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Federalism and the End of Obamacare

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ABSTRACT. Federalism has become a watchword in the acrimonious debate over a possible replacement for the Affordable Care Act (ACA). Missing from that debate, however, is a theoretically grounded and empirically informed understanding of how best to allocate power between the federal government and the states. For health reform, the conventional arguments in favor of a national solution have little resonance: federal intervention will not avoid a race to the bottom, prevent externalities, or protect minority groups from state discrimination. Instead, federal action is necessary to overcome the states' fiscal limitations: their inability to deficit-spend and the constraints that federal law places on their taxing authority. A more refined understanding of the functional justifications for federal action enables a crisp evaluation of the ACA—and of replacements that claim to return authority to the states.

The election of Donald Trump and an ascendant Republican majority in Congress may mean the end of the Affordable Care Act (ACA), better known as Obamacare.[1] Within weeks, Congress could enact legislation repealing most of the ACA's tax- and spending-related provisions. Although Republicans have promised to craft a replacement, leading commentators on both the left and the right are skeptical. They note that Republicans have never yet coalesced around an ACA alternative; that any such alternative is unlikely to attract the Democratic votes that Republicans need to overcome the filibuster; and that, having repealed the ACA's taxes, Republicans will be unable to finance a coverage expansion.[2] "Repeal and replace" might just be "repeal."

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. For ease of reference, and unless otherwise noted, citations will be to the scattered provisions of the U.S. Code codifying the ACA.

2. From the right, see Joseph Antos & James Capretta, *The Problems with "Repeal and Delay,"* HEALTH AFFAIRS BLOG (Jan. 3, 2017), http://healthaffairs.org/blog/2017/01/03/the-problems-with-repeal-and-delay [http://perma.cc/KR45-SYZ3]; Gail Wilensky, *When Political Imperatives Collide With Policy Objectives*, MILBANK Q. (2016),

If the ACA is undone and a stalemate emerges, attention will turn to the states. One question that is likely to emerge—indeed, it has already emerged—is why national reform was ever thought necessary in the first place. At the core of our federal system is the principle that the states should take the lead unless there is a need for national action. Federalism is said to foster political participation, to enable experimentation, and, especially, to allow states to tailor their laws to better suit the preferences of their citizens.[3] Yet the progressive push for universal health coverage has had a doggedly national focus. Why?

Purely as a strategic matter, the emphasis on federal law needs some defense. By way of analogy, consider same-sex marriage. When Massachusetts eliminated its prohibition on same-sex marriage in 2003, advocates did not turn immediately to the Supreme Court. They built the groundwork for a national strategy by winning in state courts and state ballot boxes. By the time the Supreme Court decided *Obergefell v. Hodges*, thirty-seven states allowed same-sex marriage, eleven through popular referendums or legislation.[4] Contrast that to universal health-care coverage, where the score was a lopsided 48 to 2, with only the deep-blue states of Massachusetts and Hawaii as outliers. Perhaps the states' collective failure to achieve near-universal coverage indicated the shallowness of public support for health reform. Perhaps the progressive commitment to a national solution was premature.

This federalism narrative has taken hold among opponents of the health reform. It was the cornerstone of the constitutional challenges in *NFIB v. Sebelius*—both the claim that the federal government lacked the power to adopt an individual mandate and the claim that the states were being unconstitutionally coerced into expanding their Medicaid programs.[5] It underwrites much of the hostility to the "federal takeover" of the health-care system. And it lends force to Republican proposals to return power over health reform to the states. As Speaker of the House Paul Ryan explains in his blueprint for replacing the ACA, the states "should be empowered to make the right tradeoffs between consumer protections and individual choice, not regulators in Washington.

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http://www.milbank.org/quarterly/articles/political-imperatives-collide-policy-objectives [http://perma.cc/2NBE-QYKM]. From the left, see Nicholas Bagley, *It's the Taxes, Stupid*, INCIDENTAL ECONOMIST (Nov. 11, 2016), http://theincidentaleconomist.com/its-the-taxes-stupid [http://perma.cc/6A6P-F8DG]; Alice M. Rivlin, Loren Adler, & Stuart M. Butler, *Why Repealing the ACA Before Replacing It Won't Work, and What Might*, BROOKINGS INST. (Dec. 13, 2016), http://www.brookings.edu/research/why-repealing-the-aca-before-replacing-it-wont-work-and-what-might [http://perma.cc/WLA5-CZXM].

3. See Gregory v. Ashcroft, 501 U.S. 452, 458 (1991).

4. *See* Julia Zorthian, *These Are the States Where SCOTUS Just Legalized Same-Sex Marriage*, TIME (June 26, 2015), http://time.com/3937662/gay-marriage-supreme-court-states-legal [http://perma.cc/5LKH-3GBG].

5. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

The federal role should be minimal and set a few broadly shared goals, while state governments determine how best to implement those goals in their own markets."[6]

As with so many paeans to federalism, political opportunism explains much of this state-centric rhetoric. But there is much to be said for the argument that the states should take the lead on health reform. Jerry Mashaw and Ted Marmor argued as much back in 1996, fresh off the defeat of President Clinton's health reform efforts. "There is unlikely to be any single system that either is or appears 'best' for the whole of these United States," they argued.[7] "Regions, states, even localities, differ in their demographic characteristics, political cultures, existing styles of medical practice, and appetites for medical services. What is both practical and desirable varies enough to make federalist variation both normatively attractive and politically wise as an alternative to national stalemate."[8] If California is keen on universal coverage and Texas is not, why should the federal government pick sides? Why not let the states make the hard calls about whether and how they want to tax their residents to finance insurance for those who lack coverage by dint of poverty, misfortune, or irresponsibility?

For those who believe in the functional virtues of federalism, these are challenging questions—more challenging than the ACA's supporters generally admit. As I explain in Part I, the traditional arguments in favor of a national solution have little resonance for health reform. Federal action is not needed to forestall a race to the bottom; states that decline to expand coverage impose no costs on other states; and states are not afflicted with political pathologies that national intervention could reliably address.

Yet for all that, a national solution was appropriate—even necessary. As discussed in Part II, two features of the health system make it difficult or impossible for those states that support universal coverage to achieve it on their own. First, the states do not have the same fiscal capacity as the federal government. Because they are prohibited by law from deficit spending, they are understandably leery of adopting countercyclical obligations that would force tax increases or spending cuts in the middle of the next recession. Second, a federal law—the Employee Retirement Income Security Act of 1974 (ERISA)—bars states from adopting the most expedient taxes necessary to finance a coverage expansion. Taken together, these legal obstacles will predictably frustrate state efforts to

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6. Paul Ryan, *A Better Way: Our Vision for a Confident America* 12 (2016), http://www.washingtonpost.com/news/powerpost/wp-content/uploads/sites/47/2016/06/ABetterWay-HealthCare-PolicyPaper.pdf [http://perma.cc/F4QL-NJ9Q].

7. Jerry L. Mashaw & Theodore R. Marmor, *The Case for Federalism and Health Care Reform*, 28 CONN. L. REV. 115, 117 (1995).

8. *Id.*

achieve near-universal coverage. For health reform, the federal government really is the only game in town.

Part III draws on this more nuanced understanding of the need for national health reform to examine critically how such reform ought to allocate responsibilities between the states and the federal government. Roughly, the states should retain control over regulation while passing to the federal government responsibility for money—the taxes and spending necessary to finance reform. In so doing, the argument exploits the distinction, emphasized most powerfully by David Super, between *fiscal* and *regulatory* federalism.[9] Evaluated against that baseline, the ACA is a mixed bag: it properly assumes control over money but also wrests more regulatory authority from states than necessary.[10] At the same time, many Republican replacement plans are insufficiently sensitive to the states' fiscal constraints and to their circumscribed taxing power. Unless the plans are revised, we may see the elimination of a federal solution combined with the retention of substantial obstacles to state action—or even the creation of new obstacles. In that event, the federalism narrative should be seen for what it is: constitutional rhetoric designed to mask a refusal to countenance health reform at any level of government.

I. THE TRADITIONAL JUSTIFICATIONS

Federal legislation is often considered necessary, first, to avoid a collective-action problem; second, to prevent states from imposing externalities on other states; or third, to correct for a political pathology at the state level. None of these justifications is adequate to support national health reform.

A. *Collective-Action Problem*

To the extent that the states cannot be excluded from the enjoyment of collective goods, they will be tempted to contribute little or nothing to the production of those goods. They will prefer, instead, to free ride on the contributions of other states. Since every state has the same incentives, contributions toward that collective good will fall short of what the states, acting in concert, would prefer. Federal action to superintend the contributions of the states may be necessary.

9. *See* David Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544 (2005).

10. Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1752 (2013) (noting the ACA's "structural schizophrenia" on the allocation of federal and state responsibilities).

It is possible to tell this race-to-the-bottom story about health reform.[11] Any state that expands coverage risks attracting sick patients who cannot get insurance in their home state. To avoid becoming a "welfare magnet," individual states might decline to expand coverage, even if they would happily expand coverage if they could confine that coverage to their own residents. Without a coordinating institution, the states will expand coverage less that they would ideally prefer.

But the welfare magnet story justifies federal intervention only if lots of sick people move to get health insurance. The evidence suggests they do not. In a 2014 study, Aaron Schwartz and Benjamin Sommers recently examined migration patterns in response to Medicaid expansions in four states.[12] They found "no evidence of significant migration effects" and could "rule out net migration effects of larger than 1,600 people a year in an expansion state."[13] A similar 2016 study by Lucas Goodman estimates that "the migration effect of Medicaid is very close to zero."[14] These findings, which jibe with other research on interstate mobility,[15] make intuitive sense. People have lots of reasons to live where they live, and they don't lightly move.[16] Those who do move rarely do so for health reasons.[17] Lower-income people in particular may not have the resources or the job flexibility to pull up stakes. And if people don't move to get insurance, there is no race to the bottom for federal action to forestall.

11. *See* Randall R. Bovbjerg, Joshua M. Wiener & Michael Housman, *State and Federal Roles in Health Care: Rationales for Allocating Responsibilities*, *in* FEDERALISM AND HEALTH POLICY 39 (John Holahan et al. eds., 2003) (telling that story).

12. Aaron L. Schwartz & Benjamin D. Sommers, *Moving For Medicaid? Recent Eligibility Expansions Did Not Induce Migration From Other States*, 33 HEALTH AFF. 88 (2014).

13. *Id.* at 88.

14. Lucas Goodman, *The Effect of the Affordable Care Act Medicaid Expansion on Migration*, 36 J. POLICY ANALYSIS & MGMT. 211, 212 (2016).

15. Mashaw & Marmor, *supra* note 8, at 121. Evidence on migration in response to traditional welfare (e.g., Aid to Families with Dependent Children) is mixed. Even those studies that find a migration effect, however, find that it is small. *See* Jan K. Brueckner, *Welfare Reform and Race to the Bottom: Theory and Evidence*, 66 S. ECON. J. 505, 519 (2000).

16. *See* David Schleicher, *Stuck in Place: Law and the Economic Consequences of Residential Stability* (Yale Law School, Public Law Research Paper No. 593, 2017), http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2896309 [http://perma.cc/PE29-K4LQ].

17. *Geographical Mobility: 2008 to 2009*, U.S. CENSUS BUREAU 16 (2011), http://www.census.gov/prod/2011pubs/p20-565.pdf [http://perma.cc/V4NN-7Q3D] (showing only 2% of people report moving from one county to another for health reasons).

B. Externalities

Federal intervention may be warranted where one state's actions impose costs on other states. A state might, for example, locate smokestacks on its downwind border in order to send its pollution to a neighbor. As a result, the state may allow more pollution than its residents would be willing to tolerate if they bore its full costs. A federal response may prevent states from passing on the costs of their productive activity to other states.

But externalities cannot justify federal health reform. If New York declines to adopt near-universal coverage for its residents, it is hard to see how that imposes costs on Connecticut or New Jersey. The country can easily accommodate a patchwork of state insurance laws; indeed, it already does. In the McCarran-Ferguson Act, Congress clarified that the states—not the federal government—will retain primary responsibility for regulating their insurance markets.[18] The states have in turn adopted widely varying rules governing health insurance.[19]

C. Political Pathologies

Federal authority is sometimes justified as an effort to correct for political pathologies at the state level. The Voting Rights Act and other laws adopted pursuant to the Reconstruction Amendments, for example, reflect the fear that elected officials and voters in many states, especially in the South, will be systematically inattentive to the interests of minority groups.[20] Perhaps federal control can assure that discrimination does not deprive those groups of a fair shot to make their voices heard.

It is perhaps possible to build a similar case for health reform. In 2013, only 13% of the non-elderly white population in the United States lacked health coverage, compared to 21% of the black population and 32% of the Hispanic population.[21] Although the ACA afforded the states an opportunity to alleviate those disparities by expanding their Medicaid programs, nineteen states have refused to expand. In conventional economic terms, this resistance to expansion is inexplicable: the federal government will pay 100% of the costs of expansion in the early years, dropping to 90% by 2020. States are passing up billions of dol-

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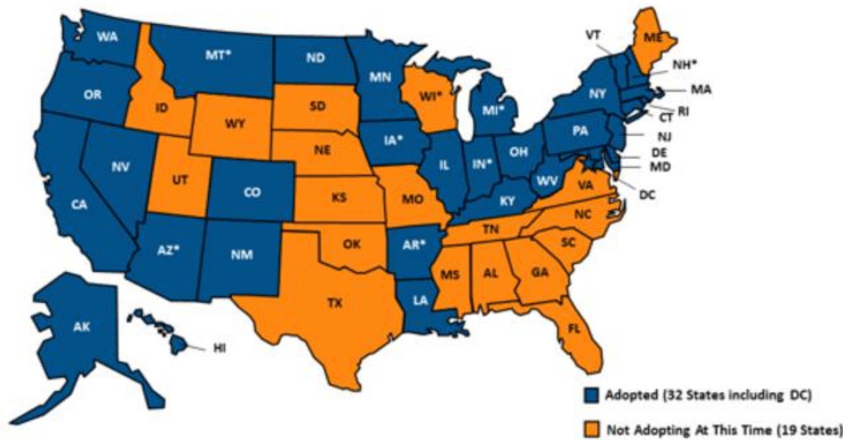
18. *See* 15 U.S.C. § 1011 (2012).
19. *See* Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL., POL'Y & L. 441 (2014).
20. *See* Heather Gerken, *Federalism All the Way Down*, 124 HARV. L. REV. 4, 9 (2010) (noting the recurring "worry that local power is a threat to minority rights").
21. *Health Coverage by Race and Ethnicity: The Potential Impact of the Affordable Care Act*, KAISER FAMILY FOUND. (2013), http://kaiserfamilyfoundation.files.wordpress.com/2014/07/8423-health-coverage-by-race-and-ethnicity.pdf [http://perma.cc/JHC8-8Y94].

lars in federal money financed, in part, by taxes on the states' own residents. What's more, Medicaid expansion boosts employment in the health sector, enables states to reduce spending on mental health services, and raises tax revenue by redirecting the consumption of low-income people toward goods that are subject to sales taxes.[22]

Figure 1.

Current Status of State Medicaid Expansion Decisions



NOTES: Current status for each state is based on KCMU tracking and analysis of state executive activity. *AR, AZ, IA, IN, MI, MT, and NH have approved Section 1115 waivers. WI covers adults up to 100% FPL in Medicaid, but did not adopt the ACA expansion.
SOURCE: "Status of State Action on the Medicaid Expansion Decision," KFF State Health Facts, updated October 14, 2016.
http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/

What explains, then, resistance to Medicaid expansion? Although opposition may speak to the states' principled objections to health reform, it is difficult to ignore that the states with the darkest history of racial discrimination have resisted most staunchly. As Mark Hall has argued:

> This degree of pitched opposition by states to a major federal domestic initiative has not been seen since the civil rights era of the 1960s. Then, too, states opposed federal intervention (for integration) based on states' rights principles. But, the true motives were patent. It is certainly possible that similar motives are among the mix of sentiments shared by at least some opponents of Medicaid expansion . . . . [Coverage]

22. John Ayanian et al., *Economic Effects of Medicaid Expansion in Michigan*, 376 NEW ENG. J. MED. 407 (2017).

> disparities suggest than politicians who oppose Medicaid expansion will do more damage to their black than their white constituencies.[23]

If racism has tainted states' decisions pertaining to the post-ACA Medicaid expansion, that same racism might likewise have impeded the adoption of near-universal coverage at the state level. If so, the Medicaid example might be taken to offer evidence of the need to nationalize health reform—to take the decision out of the hands of states that cannot be trusted to make it fairly.

But the case is harder to sustain than it may at first appear. Prior to the ACA, there was no racial divide among the states that had adopted near-universal coverage and those that had not. Almost no states had acted. If racism is at the root of the states' collective failure to expand health coverage, federalizing health reform would duplicate the political pathology, not alleviate it.

Setting that aside, national action to counteract lingering discrimination has historically been narrow in scope. Congress may enforce the strictures of the Fourteenth Amendment only when "there is a congruence and proportionality between the injury to be prevented or remedied and the means adopted to that end,"[24] and the courts will invalidate under the Equal Protection Clause only those state laws enacted with discriminatory intent.[25] The narrowness of the federal role affords states with a taste for discrimination wide latitude to indulge that taste. A state's tax code might be restructured, for example, to disfavor those at the bottom of the economic ladder (e.g., by substituting a sales tax for a progressive income tax). Alternatively, a state might reduce direct outlays on public education, leaving it to municipalities to fund their schools through local property taxes. In both cases, the changes in state law would inflict disproportionate harm on historically disadvantaged communities.

Federal law has little to say about this.[26] Outside the enclave of federally protected rights, the risk that states might abuse their lawmaking power has generally not been thought an adequate justification to strip them of it. If it were, lingering discrimination would be reason enough to oust the states of their authority to tax and spend, spelling the end of federalism in any meaningful sense of the word. That kind of all-purpose justification is in serious tension with a constitutional system that remains committed to federalism, however imperfectly.

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23. Mark Hall, *States' Decisions Not to Expand Medicaid*, 92 N.C. L. REV. 1459, 1464 (2014).

24. City of Boerne v. Flores, 521 U.S. 507, 520 (1997).

25. *See* Washington v. Davis, 426 U.S. 229 (1976).

26. *See, e.g.*, San Antonio Indep. School Dist. v. Rodriguez, 411 U.S. 1 (1973) (rejecting a constitutional challenge to Texas's system of financing public education).

II. BETTER JUSTIFICATIONS

For health reform, the weakness of the conventional justifications for federal intervention presents a puzzle. Why were supporters of health reform so committed to a national solution? Why did the possibility of leaving reform to the states seem hardly to come up?

There are, in fact, very good reasons for pursuing national health reform. State governments have neither the fiscal capacity nor the freedom to tax that the federal government does. That puts states in a bind: they cannot act even if they would prefer to adopt universal coverage and even if they are willing to tax their residents in order to do so. As the dismal history of state-level reform suggests, the states can't go it alone.[27]

A. *The Countercyclical Trap*

In their attacks on the ACA, Republicans take aim at the federal regulations that, in their view, stymie the market, inflate the costs of health insurance, and limit consumer choice. But framing the ACA as a regulatory incursion obscures that it is not only—not even primarily—a regulatory statute. True, it creates a comprehensive suite of new rules for the (relatively small) individual insurance market. It also imposes some new rules (not many) on employer-sponsored plans. But what the ACA chiefly does is distribute tax revenue to the poor and near-poor to finance insurance coverage. The distribution comes in two main forms: first, through the Medicaid expansion, which benefits those below or near the poverty level; and second, through the subsidies available to those buying coverage in the individual market who make less than four times the poverty level. The regulations imposed on the individual market were thought necessary to assure the health of that market and to protect consumers, but they were in an important sense incidental. While the ACA does do a fair amount of regulating, it is mainly a spending program—and a large one at that.

It is also a countercyclical spending program.[28] When a recession hits, many people will lose both their jobs and their employer-sponsored coverage.

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27. *See* JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 41 (2011) (discussing failed reform efforts in Kentucky, Maine, New Hampshire, New Jersey, New York, Vermont, and Washington). The most prominent failure came in 2007, when then-Governor Schwarzenegger of California joined with Democrats in the state legislature to advance an ambitious reform bill, only to watch it crumble. *See* Marian R. Mulkey & Mark D. Smith, *The Long and Winding Road: Reflections On California's 'Year Of Health Reform,'* 28 HEALTH AFF. w446 (2017).

28. For the definitive work on the distinction between regulatory and fiscal federalism, and on the countercyclical challenges to the latter, see Super, *supra* note 9.

The ranks of those eligible for Medicaid and for ACA subsidies will predictably grow, leading to larger federal outlays. At the same time, the economic downturn will depress tax revenues. The federal government can deficit-spend to manage these countercyclical fluctuations. The states, however, cannot. With the exception of Vermont, the states are legally obliged to balance their budgets every year.[29] And states are understandably reluctant to adopt large obligations that will require savage spending cuts or hefty tax increases when times get tough. Cuts and taxes are not only unpopular, but they would also depress the economy further, exacerbating the recession. Broad coverage expansions thus commit states to an economic policy that could inflict serious damage on their residents.[30]

As the exception that proves the rule, Massachusetts is instructive. When it adopted statewide reform, Massachusetts had two advantages that no other state had. First, it had the lowest rate of uninsured in the country, meaning that its countercyclical obligations would be more modest than those of other states.[31] Second, with the help of Senator Ted Kennedy, the state got a sweetheart deal from the George W. Bush Administration offering it more than $1 billion in Medicaid funding to support a coverage expansion.[32] Massachusetts could afford to bite the bullet; states without those advantages cannot—at least without help from the federal government.

B. Federal Limits on State Tax Authority

No government, state or federal, likes to impose new taxes. But governments face a special challenge when their residents can complain that the new tax is discriminatory. That problem arises with particular force when states try to impose new taxes to finance a coverage expansion. A resident who gets health coverage through her job—let's call her Anna—already faces a reduction in take-home pay commensurate with the value of that coverage. Another resident who works at a similar job but does not get health coverage—let's call him Bob—likely receives higher cash wages. Should Anna and Bob both face the same new tax, even if it finances a coverage expansion that will only benefit Bob?

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29. *Id.* at 2609.

30. *See* Mulkey & Smith, *supra* note 27, at w454 (arguing that the "boom-and-bust cycles" of state finances has contributed to the collapse of "virtually every major state expansion of health coverage across the country in the past two decades").

31. *See* McDonough, *supra* note 27, at 37-43.

32. *See id.* at 39.

Penalizing employers who fail to offer health coverage to their employees avoids this problem. "Pay or play" laws thus have a clear political logic: employers that don't offer coverage are failing to live up to their end of the social bargain. They have a certain economic logic, too: if Bob starts getting coverage through his employment because of a pay-or-play law, he will see an offsetting wage reduction, tying the costs of coverage to the person who receives it.

The trouble is that ERISA preempts state laws that "relate to any employee benefit plan," including a plan offering health coverage.[33] Although there is some legal uncertainty, preemption probably means that states cannot impose a penalty on employers that refuse to offer health coverage.[34] By taking pay-or-play laws off the table, ERISA complicates the politics of financing state efforts to achieve near-universal coverage.[35]

Why might a pay-or-play law "relate to" employee-benefit plans? In *Retail Industry Leaders Association v. Fielder*,[36] the Fourth Circuit examined a Maryland law requiring companies with more than 10,000 employees in the state to devote at least 8% of their payroll toward health coverage or pay the equivalent as a tax. By design, the law applied only to Wal-Mart, which had come under fire for shunting its employees onto Medicaid.[37] Any taxes that Maryland collected would be deposited in a specified health fund to support health coverage for Maryland residents.

The Fourth Circuit started with first principles. Under ERISA, Maryland could not direct Wal-Mart to offer health insurance as an employment benefit. That sort of law would "relate to" the design of an employee-benefit plan within the meaning of ERISA.[38] By extension, the court reasoned, Maryland could not achieve the same result by taxing a company's failure to offer health coverage. The court brushed aside Maryland's objection that the statute left the employer with a choice about how to structure its employees' benefits:

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33. 29 U.S.C. § 1144(a) (2012).

34. For a sampling of the literature on the question, see Peter Jacobson, *The Role of ERISA Preemption in Health Reform: Opportunities and Limits*, 37 J.L. MED. & ETHICS 88 (2009); Amy Monahan, *Pay or Play Laws, ERISA Preemption, and Potential Lessons from Massachusetts*, 55 KAN. L. REV. 1203 (2007); Christen Linke Young, *Pay or Play Programs and ERISA Section 514: Proposals For Amending The Statutory Scheme*, 10 YALE J. HEALTH POL'Y, L. & ETHICS 197 (2010).

35. *See* Mulkey & Smith, *supra* note 27, at w453 ("Navigating [ERISA] law, which prevents states from regulating employee benefits, is a well-known challenge in designing state coverage expansion proposals . . . that preserve a central role for employer coverage.").

36. 475 F.3d. 180 (4th Cir. 2007).

37. *See* Michael Barbaro, *Maryland Sets a Health Cost for Wal-Mart*, N.Y. TIMES (Jan. 13, 2006), http://www.nytimes.com/2006/01/13/business/maryland-sets-a-health-cost-for-walmart.html [http://perma.cc/T7SL-R879].

38. Fielder, 475 F.3d. at 192 (citing Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 97 (1983)).

> Healthcare benefits are a part of the total package of employee compensation an employer gives in consideration for an employee's services. An employer would gain from increasing the compensation it offers employees through improved retention and performance of present employees and the ability to attract more and better new employees. In contrast, an employer would gain nothing in consideration of paying a greater sum of money to the State. Indeed, it might suffer from lower employee morale and increased public condemnation . . . . In effect, the only rational choice employers have . . . is to structure their ERISA healthcare benefit plans so as to meet the minimum spending threshold.[39]

The *Fielder* court's reasoning is not unassailable. Rick Hills, for one, has written persuasively about why an expansive view of ERISA preemption should be rejected.[40] Even with the utmost sensitivity to state interests, however, the core of the Fourth Circuit's decision appears sound. If ERISA prevents a state from demanding that employers provide health insurance to their employees—and it does, at least under current case law—it should likewise prevent a state from imposing a substantial penalty on employers that choose not to.

The Ninth Circuit seemed to acknowledge as much in *Golden Gate Restaurant Association v. City and County of San Francisco*,[41] even as it distinguished *Fielder* in a somewhat strained effort to uphold a municipal pay-or-play ordinance. For the Ninth Circuit, distinctive features of the San Francisco ordinance left employers with "a meaningful alternative" to restructuring their employee-benefit plans.[42] In particular, any tax penalty paid under the San Francisco ordinance would go toward a public program dedicated to residents whose employers did not offer health coverage. In the Ninth Circuit's view, that gave employers a real choice: they could offer coverage directly (as a fringe benefit of employment) or indirectly (via an earmarked tax).[43] An employer that chose the latter approach would have to make no changes at all to its em-

39. *Id.* at 193.

40. *See* Rick Hills, *Local Democracy's Struggle with ERISA Preemption*, PRAWFSBLAWG (Dec. 26, 2008), http://prawfsblawg.blogs.com/prawfsblawg/2008/12/city-power-to-impose-healthcare-mandates-on-employers-erisa.html [http://perma.cc/PQ3U-QVGH]; Roderick Hills, *Against Preemption: How Federalism Can Improve the Federal Legislative Process*, 82 N.Y.U. L. REV. 1 (2007).

41. 546 F.3d 639, 655 (9th Cir. 2008) (noting that ERISA would preempt a state law that "require[d] any employer to adopt [a] health plan" for its employees).

42. *Id.* at 660.

43. *Id.* at 655.

ployee benefit plan. As such, the court reasoned, ERISA did not preempt the ordinance.[44]

The Ninth Circuit's decision was controversial.[45] Unsurprisingly, the ensuing petition for certiorari argued that the court had opened a split with the Fourth Circuit. By the time the Supreme Court called for the views of the Solicitor General, however, President Obama had taken office—and by the time the brief was submitted, the ACA had been enacted.[46] Because the ACA "significantly reduces the potential that state or local governments will choose to enact health care programs" like the San Francisco ordinance, the Solicitor General recommended that the Court decline to hear the case.[47] The Court obliged,[48] leaving the tension between the Ninth and Fourth Circuit decisions unresolved.

For all practical purposes, the resulting state of affairs gives the states little room to maneuver. The apparent circuit split notwithstanding, ERISA almost certainly preempts pay-or-play laws that impose substantial taxes on employers, at least where those taxes are not earmarked for use of particular employees. States could minimize the risk of preemption by limiting the size of the tax penalty; as Amy Monahan has argued, a small penalty arguably leaves employers with a real choice about whether to offer coverage.[49] That was Massachusetts's approach: it levied a small pay-or-play tax of $295 per employee.[50] But a small tax does little to encourage employers to offer insurance or to finance a coverage expansion—and even a small tax might still be subject to preemption. Alternatively, states could undertake the cumbersome, complex task of creating public health plans for employee use. Per *Golden Gate*, pay-or-play laws that earmark employer contributions might avoid ERISA preemption.

But probably not. Even if the presumption against preemption has purchase in other corners of the law, it does not appear to move the Supreme Court in ERISA cases.[51] Without the motivating force of that interpretive presumption, it is difficult—not impossible, but difficult—to defend the Ninth Circuit's heroic effort to save the San Francisco ordinance from preemption.

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44. *Id.* at 655-56.
45. Golden Gate Rest. Ass'n v. City and County of San Francisco, 558 F.3d 1000 (9th Cir. 2009) (en banc) (eight judges dissenting from the refusal to rehear the case).
46. Brief for the United States as Amicus Curiae, Golden Gate Rest. Ass'n v. City and County of San Francisco, 130 S. Ct. 3497 (U.S. 2010) (No. 08-1515), 2010 WL 2173776.
47. *Id.* at 8.
48. Golden Gate Rest. Ass'n v. City and County of San Francisco, 130 S. Ct. 3497 (2010) (denying certiorari).
49. *See* Monahan, *supra* note 34, at 1214.
50. *Id.*
51. *See* Jacobson, *supra* note 34 (describing the Supreme Court's tendency to favor broad ERISA preemption).

Perhaps more to the point, the vote line-ups in *Fielder* and *Golden Gate* suggest that judges are split over the scope of ERISA preemption along predictable political lines. Conservative judges, with their sensitivity to business interests, tend to take an expansive view of ERISA preemption, even as liberal judges resist construing ERISA to curtail states' regulatory authority. With President Trump's victory and the likely confirmation of Judge Gorsuch to replace Justice Scalia, the Supreme Court probably will not be receptive to creative efforts to avoid ERISA preemption. At a minimum, the unsettled scope of ERISA preemption will give states pause. Why take the political hit for imposing a new "employer mandate" when the courts will probably invalidate it anyhow?[52]

Here, Hawaii is the exception that proves the rule. The central feature of Hawaii's success in achieving universal coverage is a stringent pay-or-play law.[53] That law remains on the books because Hawaii is the only state with an explicit carve-out from ERISA preemption.[54] Lacking a similar carve-out, the other states will have an exquisitely hard time moving forward with reform. To put it bluntly: anyone who says the states can expand coverage on their own doesn't understand ERISA.

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National health reform does not resolve a collective-action problem; it mitigates no externalities; and it is not an answer to state-level political pathologies. It is nonetheless readily justified as a response to the states' limited fiscal powers and ERISA's sweeping displacement of state law. Taken together, these obstacles will impair the states' ability to enact and sustain efforts to cover the uninsured.

III. IMPLICATIONS FOR REFORM

A more refined understanding of the functional justifications for federal action yields insight into how to allocate responsibility over health reform. It also enables a crisp evaluation of the ACA and the merits of reform proposals that purport to return authority to the states.

A. *The Affordable Care Act*

The discussion of collective-action problems, externalities, and political pathologies suggests the difficulty of justifying federal control over the regulation

52. Mulkey & Smith, *supra* note 27, at 453 (observing that ERISA "virtually oblig[es] state policymakers to take a major risk when they design coverage-expansion plans").

53. HAW. REV. STAT. § § 393-11, 393-33.

54. 8 U.S.C. 1144(b)(5) (2012).

of insurance. At the same time, the federal government's superior fiscal powers must be enlisted to make coverage expansions possible. That implies a rough allocation of responsibility. The federal government should finance the bulk of any coverage expansion that commands support in Congress, but the states should retain substantial authority to structure their health-care markets as they see fit.

As always, there are federalism costs to making a collective decision about taxes and spending. Nebraskans, for example, may bridle at federal tax hikes that are used to finance a coverage expansion that they wouldn't choose for themselves. But the alternative is worse: because of the countercyclical trap and ERISA preemption, *all* the states are disabled from acting alone, even if most would prefer to bear the costs that addressing the crisis of the uninsured would entail. Financing coverage at the federal level will not suit all the states, but it will suit more Americans than no solution at all.

In many respects, the ACA embraces this allocation of federal-state responsibility. The Medicaid expansion, for example, is financed almost entirely by the federal government, but states retain operational control over the program.[55] The Obama Administration's willingness to grant broad Medicaid waivers has allowed the states to adopt policies that align with their interests. Similarly, subsidies for individual plans purchased through the health-care exchanges come out of federal funds, even as states were given the option of running the exchanges themselves.[56] Most dramatically, the ACA authorizes states to seek a waiver from most of the statute's regulatory restrictions if the state can show how it will use federal money—both Medicaid and subsidy dollars—to achieve the same level of coverage. If a waiver is granted, that money passes through to the state directly.[57]

In other respects, however, the ACA takes a heavier hand. All insurers are prohibited, for example, from refusing to cover someone with a preexisting condition.[58] They must write insurance for all comers.[59] They must charge them all the same price, with limited exceptions for differential pricing based on age and smoking habits.[60] And they must cover a comprehensive roster of benefits and cap their customers' out-of-pocket spending.[61] These are all per-

55. Affordable Care Act, § 2001.

56. *See* 42 U.S.C. § 18031 (2012).

57. *See* 42 U.S.C. § 18052 (2012).

58. *See* 42 U.S.C. § 300gg-3 (2012).

59. *See* 42 U.S.C. § 300gg-2 (2012).

60. *See* 42 U.S.C. § 300gg (2012).

61. *See* 42 U.S.C. § 18022 (2012). By regulation, HHS asked the states to designate a "benchmark plan" from a list of plans in which their residents are already enrolled. Whatever bene-

fectly reasonable policies, but they are not policies that the states uniformly endorse. And while states that wish to opt out of the insurance regulations can seek a waiver, the conditions on receipt of the waiver are stringent: the state plan must cover at least the same number of people with insurance that is at least as comprehensive and affordable as the insurance available under the ACA.[62] Unsurprisingly, only one Obamacare waiver has been granted so far. It went to Hawaii, and it was modest in scope.[63] No waiver has issued to red states that wished to depart more dramatically from the ACA's rules.

The states thus have some reason to complain (though not as much they often claim) that the federal government has inhibited their lawmaking powers without adequate justification. Take the prohibition on charging older people more than three times what younger people pay for coverage.[64] In the absence of that prohibition, the young would pay less for their coverage and the old would pay more. Maybe that's sensible, maybe it's not: it depends on a value judgment about how to fairly allocate health-care costs across a population. Why not leave that judgment to the states?

To push the point harder, consider the ban on medical underwriting. The ACA reflects the judgment that it is unfair to deny coverage to the sick or to ask them to pay more for their coverage. The ACA thus embraces policies—in particular, the much-maligned individual mandate—that its drafters thought necessary to cope with the risk that people will wait until they got sick to purchase coverage. For the ACA's supporters, the individual mandate is a reasonable price to pay to prevent discrimination against the sick. But many people don't see it the same way. Some reject the claim that the government should be in the business of guaranteeing coverage for everyone. Others don't think that medical underwriting, however distasteful, warrants a heavy-handed purchase obligation. Still others doubt that the individual mandate is strictly necessary to prevent adverse selection, and would prefer less-intrusive alternatives. If those who disagree with the ACA's approach command the levers of political power within a state, why shouldn't those states be allowed to try something different?

The argument can be generalized to most of the ACA's insurance reforms. And I can already hear the response: *Because this "something different" will not*

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fits are covered by the benchmark plans would then be considered essential. *See* Bagley & Levy, *supra* note 19.

62. *See* 42 U.S.C. 18052.

63. *Fact Sheet: Hawai'i: State Innovation Waiver*, CTRS. FOR MEDICARE & MEDICAID SERVS. (2016), http://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Hawaii-1332-Waiver-Fact-Sheet-12-30-16-FINAL.pdf [http://perma.cc/JRT4-94AQ].

64. 42 U.S.C. § 300gg(a)(1)(A)(3) (2012).

work. The ACA's opponents are completely unrealistic about the tough tradeoffs that health-care policymaking entails. They will take federal money and squander it, leaving millions of people without coverage.

That might be right; indeed, I suspect it *is* right. But that is my judgment. Lots of smart people do not share that judgment. And if federalism means anything, it is that national judgment should not supersede state judgment, absent a good reason for federal intervention. Yes, federal money might be squandered in a state that adopts stupid insurance rules. People could go bankrupt and even die as a result of the lack of coverage. But that's an issue between the state and its voters. If other states use the money more effectively, the state with the stupid rules will come under pressure to improve them. And what if it turns out that what seemed stupid is not so stupid after all?[65]

Democracy rests on the conceit that we all have an equal voice in determining what the good is, which is why Michigan voters don't get to tell Ohioans how to spend their tax dollars, even if Wolverines know in their hearts that they make better decisions than Buckeyes. And while the federal government *can* make decisions for Ohio, it should not do so just because it doubts the wisdom, intelligence, or values of Ohio residents. "The states have bad ideas" is a poor justification for federal law (unless, again, those bad ideas turn on views about the inferiority of minority groups). Federalism thrives when we recognize the limits of what we know, appreciate that good people can hold views that many others find repugnant, and acknowledge that our own misconceptions and prejudices can blind us. Sometimes federalism means letting the states wave their crazy flags.

To be clear, Congress can and should place some conditions on the money it disburses to states. The possibility that a state might abuse unrestricted funds could make it difficult to enact and sustain federal legislation—which would be especially unfortunate in a domain, like health reform, where the states are disabled from acting on their own. If Congress imposes new taxes to finance a coverage expansion, only to watch Iowa use that money to subsidize corn farmers, Iowa's actions could imperil a policy of health reform that, collectively, the American public supports. Policymakers are justified in taking that political risk into account and creating broad conditions on the use of funds.

More than that: Congress can establish guardrails to prevent states from subverting the purposes of federal action, only to use the failure of the federal initiative as an excuse to lobby for its dismantlement.[66] Mashaw and Marmor

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65. *Cf.* Mashaw & Marmor, *supra* note 8, at 121 ("The 'problem' of 'inadequate' state health plans is, in many respects, not a problem at all . . . There is no agreed-upon 'best' health insurance (or medical care) system that a state could offer.").

66. *See* David A. Super, *The Political Economy of Entitlement*, 104 COLUM. L. REV. 633, 716-18 & n.308 (2004).

propose, for example, to require states to use federal money to achieve universal, comprehensive, portable health coverage, while establishing a plan for accountability and fiscal viability.[67] In other words, states should be obliged to use federal money to create an entitlement to health insurance—no lotteries or queuing permitted—but the entitlement should be articulated at a high level of generality and implemented in a manner that gives the states room to adopt their own distinctive approaches.[68]

The calculus might be different with respect to Medicaid, where the racial overtones surrounding the program are difficult to overlook. Concerns about state-level discrimination, for example, may have justified Congress's original (and unconstitutional) attempt to link the Medicaid expansion to existing Medicaid dollars, which would have left the states with little choice but to expand.[69] Lingering worries about state-level discrimination might likewise have informed the Obama Administration's negotiations with states over the conditions under which they would expand their Medicaid programs. Although the administration generally exhibited great flexibility—it approved an Arkansas "private option" that channeled new Medicaid enrollees onto the exchanges, for example,[70] and allowed Indiana and Michigan to impose limited cost-sharing obligations[71]—it drew the line at state requests to impose work requirements or to shift substantial costs to beneficiaries.[72] The Administration's refusals could be seen as efforts to shield the interests of historically disadvantaged minorities from states that systematically slight their interests.

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67. *See* Mashaw & Marmor, *supra* note 8, at 118.

68. David Super has argued that programs based on unrestricted grants—money with few or no strings—have proven fragile because "federal policymakers must bear the political costs of raising the revenue and forgo the political rewards of spending that revenue on programs for which they would receive political credit." Super, *supra* note 9, at 2557-58 n.54; *see also* Super, *supra* note 66, at 710-11. Super's point is well-taken, but adding strings to federal money can create its own form of fragility: states may bridle so much at the restrictions that they agitate for radically altering or undoing the program altogether. In the politically contentious environment of health reform, relaxing federal control may enhance sustainability, even if federal policymakers can claim somewhat less credit for reform than they might have if they had imposed more restrictions on federal funds.

69. *See* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

70. *See* Nicholas Bagley, *Legal Limits and the Implementation of the Affordable Care Act*, 164 PENN. L. REV. 1715, 1740-44 (2016).

71. *See* John Z. Ayanian, *Michigan's Approach to Medicaid Expansion and Reform*, 368 NEW ENG. J. MED. 1773 (2013).

72. *See* Robin Rudowitz & MaryBeth Musumeci, *The ACA and Medicaid Expansion Waivers*, KAISER FAMILY FOUND. (Nov. 20, 2015), http://kff.org/medicaid/issue-brief/the-aca-and-medicaid-expansion-waivers [http://perma.cc/2MQS-3VFU].

B. Replacing Obamacare

The new Congress hopes to use the opportunity of Obamacare's repeal to return power to the states. As I have argued, however, repealing the ACA would do nothing to remove the obstacles to the states' adoption of near-universal coverage. If Congress wishes to give them genuine flexibility, its adoption of an Obamacare replacement must be sensitive to the features of the health-care system that have frustrated state action in the past.

1. Regulation

For health reform, the most challenging federalism questions arise with respect to Medicaid and the private insurance market, where the lines of federal and state power are blurry, shifting, and contested. It is those aspects of the ACA that are the focus of the new Congress's repeal-and-replace strategy—and the ones that can be usefully evaluated in light of Speaker Ryan's professed aim to "empower" the states.[73]

Although replacement proposals are still on the drawing board, broad commitments have been sketched out. Some of those commitments advance federalism values. Republican legislators object, for example, to portions of the ACA requiring insurers to cover the "essential health benefits." They would prefer to allow insurers to cover a narrower roster of benefits, which would in turn enable consumers to shop for insurance that is tailored to their needs and pocketbooks. There are reasonable policy objections to the approach: that expansive plans will attract sicker customers, fueling adverse selection and driving up premiums for everyone; that insurance is such a complex financial product that consumers shouldn't have to worry that their plans exclude services they might one day need; and that the coverage requirements are not that onerous anyhow. But these are also the sorts of policy objections that the states can disagree about, and the United States can tolerate a patchwork of laws about what health insurers must cover. On federalism grounds, relaxing the rules governing essential health benefits appears appropriate on federalism grounds. At the same time, respect for federalism would require Congress to clarify that the states remain free to establish their own coverage requirements—including requiring coverage of the essential health benefits.

The same holds true for most of the ACA's insurance reforms, including the obligation to cover preventive services, age bands, and the ban on medical underwriting. It even applies to the individual mandate. Recognizing that stable insurance markets require a balanced risk pool, Republican legislators have

73. Ryan, *supra* note 6, at 12.

been exploring alternatives. One approach would allow medical underwriting only for those people who do not maintain "continuous coverage," which might encourage healthy people to come into the insurance market before they get sick.[74] Another alternative would automatically enroll people in an insurance plan, but leave them free to opt out if they choose to do so.[75] Through sheer inertia, healthy people who might not have taken the trouble to enroll might stay insured. It is not clear whether either of these proposals would be adequate to foster healthy insurance markets (or whether auto-enrollment is even technically feasible). But that is the point: it is not clear. And even if the individual mandate works better than these alternatives, many people might reasonably prefer a less-effective alternative that doesn't involve a heavy-handed government mandate. Again, given the diversity of opinion, decentralization seems appropriate.

Congress could adopt a permissive baseline—perhaps a continuous-coverage provision—while at the same time leaving the states free to adopt pure community rating and the individual mandate. That way, if Connecticut prefers the approach that the ACA previously mandated, Connecticut could respond to any repeal-and-replace plan by adopting its own individual mandate.[76] To avoid any question that such patches would conflict with legislative purposes and hence be preempted,[77] Congress should specify that states have a free hand to adopt whatever mechanisms they deem necessary to get healthy people into the markets.

In short, many of the Republican proposals restore power to the states in a manner that may advance federalism values. At the same time, however, some proposals would actively impair state authority. Most significantly, President Trump ran for office on a vow to allow the cross-border sale of health insurance.[78] Proposals to that effect are in most Republican plans.[79] If adopted, they

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74. *Id.*

75. *See* Caitlin Owens, *Why Trumpcare Might Sign You Up For Health Insurance Without Asking*, AXIOS (Jan. 19, 2017), http://www.axios.com/why-trumpcare-might-sign-you-up-for-health-insurance-without-asking-2162181493.html [http://perma.cc/3D93-VCEP].

76. *See* Nicholas Bagley, *Patching Obamacare at the State Level*, INCIDENTAL ECONOMIST (Dec. 16, 2016), http://theincidentaleconomist.com/patching-obamacare-at-the-state-level [http://perma.cc/SU7D-6R9V].

77. Hines v. Davidowitz, 312 U.S. 52, 67 (1941) (laying out the principles of conflict preemption).

78. *See* Michael Ollove, *Interstate Health Insurance: Sounds Good, But Details Are Tricky*, PEW CHARITABLE TRUSTS (Jan. 18, 2017), http://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2017/01/18/interstate-health-insurance-sounds-good-but-details are-tricky [http://perma.cc/XV57-7R2Q].

79. *See, e.g.*, Ryan, *supra* note 6, at 2.

would allow the residents of one state to purchase health insurance that is licensed and regulated in another state.

To enable cross-border sales, Congress would have to strip the states of their authority, confirmed under the McCarran-Ferguson Act, to regulate insurance sold within their borders.[80] States would be left with the residual power to oversee those insurers that are domiciled within the state. Given the ease of changing corporate domicile, insurers may move their headquarters to jurisdictions that with permissive insurance regulations. The same dynamic has already played out with credit card regulation, which is why your credit card bills come from South Dakota.

As a result, a state with permissive health insurance regulations—maybe North Dakota this time—could effectively establish insurance rules that govern in every other state. Voters in California and New York would have no say in the matter, even if they preferred consumer protections that North Dakota had abandoned. That is why allowing sales across state lines is even worse for federalism than a needlessly intrusive federal statute. When Congress preempts state law, at least voters in California and New York have a say in the matter. They have no say over North Dakota's insurance rules.

As it stands, the states already have the authority to permit cross-border sales; indeed, six states have done so.[81] And the ACA explicitly authorizes states to band together in "interstate compacts" to enable sales across state lines.[82] But it's one thing for a state to *choose* to allow its residents to purchase insurance that another state regulates. If Oklahoma has no objection to plans sold by North Dakota insurers, Oklahoma can agree to allow North Dakota plans to be sold in its state. It is another thing altogether to *prohibit* states from making that choice, as Republican proposals would entail. This is not a strategy to empower the states. It is a strategy to deregulate the insurance market, even in those states that would prefer tighter regulation.

2. *Money*

Simply wiping the ACA from the books would not enable the states to tackle health reform. Because of the countercyclical trap and ERISA preemption, facilitating a state-centric approach will require Congress to adopt a replace-

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80. *See* 15 U.S.C. § 1011 (2012).

81. *See* Sabrina Corlette et al., *Selling Health Insurance Across State Lines: An Assessment of State Laws and Implications for Improving Choice and Affordability of Coverage*, CTR. ON HEALTH INS. REFORMS (2012), http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2012/rwjf401409 [http://perma.cc/3LVJ-ZV2N].

82. 42 U.S.C. § 18053 (2012).

ment under which Congress continues to pay for health reform. To be sure, Congress could always amend ERISA to clarify that states can adopt pay-or-play laws; indeed, it should do so. But the prospects for amending ERISA are dim given the strength of the business lobby and its intense resistance to limiting the statute's preemptive scope.[83] Plus, even if ERISA were amended, the countercyclical trap would remain.

Because congressional replacement plans remain sketchy, working out whether they retain the ACA's funding streams is difficult. Even at this early stage, however, three aspects of Republican proposals present cause for concern. First, Congress's top priority appears to be the adoption of a reconciliation bill that zeroes out the ACA's taxes.[84] The resulting tax break would be enormous: the Congressional Budget Office estimated that an earlier bill that Congress is using as a template would have cut taxes by $629.3 billion over ten years.[85] Congress also means to end the premium subsidies and the Medicaid expansion, but will delay their end-date for a few years to give congressional Republicans a chance to devise a replacement.

This is a high-risk strategy. Zeroing out the taxes that finance the ACA's subsidies and the Medicaid expansion will leave Congress with three unappealing options as it searches for a replacement: it can raise taxes, cut spending, or run a budget deficit. Fractures within the Republican caucus over the appropriate course of action are likely to emerge, complicating negotiations and impairing its ability to coalesce around an alternative.[86] What is more, avoiding a filibuster will require securing Democratic votes for any replacement—and, at least for the moment, Democrats do not appear inclined to cooperate. There may be no replacement; the ACA may just be repealed. If so, it will be the worst of both worlds: the federal government won't act and the states can't act.

Second, several Republican proposals would end the ACA's rules guaranteeing the affordability of insurance coverage. Under current law, no one making less than four times the poverty level has to devote more than 9.69% of her income toward a typical plan on the ACA's exchanges (and most pay much

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83. *See* Mashaw & Marmor, *supra* note 8, at 125-26.

84. *See* Sarah Kliff, *Senate Republicans Just Introduced an Obamacare Repeal Plan*, VOX, (Jan. 3, 2017), http://www.vox.com/policy-and-politics/2017/1/3/14154820/senate-obamacare-budget-resolution-reconciliation [http://perma.cc/93ZR-X36A].

85. Letter from Keith Hall, Dir., Cong. Budget Office, to Senator Mike Enzi, Chairman, Comm. on the Budget 6-7 (Dec. 11, 2015), http://www.cbo.gov/sites/default/files/114th-congress-2015-2016/costestimate/hr3762senatepassed.pdf [http://perma.cc/J9W9-T5MZ].

86. *See* Ramesh Ponnuru, *Replacing Obamacare Will Be a Slog, Not a Race*, BLOOMBERG VIEW (Nov. 28, 2016), http://www.bloomberg.com/view/articles/2016-11-28/replacing-obamacare-will-be-a-slog-not-a-race [http://perma.cc/VZ2Y-S5BH].

less).[87] Premium subsidies thus rise and fall with the price of coverage: the cheaper the insurance, the lower the subsidies, and vice versa. Some Republican plans, in contrast, would key the subsidy to a fixed amount, perhaps indexed to economy-wide inflation, and distribute it based on age, not income.[88] If subsidies do not keep pace with medical inflation, their value relative to the price of coverage will diminish. As coverage becomes more unaffordable, states that wish to maintain universal coverage will have to raise taxes to make up the difference—a difficult trick in light of the countercyclical trap and ERISA preemption.

Third, and finally, congressional Republicans hope to transform Medicaid from an individual entitlement to a block grant—a fixed sum of money that places few restrictions on the purposes that states can use it for.[89] In some respects, block grant proposals promote federalism: they afford states more discretion about how to put Medicaid dollars to work.[90] A state, for example, could place limits on eligibility or benefits; more creatively, it could use some of its Medicaid money for lead abatement in urban cores, as Michigan has recently been allowed to do on a small scale.[91] But the devil is in the details. A fixed block grant that increased with economy-wide inflation and was insensitive to the business cycle would not give states the fiscal flexibility necessary to cope with a recession. Over time, as well, the galloping pace of medical inflation would erode the value of the block grants, requiring states to ration access to medical care, either through cuts to benefits or to eligibility.[92] Proposals to transform Medicaid into a block-grant program may trade on the rhetoric of states' rights, but they have the perverse effect of inhibiting state power.

Alternative approaches could mitigate the concern somewhat. Per capita grants anchored to a formula that accounted for the number of people within a state under a particular income threshold, for example, would avoid the coun-

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87. IRS Rev. Proc. 2016-24.

88. Empowering Patients First Act, H.R. 2300, sec. 101 (114th Cong., 1st Sess.).

89. Ryan, *supra* note 6, at 12.

90. *See* Joseph Antos & James Capretta, *The House Republicans' Health Plan*, HEALTH AFFAIRS BLOG (June 22, 2016), http://healthaffairs.org/blog/2016/06/22/the-house-republicans-health-plan [http://perma.cc/C62E-PC3L].

91. Press Release, Centers for Medicare & Medicaid Services, CMS Approves Michigan Plan To Abate Lead Hazards From Flint And Other Impacted Areas In The State With Federal Support (Nov. 14, 2016), http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-11-14-3.html [http://perma.cc/AKS9-TNTN].

92. Andrew J. Goodman-Bacon & Sayeh S. Nikpay, *Per Capita Caps in Medicaid—Lessons from the Past*, NEW ENG. J. MED. (2017) (arguing that historical experience suggests that "Ryan's proposal would result in restrictions in coverage and benefits rather than state innovations to reduce program costs").

tercyclical trap: federal outlays would then increase as more people lost their jobs and became dependent on government assistance. But because the data necessary to calculate funding levels may lag the economy by several years, a state could find itself in a financial pinch just as a recession takes hold.[93] Nor would a per capita grant account for unanticipated cost spikes associated with the release of costly new therapies (like the new Hepatitis C drugs) or epidemics (like the Zika outbreak). Of greater concern, the size of per capita grants would have to increase with medical inflation.[94] Yet Republican proposals anticipate achieving large cost reductions through Medicaid reform—suggesting that the goal is not to provide sufficient funds to cover those who are currently eligible, but instead to force states to shrink their programs through blunt eligibility restrictions and benefit cuts.[95]

CONCLUSION

The first health reform bill introduced in Congress after the 2016 election takes federalism seriously. Supported by a coterie of relatively moderate Republican senators, the Patient Freedom Act of 2017 retains the ACA's taxes and funding streams while giving states a new set of choices about how best to implement reform.[96] States can reject the ACA outright, albeit at the cost of federal funding.[97] They can adopt an alternative that channels federal money into health savings accounts.[98] Or they can stick with the ACA, individual mandate and all.[99] In other words, the federal government will pay for reform and the states have a menu of implementation options.[100]

For now, the bill's prospects are dim. It lacks support from the Republican leadership and Democrats are unlikely to support efforts to pare back the ACA. But it offers a model that both parties would do well to examine closely. By giving states more room to chart their own path, the bill embraces the diversity

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93. *See* Super, *supra* note 66, at 681-82.
94. *See* Edwin Park, *Like a Block Grant, Medicaid Per Capita Cap Would Shift Costs to States and Place Beneficiaries at Risk*, CTR. BUDGET & POL'Y PRIORITIES (June 16, 2016), http://www.cbpp.org/sites/default/files/atoms/files/6-16-16health-commentary.pdf [http://perma.cc/339U-KAVU].
95. See Super, *supra* note 66, at 710-11.
96. Patient Freedom Act of 2017, S. 191, 115th Cong. (2017).
97. *Id.* at 102(a)(3).
98. *Id.* at 102(a)(2).
99. *Id.* at 102(a)(1).
100. The bill also retains the ACA's waiver provision, potentially enabling even more state experimentation than is apparent on the face of the bill. *Id.* at 101(b)(5).

that federalism celebrates. And it does so without cutting states off from the federal financial support that makes health reform possible. The end result will not be pretty: some states will make bad choices about how to reform their health-care systems (although we may disagree about which states those are). But a law along these lines might enable partisans on both sides to move past the rancorous debate over the ACA.

At a minimum, both Republicans and Democrats should remain attentive to the justifications for vesting the federal government with power over health reform. Neither screeds about federal takeovers nor invectives about the heartlessness of the ACA's opponents do justice to the complex interplay between state and federal authority. The states can't act without the federal government: its financial support is the lifeblood of health reform. At the same time, the federal government has little cause to deprive states of the power to decide on the approach to reform that they think best. In a country marked by deep divisions, there is much to be said for an Obamacare replacement that treads as little on state authority as possible.

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