined the scope of application of § 1557 broadly to encompass all entities participating in federal health programs (including health insurers offering Medicare, Medicaid, and Marketplace health plans that qualify for refundable tax credits), and defined "discrimination" to include discrimination on the basis of sexual orientation, gender identity, and abortion. In *Franciscan Alliance Inc. v Burwell* (N.D. Tex. 2016) a federal district court in Fort Worth, Texas (the same court that also declared the entire ACA unconstitutional, as discussed later in this Supplement), issued a nationwide injunction barring the Obama administration from enforcing the rule's non-discrimination provisions based on sex, because in their view the rule violates RFRA. Nevertheless, private individuals continued to bring numerous enforcement actions (many successful) against hospitals, Medicaid programs, employer health plans, and others for violating the § 1557 non-discrimination guarantee (many of these cases involved access to care by transgender patients and refusal to cover gender-affirming treatment). Katie Keith, More Courts Rule on Section 1557 as HHS Reconsiders Regulation, *Health Affairs Blog* (October 2, 2018),

https://www.healthaffairs.org/do/10.1377/hblog20181002.142178/full/ (Accessed August 1, 2020).

In 2020, the United States Supreme Court held that the word "sex," as used in Title VII, encompasses sexual orientation and gender identity. *Bostock v Clayton County, Georgia,* 140 S. Ct. 1731 (June 15, 2020). The decision came literally on the heels of publication, by the Trump administration, of a final revised § 1557 rule that rolls back the reach of the rule and, most prominently, eliminates the 2016 definition of "sex". Katie Keith, HHS Strips Gender Identity, Sex Stereotyping, Language Access Protections From ACA Anti-Discrimination Rule, *Health Affairs Blog* (June 13, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200613.671888/full/(Accessed August 1, 2020). The Administration, in its Preamble, also makes clear that come what may, it has no intention of withdrawing its rule regardless of the decision in *Bostock.*

So here matters stand. As a matter of official federal policy regarding the role of religion in health care, the administration has withdrawn civil rights protections for the LGBTQ community under § 1557, leaving the health care system (through which federal funding flows like a massive river) free to engage in outright discrimination, including refusing to treat people based on sex, carving out sex-related health care needs from the terms of coverage, or engaging in other overt discriminatory practices. The same Administration also has now exempted employers, based on religion, from covering contraception—one of the greatest of all public health achievements of the 20th century because of the critical role of timing and spacing of pregnancy in maternal, infant, and family health.

Where this all ends is unclear. A new administration might attempt to reverse course and reverse a raft of policy decisions that give religion primacy in relation to health care and public health. But the same immediate pushback to the rules promulgated by the Obama Administration is likely to ensue. Ultimately, until there is a complete change in society or the Court finally decides where religious freedom ends and what level of accommodation is sufficient under religious freedom laws, expect this battle to the death to continue.

* * *

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 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. 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).

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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.

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 Supplement), and the questions are just as important here.

Fourth Postscript to Part Two: *Maine Community Health Options*, the ongoing attempts by the previous Congress to weaken the Marketplace

Maine Community Health Options
v.
UNITED STATES
140 S. Ct. 1308 (2020)

Justice SOTOMAYOR delivered the opinion of the Court.

The Patient Protection and Affordable Care Act expanded healthcare coverage to many who did not have or could not afford it. The Affordable Care Act did this by, among other things, providing tax credits to help people buy insurance and establishing online marketplaces where insurers could sell plans. To encourage insurers to enter those marketplaces, the Act created several programs to defray the carriers' costs and cabin their risks.

Among these initiatives was the "Risk Corridors" program, a temporary framework meant to compensate insurers for unexpectedly unprofitable plans during the marketplaces' first three years. The since-expired Risk Corridors statute, § 1342, set a formula for calculating payments under the program: If an insurance plan loses a certain amount of money, the Federal Government "shall pay" the plan; if the plan makes a certain amount of money, the plan "shall pay" the Government. Some plans made money and paid the Government. Many suffered losses and sought reimbursement. The Government, however, did not pay.

These cases are about whether petitioners—insurers who claim losses under the Risk Corridors program—have a right to payment under § 1342 and a damages remedy for the unpaid amounts. We hold that they do. We conclude that § 1342 established a money-mandating obligation, that Congress did not repeal this obligation, and that petitioners may sue the Government for damages in the Court of Federal Claims.

I
A

In 2010, Congress passed the Patient Protection and Affordable Care Act, seeking to improve national health-insurance markets and extend coverage to millions of people without adequate (or any) health insurance. To that end, the Affordable Care Act called for the creation of virtual health-insurance markets, or "Health Benefit Exchanges," in each State. 42 U.S.C. § 18031(b)(1). Individuals may buy health-insurance plans directly on an exchange and, depending on their household income, receive tax credits for doing

so. 26 U.S.C. § 36B; 42 U.S.C. §§ 18081, 18082. Once an insurer puts a plan on an exchange, it must "accept every employer and individual in the State that applies for such coverage," 42 U.S.C. § 300gg–1(a), and may not tether premiums to a particular applicant's health, § 300gg(a). In other words, the Act "ensure[s] that anyone can buy insurance." *King* v. *Burwell*, 576 U.S. 473 (2015).

Insurance carriers had many reasons to participate in these new exchanges. Through the Affordable Care Act, they gained access to millions of new customers with tax credits worth billions of dollars in spending each year. But the exchanges posed some business risks, too—including a lack of reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage.

This uncertainty could have given carriers pause and affected the rates they set. So the Affordable Care Act created several risk-mitigation programs. At issue here is the Risk Corridors program. [2]

B

The Risk Corridors program aimed to limit participating plans' profits and losses for the exchanges' first three years. See § 1342, 42 U.S.C. § 18062. It did so through a formula that computed a plan's gains or losses at the end of each year. Plans with profits above a certain threshold would pay the Government, while plans with losses below that threshold would receive payments from the Government. Specifically, § 1342 stated that the eligible profitable plans "shall pay" the Secretary of the Department of Health and Human Services (HHS), while the Secretary "shall pay" the eligible unprofitable plans.

When it enacted the Affordable Care Act in 2010, Congress did not simultaneously appropriate funds for the yearly payments the Secretary could potentially owe under the Risk Corridors program. Neither did Congress limit the amounts that the Government might pay under § 1342. Nor did the Congressional Budget Office (CBO) "score"—that is, calculate the budgetary impact of—the Risk Corridors program.[3]

In later years, the CBO noted that the Risk Corridors statute did not require the program to be budget neutral. The CBO reported that, "[i]n contrast" to the Act's other risk-mitigation programs, "risk corridor collections (which will be recorded as revenues)

[2] The others were the "Reinsurance" and "Risk Adjustment" programs. The former ran from 2014 to 2016 and required insurers to pay premiums into a pool that compensated carriers covering "high risk individuals." § 1341 42 U.S.C. § 18061. The latter is still in effect and annually transfers funds from insurance plans with relatively low-risk enrollees to plans with higher risk enrollees. See § 1343, 42 U.S.C. § 18063.

[3] If a health insurance plan made (or lost) up to 3 percentage points more than expected in a plan year, the plan would keep the gains (or losses). If the plan made (or lost) between 3 and 8 percentage points more than predicted, it would give up half of the earnings (or would be compensated for half of the shortfalls) exceeding the 3 percentage-point threshold. If the gains (or losses) exceeded predictions by eight percentage points, the insurers would pay (or receive) 80 percent of the gains (or losses) exceeding the 8 percentage-point mark. See § 1342(b) 42 U.S.C. § 18062(b).

will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit." CBO, The Budget and Economic Outlook: 2014 to 2024 (2014). The CBO thus recognized that "[i]f insurers' costs exceed their expectations, on average, the risk corridor program will impose costs on the federal budget."

Like the CBO, the federal agencies charged with implementing the program agreed that § 1342 did not require budget neutrality. Nine months before the program started, HHS acknowledged that the Risk Corridors program was "not statutorily required to be budget neutral." 78 Fed. Reg. 15473 (2013). HHS assured, however, that "[r]egardless of the balance of payments and receipts, HHS will remit payments as required under Section 1342 of the Affordable Care Act."

Similar guidance came from the Centers for Medicare and Medicaid Services (CMS), the agency tasked with helping the HHS Secretary collect and remit program payments. CMS confirmed that a lack of payments from profitable plans would not relieve the Government from making its payments to the unprofitable plans. Citing "concerns that risk corridors collections may not be sufficient to fully fund risk corridors payments" to the unprofitable plans, CMS declared that "[i]n the unlikely event of a shortfall . . . HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."

C

The program's first year, 2014, tallied a deficit of about $2.5 billion. Profitable plans owed the Government $362 million, while the Government owed unprofitable plans $2.87 billion. At the end of the first year, Congress enacted a bill appropriating a lump sum for CMS' Program Management. The bill included a rider restricting the appropriation's effect on Risk Corridors payments out to issuers: "None of the funds made available by this Act . . . or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors)."

The program's second year resembled its first. In February 2015, HHS repeated its belief that "risk corridors collections w[ould] be sufficient to pay for all" of the Government's "risk corridors payments." 80 Fed. Reg. 10779 (2015). The agency again "recognize[d] that the Affordable Care Act requires the Secretary to make full payments to issuers." "In the unlikely event that risk corridors collections" were "insufficient to make risk corridors payments," HHS reassured, the Government would "use other sources of funding for the risk corridors payments, subject to the availability of appropriations."

The 2015 program year also ran a deficit, this time worth about $5.5 billion. Facing a second shortfall, CMS continued to "recogniz[e] that the Affordable Care Act requires the Secretary to make full payments to issuers." CMS also confirmed that "HHS

w[ould] record risk corridors payments due as an obligation of the United States Government for which full payment is required." And at the close of the second year, Congress enacted another appropriations bill [for Fiscal Year 2016] with the same rider as before.

The program's final year, 2016, was similar. The Government owed unprofitable insurers about $3.95 billion more than profitable insurers owed the Government. And Congress passed an appropriations bill with the same rider. All told, the Risk Corridors program's deficit exceeded $12 billion.

D

The dispute here is whether the Government must pay the remaining deficit. Petitioners in these consolidated cases are four health-insurance companies that participated in the healthcare exchanges: Maine Community Health Options, Blue Cross and Blue Shield of North Carolina, Land of Lincoln Mutual Health Insurance Company, and Moda Health Plan, Inc. They assert that their plans were unprofitable during the Risk Corridors program's 3-year term and that, under § 1342, the HHS Secretary still owes them hundreds of millions of dollars.

These insurers sued the Federal Government for damages in the United States Court of Federal Claims, invoking the Tucker Act, 28 U.S.C. § 1491. They alleged that § 1342 of the Affordable Care Act obligated the Government to pay the full amount of their losses as calculated by the statutory formula and sought a money judgment for the unpaid sums owed—a claim that, if successful, could be satisfied through the Judgment Fund.[4] These lawsuits saw mixed results in the trial courts. Petitioner Moda prevailed; the others did not.

A divided panel of the United States Court of Appeals for the Federal Circuit ruled for the Government in each appeal. As relevant here, the Federal Circuit concluded that § 1342 had initially created a Government obligation to pay the full amounts that petitioners sought under the statutory formula. The court also recognized that "it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances."

Even so, the court held that Congress' appropriations riders impliedly "repealed or suspended" the Government's obligation. Although the panel acknowledged that "[r]epeals by implication are generally disfavored"—especially when the "alleged repeal occurred in an appropriations bill"—it found that the riders here "adequately expressed

[4] For a meritorious claim brought within the Tucker Act's 6-year statute of limitations, federal law generally requires that the "final judgment rendered by the United States Court of Federal Claims against the United States . . . be paid out of any general appropriation therefor." § 2517(a). The Judgment Fund is a permanent and indefinite appropriation for "[n]ecessary amounts . . . to pay final judgments, awards, compromise settlements, and interest and costs specified in the judgments or otherwise authorized by law when . . . payment is not otherwise provided for."

Congress's intent to suspend" the Government's payments to unprofitable plans "beyond the sum of payments" it collected from profitable plans.

Judge Newman dissented, observing that the Government had not identified any "statement of abrogation or amendment of the statute," nor any "disclaimer" of the Government's "statutory and contractual commitments." The dissent also reasoned that precedent undermined the court's conclusion and that the appropriations riders could not apply retroactively because the Government had used the Risk Corridors program to induce insurers to enter the exchanges. Emphasizing the importance of Government credibility in public-private enterprise, the dissent warned that the majority's decision would "undermin[e] the reliability of dealings with the government."

A majority of the Federal Circuit declined to revisit the court's decision en banc.

These cases present three questions: First, did § 1342 of the Affordable Care Act obligate the Government to pay participating insurers the full amount calculated by that statute? Second, did the obligation survive Congress' appropriations riders? And third, may petitioners sue the Government under the Tucker Act to recover on that obligation? Because our answer to each is yes, we reverse.

II

The Risk Corridors statute created a Government obligation to pay insurers the full amount set out in § 1342's formula.

A

An "obligation" is a "definite commitment that creates a legal liability of the government for the payment of goods and services ordered or received, or a legal duty . . . that could mature into a legal liability by virtue of actions on the part of the other party beyond the control of the United States." GAO, A Glossary of Terms Used in the Federal Budget Process 70 (GAO–05–734SP, 2005). The Government may incur an obligation by contract or by statute.

Incurring an obligation, of course, is different from paying one. After all, the Constitution's Appropriations Clause provides that "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." Art. I, § 9, cl. 7. Creating and satisfying a Government obligation, therefore, typically involves four steps: (1) Congress passes an organic statute (like the Affordable Care Act) that creates a program, agency, or function; (2) Congress passes an Act authorizing appropriations; (3) Congress enacts the appropriation, granting "budget authority" to incur obligations and make payments, and designating the funds to be drawn; and (4) the relevant Government entity begins incurring the obligation.

But Congress can deviate from this pattern. It may, for instance, authorize agencies to enter into contracts and "incur obligations in advance of appropriations."

GAO Redbook. In that context, the contracts "constitute obligations binding on the United States," such that a "failure or refusal by Congress to make the necessary appropriation would not defeat the obligation, and the party entitled to payment would most likely be able to recover in a lawsuit." Id.

Congress can also create an obligation directly by statute, without also providing details about how it must be satisfied. Consider, for example, United States v. Langston, 118 U.S. 389 (1886). In that case, Congress had enacted a statute fixing an official's annual salary at "$7,500 from the date of the creation of his office." Years later, however, Congress failed to appropriate enough funds to pay the full amount, prompting the officer to sue for the remainder. Understanding that Congress had created the obligation by statute, this Court held that a subsequent failure to appropriate enough funds neither "abrogated [n]or suspended" the Government's pre-existing commitment to pay. The Court thus affirmed judgment for the officer for the balance owed.[6]

The GAO shares this view. As the Redbook explains, if Congress created an obligation by statute without detailing how it will be paid, "an agency could presumably meet a funding shortfall by such measures as making prorated payments." GAO Redbook. But "such actions would be only temporary pending receipt of sufficient funds to honor the underlying obligation" and "[t]he recipient would remain legally entitled to the balance." Thus, the GAO warns, although a "failure to appropriate" funds "will prevent administrative agencies from making payment," that failure "is unlikely to prevent recovery by way of a lawsuit." Id. (citing, e.g. *Langston*.)

Put succinctly, Congress can create an obligation directly through statutory language.

B

Section 1342 imposed a legal duty of the United States that could mature into a legal liability through the insurers' actions—namely, their participating in the healthcare exchanges. This conclusion flows from § 1342's express terms and context. Section 1342 uses the command three times: The HHS Secretary "shall establish and administer" the Risk Corridors program from 2014 to 2016, "shall provide" for payments according to a precise statutory formula, and "shall pay" insurers for losses exceeding the statutory threshold. §§ 1342(a), (b)(1).

Section 1342's adjacent provisions also underscore its mandatory nature. In § 1341 (a reinsurance program) and § 1343 (a risk-adjustment program), the Affordable Care Act differentiates between when the HHS Secretary "shall" take certain actions and

[6] The Government suggests that *Langston* is irrelevant because that case predates the Judgment Fund, *supra*, meaning that the Court "had no occasion" to determine whether the statute at issue "authorized a money-damages remedy" against the Government. But by affirming a judgment against the United States, *Langston* necessarily confirmed the Government's obligation to pay independent of a specific appropriation. What remedies ensure that the Government makes good on its duty to pay is a separate question that we take up below.

when she "may" exercise discretion. Yet Congress chose mandatory terms for § 1342. When, as is the case here, Congress distinguishes between "may" and "shall," it is generally clear that "shall" imposes a mandatory duty.

Nothing in § 1342 requires the Risk Corridors program to be budget neutral, either. Nor does the text suggest that the Secretary's payments to unprofitable plans pivoted on profitable plans' payments to the Secretary, or that a partial payment would satisfy the Government's whole obligation. Thus, without any indication that § 1342 allows the Government to lessen its obligation, we must give effect to [Section 1342's] plain command. That is, the statute meant what it said: The Government "shall pay" the sum that § 1342 prescribes.[7]

C

The Government does not contest that § 1342's plain terms appeared to create an obligation to pay whatever amount the statutory formula provides. It insists instead that the Appropriations Clause, Art. I, § 9, cl. 7, and the Anti-Deficiency Act, 31 U.S.C. § 1341, qualified that obligation by making HHS's payments contingent on appropriations by Congress. Because Congress did not appropriate funds beyond the amounts collected from profitable plans, this argument goes, HHS's statutory duty [to pay unprofitable plans] extended only to disbursing those collected amounts.

That does not follow. Neither the Appropriations Clause nor the Anti-Deficiency Act addresses whether Congress itself can create or incur an obligation directly by statute. Rather, both provisions constrain how federal employees and officers may make or authorize payments without appropriations. As we have explained, [an] appropriation per se merely imposes limitations upon the Government's own agents, but its insufficiency does not pay the Government's debts, nor cancel its obligations. If anything, the Anti-Deficiency Act confirms that Congress can create obligations without contemporaneous funding sources: That Act's prohibitions give way "as specified" or "authorized" by "any other provision of law." 31 U.S.C. § 1341(a)(1). Here, the Government's obligation was authorized by the Risk Corridors statute.

And contrary to the Government's view, § 1342's obligation-creating language does not turn on whether Congress expressly provided budget authority before appropriating funds. Budget authority is an agency's power provided by Federal law to incur financial obligations, that will result in immediate or future outlays of government funds, GAO Redbook. As explained above, Congress usually gives budget authority through an appropriations Act or by expressly granting an agency authority to contract

[7] Our conclusion matches the interpretations that HHS and CMS have repeated since before the Risk Corridors program began. In the agencies' view, the Risk Corridors program was "not statutorily required to be budget neutral" and instead required HHS to "remit payments" "[r]egardless of the balance of payments and receipts." 78 Fed. Reg. 15473 (HHS regulation); accord, 79 Fed. Reg. 30260 (CMS regulation noting that even "[i]n the unlikely event of a shortfall for the 2015 program year, . . . the Affordable Care Act requires the Secretary to make full payments to issuers").

for the Government. But budget authority is not necessary for Congress itself to create an obligation by statute. See Langston.

The Government's arguments also conflict with well settled principles of statutory interpretation. At bottom, the Government contends that the existence and extent of its obligation here is subject to the availability of appropriations. But that language appears nowhere in § 1342, even though Congress could have expressly limited an obligation to available appropriations or specific dollar amounts. Indeed, Congress did so explicitly in other provisions of the Affordable Care Act.[8]

This Court generally presumes that when Congress includes particular language in one section of a statute but omits it in another, Congress intended a difference in meaning. The Court likewise hesitates to adopt an interpretation of a congressional enactment which renders superfluous another portion of that same law. The "subject to appropriations" and payment-capping language in other sections of the Affordable Care Act would be meaningless had § 1342 simultaneously achieved the same end with silence. In sum, the plain terms of the Risk Corridors provision created an obligation neither contingent on nor limited by the availability of appropriations or other funds.

III

The next question is whether Congress impliedly repealed the obligation through its appropriations riders. It did not.

A

Because Congress did not expressly repeal § 1342, the Government seeks to show that Congress impliedly did so. But repeals by implication are not favored and are a rarity. Presented with two statutes, the Court will regard each as effective—unless Congress' intention to repeal is clear and manifest or the two laws are irreconcilable. This Court's aversion to implied repeals is "especially" strong in the appropriations context. The Government must point to "something more than the mere omission to appropriate a sufficient sum; accord, GAO Redbook ("The mere failure to appropriate sufficient funds is not enough"). The question, then, is whether the appropriations riders manifestly repealed or discharged the Government's uncapped obligation.

Langston confirms that the appropriations riders did neither. Recall that in *Langston*, Congress had established a statutory obligation to pay a salary of $7,500, yet later appropriated a lesser amount. This Court held that Congress did not "abrogat[e] or suspen[d]" the salary-fixing statute by "subsequent enactments [that] merely appropriated

[8] See, e.g., 42 U.S.C. § 280k(a) ("The Secretary ... shall, subject to the availability of appropriations, establish a 5-year national, public education campaign"). . . . This kind of limiting language is not unique to the Affordable Care Act. Congress has also been explicit when it has capped payments, often setting a dollar amount or designating a specific fund from which the Government shall pay. These common limitations—and our discussion below, see Part IV, infra—diminish the dissent's concern that other statutes may support a damages action in the Court of Federal Claims.

a less amount" than necessary to pay, because the appropriations bill lacked "words that expressly or by clear implication modified or repealed the previous law." At most, the appropriations had "temporarily suspend[ed]" payments, but they did not use the most clear and positive terms required to modif[y] or repea[l] the Government's obligation itself.

Here, like in *Langston*, [other parallel cases omitted] Congress "merely appropriated a less amount" than that required to satisfy the Government's obligation, without "expressly or by clear implication modif[ying]" it. The riders stated that "[n]one of the funds made available by this Act," as opposed to any other sources of funds, may be used for payments under the Risk Corridors statute. But "no words were used to indicate any other purpose than the disbursement of a sum of money for the particular fiscal years." And especially because the Government had already begun incurring the prior year's obligation each time Congress enacted a rider, reasonable (and nonrepealing) interpretations exist. Indeed, finding a repeal in these circumstances would raise serious questions whether the appropriations riders retroactively impaired insurers' rights to payment.

The relevant agencies' responses to the riders also undermine the case for an implied repeal here. Had Congress "clearly expressed" its intent to repeal, one might have expected HHS or CMS to signal the sea change. But even after Congress enacted the first rider, the agencies reiterated that the Affordable Care Act requires the Secretary to make full payments to issuers, and that "HHS w[ould] record risk corridors payments due as an obligation of the United States Government for which full payment is required," They understood that profitable insurers' payments to the Government would not dispel the Secretary's obligation to pay unprofitable insurers, even "in the event of a shortfall."

Given the Court's potent presumption in the appropriations context, an implied-repeal-by-rider must be made of sterner stuff.

B

To be sure, this Court's implied-repeal precedents reveal two situations where the Court has deemed appropriations measures irreconcilable with statutory obligations to pay. But neither one applies here.

The first line of cases involved appropriations bills that, without expressly invoking words of "repeal," reached that outcome by completely revoking or suspending the underlying obligation before the Government began incurring it. United States v. Will, 449 U.S. 200 (1980). *Will* concluded that Congress had canceled an obligation to pay cost-of-living raises through appropriations bills that bluntly stated that future raises "'shall not take effect'" or that restricted funds from "'this Act or any other Act.'" Here, by contrast, the appropriations riders did not use the kind of "shall not take effect" language decisive in *Will*. Nor did the riders purport to suspend § 1342 prospectively or

to foreclose funds from "any other Act" "notwithstanding" § 1342's money-mandating text. [No precedent] supports the Department's implied repeal argument.

The second strand of precedent turned on provisions that reformed statutory payment formulas in ways "irreconcilable" with the original methods. See United States v. Mitchell, 109 U.S. 146 (1883); see also United States v. Fisher, 109 U.S. 143 (1883). In *Mitchell*, an appropriations bill decreased the salaries for federal interpreters (from $400 to $300) and changed how the agency would distribute any additional pay from "all emoluments and allowances whatsoever" to payments at the agency head's discretion. And in *Fisher*, Congress altered an obligation to pay judges $3,000 per year by providing that a lesser appropriation would be "in full compensation" for services rendered in the next fiscal year. The appropriations bills here created no such conflict. The riders did not reference § 1342's payment formula at all, let alone "irreconcilabl[y]" change it. Nor did they provide that Risk Corridors payments from profitable plans would be in full compensation of the Government's obligation to unprofitable plans. Instead, the riders here must be taken at face value: as a "mere omission" to appropriate a sufficient sum. Congress could have used the kind of language we have held to effect a repeal or suspension—indeed, it did so in other provisions of the relevant appropriations bills. But for the Risk Corridors program, it did not.

C

We also find unpersuasive the only pieces of legislative history that the Federal Circuit cited. According to the Court of Appeals, a floor statement and an unpublished GAO letter provided "clear intent" to cancel or "suspend" the Government's Risk Corridors obligation. We doubt that either source could ever evince the kind of clear congressional intent required to repeal a statutory obligation through an appropriations rider. But even if they could, they did not do so here.

The floor statement (which Congress adopted as an "explanatory statement") does not cross the clear-expression threshold. That statement interpreted an HHS regulation as saying that "the risk corridor program will be budget neutral, meaning the federal government will never pay out more than it collects."[11] But that misunderstands the referenced regulation, which provided only that HHS "project[ed]" that the program would be budget neutral and that the agency intend[ed] to treat it that way, while making clear that it [was] difficult to estimate the aggregate risk corridors payments and charges at [the] time. HHS' goals did not alter its prior interpretation that the Risk Corridors program was not statutorily required to be budget neutral. And neither the floor statement

[11] The statement provides in full: "In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." 160 Cong. Rec., at 18307.

nor the appropriations rider said anything requiring budget neutrality or redefining § 1342's formula.[12]

The GAO letter is even more inapt. In it, the GAO responded to two legislators' inquiry by identifying two sources of available funding for the first year of Risk Corridors payments: CMS' appropriations for the 2014 fiscal year and profitable insurance plans' payments to the Secretary. Because the rider cut off the first source of funds, the Federal Circuit inferred congressional intent "to temporarily cap" the Government's payments "at the amount of payments" profitable plans made "for each of the applicable years" of the Risk Corridors program. That was error. The letter has little value because it appears nowhere in the legislative record. Perhaps for that reason, the Government does not rely on it.

IV

Having found that the Risk Corridors statute established a valid yet unfulfilled Government obligation, this Court must turn to a final question: Where does petitioners' lawsuit belong, and for what relief? We hold that petitioners properly relied on the Tucker Act to sue for damages in the Court of Federal Claims.

A

The United States is immune from suit unless it unequivocally consents. The Government has waived immunity for certain damages suits in the Court of Federal Claims through the Tucker Act. That statute permits "claim[s] against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort."

The Tucker Act, however, does not create substantive rights. A plaintiff relying on the Tucker Act must premise her damages action on "other sources of law," like "statutes or contracts." For that reason, [not] every claim invoking the Constitution, a federal statute, or a regulation is cognizable under the Tucker Act. Nor will every failure to perform an obligation . . . creat[e] a right to monetary relief against the Government. To determine whether a statutory claim falls within the Tucker Act's immunity waiver, we typically employ a "fair interpretation" test. A statute creates a "right capable of

[12] In this implied-repeal context, it is also telling that Congress considered—but did not enact—bills containing the type of text that may have satisfied the clear-expression rule. See *e.g.,* Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong., 2d Sess., § 2 (2014) ("'[T]he Secretary shall ensure that payments out and payments in . . . are provided for in amounts that the Secretary determines are necessary to reduce to zero the cost . . . to the Federal Government of carrying out the program under this section'"); Taxpayer Bailout Protection Act, S. 359, 114th Cong., 1st Sess., § 2 (2015) ("'The Secretary shall ensure that the amount of payments to plans . . . does not exceed the amount of payments to the Secretary'" and "'shall proportionately decrease the amount of payments to plans'"); Taxpayer Bailout Protection Act, H. R. 724, 114th Cong., 1st Sess., § 2 (2015) (same).

grounding a claim within the waiver of sovereign immunity if, but only if, it can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained. The other source of law need not explicitly provide that the right or duty it creates is enforceable through a suit for damages. Satisfying this rubric is generally both necessary and sufficient to permit a Tucker Act suit for damages in the Court of Federal Claims.[13]

But there are two exceptions. The Tucker Act yields when the obligation-creating statute provides its own detailed remedies, or when the Administrative Procedure Act provides an avenue for relief.

B

Petitioners clear each hurdle: The Risk Corridors statute is fairly interpreted as mandating compensation for damages, and neither exception to the Tucker Act applies.

1

Rarely has the Court determined whether a statute can fairly be interpreted as mandating compensation by the Federal Government. Likely this is because so-called money-mandating provisions are uncommon, and because Congress has at its disposal several blueprints for conditioning and limiting obligations. But Congress used none of those tools in § 1342. The Risk Corridors statute is one of the rare laws permitting a damages suit in the Court of Federal Claims.

Here again § 1342's mandatory text is significant. Statutory "shall pay" language often reflects congressional intent to create both a right and a remedy under the Tucker Act. Section 1342's triple mandate—that the HHS Secretary "shall establish and administer" the program, "shall provide" for payment according to the statutory formula, and "shall pay" qualifying insurers—falls comfortably within the class of money-mandating statutes that permit recovery of money damages in the Court of Federal Claims.

Bolstering our finding is § 1342's focus on compensating insurers for past conduct. In assessing Tucker Act actions, this Court has distinguished statutes that attempt to compensate a particular class of persons for past injuries or labors from laws

[13] Relying on *Alexander v. Sandoval*, 532 U.S. 275 (2001), the dissent's logic suggests that a federal statute could never provide a cause of action for damages absent magic words explicitly inviting suit. We have repeatedly rejected that notion—including in opinions written by *Sandoval*'s author. Not even *Sandoval* went as far as the dissent; that decision instead explained that [t]he judicial task is to interpret the statute Congress has passed to determine whether it displays an intent to create not just a private right but also a private remedy. That is precisely what the money-mandating inquiry does: It provides a framework for determining when Congress has authorized a claim against the Government.

that subsidize future state expenditures. The first group permits Tucker Act suits; the second does not. The Risk Corridors statute sits securely in the first category: It uses a backwards-looking formula to compensate insurers for losses incurred in providing healthcare coverage for the prior year.

2

Nor is there a separate remedial scheme supplanting the Court of Federal Claims' power to adjudicate petitioners' claims. True, the Tucker Act "is displaced" when a law assertedly imposing monetary liability on the United States contains its own judicial remedies. A plaintiff in that instance cannot rely on our "fair interpretation" test, and instead must stick to the money-mandating statute's own text to determine whether the damages liability Congress crafted extends to the Federal Government. Examples include the Fair Credit Reporting Act and the Agricultural Marketing Agreement Act of 1937. The former superseded the Tucker Act by creating a cause of action, imposing a statute of limitations, and providing subject-matter jurisdiction in federal district courts. And the latter did so by allowing aggrieved parties to petition the Secretary of Agriculture and by paving a path for judicial review. Unlike those statutes, however, the Affordable Care Act did not establish a comparable remedial scheme. Nor has the Government identified one. So this exception to the Tucker Act is no barrier here.

Neither does the Administrative Procedure Act bar petitioners' Tucker Act suit. To be sure, in [Bowen v Massachusetts, 108 S. Ct. 272 (1988)], this Court held in the Medicaid context that a State properly sued the HHS Secretary under the Administrative Procedure Act (not the Tucker Act) in district court (not the Court of Federal Claims) for failure to make statutorily required payments. But *Bowen* is distinguishable on several scores. First, the relief requested there differed materially from what petitioners pursue here. In *Bowen*, the State did not seek money damages, but instead sued for prospective declaratory and injunctive relief to clarify the extent of the Government's ongoing obligations under the Medicaid program. Unlike § 1342, which [provides] compensation for specific instances of past injuries or labors, the pertinent Medicaid provision was a grant-in-aid program, which [directed] the Secretary . . . to subsidize future state expenditures. Thus, the suit in Bowen was not merely for past due sums, but for an injunction to correct the method of calculating payments going forward. And because the Court of Federal Claims does not have the general equitable powers of a district court to grant prospective relief, the Court reasoned that *Bowen* belonged in district court.

Second, the parties' relationship in *Bowen* also differs from the one implicated here. The State had employed the Administrative Procedure Act in Bowen because of the litigants' complex ongoing relationship, which made it important that a district court adjudicate future disputes. The Court added that the Administrative Procedure Act "is tailored" to [m]anaging the relationships between States and the Federal Government that occur over time and that involve constantly shifting balance sheets, while the Tucker Act is suited to [remedying] particular categories of past injuries or labors for which various federal statutes provide compensation.

These observations confirm that petitioners properly sued the Government in the Court of Federal Claims. Petitioners' prayer for relief under the Risk Corridors statute looks nothing like the requested redress in *Bowen*. Petitioners do not ask for prospective, nonmonetary relief to clarify future obligations; they seek specific sums already calculated, past due, and designed to compensate for completed labors. The Risk Corridors statute and Tucker Act allow them that remedy. And because the Risk Corridors program expired years ago, this litigation presents no special concern about managing a complex ongoing relationship or tracking ever-changing accounting sheets. Petitioners' suit thus lies in the Tucker Act's heartland.[15]

V

In establishing the temporary Risk Corridors program, Congress created a rare money-mandating obligation requiring the Federal Government to make payments under § 1342's formula. And by failing to appropriate enough sums for payments already owed, Congress did simply that and no more: The appropriation bills neither repealed nor discharged § 1342's unique obligation. Lacking other statutory paths to relief, and absent a *Bowen* barrier, petitioners may seek to collect payment through a damages action in the Court of Federal Claims.

These holdings reflect a principle as old as the Nation itself: The Government should honor its obligations. Soon after ratification, Alexander Hamilton stressed this insight as a cornerstone of fiscal policy. "States," he wrote, "who observe their engagements . . . are respected and trusted: while the reverse is the fate of those . . . who pursue an opposite conduct." Report Relative to a Provision for the Support of Public Credit (Jan. 9, 1790), in 6 Papers of Alexander Hamilton 68 (H. Syrett & J. Cooke eds. 1962). Centuries later, this Court's case law still concurs.

The judgments of the Court of Appeals are reversed, and the cases are remanded for further proceedings consistent with this opinion.

It is so ordered.

Justice ALITO, dissenting.

Twice this Term, we have made the point that we have basically gotten out of the business of recognizing private rights of action not expressly created by Congress. Other

[15] The dissent concedes that there may "be some sharply defined categories of claims that may be properly asserted" through the Tucker Act "simply as a matter of precedent." (citing takings, breach-of-contract, failure-to-pay-compensation, and breach-of-fiduciary-duty claims as examples). Petitioners' claim—breach of an unambiguous statutory promise to pay for services rendered to the Government—fits easily within those precedents. The only differences the dissent seems to assert here are that the dollar figure is higher and that petitioners do not deserve a "bailout" for their "bet" that the Federal Government would comply with federal law. Our analysis in Tucker Act cases has never revolved on such results-oriented reasoning.

recent opinions are similar. Today, however, the Court infers a private right of action that has the effect of providing a massive bailout for insurance companies that took a calculated risk and lost. These companies chose to participate in an Affordable Care Act program that they thought would be profitable. I assume for the sake of argument that the Court is correct in holding that § 1342 of the Affordable Care Act created an obligation that was not rescinded by subsequent appropriations riders. Thus, for present purposes, I do not dispute the thrust of the analysis in Parts I–III of the opinion of the Court.

I

My disagreement concerns the critical question that the Court decides in the remainder of its opinion. In order for petitioners to recover, federal law must provide a right of action for damages. The Tucker Act, under which petitioners brought suit, provides a waiver of sovereign immunity and a grant of federal-court jurisdiction, but it does not create any right of action. Nor does any other federal statute expressly create such a right of action. The Court, however, holds that § 1342 of the Affordable Care Act does so by implication. Because § 1342 says that the United States "shall pay" for the companies' losses, the Court finds it is proper to infer a private right of action to recover for these losses.

This is an important step. Under the Court's decision, billions of taxpayer dollars will be turned over to insurance companies that bet unsuccessfully on the success of the program in question. This money will have to be paid even though Congress has pointedly declined to appropriate money for that purpose.

Not only will today's decision have a massive immediate impact, its potential consequences go much further. The Court characterizes provisions like § 1342 as "rare," but the phrase the "Secretary shall pay"—the language that the Court construes as creating a cause of action—appears in many other federal statutes.

One might argue that the assumptions underlying the enactment of the Tucker Act justify our exercising more leeway in inferring rights of action that may be asserted under that Act. When the Tucker Act was enacted in 1887, Congress undoubtedly assumed that the federal courts would [r]ais[e] up causes of action, Alexander v. Sandoval, 532 U.S. 275 (2001), in the manner of a common-law court. At that time, federal courts often applied general common law. But since Erie R. Co. v. Tompkins, 304 U.S. 64 (1938), the federal courts have lacked this power. Yet the "money-mandating" test that the Court applies today, bears a disquieting resemblance to the sort of test that a common-law court might use in deciding whether to create a new cause of action. To be sure, some of the claims asserted under the Tucker Act, most notably contract claims, are governed by the new federal common law that applies in limited areas involving uniquely federal interests. And the recognition of an implied right to recover on such claims is thus easy to reconcile with the post-Erie regime. There may also be some sharply defined categories of claims that may be properly asserted simply as a matter of precedent. But the exercise of common-law power in cases like the ones now before us is a different matter.

An argument based on Congress's assumptions in enacting the Tucker Act would present a question that is similar to one we have confronted under the Alien Tort Statute (ATS), a provision like the Tucker Act that grants federal jurisdiction but does not itself create any right of action. There is every reason to believe that a similar caution should guide cases under the Tucker Act—especially when billions of dollars of federal funds are at stake. The money-mandating test that the Court applies here is in stark tension with this precedent.

Despite its importance, the legitimacy of inferring a right of action under § 1342 has not received much attention in these cases. I am unwilling to endorse the Court's holding in these cases without understanding how the "money-mandating" test on which the Court relies fits into our general approach to the recognition of implied rights of action.[5] Because the briefing and argument that we have received have not fully addressed this important question, I would request supplemental briefing and set the cases for re-argument next Term.

For these reasons, I respectfully dissent.

Notes

1. *Channeling the Founders here and elsewhere.* This was quite the term for the nation's Founders. Here Justice Sotomayor, writing for an 8-Justice majority, invokes Alexander Hamilton for the proposition that a government honors its financial obligations. In *Trump v Vance,* 2020 WL 3848062 (2020), the Chief Justice opened his opinion for the Court with the story of the subpoena *duces tecum* issued to President Jefferson to produce documents in Aaron Burr's spectacular trial for treason. It is a given that the Court's opinions are grounded in legal precedent, but clearly the Court's 2019-2020 term led the Justices to remind us in notable and eloquent ways about the first principles that continue to guide the nation. The majority opinion in this case embodies two of those principles. First, when a government promises to pay its debts, the courts will set aside

[5] The Court claims that the logic of this opinion "suggests that a federal statute could never provide a cause of action for damages absent magic words explicitly inviting suit." But all I suggest is that the Court request briefing on the question of inferring causes of action to recover damages under the Tucker Act. The Court makes no effort to explain how the test it applies here can be reconciled with our general approach to inferring private rights of action but is apparently content to allow that inconsistency to remain. The Court is flatly wrong in saying that the test in *Alexander v. Sandoval*, 532 U.S. 275, (2001)—whether a statute "displays an intent to create not just a private right but also a private remedy"—is "precisely" the same as its "money-mandating inquiry." In fact, the "money-mandating inquiry" is precisely contrary to the statement in *Sandoval. Sandoval* said unequivocally that it is not enough if a statute merely displays an intent to create . . . a private right, but according to the Court, it is sufficient for a statute to manifest only an intent to create a right to receive money. The Court asserts that there is no real difference between the billion-dollar private right of action that the Court now creates on behalf of sophisticated economic actors and our prior precedents, but the Court does not identify analogous precedents—perhaps because there are none to cite.

later efforts to renege on such a promise unless Congress does so unequivocally. Second a clear promise to pay creates an enforceable right to collect.

2. *Private enforcement rights.* The majority opinion sweeps aside the absence of an explicit right of action, holding that the right of action to enforce the claim for money judgment is inherent in the creation of the right to money payment itself. That assertion seems to be the core of Justice Alito's complaint with the majority's decision; in other words, he does not quarrel with the importance of government promises to pay creditors but instead with who can enforce that promise. (Although if Justice Alito is correct, the promise to pay becomes totally meaningless—is the government going to enforce the promise against itself? One suspects not.).

As you either have or will learn from the Medicaid materials in this book, the right to privately enforce claims against the government is a crucial concept. The concept is critical not just in the case of creditors owed money but in the case of individuals who are the intended beneficiaries of a government program such as Medicaid. As the Medicaid cases in this textbook demonstrate, Supreme Court Medicaid jurisprudence has evolved to the point that private enforcement is fundamentally threatened by a series of decisions that effectively slam the door on most private enforcement cases brought against state Medicaid agencies to secure program benefits. In *Maine Community Health Options,* one sees that the Court may be willing to adopt a different view when the claim involves money owed a creditor who sues under the Tucker Act. A lingering question is whether the Court's respect for promises made by governments to private individuals has any sort of spillover effect when the promise involves provision of means-tested government benefits rather than payment of money.

3. *History and context—what's going on here and is this a case of Kabuki theater?* If you are mystified by why this case even happened, you are not alone. As Justice Sotomayor explains, multiple insurers sued for their money, one of which was Maine Community Health Options, one of the nonprofit start-up health insurance cooperatives whose creation was authorized under the ACA, along with some initial capitalization.[*] By the time the cases reached the Court, companies were owed more than $12 billion—a lot of money no matter how one slices it. Katie Keith, Supreme Court Rules That Insurers Are Entitled To Risk Corridors Payments: What The Court Said and What Happens Next, *Health Affairs Blog* (April 28, 2020),

[*] By the end of 2015 one-third of the Coop plans had collapsed, some shuttering voluntarily and others ordered to do so by state insurance departments because they were insolvent. Of 23 cooperative plans available in 2014, by 2015 only two-thirds remained after a year. Susan Levine & Amy Goldstein, Two More Obamacare Health Insurance Plans Collapse, *Washington Post* (October 16, 2015), https://www.washingtonpost.com/national/health-science/two-more-obamacare-health-insurance-plans-collapse/2015/10/16/cc324fd0-7449-11e5-8d93-0af317ed58c9_story.html (Accessed August 1, 2020). The Coop plans were the Senate compromise on the issue of whether to create a public insurance option to bring stability and competition to the newly restructured private insurance market. Creation of the public option was resoundingly opposed by the insurance industry then, and there is no reason to believe that the industry will not oppose the revival of such an option in 2021, assuming a Presidential election outcome in which strengthening and improving the ACA becomes central to the health policy debate.

https://www.healthaffairs.org/do/10.1377/hblog20200427.34146/full/ (Accessed August 1, 2020).

The risk corridors case is one of multiple types of legal actions that arose in the wake of the ACA, many of which are presented in this Textbook and Supplement. The cases traveled two paths. Some, like the risk corridors case, resulted from efforts by Congressional opponents to unravel certain key underpinnings of the law. Others, like *National Federation of Independent Business v Sebelius* and *King v Burwell* (both presented in this Supplement) were filed by opponents of the law intent on unraveling the Act in its entirety or at least inflicting existential damage. Timothy Stoltzfus Jost & Katie Keith, The ACA and the Court's Litigation's Effects on the Law's Implementation and Beyond, 39 Health Affairs 122 (March 2020).

Even so, this case is a head-scratcher. As the Court discusses at length, Congress certainly knows how to draft legislation, including laws that do (or do not) create (or maintain) privately enforceable promises to pay debts owed. (As Justice Sotomayor notes, Congress could not constitutionally extinguish a past promise to pay but could eliminate its obligations going forward. This, of course, presents a basic limit when it comes to using appropriations bills to alter promises, since these enactments, as is the case here, frequently may come well after the obligation is legally incurred). If lawmakers do not do so explicitly, then the GAO is there to remind them through its legislative practice treatise, The Red Book. Yet lawmakers clearly did not do so.

Another head scratcher is that, as the Court points out, both the risk corridor and the reinsurance programs* were time-limited and, indeed, are highly-favored market-based solutions to stabilizing private insurance markets. Why did a Republican-controlled House (and later, after the 2014 Congressional mid-term elections, a Republican-controlled Senate) go after risk corridors with such a vengeance? There is no question that $12 billion is a boatload of money, but really, not in the vast financial scheme of either the ACA or annual appropriations bills. So it wasn't money. Furthermore, why did the Obama administration not fight back more fiercely, at least in the initial years of this battle, when Democrats still controlled the Senate?

Part of the answer may lie in the groundwork laid by the administration in implementing the risk corridors program. At every turn, beginning in the years following the 2010 mid-term elections when the Democratic House fell, the Centers for Medicare and Medicaid Services (CMS), which administers the market reforms and financial stabilization payments, reiterated its view that the legislation created a legal obligation to pay, thereby building a legal record so that insurers could sue to enforce the government's obligation to pay. Between its regulatory policy and the GAO Red Book, a key treatise that guides statutory drafting and enactment, defenders of the ACA's premium stabilization policies may have felt they had done what they needed to do in

* Reinsurance protects insurers against excessive costs arising from specific outlier cases. Risk corridors, by contrast, limit aggregate risk exposure tied to the cost of the entire insured population.

order to protect insurers. Ultimately, in their view, insurers would win in court through Tucker Act cases, meaning that the best strategy would be to water down subsequent appropriations statutes to no more than precatory language. Of course, this strategy also would mean that insurers would need to wait years to collect.

Now the collection wheels begin to turn, meaning that even if the strategy works, it could be years to payment . The case now heads back to the Court of Claims, which ultimately will issue a judgment for each plaintiff, to be enforced against HHS. As Katie Keith points out, this judgment will then be referred to the Judgment Fund for payment, although everything could be held up further if each tally for each year is disputed. And of course, more insurers that sat out the litigation waiting to see what would happen, might now sue (assuming they are not barred by a statute of limitations), thereby piling up more cases. In the meantime, some of these insurers may have gone out of business or ceased selling in the Marketplace simply because they have been undone by the government's failure to pay. This dispute might never end.

Then there is the question about why ACA opponents—Republican Members of Congress who strongly support market-based solutions to insurance coverage—would have gone after the Risk Corridors program. One could be a total cynic and conclude that opponents knew that the language they were drafting would never hold up in court; imagine their surprise then, when the appeals court found for the government. Another theory—and one that helps explain the 2017 legislative onslaught against the ACA discussed in this Supplement—was a desire to blow the law to smithereens, in this instance by leaving Marketplaces without insurers willing to take on the risk of selling plans. This way proponents of "repeal and replace" could persuade companies to come to the table and work with lawmakers in opposition to write an alternative, one more to their liking.

What makes the Republican effort to destabilize the Marketplace through defunding the Risk Corridors so hard to understand is that market orthodoxy advocates policies such as this one. Indeed, the Medicare Part D outpatient prescription drug benefit—championed and enacted by a Republican administration—rests on *permanent* limits on insurers' risk exposure in order to ensure a stable market, one in which the government shared unanticipated, excessive risk with participating insurers. (For a helpful explanation of how the Part D market structure compares to that established by the ACA Exchange system, see Deloitte, Health Current: Medicare Part D vs the Exchanges: With So Many Similarities, Why Have The Two Programs Fared So Differently? (2018), https://www2.deloitte.com/us/en/pages/life-sciences-and-health-care/articles/health-care-current-june12-2018.html (Accessed August 1, 2020).

4. *Managing risk exposure.* The concept of risk sharing between government and private insurers is a staple of insurance policymaking, both state and federal. In some cases, risk sharing (and risk shielding) takes the form of overt policies such as risk corridors and reinsurance, both of which shield issuers from financial liability above a certain attachment point. The federal government is not alone in this regard; many states

have reinsurance programs both to stabilize plans and to keep premium affordable. Jennifer Tolbert et al., State Actions to Improve the Affordability of Health Insurance in the Individual Market (Kaiser Family Foundation, 2019), https://www.kff.org/health-reform/issue-brief/state-actions-to-improve-the-affordability-of-health-insurance-in-the-individual-market/ (Accessed August 1, 2020). Then, of course, there are more indirect types of risk-shielding, premium-controlling policies, such as regulatory standards that give issuers the power to limit coverage itself, such as discretion to define what is medically necessary, the power to impose across-the-board treatment limits, and the power to exclude certain conditions from coverage. Think about the limits and exclusions in *Bedrick v Travelers Insurance* (main text), which were designed to protect Travelers from high-cost claims filed by children with chronic and serious health conditions. Consider also the power sanctioned by the Supreme Court in *Firestone Tire and Rubber v Bruch* (main text), to embed a broad deference clause within plans, thereby shielding insurer decisions from de novo judicial review. These strategies all help insurers from (as they see it) getting swamped by too much risk, while also enabling them to perhaps keep some lid on premium increases, especially in an era when, as a result of the ACA's central market achievement, issuers have lost the ability to deny coverage altogether or charge higher rates for sicker people.

Fifth 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 2020 and what may lie ahead. The Sixth Postscript follows and updates this one.]

Introduction

As this Supplement 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 this Supplement 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/ (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 (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 (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:

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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 outsize 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 (Accessed July 23, 2017).

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 Supplement); 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 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/medicaids-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

* 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.

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 (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* (Supplement) 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.

* 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.

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 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

[*] Alan Weil, There's Something About Medicaid," 22 *Health Affairs* 13 (2003).

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/brief_pdfs/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.

* The Supreme Court's decision in *King v Burwell* (2015) (found in this Supplement), 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.

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 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.[*****]

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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 Supplement materials on the ACA and contraceptive 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 obligations to a few hundred dollars rather than thousands of dollars annually. Commonwealth Fund, Essential Facts About Health Reform Alternatives: Eliminating Cost-Sharing Reductions (2017), http://www.commonwealthfund.org/publications/explainers/2017/apr/cost-sharing-reductions (Accessed July 2, 2017).

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 load 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 Supplement) 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 Adults," 36 Health Affairs 1119 (June 2017), http://content.healthaffairs.org/content/early/2017/05/15/hlthaff.2017.0293?ijkey=L2XONHRifNgio&keytype=ref&siteid=healthaff (Accessed July 22, 2017).

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). It is possible that at least 45 counties—heavily rural—might have no insurer when the 2017 open enrollment season begins in November 2017. Haeyoun Park & Audrey Carleson, For the First Time, 45 Counties Could Have No Insurer in the Obamacare Marketplace, NY Times (June 9, 2017), https://www.nytimes.com/interactive/2017/06/09/us/counties-with-one-or-no-obamacare-insurer.html?_r=0 (Accessed July 22, 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

[*] 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

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 work requirements in a March 2017 letter to states. https://www.hhs.gov/sites/default/files/sec-price-admin-verma-ltr.pdf (Accessed July 2, 2017).

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%.

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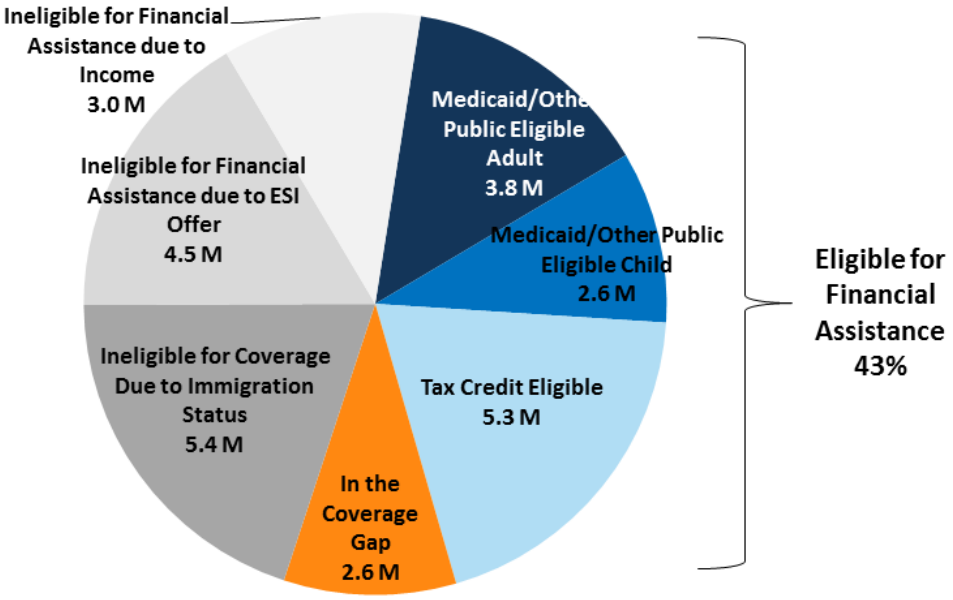
than a more modern policy update of Medicaid to parallel the ACA policy. It is striking that as recently as 2006, when § 1916 was last amended by Congress, the concept of premiums on the poor was considered unwise, even by a conservative President and a Republican Congress. Four years later, a Democratic President and Congress would impose premiums beginning at 100 percent of poverty.

Figure 1

Eligibility for ACA Coverage Among Nonelderly Uninsured as of 2016



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.
SOURCE: Kaiser Family Foundation analysis based on 2016 Medicaid eligibility levels and 2016 Current Population Survey.

THE HENRY J. KAISER FAMILY FOUNDATION

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.

Private insurance reforms. H.R. 1628, the American Health Care Act, would eliminate the individual mandate effective in 2016. This exemption follows the Trump Administration's Executive Order issued on January 20, 2017,' directing federal agencies to unwind federal regulations affecting individuals and industries, including the authority to "waive, defer, grant exemptions from or delay" ACA rules. Executive Order Minimizing the Economic Burden of the Patient Protection and Affordable Care Act Pending Repeal, https://www.whitehouse.gov/the-press-office/2017/01/2/executive-order-minimizing-economic-burden-patient-protection-and (Accessed July 3, 2017).

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

[*] 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.

allowed insurers to sell cheap, medically underwritten policies to the healthy if they also 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." https://www.ahip.org/letter-to-u-s-senate-regarding-consumer-freedom-option/ (Accessed July 19, 2017).

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.

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

* 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.

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 capita 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-strip-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

* 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).

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).

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.

* * *

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-consequences-of-per-capita-spending-caps-in-medicaid/ (Accessed July 4, 2017). 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).

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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.

Sixth Postscript to Part Two: The Affordable Care Act: The Unraveling during the Trump Years and the Nascent Un-Unraveling in the Early Biden Administration

The Unraveling During the Trump 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 (Trump); 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,

* 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.

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 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, followed by California v. Texas (again, this Supplement). The other way to go after the law is to eat away at it through regulatory disruption in order to undermine and destabilize it, the basic game plan during the Trump years. However, two can play that game and at least so far, the unravelling wrought during those years is about to be unraveled itself by the Biden administration.

Blowing up the law in court

As we detail elsewhere in this Supplement, the Supreme Court has largely, although not entirely, thwarted the ACA opponents attempts to blow up the law in court. One marvels at the havoc that would be wrought had any such attempt succeeded. Should ACA opponents prevail in having the entire law declared unconstitutional, the question becomes: 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)),

* 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.

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 hello to 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 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 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 Texas v. California 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 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: 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 tried to 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

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.

[*] 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.

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_2018-08-05&utm_medium=Email&cm_mmc=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 million lost to the ACA pool by 2028; other analysts have estimated a far deeper and immediate impact. See, e.g., 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/ (Accessed July 18, 2019).

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 regulation allowing for more short-term plans, in July 2020, the United States Court of Appeals upheld the Trump administration rule aimed at expanding the size and scope of the STLDI market as a reasonable exercise of rulemaking power. Katie Keith, Appeals Court Upholds Rule Relaxing Short-Term Plan Restrictions (Health Affairs Blog, July 19, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200719.720906/full/ (Accessed August 3, 2020). 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.

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). By July 2021, expansion states had grown to 40 (one state, Missouri, was dragged kicking and screaming over the finish line when that state's Supreme Court upheld as lawful a voter initiative adding expansion as a matter of constitutional right, https://www.stltoday.com/news/local/crime-and-courts/in-a-unanimous-ruling-missouri-high-court-says-medicaid-expansion-valid/article_500d2045-c6dd-55b6-9f6a-575aa0dab01b.html (Accessed August 1, 2021)). Still, seven years after full implementation of the ACA, 11 states remained holdouts, compared to the lone state (Arizona) that had not adopted Medicaid by 1972, seven years after the law's original enactment. This shameful state of affairs continues despite the unbelievable financial incentives to expand included in the original ACA and further enhanced under the American Rescue Plan of 2021. States literally were offered expansion in exchange for hundreds of millions of dollars over and above their own costs to expand (10 percent of the cost of covering the newly eligible population). https://www.commonwealthfund.org/publications/issue-briefs/2021/may/economic-employment-effects-medicaid-expansion-under-arp (Accessed August 1, 2021). Nevertheless, the holdout states have persisted, leaving over 2 million people without a pathway to affordable coverage as of mid-summer 2021.

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 unraveling 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 Expand Medicaid (Kaiser Family Foundation, 2019), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/ (Accessed July 18, 2019).

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 Nutrition Assistance Program—i.e., the food stamp program—resulted in widespread loss of benefits with no gains in employment or income (and no increase in access to already-nonexistent employer insurance). Medicaid and CHIP Payment and Access Commission (MACPAC) Work as a Condition of Medicaid Eligibility: Key Take-Aways from TANF (2018), https://www.macpac.gov/wp-content/uploads/2017/10/Work-as-a-Condition-of-Medicaid-Eligibility-Key-Take-Aways-from-TANF.pdf (Accessed July 20, 2019). How could compulsory work experiments promote Medicaid's core objective of furnishing medical assistance to eligible people? They could not.

So the Administration effectively devised 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.

In July 2019 a ruling on the challenge in New Hampshire was 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.

In February 2020, the United States Court of Appeals for the D.C. Circuit affirmed the lower court ruling on the same ground – that in approving the experiments, the Secretary acted in an arbitrary and capricious fashion by failing to consider the central issue in exercising 1115 research authority, namely whether the experiment would promote the objective of Medicaid – to insure people. Sara Rosenbaum and Alex Somodevilla, Inside the D.C. Circuit's Opinion in *Gresham v Azar* (Health Affairs Blog, February 20, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200220.823038/full/. By the time *Gresham* was decided, Kentucky's newly-elected Governor had withdrawn his state's work experiment proposal. One would like to think this ends the matter, but the administration now has filed a petition for *certiorari,* demanding that the decision vacating the approval be reversed. And on we go.

By winter 2021, just in time for the Biden administration, the Court of Appeal's ruling had made its way to the United States Supreme Court, with appeals from both Arkansas and New Hampshire, whose experiments ultimately had been ruled unlawful by the District Court. Oral arguments were scheduled, and the first-ever case focused on the scope of the Secretary's power to invent a brand new purpose—to promote a work ethic for the nation's largest public health insurer—was about to be heard. At this point, the new administration began unwinding the prior administration's handiwork, notifying Arkansas that it was rescinding approval, given the COVID-19 pandemic and the damage that the experiment already inflicted on the poor during the 7-month period when it had been in effect and before the initial order vacating approval. The administration made a notably restrained request, asking the Court to vacate the appellate decision and to send the matter back to the Secretary to continue the unwinding process. Not surprisingly, Arkansas fought back, challenging the power of the Secretary to reverse course on an experiment already approved (even though the boilerplate language in every 1115 approval explicitly gives the Secretary the authority to terminate). https://www.healthaffairs.org/do/10.1377/hblog20210216.717854/full/. While the Court

took the case off it schedule for oral argument, it simply parked the case to one side, waiting to see what would happen next, and the 2020 term ended with the case still pending. https://news.bloomberglaw.com/us-law-week/supreme-court-leaves-fight-over-medicaid-work-rules-in-limbo.

Although Arkansas's challenge to termination of its waiver remains live, in fact in July 2021 the state submitted an entirely new request for request for renewal of its waiver that, in its latest iteration, lacks a component establishing compelled work as a condition of eligibility. (Work incentives would be offered in the form of better benefits, but no one would lose coverage for failure to work—a tacit admission by the state that the days of compelled work as health promotion no longer enjoy purchase). https://news.bloomberglaw.com/health-law-and-business/bidens-sway-seen-in-arkansas-medicaid-plan-without-work-mandate. One would think that the case is now moot.

The Nascent Un-Unraveling in the Early Biden Administration

To some extent, just as the Trump administration used executive power in its attempt to unravel the ACA. Stymied in Congress, it had no other tools to use, aside from aiding the efforts by others to blow the thing out of the water in the courts, efforts discussed previously in this Supplement. However, two can play the same game and with the change in administrations, the Biden administration set about in using its executive power to unwind what the Trump administration had wrought.

However, the context in 2021 was vastly different—and one could say differed from anything humankind had experienced in about 100 years—because of the COVID-19 pandemic. As a result, the tools to rebuild the ACA, as well as to enact significant changes to health policy and the sector, are now quite different, as is the political situation in which one party controls, albeit by the slimmest of possible margins, both the Presidency and both Houses of Congress.

Therefore, in the early years of the Biden Administration the most important efforts to change health care policy, the delivery system and the health insurance system have occurred as part of the effort to deal with the terrible pandemic, the vast harm it has caused and the horror of our health care financing and delivery (non)system that it has exploded and revealed in the full light of day, as discussed more fully in the book's new introduction set out in the beginning of this Supplement. For that reason, our discussion of where things currently stand is framed in the light of the Biden Administration's health policy response to COVID-19.

Immediately upon taking office, the Biden administration began to strengthen the government response for the millions of low income, minority, and medically underserved Americans so disproportionately burdened by the pandemic's health, economic, and social impact. Beginning the afternoon of Inauguration Day, the President began to issue a raft of Executive Orders that instructed both White House officials and

Cabinet agencies on administrative reforms. These orders were accompanied by the American Rescue Plan, the administration's blueprint for legislative action.

The Executive Orders included, among others:

- "Advancing Racial Equity and Support for Underserved Communities Through the Federal Government", https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01753.pdf;

- "Organizing and Mobilizing the United States Government To Provide a Unified and Effective Response To Combat COVID–19 and To Provide United States Leadership on Global Health and Security", which reiterated an emphasis on reducing disparities in health and health care as part of the response, https://www.govinfo.gov/content/pkg/FR-2021-01-25/pdf/2021-01759.pdf;

- Ensuring an Equitable Pandemic Response and Recovery, https://www.federalregister.gov/documents/2021/01/26/2021-01852/ensuring-an-equitable-pandemic-response-and-recovery; and

- Improving and Expanding Access to Care and Treatments for COVID-19, https://www.federalregister.gov/documents/2021/01/26/2021-01858/improving-and-expanding-access-to-care-and-treatments-for-covid-19, and Strengthening Medicaid and the Affordable Care Act, https://www.federalregister.gov/documents/2021/02/02/2021-02252/strengthening-medicaid-and-the-affordable-care-act.

The sweeping public health, health care, and economic provisions of the American Rescue Plan, https://www.whitehouse.gov/briefing-room/legislation/2021/01/20/president-biden-announces-american-rescue-plan/, laid out an "all of government" response to aid in treatment, recovery, and prevention, not only for the millions of affected families but for hard-hit communities, cities, and states. Over the next several months, the Plan would be enacted and the federal agencies would begin to move forward under the executive orders.

Not surprisingly, improving federal public health and health care programs and policies emerged as a major focus of reform. Many of these programs—in particular Medicaid and the subsidized health insurance marketplace—had taken a beating under the Trump administration, and reversing course became a priority. The legislation and regulatory actions that followed thus represented a 180-degree turn from those pursued by the Trump Administration.

The cornerstone of the Biden administration's early efforts was the American Rescue Plan Act (ARPA), Pub. L. 117-2 (117th Cong. 1st Sess.), a massive $1.9 trillion emergency measure, two aspects of which are our focus here. First, ARPA contains

scores of investments in economic, social, and community supports for hard hit families, communities, and states. (There are numerous summaries of the Act in its entirety; the National League of Cities offers a useful one searchable by topic, https://www.nlc.org/resource/american-rescue-plan-act-of-2021-summary-of-provisions/). Second, many of among ARPA's provisions are designed to increase greatly the affordability of subsidized marketplace health plans.

Building Capacity in Public Health and Health Care Delivery in Underserved Areas

A substantial number of ARPA health provisions take the form of funds to strengthen the public health activities of the CDC, the FDA, and the NIH, along with those of state and local health agencies charged with measuring and monitoring community health. ARPA also includes programs that represent direct investments to build health care capacity in medically underserved urban and rural communities that have faced COVID-19's highest burdens. An example of such investments is the Community Health Centers (CHC) Program, 42 U.C.C. § 254b et seq. As discussed in Part One of the textbook, CHCs began as a small demonstration project launched in 1966 by the Office of Economic Opportunity (OEO) to create a new type of community health clinic (pioneered in the South African homelands under Apartheid) that combines comprehensive primary health care and public health. Ultimately—a rarity in small experimental programs—CHCs grew into a major federal initiative, the largest publicly funded primary care system in the country. Sara Rosenbaum and Daniel Hawkins, The Good Doctor: Jack Geiger, Social Justice, and U.S. Health Policy, 384 *New Eng. J. Med.* 983 (March 18, 2021). By 2019, CHCs served nearly 30 million patients in the nation's poorest communities. As the pandemic took hold, CHCs emerged as a vital source of testing, treatment, and ultimately, immunization.

The Biden administration seized upon expanding the CHCs as a means to increase access and equity. National Association of Community Health Centers, *Incoming Biden Administration Proposes Expansion of Community Health Centers to Fight COVID-19*, https://www.nachc.org/incoming-biden-administration-proposes-expansion-of-community-health-centers-to-fight-covid-19/, With ARPA providing $10 billion in supplemental federal funding. *FACT SHEET: Biden Administration Announces Historic $10 Billion Investment to Expand Access to COVID-19 Vaccines and Build Vaccine Confidence in Hardest-Hit and Highest-Risk Communities*, https://www.whitehouse.gov/briefing-room/statements-releases/2021/03/25/fact-sheet-biden-administration-announces-historic-10-billion-investment-to-expand-access-to-covid-19-vaccines-and-build-vaccine-confidence-in-hardest-hit-and-highest-risk-communities/. As of April 2021, CHCs had tested nearly 9 million patients and were rapidly ramping up community-wide vaccination efforts. The demographics of CHC patients mean that those served are disproportionately members of racial and ethnic minority groups. Jessica Sharac et al., Community Health Center Accomplishments and Challenges One Year into the COVID-19 Pandemic (George Washington University, 2021) https://www.rchnfoundation.org/wp-content/uploads/2021/04/FINAL-GG-RCHN-IB-65-April-2021.pdf.

Despite this important infusion of grant funding, CHCs, like other providers, depend on health insurance for their main funding, particularly Medicaid, their single largest revenue source, in light of the patients they serve. Sara Rosenbaum et al., *Community Health Center Financing: The Role of Medicaid and Section 330 Grant Funding Explained.* (Kaiser Family Foundation, 2019), https://www.kff.org/report-section/community-health-center-financing-the-role-of-medicaid-and-section-330-grant-funding-explained-executive-summary/**.** Thus, building capacity alone fails to address the health disparities tied to poverty and race that have historically been a hallmark of the American health care system. Instead, sustaining that capacity necessitates concomitant reforms to what have become its primary revenue streams, the subsidized private health insurance marketplace established under the ACA and Medicaid, both in Part Two of the textbook.

Administrative and ARPA Reforms to the Health Insurance Marketplace

The reforms to date have concerned two fundamental considerations relating to the question whether the marketplaces meet current needs. First, is the market even open for people to sign up? Second, is coverage affordable?

Signing up for help: a pandemic special enrollment period. The marketplace is essentially a subdivision of the broader individual insurance market—it's the place to go to be able to more easily comparison shop on line for coverage and, if eligible, qualify for refundable tax credits and cost-sharing subsidies that bring down insurance costs. As a subdivision of the private insurance market (which, as Part Two explains, consists of policies sold in both the individual and employer group markets and regulated by both federal and state law), the marketplace, which sells ACA-compliant policies,[*] operates by private insurance rules. One of the most basic rules governing the private insurance market is "open enrollment"—an oxymoron of sorts that describes an enrollment system that limits entry to specific time periods in order to guard against "adverse selection" by individuals who try to avoid paying for health insurance until they actually need health care. Were people to treat private insurance this way, of course, the entire system would

[*] Individuals can buy a range of health insurance policies in the open market. Some, like short-term limited duration plans, remain riddled with coverage limits and exclusions based on health status and have low actuarial value (what the plan actually covers and pays for in relation to the premium charged). These plans are considered ACA—noncompliant—that is, they fail to meet the minimum coverage and value rules of the ACA. In the health insurance marketplace however, where subsidies are available, issuers are permitted to sell only ACA-compliant plans. The Trump administration spent years encouraging people to buy ACA-non-compliant plans (also known in the business as junk insurance), although it did not succeed in making such plans eligible for federal subsidies. Rachel Schwab et al., Federal Policy Priorities for Preserving and Improving Access to Coverage: Perspectives from State-Based Marketplaces (Commonwealth Fund, 2021) https://www.commonwealthfund.org/publications/issue-briefs/2021/feb/federal-policy-priorities-preserving-coverage-state-based-marketplaces.

go into a death spiral, since the risk pool would simply be filled with high-cost health care users.*

As we describe in a number of places in the textbook, to survive, insurance risk pools need a ton of low-risk members to balance out the cost of caring for those with high needs. Both private insurance as well as Medicare (which rests on social insurance principles that track many of those found in the private market) thus limit enrollment to once per year for several weeks. (You all undoubtedly have watched the unending ads for Medicare Advantage that play nonstop during Medicare's fall open enrollment period). Only Medicaid—the nation's true "safety net" insurer—entitles eligible people to enroll whenever they need coverage.

Although open enrollment rules are essential to the ability of the health insurance market to function, both state and federal law make exceptions to this policy, known as "special enrollment periods." This exception process essentially ensures that certain public welfare policy considerations temper the rigid operation of the marketplace by permitting people to enroll in between open enrollment periods under certain circumstances. The Affordable Care Act authorizes the HHS Secretary to expand existing state and federal special enrollment periods (SEPs) in order to recognize additional "qualifying events." For example, long time federal and state law and custom recognized SEPs for getting married and needing to add a spouse to coverage, getting a divorce and suddenly needing coverage of one's own, adding a baby to a family policy, or losing employer coverage or coverage under an individually-purchased policy. https://www.healthcare.gov/coverage-outside-open-enrollment/special-enrollment-period/ Utilizing a SEP can be quite cumbersome—regulators and the industry do not want to encourage excessive SEP use—but SEPs do exist. And as noted, the ACA allows the HHS Secretary to add a SEP for extraordinary circumstances that carry the types of economic dislocations that can in turn trigger the need for coverage, such as a massive public health event.

At the time that the pandemic hit with full force in March 2020, only the normal SEP policies were in effect, of course. Under these normal policies, people losing jobs and workplace coverage could qualify since they had been continuously covered up to the time of layoff. However, there was no SEP for the far larger group of economically dislocated workers—those working at jobs without benefits, disproportionately low-wage workers of color and their families. These people had not had coverage. Some, who lost everything and lived in a state that extended Medicaid to all low-income working age adults and their families, might qualify for medical assistance. Others, however, might

* An excellent, succinct explanation of insurance death spiral issues can be found in Chief Justice John Roberts' opinion in King v Burwell (in the Supplement), 576 U.S. 473 (2015). Needless to say, there is a paradox built into this description, since the point of health insurance is, of course, to make health care affordable and thus used. It is one thing to use health maintenance or routine care, of course, and quite another to use extensive care to treat advanced illness. But open enrollment principles apply to all insured services, meaning that the limits on enrollment apply to both low-cost preventive and high-cost treatment services.

have incomes slightly above Medicaid eligibility levels but still low and would qualify for a marketplace subsidy.

For this reason, Congressional leaders of both parties urged the Trump administration to use its ACA regulatory powers (as did virtually every state that operated its own health insurance marketplace) to create a pandemic SEP open to anyone in need of affordable insurance for reasons related to the pandemic, such as job loss, and without regard as to whether the individual previously had been covered through a workplace plan. But federal officials refused—one of the first clues into how the administration's pandemic response would repeatedly—and deliberately—fail the most at-risk populations. Sara Rosenbaum et al., "How the Trump Administration's Pandemic Health Care Response Failed Racial Health Equity: Case Studies of Structural Racism and a Call for Equity Mindfulness in Federal Health Policy Making," [forthcoming] *J. Health Pol., Pol'y & Law* (2021).

Eight days after assuming office, President Biden issued an Executive Order to establish a COVID-based SEP. Katie Keith, Biden Executive Order To Reopen HealthCare.gov, Make Other Changes, *Health Affairs* [Blog], https://www.healthaffairs.org/do/10.1377/hblog20210129.998616/full/. Support for this shift in policy came from all corners, including the insurance industry itself. As of the end of May 2021, over 1.2 million people had signed up during the pandemic SEP, which lasts until August 15th—between two and three times the normal number of SEP-related enrollments that normally occur over this time period. Centers for Medicare and Medicaid Services, 2021 Marketplace Special Enrollment Period Report, https://www.cms.gov/newsroom/fact-sheets/2021-marketplace-special-enrollment-period-report-1.

The vast expansion of SEP enrollment as a result of the pandemic likely was helped by the structural changes to the subsidy system contained in ARPA and described below. But these affordability changes would have made little difference—not until open enrollment at least—had the Biden administration not re-opened the marketplace.

Marketplace affordability: The Affordable Care Act provides subsidies to make marketplace insurance affordable, and since the marketplace opened, millions have qualified for help. This help comes in two direct forms: refundable tax credits that lower premium costs; and subsidies that lower out-of-pocket cost sharing. Additional help has come in the form of a cap on what individuals and families can pay annually for insurance (tied to family income and previously limited to 400 percent of the federal poverty level—$106,000 in 2021 for a family of four). It also includes an annual out-of-pocket maximum on covered expenses, but this maximum does not include premiums, nor does it include expenditures for uncovered services or expenses that providers may charge over and above what insurance pays (balance billing). For the 2021 plan year, the out-of-pocket maximum is set at $8550 for an individual and $17,100 for a family. Healthcare.gov, Out-of-pocket maximum, https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.

ARPA makes use of marketplace insurance more affordable in several basic ways. Matthew Rae et al., How the American Rescue Plan Act Affects Subsidies for Marketplace Shoppers and People Who Are Uninsured (Kaiser Family Foundation, 2021), https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-act-affects-subsidies-for-marketplace-shoppers-and-people-who-are-uninsured/. First, for two years, it eliminates the 400-percent-of-poverty cap on the provision of federal subsidies to pay premiums, meaning that families of all incomes can get help, with the goal that no family will pay more than 8.5 percent of income for coverage. Karen Pollitz, How the American Rescue Plan Will Improve Affordability of Private Health Coverage (Kaiser Family Foundation, 2021), https://www.kff.org/health-reform/issue-brief/how-the-american-rescue-plan-will-improve-affordability-of-private-health-coverage/. Second, ARPA also made premium subsidies more generous for lower income individuals and families; whereas someone with income up to 150 percent of poverty ($39,750 for a family of four; $19,320 for a single individual in 2021) previously would have paid hundreds of dollars annually for insurance, premiums will now be set at zero. Before ARPA a 40-year-old with income of three times poverty, whose premium, without a subsidy, would be $5409—premiums rise somewhat with age—previously would have paid, after subsidy, $3763 for coverage; under ARPA, her payment drops to $2297. Id. ARPA does not change the value of cost-sharing assistance, but its impact on marketplace premiums for 2 years is notable, especially at the lower end of income levels. These more generous subsidies, of course, help explain why enrollment has grown so much since ARPA's passage.

Even more help goes to people receiving unemployment insurance for any week in 2021. Id. For these individuals, all income above 133 percent of poverty is disregarded in the calculation of eligibility for subsidies—i.e., it is as if their incomes are 133 percent lower than their actual incomes—and premium and cost sharing subsidies rise commensurately. This level of assistance lasts only during 2021. Finally, laid-off workers who qualify for continuation employer coverage (COBRA) during 2021 will get several months of premium assistance. *Id.*

ARPA's making marketplace insurance more affordable has a considerable impact. The Kaiser Family Foundation estimates that the number of people eligible for premium subsidies will rise from 18.1 million to 21.8 million—over three million people. Average monthly savings will range from $33 for people with incomes below 133 percent of poverty to over $200 monthly for those with incomes between 400 percent and 600 percent of the federal poverty level, at which point the cap on eligibility—no family pays more 8.5 percent of incomes on premiums—is reached. Id. Kaiser Family Foundation estimates that 63 percent of the uninsured—over 30 million people—are eligible for subsidized coverage through Medicaid (or its small companion Children's Health Insurance Program (CHIP)), the Basic Health Plan (essentially an extension of Medicaid using marketplace subsidies, an ACA-sanctioned model used only by a couple of states), or the subsidized marketplace. Id.

Providing Health Insurance to the Poorest Americans: Expanding Medicaid

Recall that the ACA was designed to achieve near universal coverage for those without an alternative path to affordable insurance, such as employer-sponsored insurance or Medicare. Working-age American adults with incomes up to 138 percent of FPL would be eligible for Medicaid and those with greater incomes up to 400 percent FPL would receive support to buy in the marketplace.

The United States Supreme Court's decision in *National Federation of Independent Business v Sebelius,* 567 U.S. 519 (2012), reprinted above in this Supplement, effectively blew the model apart. While *NFIB* held that the "individual mandate" was constitutional, the Court also ruled that Congress had no consititutional authority to mandate that the states expand Medicaid. In other words, to the extent that states refused to implement the Medicaid expansion (which remains part of the statute as a permanent mandatory eligibility category), the HHS Secretary could not enforce its terms as a condition of a state's eligibility for federal Medicaid funding for its "traditional" (i.e., pre-ACA) program. States that do expand must do so under the terms of the ACA. Those that did expand beginning in the first year of implementation (2014) were entitled to enhanced federal funding at 100 percent federal funding over the 2014-2017 time period, gradually declining to 90 percent federal financial participation beginning in Calendar Year 2020 and thereafter).

The political battle became one to persuade states to expand. In 2014, 25 states and the District of Columbia did so immediately. Another 7 states expanded by 2016 by persuading HHS to use its special experimental authority under § 1115 of the Social Security Act to permit these states to expand under terms more restrictive than the Medicaid statute normally permits—typically somewhat slimmer benefits and higher cost sharing imposed on beneficiaries. Sara Rosenbaum et al., How States Are Expanding Medicaid to Low-Income Adults Through Section 1115 Waiver Demonstrations (Commonwealth Fund, 2014), https://www.commonwealthfund.org/publications/issue-briefs/2014/dec/how-states-are-expanding-medicaid-low-income-adults-through. A few more states expanded under the Trump administration, but essentially as of July 2021 twelve states have refused all enticement. Put differently, so far, with regard to those twelve states, it is not the decision in *NFIB* that has precluded expansion but the fact that the political war has yielded a different result than in the other states enticed to take up the expansion. Sara Rosenbaum, Confronting the Consequences of *National Federation of Independent Business v Sebelius* to Insure the Poor," *Milbank Quarterly* (2021), https://www.milbank.org/quarterly/opinions/confronting-the-consequences-of-national-federation-of-independent-business-v-sebelius-to-insure-the-poor/?utm_medium=email&utm_campaign=How%20the%20National%20Federation%20of%20Independent%20Business%20v%20Sebelius%20Keeps%20Poor%20People%20Uninsured&utm_content=How%20the%20National%20Federation%20of%20Independent%20Business%20v%20Sebelius%20Keeps%20Poor%20People%20Uninsured+CID_2b48404b9cddbd224f8264a8155f5c62&utm_source=Email%20Campaign%20Monitor&utm_term=Confronting%20the%20Consequences%20of%20National%20Federation%20o

f%20Independent%20Business%20v%20Sebelius%20to%20Insure%20the%20Poor. Some 2.2 million people, disproportionately living in Southern states and disproportionately Black or Native American, remain uninsured, left to confront a pandemic without health insurance. These people fall within the so-called "coverage gap" in that their incomes are below the 100 percent FPL threshold necessary to obtain subsidies to buy on the marketplaces—thus they cannot afford that insurance—while their incomes exceed their states' caps for Medicaid eligibility.

Despite all the good things it contained, the President's American Rescue Plan Congressional blueprint offered virtually nothing for this group other than a tacit hope that the 12 holdout states would swing around (as of the end of July 2021, Texas, Florida, Georgia, Alabama, North Carolina, South Carolina, Tennessee, Kansas, Oklahoma, Wyoming, South Dakota, and Wisconsin). The only provision in ARPA to make that hope a reality is to slightly sweeten the expansion pot for non-expansion states by offering even more money (what the Chief Justice in *NFIB* termed a "blandishment") if they only would insure their poorest residents. Robin Rudowitz et al., New Incentive for States to Adopt the ACA Medicaid Expansion: Implications for State Spending (Kaiser Family Foundation, 2021), https://www.kff.org/medicaid/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending/. The Kaiser Family Foundation estimates that the new incentive would offset states' costs for expansion entirely, id., but because what we are dealing with here is political and ideological, the money simply doesn't matter. In other words, Medicaid expansion is in the category of masks as means to stave off COVID-19—an incomprehensible decision driven by ideology and with an enormous human toll.

What are the constitutional solutions to this grossest of health inequities, triggered by an unprecedented Supreme Court ruling on unconstitutional coercion? One option is to keep bribing states, *a la* ARPA and hope for an eventual turnaround, but this strategy obviously is not working, at least not any time soon.

The simplest alternative would be free coverage through the marketplace for persons falling into the coverage gap. This model effectively would utilize the "other constitutional federalism" model—one that is not dependent on consenting states (even if lavished with money) as is the case with Social Security Act grant-in-aid programs, but that instead gives states a choice as to whether or not to act, with a federal fallback if they do not. Sara Rosenbaum and Gail Wilensky, "Closing the Medicaid Coverage Gap: Options for Reform," 40 *Health Affairs* 134 (March 2020). This fallback option would entitle coverage-gap residents of non-expansion states to zero-premium coverage under health plans that also provide nearly-100-percent cost-sharing assistance, with enrollment through the federal marketplace (All non-expansion states also have refused to establish their own marketplaces and therefore in all of these states, the marketplace alternative also would be federally administered). In terms of coverage, the "qualified health plan" model could be the basic plan design, with extra benefits of the sort that Medicaid also provides, for example, better coverage for rehabilitation care, non-emergency transportation to health care, and vision, dental and hearing coverage for older

adolescents ages 18-21, who would get these additional benefits were these states to expand Medicaid. In other words, tweaking qualified health plans to work for the coverage gap group is pretty straightforward.

This federal default solution is entirely consistent with the ACA itself, which gave states the choice of either operating their own marketplaces and being the primary enforcers of the ACA insurance reforms or, instead, defaulting to federal management. (Indirectly, this default operational model, in which the HHS Secretary essentially stands in a state's shoes to run the subsidized insurance market, lay at the heart of what *King v Burwell* (this Supplement)) upheld as conforming to the ACA). This federalism defer-to-states-but-default-to-the-federal-government model, as Part Two of the main text points out, was pioneered by HIPAA, which introduced the first federal private health insurance market reforms, the structural precursor to the ACA. For the seminal article on federalism and Medicaid, see Abby R. Gluck and Nicole Huberfeld, What is Federalism in Healthcare For?, 70 *Stanford L. Rev.* 1689 (2018).

There is also a relatively obvious potential problem with this solution: What if other states decide that they no longer want to run their own Medicaid expansion programs, even if generously funded, and instead want to dump expansion and go with the default model? This consequence would result in shrinkage of the Medicaid program and expansion of the private market, which, even with some tweaks, does not provide nearly as generous benefits for the poor as does Medicaid. *Health Equity and Medicaid Transformation, supra.*

There are plenty of practical and political arguments against such a move, in particular, the fact that states would lose control over the flow of funds to qualified health care providers and plans that Medicaid gives them—a real powerhouse matter. Qualified health plans would form their own networks and, in doing so, might or might not direct members and plans to the providers that states themselves might favor for any number of reasons, such as large politically powerful teaching hospitals. The Medicaid managed care industry (Insurers such as Centene that have a big Medicaid managed care business—Medicaid managed care plans now enroll about 70 percent of all Medicaid beneficiaries—likely would fight the loss of such a lucrative market, although many of the same companies that sell Medicaid products also sell subsidized marketplace plans.). Furthermore, even with a few bells and whistles, qualified health plans offer considerably less coverage for adults with serious and chronic health conditions. Finally, of course, there is the small matter of terminating eligibility for hundreds of thousands (or even millions in some states) of Medicaid beneficiaries and telling them to go enroll in some other plan sold in the marketplace. One can never assume that persons losing one pathway to insurance automatically get "picked up" by another source—they simply don't.

And insuring poor people through marketplace subsidies also would cost the federal government more than federal participation in funding the Medicaid expansion, regardless of the fact that the states pay only a small portion of that funding. By contrast,

the expense of opening the marketplaces to those in the coverage gap with zero premiums and no cost-sharing, and with souped-up benefits, would be borne entirely by the federal government—something not too popular in Congress, BTW. Furthermore, on a per capita basis, private insurance coverage is significantly more costly than Medicaid. Despite these drawbacks, however, it is now apparent that financial generosity to states is not the deciding factor whether the holdout states can be moved off the dime (sorry!)—the real driver is political and ideological. Further, perhaps some of the *current* expansion states might be persuaded to stay in the expansion—not abandon it for the alternative now under discussion—if the federal contribution is raised even higher, but that result is not a sure thing. But in the end, if *NFIB* stands for anything, it is that states have the absolute constitutional right to get out if they want and can do so today despite the complete lack of any default system for the victims of a decisions to exit (The ACA Medicaid expansion option, coupled with other reforms to streamline enrollment, made about 15 million people eligible for benefits.).

In terms of non-legislative options, the Biden administration has the same basic tool as that available to the Obama administration—lure in non-expansion states by allowing them to decrease benefits and increase patient cost sharing while still receiving enhanced funding. That is the sugar used over the 2014-2016 time period to bring holdout states into the expansion, but there is no sign that the remaining holdout states are in any mood to deal.

There is a possibility that as part of a second major legislative package that will accompany the infrastructure deal announced in Summer, 2021, Congress will take the bull by the horns and create what is being called a "federal fallback" for residents of non-expansion states who have been left to face a pandemic without any affordable insurance. One option would be to create a new federally-funded, federally-administered Medicaid program offering coverage to residents of the holdout states. This model has been proposed by Senators Warnock, Ossoff and Baldwin, all of whom represent non-expansion states (Georgia and Wisconsin, respectively). This approach, however, would require the administration to build literally an entirely new program, never before attempted. The other model, which appears to be favored by the House of Representatives, would extend fully subsidized qualified health plans through the marketplace to affected residents in the holdout states. Such an approach could be implemented relatively fast, since the existing QHP market and subsidy systems simply would need to be tweaked. However, it would also be a dramatic break in precedent—no Medicaid for the very poorest in these states but instead, subsidized private insurance. Medicaid is undoubtedly the better deal for the poorest Americans because coverage is so comprehensive, but at this point the issue, frankly, is how long the most destitute Americans in the cruelest states should be made to wait for decent coverage—indeed for any coverage at all.

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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 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).

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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
136 S.Ct. 1989 (2016)

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.

I
A

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).

B

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 "repeated[ly] 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:

[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.

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 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

[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).

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) "[if] 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.[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

[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.

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. *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 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"?

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

* 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.

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 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:

* Criminal prosecutions for false claims raise additional considerations and are not our focus in these materials.

> 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?[*]

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[*] 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?

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 rending violation of a legal duty, designed to affect those judgments, (immaterial? material?). See, e.g., United States v. AseraCare, 2016 WL 1270521 (N.D. Ala. March 31, 2016) (ruling that claims were not false, and granting defendant summary judgment, because the only proof offered by the government was its expert physician's opinion that patients would not die within six months and therefore were not qualified for Medicare's hospice benefit).

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?

* * *

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 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.

[*] [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.

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.

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 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 probibition 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]

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[3]Sec. 6001(a) (3) of Patient Protection and Affordable Care Act (Pub. L. No. 111-148 *Stat*. 119).
[4]Id.

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.[5] 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.[6] 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

[5] Id.
[6] CMS Advisory Opinion No. CMS-AO-2013-03.

exception to the repeal of the whole hospital exception to the prohibition of the Stark Law.

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.

* * *

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.

* * *

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 test.* 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

* We omit discussion of other aspects of the decisions.

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 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 Supplement, 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.

* * *

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.

Letter from Markus H. Meier, Assistant Director, Health Care Division, Bureau of Competition to Michael E. Joseph, Esq., McAfee & Taft, Concerning Norman PHO's Proposal to Create a "Clinically Integrated" Network (Feb. 13, 2013) (http://www.ftc.gov/os/2013/02/130213normanphoadvltr.pdf).

* * *

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 Supplement, raise considerable antitrust concern. A recent advisory letter from the FTC to Minnesota raises the antitrust issues and shows the structure and content of the antitrust analysis. See Letter from Marina Lao, Director, FTC Office of Policy Planning; Deborah L. Feinstein, Director, Bureau of Competition; Francine Lafontaine, Director, Bureau of Economics to The Honorable Joe Hoppe, Minnesota House of Representatives; The Honorable Melissa Hortman, Minnesota House of Representatives (June 29, 2015) [hereinafter "*FTC Staff Letter on Transparency Laws*"], https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-regarding-amendments-minnesota-government-data-practices-act-regarding-health-care/150702minnhealthcare.pdf (Accessed July 23, 2015).

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

[*] 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).

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 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 Supplement 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. Reinhardt, Health Care Price Transparency and Economic Theory, 312 JAMA 1642 (2014).

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).

* * *

Insert at textbook, p. 1341 at the end of Note 4:

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.

[*] Much of the following discussion of the degree and effect of consolidation is drawn from David M. Frankford & Sara Rosenbaum, Taming Healthcare Spending: Could State Rate Setting Work? Robert Wood Johnson Issue Brief, at 9-10, http://www.cshp.rutgers.edu/Downloads/11170.pdf (Accessed July 17, 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 insurance organizations in nearly two-thirds of those 100 counties." Brian Biles, Giselle Casillas, & Stuart Guterman, Competition among Medicare's Private Health Plans: Does It Really Exist? Issue Brief. New York: Commonwealth Fund (2015), http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/aug/1832_biles_competition_medicare_private_plans_ib_v2.pdf. (Accessed July 17, 2017).

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

* 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).

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 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 effect of all of this consolidation is to raise prices. Substantial evidence shows that prices rise after hospitals merge. See, e.g., Gaynor and Town. One recent study found increased prices even when hospitals in different, within-state local markets merge, a finding that is particularly troubling because antitrust law and officials are usually concerned only with concentration in local markets. See Leemore Dafny, Kate Ho, and Robin S. Lee, The Price Effects of Cross-Market Hospital Mergers, NBER Working Paper, no. 22106, Cambridge, MA: National Bureau of Economic Research (2016), http://www.nber.org/papers/w22106.pdf. (Accessed July 17, 2017). More generally, concentrated hospital markets are strongly correlated with higher prices. See, e.g., Zake Cooper et al., The Price Ain't Right? Hospital Prices and Health Spending on the

* 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. The other extreme is a growing number of large groups primarily organized by hospitals in vertical arrangements.

Privately Insured, NBER Working Paper, no. 21815, Cambridge, MA: National Bureau of Economic Research, http://www.nber.org/papers/w21815.pdf (Accessed July 17, 2017).

Concentrated physician markets have been studied less often than hospital markets but evidence correlates higher fees with greater concentration. See, e.g., Daniel R. Austin & Laurence C. Baker, Less Physician Practice Competition Is Associated with Higher Prices Paid for Common Procedures, 34(10) Health Affairs 1753 (2015), http://content.healthaffairs.org/content/34/10/1753.abstract (Accessed July 17, 2017); Laurence C. Baker, M. Kate Bundorf, & Anne B. Royalty, Physician Practice Competition and Prices Paid by Private Insurers for Office Visits, 312(16) JAMA 1653, http://jamanetwork.com/journals/jama/fullarticle/1917436 (Accessed July 17, 2017); Eric Sun & Laurence C. Baker, Concentration in Orthopedic Markets Was Associated with a 7 Percent Increase in Physician Fees for Total Knee Replacements, 34(6) Health Affairs 916 (2015), http://content.healthaffairs.org/content/34/6/916.abstract. More recent evidence shows that vertical integration among hospitals and physicians likewise increases prices. See, e.g., Laurence C. Baker, M. Kate Bundorf, & Daniel P. Kessler, Vertical Integration: Hospital Ownership of Physician Practices Is Associated with Higher Prices and Spending, 33(5) Health Affairs 756–63 (2014), http://content.healthaffairs.org/content/33/5/756.abstract (Accessed July 17, 2017); Rena M. Conti, Mary Beth Landrum, and Mireille Jacobson, The Impact of Provider Consolidation on Outpatient Prescription Drug-Based Cancer Spending, Issue Brief, Washington, DC: Health Care Cost Institute, http://www.healthcostinstitute.org/files/HCCI-Issue-Brief-Impact-of-Provider-Consolidation.pdf (Accessed July 17, 2017); Jeff Goldsmith, Nathan Kaufman, and Lawton Burns, The Tangled Hospital-Physician Relationship, Health Affairs Blog, May 9, 2016, http://healthaffairs.org/blog/2016/05/09/the-tangled-hospital-physician-relationship/ (Accessed July 17, 2017); Hannah T. Neprash et al., Association of Financial Integration Between Physicians and Hospitals with Commercial Health Care Prices, 175(12) JAMA Internal Medicine 1932, http://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2463591; Robinson & Miller. Finally, evidence shows that insurance premiums are higher in concentrated insurance markets. See, e.g., Leemore Dafny, Are Insurance Markets Competitive?, 100(4) American Economic Review 1339 (2010); Leemore Dafny, Mark Duggan, and Subramaniam Ramanarayanan, Paying a Premium on Your Premium? Consolidation in the US Health Insurance Industry, 102(2) American Economic Review 1161 (2012).

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 Supplement, 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 Supplement.

a. CVS, a new integrated health care company.

Much of this discussion comes from a recent, excellent article, *How CVS Quit Smoking and Grew into a Health Care Giant*, NEW YORK TIMES (July 11, 2015), http://www.nytimes.com/2015/07/12/business/how-cvs-quit-smoking-and-grew-into-a-health-care-giant.html (Accessed July 17, 2017). As the article's title intimates, in 2014 CVS announced that as of October 1, 2014, it would no longer sell tobacco products in its stores, thereby giving up two billion dollars in annual revenues. See, e.g., http://www.cvshealth.com/research-insights/health-topics/this-is-the-right-thing-to-do (Accessed July 17, 2017).[*] Because companies rarely give up something for nothing—particularly $2B per year—despite pronouncements that they're just doing the "right thing," one might wonder why CVS did this. The article in the *New York Times* answers why, as announced by its subtitle in the print edition: "The drugstore chain, already arguably the nation's biggest health care company, has ambitious plans. And tobacco doesn't fit them." Why not? Because CVS has become "the largest operator of health clinics, the largest dispenser of prescription drugs and the second-largest pharmacy

[*] In July 2015 CVS also announced that it was quitting the United States Chamber of Commerce, which had just gotten very bad press about how it is widely fighting antismoking laws in other countries, the main market now of Big Tobacco. See, e.g., Danny Hakim, U.S. Chamber of Commerce Works Globally to Fight Antismoking measures, NEW YORK TIMES (June 30, 2015), http://www.wsj.com/articles/teva-poised-to-get-a-big-boost-in-generics-1437954183 (Accessed July 17, 2017).

benefits manager." How did this happen? Not through internal growth but as part of the merger mania sweeping across the health care sector.

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.
- 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 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 Supplement 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 stop for consumers with health issues. Pharmacists or medical professionals in a neighborhood health hub could help schedule people's appointments or focus on nonmedical forms of help, such as coordinating rides, meal assistance, nutrition counseling or social supports. Wearable technologies monitored by health professionals could help people stay on the right medication regimens or flag health problems before they evolve into an emergency. CVS's brick and mortar locations would give both health-care companies a foothold in the time Americans spend awake each year." Carolyn Y. Johnson, CVS-Aetna Wants To Be in Your Neighborhood Because Zip Codes Powerfully Shape People's Health, The Washington Post, March 26, 2018, https://www.washingtonpost.com/news/wonk/wp/2018/03/26/cvs-aetna-wants-be-in-your-neighborhood-because-zip-codes-powerfully-shape-peoples-health/?utm_term=.e9b0adf9a861 (Accessed July 22, 2019). See, e.g., Anna Wilde Mathews & Dana Mattioli, CVS Bid for Aetna Followed a Long Hunt, WSJ, Oct. 27, 2017, https://www.wsj.com/articles/cvs-bid-for-aetna-followed-a-long-hunt-1509147450 (Accessed July 22, 2019).

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/NEJMp171713 (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.

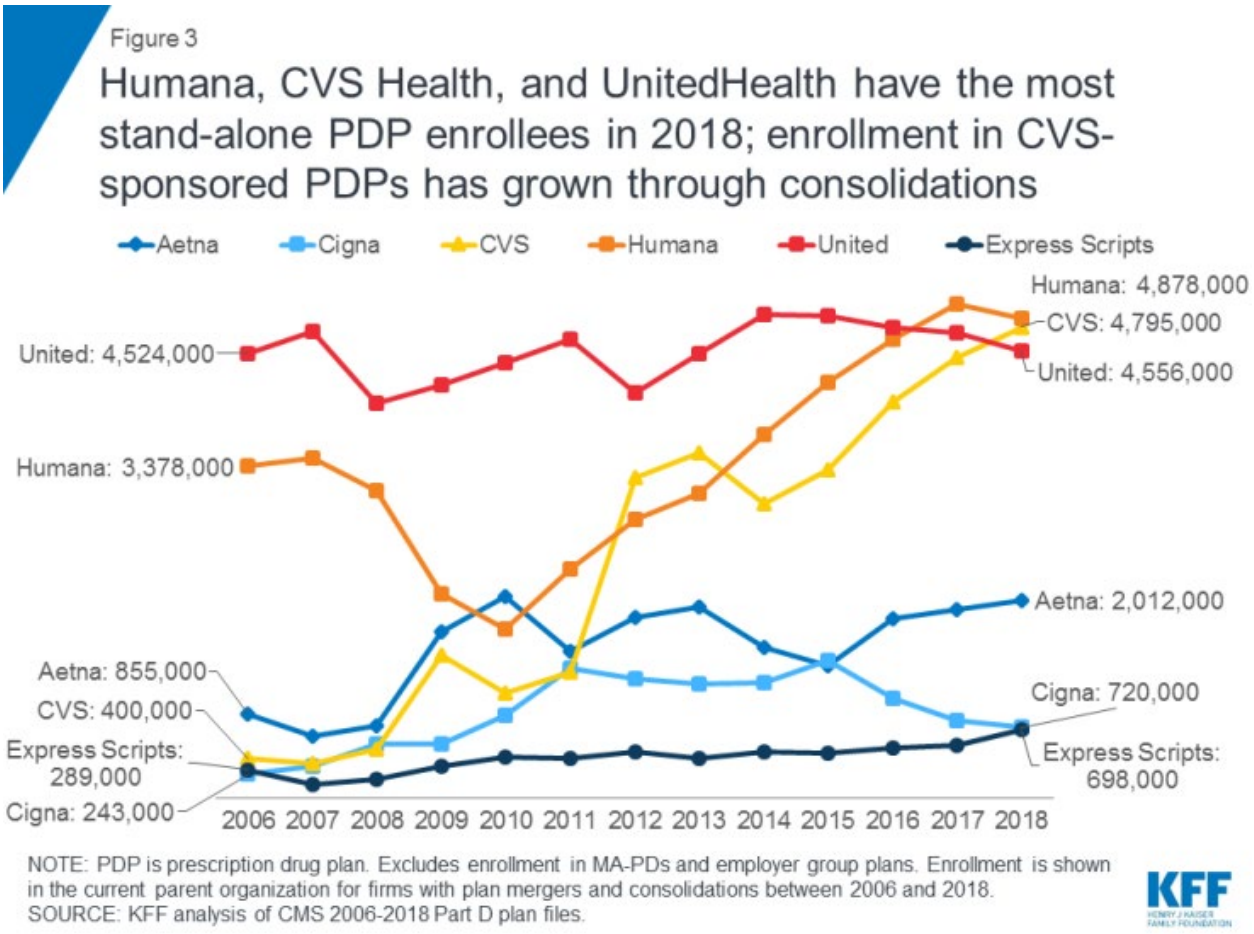
Part of the basis for this business plan is, as described above, that CVS has already morphed into a provider, furnishing a number of services in its Minute Clinics. Nurses, dietitians, pharmacists and other professionals can expand the current base to treat not only things like sore throats but also 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/eyJpZCI6IjAwMDAwMTYwMzI4M2QwYzlhYmYwM2JmZmQ2OTgwMDAwIiwiY3R4dCI6IkJCTkEiLCJ1dWlkIjoib1FyUGNveTBVSy85c3NHVWpMeEJIQT09SFRZQ290d0JYRlNEWm9wTVFtWk9LUT09IiwidGltZSI6IjE1MTI2ODk0MzM0OTYiLCJzaWciOiJsLzlRQkR3Y3dpNzVaU3J0YTBzMTdzTkZlcnM9IiwidiI6IjEifQ==?emc=bnahce:4&service_acronym=HCE (Accessed July 22, 2019). Additionally, there is evidence that integrating pharmacy and health care delivery functions can lead to better health outcomes. See, e.g., Austin Frakt & Craig Garthwaite, The CVS-Aetna Merger: Another Large Bet on the Changing U.S. Health Care Landscape, 168(7) Annals of Internal Medicine 511 (April 3, 2018), http://annals.org/aim/article-abstract/2668212/cvs-aetna-merger-another-large-bet-changing-u-s-health (Accessed July 22, 2019).

However, as delineated in the main text and in this Supplement, 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 Supplement 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.

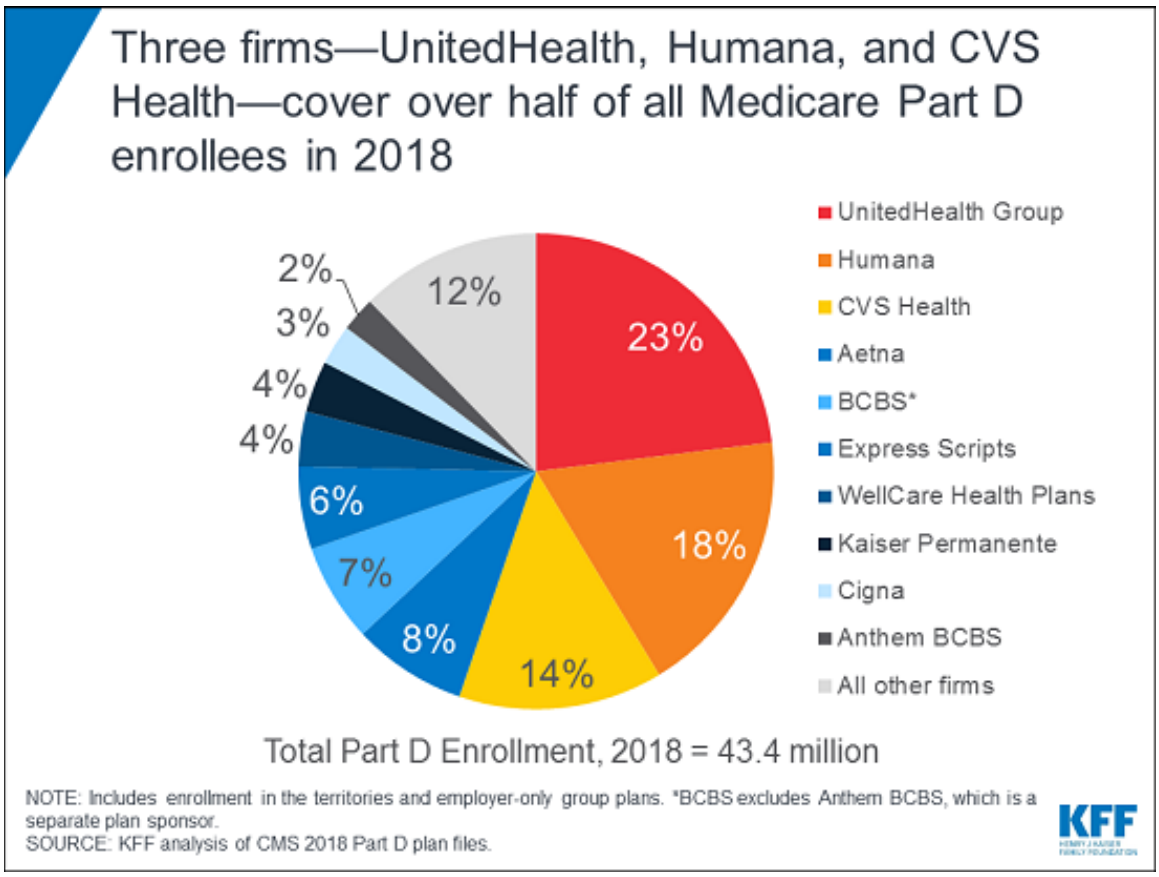
There is ample evidence for concern that the merger will create greater market power. For one thing, because both CVS and Aetna have a large presence in the market for Medicare prescription drug plans ("PDPs"), the deal raises horizontal problems, although this discussion will largely focus on the vertical 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):

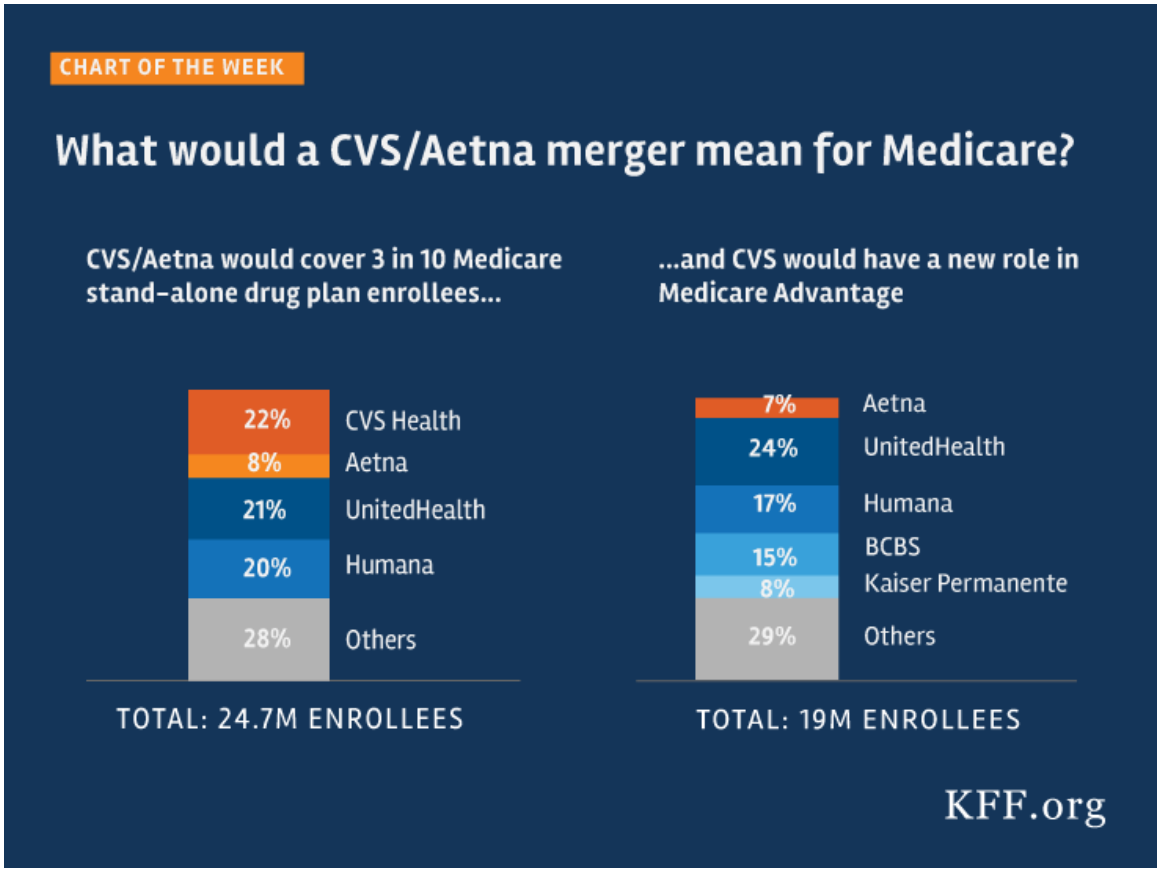


Necessarily, the combination of Aetna and CVS will create a firm with even greater market share and an overall increase in concentration in the market, particularly for stand-alone PDPs.* "The proposed mergers of CVS Health and Aetna, and [the now-

* 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/cvsaetna-deal-drive-n73014477673/ (Accessed July 22, 2019). We omit discussion of this issue here.

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.


Three firms—UnitedHealth, Humana, and CVS Health—cover over half of all Medicare Part D enrollees in 2018
23%
18%
14%
8%
7%
6%
4%
4%
3%
2%
12%
UnitedHealth Group
Humana
CVS Health
Aetna
BCBS*
Express Scripts
WellCare Health Plans
Kaiser Permanente
Cigna
Anthem BCBS
All other firms
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.
SOURCE: KFF analysis of CMS 2018 Part D plan files.
KFF



For another thing, as described in the main text and this Supplement, 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).*

* For a succinct statement of the manner in which the vertical merger might foreclose inputs to rivals at multiple horizontal levels, see Hal Singer, Why the Justice Department Waved Through the CVS-Aetna Merger, American Prospect, July 17, 2019, https://prospect.org/article/why-justice-department-waved-through-cvs-aetna-merger (Accessed July 23, 2019). For a much fuller explication, see, for example, Tunney Act Comments of the American Medical Association on the Proposed Final Judgment, United States v. CVS Health Corp, Civ. Case No. 18-2340, https://media.justice.gov/vod/atr/cvs-aetna-comments/tc-003.pdf (Accessed July 23, 2019).

As described in this Supplement 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&jcsearch=bna%25200000016022e2d447ade3fafeb0150000 - 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:

* 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.

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.
>
> 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.

Department of Justice, United States v. CVS and Aetna: Questions and Answers for the General Public 5, https://www.justice.gov/opa/press-release/file/1099806/download (Accessed July 22, 2019). Otherwise, there is nothing in the complaint, proposed settlement or the Competitive Impact Statement created for judicial review under the Tunney Act. See Department of Justice, Antitrust Division, United States v. CVS Health Corporation and Aetna Inc.; Proposed Final Judgment and Competitive Impact Statement, 83 Fed. Reg. 52558 (Oct. 17, 2018).*

However, then something remarkable happened. Judge Leon, who is presiding over the litigation and must find that the settlement is in the public interest, announced that he "is not a rubber stamp." Robert Teitelman, Meet the Judge Who Is Tormenting the Justice Department over the CVS-Aetna Merger, Barron's, April 8, 2019, https://www.barrons.com/articles/united-technologies-earnings-tuesday-aerospace-industrials-raytheon-merger-otis-elevator-pratt-whitney-51563565003 (Accessed July 22, 2019); About That CVS-Aetna Merger, John & Rusty Report, June 11, 2019, https://jrreport.wordandbrown.com/2019/06/11/about-that-cvs-aetna-merger/ (Accessed July 22, 2019). Not only did Judge Leon allow intervention by a number of amici hostile to the merger—most notably, the American Medical Association—but he also held a mini-hearing in the summer of 2019, to hear evidence about the anti-competitive effects of the merger, notably including the problems addressed above stemming from the vertical integration. See, e.g., United States v. CVS Health Corporation, Civ. Case No. 18-2340, Memorandum Orders of Jan. 11, 2019 and May 13, 2019. These actions are

* 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).

unheard of in that judges presiding over such settlements never hold evidentiary hearings; nor do they consider issues outside of the four corners of DOJ's complaint, proposed settlement or Competitive Impact Statement. See, e.g., James J. Kovacs, Federal Court Extends Tunney Act Review to Embrace Mini-Trial on DOJ Settlement of CVS-Aetna Merger, Constantine Cannon, May 3, 2019, https://constantinecannon.com/2019/05/03/federal-court-extends-tunney-act-review-to-embrace-mini-trial-on-doj-settlement-of-cvs-aetna-merger/ (Accessed July 23, 2019). According to a number of observers, this is one unhappy judge. For example, one report contained the following:

> [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."

Susannah Luthi, Judge Considering Adding Conditions to CVS-Aetna Approval, Modern Healthcare, July 19, 2019, https://www.modernhealthcare.com/mergers-acquisitions/judge-considering-adding-conditions-cvs-aetna-approval?utm_source=modern-healthcare-am&utm_medium=email&utm_campaign=20190722&utm_content=article2-readmore (Accessed July 22, 2019).

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 horizonal effects of a vertical merger.* See, e.g., Jeny Maier & Adam Cella, UnitedHealth-DaVita and Trends in Vertical Merger Enforcement, American Health Lawyers Association, July 11, 2019, https://www.axinn.com/assets/htmldocuments/190711_AT_Briefing_UnitedHealth-Davita_Reprint%20003.pdf (Accessed July 23, 2019). Additionally, DOJ and the FTC have both confirmed that each would revisit the Vertical Merger Guidelines for the first time since 1984. See, e.g., Victoria Graham, Justice Department, FTC Working on New Vertical Merger Guideline, Bloomberg Law, March 29, 2019, https://www.bloomberglaw.com/document/X8I9SUM8000000?bna_news_filter=mergers-and-antitrust&jcsearch=BNA%252000000169ca63d88fa9ebeee71cd70002#jcite (Accessed July 23, 2019); see also Alexei Alexis, Vertical Deals Face More Intense Scrutiny Amid FTC Push, Bloomberg Law, March 19, 2019, https://www.bloomberglaw.com/product/blaw/document/XDGN4EKG000000?bna_news_filter=mergers-and-antitrust&jcsearch=BNA%25200000016982adde26a57b9bff34850002#jcite (Accessed July 23, 2019).

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 horizonal 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

* 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 Slaughter & Rohit Chopra, https://www.ftc.gov/system/files/documents/public_statements/1529359/181_0057_united_davita_statement_of_cmmrs_s_and_c.pdf (Accessed July 23, 2019), both in In re UnitedHealth Group and DaVita, FTC 181-0057 (June 19, 2019).

> 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.

Thomas L. Greaney, The New Health Care Merger Wave: Does the "Vertical, Good" Maxim Apply, 46 J. L., Med. & Ethics 918. 921 (2018) (footnote omitted).

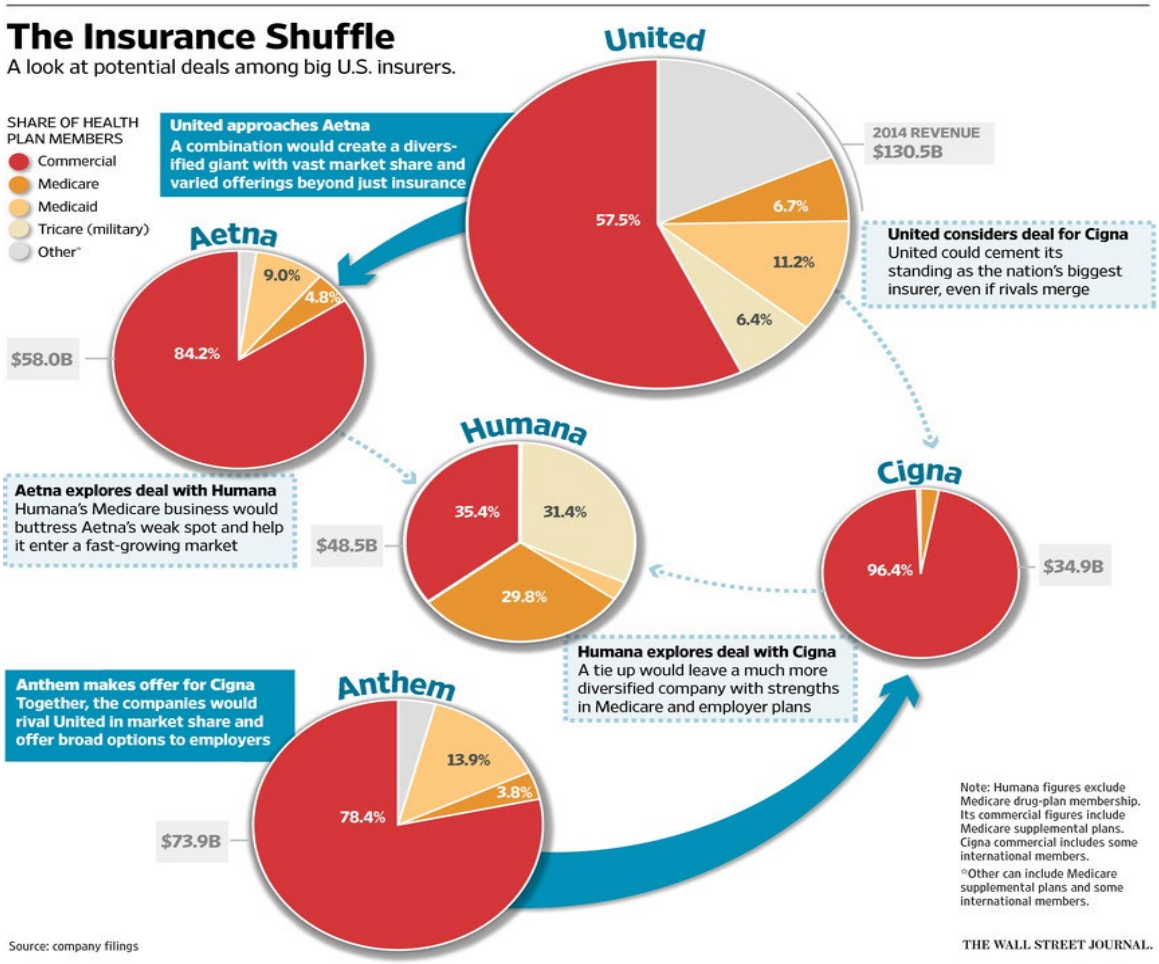
Perhaps Judge Leon is right that he cannot determine whether the CVS-Aetna merger is in the public interest without more facts. At this writing, on July 23, 2019, we await his decision.

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

* This account has been stitched together from the references in the text, as well as: Michael J. de la Merced & Chad Bray, Anthem to Buy Cigna Amid Wave of Insurance Mergers, NEW YORK TIMES (July 24, 2015), http://www.nytimes.com/2015/07/25/business/dealbook/anthem-cigna-health-insurance-deal.html (Accessed July 17, 2017); Dana Mattioli et al, Anthem Nears Deal to Buy Cigna for $48 Billion, WALL ST. J. (July 22, 2015), http://www.wsj.com/articles/anthem-nears-deal-to-buy-cigna-1437604564 (Accessed July 17, 2017); Dana Mattioli & Anna Wilde Mathews, Anthem, Cigna Talking as Centene Makes a Deal, WALL ST. J. (July 2, 2015), http://www.wsj.com/articles/anthem-cigna-rekindle-merger-talks-1435845994?mod=ST1 (Accessed July 17, 2017);.and Michael J. de la Merced & Julie Creswell, Humana Is Said to Consider Sale of Company, NEW YORK TIMES (May 29, 2015), http://www.nytimes.com/2015/05/30/business/dealbook/humana-is-said-to-consider-sale-of-company.html (Accessed July 17, 2017).

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 Supplement, 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 Supplement, 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.

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[*] United States v. Aetna, 2017 WL 325189 (D.D.C. 2017); United States v. Anthem, 2017 WL 685563 (D.D.C.), aff'd, 855 F.3d 345 (D.C. Cir.), petition for cert. dismissed, 2017 WL 1807377 (2017).

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

* 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.

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.

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.

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[*] 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.

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. No new value is added. And so forth. All that happens is that wealth is transferred from the 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.

[*] Each party is now suing the other for billions of dollars, with each alleging breach.