ARTICLES

Affordable Care Act Entrenchment

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The Affordable Care Act (ACA) is the most challenged—and the most resilient—statute in modern American history. Through and despite hundreds of court challenges, scores of congressional repeal efforts, unexpected state resistance, gutting by the Supreme Court, unprecedented administrative strangulation, and criticism from the beginning that the statute did not go far enough to embrace the principle of universal healthcare, the ACA has changed the way many Americans and the political arena think about healthcare and the entitlement to it.

Over its ten-year lifespan, the ACA went from being the rallying cry of the GOP in 2010, to the center of the Democratic platform in 2018, catapulting universal healthcare to the top of the 2020 Democratic presidential primary agenda. It began as a statute criticized for its practical compromises and its incrementalism—including leaving most insurance in the private market and retaining state control over large swaths of health policy—but those very compromises have, surprisingly, proved key to the ACA's resilience. They have also been instrumental in the ACA's entrenchment of not only its own reforms but also a broader, emerging principle of a universal right to healthcare. The idea of healthcare for all Americans administered through the federal government was long viewed as political suicide, including as recently as the 2016 presidential election. In an astonishingly fast turnaround, that idea has now been considered and debated by every Democratic presidential hopeful.

The ACA's principles have been codified outside of federal law and into state law, voted on in ballot initiatives, and advocated for on late-night TV. The Supreme Court has treated the ACA differently from other laws. Core features of the ACA—a law that Republicans have sought to repeal scores of times—are now mainstream positions in the Republican Party.

This Article offers a comprehensive account of the ACA's structure, the challenges it survived, and how a law that itself evinces a philosophical ambivalence about the right to government-provided healthcare has

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nevertheless made that right politically and practically possible for the first time in American history. We examine not only court cases and the political tides but also the statute's governance, implementation, and financing structures to tell a story of entrenchment through multiple modalities—architectural, legal, democratic, political, financial, and expressive—and normative transformation.

Legislation scholars will see in this story themes that echo theoretical concepts of special statutes—statutes whose norms transform the legal landscape beyond the statute itself and change the way we think about fundamental rights. Despite our doubts about the practical payoff of those theories, the concept is a helpful jumping-off point for a more detailed exploration of how the particulars of statutory design can facilitate entrenchment and of the various forms entrenchment can take.

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INTRODUCTION

The Affordable Care Act (ACA)[1] has been the most challenged statute in modern American history. It also has been the most resilient. Despite hundreds of court challenges, scores of congressional repeal efforts, unexpected state resistance, unprecedented administrative strangulation, and criticism from the beginning that the statute did not go far enough toward the principle of universal healthcare, the ACA not only has endured, but it has changed the way many Americans and the political arena think about healthcare and the entitlement to it.

The ACA has faced attacks at every level of government. It went to the Supreme Court five times in its first nine years of existence[2] with more cases on the horizon.[3] It survived, but not before the Court gutted its Medicaid expansion[4]—an action that unwittingly forced states to bargain and engage with the ACA and so actually contributed to the ACA's entrenchment. The state-level political debates that ensued over Medicaid also came to be associated with the ACA and furthered the statute's normative transformation: a statute initially thought to be philosophically ambiguous about healthcare for all has now become synonymous with the broader universal-coverage principle that Medicaid represents.

Congress has tried to repeal the ACA more than seventy times,[5] coming very close during the first year of the Trump Administration but ultimately failing to

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 26 and 42 U.S.C.).

2. *See* Zubik v. Burwell, 136 S. Ct. 1557 (2016) (per curiam); King v. Burwell, 135 S. Ct. 2480 (2015); Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014); Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 567 U.S. 519 (2012); Moda Health Plan, Inc. v. United States, 892 F.3d 1311, 1320, 1324 (Fed. Cir. 2018), *cert. granted*, 139 S. Ct. 2743 (June 24, 2019) (mem.), *and argued*, No. 18-1028 (Dec. 10, 2019).

3. An important case about payments to ACA insurers, *Moda Health Plan, Inc.*, 892 F.3d at 1320, 1324, was heard by the Court in December 2019, consolidated with two other ACA cases. At the time of this Article, the Supreme Court had agreed to hear yet two more ACA cases. *See* Trump v. Pennsylvania, No. 19-454, 2020 WL 254168 (U.S. Jan. 17, 2020) (mem.) (granting certiorari to review implementation of the ACA contraception mandate); Texas v. California, No. 19-1019, 2020 WL 981805 (U.S. Mar. 2, 2020) (mem.) (granting certiorari to review lower court opinion holding individual mandate unconstitutional and entire ACA invalid).

4. *See NFIB*, 567 U.S. at 575–88 (holding that the threat to withdraw Medicaid funding from states that did not adopt the expansion was unduly coercive, rendering the expansion optional in practice).

5. *See* Chris Riotta, *GOP Aims to Kill Obamacare Yet Again After Failing 70 Times*, NEWSWEEK (July 29, 2017, 6:53 PM), https://www.newsweek.com/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832 [https://perma.cc/3VNH-GYM8]; Andy Slavitt, *Republicans Hoped Voters Would Forget They Tried to Kill Obamacare. They Bet Wrong.*, USA TODAY (Sept. 21, 2018, 3:15 AM), https://www.usatoday.com/story/opinion/2018/09/21/republicans-pre-existing-conditions-obamacare-repeal-voters-remember-column/1366662002/ [https://perma.cc/KJG3-QNZS].

"repeal and replace"[6] it, except for eliminating the penalty for the individual-insurance mandate that was once thought essential to the law's stability.[7] Those constant political attacks destabilized the law at first but ultimately helped the ACA withstand attack, focusing ordinary people on what they would lose with repeal and making the right to healthcare the subject of continued public deliberation and engagement.

Features of the law that were initially viewed as pathologies have turned out to be powerful assets. When the majority of states resisted implementation of the ACA's insurance reforms, many proponents of the law argued that Congress's decision to vest the ACA's implementation in a federalist structure was a huge mistake. But, in the end, more than half of the states implemented the law themselves and many more, including red states, secretly cooperated with the Obama Administration to do so.[8] These efforts, because they required state legislative and administrative action, wove the ACA into legal systems completely outside of federal control, including into the fabric of state laws, regulations, and bureaucracies. Those actions, in turn, have protected the ACA against repeated attempts at sabotage by a new presidential administration hostile to the law. In at least eighteen states, some ACA reforms are now codified in state law itself, insulating them even against any federal repeal of the ACA.[9]

Medicaid expansion, which also initially faced broad resistance, has now been adopted by thirty-seven states (including the District of Columbia),[10] with four recent additions thanks to successful ballot initiatives in a 2017 special election

6. MJ Lee et al., *GOP Obamacare Repeal Bill Fails in Dramatic Late-Night Vote*, CNN (July 28, 2017, 8:15 AM), https://www.cnn.com/2017/07/27/politics/health-care-debate-thursday/index.html [https://perma.cc/L7PV-96F2].

7. *See* Tax Cuts and Jobs Act, Pub. L. No. 115–97, § 11081, 131 Stat. 2054, 2092 (2017) (codified as amended at 26 U.S.C. § 5000A (2017)), *invalidated by* Texas v. United States, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom.* Texas v. California, No. 19-1019, 2020 WL 981805 (U.S. Mar. 2, 2020) (mem.). In addition, the budget deal for 2020, agreed to at the end of 2019, includes a bipartisan repeal of three ACA taxes unpopular with both parties and separate from the general repeal-and-replace debate: the Cadillac tax on the most expensive employer plans, the medical device tax, and the health insurance tax (HIT). *See* Further Consolidated Appropriations Act, 2020, H.R. 1865, 116th Cong. §§ 501, 502, 503 (2019) ("[r]epeal of medical device excise tax," "[r]epeal of annual fee on health insurance providers," and "[r]epeal of excise tax on high cost employer-sponsored health coverage").

8. *See* Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1767–72 (2018) (detailing state engagement with the ACA across all exchange types); *State Health Insurance Marketplace Types, 2020*, KAISER FAMILY FOUND., [https://perma.cc/DJ5K-YWCX] (last visited Dec. 20, 2019) (showing that more than half the states have a federally facilitated state health insurance marketplace).

9. *See* Sabrina Corlette et al., *Lawsuit Threatens Affordable Care Act Preexisting Condition Protections but Impact Will Depend on Where You Live*, COMMONWEALTH FUND (Aug. 29, 2018), https://www.commonwealthfund.org/blog/2018/lawsuit-ACA-preexisting-condition-protections-where-you-live [https://perma.cc/DQS4-7BC2].

10. *Status of State Action on the Medicaid Expansion Decision*, KAISER FAMILY FOUND., [https://perma.cc/75TQ-2VNG] (last visited Dec. 20, 2019).

and in the 2018 midterm elections.[11] Three of those ballot initiatives took place in red states, an act of direct democracy that has been called a "Medicaid Wave."[12]

The ACA has also transformed healthcare politics. "Obamacare," as opponents call it, went from being the rallying cry of the GOP in the 2010 midterm elections to the center of the Democratic platform in the 2018 midterms, a message that has been credited with returning the House of Representatives to the Democrats.[13] Medicaid, which has long been pilloried by the right as a "broken" program that fostered dependency[14] (then-Governor Rick Perry memorably compared expanding Medicaid to "adding a thousand people to the Titanic"[15]), was the most important reason that repeal and replace failed in 2017.[16]

Finally, the idea of universal healthcare—healthcare for all Americans administered through the federal government—was long viewed as political suicide. Many saw it as "socialized medicine" as recently as the 2016 presidential primaries, when Senator Bernie Sanders promoted it.[17] By the 2018 elections, large

11. *See* Sarah Kliff, *Idaho, Nebraska, and Utah Vote to Expand Medicaid*, VOX (Nov. 7, 2018, 6:48 AM), https://www.vox.com/2018/11/7/18055848/medicaid-expansion-idaho-nebraska-utah [https://perma.cc/6VN6-XH64] (noting that Idaho, Nebraska, and Utah voted to expand Medicaid in 2017, and that Maine was the first state to do so by ballot initiative in 2017).

12. David K. Jones, *The Medicaid Wave*, HEALTH AFF. BLOG (Nov. 8, 2018), https://www.healthaffairs.org/do/10.1377/hblog20181108.484046/full/?utm_source=Newsletter&utm_medium=email&utm_content=Introducing+Leading+To+Health-A+Medical+School+for+the+Community%3B+Health+Insurance+Television+Advertising%3B+The+Medicaid+Wave&utm_campaign=HAT [https://perma.cc/3JF3-CUSP].

13. *See, e.g.*, Robert Pear, *Democrats Won a Mandate on Health Care. How Will They Use It?*, N.Y. TIMES (Nov. 10, 2018), https://www.nytimes.com/2018/11/10/us/politics/health-care-democrats-congress.html.

14. Sara Rosenbaum, *The (Almost) Great Unraveling*, 43 J. HEALTH POL., POL'Y & L. 579, 586–87 (2018); Benjamin D. Sommers & Arnold M. Epstein, *U.S. Governors and the Medicaid Expansion—No Quick Resolution in Sight*, 368 NEW ENG. J. MED. 496, 498 (2013); *see also* Ian Millhiser, *Trump's Health Secretary Claims Medicaid Takes Away People's Health Care*, THINKPROGESS (Mar. 7, 2017, 7:24 PM), https://thinkprogress.org/trumps-health-secretary-claims-medicaid-takes-away-people-s-health-care-ffa7f0684822/ [https://perma.cc/WG97-H6GF] (quoting then-Secretary of Health and Human Services Tom Price as saying, "Medicaid is a program that by and large has decreased the ability for folks to gain access to care"); Avik Roy, *Romneycare Improved Health Outcomes, Thanks to Private-Sector Coverage*, FORBES (May 7, 2014, 2:52 PM), https://www.forbes.com/sites/theapothecary/2014/05/07/romneycare-improved-health-outcomes-thanks-to-private-sector-coverage/#232eb23c1de5 [https://perma.cc/9923-5XUZ] ("[T]he left has systematically ignored the mountains of clinical evidence showing that the Medicaid program doesn't actually make people healthier.").

15. Kathryn Smith, *Perry: Medicaid Is Like the Titanic*, POLITICO (July 9, 2012, 1:04 PM), https://www.politico.com/story/2012/07/perry-medicaid-is-like-adding-people-to-titanic-078239 [https://perma.cc/54JR-6DVN].

16. *See, e.g.*, Mark Schmitt, *Medicaid Saved the Affordable Care Act. Liberals Should Take Notice.*, VOX (Aug. 2, 2017, 11:20 AM), https://www.vox.com/the-big-idea/2017/8/2/16083310/medicaid-targeted-aca-univeral-programs-safety-net [https://perma.cc/LYP2-KGWJ].

17. This argument dates back a long way. The American Medical Association helped defeat Harry Truman's efforts to create a national health insurance plan by assailing it as "socialized medicine." *See* Robert D. Schremmer & Jane F. Knapp, *Harry Truman and Health Care Reform: The Debate Started Here*, 127 PEDIATRICS 399, 400–01 (2011). In the early 1960s, Ronald Reagan used the term to oppose the expansion of Medicare as "an opening wedge for a government takeover of 'every area of freedom as we have known in this country.'" *See* RICK PERLSTEIN, THE INVISIBLE BRIDGE: THE FALL OF NIXON AND THE RISE OF REAGAN 401–05 (2014). During the battle over Bill Clinton's failed health reform push

swaths of Democrats were beating the single-payer—or "Medicare for All"—drum, with many remarking on the "dramatic change" on this issue from 2016[18] and the "astonishing speed" with which this turnaround occurred.[19] During its first week of Democratic control in 2019, the House of Representatives agreed to hold the first-ever hearings on Medicare for All.[20] The Party position has now shifted so much that a "public option"—a government-run public insurance plan that would compete with market plans—has gone from an idea that was too progressive to make it into the ACA in 2008 to one of the more modest healthcare proposals on the table today.[21] In 2008, no leading Democratic candidate backed a version of Medicare for All;[22] going into 2020, many expressed support for the concept.[23]

But it is more than just the change of view that the ACA wrought. It is the resilience. In addition to the constant onslaught of courtroom challenges—the first court case was filed the same day the ACA was enacted, and new major cases still pend today—the ACA has been financially starved by Congress, rebelled against by the majority of states, and sabotaged by the President. Beginning in 2014, the Republican-controlled Congress cut off several essential funding streams on which the statute depended.[24] Red states that had initially demanded control of ACA markets decided not to implement the law in public displays of resistance.[25] President Trump vowed to "dismantle[]" the law and has repeatedly directed his agencies to take measures to undermine it, including by splintering the insurance

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in the 1990s, Newt Gingrich decried the plan as "socialism now or later." CRAIG SHIRLEY, CITIZEN NEWT: THE MAKING OF A REAGAN CONSERVATIVE 342 (2017). It is therefore unsurprising that, in the lead-up to the 2016 election, high-level Democrats warned against even talking about single-payer healthcare. *See, e.g.*, Stephanie Condon, *Hillary Clinton: Single-Payer Health Care Will "Never, Ever" Happen*, CBS NEWS (Jan. 29, 2016, 6:56 PM), https://www.cbsnews.com/news/hillary-clinton-single-payer-health-care-will-never-ever-happen/ [https://perma.cc/MU3L-8TQZ]; Susan Ferrechio, *Pelosi Throws Cold Water on Sanders' Single-Payer Plan*, WASH. EXAMINER (Jan. 28, 2016, 10:52 AM), http://www.washingtonexaminer.com/pelosi-throws-cold-water-on-sanders-single-payer-plan/article/2581598 [https://perma.cc/YK3N-JT6K].

18. Peter Sullivan, *Democrats March Toward Single-Payer Health Care*, HILL (Feb. 25, 2018, 8:00 AM), https://thehill.com/policy/healthcare/375376-democrats-march-toward-single-payer-health-care [https://perma.cc/U4YE-CVDU].

19. Dylan Matthews, *The Stunning Democratic Shift on Single-Payer*, VOX (Sept. 7, 2017, 1:10 PM), https://www.vox.com/policy-and-politics/2017/9/7/16267256/single-payer-democrats-2020 [https://perma.cc/X7GD-BUK2].

20. David Weigel, *House Democrats Plan to Hold Hearings on Medicare for All*, WASH. POST (Jan. 3, 2019, 6:06 PM), https://www.washingtonpost.com/powerpost/democrats-plan-to-hold-hearings-on-medicare-for-all/2019/01/03/7051eccc-0f6c-11e9-84fc-d58c33d6c8c7_story.html; *cf.* Robert Draper, *How "Medicare for All" Went Mainstream*, N.Y. TIMES MAG. (Nov. 1, 2019), https://www.nytimes.com/2019/08/27/magazine/medicare-for-all-democrats.html (quoting Bernie Sanders: "In fact, until this year there's never even been a goddamned hearing on single payer!").

21. *See* Kevin Uhrmacher et al., *Where 2020 Democrats Stand on Health Care*, WASH. POST (Dec. 19, 2019), https://www.washingtonpost.com/graphics/politics/policy-2020/medicare-for-all/?noredirect=on.

22. Matthews, *supra* note 19.

23. *See* Uhrmacher et al., *supra* note 21.

24. *See, e.g.*, Robert Pear, *Marco Rubio Quietly Undermines Affordable Care Act*, N.Y. TIMES (Dec. 9, 2015), https://www.nytimes.com/2015/12/10/us/politics/marco-rubio-obamacare-affordable-care-act.html.

25. *See* Gluck & Huberfeld, *supra* note 8, at 1728–31.

markets, cutting outreach funds, and stifling enrollment.[26] The ACA adapted and endured.

How much of the ACA's strength and transformative quality is due to its legal and governance structures? How much was just inevitable—an idea whose time had come after years of incremental reform? Heretofore-assumed weaknesses in the law, including its incremental approach, its reliance on the private market, its dependence on the states, and even its partial evisceration by the Supreme Court, have all worked to entrench the law deeper and to evolve it more dramatically than the ACA's drafters likely imagined.

Our goals here are both to document how the statute accomplished this and to analyze the various modes and institutions of normative and legal entrenchment. We see legal, political, democratic, structural, expressive, and financial entrenchment at work. Some entrenching features of the law were intentional and expected—for instance, doling out popular benefits that are hard to take away is an obvious protective strategy against repeal. But other features that have proved critical to the law's resilience are not obvious and were not foreseen, including the ACA's private financing structure, its federalist regulatory scheme, and even the optional nature of its Medicaid expansion (which the Supreme Court, not the ACA's enacting Congress, created). We discuss how these various aspects of statutory design and policy implementation came together to turn the ACA into a law that once stood for an uneasy policy compromise but now stands for the right to universal healthcare.

To be clear at the outset, the ACA itself—in the sense of the words on the page—does not work a wholesale transformation of the healthcare system. What makes the story particularly interesting is that the statute's transformative success is not the product of radical statutory design but, rather, of a practical incrementalism that many criticized when the statute was drafted. At the time of its enactment, not only was the ACA unpopular, but it was also marketed as a "reform" that built on the system we already had. "If you like your healthcare plan, you can keep [it]" was the common refrain, as was the insistence that the healthcare system would continue to largely depend, even post-ACA, on the private market, state insurance control, and the employer-sponsored private insurance system.[27] But in 2020, even though the ACA itself does not achieve universal health coverage, it has made that goal not only seem feasible and politically possible for the first time in modern American history but also, to many, now the marker of a just healthcare system.

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26. *See* Nicholas Bagley & Abbe R. Gluck, *Trump's Sabotage of Obamacare Is Illegal*, N.Y. TIMES (Aug. 14, 2018), https://www.nytimes.com/2018/08/14/opinion/trump-obamacare-illegal.html; *see also* Complaint For Declaratory and Injunctive Relief ¶¶ 1–5, City of Columbus v. Trump, No. 1:18-cv-02364-DKC (D. Md. Aug. 2, 2018), 2018 WL 3655066 [hereinafter Complaint, City of Columbus v. Trump] (detailing acts of sabotage in litigating over the President's actions).

27. *Obama: "If You Like Your Health Care Plan, You'll Be Able to Keep Your Health Care Plan"*, POLITIFACT, https://www.politifact.com/obama-like-health-care-keep/ [https://perma.cc/9K6J-HUX5] (last visited Dec. 20, 2019).

We begin in Part I with the structure of the statute, what it changed, what it did not change, and how its incremental, Solomonic design became a vehicle for greater transformation. Part II offers a comprehensive account of the unprecedented array of challenges the ACA has survived thus far in the courts, the Congress, the election cycles, the states, and across presidential administrations. Part III details the strategy and process of entrenchment and normative transformation, and also identifies different modalities of entrenchment ranging from legal, to political, to expressive. Along the way, we consider legal theories of statutes that are special—particularly resilient and particularly influential—and how those theories apply to the ACA.

I. THE ACA: TRANSFORMATIVE CHANGE THROUGH INCREMENTAL REFORM

One of the most intriguing features of the ACA from a structural perspective is that it is an inherently incremental reform. The ACA as written seems philosophically ambivalent as to the right to nationally provided universal healthcare; it aims to increase insurance access but also retains the private-market and state-led insurance models. Implementation, however, has worked a system-wide transformation that now points toward universal care.

A. THE FRAGMENTATION THE ACA TRIED TO ADDRESS

The healthcare system that Congress confronted when drafting the ACA was, as countless scholars had pointed out, incredibly fragmented[28]: there were different insurance systems—each with different structures—for different populations. The elderly and disabled received insurance via Medicare, an all-federal program.[29] Low-income individuals, particularly pregnant women, children, and those in nursing homes, were insured via Medicaid, a state–federal partnership that varied from state to state in terms of generosity and the categories of populations covered.[30] Veterans received insurance via the Veterans Health Administration (VHA), which offers its own facilities and providers.[31] More than half of Americans received health insurance through work, putting them in the private system, although not without a large, unseen tax subsidy on those policies that the federal government paid employers.[32] And the remaining populations were either

28. For a discussion of this fragmentation, see generally THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS (Einer R. Elhauge ed., 2010).

29. *See* Gluck & Huberfeld, *supra* note 8, at 1711–13.

30. *See id.*

31. *See About VHA*, U.S. DEP'T OF VETERANS AFF., https://www.va.gov/health/aboutVHA.asp [https://perma.cc/9JRN-TUG9] (last visited Dec. 20, 2019) (describing the kinds of medical providers and facilities the VHA runs).

32. *See* EDWARD R. BERCHICK ET AL., U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018, at 3 tbl.1 (2019), https://www.census.gov/content/dam/Census/library/publications/2019/demo/p60-267.pdf [https://perma.cc/LD2Y-8DDL] (finding that 55.1% of Americans receive insurance through an employment-based plan); MATTHEW RAE ET AL., KAISER FAMILY FOUND., TAX SUBSIDIES FOR PRIVATE HEALTH INSURANCE 1 (2014), https://www.kff.org/private-insurance/issue-brief/tax-subsidies-for-private-health-insurance/ [https://perma.cc/5BHQ-BR5Q] ("The largest tax subsidy for private health insurance—the exclusion from income and payroll

uninsured—around 18% to 20% of the nonelderly population[33]—or dangerously underinsured, which included another 16% of nonelderly adults[34] who depended on hospital emergency rooms and charity for care.[35]

A different form of fragmentation arose from the way in which patients paid for healthcare. Pre-ACA, most healthcare providers relied on a "fee-for-service" model of care where individual healthcare services, often provided by different providers, were billed separately. A classic example is a caesarian delivery: the new mother pays her obstetrician, the hospital, and the anesthesiologist separately instead of paying for a bundled episode of care. As David Hyman characterized the problem at the time: when people fly, they "[do] not have to find, negotiate, contract with, and separately pay the airline, pilot, co-pilot, flight attendant, baggage handler, gate agent, and so on."[36]

These types of healthcare fragmentation have been deeply embedded in American governance and culture since the time of the Revolution and have endured. Legislative path dependence is one culprit.[37] Another is the persisting American normative ambivalence about the role of government in healthcare in the first place.[38]

1. Path Dependence

Congress is a notoriously incrementalist policymaker across many fields of law. Charles Lindblom famously described this kind of decisionmaking as "continually building out from the current situation, step-by-step and by small degrees."[39] Healthcare is no exception. As one of us has detailed elsewhere, the

taxes of employer and employee contributions for employer-sponsored insurance (ESI)—was estimated to cost approximately $250 billion in lost federal tax revenue in 2013."); Nicole Huberfeld & Jessica L. Roberts, *Health Care and the Myth of Self-Reliance*, 57 B.C. L. REV. 1, 16–17 (2016) (detailing the "hidden" subsidy of tax benefits for employer-sponsored health insurance).

33. KAISER FAMILY FOUND., KEY FACTS ABOUT THE UNINSURED POPULATION 2 & fig.1 (2017), http://files.kff.org/attachment/Fact-Sheet-Key-Facts-about-the-Uninsured-Population [https://perma.cc/SB9T-7KEA] (showing that the percentage of the nonelderly and uninsured population was around 16% from 1998 to 2007, then peaked at around 18% in 2010); Cathy Schoen et al., *Affordable Care Act Reforms Could Reduce The Number of Underinsured US Adults by 70 Percent*, 30 HEALTH AFF. 1762, 1765 ex.1 (2011) (finding that 20% of nonelderly adults were uninsured when surveyed in 2010).

34. *See* Schoen et al., *supra* note 33, at 1765 ex.1.

35. *See* Craig Garthwaite et al., *Who Bears the Cost of the Uninsured? Nonprofit Hospitals*, KELLOGG INSIGHT (June 22, 2015), https://insight.kellogg.northwestern.edu/article/who-bears-the-cost-of-the-uninsured-nonprofit-hospitals [https://perma.cc/W65N-AEPS].

36. David A. Hyman, *Health Care Fragmentation: We Get What We Pay For*, *in* THE FRAGMENTATION OF U.S. HEALTH CARE: CAUSES AND SOLUTIONS, *supra* note 28, at 21, 21–22.

37. *See* Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble* 283–87, *in* THE HEALTH CARE CASE (Persily et al. eds., 2013); Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1759–65 (2013) (detailing pre-ACA fragmentation and Congress's tendency toward path dependence, and how both resulted in the ACA's federalist structure and incremental approach).

38. *See infra* Section I.A.2.

39. Charles E. Lindblom, *The Science of "Muddling Through"*, 19 PUB. ADMIN. REV. 79, 81 (1959); *see also* Charles E. Lindblom, *Still Muddling, Not Yet Through*, 39 PUB. ADMIN. REV. 517, 517, 520–22 (1979) (defining political incrementalism as "political change by small steps" and describing the incrementalist nature of the U.S. political system).

pre-ACA state–federal patchwork of health insurance and regulation was built on slow accretion and adherence to tradition.[40] The VHA was built piece-by-piece over time on the backs of existing programs that span back to the Revolutionary War.[41] The employer-sponsored health insurance system emerged almost by accident from a federal tax incentive designed to give employers new ways to attract workers during the wage freezes of World War II.[42] It stuck—and grew—and is now worth $200 billion per year and helps insure more than half of all Americans.[43] Local governments, and then states, were historically responsible for their poor. For years, Congress intervened with small steps to assist states,[44] culminating with Medicaid, which built directly on that history with its state-led structure.[45]

Every now and then a new policy model breaks through. Medicare is a key example: a once-in-a-generation expansion of federal services to a new population. However, even there, Congress had previously passed the Old Age Assistance program and coupled Medicare in a legislative bundle with the more path-dependent Medicaid program.[46] This step-by-step process of discrete federal interventions in state and private healthcare markets resulted in the patchwork of disjointed programs that characterized the pre-ACA regulatory landscape.

2. Philosophical Ambivalence

Next, the normative point. The regulatory patchwork that emerged from this fragmented policymaking approach relates to the philosophical ambivalence problem, which is more fundamental. As Deborah Stone and Wendy Mariner documented years ago, the United States remains trapped between two models of health insurance: the "personal responsibility" model, under which everyone receives only the healthcare they can pay for, and the "social solidarity" model, which places responsibility on the community for ensuring a minimal right to healthcare for all.[47] The mixed-model insurance system that predated the ACA—a combination of government programs and private insurance—reflects that tension. So did the payment system: The fee-for-service payment model reflects a more capitalistic, every-one-for-himself-or-herself perspective than would a payment model that focuses on holistic, coordinated care—a model that, before the

40. *See* Gluck & Huberfeld, *supra* note 8, at 1703–24.

41. *See* BARBARA MCCLURE, CONG. RESEARCH SERV., NO. 83-99 EPW, MEDICAL CARE PROGRAMS OF THE VETERANS ADMINISTRATION 1–4 (1983) (tracing the history of healthcare programs for veterans); TIMOTHY STOLTZFUS JOST, DISENTITLEMENT?: THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE 77 (2003) (tracing various early federal payments for health care, including those for veterans and merchant seamen).

42. Gluck & Huberfeld, *supra* note 8, at 1708–09.

43. *Id*.

44. *Id*. at 1706–11.

45. *Id*. at 1711–13.

46. SOC. SEC. ADMIN., HISTORICAL DEVELOPMENT 3–5 (n.d.), https://www.ssa.gov/history/pdf/histdev.pdf [https://perma.cc/8S4R-JAZT] (tracing the history of Medicare).

47. *See* Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 CONN. INS. L.J. 199, 201–08 (2008). Deborah A. Stone's classic article, *The Struggle for the Soul of Health Insurance*, 18 J. HEALTH POLITICS, POL'Y & L. 287 (1993), called this the struggle between "the solidarity principle or the logic of actual fairness."

ACA, existed primarily in various private experiments, such as the well-known coordinated-care model of the Mayo Clinic.[48]

Another substantiation of these tensions pre-ACA was the country's excessive reliance on indirect, unseen forms of government help—the employer tax deduction being key among them. The negative connotation of government-provided healthcare that surged in the 1960s with the highly effective campaign against "socialized medicine"[49] resulted in a system that tended to *hide* what were, in fact, substantial moves toward solidarity, including government support for healthcare. As a result, many who laud the private health insurance system rarely admit (or even realize) its dependence on a massive, $200 billion government tax subsidy.

These political concerns and the ambivalence that underlies them animated the position of the Democratic Party for the past half century, including through the ACA's enactment. President Clinton's healthcare reform effort failed in 1994 amidst charges that it would work a government takeover of the healthcare system.[50] During the debates over the ACA, members of the Obama Administration insisted that the Administration was not interested in replacing private insurance with government insurance.[51] President Obama himself intoned that "when you hear the naysayers claim that I'm trying to bring about government-run healthcare, know this—they are not telling the truth."[52] Instead he looked to the example of Massachusetts, praising the success that had been achieved there by "connect[ing] the progressive vision of healthcare for all with some ideas about markets and competition that had long been championed by conservatives."[53] As recently as

48. *See, e.g.*, Atul Gawande, *The Cost Conundrum: What a Texas Town Can Teach Us About Health Care*, NEW YORKER (May 25, 2009), https://www.newyorker.com/magazine/2009/06/01/the-cost-conundrum (providing a widely cited description of the Mayo Model); *see also* Robert Pear, *Health Care Spending Disparities Stir a Fight*, N.Y. TIMES (June 8, 2009), https://www.nytimes.com/2009/06/09/us/politics/09health.html (noting the effect of Gawande's article on President Obama, who made it "required reading in the White House").

49. David Leonhardt, *Obamacare and Reagan*, N.Y. TIMES: THE UPSHOT (June 26, 2015), https://www.nytimes.com/2015/06/28/upshot/why-undoing-social-safety-net-expansions-is-so-hard.html; *see also* PERLSTEIN, *supra* note 17, at 401–05 (discussing Ronald Reagan's role in the campaign against what he considered to be "socialized medicine" and his criticisms of Medicare in the early 1960s).

50. *See* Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, 14 HEALTH AFF. 66, 69–71 (1995); *see also* Jonathan Oberlander, *Learning from Failure in Health Care Reform*, 357 NEW ENG. J. MED. 1677, 1679 (2007) ("[E]xpanding government authority over a health care system that accounts for more than $2 trillion and one sixth of the economy in a country that is ambivalent about public power is an inherently controversial exercise.").

51. *See Sebelius: Single-Payer Health Care Not in Plans*, NPR (June 16, 2009, 12:01 AM), https://www.npr.org/templates/story/story.php?storyId=105442888 [https://perma.cc/QGX7-9Q5V] (quoting Secretary Sebelius: "This is not a trick. This is not single-payer . . . . That's not what anyone is talking about—mostly because the president feels strongly, as I do, that dismantling private health coverage for the 180 million Americans that have it, discouraging more employers from coming into the marketplace, is really the bad, you know, is a bad direction to go.").

52. Ben Smith, *Obama Rejects Single Payer*, POLITICO: BEN SMITH BLOG (June 15, 2009, 1:05 PM), https://www.politico.com/blogs/ben-smith/2009/06/obama-rejects-single-payer-019106 [https://perma.cc/T47C-VLGR].

53. *Transcript: President Obama's Oct. 30 Remarks on the New Health-Care Law in Boston*, WASH. POST (Oct. 30, 2013), https://www.washingtonpost.com/politics/transcript-president-obamas-oct-30-remarks-on-the-new-health-care-law-in-boston/2013/10/30/3ef5beb2-419d-11e3-a624-41d661b0bb78_story.html.

the 2016 presidential election, the Democratic Party's nominee, Hillary Clinton, criticized a "single-payer" system—in which the government provides coverage for everyone—as a system that would leave "many people . . . worse off"[54] and a "theoretical debate" about something that "will never, ever come to pass."[55] At the time, House Minority Leader Nancy Pelosi said of single-payer: "There is no use having a conversation about something that is never going to happen."[56] The ACA's internal compromises are direct descendants of this environment.

B. WHAT THE ACA DID: HOW AN INCREMENTAL REFORM CAN BE TRANSFORMATIVE

A fascinating aspect of the transformations worked by the ACA is that the structure of the statute itself does not really change much of this fragmentation or normative ambivalence. The ACA did not wipe the slate clean, as many health policy experts might have wanted if political practicalities were no issue.[57] Instead, as President Obama repeatedly emphasized, the ACA was to build on the fragmented system that it found—keeping it in place, but essentially expanding coverage across most of the existing programs.[58] The strategy was driven by political necessity; it was the only way to get the statute passed. It also reflected the ambivalence within even the Democratic Party about the government's proper role in healthcare. President Obama was determined not to repeat the mistakes of President Clinton's failed, too-much, top-down-driven healthcare reform effort of 1993. President Obama moved quickly while he still had political capital and left the details to Congress.[59] And the details took a backseat to the broader goal:

54. Cary Gibson, *Clinton Gets It on Health Care*, U.S. NEWS & WORLD REP. (Feb. 12, 2016), https://www.usnews.com/opinion/blogs/opinion-blog/articles/2016-02-12/hillary-clinton-gets-it-on-health-care-bernie-sanders-doesnt [https://perma.cc/87KS-7VAU].

55. Condon, *supra* note 17 (internal quotation marks omitted).

56. Ferrechio, *supra* note 17 (internal quotation marks omitted).

57. *See* JOHN E. MCDONOUGH, INSIDE NATIONAL HEALTH REFORM 287 (2011) (noting that "[t]here was a better national health reform law to be written than the Affordable Care Act," but that it was the best reform that could have been achieved at the time).

58. *See, e.g.*, *Obama's Health Care Speech to Congress*, N.Y. TIMES (Sept. 9, 2009), https://www.nytimes.com/2009/09/10/us/politics/10obama.text.html (rejecting "radical shift[s]" because "it makes more sense to build on what works and fix what doesn't, rather than try to build an entirely new system from scratch"); *Remarks of President Barack Obama – State of the Union Address As Delivered*, WHITE HOUSE (Jan. 13, 2016), https://obamawhitehouse.archives.gov/the-press-office/2016/01/12/remarks-president-barack-obama-%E2%80%93-prepared-delivery-state-union-address [https://perma.cc/7J78-UCE7] (describing "what the Affordable Care Act is all about" as "filling the gaps in employer-based care").

59. *See* James A. Morone, *Presidents and Health Reform: From Franklin D. Roosevelt to Barack Obama*, 29 HEALTH AFF. 1096, 1097 (2010), (describing how Obama sought to avoid the delays that had contributed to the derailing of the Clinton plan); Anthony Wilson, *Why 'HillaryCare' Failed and 'ObamaCare' Succeeded*, AM. HEALTH LINE, http://www.americanhealthline.com/analysis-and-insight/features/why-hillarycare-failed-and-obamacare-succeeded [https://perma.cc/Z63M-HRLC] (last visited Dec. 20, 2019) (describing a lack of transparency in the development of the Clinton plan and the failure to coalesce Democratic congressional support as reasons for its failure); *see also* Yale Law Sch., *The Affordable Care Act at 10, Keynote Address: Rahm Emanuel and Ezekiel J. Emanuel* at 39:02–41:08, VIMEO (Oct. 14, 2019, 11:17 AM), https://vimeo.com/showcase/6372731/video/366269775 (describing Obama's plan to leave the drafting to Congress to avoid the mistakes of the Clinton effort).

getting baseline changes through the door, in whatever form, on the theory that such changes would allow for later and wider expansion.

The proponents of the ACA, including President Obama, publicly presented the statute as addressing three critical problems in healthcare: access, quality, and cost.[60] In reality, however, most policy experts agree that the ACA's primary focus is access—getting everyone insured so, in turn, everyone can access healthcare.[61]

1. Quality and Cost

Delivery-system reforms are scattered throughout the statute. Several sections provide financial incentives for medical practices to coordinate care and move from fee-for-service billing to value-based payment models, such as where a patient makes payments for entire episodes of care rather than making different payments for each individual service.[62] But the statute as a whole does not mandate delivery-system reform. With respect to cost, there are likewise reforms that are targeted at reducing healthcare costs and that appear to have had success, but the statute relies on getting people insured as the mechanism to lower healthcare costs for all.[63] A healthier population is a cheaper medical population, and a population with more people (especially more healthy people) in the insurance pool will have lower insurance rates and less uncompensated care.[64] Since the ACA was passed in 2010, health spending has, in fact, slowed, although the statute's exact role in this remains contested.[65]

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60. *See, e.g.*, *Obama's Health Care Speech to Congress*, *supra* note 58.

61. *See, e.g.*, PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 241 (rev. ed. 2013) ("The Affordable Care Act restructures health insurance so as to achieve for all Americans the aims it has been serving only for some—to provide access to health care and protection against the risk of being bankrupted by medical costs."); Jonathan Skinner & Amitabh Chandra, *The Past and Future of the Affordable Care Act*, 316 J. AM. MED. ASS'N 497, 497 (2016) (stating that "the primary goal of the ACA" is "to expand the number of people with health insurance").

62. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, 353–415 (2010) (codified in scattered sections of 42 U.S.C.) (providing for reforms of healthcare delivery systems); LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO KNOW 145–46 (3d ed. 2016); Jeremy P. Ziring et al., *Coverage Expansion and Delivery System Reform in the Safety Net: Two Sides of the Same Coin*, NEJM CATALYST (Oct. 18, 2017), https://catalyst.nejm.org/safety-net-coverage-expansion-system-reform/; Jason Furman & Matt Fiedler, *Continuing the Affordable Care Act's Progress on Delivery System Reform Is an Economic Imperative*, WHITE HOUSE BLOG (Mar. 24, 2015, 4:35 PM), https://obamawhitehouse.archives.gov/blog/2015/03/24/continuing-affordable-care-act-s-progress-delivery-system-reform-economic-imperative [https://perma.cc/4DFZ-HYW3]; *Innovation Models*, CTRS. FOR MEDICARE & MEDICAID SERVS., https://innovation.cms.gov/initiatives/#views=models [https://perma.cc/F9DL-ZQ7H] (last visited Dec. 20, 2019).

63. *See, e.g.*, TIMOTHY STOLTZFUS JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 3–10, 28–29 (2010), http://www.thalassemia.org/updates/pdf/HealthInsuranceExchanges.pdf [https://perma.cc/S5ZS-JX2R] (describing the ACA's ability to attract healthy people into the insurance pool as crucial to its ability to lower costs and function effectively).

64. *Id.*

65. *See* Janet Weiner et al., *Effects of the ACA on Health Care Cost Containment*, 21 U. PA. LDI ISSUE BRIEF, Feb. 2017, https://ldi.upenn.edu/brief/effects-aca-health-care-cost-containment [https://perma.cc/2SD7-F9SS] (summarizing the evidence on the ACA's effect on cost containment); *see also* STACEY MCMORROW &

2. Insurance

The key to the statute is insurance access. The ACA accomplishes its access goal largely by just expanding the various forms of insurance already in existence.

Uninsurance had reached a modern record high of more than 16% during the first year of the Obama Administration, a trend exacerbated by the Great Recession, and the uninsured were concentrated among people earning less than 250% of the federal poverty level (FPL).[66] Fewer employers offered health insurance as an employment benefit, and those that did had increased employee cost sharing over time.[67] Individual and small-group health insurance markets were inaccessible for many (especially the lower- and middle-income uninsured) because of high prices and exclusionary policies designed to exclude from coverage subscribers who were not "healthy."[68]

Medicaid had far less reach before the ACA than most people grasp. Although Medicaid had expanded since 1965 to include additional populations, it still offered an incomplete safety net, with many populations not covered in most states.[69] Many state Medicaid programs before the ACA covered only pregnant

JOHN HOLAHAN, THE WIDESPREAD SLOWDOWN IN HEALTH SPENDING GROWTH IMPLICATIONS FOR FUTURE SPENDING PROJECTIONS AND THE COST OF THE AFFORDABLE CARE ACT: AN UPDATE 10–11 (2016), https://www.urban.org/sites/default/files/publication/81636/2000824-The%20Widespread-Slowdown-in-Health-Spending-Growth-Implications-for-Future-Spending-Projections-and-the-Cost-of-the-Affordable-Care-Act-an-Update.pdf [https://perma.cc/B4K8-DPFE] (finding reduced healthcare costs attributable in part to the ACA). *But see* Bradley Herring & Erin Trish, *Explaining the Growth in US Health Care Spending Using State-Level Variation in Income, Insurance, and Provider Market Dynamics*, INQUIRY: J. HEALTH CARE ORG., PROVISION, & FIN., 2015, at 10 (finding that reductions in healthcare costs were unlikely to be associated with the ACA).

66. *See* CARMEN DENAVAS-WALT ET AL., U.S. CENSUS BUREAU, U.S. DEP'T OF COMMERCE, INCOME, POVERTY, AND HEALTH, INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 22–28, 26 tbl.9 (2010), https://www.census.gov/prod/2010pubs/p60-238.pdf [https://perma.cc/Q9AH-GUBL] (reporting an increase in the uninsurance rate from 2007 to 2009 and noting that the greatest percentage of uninsured individuals earned less than $25,000 at the time the ACA was enacted); Andrew Villegas & Phil Galewitz, *Uninsured Rate Soars, 50+ Million Americans Without Coverage*, KAISER HEALTH NEWS (Sept. 16, 2010), https://khn.org/news/census-uninsured-rate-soars/ [https://perma.cc/JN5U-2YZC] (describing the number of uninsured as at "an all time high"); *The 2009 HHS Poverty Guidelines: One Version of the [U.S.] Federal Poverty Measure*, ASPE (Dec. 1, 2009), https://aspe.hhs.gov/2009-hhs-poverty-guidelines [https://perma.cc/8428-YKHE] (setting the FPL in 2009 for one person at $10,830).

67. *See* STARR, *supra* note 61, at 79–80, 155–56.

68. *See* Tom Baker, *Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1589 (2011) (discussing the ACA provisions designed to address pricing practices that made nongroup insurance too costly for most who did not fit into other insurance mechanisms); *see generally* Jessica L. Roberts & Elizabeth Weeks Leonard, *What Is (and Isn't) Healthism?*, 50 GA. L. REV. 833, 837–44 (2016) (considering which types of health-based distinctions are unjustifiable discrimination, deemed "healthism"). Job loss was another factor. People lost jobs and, with them, their health insurance.

69. *See* DAVID G. SMITH & JUDITH D. MOORE, MEDICAID POLITICS AND POLICY: 1965–2007, at 8–10 (2008); Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 436–46 (2011) (describing a welfare-based approach to health care that encoded a philosophy of aiding only the "deserving poor"); Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1, 19–24 (2013) (detailing amendments to Medicaid that expanded eligibility, such as for pregnant women and children); *see also*

women, some parents with dependent children, seniors in long-term care, and low-income individuals with disabilities.[70] Single adult men were often completely left out of the healthcare safety net.[71] As of 2006, only about 45% of the nation's low-income uninsured were eligible for Medicaid.[72] Those excluded from insurance coverage would often seek care in emergency rooms—a poor and increasingly expensive substitute for systematic care.[73]

The ACA responded to those gaps by attempting to increase coverage in every category, but it did not profoundly change the underlying structure of any program. First, the ACA kept Medicaid in place but compelled states to expand Medicaid coverage to populations long excluded from categorical eligibility, namely nonelderly childless adults—including men—with incomes up to 138% of the FPL.[74]

Second, it facilitated and expanded individual access to insurance in the private market. The law supports the private market by creating new insurance markets (called "exchanges") that make options more transparent for consumers, guaranteeing that the insurance purchased meets a minimum standard of coverage, and administering newly created federal tax credits that subsidize the purchase of private health insurance for individuals earning below 400% of the FPL.[75] Notably, even with these new national changes, the ACA nonetheless leaves the underlying structure of the insurance markets where they were before—privatized and in state control.

Third, the ACA increased the onus on all employers (except certain small employers) to insure their employees or pay a penalty;[76] small employers can,

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Timothy Stoltzfus Jost, Wash. & Lee Univ. Sch. of Law, Medicaid's Original Sin, Remarks at the Yale Law School Conference on the Law of Medicare and Medicaid at 50, at 6–8 (Nov. 7, 2014) (transcript on file with authors) (discussing the link between state control of healthcare and continued limitations on serving all poor people).

70. *See* Huberfeld et. al., *supra* note 69, at 18–26.

71. *Id.*

72. *See* STAN DORN, AARP PUB. POLICY INST., MILLIONS OF LOW-INCOME AMERICANS CAN'T GET MEDICAID: WHAT CAN BE DONE? 5 & fig.1 (2008), https://assets.aarp.org/rgcenter/health/2008_13_medicaid.pdf [https://perma.cc/3UHF-SE7W].

73. *See* Gluck & Huberfeld, *supra* note 8, at 1791.

74. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271 (2010) (codified as amended at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012)) (creating a new Medicaid eligibility category). The Health Care and Education Reconciliation Act of 2010 immediately amended the ACA and created a 5% income disregard, raising eligibility for the new category to 138% of the FPL. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1029, 1036 (codified at 42 U.S.C. § 1396a(e)(14)(I) (2012)). The ACA funded the eligibility expansion completely from 2014 through 2016, after which the federal match decreased slightly so that 90% of the expansion population's cost will be paid by 2020. *See* 42 U.S.C. § 1396d(y)(1) (2012). Even at 90%, this "supermatch" is more generous than the matching rates that states have received historically, which are tied to per capita income and range from 50% to about 75%. *See* MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 17 ex.6 (2017), https://www.macpac.gov/wp-content/uploads/2015/12/MACStats-Medicaid-CHIP-Data-Book-December-2017.pdf [https://perma.cc/D8X2-RWR8].

75. *See* Patient Protection and Affordable Care Act, §§ 1301–12, 1401–12.

76. *See id.* § 1513, 124 Stat. at 253–56; *see also* 26 U.S.C. § 4980H (2012).

instead, offer insurance through a special insurance exchange.[77]

Fourth, the Act made Medicare's pharmaceutical-coverage provisions and preventive-care benefits much more generous, but the provisions left the rest of the program mostly untouched.[78]

Critically, the way in which the preexisting, varied structures of these programs fragment the population across very different insurance schemes was also left unchanged. Medicaid remains a state-led program. Medicare and the VHA remain entirely federal. The ACA does not repeal Medicare, Medicaid, VHA benefits, the private insurance system, or anything else; it just makes them all more generous. The ACA also leaves the majority of coverage in the private markets, both through the exchanges and through maintaining—indeed strengthening—the employer-sponsored insurance system. It does not work a massive shift toward government programs. And it retains the American tradition of state control over insurance by giving states the right of first refusal, permitting them to run their own exchanges rather than automatically nationalizing control over the insurance markets.[79] The statute's expansion, as important as it is, is fundamentally incremental and path-dependent.

C. MAINTAINING THE INDIVIDUAL-RESPONSIBILITY MODEL WHILE PLANTING THE SEEDS FOR UNIVERSAL COVERAGE

So how did the ACA transform? There were some "Trojan horse[s]," as one Republican economist colorfully put it[80]—some seeds in the law from which more sweeping federal change could grow.

The ACA carefully straddles the two philosophies that have been in tension in health policy for years and that we discussed above in section I.A.2: the individual-responsibility model and the social-solidarity model. In striking this balance, the ACA arguably paved the way for either one of those models to flourish. With respect to the individual-responsibility model, the ACA retains and expands the private insurance markets. It also embraces other aspects of that model, most prominently

77. *See Offer SHOP Insurance to Your Employees*, HEALTHCARE.GOV, https://www.healthcare.gov/small-businesses/employers/ [https://perma.cc/4LGY-R76R] (last visited Dec. 20, 2019) (defining "small employer" as "generally one with 1-50 employees").

78. In particular, the ACA gradually reduced a coverage gap under Medicare—known as the "donut hole"—under which recipients had to start paying for the entire cost of their brand-name drugs after a certain point and until a financial level where catastrophic coverage kicked in. *See* DEP'T OF HEALTH & HUMAN SERVS., CLOSING THE COVERAGE GAP—MEDICARE PRESCRIPTION DRUGS ARE BECOMING MORE AFFORDABLE 1–7 (2017), https://www.medicare.gov/sites/default/files/2018-07/11493-coverage-gap.pdf [https://perma.cc/U8H9-9GE8] (describing the "donut hole" coverage gap and explaining discount possibilities until the gap closes in 2020); *see also Affordable Care Act Expands Medicare Coverage for Prevention and Wellness*, CTR. FOR MEDICARE ADVOC. (Sept. 9, 2010), https://www.medicareadvocacy.org/affordable-care-act-expands-medicare-coverage-for-prevention-and-wellness/ [https://perma.cc/9PPT-7JFP] (describing the expansion of Medicare to cover an annual wellness visit and to reduce cost sharing for preventive services).

79. *See supra* Section I.A.1. For more detail on the ACA's structure and incrementalist approach, see generally Gluck & Huberfeld, *supra* note 8.

80. Douglas Holtz-Eakin, *Yes to State Exchanges*, NAT'L REV. (Dec. 6, 2012, 5:00 PM), https://www.nationalreview.com/2012/12/yes-state-exchanges-douglas-holtz-eakin/ [https://perma.cc/7ZHW-F464].

through the law's so-called workplace "wellness provision[s]" that allow for reduced insurance premiums for those workplaces that subsidize gym memberships or other health-promoting initiatives such as smoking-cessation programs.[81] In another strike against the social-solidarity model—a model with the goal of universal coverage—some populations are left out of the ACA's generosity entirely, including undocumented immigrants. Documented immigrants also continued to face restricted access to Medicaid, including the expansion provisions.[82]

On the other hand, there are indisputably solidarity-enhancing aspects of the law. Although Medicaid under the ACA retains its traditional state-led structure, Medicaid also included a major nationalizing component under the ACA as drafted. The ACA required the expansion of Medicaid to the *entire* population with incomes up to 138% of the FPL nationwide—to reach, for example, formerly excluded, able-bodied, childless adults—rather than leaving those expansion decisions to each state.[83] Another important intervention was the establishment of a multibillion Community Health Center Fund to support community health centers, which served twenty-eight million patients in 2018 (including undocumented immigrants who are not covered by the ACA)[84], and, as we elaborate in Part II.B.4, a groundbreaking expansion in civil rights through ACA section 1557, which prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in most major health programs and all plans offered by insurers participating in the marketplace.[85]

It was the Supreme Court, as discussed below, that altered the ACA's intended Medicaid structure. But from the start, the animating push of the Medicaid expansion was nationalizing and, to use Nicole Huberfeld's term, aimed at "universality" of coverage.[86]

With respect to the insurance exchanges, there are at least two Trojan horses. First, the ACA provides for a "federal fallback" exchange: states that fail to successfully implement their own exchanges must have the federal government do it

81. *See* Baker, *supra* note 68, at 1604 n.128. These programs have been criticized for privileging the wealthy, who have more time for and access to them, and for discriminating against those who are unhealthy. *See, e.g.*, L.V. Anderson, *Workplace Wellness Programs Are a Sham*, SLATE (Sept. 1, 2016, 5:45 AM), https://slate.com/technology/2016/09/workplace-wellness-programs-are-a-sham.html [https://perma.cc/GCW3-9VG3].

82. *See* KAISER FAMILY FOUND., HEALTH COVERAGE OF IMMIGRANTS 3 (2019), http://files.kff.org/attachment/Fact-Sheet-Health-Coverage-for-Immigrants [https://perma.cc/4L33-BVGW] (describing limitations on documented immigrants' access to Medicaid expansion).

83. *See* Patient Protection and Affordable Care Act, §§ 1301–12, 1401–12.

84. Sara Rosenbaum, *Toward Equality and the Right to Health Care*, *in* THE TRILLION DOLLAR EXPERIMENT: A DECADE OF THE AFFORDABLE CARE ACT 313, 317–18 (Ezekiel J. Emanuel & Abbe R. Gluck eds., forthcoming Mar. 2020) (on file with authors); *see also* ELAYNE J. HEISLER, CONG. RESEARCH SERV., R43911, THE COMMUNITY HEALTH CENTER FUND: IN BRIEF (2019), https://www.everycrsreport.com/files/20190513_R43911_917d526715396c28334a24ccab1d7f4f9deb8c6c.pdf [https://perma.cc/7JAW-ZVAR]; SAMANTHA ARTIGA & MARIA DIAZ, KAISER FAMILY FOUND., HEALTH COVERAGE AND CARE OF UNDOCUMENTED IMMIGRANTS (2019), https://www.kff.org/disparities-policy/issue-brief/health-coverage-and-care-of-undocumented-immigrants/ [https://perma.cc/PB8K-LBML].

85. 42 U.S.C. §18116(a) (2012); *see also* Rosenbaum, *supra* note 84, at 318–19.

86. *See* Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH, POL'Y, L., & ETHICS 67, 68 (2015).

for them.[87] The fallback, when triggered, paves a path toward nationalizing the regulation of insurance markets because it allows the federal government to take control of state insurance markets for the first time in history. Second, and equally important, are the ACA's new national legal guardrails on insurance. The ACA flips the preexisting business model of the insurance industry on its head. Before the ACA, the insurance industry profited off of risk assessment, seeking out healthier customers to insure. The ACA changes that and, for the first time, imposes federal requirements on all insurers to, among other things, cover all customers at essentially equal rates regardless of preexisting conditions and health status, remove lifetime and annual coverage limits, and cover core essential and preventative benefits.[88] Thus, even as the ACA retains much of the preexisting regulatory structure of insurance—in the sense that it retains the private, state-led model—the ACA simultaneously revolutionizes the framework of insurance law with an overarching principle of universal access.

To pay for the new insurance reforms, the ACA imposed a requirement—the individual responsibly requirement (known colloquially as the "individual insurance mandate")—that required everyone to be insured or pay a tax penalty.[89] The mandate was to subsidize the reforms by guaranteeing a stronger and larger customer base to insurers. Its enforcement mechanism—the penalty—has since been repealed, as discussed below.[90] Although a financing mechanism for the new benefits was more attractive to the Democrats than an outright tax, the mandate further embodied the point that insurance was to be universal. Not only was everyone to have access to insurance, but the government would ensure that those who needed care now would be subsidized in part by those who did not—embodying the idea of "mutual aid and support" at the heart of the social solidarity model.[91]

Finally, the ACA introduced one new form of insurance. Title VIII, called the Community Living Assistance Services and Supports Act (the CLASS Act), would have created a new long-term care insurance system.[92] The CLASS Act was the brainchild of Senator Edward Kennedy, and was motivated by the need for support for an increasingly aging American society. However, a financially sustainable long-term care program had long proved elusive for policymakers.[93]

87. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1321(c), 124 Stat. 119, 186–87 (2010).

88. *Id.* §§ 1001, 1201, 1302, 10101, 124 Stat. at 130–38, 154–61, 163–68, 883–91.

89. *See* MCDONOUGH, *supra* note 57, at 121–24.

90. *See infra* notes 172–76 and accompanying text.

91. *See* Mariner, *supra* note 47, at 205–08 (contrasting the "personal responsibility model," under which "people are different and we should not be responsible for those who are different from us," with the "solidarity model," which calls on "everyone to chip in and make sure that, when injury or illness occurs, help is available to anyone who needs it").

92. *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §§ 8001–02, 124 Stat. 119, 828–47 (2010).

93. *See* Jason Kane, *What the Death of the CLASS Act Means for Long-Term Disability Care*, PBS NEWS HOUR (Oct. 14, 2011, 8:17 PM), https://www.pbs.org/newshour/health/what-the-death-of-the-class-act-means-for-long-term-disability-care [https://perma.cc/ZN7T-3QNQ].

In recognition of that difficulty, the CLASS Act—like the rest of the ACA—straddled the line between embracing a market model and favoring community solidarity, and provided that no taxpayer funds could be used for the program. It had to be solvent of its own accord.[94] As a result, the CLASS Act never took effect. But arguably, the CLASS Act put down another marker of what a just (and possibly universal) healthcare system *should* include. Notably, nearly all of the 2020 Democratic presidential candidates now would either require insurance companies to cover long-term care as a benefit, back Medicare for All bills that include coverage for long-term care, or have proposed new government programs or financing to make long-term care more accessible and affordable.[95]

II. WHAT THE ACA SURVIVED—AND HOW THE FIGHT ITSELF TRANSFORMED THE LAW

We build here on a deep literature about entrenchment and "special" statutes—statutes with outsized effect on legal norms and exceptional staying power. Adrian Vermeule has argued that "[t]he acid test of entrenchment occurs when a statute survives despite the opposition of a current majority or supermajority."[96] But challenges to the ACA are the proverbial hydra that grows two heads for each one cut down, and the ACA is the proverbial phoenix that never stops rising. It has survived all the types of challenges often mentioned in special statute theory: legal, political, and electoral. But it has done more than that. The ACA has also overcome administrative sabotage by the Executive Branch, its own incremental statutory design, and dramatic and unexpected resistance from the same states that asked to implement the law in the first place. This Part begins by describing special statute theory. It then offers the first comprehensive account of the challenges the ACA has withstood at every level: in the courts, from Congress, through five election cycles, in resisting states, and from the presidency itself.

A. SPECIAL STATUTES

The idea that some statutes are more special than others is a much-debated theoretical concept in the academic field of legislation. William Eskridge, Jr. and John Ferejohn introduced the term "super-statutes" to describe laws that do more than just endure major challenges: their "institutional or normative principles have a broad effect on the law—including an effect beyond the four corners of

94. *See id.*

95. *See, e.g.*, *How the Democratic Candidates Responded to a Health Policy Survey*, N.Y. TIMES (Jun. 23, 2019), https://www.nytimes.com/2019/06/23/us/politics/2020-democrats-health-care.html; Dylan Scott, *The Real Differences Between the 2020 Democrats' Health Care Plans, Explained*, VOX (Dec. 19, 2019, 8:00 AM), https://www.vox.com/policy-and-politics/2019/12/19/21005124/2020-presidential-candidates-health-care-democratic-debate [https://perma.cc/76NY-9XB8]; *Dignity and Security in Retirement*, PETE BUTTIGIEG FOR PRESIDENT, https://peteforamerica.com/policies/dignity/ [https://perma.cc/E3JF-KBS5] (last visited Jan. 19, 2020).

96. Adrian Vermeule, *Superstatutes*, NEW REPUBLIC (Oct. 26, 2010), https://newrepublic.com/article/78604/superstatutes.

the statute."[97] They are, it is said, able to "transform Constitutional baselines."[98] Others have advanced similar concepts, including Bruce Ackerman, who introduced the concept of "landmark statutes"—statutes that themselves define and bring about key moments of constitutional change.[99]

The special-statute concept has many critics (including erstwhile one of us).[100] The label arguably says too little and too much. One woman's super-statute is another's mundane law. Apart from the Civil Rights Act, there has been virtually no agreement over which statutes are indisputably super.[101] Nor are we the first to link the ACA to this concept. For example, an article by Erin Fuse Brown shortly after the ACA was enacted predicted that the law was too weak to attain super-statutory status.[102] William Sage also wondered if the ACA would become a super-statute,[103] while David Super instead posited that the enactment process might be an Ackermanian "constitutional moment" in the opposite direction, entrenching the private-market model of health law.[104] As we detail below, our entrenchment analysis takes a very different view from these early commentators.

The doctrinal implications—the payoffs—of being a special statute also are unclear. It may be the case that, as a practical and political matter, there are some statutes, such as the Civil Rights Act, that most believe could never be repealed. But courts have not yet given formalist legal punch, such as special or stronger

97. William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 DUKE L.J. 1215, 1216 (2001).

98. WILLIAM N. ESKRIDGE, JR. & JOHN FEREJOHN, A REPUBLIC OF STATUTES: THE NEW AMERICAN CONSTITUTION 6 (2010).

99. *See* 3 BRUCE ACKERMAN, WE THE PEOPLE: THE CIVIL RIGHTS REVOLUTION 8–11, 59–62 (2014); Bruce Ackerman, *The Living Constitution*, 120 HARV. L. REV. 1737, 1742 (2007).

100. *See* Abbe Gluck, *Obamacare as Superstatute*, BALKINIZATION (July 29, 2017, 10:18 AM), https://balkin.blogspot.com/2017/07/obamacare-as-superstatute.html [https://perma.cc/4NXA-C52V].

101. *See* Vermeule, *supra* note 96. Eskridge and Ferejohn, for instance, have referenced the Sherman Act, and the Social Security Act, and the "Green Constitution" of environmental statutes as meeting the definition. ESKRIDGE & FEREJOHN, *supra* note 98, at 165–302; Eskridge & Ferejohn, *supra* note 97, at 1230–37. Other scholars have nominated other statutes. *See, e.g.*, Lewis A. Grossman, *AIDS Activists, FDA Regulation, and the Amendment of America's Drug Constitution*, 42 AM. J.L. & MED. 687, 690–91 (2016) (arguing that the Food, Drug, & Cosmetic Act is a super-statute); Kathryn E. Kovacs, *Superstatute Theory and Administrative Common Law*, 90 IND. L.J. 1207, 1223–37 (2015) (arguing that the Administrative Procedure Act is a super-statute); Sam Simon, *How Statutes Create Rights: The Case of the National Labor Relations Act*, 15 U. PA. J. CONST. L. 1503, 1505–30 (2013) (arguing that the National Labor Relations Act is a super-statute).

102. *See* Erin C. Fuse Brown, *Developing a Durable Right to Health Care*, 14 MINN. J.L. SCI. & TECH. 439, 444, 465–76 (2013) (viewing some of the features we find to be modalities of entrenchment as instead rendering the right to healthcare "fragile" and as fatal to a "durable right to health").

103. *See* William M. Sage, *Relating Health Law to Health Policy: A Frictional Account*, *in* THE OXFORD HANDBOOK OF U.S. HEALTH LAW 3, 28 (I. Glenn Cohen et al. eds., 2017).

104. William M. Sage, *Putting Insurance Reform in the ACA's Rear-View Mirror*, 51 HOUS. L. REV. 1081, 1098 (2014) (noting how the ACA's focus on collective commitment put it "on par with the national health insurance programs of the social democracies in Canada and Western Europe"); David A. Super, *The Modernization of American Public Law: Health Care Reform and Popular Constitutionalism*, 66 STAN. L. REV. 873, 897–918, 941–49 (2014) (predicting that the ACA could "break the back of the New Deal constitution of public law and enshrine economic efficiency as the dominant principle of U.S. public law," pushing healthcare to a more privatized, market model); *see also* Rebecca E. Zietlow, *Democratic Constitutionalism and the Affordable Care Act*, 72 OHIO ST. L.J. 1367 (2011) (describing the passage itself of the ACA as "democratic constitutionalism").

stare decisis, to the concept. And it is not our claim that healthcare has become a constitutional right.

But special-statute theory may be helpful in other ways. For example, signposting those laws that contain features allowing for particular resilience and entrenchment yields lessons for future legislative design choices. A future Congress legislating in a different field might look to the ACA's federalist implementation structure in deciding whether fully to nationalize a new statutory scheme or rely on state implementation.

The label may also have some helpful legal explanatory power; for instance, it may help explain why the Supreme Court appears to have gone out of its way—twice—to save the ACA.[105] Normative implications are trickier. The very notion that some statutes are more important than others, or may be less legitimately alterable by agencies, Congress, or courts, is dissonant with the way in which American law usually conceptualizes statutes. Constitutional scholars have argued that any effort to entrench a particular law more than other laws would be unconstitutional.[106] But this is exactly where Ackerman, Eskridge, and Ferejohn are going. Their aim is to push against the commonly accepted hierarchy of American law—where constitutional law sits on a higher plane and ordinary statutes sit below—and introduce a third category akin to "fundamental law" (or "small 'c' constitutional law"[107]) that offers an easier means of defining fundamental rights than the Constitution, in a way that is also more evolutive and more closely linked to popular sovereignty.[108]

Ultimately, we are not interested in opening up well-trodden debates about the utility or replicability of special-statute theory. Instead, we offer a friendly amendment to the theory: a story of how a statute entrenched and transformed the debate through a multipronged strategy that was largely unpredictable at the outset, and through statutory design that differs from other famous special statutes. Special-statute theory has not generally focused on either specific statutory design choices—the structural features of a law that entrench it—or the federalist architecture of a law.[109] The ACA did not work a full-scale national takeover to

105. *See* King v. Burwell, 135 S. Ct. 2480, 2496 (2015); *NFIB*, 567 U.S. 519, 574 (2012); Eskridge & Ferejohn, *supra* note 97, at 1249 (using the super-statute label to explain deviations in cases involving purported super-statutes).

106. *See* Eric A. Posner & Adrian Vermeule, *Legislative Entrenchment: A Reappraisal*, 111 YALE L.J. 1665, 1673–93 (2002) (summarizing critiques of formal entrenchment).

107. ESKRIDGE & FEREJOHN, *supra* note 98, at 1–24; *see also supra* sources cited note 99 and accompanying text (discussing Bruce Ackerman's theory of "landmark statutes").

108. The United States, of course, differs from many peer nations in the absence of a positive right to health as a matter of constitutional law. Approximately 36% of the 191 countries in the United Nations have a constitutionally guaranteed "right to health," including 28% of high-income countries. *See* Jody Heymann et al., *Constitutional Rights to Health, Public Health and Medical Care: The Status of Health Protections in 191 Countries*, 8 GLOBAL PUB. HEALTH 639, 645 tbl.1, 648, 649 tbl.5 (2013).

109. *See* Abbe R. Gluck, *Intrastatuory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyon*d, 121 YALE L.J. 534, 545–46, 561–64 (2011) (critiquing the Eskridge and Ferejohn theory for neglecting to focus on federalism structures).

impose new rights, like the Social Security Act and the Civil Rights Act did. The ACA's staying power has instead come from more diffuse and multi-modal factors that are mostly unaccounted for by super-statute theorists. These aspects are critical to our story.

The rest of this Part focuses on the other key aspect of the ACA that differentiates it from other oft-cited special statutes: the ACA remains under relentless assault—even after a decade of courtroom and political victories. The Social Security Act and the Civil Rights Act, two of Eskridge and Ferejohn's paradigm super-statutes, both survived initial major constitutional showdowns[110] and then saw decisive electoral victories for the party that had passed them, which quieted major attempts to bring down the statutes as a whole.[111] By contrast, in December 2019, the Fifth Circuit decided yet another constitutional challenge to the ACA that threatens the entire Act, and in March 2020, the Supreme Court granted review, making it the seventh ACA Supreme Court showdown on the calendar.[112] The Supreme Court also heard a different ACA case in December 2019—its fifth major one so far, and it already granted review on the sixth.[113] And President Trump remains bent on using executive action to destroy the law.

We now turn to the history of all of these challenges and how the ACA's survival of each one has contributed to the law's entrenchment.

B. THE COURTS

Opponents brought a lawsuit challenging the ACA's constitutionality on the day the statute was enacted.[114] That suit turned out to be only the beginning of incessant attacks on the statute in the courts. Each litigation has, in its own way,

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110. *See* Heart of Atlanta Motel, Inc. v. United States, 379 U.S. 241, 261–62 (1964) (upholding the Civil Rights Act as a valid exercise of the Commerce Power); Katzenbach v. McClung, 379 U.S. 294, 295, 305 (1964) (same); Carmichael v. S. Coal & Coke Co., 301 U.S. 495, 525–27 (1937) (upholding the federalism framework of the Social Security Act); Helvering v. Davis, 301 U.S. 619, 639–46 (1937) (upholding Titles II and VIII of the Social Security Act); Steward Mach. Co. v. Davis, 301 U.S. 548, 578–98 (1937) (upholding Title IX of the Social Security Act).

111. ESKRIDGE & FEREJOHN, *supra* note 98, at 185–86 (noting that Franklin Delano Roosevelt's defeat of Landon in an election where social security had been a core issue was "the biggest electoral landslide since the founding era"); Michael Levy, *United States Presidential Election of 1964*, ENCYC. BRITANNICA, https://www.britannica.com/event/United-States-presidential-election-of-1964 [https://perma.cc/6FHF-3UZL] (last visited Dec. 23, 2019) (noting that Lyndon Baines Johnson defeated Barry Goldwater by more than 15 million votes).

112. *See* Texas v. California, No. 19-1019, 2020 WL 981805 (U.S. Mar. 2, 2020) (mem.) (granting certiorari to review lower court opinion holding the individual mandate unconstitutional and leaving open the question of whether the entire ACA is inseverable and hence invalid). The sixth case is *Trump v. Pennsylvania*, No. 19-454, 2020 WL 254168 (U.S. Jan. 17, 2020) (mem.) (granting certiorari to review implementation of the ACA contraception mandate).

113. *See* Transcript of Oral Argument, Moda Health Plan, Inc. v. United States (*Moda*), No. 18-1028 (Dec. 10, 2019), https://www.supremecourt.gov/oral_arguments/argument_transcripts/2019/18-1023_m648.pdf [https://perma.cc/9JVX-XFZY]; *Trump v. Pennsylvania*, 2020 WL 254168.

114. Rosalind S. Helderman, *Cuccinelli Sues Federal Government to Stop Health-Care Reform Law*, WASH. POST (Mar. 24, 2010), http://www.washingtonpost.com/wp-dyn/content/article/2010/03/23/AR2010032304224.html.

contributed to the ACA's own dynamic evolution, sometimes because of what the courts said about the law, including how the courts described the ACA's structure and goals. In other cases, evolution and entrenchment occurred simply because the law survived.

1. *NFIB v. Sebelius*

The focus of the challenge filed on the date of the ACA's enactment was the constitutionality of the individual mandate. Opponents argued that Congress lacked the authority under its power to regulate interstate commerce to order all Americans to obtain health insurance or else pay a penalty.[115] Initially dismissed as a non-starter, the politics of the moment and the extremely successful messaging by the suit's supporters moved the claims (filed in several courts) from being, as Jack Balkin put it at the time, "off the wall to on the wall."[116] ACA challengers relentlessly compared the individual mandate to a hypothetical requirement by Congress to eat one's broccoli,[117] a comparison that resonated.

The Republican Party also quickly made ACA opposition a "loyalty litmus test."[118] As detailed below, after *NFIB* was filed, Republican officials who cooperated to implement the insurance reforms in their states and governors who wished to expand Medicaid were deemed to have betrayed the party.[119] These factors, plus an early victory in the U.S. Court of Appeals for the Eleventh Circuit, lent surprising momentum to the litigation.[120] The case came to signify more than just a doctrinal dispute; Republican-appointed lower-court judges who declined to strike down the ACA paid a price in conservative legal circles, with some risking potential blacklisting as future Supreme Court nominees.[121]

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115. *See NFIB*, 567 U.S. 519, 552–74 (2012).

116. Jack M. Balkin, *From off the Wall to on the Wall: How the Mandate Challenge Went Mainstream*, ATLANTIC (June 4, 2012), https://www.theatlantic.com/national/archive/2012/06/from-off-the-wall-to-on-the-wall-how-the-mandate-challenge-went-mainstream/258040/.

117. *See NFIB*, 567 U.S. at 558 (describing the government's argument that a mandatory purchase of broccoli differs from the healthcare mandate).

118. Gluck & Huberfeld, *supra* note 8, at 1759.

119. *Id.* at 1759–69.

120. Florida *ex rel.* Att'y Gen. v. U.S. Dep't of Health & Human Servs., 648 F.3d 1235 (11th Cir. 2011), *aff'd in part, rev'd in part sub nom. NFIB*, 567 U.S. 519 (2012). The Sixth and D.C. Circuits upheld the individual mandate under Congress's commerce power. Seven-Sky v. Holder, 661 F.3d 1, 4, 20–21 (D.C. Cir. 2011), *abrogated by NFIB*, 567 U.S. 519; Thomas More Law Ctr. v. Obama, 651 F.3d 529, 565 (6th Cir. 2011), *abrogated by NFIB*, 567 U.S. 519. The Fourth Circuit found that the challenge was barred by the Anti-Injunction Act. Liberty Univ., Inc. v. Geithner, 671 F.3d 391, 400–03 (4th Cir. 2011), *abrogated by NFIB*, 567 U.S. 519.

121. *See, e.g.*, Scott Lemieux, *Brett Kavanaugh's Supreme Court Nomination Is the Result of Years of Unopposed Conservative Organizing*, NBC (July 10, 2018, 11:56 AM), https://www.nbcnews.com/think/opinion/brett-kavanaugh-s-supreme-court-nomination-result-years-unopposed-conservative-ncna890226 [https://perma.cc/FG6M-7PYJ] (noting that Professor Orrin Kerr claimed that Judge Jeffrey Sutton "lost favor among conservative legal activists" because of his 2012 decision upholding the ACA); Alex Pappas, *Supreme Court Shortlister Kavanaugh's Role in ObamaCare's Survival Fiercely Debated by Conservatives*, FOX NEWS (July 9, 2018), http://www.foxnews.com/politics/2018/07/09/supreme-court-shortlister-kavanaughs-role-in-obamacares-survival-fiercely-debated-by-conservatives.html [https://perma.cc/2TSB-JNAZ] (describing conservative criticism of Kavanaugh's avoidance of taking a position on the ACA in the D.C. Circuit).

The Supreme Court granted review in 2011. The Court surprised some experts by agreeing to hear not only the mandate question but also the constitutionality of the structure of the ACA's Medicaid expansion: The ACA required states to expand Medicaid or lose their existing Medicaid funds.[122] Ultimately, the ACA's challengers won in part and lost in part. Four Justices held that Congress did not have the power to enact the mandate;[123] five Justices held that it did.[124] The Chief Justice cast the deciding vote, agreeing with the dissenters that the mandate was an unconstitutional exercise of Congress's commerce power but saving the law by construing the mandate as a tax, and thereby a permissible exercise of Congress's taxing power.[125]

The Medicaid holding was more dramatic and stunned many. Seven Justices held that the threat to withhold Medicaid funding from states that did not expand the program made the expansion effectively mandatory and, as such, was unconstitutionally coercive toward states in violation of the Tenth Amendment and Congress's spending power.[126] As a remedy, the Court rendered the expansion optional.[127]

From the perspective of ACA entrenchment and broader normative transformation, three aspects of *NFIB* are most relevant. The first is what the Court said about Medicaid. The Medicaid portion of the opinion turned on the centrality of the Medicaid program to virtually all state budgets. The threat of losing Medicaid funds was so severe that the Court said it constituted "economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion."[128] Although that very centrality ultimately doomed the mandatory nature of the expansion, in retrospect *NFIB* forecasted the extent to which Medicaid would become such an important part of the ACA's right-to-healthcare story. Medicaid was ultimately the main reason Congress did not repeal and replace the ACA in 2017.[129] And it is the Medicaid expansion's philosophy of universality and solidarity—and the government's role in both—that underpins much of the normative shift around healthcare that has come since.

Second, by making the Medicaid expansion optional, the Court handed the states major leverage vis-à-vis the federal government and, at the same time, unwittingly created a new pathway toward statutory entrenchment. One kind of entrenchment facilitated by *NFIB* has been legal and regulatory. The seven years since the Court decided the case have seen a continuous feedback loop of state–federal negotiation and external feedback from the citizenry over whether and how

122. Dep't of Health & Human Servs. v. Florida, 565 U.S. 1034 (2011) (mem.) (granting certiorari on the Medicaid expansion question).

123. *NFIB*, 567 U.S. 519, 646–69 (2012) (Scalia, Kennedy, Thomas & Alito, J.J., dissenting).

124. *Id*. at 561–74 (majority opinion).

125. *See id*. at 574.

126. *Id*. at 575–85 (majority opinion); *id*. at 671–89 (Scalia, Kennedy, Thomas & Alito, J.J., dissenting).

127. *Id*. at 585–88 (majority opinion).

128. *Id*. at 582.

129. *See infra* Section II.C.5.

to expand the Medicaid program precisely because of the Court's holding. States negotiated advantageous waivers to the program—including elements largely disliked by liberals, such as privatization—to which Obama Administration officials, eager to entrench the law at any cost, largely capitulated.[130] This negotiation-and-implementation loop invested many state officials, including Republicans, with the role of tailoring and entrenching Medicaid in their various states—perhaps even more than the universal expansion by federal fiat that the ACA originally intended would have done.[131]

Another kind of entrenchment that grew out of the *NFIB* opinion was democratic and expressive. The very fact that Medicaid expansion is now a *choice* has put the question of Medicaid's value to each state front and center as a matter of public deliberation. The question of whether to expand Medicaid has wound up being the stuff of front-page news, gubernatorial elections, and even ballot initiatives,[132] as well as state legislation and executive orders that have sought to bypass opposing factions of state government to accomplish the expansion. In Maine, the will of the people trumped the Republican governor in 2017 when the state voted by a significant margin to expand Medicaid.[133] And three conservative

130. For example, the Obama Administration allowed states to put their Medicaid populations into the private market, offering premium assistance waivers, enforceable premium payments, alterations to cost sharing, and waivers of requirements to include certain services with coverage. Gluck & Huberfeld, *supra* note 8, at 1736–41.

131. In the significantly different context of abortion, prominent advocates have argued that state-by-state enactment rather than top-down fiat could have been a more effective entrenchment strategy. *See, e.g.*, Ruth Bader Ginsburg, *Some Thoughts on Autonomy and Equality in Relation to* Roe v. Wade, 63 N.C. L. REV. 375, 381–82 (1985) (describing a shift in the aftermath of *Roe v. Wade*, 410 U.S. 113 (1973), from state legislatures moving "toward liberalization of abortion statutes" to re-energized opposition); *see also* RICHARD A. POSNER, LAW, PRAGMATISM, AND DEMOCRACY 124–26 (2003) (arguing that *Roe* stopped "state experimentation with abortion laws" that might have allowed "some approximation to consensus" to emerge).

132. *See, e.g.*, John George, *Wolf Begins Dismantling Corbett's Healthy PA Plan*, PHILA. BUS. J. (Feb. 10, 2015, 3:46 PM), https://www.bizjournals.com/philadelphia/blog/health-care/2015/02/wolf-begins-dismantling-of-corbett-s-healthy-pa.html?s=print (describing a shift in Medicaid expansion policy in Pennsylvania after a new governor was elected); David K. Jones, *Obamacare Politics: Lessons from the Kentucky Governor's Race*, HEALTH AFF. BLOG (Nov. 4, 2015), https://www.healthaffairs.org/do/10.1377/hblog20151104.051634/full/ [https://perma.cc/52LP-N53P] (noting the role of the ACA in the 2017 Kentucky gubernatorial race); Dan Mangan, *Health Care Played Big Role in Democratic Win in Virginia: Poll*, CNBC (Nov. 8, 2017, 7:58 PM), https://www.cnbc.com/2017/11/08/health-care-played-big-role-in-democratic-win-in-virginia-poll.html [https://perma.cc/8DRL-58UN] (noting that almost 70% of voters in the 2017 Virginia gubernatorial election said that healthcare was the most important issue affecting their choice); Rachana Pradhan, *Scott Walker Wants to Save Obamacare in Wisconsin*, POLITICO (Feb. 23, 2018, 5:00 AM), https://www.politico.com/story/2018/02/23/scott-walker-obamacare-wisconsin-358043 [https://perma.cc/9ZT5-HWXV] (noting that Republican Governor Scott Walker of Wisconsin was campaigning on saving the ACA in his state); *see also* Dylan Scott, *How Obamacare Shook Up the Arkansas GOP Governor's Primary*, VOX (May 22, 2018, 11:05 AM), https://www.vox.com/policy-and-politics/2018/5/21/17369478/arkansas-governor-election-asa-hutchinson-jan-morgan [https://perma.cc/5YS9-HT58] (attributing Arkansas Republican Governor Asa Hutchinson's popularity partly to expansion of Medicaid).

133. Matthew Bloch & Jasmine Lee, *Election Results: Maine Medicaid Expansion*, N.Y. TIMES (Dec. 20, 2017, 9:15 PM), https://www.nytimes.com/elections/results/maine-ballot-measure-medicaid-expansion.

states—Nebraska, Utah, and Idaho—voted to expand Medicaid in 2018.[134] In Virginia, state elections in 2017 delivered a legislature that voted to expand Medicaid in what had been the first state to bring a lawsuit against the ACA.[135] All of these actions contributed to ACA entrenchment.

Third, *NFIB* is important for what it did *not* say about the ACA. The opinions of both the Chief Justice and the dissenting conservative Justices refused to acknowledge the basic philosophical premises of the government's justification for the ACA—including that healthcare is a unique good (or at least not an ordinary commercial product like broccoli). These assumptions changed later. But as early as 2012, most commentators saw the Chief Justice's efforts to save the statute in *NFIB* by using a different interpretation of the source of Congress's power as evidence that he recognized the ACA's public salience; the Court as an institution would risk its legitimacy by striking down the ACA.[136] This theory gained more traction once accounts emerged that the Chief Justice may have originally sided with the dissenters but then switched his vote at the last minute to save the law.[137]

It is worth noting that, when *NFIB* was decided in June 2012, only a small portion of the ACA had been implemented. This was not a situation in which massive benefits that would be hard to rescind had already been doled out. The key insurance-access reforms both in the private markets and in the Medicaid expansion were not to take effect until 2014. Some health policy commentators and scholars lamented before *NFIB* that the political choice to delay implementation of the law's key provisions—motivated by the Democrats' desire to keep the ten-year price tag under the one trillion dollar mark[138]—would make the ACA easier for the Court to strike down.[139] As it turned out, the relatively few reforms already in place—including the removal of lifetime and annual limits on coverage, and the requirement that young adults under age twenty-six could remain on their parents' insurance[140]—were extremely popular by the time the case was decided.

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134. Kliff, *supra* note 11. Montana narrowly rejected a proposal to permanently extend its Medicaid expansion in part because it would have also increased cigarette taxes. *See id.*

135. Abby Goodnough, *After Years of Trying, Virginia Finally Will Expand Medicaid*, N.Y. TIMES (May 30, 2018), https://www.nytimes.com/2018/05/30/health/medicaid-expansion-virginia.html; *see also* Helderman, *supra* note 114.

136. Lincoln Caplan, *John Roberts's Court*, NEW YORKER (June 29, 2015), https://www.newyorker.com/news/news-desk/the-chief-justice; Jeffrey Rosen, *John Roberts, the Umpire in Chief*, N.Y. TIMES (June 27, 2015), https://www.nytimes.com/2015/06/28/opinion/john-roberts-the-umpire-in-chief.html.

137. *E.g.*, JOAN BISKUPIC, THE CHIEF: THE LIFE AND TURBULENT TIMES OF CHIEF JUSTICE JOHN ROBERTS 229–48 (2019); Jan Crawford, *Roberts Switched Views to Uphold Health Care Law*, CBS (July 2, 2012, 9:43 PM), https://www.cbsnews.com/news/roberts-switched-views-to-uphold-health-care-law/ [https://perma.cc/WGR6-TDVR].

138. *See* Ezra Klein, *The Affordable Care Act Does Not Have 10 Years of Taxes for Six Years of Spending*, WASH. POST (Apr. 12, 2010, 12:04 PM), http://voices.washingtonpost.com/ezra-klein/2010/04/the_affordable_care_act_does_n.html.

139. *See* Brown, *supra* note 102, at 465–76, 480–87 (arguing that, even after *NFIB*, the long time frame for implementation risked preventing the ACA from becoming a super-statute and instead making it a "quasi-superstatute").

140. MEGAN REEVE ET AL., INST. OF MED. OF THE NAT'L ACADS., THE IMPACTS OF THE AFFORDABLE CARE ACT ON PREPAREDNESS RESOURCES AND PROGRAMS 136, 138 (2014), https://www.ncbi.nlm.nih.gov/books/NBK241392/pdf/Bookshelf_NBK241392.pdf [https://perma.cc/EQ3P-9JQB].

2. *King v. Burwell*

Common theories of statutory entrenchment include a paradigmatic sequence: a major constitutional showdown, followed by public debate over the showdown, leading to a reaffirmation or modification of core principles of the law.[141] *NFIB*, followed by the 2012 reelection of President Obama and Democratic gains in the Senate and House (although not on the level of the waves that succeeded the Civil Rights Act or the Social Security Act)[142] seemed to fit the bill. What makes the ACA's story unique is that its opponents did not come around to the political advantages of working with or coopting the law.

At one widely reported critical strategy meeting after *NFIB*, opponents focused on what became a theme of ACA destruction at all costs. A key speaker exhorted the crowd to find any means to "kill" the law:

> This bastard has to be killed as a matter of political hygiene. I do not care how this is done, whether it's dismembered, whether we drive a stake through its heart, whether we tar and feather it and drive it out of town, whether we strangle it. I don't care who does it, whether it's some court, some place, or the United States Congress. Any which way. . . .[143]

The direct result of this strategy was the next major Supreme Court case, *King v. Burwell*.[144] The case's architects sought, as they put it, to "exploit[]" four isolated words in the 2,000-page law—which they called a "monster" filled with "contradictions and incongruities."[145] The goal was to accomplish a do-over of the failed 2012 constitutional challenge by pulling at a small string in the law in the hopes it would all unravel.

At issue in *King* was the provision of the ACA that provides subsidies to insurance sold in the ACA's new marketplaces—the "exchanges." States had the right of first refusal to establish their own exchanges but, as noted, the federal government would provide a fallback if they did not.[146] The provision in question directs individuals to calculate their subsidies for tax purposes based on a calculation involving "the monthly premiums for such month . . . the taxpayer [was] enrolled in through an Exchange established by *the State* under [section] 1311."[147]

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141. Eskridge & Ferejohn, *supra* note 97, at 1270–71.

142. See *supra* note 111 for a description of post-Civil Rights Act and Social Security Act electoral victories.

143. Only a YouTube recording of the remarks is available. Am. Enter. Inst., *Who's in Charge? More Legal Challenges to the Patient Protection and Affordable Care Act* at 1:30:55–1:31:15, YOUTUBE (Mar. 11, 2014), http://www.youtube.com/watch?&v=C7nRpJURvE4 (remarks of Michael S. Greve at a Dec. 7, 2010 panel).

144. *See* 135 S. Ct. 2480 (2015); *see also* Abbe R. Gluck, *Imperfect Statutes, Imperfect Courts: Understanding Congress's Plan in the Era of Unorthodox Lawmaking*, 129 HARV. L. REV. 62, 69–71 (2015) [hereinafter Gluck, *Imperfect Statutes*] (explaining the genesis of the question in *King v. Burwell*).

145. Am. Enter. Inst., *supra* note 143, at 1:32:50–1:33:16.

146. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1321(c), 124 Stat. 119, 186–87 (2010) (codified at 42 U.S.C. § 18041(c) (2012)).

147. 26 U.S.C. § 36B(b) (2012) (emphasis added).

Because section 1311 of the ACA establishes the state-run exchanges, the challengers argued that consumers on *federally* run exchanges could not benefit from the subsidies[148]—an outcome that would have made insurance unaffordable in the more than thirty states with federal exchanges at the time, most likely leading the ACA markets to collapse in those states.[149]

The Supreme Court, once again led by the Chief Justice but this time with a vote of six-to-three (Justice Kennedy switched sides), rejected the challenge.[150] From an entrenchment perspective, it is the change in the Court's approach from *NFIB* that is most significant.

First, *King* was styled as a major test of statutory interpretation formalism. The challengers took advantage of the dominant theory of statutory interpretation on the Court—the textualist approach pioneered by Justice Scalia—to try to persuade the Court to read the statute as narrowly and as unforgivingly as possible.[151] The challengers argued the statute was so complex—they portrayed it as a "law that no one understands"—that the Court could not possibly do more than give it the most literal reading.[152]

The majority did not take the bait. The Court did not conclude that the ACA was too difficult to understand or decide to enforce the contested text in isolation. Instead, the Court in *King* held that the normal assumptions of perfection underlying the textualist rules were unrealistic as applied to the ACA, given the statute's complexity and convoluted enactment process.[153] That holding appears to have been a first-of-its-kind position for the Court to stake out in a statutory case in the modern era—cutting a statute slack for its intricacy and legislative process.[154]

The Court recounted in exceptional detail the structure of the statute, how its provisions work together, and its goals.[155] It also provided a narrative of the ACA's legislative process and concluded that the Court "must do [its] best" to interpret the law.[156] Finally, the Court held that the question presented was simply too important to assume that Congress would have sowed the seeds of the statute's destruction into the law without being more explicit.[157]

148. *King*, 135 S. Ct. at 2487.

149. *See, e.g.*, *id.* at 2493; Brendan Mochoruk & Louise Sheiner, King v. Burwell *Explained*, BROOKINGS (Mar. 3, 2015), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2015/03/03/king-v-burwell-explained/ [https://perma.cc/37CQ-GB93].

150. *King*, 135 S. Ct. at 2496.

151. *See* Abbe R. Gluck, *Symposium: The Grant in* King *– Obamacare Subsidies as Textualism's Big Test*, SCOTUSBLOG (NOV. 7, 2014, 12:48 PM), http://www.scotusblog.com/2014/11/symposium-the-grant-in-king-obamacare-subsidies-as-textualisms-big-test/ [https://perma.cc/ZS2R-QY2C].

152. Gluck, *Imperfect Statutes*, *supra* note 144, at 69–71.

153. *King*, 135 S. Ct. at 2495–96.

154. *See* Gluck, *Imperfect Statutes*, *supra* note 144, at 64, 87–93.

155. *King*, 135 S. Ct. at 2489–92.

156. *Id.* at 2492 (quoting Util. Air Regulatory Grp. v. EPA, 573 U.S. 302, 320 (2014)).

157. *Id.* at 2489–92, 2495.

The stark difference from *NFIB* in terms of the Court's apparent grasp of the law—and its insistence on the law's internal coherence—is further proof of changing perceptions about the ACA. Another still is the Chief Justice's decision to reach for a different interpretive method than the highly textualist method typically employed. The Court looked instead to the more forgiving interpretive methodology associated with the earlier era of Legal Process, a school of thought that emphasizes Congress's rationality and the Court's duty as Congress's cooperative partner.[158] Indeed, the majority's refusal to apply earlier precedents under which a statutory mistake was read literally if the statute could be read grammatically[159] led Justice Scalia to conclude: "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."[160]

3. *Burwell v. Hobby Lobby Stores, Inc.*

Burwell v. Hobby Lobby Stores, Inc.[161] was not a showdown that put the whole ACA at risk like *King* or *NFIB*, but it was another high-profile case about the ACA's implementation of a particular policy that ended up in the Supreme Court during the time between them. In *Hobby Lobby*, religious owners of closely held family companies sued under the Religious Freedom Restoration Act (RFRA) for an exemption from Health and Human Services (HHS) regulations mandating that employers provide coverage without cost-sharing to female employees for various forms of contraception.[162] HHS had already made a regulatory exception for religious nonprofits, and the plaintiff for-profit companies argued that, under RFRA, they were entitled to the same.[163] The challenge drew on a similar narrative as that in *NFIB*, one in which the healthcare law was depicted as a significant federal intrusion into a private sphere (this time, conscience and employer–employee relations).

158. *See id.* at 2492, 2496. *See also* HENRY M. HART, JR. & ALBERT M. SACKS, THE LEGAL PROCESS: BASIC PROBLEMS IN THE MAKING AND APPLICATION OF LAW 1124–25 (William N. Eskridge, Jr. & Philip P. Frickey eds., Foundation Press 1994) (1958) (explaining the Legal Process approach to statutes); Abbe R. Gluck, *Congress Has a "Plan" and the Court Can Understand It – The Court Rises to the Challenge of Statutory Complexity in* King v. Burwell, SCOTUSBLOG (June 26, 2015, 8:55 AM), https://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/ [https://perma.cc/HEF5-3ZSC] ("The Legal Process School – associated with legal giants Henry Hart and Albert Sacks of Harvard (the alma mater of five of the six *King* majority justices, including the Chief himself) – brushed aside the harsh and cynical realism of the prior era in favor of an approach that, while still tethered to text, was grounded in a focus on institutional context, and a belief in the reasonableness of federal legislation and the federal courts' competence and duty to understand it.").

159. *E.g.*, Lamie v. U.S. Treasury, 540 U.S. 526, 533–39 (2004).

160. *King*, 135 S. Ct. at 2497 (Scalia, J., dissenting). Eskridge and Ferejohn actually argued that even textualists have read super-statutes more purposively. *See* Eskridge & Ferejohn, *supra* note 97, at 1234–35.

161. 134 S. Ct. 2751 (2014).

162. *Id.* at 2765.

163. *See id.* at 2763, 2765.

In a five-to-four decision, the Court ruled that the government was required to make the religious accommodation.[164] Yet by the Court's terms, the plaintiffs' victory effectively left the ACA and its implementing regulations in place.[165] Justice Alito, writing for the Court, took pains to make clear that the accommodations would not interfere with the operation of the law, and that female employees of these companies "would still be entitled to all FDA-approved contraceptives without cost sharing."[166] Further, the Court assumed without deciding that providing contraceptive coverage without copayments was a compelling government interest (even crediting HHS's assertion that moderate copayments can deter access to care),[167] a point that Justice Kennedy—who provided the crucial fifth vote—emphasized in his concurrence.[168] The Court's restraint in interpreting a law that three members of the *Hobby Lobby* majority had voted to strike down just a few years earlier furthers the story of the ACA's shifting momentum.

After *Hobby Lobby*, religious nonprofits continued to object to the accommodation arguing that it impermissibly burdened the exercise of their religious beliefs.[169] Two years later, in *Zubik v. Burwell*, the Court declined to reach the merits of the validity of the accommodation and directed the government and the challengers to attempt once again to resolve the issue through the administrative process.[170] The Trump Administration then issued new rules that vastly expanded the exemptions available for objecting employers. In January 2020, the Supreme Court granted certiorari on this question of the implementation of the contraception mandate—making it the sixth ACA case in the Court.[171]

4. *Texas v. United States* and More than 100 Other Court Challenges

There have been more than 100 other court challenges along the way in the lower courts.[172] At the time of this writing, the most significant pending challenge is *Texas v. United States*,[173] a case originally brought by twenty states[174] that

164. *See id.* at 2785.

165. Specifically, the Court expanded the regulatory accommodation already available for nonprofits to closely held for-profit employers with religious objections. *See id.* at 2774–75.

166. *See id.* at 2760.

167. *See id.* at 2780.

168. *Id.* at 2786 (Kennedy, J., concurring) ("It is important to confirm that a premise of the Court's opinion is its assumption that the HHS regulation here at issue furthers a legitimate and compelling interest in the health of female employees.").

169. *See* Zubik v. Burwell, 136 S. Ct. 1557, 1559 (2016) (per curiam).

170. *Id.* at 1560–61 (plurality opinion).

171. Trump v. Pennsylvania, No. 19-454, 2020 WL 254168 (U.S. Jan. 17, 2020) (mem.) (granting certiorari to review implementation of the ACA contraception mandate).

172. For a list of most of these cases, see AFFORDABLE CARE ACT LITIGATION, https://affordablecareactlitigation.com [https://perma.cc/J3MY-F3D8] (last visited Dec. 23, 2019). This does not include the tens of extra contraception- and RFRA-related cases, some of which are available at *Becket Case Database*, BECKET, https://www.becketlaw.org/cases [https://perma.cc/2X83-V2EU] (last visited Dec. 23, 2019).

173. 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom.* Texas v. California, No. 19-1019, 2020 WL 981805 (U.S. Mar. 2, 2020) (mem.).

174. Maine and Wisconsin dropped out after the 2018 elections.

poses another existential threat to the statute as a whole. In December 2018, the U.S. District Court for the Northern District of Texas effectively struck down the entire ACA.[175] On appeal, the Fifth Circuit affirmed the district court in part and remanded for further proceedings. The U.S. Supreme Court has already granted review; the case will be the Court's 2020 election-year ACA showdown.

The Texas case stems from the 2017 Tax Cuts and Jobs Act, which eliminated the tax penalty associated with the individual mandate.[176] It was a Republican-controlled Congress that passed the tax law; the elimination of the mandate penalty was the only aspect of the ACA that was repealed, and it followed the GOP's repeated and failed attempts to "repeal and replace" the law during the first year of the Trump Administration.[177]

The *Texas v. United States* challengers argue that without the tax penalty, the mandate—which the Court had sustained as a tax in *NFIB*—lacks a constitutional basis in the Taxing and Spending Clause and is therefore unconstitutional.[178] The district court and Fifth Circuit agreed. The suit goes further, however, and also argues that without the mandate the *entire* statute cannot stand. The argument is an extreme application of a legal doctrine known as "severability," which asks courts to consider what to do with the rest of a statute if one part is struck down. Applying that doctrine, the challengers argued that all 2,000 pages of the ACA are inextricably intertwined with the mandate, and so must fall with it.[179] The district court agreed with this extreme argument, but the Fifth Circuit remanded the case for more detailed proceedings on the severability questions.[180] Adding to the drama, the Trump Administration Department of Justice refused to defend the law.[181] *Texas v. United States* has many of the same features of *King*, most saliently in its shared strategy of using a thin string to pull the entire statute loose.[182]

From an entrenchment perspective, the Republican response to the suit is most important. Prominent Republican legal experts, including several who were architects of the earlier major ACA challenges, have argued that the lawsuit is

175. *See* Texas v. United States, 340 F. Supp. 3d 579, 619 (N.D. Tex. 2018).

176. Pub. L. No. 115–97, § 11081, 131 Stat. 2054, 2092 (2017) (codified at 26 U.S.C. § 5000A (2017)), *invalidated by Texas v. United States*, 945 F.3d 355.

177. *See infra* Section II.C.5.

178. *See Texas v. United States*, 945 F.3d at 371.

179. *Id.* at 373.

180. *Id.* at 373, 403.

181. Letter from Joseph Hunt, Assistant Att'y Gen. et. al, to Lyle W. Cayce, Clerk of the Court for the U.S. Court of Appeals for the Fifth Cir., Texas v. United States No. 19-10011 (5th Cir. filed Mar. 25, 2019) (No. 00514887530), https://s3.amazonaws.com/wvmetro-uploads-prod/2019/03/DOJ-Obamacare-letter.pdf [https://perma.cc/FVK5-THEE].

182. *Cf.* Jonathan H. Adler & Abbe R. Gluck, *An Obamacare Case So Wrong It Has Provoked a Bipartisan Outcry*, N.Y. TIMES (June 19, 2018), https://www.nytimes.com/2018/06/19/opinion/an-obamacare-case-so-wrong-it-has-provoked-a-bipartisan-outcry.html (describing the weakness of the legal claims in *Texas v. United States*).

meritless.[183] Some have filed bipartisan amicus briefs.[184] Some Republican elected officials have spoken out against the suit. Two Republican attorneys general have even filed an amicus brief opposing the decision,[185] whereas more still have at least distanced themselves from it.[186] Michael Cannon of the Cato Institute, self-declared "Obamacare's Enemy No. 1," accused the district court of "jettison[ing] the rule of law to achieve a politically desired outcome."[187] The conservative *Wall Street Journal* editorial board, in an op-ed that began, "[n]o one opposes ObamaCare more than we do," argued the judge had misapplied the law and predicted (incorrectly) that "even the right-leaning Fifth Circuit Court of Appeals judges will overturn" the decision.[188] The relevance for the transformation and entrenchment story is in the political shift: ACA opposition at all costs is no longer a Republican Party litmus test.

Dozens of other lawsuits were filed during the Obama era. For instance, the House of Representatives sued to stop the Obama Administration from making one type of ACA insurance stabilization payment ("cost-sharing reductions") on the grounds that the funds had not been expressly appropriated in the ACA's text.[189] The House won in the district court,[190] and President Trump stopped making the payments while the case was on appeal.[191] Insurers have since sued for

183. *See id.*; Jonathan H. Adler & Abbe R. Gluck, *What the Lawless Obamacare Ruling Means*, N.Y. TIMES (Dec. 15, 2018), https://www.nytimes.com/2018/12/15/opinion/obamacare-ruling-unconstitutional-affordable-care-act.html; Ilya Somin, *Thoughts on Today's Federal Court Decision Against Obamacare*, VOLOKH CONSPIRACY (Dec. 14, 2018, 10:48 PM), https://reason.com/volokh/2018/12/14/thoughts-on-todays-federal-court-decisio [https://perma.cc/2ZLZ-YRER].

184. Including alongside one of us, *see* Brief of Amici Curiae Jonathan H. Adler, Nicholas Bagley, Abbe R. Gluck, and Ilya Somin in Support of Intervenors-Defendants-Appellants, Texas v. United States, No. 4:18-cv-00167 (5th Cir. Apr. 1, 2019). *See also* Brief of Amici Curiae Samuel L. Bray, Michael W. McConnell, and Kevin C. Walsh in Support of Intervenors-Defendants-Appellants, Texas v. United States, No. 4:18-cv-00167 (5th Cir. Apr. 1, 2019); Brief for Amici Curiae Walter Dellinger and Douglas Laycock in Support of Intervenors-Defendants-Appellants Supporting Remand and Dismissal, Texas v. United States, No. 4:18-cv-00167 (5th Cir. Apr. 1, 2019).

185. Brief of Amicus Curiae States of Ohio and Montana in Support of Neither Party, Texas v. United States, No. 4:18-cv-00167-O (5th Cir. Apr. 1, 2019).

186. *See* KHN Morning Briefing, *Republicans' Muted Response to Judge's Ruling Highlights Shifting Politics, Attitudes About Health Law*, KAISER HEALTH NEWS (Dec. 18, 2018), https://khn.org/morning-breakout/republicans-muted-response-to-judges-ruling-highlights-shifting-politics-attitudes-about-health-law/ [https://perma.cc/T9TR-PEG3]; Peter Sullivan, *GOP Lawmakers Distance Themselves from ObamaCare Ruling*, HILL (Dec. 17, 2018, 6:46 PM), https://thehill.com/policy/healthcare/421790-republicans-distance-themselves-from-obamacare-ruling [https://perma.cc/HU4R-E4EY].

187. Michael F. Cannon, *Obamacare's Enemy No. 1 Says This Is the Wrong Way to Kill It*, CATO INST. (Mar. 28, 2019), https://www.cato.org/publications/commentary/obamacares-enemy-no-1-says-wrong-way-kill-it [https://perma.cc/5YXN-CDGG].

188. Editorial, *Texas ObamaCare Blunder*, WALL ST. J. (Dec. 16, 2018, 4:40 PM), https://www.wsj.com/articles/texas-obamacare-blunder-11544996418.

189. U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 168 (D.D.C.), *appeal held in abeyance*, 676 F. App'x 1 (D.C. Cir. 2016) (per curiam).

190. *Id.* at 189.

191. Katie Keith, *States' Lawsuit over Cost-Sharing Reductions Is Dismissed*, HEALTH AFF. BLOG (July 19, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180719.822849/full/ [https://perma.cc/6M7H-UQBS]; Dylan Scott, *Trump Ended Key Obamacare Payments. But Bringing Them Back*

damages successfully in two cases.[192]

Other significant cases included unsuccessful challenges to the ACA under the Origination Clause,[193] unsuccessful challenges to the employer play-or-pay system,[194] and unsuccessful challenges to the Obama Administration's "administrative fix" perpetuating various plans in effect at the time the ACA was passed.[195] Several suits challenged the Obama Administration's regulations implementing section 1557 of the ACA, the non-discrimination provision of the statute; the most prominent of these suits challenged a regulation prohibiting discrimination on the basis of gender identity and termination of pregnancy.[196] The contraceptive mandate has remained the subject of litigation: one lower court enjoined the contraceptive mandate and the Obama-era accommodations process for contraception coverage,[197] while two other courts enjoined the Trump Administration's new rules on the same subject,[198] setting up conflicting nationwide injunctions.

Could Do More Harm than Good., VOX (Mar. 21, 2018, 2:40 PM), https://www.vox.com/policy-and-politics/2018/3/21/17148326/democrats-oppose-stabilizing-obamacare [https://perma.cc/V8ZT-Y7LY].

192. Sanford Health Plan v. United States, 139 Fed. Cl. 701, 702 (2018), *appeal filed*, No. 19-1290 (Fed. Cir. Dec. 11, 2018); Mont. Health Co-Op v. United States, 139 Fed. Cl. 213, 214 (2018), *appeal filed*, No. 19-1302 (Fed. Cir. Dec. 12, 2018).

193. *See* Sissel v. U.S. Dep't of Health & Human Servs., 760 F.3d 1, 2–3 (D.C. Cir. 2014), *cert. denied*, 136 S. Ct. 925 (2016) (mem.).

194. Hotze v. Burwell, 784 F.3d 984, 986 (5th Cir. 2015), *cert. denied*, 136 S. Ct. 1165 (2016) (rejecting the suit on Anti-Injunction Act and standing grounds); Liberty Univ. v. Lew, 733 F.3d 72, 83–84 (4th Cir. 2013), *cert. denied*, 571 U.S. 1071 (2013) (mem.) (rejecting the suit on the merits).

195. Am. Freedom Law Ctr. v. Obama, 106 F. Supp. 3d 104, 105–06 (D.D.C. 2015) (dismissing the case for lack of standing), *aff'd*, 821 F.3d 44 (D.C. Cir. 2016), *cert. denied*, 137 S. Ct. 1069 (2017) (mem.); West Virginia v. U.S. Dep't of Health & Human Servs., 145 F. Supp. 3d 94, 95–97 (D.D.C. 2015) (same), *aff'd sub nom.* West Viginia *ex rel.* Morrisey v. U.S. Dep't of Health & Human Servs., 827 F.3d 81 (D.C. Cir. 2016), *cert. denied*, 137 S. Ct. 1614 (2017) (mem.).

196. *See* Franciscan All. v. Burwell, No. 7:16-cv-00108-O, 2016 WL 9281524, at *1 (N.D. Tex. Nov. 1, 2016) (challenging 45 C.F.R. pt. 92 (2018)). In April 2018, the Department of Justice took the position that the Obama-era regulation was unlawful and proposed rules of its own, which were finalized in November 2018. *See* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536, 57,536 (Nov. 15, 2018); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592, 57,592 (Nov. 15, 2018).

197. DeOtte v. Azar, No. 4:18-cv-00825-O, 2019 WL 3786545, at *1 (N.D. Tex. July 29, 2019). This case concerns the Obama Administration's second iteration of the general religious accommodation to the ACA's contraceptive mandate. *Hobby Lobby* concerned only closely held corporations, Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2014), but litigation continued after the case. For example, Wheaton Coll. v. Burwell, 134 S. Ct. 2806 (2014), which concerned the accommodation process itself for religious nonprofits, and Zubick v. Burwell, 136 S. Ct. 1557, 1561 (2016), where the Court remanded cases involving religious organizations other than churches. This accommodation allowed employers who wanted it to either fill out the form from the previous accommodation or notify the HHS Secretary directly of their religious objections. The district court found that requiring individuals to do either of those two things impermissibly burdened religious exercise under RFRA. *See* DeOtte, 2019 WL 3786545, at *2.

198. *See* Pennsylvania v. Trump, 351 F. Supp. 3d 791 (E.D. Pa. 2019), *aff'd sub nom.* Pennsylvania v. President United States, 930 F.3d 543 (3d Cir. 2019), *cert. granted sub nom.* Trump v. Pennsylvania, No. 19-454, 2020 WL 254168 (U.S. Jan. 17, 2020); *see also* California v. Health & Human Servs., 351 F. Supp. 3d 1267 (N.D. Cal. 2019), *aff'd sub nom.* California v. U.S. Dep't of Health & Human Servs., 941 F.3d 410 (9th Cir. 2019).

As noted, the Supreme Court has granted review of one of those cases.[199]

Suits have also arisen from the mandate on employers to provide insurance, including suits by groups seeking exceptions[200] and a class action suit challenging a corporation's alleged reduction of employee hours to avoid having to provide its employees with insurance.[201]

5. Affirmative Litigation Defending the Law

The most recent phase of the ACA's litigation story substantiates the shifting momentum. Lawsuits are now more frequently being filed not to challenge the law but to affirmatively defend and enforce it. Not only did the House of Representatives intervene to defend the ACA in *Texas v. United States*,[202] but dozens of other lawsuits have been filed to enforce the law.

Among these are many important insurance cases. Insurers have brought cases seeking payments promised under the law that were halted to make (these cases come out of the "cost-sharing reductions" case described in the previous section, brought by the Republican-controlled House to halt the payments).[203] A second set of insurer lawsuits claim damages for other stabilization payments (the so-called "risk corridors payments") under the ACA that the Republican-controlled Congress passed an appropriations rider to withhold in 2014.[204] Although those risk-corridor suits had been largely unsuccessful, in June 2019, the Supreme Court granted review of the cases—collectively worth $12 billion—and they were argued on December 10.[205] Insurers have also sued over the risk adjustment methodology the government has used to calculate the amount that insurers with healthier, less expensive risk pools must pay to insurers with sicker, more expensive risk pools to spread costs among insurers participating in the exchanges.[206]

In addition, states and consumer organizations have brought cases challenging the legality of the Trump Administration's new rules that offer pathways out of the ACA insurance markets and aim to narrow Medicaid access by imposing

199. *See Trump v. Pennsylvania*, No. 19-454, 2020 WL 254168 (granting certiorari).

200. *E.g.*, N. Arapaho Tribe v. Burwell, 90 F. Supp. 3d 1238, 1240–41 (D. Wyo. 2015).

201. *See* Class Action Complaint, Marin v. Dave & Buster's, Inc., No. 1:15-cv-03608-AKH (S.D.N.Y. May 8, 2015).

202. *See* Opposed Motion of the U.S. House of Representatives to Intervene and Memorandum of Points and Authorities in Support Thereof, Texas v. United States, 352 F. Supp. 3d 665 (N.D. Tex. 2018), 2019 WL 114796.

203. *See* Sanford Health Plan v. United States, 139 Fed. Cl. 701, 701 (2018), *appeal filed*, No. 19-1290 (Fed. Cir. Dec. 11, 2018); Mont. Health Co-Op v. United States, 139 Fed. Cl. 213, 214 (2018), *appeal filed*, No. 19-1302 (Fed. Cir. Dec. 12, 2018); California v. Trump, 267 F. Supp. 3d 1119, 1121 (N.D. Cal. 2017).

204. *See, e.g.*, Moda Health Plan, Inc. v. United States, 892 F.3d 1311, 1320, 1324 (Fed. Cir. 2018), *cert. granted*, 139 S. Ct. 2743 (June 24, 2019) (mem.), *and argued*, No. 18-1028 (Dec. 10, 2019).

205. *See* Land of Lincoln Mutual Health Ins. Co. v. United States, 892 F.3d 1184 (Fed. Cir. 2018), *cert. granted*, 139 S. Ct. 2744 (June 24, 2019) (mem.), *and argued*, No. 18-1038 (Dec. 10, 2019).

206. *See, e.g.*, N.M. Health Connections v. U.S. Dep't of Health & Human Servs., No. 18-2186, 2019 WL 7343450 (10th Cir. Dec. 31, 2019).

work requirements.[207] One federal court in the case challenging the Administration's rule expanding a type of ACA-exempt health plan has already found for the plaintiffs and held the rule unlawful.[208] Kentucky, Arkansas, and New Hampshire's Medicaid waivers under the new rules have been struck down by lower federal courts, and in February 2020, the D.C. Circuit—in an opinion by one of that court's most conservative judges—invalidated Arkansas' waiver.[209] Cities have sued, arguing that President Trump's intentional executive sabotage of the ACA is unconstitutional.[210]

Finally, multiple plaintiffs including states, local governments, and advocacy organizations have challenged the Trump Administration's "public charge" rule, which makes the receipt of certain federal benefits, including health benefits grounds, for denying an application for admission or a green card.[211] The challengers have argued that the rule violates the APA, the Rehabilitation Act and the Equal Protection Clause.[212] Plaintiffs have also challenged the Administration's immigration proclamation, which moves beyond the Medicaid population targeted by the public charge rule to also bar certain immigrants who could rely on receiving ACA insurance subsidies on the exchanges from entering the country. In November 2019, a federal district court stopped the proclamation from going into effect by granting a nationwide injunction. With respect to the public charge rule, several lower courts had preliminarily enjoined the rule, but by February 2020, all of those injunctions had been stayed by courts of appeals or the Supreme Court, allowing the rule to go into effect while the litigation proceeds on the merits.[213]

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207. Ass'n for Cmty. Affiliated Plans v. U.S. Dep't of Treasury, No. 1:18-cv-02133-RJL (D.D.C. July 18, 2019) (challenging a rule known as the "Short-Term Plans" rule, Short-Term, Limited Duration Insurance, 83 Fed. Reg. 38,212 (Aug. 3, 2018)); New York v. U.S. Dep't of Labor, No. 1:18-cv-01747-JDB (D.D.C. Mar. 28, 2019) (challenging a rule known as the "Association Health Plans" rule, Definition of "Employer" Under Section 3(5) of ERISA–Association Health Plans, 83 Fed. Reg. 28, 912, 28,912 (June 21, 2018) (codified at 29 C.F.R. pt. 2510 (2018)).

208. New York v. U.S. Dep't of Labor, 363 F. Supp. 3d 109, 141 (D.D.C. 2019) (holding that the association health plans rule "ignor[ed] the language and purpose of both ERISA and the ACA" and vacating it), *appeal filed*, No. 19-5125 (D.C. Cir. Apr. 30, 2019).

209. *See* Gresham v. Azar, 363 F. Supp. 3d 165, 185 (D.D.C. 2019), *appeal filed*, No. 19-5094 (D.C. Cir. Apr. 11, 2019), aff'd, No. 19-5094, 19-5096 (D.C. Cir. Feb. 14, 2020); Stewart v. Azar, 313 F. Supp. 3d 237, 274 (D.D.C. 2018), *appeal after remand*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019), *and appeal filed*, No. 19-5095 (D.C. Cir. 2019). Following the November 2019 election of a Democratic governor in Kentucky, Kentucky informed CMS of its decision to terminate its section 1115 waiver that included a work requirement. Letter from Eric Friedlander, Acting Secretary, to Andrea J. Casart, Director, Division of Medicaid Expansion Demonstrations (Dec. 16, 2019), https://governor.ky.gov/attachments/20191216_Letter-to-CMS.pdf [https://perma.cc/79ER-LZ9T].

210. *See* Complaint, City of Columbus v. Trump, *supra* note 26, ¶¶ 1–5.

211. Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts. 103, 212, 213, 214, 245, 248).

212. *See* Make the Road N.Y. v. Cuccinelli, No. 19-civ-7993 (GBD), 2019 WL 5484638, at *8–10 (S.D.N.Y. Oct. 11, 2019) (holding that plaintiffs had shown a likelihood of success on the merits on these three claims).

213. New York v. U.S. Dep't of Homeland Sec., No. 19-3591, 2020 WL 95815 (2d Cir. Jan. 8, 2020), rev'd sub nom., Dep't of Homeland Sec. v. New York, 140 S. Ct. 599 (mem.) (2020).

C. CONGRESS

The ACA's dramatic trajectory through Congress and the nearly five election cycles since its enactment tells a parallel story.

1. 2010 to 2012: Early Opposition and Election Victories for Opponents

Despite two years of deliberation and efforts to reach bipartisan compromise before enactment,[214] the ACA ultimately passed without a single Republican vote.[215] Republicans continued to stoke opposition to the law after the statute was enacted. In particular, 2010 saw the rise of the conservative "Tea Party movement."[216] Tea Party activists had stormed town halls before the ACA was enacted, warning that the law was going to take away people's healthcare or establish "death panels" that would decide which people were worthy of treatment.[217] One hundred thirty-eight Tea Party candidates ran for Congress in the 2010 midterms,[218] including primary challengers who unseated incumbent Republicans who were perceived as insufficiently oppositional to President Obama.[219]

In the 2010 general elections, Republicans dislodged the Democrats from control of the House, gaining the most seats since 1938.[220] One study estimated that thirteen Democrats had lost their reelections specifically because of their support for the ACA.[221] After the midterms, *Time* ran a piece about the Democrats partially titled, *No Celebrating for Health Care Reform*.[222]

Immediately upon retaking control of the House, Republicans set out to repeal the ACA.[223] The first attempt was the Repealing the Job-Killing Health Care Law Act, which passed the House (with three Democratic votes) before failing in the Democrat-controlled Senate.[224] There would be approximately seventy such bills

214. *See* MCDONOUGH, *supra* note 57, at 63–101 (describing bipartisan negotiations in Congress leading up to the ACA's enactment).

215. *See Roll Call Vote 111th Congress – 1st Session*, SENATE.GOV, https://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396 [https://perma.cc/4JG5-HTB3] (last visited Dec. 23, 2019).

216. *See* Ilya Somin, *The Tea Party Movement and Popular Constitutionalism*, 105 NW. U. L. REV. COLLOQUY 300, 303 (2011).

217. *See* Don Gonyea, *From the Start, Obama Struggled with Fallout from a Kind of Fake News*, NPR (Jan. 10, 2017, 4:08 PM), https://www.npr.org/2017/01/10/509164679/from-the-start-obama-struggled-with-fallout-from-a-kind-of-fake-news [https://perma.cc/8SCG-HSNG].

218. Kate Zernike, *Tea Party Set to Win Enough Races for Wide Influence*, N.Y. TIMES (Oct. 14, 2010), https://www.nytimes.com/2010/10/15/us/politics/15teaparty.html.

219. *See, e.g.*, David Catanese, *Sen. Bennett Loses GOP Nomination*, POLITICO (May 10, 2010, 7:02 AM), https://www.politico.com/story/2010/05/sen-bennett-loses-gop-nomination-036960 [https://perma.cc/W97Z-QLSP].

220. Paul Harris & Ewen MacAskill, *US Midterm Election Results Herald New Political Era as Republicans Take House*, GUARDIAN (Nov. 3, 2010, 12:22 PM), https://www.theguardian.com/world/2010/nov/03/us-midterm-election-results-tea-party.

221. Paul Bedard, *Healthcare Vote Doomed 13 Democrats in 2010 Elections*, U.S. NEWS (Apr. 12, 2011), https://www.usnews.com/news/blogs/washington-whispers/2011/04/12/healthcare-vote-doomed-13-democrats-in-2010-elections [https://perma.cc/4TQS-DP8K].

222. Kate Pickert, *After a Rocky Year, No Celebrating for Health Care Reform*, TIME (Dec. 24, 2010), http://content.time.com/time/politics/article/0,8599,2039609,00.html.

223. *See* Riotta, *supra* note 5.

224. *Id.*

to come.[225] Besides repeal, other forms of congressional opposition to the law emerged. As Republican Senator Jim DeMint put it, the GOP was now in a position "to make sure no funding goes forward for Obamacare."[226]

The ACA loomed large over the 2012 presidential election. Voters cited healthcare as the second most important issue in the election, the highest it had been ranked since 1992.[227] The stakes were high because the bulk of the ACA had not yet been implemented, including the Medicaid expansion and the insurance marketplace provisions which were set to go into effect in 2014.[228] Although Democrats sought to point out how then-Governor Mitt Romney had created a similar market-based program in Massachusetts,[229] even Romney ran on repealing the ACA.[230]

President Obama's victory was convincing, but it was not the same landslide that marked the victories of the presidents reelected after the Social Security Act and the Civil Rights Act challenges.[231] The Democrats gained eight seats in the House, and the Republicans lost two seats in the Senate.[232]

2. 2012 to 2014: Congressional Efforts to Financially Starve the Law

Despite President Obama's reelection in 2012, Republican opposition to the ACA continued. In early 2013, conservative groups signed a letter, spearheaded by Reagan Attorney General Edwin Meese, calling for Congress to refuse to pass a continuing resolution that would ensure the government would remain continuously funded unless the ACA was defunded.[233] These efforts had a particular

225. *See supra* note 5 and accompanying text.

226. Igor Volsky, *DeMint Predicts 'A Very Intense Showdown' if Obama Opposes GOP Efforts to Defund Health Reform*, THINKPROGRESS (Nov. 4, 2010, 12:45 AM), https://thinkprogress.org/demint-predicts-a-very-intense-showdown-if-obama-opposes-gop-efforts-to-defund-health-reform-7d6b9f22f5e3/ [https://perma.cc/X69W-RFJR].

227. Robert J. Blendon et al., *Understanding Health Care in the 2012 Election*, 367 NEW ENG. J. MED. 1658, 1658 (2012).

228. Ezra Klein, *The Most Important Issue of this Election: Obamacare*, WASH. POST (Oct. 26, 2012, 11:13 AM), https://www.washingtonpost.com/news/wonk/wp/2012/10/26/the-most-important-issue-of-this-election-health-reform/?utm_term=.cde3b0ff4d8f.

229. *See US Election 2012 Guide: Mitt Romney and Barack Obama's Policy Positions*, TELEGRAPH (Aug. 17, 2012, 4:59 PM), https://www.telegraph.co.uk/news/worldnews/us-election/9480647/US-Election-2012-guide-Mitt-Romney-and-Barack-Obamas-policy-positions.html.

230. Mitt Romney, *Replacing Obamacare with Real Health Care Reform*, *in Health Care Reform and the Presidential Candidates*, 367 NEW ENG. J. MED. 1377, 1378 (2012).

231. *See President Map*, N.Y. TIMES (Nov. 29, 2012), https://www.nytimes.com/elections/2012/results/president.html?mtrref=www.google.com&gwh=31BD661A807241A023CB320C2B132F2D&gwt=pay (noting that Obama received 332 electoral votes and 3 million more popular votes than Romney); *supra* note 111 and accompanying text.

232. *See House Map*, N.Y. TIMES (Nov. 29, 2012), https://www.nytimes.com/elections/2012/results/house.html?mtrref=www.nytimes.com&gwh=BF56DA0F2740CBADFC4A37B3EF575534&gwt=pay; *Senate Map*, N.Y. TIMES (Nov. 29, 2012), https://www.nytimes.com/elections/2012/results/senate.html?mtrref=www.nytimes.com&gwh=AB31FD54AD2C0C5A247786D215610548&gwt=pay.

233. Matt Kibbe, *Coalition Letter: Congress Must Honor Sequester Savings and Defund ObamaCare Before It Is Too Late*, FREEDOMWORKS BLOG (Feb. 14, 2013), http://www.freedomworks.org/content/coalition-letter-congress-must-honor-sequester-savings-and-defund-obamacare-it-too-late [https://perma.cc/FFT5-B8Q9].

urgency: Republicans were (presciently) concerned that once the bulk of the ACA went into effect in 2014 the law would be harder to repeal.[234] By October 2013, the Tea Party had won the internal Republican Party battles, and the Republicans in the House triggered a government shutdown by refusing to pass a continuing resolution to fund the government unless Democrats agreed to their demands on the ACA.[235]

Two weeks later, with the Treasury Department warning of a default, Republicans temporarily relented.[236] But next they targeted provisions of the law that provided crucial transitional financing to steady the insurance markets during the early years of implementation—the risk corridor payments discussed in section II.B.5. Senator Marco Rubio, calling the money an insurance "bailout," sponsored a measure to prevent appropriation of some of those funds; that measure passed in 2014 (and is now the subject of the pending Supreme Court case, *Moda*, already discussed).[237]

Congress likewise refused to appropriate other funding required for HHS to satisfy its outreach obligations under the law—including funds used to inform individuals of their coverage options, a task that was necessary to draw more people into the insurance markets.[238] HHS resorted to shifting money around from other programs and requesting philanthropic outreach funding from the business sector and nonprofits, prompting Republican outcry.[239]

Also in 2014, the House brought the lawsuit referenced in section II.B.4, *House of Representatives v. Burwell*, challenging another essential line of stabilization funds—the cost-sharing reduction payments (CSRs) that the ACA promises to insurers to offset reductions in the premiums low-income consumers pay.[240] Later, when President Trump took office (and while the suit was still pending), he

234. *See* Kibbe, *supra* note 233; Sheryl Gay Stolberg & Mike McIntire, *A Federal Budget Crisis Months in the Planning*, N.Y. TIMES (Oct. 5, 2013), https://www.nytimes.com/2013/10/06/us/a-federal-budget-crisis-months-in-the-planning.html.

235. *See* Jonathan Weisman & Jeremy W. Peters, *Government Shuts Down in Budget Impasse*, N.Y. TIMES (Sept. 30, 2012), https://www.nytimes.com/2013/10/01/us/politics/congress-shutdown-debate.html.

236. Jonathan Weisman & Ashley Parker, *Republicans Back Down, Ending Crisis over Shutdown and Debt Limit*, N.Y. TIMES (Oct. 16, 2013), https://www.nytimes.com/2013/10/17/us/congress-budget-debate.html.

237. Pear, *supra* note 24.

238. *See* Kathleen Sebelius & Nancy-Ann DeParle, *Present at the Creation: Implementation of the Affordable Care Act, 2010 to 2014*, *in* THE TRILLION DOLLAR EXPERIMENT, *supra* note 84; Jason Millman, *Following Sebelius Phone Call, Foundation Donated $13M to Obamacare Outreach Group, Report Says*, WASH. POST (Apr. 21, 2014), https://www.washingtonpost.com/news/wonk/wp/2014/04/21/following-sebelius-phone-call-foundation-donated-13m-to-obamacare-outreach-group-report-says/?noredirect=on&utm_term=.61a3e9fbebeb.

239. Millman, *supra* note 238; *see also Coverage of HHS Secretary Kathleen Sebelius Testifying Before Congress Concerning the Obamacare Website* (CNN television broadcast Oct. 30, 2013, 12:00 PM), http://transcripts.cnn.com/TRANSCRIPTS/1310/30/cnr.07.html [https://perma.cc/W95W-D3ME] (showing HHS Secretary Sebelius describing how the agency drew funding from related programs).

240. U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 168 (D.D.C.), *appeal held in abeyance*, 676 F. App'x 1 (D.C. Cir. 2016) (per curiam).

threatened to discontinue the CSRs on a near weekly basis.[241] Instability roiled the insurance markets as insurers tried to build that risk into their pricing by raising premiums. Some insurers even put out two different possible sets of future rates to account for the uncertainty.[242] In 2017, after President Trump cut off the payments,[243] the parties settled the case.[244] The payments remain terminated.[245]

The 2014 midterm elections consolidated Republican control over the House and gave the party control of the Senate.[246] Commentators reported that the ACA was partly to blame for the Democrats' losses.[247] Despite the rollout of the core ACA provisions expanding benefits and a significant drop in the percentage of uninsured Americans, polling showed that support for the law had fallen significantly since its enactment.[248] A slim majority of Americans opposed the ACA and a larger number disapproved of President Obama's handling of healthcare.[249] Almost double the number of Americans claimed that the ACA had hurt their family (27%) than claimed that it had helped them (14%).[250] Republicans, meanwhile, sought to spotlight what had been an extraordinarily rocky rollout of the

241. *See, e.g.*, Lydia Ramsey & Bob Bryan, *Trump Is Threatening a Move that Could Make Obamacare Implode and Hurt Lawmakers' Coverage*, BUS. INSIDER (July 31, 2017), https://www.businessinsider.my/trump-obamacare-cost-sharing-payments-2017-7/ [https://perma.cc/N8VB-3YEU] (citing tweets by President Trump threatening to cut off the payments); Dylan Scott, *Trump Will Pull Obamacare Subsidies in Another Attack on Health Law*, VOX (Oct. 12, 2017, 10:52 PM), https://www.vox.com/policy-and-politics/2017/10/12/16070724/trump-cost-sharing-reductions-pulled [https://perma.cc/RG95-TG27] (describing how "President Donald Trump has been threatening to end the payments . . . for months").

242. Amy Goldstein, *Timing of White House Actions Unrolling Parts of ACA "Couldn't Be Worse," States Say*, WASH. POST (Oct. 14, 2017), https://www.washingtonpost.com/national/health-science/timing-of-white-house-actions-unrolling-parts-of-aca-couldnt-be-worse-states-say/2017/10/14/bab688bc-b0f0-11e7-9e58-e6288544af98_story.html?utm_term=.e3bf53a2d27b.

243. Notice at 1–2, U.S. House of Representatives v. Hargan, No. 16-5202, ECF No. 1698827 (D.C. Cir. Oct. 13, 2017); *see also* Timothy Jost, *Administration's Ending of Cost-Sharing Reduction Payments Likely to Roil Individual Markets*, HEALTH AFF. BLOG (Oct. 13, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171022.459832/full/ [https://perma.cc/95K8-DQFT].

244. Exhibit A: Settlement Agreement at 2, U.S. House of Representatives v. Hargan, No. 1:14-cv-01967-RMC, (D.D.C. Dec. 15, 2017).

245. PREETHI RAO & SARAH A. NOWAK, RAND CORP., EFFECTS OF ALTERNATIVE INSURER RESPONSES TO DISCONTINUED FEDERAL COST-SHARING REDUCTION PAYMENTS 1 (2019), https://www.rand.org/pubs/research_reports/RR2963.html [https://perma.cc/DRH3-A87G] (noting that "the federal government is no longer making CSR payments to insurers").

246. *Senate Election Results, 2014*, N.Y. TIMES (Dec. 17, 2014, 12:28 PM), https://www.nytimes.com/elections/2014/results/senate?utm_source=top_nav&utm_medium=web&utm_campaign=election-2014.

247. *See, e.g.*, Kimberley Leonard, *Obamacare's Role in the Election*, U.S. NEWS (Nov. 3, 2014, 10:10 PM), https://www.usnews.com/news/articles/2014/11/03/obamacare-among-issues-voters-are-unhappy-about [https://perma.cc/P29B-8DBN].

248. Robert J. Blendon & John M. Benson, *Voters and the Affordable Care Act in the 2014 Election*, 371 NEW ENG. J. MED. e31(1), e31(2) & tbl.1 (2014) (finding that support for the ACA fell by a net eight points between enactment and September of 2014); *KFF Health Tracking Poll: The Public's Views on the ACA*, KAISER FAMILY FOUND. (Nov. 20, 2019), [https://perma.cc/TUZ5-WCC2] (finding a net drop in support between April 2010 and October 2014 of ten points).

249. Blendon & Benson, *supra* note 248, at (e)31(2) tbl.1.

250. *Id.* at e31(4) tbl.3.

federal insurance marketplace website.[251]

After the election defeat, future Senate Minority Leader Charles Schumer declared: "Democrats blew the opportunity the American people gave them. We took their mandate and put all of our focus on the wrong problem – health-care reform."[252] Some vulnerable Democrats had run in the midterms by highlighting their opposition to some parts of the ACA,[253] and some commentators questioned whether "Obamacare [was] destroying the Democratic Party."[254] Throughout this time, Republicans in Congress continued to pass bills repealing the ACA in whole or in part—each of which was vetoed by President Obama.[255]

3. 2016: The Political Tide Starts to Turn

Ironically, it took a change in administration to really entrench the law, or at least reveal how entrenched it already had become. As early as the 2016 Republican primaries, the messaging started to turn. Later, even with control of both Congress and the presidency, Republicans could not repeal the law.

Candidate Trump surprised many in 2016 when he seemed to embrace a solidarity paradigm for healthcare.[256] He assured voters that, under his health plan, "I am going to take care of everybody" and "[t]he government's going to pay for it."[257] Trump's message of "tak[ing] care of people that can't take care of themselves" did not dissuade primary voters; in the candidate's own words, "[e]very time I say this at a rally . . . it got [sic] a standing ovation."[258]

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251. David Nather, *Obamacare Wins? See You in 2014*, POLITICO (Oct. 18, 2013, 5:22 PM), https://www.politico.com/story/2013/10/obamacare-2014-elections-098503 [https://perma.cc/8V3L-YC5G].

252. Sean Sullivan, *Schumer: Democrats "Blew" Opportunity by Focusing on "Wrong Problem" – Health Care*, WASH. POST (Nov. 25, 2014, 7:02 PM), https://www.washingtonpost.com/news/post-politics/wp/2014/11/25/schumer-democrats-blew-opportunity-by-focusing-on-wrong-problem-of-health-care/?noredirect=on&utm_term=.c1337db2ec45.

253. *See* Halimah Abdullah, *Why Are Some Democrats Running from Obamacare?*, CNN (Apr. 22, 2014, 9:44 AM), https://www.cnn.com/2014/04/18/politics/democrats-running-from-obamacare/index.html [https://perma.cc/8WWB-HXVK].

254. *E.g.*, Thomas B. Edsall, *Is Obamacare Destroying the Democratic Party?*, N.Y. TIMES (Dec. 2, 2014), https://www.nytimes.com/2014/12/03/opinion/is-obamacare-destroying-the-democratic-party.html?_r=0.

255. Riotta, *supra* note 5.

256. *See, e.g.*, Sarah Kliff, *Donald Trump: Single-Payer "Works Well in Canada,"* VOX (Aug. 6, 2015, 10:05 PM), https://www.vox.com/2015/8/6/9114601/donald-trump-single-payer [https://perma.cc/4SSH-A3MR] (describing surprise at Trump's prior healthcare positions); Benjy Sarlin, *What President Donald Trump Would Do, According to Donald Trump*, MSNBC (July 27, 2015, 8:26 PM), http://www.msnbc.com/msnbc/what-president-donald-trump-would-do-according-donald-trump [https://perma.cc/NAY8-RVPY] (describing Trump's healthcare positions, among others, as "surprisingly liberal").

257. Linda Qiu, *Ted Cruz's False Claim that Trump, Clinton and Sanders "Have the Identical Position on Health Care,"* POLITIFACT (Jan. 31, 2016, 4:16 PM), http://www.politifact.com/truth-o-meter/statements/2016/jan/31/ted-cruz/ted-cruzs-false-claim-trump-clinton-and-sanders-ha/ [https://perma.cc/BR56-Q4Q3] (noting that, though he criticized "Obamacare," Trump assured voters "I am going to take care of everybody").

258. Tami Luhby, *Trump's Health Care Plan: What He Promises and What It Really Says*, CNN (Mar. 3, 2016, 6:35 PM), http://money.cnn.com/2016/03/03/news/economy/trump-health-care/index.html [https://perma.cc/3BPR-7RLZ].

He would, of course, subsequently retreat from these positions. But that he took these positions—and won—reflected a sensitivity to changing norms around universal coverage in the wake of the ACA.

In the aftermath of the 2016 election, when Republican congressional leaders tried to make good on their longstanding promise to repeal the ACA, now-President Trump continued to promise that "[w]e're going to have insurance for everybody."[259] He explicitly characterized his position in contrast to conservative orthodoxy: "There was a philosophy in some circles that if you can't pay for it, you don't get it. That's not going to happen with us."[260] He also stressed the importance of covering people with preexisting conditions.[261] President Trump's publicly stated position at the time meant that repeal might no longer mean the loss of healthcare for large swaths of the population. The ACA appeared to already have entrenched that principle, regardless of whether the ACA itself survived. And precisely because President Trump had rejected the idea of repealing the ACA without a replacement,[262] the repeal push was burdened with articulating what such a replacement would look like.

An initial bill, the American Health Care Act (AHCA), would have repealed the individual mandate, sunsetted much of the federal funding for the Medicaid expansion population, converted Medicaid funding to per capita block grants, and allowed states to restrict access to coverage through conditions like work requirements.[263] The nonpartisan Congressional Budget Office (CBO) projected that by 2020, twenty-one million fewer people would be insured under the AHCA than under the ACA,[264] and protestors filled town halls, decrying attempts

259. Robert Costa & Amy Goldstein, *Trump Vows "Insurance for Everybody" in Obamacare Replacement Plan*, WASH. POST (Jan. 15, 2017), https://www.washingtonpost.com/politics/trump-vows-insurance-for-everybody-in-obamacare-replacement-plan/2017/01/15/5f2b1e18-db5d-11e6-ad42-f3375f271c9c_story.html?utm_term=.610fb3d4877d.

260. *Id.*

261. *Trump Says New GOP Healthcare Bill 'Guarantees"' Coverage for Pre-Existing Conditions*, L.A. TIMES (Apr. 30, 2017, 12:27 PM), http://www.latimes.com/politics/la-pol-updates-everything-president-trump-says-new-gop-health-care-bill-1493580454-htmlstory.html ("Pre-existing conditions are in the bill. And I mandate it. I said, 'Has to be.'").

262. Maggie Haberman & Robert Pear, *Trump Tells Congress to Repeal and Replace Health Care Law 'Very Quickly*,' N.Y. TIMES (Jan. 10, 2017), https://www.nytimes.com/2017/01/10/us/repeal-affordable-care-act-donald-trump.html; Greg Sargent, *How Trump Could Blow Up the GOP's Obamacare Repeal Strategy*, WASH. POST (Jan. 10, 2017, 9:41 AM), https://www.washingtonpost.com/blogs/plum-line/wp/2017/01/10/how-trump-could-blow-up-the-gops-obamacare-repeal-strategy/?utm_term=.259b8924b032.

263. American Health Care Act of 2017, H.R. 1628, 115th Cong. *See* KAISER FAMILY FOUND., SUMMARY OF THE AMERICAN HEALTH CARE ACT 1–2 (2017), http://files.kff.org/attachment/Proposals-to-Replace-the-Affordable-Care-Act-Summary-of-the-American-Health-Care-Act [https://perma.cc/JB7Z-UKGC]; Rosenbaum, *supra* note 14, at 589–91; *The American Health Care Act of 2017 (H.R. 1628) Executive Summary*, HEALTH REFORM TRACKER, https://web.archive.org/web/20190414235812/http://www.healthreformtracker.org/the-american-health-care-reform-act-of-2017-h-r-277-executive-summary/ [https://perma.cc/N2TA-84LF] (last visited Dec. 27, 2019).

264. CONG. BUDGET OFFICE, AMERICAN HEALTH CARE ACT 2 (2017), https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/americanhealthcareact.pdf [https://perma.cc/7NMW-G5XY].

to take away coverage.[265] Speaker Paul Ryan pulled the bill from the floor in March 2017.[266] The collapse of this first effort culminated in Ryan's public concession—seemingly acknowledging the end of the fight: "We're going to be living with Obamacare for the foreseeable future."[267]

He was wrong. By April 2017, repeal efforts were active again. The conservative Freedom Caucus signed on to a revived AHCA after the addition of an amendment that would both: (1) repeal the Essential Health Benefits requirement (the ACA's minimum requirements for what insurance plans must offer), and (2) permit states to obtain waivers to allow insurers to charge more to people with preexisting conditions if they had let their coverage lapse.[268] More moderate Republicans came on board through another amendment that created an $8 billion fund to subsidize high-risk insurees.[269] On May 4, 2017, the House narrowly passed the bill.[270] With the bill lacking Senate support, a flurry of re-drafting ensued and produced several possible bills (some of which had several versions): the Better Care Reconciliation Act (BCRA),[271] the Obamacare Repeal Reconciliation Act (ORRA),[272] and the so-called "skinny repeal."[273]

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265. MJ Lee & Lauren Fox, *The Many Reasons Republicans Are Stuck on Obamacare Repeal*, CNN (Feb. 16, 2017, 6:16 AM), https://www.cnn.com/2017/02/16/politics/reasons-republicans-stuck-obamacare-repeal/index.html [https://perma.cc/L27F-7XMY].

266. Robert Pear et al., *In Major Defeat for Trump, Push to Repeal Health Law Fails*, N.Y. TIMES (Mar. 24, 2017), https://www.nytimes.com/2017/03/24/us/politics/health-care-affordable-care-act.html.

267. German Lopez, *Paul Ryan:"Obamacare Is the Law of the Land,"* VOX (Mar. 24, 2017, 5:12 PM), https://www.vox.com/policy-and-politics/2017/3/24/15055128/ahca-obamacare-paul-ryan [https://perma.cc/29KK-KXC4].

268. For an archived resource detailing Republican efforts at healthcare reform, see *Macarthur Amendment to the AHCA: Executive Summary*, HEALTH REFORM TRACKER, http://web.archive.org/web/20190219184130/http://www.healthreformtracker.org/macarthur-amendment-to-the-ahca/ [https://perma.cc/ZJ8C-WXLW] (last visited Dec. 27, 2019).

269. *Id*. (detailing the so-called Upton Amendment).

270. Rachel Roubein, *Timeline: The GOP's Failed Effort to Repeal ObamaCare*, HILL (Sept. 26, 2017, 8:02 PM), https://thehill.com/policy/healthcare/other/352587-timeline-the-gop-effort-to-repeal-and-replace-obamacare [https://perma.cc/4YGU-PZKV].

271. Better Care Reconciliation Act of 2017, Amendment in the Nature of Substitute to H.R. 1628, 115th Cong., https://www.budget.senate.gov/imo/media/doc/BetterCareReconcilistionAct.6.26.17.pdf [https://perma.cc/B7AH-7LAL].

272. Obamacare Repeal Reconciliation Act of 2017, Amendment in the Nature of Substitute to H.R. 1628, 115th Cong., https://www.budget.senate.gov/imo/media/doc/REPEAL7.19.17.pdf [https://perma.cc/V7KH-ZLSV].

273. *See* Health Care Freedom Act, Amendment in the Nature of Substitute to H.R. 1628, 115th Cong. (2017), https://www.budget.senate.gov/imo/media/doc/HealthCareFreedomAct.pdf [https://perma.cc/66YA-4G2V]; Dylan Scott, *"Skinny Repeal," Explained: Senate Republicans' Shrinking Obamacare Repeal Dreams*, VOX (July 27, 2017, 2:42 PM), https://www.vox.com/policy-and-politics/2017/7/26/16029976/senate-health-care-bill-skinny-obamacare-repeal-now [https://perma.cc/2FJE-JY25]. For a side-by-side comparison of the three bills and the ACA, see Timothy Stoltzfus Jost, *Health Care Reform in the Senate's Hands*, 36 HEALTH AFF. 1365, 1365 (2017), and *Brief Summary of ACA Repeal Bills*, HEALTH REFORM TRACKER, https://web.archive.org/web/20190416153620/http://www.healthreformtracker.org/brief-summary-of-aca-repeal-bills/ [https://perma.cc/PTE8-8T9D] (last visited Dec. 27, 2019).

A draft of the BCRA was first released to the public on June 22 and went through several revisions. *See* Roubein, *supra* note 270. Among other things, the draft replaced the individual mandate with enrollment provisions to punish gaps in coverage, reduced eligibility for tax credits and essential health

Republicans saw skinny repeal as the last hope.[274] As indicated by its moniker and unlike the other proposals—which were more draconian—the skinny repeal was a barebones proposal. As initially envisioned, it would have removed some of the less popular provisions of the ACA, including the individual mandate and the employer mandate until 2024, and replaced them with nothing for the time being.[275] The skinny repeal lacked details, including specific plans for Medicaid, because its goal was to get the bill to a conference committee with House and Senate members where real replacement details could be ironed out.[276]

The CBO estimated that sixteen million fewer Americans would have coverage under the bill.[277] Republican Senators Lisa Murkowski and Susan Collins, focusing their concerns on those who would lose coverage, withheld their support.[278] Attempts to retreat from the ACA's new baseline of coverage kept creating roadblocks.

The Senate voted against the BCRA on July 25 and against the ORRA on July 26.[279] The skinny repeal was last to fail when, on July 28, Senator John McCain gave his now-famous thumbs down on the floor of the Senate after midnight.[280] At 2:05 AM, in an iconic moment of ACA resilience, Majority Leader Mitch McConnell declared "it is time to move on."[281] A renewed repeal-and-replace effort in September, the Graham–Cassidy Amendment, collapsed out of the gate[282] after the CBO again indicated that this bill would cause millions of people

benefits requirements, lifted the employer mandate, allowed states to block grant Medicaid, and reduced federal funding for the Medicaid expansion. *See* Jost, *supra*. An amendment to the BCRA proposed by Senator Ted Cruz would have permitted states to allow insurers to consider preexisting conditions for some plans. *See Brief Summary of ACA Repeal Bills*, *supra*. ORRA was released on July 19, and was an even more drastic repeal of ACA protections. *Id.*

274. *See* Tami Luhby, *What Was in the Failed Senate "Skinny Repeal" Health Care Bill?*, CNN (July 28, 2017, 8:57 AM) https://money.cnn.com/2017/07/27/news/economy/senate-skinny-repeal-health-care/index.html [https://perma.cc/8Z7J-ETYT] (noting that the failure of the skinny repeal effectively "halt[ed] the party's years-long effort to dismantle the health reform law").

275. *Id.*; Timothy Stoltzfus Jost, *A Midsummer Night's Strange Reality*, 36 HEALTH AFF. 1528, 1529 (2017).

276. Scott, *supra* note 273.

277. Vann R. Newkirk II, *The Skinny Repeal Gets a Score*, ATLANTIC (July 27, 2017), https://www.theatlantic.com/politics/archive/2017/07/the-skinny-repeal-gets-a-score/535038/.

278. Dylan Scott, *How Graham-Cassidy Measures Up to Lisa Murkowski's Standards for Health Care Reform*, VOX (Sept. 21, 2017, 4:40 PM), https://www.vox.com/policy-and-politics/2017/9/21/16347012/graham-cassidy-murkowski-standards-health-reform (quoting Senator Lisa Murkowski, who said: "I want greater access and lower costs. . . . If you are going to eliminate Medicaid expansion or even if you're going to wind down Medicaid expansion, that's not increasing access" (alteration in original)); Nick Visser, *Sen. Susan Collins Comes out Against Health Care Bill*, HUFFPOST (June 26, 2017, 8:09 PM), https://www.huffingtonpost.com/entry/susan-collins-no-health-care_us_59519143e4b02734df2cdc97 [https://perma.cc/5FK3-KC6Q] (quoting Senator Collins, who said she would not "support a bill that is going to result in tens of millions of people losing their health insurance").

279. Jost, *supra* note 275, at 1528–29.

280. Carl Hulse, *McCain Provides a Dramatic Finale on Health Care: Thumb Down*, N.Y. TIMES (July 28, 2017), https://www.nytimes.com/2017/07/28/us/john-mccains-real-return.html; Roubein, *supra* note 270.

281. Roubein, *supra* note 270.

282. Rosenbaum, *supra* note 14, at 581, 593–94. Among other things, the amendment would have struck the ACA's mandate penalties, eliminated premium tax credits and cost-sharing reductions by

to lose insurance coverage.[283]

4. Broader Changes in Political Rhetoric

President Trump was not the only Republican whose rhetoric about healthcare coverage reflected a values shift. Throughout the debates over ACA repeal, various Republican senators, governors, and even President Trump's own Office of Management and Budget (OMB) Director, voiced the importance of preserving the baseline norm of coverage established by the ACA. Typical comments during this time included:

- "I think everybody will have coverage that's better than what they had under Obamacare."—OMB Director Mick Mulvaney[284]
- "As I have said before, I did not come to Washington to hurt people. . . . I have serious concerns about how we continue to provide affordable care to those who have benefited from West Virginia's decision to expand Medicaid."—Republican Senator Shelley Moore Capito[285]
- "We've made great strides at protecting the most vulnerable and I believe, in its present form, [repeal] would not be good for Vermont."—Republican Governor Phil Scott[286]
- "[The GOP replacement bill] calls into question coverage for the vulnerable and fails to provide the necessary resources to ensure that no one is left out, while shifting significant costs to the states."—Republican Governors John Kasich, Brian Sandoval, and Charles Baker, in a joint letter with Democratic governors[287]

Another key moment in the repeal-and-replace debate came from mainstream media—a different mode of modern public deliberation and another kind of

2020, and turned Medicaid into block grants to states. Timothy Stoltzfus Jost, *Much Activity, Uncertainty Remains*, 36 HEALTH AFF. 1864, 1864 (2017).

283. Jost, *supra* note 282, at 1864.

284. *OMB Director Mick Mulvaney Interview: Full Transcript*, CBS NEWS (May 7, 2017, 12:16 PM), https://www.cbsnews.com/news/omb-director-mick-mulvaney-interview-full-transcript/ [https://perma.cc/CT8C-3DTJ].

285. Press Release, Senator Shelley Moore Capito, U.S. Senate, Capito Statement on Health Care, Vote to Repeal Obamacare (July 18, 2017), https://www.capito.senate.gov/news/press-releases/capito-statement-on-health-care-vote-to-repeal-obamacare [https://perma.cc/A2JD-CKNL].

286. Jonathan Martin & Alexander Burns, *Governors from Both Parties Denounce Senate Obamacare Repeal Bill*, N.Y. TIMES (July 14, 2017), https://www.nytimes.com/2017/07/14/us/politics/governors-oppose-senate-affordable-care-act-repeal.html.

287. Letter from John R. Kasich et al., state governors, to Mitch McConnell, Majority Leader, U.S. Senate, and Charles E. Schumer, Minority Leader, U.S. Senate (June 16, 2017), https://www.governor.pa.gov/wp-content/uploads/2017/06/20170616-Bipartisan-Governors-Letter-to-Senate-Leadership.pdf [https://perma.cc/6UHW-CZM7]; *see also* Megan Messerly, *Sandoval, Other Governors Say ACA Repeal Bill "Calls into Question" Health Care Coverage for Vulnerable Americans*, NEV. INDEP. (June 16, 2017, 11:15 AM), https://thenevadaindependent.com/article/sandoval-other-governors-say-aca-repeal-bill-calls-into-question-health-care-coverage-for-vulnerable-americans [https://perma.cc/VN65-KDMY].

entrenchment evidence—when in 2017 late-night host Jimmy Kimmel recounted the traumatic birth of his newborn son and emphasized the importance of health insurance for any new parent in the same situation.[288] Republican Senator Bill Cassidy's comment in describing his new litmus test for an ACA replacement captured the influence of Kimmel's moment:

> I ask does it pass the Jimmy Kimmel test. . . . Would the child born with a congenital heart disease be able to get everything she or he would need in that first year of life . . . even if they go over a certain amount? . . . So simple answer: I want to make sure folks get the care they need.[289]

Many of the specific policies Republicans touted during the GOP debate would not have provided the same degree of coverage as the ACA, regardless of comments like Senator Cassidy's. But writing that tension off as hypocrisy would miss the importance of the rhetorical shift in which several baselines set by the ACA were adopted by (some) Republicans who had initially opposed the law.

5. Social Movements and the Surprising Rise of Medicaid—and Its Values

The same period saw extensive popular mobilization in defense of the ACA, a different kind of entrenchment that we call expressive entrenchment.

There is a large body of literature on the role of social movements in shifting legal baselines.[290] In the case of the ACA, it took the threat of repeal to spark the massive popular mobilization that emerged during the fights of 2017. Sensing the fight ahead, Senator Bernie Sanders and Democratic National Committee Chair Tom Perez embarked on a nationwide tour to rally support in defense of the ACA, which included a 348-mile van tour through Appalachia.[291] In Washington, large-scale protests produced images of the Capitol Police removing Americans with disabilities.[292] Across the country, constituents flooded town

288. Laura Bradley, *The Incredible Reach of Jimmy Kimmel's Emotional Monologue About His Son*, VANITY FAIR (May 3, 2017), https://www.vanityfair.com/hollywood/2017/05/jimmy-kimmel-son-monologue-stephen-colbert-health-care; Jimmy Kimmel Live, *Jimmy Kimmel Reveals Details of His Son's Birth Defect & Heart Disease* at 10:46–12:40, YOUTUBE (May 1, 2017), https://www.youtube.com/watch?v=MmWWoMcGmo0.

289. Melissa Mahtani, *Health Care Bill Should Pass "Jimmy Kimmel Test," Senator Says*, CNN (May 5, 2017, 1:10 PM), http://www.cnn.com/2017/05/05/politics/senator-cassidy-health-bill-jimmy-kimmel-test-cnntv/ [https://perma.cc/PF2P-WXLM].

290. *See generally* 2005–06 Brennan Center Symposium Lecture, Reva B. Siegel, *Constitutional Culture, Social Movement Conflict and Constitutional Change: The Case of the De Facto ERA*, 94 CALIF. L. REV. 1323 (2006) (summarizing scholarship that examines the effects of social movements on constitutional law).

291. Jeff Stein, *Inside Bernie Sanders's Campaign to Save Obamacare*, VOX (Aug. 7, 2017, 8:30 AM), https://www.vox.com/policy-and-politics/2017/8/7/16069112/bernie-sanders-obamacare-trumpcare [https://perma.cc/8PTL-Q7YN].

292. *See, e.g.*, Jeff Stein, "*No Cuts to Medicaid!" : Protesters in Wheelchairs Arrested After Release of Health Care Bill*, VOX (June 22, 2017, 2:40 PM), https://www.vox.com/policy-and-politics/2017/6/22/15855424/disability-protest-medicaid-mcconnell [https://perma.cc/U67M-DD5P]; David Weigel, *Left Out of AHCA Fight, Democrats Let Their Grass Roots Lead – and Win*, WASH. POST (Mar. 24,

halls confronting legislators.[293] One commentator at the time wrote that for the GOP, there was "no escape from . . . town-hall hell."[294]

New interest groups, like Indivisible, rose to the fore.[295] More established progressive groups, like MoveOn and AARP, took up the ACA's cause as their own.[296] A *Washington Post* article reported: "Democrats let their grass roots lead—and win."[297]

And perhaps most surprising of all, Medicaid—the long-pilloried government program for low-income individuals, the program that symbolizes a government guarantee of universal coverage more than any other—became the central talking point and sticking point of the entire debate over repeal and replace. Typical of many comments was this one, supporting Medicaid, from swing vote GOP Senator Lisa Murkowski's communications office:

> Sen. Murkowski understands that Alaska's relationship with Medicaid has changed since 2015. And throughout the health care reform process this Congress, she has been very vocal about her concerns with what any bill would do in regard to Medicaid cuts and wanted to ensure that we didn't pull the rug out from under anyone.[298]

Republican Senators Susan Collins,[299] Shelley Moore Capito,[300] and Dean Heller[301] specifically singled out Medicaid in voicing concerns about the proposed legislation. And it was the threat to the Medicaid expansion that prompted the important bipartisan governors' letter excerpted above urging Congress to pull the repeal legislation.[302] As Wisconsin Republican Governor Scott Walker

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2017, 9:35 PM), https://www.washingtonpost.com/news/powerpost/wp/2017/03/24/left-out-of-ahca-fight-democrats-let-their-grass-roots-lead-and-win/.

293. *See, e.g.*, Jessica Taylor, *Anger Rises Across the Country at GOP Congressional Town Halls*, NPR (Feb. 22, 2017, 11:59 AM), https://www.npr.org/2017/02/22/516527499/anger-rises-across-the-country-at-gop-congressional-town-halls [https://perma.cc/7KMQ-S28T].

294. A.B. Stoddard, *There's No Escape from the GOP's Town-Hall Hell*, REALCLEARPOLITICS (Feb. 15, 2017), https://www.realclearpolitics.com/articles/2017/02/15/theres_no_escape_from_the_gops_town-hall_hell_133093.html [https://perma.cc/X5XH-CWCP].

295. *See* Weigel, *supra* note 292. Indivisible is a nationwide group founded by former congressional staffers in the aftermath of the 2016 election, which played a crucial role in sharing organizational tools and rallying members to attend town halls across the country in support of the ACA. *Id.*

296. *Id.*

297. *Id.*

298. Erin Granger, *Then and Now: Sen. Murkowski's Health Care Repeal Vote*, FAIRBANKS DAILY NEWS-MINER (Aug. 9, 2017), http://www.newsminer.com/news/local_news/then-and-now-sen-murkowski-s-health-care-repeal-vote/article_d8570d70-7cd8-11e7-b625-47807d2e2af2.html.

299. Saisha Talwar, *GOP Bill Would "Jeopardize the Very Existence of Rural Hospitals and Nursing Homes": Collins*, ABCNEWS (July 16, 2017, 10:23 AM), https://abcnews.go.com/Politics/gop-bill-jeopardize-existence-rural-hospitals-nursing-homes/story?id=48656587 [https://perma.cc/88AA-XT22].

300. Press Release, Shelley Moore Capito, *supra* note 285.

301. Clare Foran, *GOP Senator Dean Heller Won't Support Senate Healthcare Bill*, ATLANTIC (June 23, 2017), https://www.theatlantic.com/politics/archive/2017/06/gop-senator-dean-heller-wont-support-senate-healthcare-bill/531483/ (quoting the Senator saying: "At the end of the day, it's all about Medicaid expansion").

302. Letter from John R. Kasich et al., state governors, *supra* note 287.

put it: "You can't cut Medicaid, there's just no way about it."[303]

In *NFIB*, the Supreme Court saw the Medicaid expansion as expendable, and "secondary" to the importance of saving the individual mandate.[304] Times changed. Medicaid was not new to the ACA—the program was enacted in 1965—and is only one piece of the ACA. But somehow, over the first four years of ACA implementation, the centrality of Medicaid in the public and political spheres brought the program—and the universal coverage principle it stands for—to center stage. In 2012 no one would have predicted that, by 2017, Medicaid would be critical to saving the ACA in Congress.

* * *

In the end, desperate for a "win," Republicans during this period succeeded in repealing only the penalty associated with the individual mandate. They were able to do this via the 2017 tax-cut bill (which, thanks to special Senate rules for budget-related legislation, needed only fifty votes rather than the sixty votes Senate rules typically require to close debate and move to a vote).[305] At the time, the measure was mostly symbolic—the mandate was the heart of the first Supreme Court case and had long been opposed by Republicans, but it had not been aggressively enforced.[306] Later, however, savvy ACA opponents seized it as the linchpin of the now-pending litigation in *Texas v. United States*, discussed in section II.B.4.

6. 2018: Healthcare for All

By the 2018 midterms, Democrats were eager to run on healthcare. Healthcare was the most commonly mentioned topic in political advertisements.[307] In one memorable advertisement, Democratic Senator Joe Manchin of West Virginia—a state that had given President Trump his second largest percentage of the vote in 2016[308]—shot a copy of the *Texas v. United States*

303. Emily Cadei, *Scott Walker, Other Governors Wary of Medicaid Cuts in Obamacare Repeal*, NEWSWEEK (Feb. 24, 2017, 1:21 PM), http://www.newsweek.com/scott-walker-medicaid-obamacare-560590.

304. *See* BISKUPIC, *supra* note 137, at 234.

305. Tax Cuts and Jobs Act, Pub. L. No. 115–97, § 11081, 131 Stat. 2054, 2092 (2017) (codified as amended at 26 U.S.C. § 5000A (2017)), *invalidated by* Texas v. United States, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom.* Texas v. California, No. 19-1019, 2020 WL 981805 (U.S. Mar. 2, 2020) (mem.); STANDING RULES OF THE SENATE, S. DOC. NO. 113-18, at 15–17 (2013), https://www.govinfo.gov/content/pkg/CDOC-113sdoc18/pdf/CDOC-113sdoc18.pdf [https://perma.cc/45XK-AJ2T] (Rule XXII); DAVID REICH & RICHARD KOGAN, CTR. ON BUDGET & POLICY PRIORITIES, INTRODUCTION TO BUDGET "RECONCILIATION" 1, 3 (2016), https://www.cbpp.org/sites/default/files/atoms/files/1-22-15bud.pdf [https://perma.cc/Y7HL-8RHU].

306. *See* Jennifer Haberkorn & Paul Demko, *Obamacare Mandate Repeal May Not Deliver Predicted Blow*, POLITICO (Nov. 20, 2017, 5:08 AM), https://www.politico.com/story/2017/11/20/obamacare-mandate-repeal-effects-167598 [https://perma.cc/ZC6P-SJDF].

307. Demetrios Pogkas & David Ingold, *What the 2018 Campaign Looks Like in Your Hometown*, BLOOMBERG (Nov. 2, 2018), https://www.bloomberg.com/graphics/2018-what-the-midterm-campaign-looks-like-in-your-hometown/; *see also* Fredreka Schouten & Aaron Kessler, *The Majority of Ads Aired by Republicans This Year? They're on the Attack*, CNN (Oct. 4, 2018, 1:24 PM), https://www.cnn.com/2018/10/04/politics/midterm-campaign-ads-negative-vs-positive/index.html [perma.cc/RT7B-7N43].

308. *2016 Presidential Election Results*, POLITICO (Dec. 13, 2016, 1:57 PM), https://www.politico.com/2016-election/results/map/president/ [https://perma.cc/MW9B-U2DD] (showing percentages state-by-state).

lawsuit with a gun.[309] Despite the party's near-uniform opposition to the ACA since its enactment, a number of Republican candidates began touting their support for protections for individuals with preexisting conditions.[310]

Voters came out in record numbers for the elections,[311] and they cared about healthcare. Although there is some dispute as to whether support for Medicare for All specifically was advantageous in the 2018 midterms,[312] exit polls reported that approximately 41% of voters identified healthcare more generally as their top concern, more than any other issue.[313]

Commentators have diverged with respect to the significance of the Democratic gains in the 2018 midterms, and those gains were tempered by the Republicans' own gain of two seats in the Senate.[314] But Democrats picked up the most seats in a midterm election for the party since Watergate,[315] with forty

309. Peter Sullivan, *Manchin Shoots Anti-ObamaCare Lawsuit with a Gun in New Ad*, HILL (Sep. 10, 2018, 9:08 AM), https://thehill.com/policy/healthcare/405839-manchin-shoots-anti-obamacare-lawsuit-with-a-gun-in-new-ad [https://perma.cc/ZQC7-VTE7].

310. Dylan Scott, *Republicans Are Misleading Voters About Preexisting Conditions*, VOX (Oct. 25, 2018, 10:35 AM), https://www.vox.com/policy-and-politics/2018/10/11/17955688/2018-midterm-elections-preexisting-conditions-obamacare [https://perma.cc/D5WB-ESCZ]; Donald J. Trump (@realDonaldTrump), TWITTER (Jan. 13, 2020, 8:39 AM), https://twitter.com/realDonaldTrump/status/1216716337822695425 [https://perma.cc/Q3ZJ-AYZ4] (stating "I was the person who saved Pre-Existing Conditions in your Healthcare, you have it now" and "I will always protect your Pre-Existing Conditions, the Dems will not!").

311. Emily Stewart, *2018's Record-Setting Voter Turnout, in One Chart*, VOX (Nov. 19, 2018, 3:20 PM), https://www.vox.com/policy-and-politics/2018/11/19/18103110/2018-midterm-elections-turnout [https://perma.cc/38QF-JGJM].

312. *Compare* Kevin Reuning, *The Nuanced Effects of Medicare for All*, DATA FOR PROGRESS (Dec. 6, 2019), https://www.dataforprogress.org/blog/2019/12/6/the-nuanced-effects-of-m4a?rq=medicare%20for%20all [https://perma.cc/HBG5-AC2S] (concluding that, controlling for variables such as 2016 vote share, endorsing Medicare for All increased 2018 vote share for Democratic incumbents, but had little effect in open seats or in races with Republican incumbents), *with* Alan I. Abramowitz, *Medicare for All a Vote Loser in 2018 U.S. House Elections*, SABATO'S CRYSTAL BALL (Nov. 14, 2019), http://crystalball.centerforpolitics.org/crystalball/articles/medicare-for-all-a-vote-loser-in-2018-u-s-house-elections/ [https://perma.cc/7H95-6PV9] (concluding that, even controlling for other factors, Democrats who endorsed Medicare for All fared worse than those who did not).

313. *Exit Polls*, CNN, https://www.cnn.com/election/2018/exit-polls [https://perma.cc/4PPT-2XJL] (last visited Dec. 28, 2019); Kate Rooney & Liz Moyer, *Health Care Topped the Economy as the Biggest Issue for Voters Now, Here's Why*, CNBC (Nov. 7, 2018, 3:19 PM), https://www.cnbc.com/2018/11/07/healthcare-topped-the-economy-as-the-biggest-issue-for-voters-now-heres-why.html [https://perma.cc/E8SA-893D] ("Forty-one percent of those polled cited health care as their top issue, followed by immigration, at 23 percent."); *see also* Chris Alcantara et al., *Battleground District Poll: What Voters in Key Districts Said on Election Day*, WASH. POST (Nov. 7, 2018, 4:30 PM), https://www.washingtonpost.com/graphics/2018/politics/midterm-battleground-districts/?tid=a_inl_manual&tidloc=4#chart-most-or-second-most-important-issue-in-vote.

314. *Compare* Nicholas Kristof, *Forget Excuses. What Counts Is Winning Elections*, N.Y. TIMES (Nov. 7, 2018), https://www.nytimes.com/2018/11/07/opinion/midterms-democrats-republicans-results.html, *with* Matthew Yglesias, *Democrats' Blue Wave Was Much Larger than Early Takes Suggested*, VOX (Nov. 13, 2018, 8:00 AM), https://www.vox.com/policy-and-politics/2018/11/13/18082490/blue-wave [https://perma.cc/X96S-6YQR]; *see also* Sarah Almukhtar et al., *U.S. Senate Election Results 2018*, N.Y. TIMES (May 15, 2019, 2:08 PM), https://www.nytimes.com/interactive/2018/11/06/us/elections/results-senate-elections.html (showing Republican Senate gains in 2018).

315. *See, e.g.*, Domenico Montanaro, *It Was a Big, Blue Wave: Democrats Pick Up Most House Seats in a Generation*, NPR (Nov. 14, 2018, 12:33 PM), https://www.npr.org/2018/11/14/667818539/it-was-a-big-blue-wave-democrats-pick-up-most-house-seats-in-a-generation [https://perma.cc/E3LH-W26R].

new seats in the House and seven new state governorships.[316] Compared to the Republican victories in 2010, Democrats won the total national popular vote in 2018 by a wider margin and received around ten million more total votes than Republicans.[317]

The new Democratic majority put healthcare at the top of its agenda. In its first week in control, the House voted to intervene in *Texas v. United States*,[318] held hearings on the effects of the case,[319] and demanded explanations for the Department of Justice's decision not to defend the ACA.[320] Committees have held hearings on Medicare for All[321] and drug price increases,[322] and sent a series of protective ACA-related inquiries to the Trump Administration.[323] In May 2019, the House passed two bills aiming

316. Sarah Almukhtar et al., *2018 Midterm Election Results: Live*, N.Y. TIMES (May 15, 2019, 2:08 PM), https://www.nytimes.com/interactive/2018/11/06/us/elections/results-dashboard-live.html; Niko Kommenda et al., *U.S. Midterms 2018: Live Results*, GUARDIAN (Nov. 7, 2018, 12:10 AM), https://www.theguardian.com/us-news/ng-interactive/2018/nov/06/midterm-elections-2018-live-results-latest-winners-and-seats?CMP=results_blog#governors.

317. *See* Daniel Chaitin, *Democrats Crush GOP's 2010 Midterm Elections Popular Vote Record with 60 Million Votes*, WASH. EXAMINER (Nov. 29, 2018, 10:14 PM), https://www.washingtonexaminer.com/news/democrats-crush-gops-2010-midterm-elections-popular-vote-record-with-60-million-votes.

318. *House Votes to Intervene in ACA Lawsuit in Texas*, AM. HOSP. ASS'N (Jan. 10, 2019, 2:55 PM), https://www.aha.org/news/headline/2019-01-10-house-votes-intervene-aca-lawsuit-texas [https://perma.cc/BVY4-CUPN].

319. *See House Committees Hold Trio of Hearings on ACA*, ASS'N OF AM. MED. COLLS. (Feb. 8, 2019), https://www.aamc.org/advocacy/washhigh/495396/020819housecommitteesholdtrioofhearingsonaca.html [https://perma.cc/23CA-L6U9]; *The Trump Administration's Attack on the ACA: Reversal in Court Case Threatens Health Care for Millions of Americans*, H. COMM. ON OVERSIGHT AND REFORM (July 10, 2019), https://oversight.house.gov/legislation/hearings/the-trump-administrations-attack-on-the-aca-reversal-in-court-case-threatens [https://perma.cc/U366-2RMF]; Press Release, House Comm. on Energy and Commerce, Pallone Announces First Three Energy and Commerce Hearings (Jan. 3, 2019), https://energycommerce.house.gov/newsroom/press-releases/pallone-announces-first-three-energy-and-commerce-hearings [https://perma.cc/2M64-4CVC].

320. Emily Tillett & Rebecca Kaplan, *House Committee Chairmen Demand Info on DOJ's Decision Not to Support Obamacare in Court*, CBS NEWS (Apr. 9, 2019, 9:27 AM), https://www.cbsnews.com/news/house-committee-chairman-demand-info-on-dojs-decision-to-not-support-obamacare-in-court/ [https://perma.cc/M87R-8DNV].

321. Four House committee hearings were held in 2019 on the subject: a Rules Committee hearing in April, a Budget Committee hearing in May, a Ways and Means Committee hearing in June, and a Subcommittee on Health of the Committee on Energy and Commerce hearing in December. *See* Dylan Scott, *Democrats' Historic, Messy, First-Ever Medicare-for-All Hearings, Explained*, VOX (Apr. 29, 2019, 3:00 PM), https://www.vox.com/policy-and-politics/2019/4/29/18518589/medicare-for-all-hearing-2020-presidential-election-biden-sanders [https://perma.cc/XV6U-UNRK]; *see also* Dylan Scott & Li Zhou, *The Democrats Who Are Still Undecided on Medicare-for-All, Explained*, VOX (June 12, 2019, 9:45 AM), https://www.vox.com/policy-and-politics/2019/6/12/18660256/medicare-for-all-hearing-house-ways-and-means [https://perma.cc/425W-QSYK]; HOUSE COMM. ON ENERGY & COMMERCE, HEARING ON "PROPOSALS TO ACHIEVE UNIVERSAL HEALTH CARE COVERAGE," Dec. 10, 2019, https://energycommerce.house.gov/committee-activity/hearings/hearing-on-proposals-to-achieve-universal-health-care-coverage.

322. *See* Robert Pear, *Drug Makers Try to Justify Prescription Prices to Senators at Hearing*, N.Y. TIMES (Feb. 26, 2019), https://www.nytimes.com/2019/02/26/us/politics/prescription-drug-prices.html.

323. *See* Letter from Frank Pallone et al., Chairmen, House and Senate Comms., to Alex Azar, Sec'y, Dep't of Health & Human Servs. & Seema Verma, Administrator, Ctrs. For Medicare & Medicaid Servs. (Jan. 10, 2019), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/ACA%20User%20Fee%20Ltr%201.10.19.pdf [https://perma.cc/83ZA-LNXR].

to strengthen the ACA, and important components of those bills were enacted.[324] As Nancy Pelosi put it: "Health care was on the ballot, and health care won."[325] Democratic health care victories continued in the 2019 off-year elections. Democrats were elected governor of Kentucky and re-elected governor of Louisiana, and took control of the Virginia state legislature, all races in which Democratic support for Medicaid expansion, without punitive measures like work requirements, played a key role.[326]

D. THE STATES

The ACA also met a wall of resistance from the states almost from the start. This was entirely unexpected.[327] As one of us has documented extensively, Congress considered several possible governance structures when it drafted the ACA.[328] The House wanted to lodge the insurance exchanges in the federal government, but the Senate pushed for a state-led insurance structure out of deference to federalism principles and the longstanding tradition of state dominance in the realm of insurance law.[329] Nationalizing Medicaid was never seriously on the table but, as noted, the ACA as written did attempt to nationalize Medicaid in an important way—by mandating a universal expansion of coverage up to 138% of the poverty line,[330] thereby removing the option states previously had to leave out certain populations from coverage.

Politics and the Supreme Court changed all of this. With respect to politics, after the ACA was challenged in court on the day it was enacted, it quickly became a perceived betrayal of the GOP to do anything to support the law—including operating a state insurance exchange.[331] Uncertainty about whether the statute

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324. *See* Protecting Americans with Preexisting Conditions Act of 2019, H.R. 986, 116th Cong. (2019) (reversing the Trump Administration's guidance that weakens the guardrails for ACA waivers); Strengthening Health Care and Lowering Prescription Drug Costs Act, H.R. 987, 116th Cong. (2019) (restoring funding for outreach, providing funding for states to switch to state-based exchanges, prohibiting the administration's rule expanding short-term health plans, preventing HHS from ending automatic enrollment in exchange plans, and expressing Congress's position that HHS should not limit the states' ability to reduce the burden of the administration's termination of CSR payments through silver-loading). The House succeeded in enacting two of these proposals in the Further Consolidated Appropriations Act of 2020. The Appropriations Act prevents HHS from ending automatic enrollment in exchange plans and prohibits the administrating from ending or restricting silver loading. *See* Further Consolidated Appropriations Act, 2020, H.R. 1865, 116th Cong. § 608 (2019).

325. Pear, *supra* note 13.

326. Ella Nilsen, Tara Golshan, Li Zhou & German Lopez, *5 Winners and 3 Losers from Election Day 2019*, VOX (Nov. 5, 2019, 10:35 PM), https://www.vox.com/2019/11/5/20949741/winners-and-losers-election-night-2019 [https://perma.cc/5VNM-NECK] (calling Medicaid expansion a "winner"); Li Zhou, *Democratic Gov. John Bel Edwards Hangs on to His Louisiana Seat*, VOX (Nov. 16, 2019, 11:23 PM), https://www.vox.com/2019/11/16/20963504/louisiana-governor-john-bel-edwards-wins-eddie-rispone-donald-trump [https://perma.cc/TPD5-FMH2].

327. Abbe Gluck & Nicole Huberfeld, *The New Health Care Federalism on the Ground*, 15 IND. HEALTH L. REV. 1, 16 (2018) (quoting former federal officials saying they were "blindsided").

328. *See* Gluck & Huberfeld, *supra* note 8, at 1726–28.

329. *Id.* at 1727.

330. *See* Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1029, 1036 (codified at 42 U.S.C. § 1396a(e)(14)(I) (2012)).

331. *See* Gluck & Huberfeld, *supra* note 327, at 2, 5.

would survive a court challenge that looked frivolous at first but soon gained momentum added to states' reluctance to set up the ACA's new insurance markets.[332] The 2010 state elections contributed to the atmosphere, as Democrats lost control of twenty-two state legislative chambers and six governorships. Ultimately, more than half of the states refused to operate their own insurance exchanges—an outcome for which the Obama Administration was completely unprepared.[333] Administration officials rushed to build infrastructure to operate many more federal exchanges than initially expected.[334] Many states halted their plans to expand Medicaid; some started negotiating concessions from the federal government.

One irony, of course, is that the same GOP-controlled states that had insisted on having the right to operate their own exchanges in the first place were the states that ultimately refused to do so. The states that had waved the flag of federalism during the ACA's drafting stage were the ones inviting the national government to run their insurance markets during its implementation stage. It was, to reiterate GOP economist Douglas Holtz-Eakin's phrase, a "Trojan horse"[335]—laying the groundwork for further federal inroads into state insurance markets.

But in reality, no exchange was just "state" or just "federal." As it turns out, the ACA's new governance structures only appeared to be black and white. Obama Administration officials labored furiously behind the scenes to innovate new models of state–federal partnership exchanges that could accommodate those red states that wished to resist publicly but still retain as much de facto ownership over their insurance markets as possible. The Administration made those concessions, allowing states that were in fact cooperating to continue to dissent publicly, in order to get the ACA ensconced in each state's legal fabric.[336] The study that Gluck and Huberfeld conducted of the ACA's federalism in implementation, which documents both this complex process of exchange implementation and the entrenchment that ultimately went with it, is elaborated on in the next Part.

With respect to Medicaid, it was the Supreme Court that changed everything. By making the Medicaid expansion optional,[337] the Court handed the states enormous new leverage and fed into the atmosphere of ACA resistance. Following

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332. *See* Gluck & Huberfeld, *supra* note 8, at 1759.

333. *Id.* at 1759–65; David K. Jones & Scott L. Greer, *State Politics and the Creation of Health Insurance Exchanges*, 103 AM. J. PUB. HEALTH e8, e8 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4007885/pdf/AJPH.2013.301429.pdf [https://perma.cc/NTV9-KAQT]; Sarah Kliff, *It's Official: The Feds Will Run Most Obamacare Exchanges*, WASH. POST (Feb. 18, 2013, 10:37 AM), https://www.washingtonpost.com/news/wonk/wp/2013/02/18/its-official-the-feds-will-run-most-obamacare-exchanges/?utm_term=.7fd5c606fd17; Michael Ollove, *State Resistance to Federal Government Goes Back to US Beginnings*, PEW (Aug. 22, 2013), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2013/08/22/state-resistance-to-federal-government-goes-back-to-us-beginnings [https://perma.cc/7XQF-EHLW]; *Establishing Health Insurance Marketplaces: An Overview of State Efforts*, KAISER FAMILY FOUND. (May 2, 2013), https://perma.cc/4UR8-V3PQ.

334. *See* Gluck & Huberfeld, *supra* note 8, at 1759–65.

335. Holtz-Eakin, *supra* note 80.

336. Gluck & Huberfeld, *supra* note 8, at 1758–72.

337. *See NFIB*, 567 U.S. 519, 587 (2012) (Roberts, C.J., joined by Breyer and Kagan, J.J.) ("As a practical matter, that means States may now choose to reject the expansion; that is the whole point.").

the decision, many states halted their pending plans to expand Medicaid. Governors and legislatures, often both Republican-controlled, were divided within some states over the question of whether and how to expand Medicaid.[338] Some states tried to extract concessions from HHS in return for expansion; others watched to see what concessions HHS granted other states so they could do better.[339]

The Court's gutting of the Medicaid expansion also put enormous pressure on the ACA's markets by undermining the insurance risk pool that was assumed when the ACA was drafted. The expansion population is generally less healthy, so keeping that population from receiving Medicaid coverage puts those individuals (who are more expensive to insure) into the general risk pool, thereby raising the cost of insurance in the ACA markets.[340] Hospitals also suffered because the ACA reduced a significant pre-ACA annual payment to hospitals that provided a disproportionate amount of charity care on the assumption—upended by *NFIB*—that nearly all low-income individuals would now have insurance through Medicaid.[341]

When the Medicaid expansion went into effect in 2014, only twenty-five states (including the District of Columbia) had adopted it.[342] By mid-2016, that number was thirty-two states.[343] By the end of 2019, thirty-seven states had adopted it—many after internal governance battles and ballot initiatives.[344]

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338. Gluck & Huberfeld, *supra* note 8, at 1733 (detailing these events).

339. *NFIB* thus heightened the importance of Medicaid section 1115 demonstration waivers, which allow the Secretary of HHS to "approve experimental, pilot, or demonstration projects that are found by the Secretary to be likely to assist in promoting the objectives of the Medicaid program." *See About Section 1115 Demonstrations*, MEDICAID.GOV, https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html [https://perma.cc/S3H9-FDZL] (last visited Dec. 28, 2019). Section 1115 waivers under Medicaid predate the ACA, and continue to operate under it. They are the vehicles through which states seek federal approval to deviate from statutory Medicaid requirements. Section 1115 allows HHS to approve state waiver proposals that further 42 U.S.C. § 1315 (2012), where it is codified.

340. ADITI P. SEN & THOMAS DELEIRE, U.S. DEP'T OF HEALTH & HUMAN SERVS., THE EFFECT OF MEDICAID EXPANSION ON MARKETPLACE PREMIUMS 2–3 (2015), https://aspe.hhs.gov/system/files/pdf/206761/McaidExpMktplPrem.pdf [https://perma.cc/M8DN-YAH9].

341. Richard C. Lindrooth et al., *Understanding the Relationship Between Medicaid Expansions and Hospital Closures*, 37 HEALTH AFF. 111, 111–12 (2018); *see also* LARISA ANTONISSE ET AL., KAISER FAMILY FOUND., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW 11–13, (2019), http://files.kff.org/attachment/Issue-brief-The-Effects-of-Medicaid-Expansion-under-the-ACA-Findings-from-a-Literature-Review [https://perma.cc/7TN3-TEJC] (describing research finding that Medicaid expansion has significantly reduced uncompensated care).

342. Donald Moulds et al., *A New Group of States Looks to Expand Medicaid*, COMMONWEALTH FUND (Aug. 27, 2018), https://www.commonwealthfund.org/blog/2018/states-look-expand-medicaid [https://perma.cc/L3GX-AHPV].

343. *Id.*

344. *Status of State Action on the Medicaid Expansion Decision, supra* note 10. Although five states chose to adopt the Medicaid expansion by legislative action or voter initiative in 2017 and 2018, actual implementation of the expansion only occurred in 2019 for Maine and Virginia and in 2020 for Utah, whereas there is not a set date for implementation in Idaho or Nebraska as of the time of this Article's publication. *Id.* at nn.1, 3, 5 & 7–9; Louise Norris, *Utah and the ACA's Medicaid expansion*, HEALTHINSURANCE.ORG (Jan. 6, 2020), https://www.healthinsurance.org/utah-medicaid/ [https://perma.cc/W7J7-2JZS]. Kansas, which has a divided state government, may expand Medicaid as well. *See*

As elaborated on in Part III, intergovernmental negotiation and state-focused policy tailoring breed new state bureaucratic structures that are difficult to unwind. They also breed buy-in. So do public debates and elections.

E. ADMINISTRATIVE SABOTAGE

Finally, the statute has been under relentless attack from the President himself. Despite his campaign-trail statements about universal coverage, President Trump has kept "killing" the ACA at the top of his agenda. His very first executive order, signed hours after he was sworn in, directed his agencies to "waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the [ACA]" that the Administration deemed to be financially or regulatorily burdensome.[345] President Trump has repeatedly stated that the defeat of the ACA repeal effort in Congress "doesn't matter" because "[w]e gutted [the ACA] anyway"[346] and "we're doing it a different way. We have to go a different route."[347] He has boasted: "Essentially, we are getting rid of Obamacare . . . . Some people would say, essentially, we have gotten rid of it."[348]

Early on, the Administration slashed funding required by the statute for outreach workers[349] and President Trump made a series of statements—designed to sow uncertainty into the market—threatening to cut off critical stabilization funds.[350] The Administration also cut back on the open enrollment period for the federal exchanges and passed several new rules designed to split the insurance markets, including allowing short-term plans that do not comply with all of the

Mitch Smith & Abby Goodnough, *Expanding Medicaid Was a Pipe Dream in Kansas. Now It May Become Reality*., N.Y. TIMES (Jan. 9, 2020), https://www.nytimes.com/2020/01/09/us/kansas-medicaid-expansion.html (describing progress in efforts in Kansas to expand Medicaid as well as ongoing pushes in other states through both legislative means and ballot initiatives).

345. Exec. Order No. 13,765, 82 Fed. Reg. 8351 (2017), https://www.govinfo.gov/content/pkg/FR-2017-01-24/pdf/2017-01799.pdf [https://perma.cc/4M6D-VUHK]; Complaint, City of Columbus v. Trump, *supra* note 26, ¶ 60.

346. *See* Laura Litvan (@LauraLitvan), TWITTER (June 23, 2018, 4:04 PM), https://twitter.com/LauraLitvan/status/1010614472946352128 [https://perma.cc/3EGR-ULTL].

347. *President Trump Calls the Show!*, RUSH LIMBAUGH SHOW (Aug. 1, 2018), https://www.rushlimbaugh.com/daily/2018/08/01/president-trump-calls-the-show/amp/ [https://perma.cc/7XTG-ZY63].

348. Alan Rappeport, *Trump Says He Got Rid of Obamacare. The I.R.S. Doesn't Agree*, N.Y. TIMES (May 6, 2018), https://www.nytimes.com/2018/05/06/business/trump-obamacare-irs.html; *see also* Carolyn Y. Johnson, *The Future of Obamacare Will Be Written by Insurers Like This One*, WASH. POST (May 12, 2017, 2:05 PM), https://www.washingtonpost.com/news/wonk/wp/2017/05/12/the-future-of-obamacare-will-be-written-by-insurers-like-this-one/.

349. *See* KAREN POLLITZ ET AL., KAISER FAMILY FOUND., DATA NOTE: CHANGES IN 2017 FEDERAL NAVIGATOR FUNDING 1–2, 8 & fig.6, 9 (2017), http://files.kff.org/attachment/Data-Note-Changes-in-2017-Federal-Navigator-Funding [https://perma.cc/JGT9-DWE7]; Karen Pollitz et al., *Data Note: Limited Navigator Funding for Federal Marketplace States*, KAISER FAMILY FOUND. (Nov. 13, 2019), https://www.kff.org/health-reform/issue-brief/data-note-further-reductions-in-navigator-funding-for-federal-marketplace-states/ [https://perma.cc/C2NA-GFKN].

350. Complaint, City of Columbus v. Trump, *supra* note 26, ¶¶ 44, 111–15.

ACA's protections and expanding categories of other excepted plans.[351] The goal of these efforts is to pull healthy individuals off ACA markets, leaving only the sickest and most expensive patients.

The Administration has also used executive authority to undercut access to care, including by: (1) encouraging states to obtain waivers that would allow the evasion of ACA protections;[352] (2) allowing states to impose new obstacles on Medicaid enrollment, such as work requirements;[353] and (3) passing new immigration rules (including the "public charge" rule discussed in section II.B) that discourage legal residents from using government healthcare by counting those services against them in determining admissibility to the United States.[354] These moves have had an impact and have certainly undercut the notion that a universal coverage norm has been fully achieved. In Arkansas, the first state in which work requirements have gone into effect, more than 17,000 people had lost coverage prior to the ruling from the United States District Court for the District of Columbia vacating HHS's approval of the waiver.[355] According to the Urban Institute: "The elimination of the individual-mandate penalties and the other policy changes, such as the withdrawal of cost-sharing reduction payments and the diminution of federal investments in advertising and enrollment assistance . . . will lead to an additional 6.4 million people uninsured in 2019 compared with prior law . . . ."[356] The Urban Institute also estimates that the Administration's executive actions to split and pull healthy people out of the ACA markets will "increase the number of people without minimum essential coverage by

351. Short-Term, Limited Duration Insurance, 83 Fed. Reg. 38,1212 (Aug. 3, 2018) (to be codified at 26 C.F.R. pt. 54, 29 C.F.R. pt. 2590, 45 C.F.R. pts. 144, 146, 148) (expanding the length and renewability of Short-Term Plans that do not have to comply with all of the ACA's protections); Definition of "Employer" Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912, *supra* note 207 (expanding the availability of Association Health Plans that do not have to comply with all of the ACA's protections).

352. *See* State Relief and Empowerment Waivers, 83 Fed. Reg. 53,575, 53,575–76 (Oct. 24, 2018) (to be codified at 31 C.F.R. § 33, 45 C.F.R. § 155) (guidance aiming to "lower barriers" for states to obtain such waivers).

353. *See Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAMILY FOUND. (Dec. 20, 2019), [https://perma.cc/JM9D-XQVJ] (counting states that have received approval to implement a work requirement, not those that have implemented it).

354. *See* Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292, 41,294–95 (Aug. 14, 2019) (to be codified at 8 C.F.R. pts.103, 212–14, 245, 248).

355. Losses are in large part due to uncertainty about eligibility and difficulty complying with the onerous reporting requirements. *Gresham v. Azar*, 363 F. Supp. 3d 165 (D.D.C. 2019); Benjamin D. Sommers et al., *Medicaid Work Requirements—Results from the First Year in Arkansas*, 381 NEW ENG. J. MED. 1073, 1073, 1081 (2019); Jennifer Wagner, *Medicaid Coverage Losses Mounting in Arkansas from Work Requirement*, CTR. ON BUDGET & POL'Y PRIORITIES (Jan. 17, 2019, 10:15 AM), https://www.cbpp.org/blog/medicaid-coverage-losses-mounting-in-arkansas-from-work-requirement [https://perma.cc/V34K-NTKH].

356. LINDA J. BLUMBERG ET AL., URBAN INST., UPDATED: THE POTENTIAL IMPACT OF SHORT-TERM LIMITED-DURATION POLICIES ON INSURANCE COVERAGE, PREMIUMS, AND FEDERAL SPENDING 2 (2018), https://www.urban.org/sites/default/files/publication/96781/2001727_updated_finalized.pdf [https://perma.cc/6L3P-T8Q2].

2.5 million in 2019."[357] The Commonwealth Fund similarly estimates that the repeal of the individual mandate combined with just one of the Administration's executive actions—allowing more individuals to claim exemption from ACA markets by adopting flimsy "short-term plans"—will reduce enrollment in ACA-protected healthcare by six million people.[358] For the 2019 plan year, premiums for baseline ACA plans (so-called silver plans) are about 16% higher than they would have been absent the unprecedented statutory sabotage.[359] The number of uninsured children has risen for the first time in a decade.[360]

Despite these undermining efforts and despite the fact that the ACA markets are not functioning as well as they could be, they have been remarkably resilient. In 2019, the markets have stabilized and exchanges have become more competitive with an increased number of insurers offering plans—and the individual market has been profitable for insurers.[361]

The sabotage, while destabilizing, also galvanized pro-ACA litigation on the other side. Whereas most of the earlier litigation was anti-ACA, the momentum, as discussed in section II.B.5, recently has shifted. Cities, states, and nonprofits have sued,[362] arguing that the Administration's moves violate the text of the ACA itself, the Administrative Procedure Act and, in some cases, the Take Care Clause of the Constitution.[363]

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357. LINDA J. BLUMBERG ET AL., URBAN INST., THE POTENTIAL IMPACT OF SHORT-TERM LIMITED-DURATION POLICIES ON INSURANCE COVERAGE, PREMIUMS, AND FEDERAL SPENDING 2 (2018), https://www.urban.org/sites/default/files/publication/96781/2001727_0.pdf [https://perma.cc/QF2H-WKBU].

358. PREETHI RAO ET AL., COMMONWEALTH FUND, WHAT IS THE IMPACT ON ENROLLMENT AND PREMIUMS IF THE DURATION OF SHORT-TERM HEALTH INSURANCE PLANS IS INCREASED? 1, 4 (2018), https://www.commonwealthfund.org/sites/default/files/2018-06/Rao_short_term_plans_enrollment.pdf [https://perma.cc/978M-5RBX].

359. RABAH KAMAL ET AL., KAISER FAMILY FOUND, HOW REPEAL OF THE INDIVIDUAL MANDATE AND EXPANSION OF LOOSELY REGULATED PLANS ARE AFFECTING 2019 PREMIUMS 2 (2018), http://files.kff.org/attachment/Issue-Brief-How-Repeal-of-the-Individual-Mandate-and-Expansion-of-Loosely-Regulated-Plans-are-Affecting-2019-Premiums [https://perma.cc/G2SX-3MN6].

360. Jesse Cross-Call, *Children's Uninsured Rate Rises for First Time in a Decade*, CTR. ON BUDGET & POLICY PRIORITIES (Nov. 30, 2018, 12:00 PM), https://www.cbpp.org/blog/childrens-uninsured-rate-rises-for-first-time-in-a-decade [https://perma.cc/3EQJ-NYUC].

361. *See* Rachel Fehr et al., *Individual Insurance Market Performance in Early 2019*, KAISER FAMILY FOUND. (June 27, 2019), [https://perma.cc/2MFF-N8BM]; *see also* Shelby Livingston, *Obamacare Exchanges Grew More Competitive in 2019*, MOD. HEALTHCARE (Mar. 21, 2019, 3:39 PM), https://www.modernhealthcare.com/insurance/obamacare-exchanges-grew-more-competitive-2019 (noting that increased profitability has helped draw insurers back onto exchanges, increasing competition).

362. *See, e.g.*, Ass'n for Cmty. Affiliated Plans v. U.S. Dep't of Treasury, 392 F. Supp. 3d 22, 25–26 (D.D.C. 2019) (lawsuit challenging the Short-Term Plans Rule), *appeal filed*, No. 19-5212 (D.C. Cir. July 30, 2019); Complaint, New York v. U.S. Dep't of Labor, No. 1:18-cv-01747 (D.D.C. Mar. 28, 2018) (No. 1) (lawsuit challenging Association Health Plans rule); Complaint, City of Columbus v. Trump, *supra* note 26 (lawsuit challenging the intentional sabotage of the ACA).

363. Complaint, City of Columbus v. Trump, *supra* note 26, at ¶ 5; Press Release, Democracy Forward, Individuals and Cities Sue President Trump for Intentionally Sabotaging ACA, Increasing Costs of Health Coverage (Aug. 2, 2018), https://democracyforward.org/press/individuals-and-cities-sue-president-trump-for-intentionally-sabotaging-aca-increasing-costs-of-health-coverage/#.W7wdSRNKj_Q [https://perma.cc/HYN3-4GBB].

Some of these cases have been decided in the lower courts and are now pending appeal. *See, e.g.*, *Ass'n for Cmty. Affiliated Plans*, 392 F. Supp. 3d at 22 (holding that the Short-Term Plans rule is

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We cannot find another statute in American history that has been the continuous and surviving target of as many direct attacks by all levels of government. Speaker Paul Ryan himself thought the first failed repeal effort would be the end of the matter.[364] Majority Leader Mitch McConnell thought the second effort would be.[365] Many constitutional scholars thought the same about *NFIB*, the first Supreme Court case.[366] They were all wrong.

The ACA's transformative effect seems enduring, regardless of what ultimately happens to the statute itself. What is more, as we detail in the next Part, that transformative effect happened not despite the obstacles the law faced, but largely because of them.

III. ENTRENCHMENT

The ACA provides a fascinating case study in legal and normative entrenchment, and how, as Eskridge and Ferejohn put it, fundamental norms introduced by statutes may spread beyond the statute itself and take firm hold.[367] There is a difference between statutes that are entrenched simply in the sense that they would be hard to change and statutes that have helped to shift normative, political, and legal baselines.[368] As an example (from Daryl Levinson), the mortgage-tax deduction had seemed for a long time virtually impossible to repeal, but it did not create or change values.[369]

There is also a difference between strategies to get statutes *enacted* and strategies to get them *entrenched*. In the ACA's case, incrementalism turned out to be an important strategy in both contexts, but for different reasons. In seeking to enact the law, President Obama was keen to avoid the pitfalls of President Clinton's failed 1993 health reform attempt.[370] That concern resulted in his approach to enactment as one in which the drafting details were not driven by the White House but, rather, were left to Congress to generate. It may well be that a congressionally oriented drafting approach generally leads to more incremental

consistent with HIPAA and the ACA), *appeal filed*, No. 19-5212 (D.C. Cir. July 30, 2019); New York v. Dep't of Labor, 363 F. Supp. 3d 109, 141 (D.D.C. 2019) (vacating the association health plans rule), *appeal filed*, No. 19-5125 (D.C. Cir. Apr. 30, 2019).

364. Lopez, *supra* note 267.

365. Roubein, *supra* note 270.

366. *See* Donald Verrilli, *The Affordable Care Act and the Supreme Court*, *in* THE TRILLION DOLLAR EXPERIMENT, *supra* note 84.

367. Eskridge & Ferejohn, *supra* note 97, at 1216.

368. *See* Anuj C. Desai, *What a History of Tax Withholding Tells Us About the Relationship Between Statutes and Constitutional Law*, 108 NW. U. L. REV. 859, 904 (2014).

369. *See* Daryl J. Levinson, *Parchment and Politics: The Positive Puzzle of Constitutional Commitment*, 124 HARV. L. REV. 657, 687 (2011). The 2017 tax law placed new limits on the deduction, indicating that it may not have been quite as entrenched as previously believed. *See* Rianka Dorsainvil, *3 New Tax Rules Homeowners Need to Know*, PBS NEWSHOUR: MAKING SEN$E (Mar. 20, 2019, 11:04 AM), https://www.pbs.org/newshour/economy/making-sense/3-new-tax-rules-homeowners-need-to-know [https://perma.cc/99XJ-UA8K].

370. *See supra* note 59 and accompanying text.

(versus sweeping) legislation,[371] because of the need to find political compromise. In the ACA's case the incrementalism did turn out to be important for the politics of enactment. But the Democrats ultimately enacted the law without a single Republican vote, and so entrenchment had to come later in the context of post-enactment implementation and opposition. As it turns out, the incremental aspects of the ACA's design were helpful there too.

In this Part, we offer evidence that the ACA is indeed one of those special laws that worked more fundamental change. We also offer some hypotheses about how and why the ACA worked these transformations. We see different modalities of entrenchment working simultaneously—political, democratic, expressive, legal, structural, financial—some predictable, some not.

One obvious strategy of entrenchment was simply doling out popular and concrete benefits early; it is hard to take benefits away once extended.[372] Another commonly mentioned strategy is public deliberation—which, through a process of airing, educating, and fighting over a new law in a way that extends far beyond Washington, D.C., can further entrench statutory norms.[373]

Less predictable was that the Supreme Court would unwittingly trigger that public deliberation with its anti-ACA Medicaid holding in *NFIB*. A still less obvious strategy turned on the state involvement in implementation—an incremental design choice criticized by many at the outset of the ACA as an obstacle to health policy goals. Federalism as entrenchment turned out to be an important way to get the ACA front and center in public and in political conversations, as well as a way to get state officials to "buy into" the law and create state bureaucracies and legal regimes around it that will prove difficult to unwind. Even the financial structure of the law and its continued reliance on private markets—also criticized by many as insufficiently transformative—helped the ACA to resist unprecedented sabotage from the new Administration. Fourth, and hardest to pinpoint, the political conversation has slowly evolved to include a new norm of universality, redefining the ideas around the relationship of the government to its citizens—and its citizens to one another. This has bled into legal action and new ways of talking about the ACA and healthcare rights in court as well.[374]

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371. *See supra* note 39 and accompanying text.

372. *See generally* Brown, *supra* note 102, at 480–85 (2013) (discussing the endowment effect with regard to the ACA); Russell Korobkin, *The Endowment Effect and Legal Analysis*, 97 NW. U. L. REV. 1227 (2003) (describing the endowment effect from a behavioral economics perspective); Levinson, *supra* note 369, at 690–91 (discussing the endowment effect with regard to political and legal frameworks).

373. See Mathew D. McCubbins & Daniel B. Rodriguez, *Superstatutory Entrenchment: A Positive and Normative Interrogatory*, 120 YALE L.J. ONLINE 387 (2011), for a discussion and critique of the notion of deliberation as a driver of normative change.

374. *See, e.g.*, *infra* notes 497–99 and accompanying text; Stewart v. Azar, 313 F. Supp. 3d 237, 242 (D.D.C. 2018), *appeal filed*, No. 19-5095 (D.C. Cir. Apr. 11, 2019) (describing the ACA as "a comprehensive national plan to provide universal health insurance coverage" across the nation); *id.* at 261 ("As the name implies, the Affordable Care Act was designed to provide 'quality, affordable health care for all Americans,' including by expanding the 'role of public programs'—like Medicaid—in achieving that goal.").

Entrenchment through benefits and normative, or expressive, entrenchment can be mutually reinforcing. But there is a crucial difference between granting direct benefits that the average person wants to keep herself and changing norms about how the average person sees *who else* deserves benefits—the crux of the social-solidarity model.[375] That leap seems in line with the ACA, and it may be the most fundamental one of all.

We begin with the more obvious story of benefits entrenchment, including the creation of new interest groups supporting the law. We then turn to changes in political and normative discourse on the federal side and how those changes then bled into state legal action. Lastly, we look at features of the law originally thought to be pathologies, including its federalism and financial architectures, and explore how those same features have helped sustain the ACA's resilience.

A. BENEFITS ENTRENCHMENT

Some aspects of entrenchment are not surprising. For example, it is hard for elected officials to take good things away. As classic "endowment-effect" theory notes, people ascribe more value to things once they have them.[376] We call this benefits entrenchment. Even in 2012, during the *NFIB* battle, it was clear that the few ACA benefits that already had been extended—including allowing young adults under age twenty-six to remain on their parents' insurance plans, removing lifetime coverage limits, and a more generous Medicare pharmaceutical benefit—had become very popular and would be difficult for the Court to strike down.

The benefits-entrenchment strategy launched with full vigor in 2014 when the remaining ACA reforms took effect. The rewards of that strategy were evident in the 2016 election and the repeal efforts of 2017 when even GOP politicians, including President Trump, insisted they were not going to take something away without replacing it with something equal or better.[377]

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375. *See* Mariner, *supra* note 47, at 205–07; *cf.* Brown, *supra* note 102, at 470 (positing in 2013 that the ACA would not reach super-statute status because it did not serve a politically cohesive interest group like Medicare did).

376. *See* Richard Thaler, *Toward a Positive Theory of Consumer Choice*, 1 J. ECON. BEHAV. & ORG. 39, 44 (1980) (originating the concept that "goods that are included in [an] individual's endowment will be more highly valued than those not held in the endowment"); *see also* Brown, *supra* note 102, at 480–85 (discussing the endowment effect with regard to the ACA); *see generally* Korobkin, *supra* note 372 (providing a general discussion of the endowment effect).

377. *See, e.g.*, *supra* notes 284–87 and accompanying text. Medicaid expansion also brought tangible benefits, including reducing the percentage of low-income Americans with unpaid medical debt, reducing the rate of uninsured, increasing access to care, and improving people's assessment of their own health. *See, e.g.*, *2018 Ohio Medicaid Group VIII Assessment*, OHIO DEP'T OF MEDICAID (2018), http://www.medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Final-Report.pdf [https://perma.cc/B38Q-M597]; Luojia Hu et al., *The Effect of the Patient Protection and Affordable Care Act Medicaid Expansions on Financial Wellbeing* 21–23 (Nat'l Bureau of Econ. Research, Working Paper No. 22170, 2018), https://www.nber.org/papers/w22170.pdf [https://perma.cc/JZ9D-LJZE]; Dylan Scott, *The Success of Medicaid Expansion, Explained in 5 charts*, VOX (Aug. 30, 2018, 4:05 PM), https://www.vox.com/policy-and-politics/2018/8/24/17779338/voxcare-medicaid-expansion-success-charts [https://perma.cc/VM8U-2TXK]; Aaron Sojourner & Ezra Golberstein, *Medicaid Expansion Reduced Unpaid Medical Debt and Increased Financial Satisfaction*, HEALTH AFF. BLOG

This is not to say that the ACA has been completely successful on this front. To this day, the law continues to suffer from poor marketing that has prevented the public from realizing just how many tangible benefits it has received from the ACA.[378] Patients with preexisting conditions—who were uninsurable pre-ACA and now have a right to insurance—likely know they have the ACA to thank. But countless other reforms—from insurance coverage for cancer screenings to higher prescription drug benefits for seniors, to the elimination of copays for many services—benefit huge swaths of the population (including the wealthy), who may not realize that they too are direct recipients of "Obamacare."[379] The benefits-entrenchment effect would likely be even stronger if all the diverse populations directly profiting from the law were aware of this.

The ACA also encountered some legislative-process obstacles that must be remembered and that offer some lessons for future benefits-entrenchment strategies. For example, to keep the statute's ten-year cost under the $1 trillion limit that President Obama desired, the ACA could not provide all of its benefits upfront but rather had to time them throughout the ten-year budget window.[380] This process limitation, plus the need for lead time to set up new systems, prevented the earlier dispensing of some of the key benefits. *NFIB* might well have been even more controversial if additional benefits had been doled out sooner. In that vein, had Medicaid expansion already occurred by 2012, it would have been very difficult for the Court to render it optional as it did. That became clear in the failed repeal effort of 2017.

But one should guard against a false sense of security about the staying power of government benefits. A full survey of how existing benefits become vulnerable is beyond the scope of this Article, but the last several decades have seen the retrenchment of some benefits thought difficult to take away, particularly in the

(July 24, 2017), https://www.healthaffairs.org/do/10.1377/hblog20170724.061160/full/ [https://perma.cc/5S89-XR2N].

378. *See, e.g.*, Kyle Dropp & Brendan Nyhan, *One-Third Don't Know Obamacare and Affordable Care Act Are the Same*, N.Y. TIMES: THE UPSHOT (Feb. 7, 2017), https://www.nytimes.com/2017/02/07/upshot/one-third-dont-know-obamacare-and-affordable-care-act-are-the-same.html (describing polling finding public confusion over the ACA, ranging from its most basic benefits to whether it was the same thing as "Obamacare"); Ashley Kirzinger et al., *Kaiser Health Tracking Poll – January 2018: The Public's Priorities and Next Steps for the Affordable Care Act*, KAISER FAMILY FOUND. (Jan. 26, 2018), [https://perma.cc/FK7U-RQ7K] (finding that only 68% of the public was aware that the ACA was still in effect and that 60% had heard little or nothing about the most recent open enrollment period); *cf.* William M. Sage, *Brand New Law! The Need to Market Health Care Reform*, 159 U. PA. L. REV. 2121 (2011) (predicting in 2011 that poor marketing by the Obama Administration would become one of the ACA's biggest problems).

379. *See The Trump Administration's Attack on the ACA: Reversal in Court Case Threatens Health Care for Millions of Americans*: *Hearing Before the H. Comm. on Oversight & Reform* at 2, 116th Cong. 11 (2019) (written statement of Abbe R. Gluck, Professor of Law, Yale Law School), https://docs.house.gov/meetings/GO/GO00/20190710/109761/HHRG-116-GO00-Wstate-GluckA-20190710.pdf [https://perma.cc/5B3K-CQX9].

380. *See* Klein, *supra* note 138; *see also* Tara Golshan, *The PAYGO Fight Roiling House Democrats, Explained*, VOX (Jan. 3, 2019, 11:20 AM), https://www.vox.com/policy-and-politics/2019/1/3/18165261/paygo-house-democrats-progressives-medicare [https://perma.cc/P8PR-BFJ8] (describing the importance to fiscally conservative Democrats of ensuring that the ACA was paid for).

welfare context through the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.[381] Retrenchment there occurred to a large extent because President Clinton signed onto a new normative vision questioning entitlements that were not tied directly to work[382] and in so doing undercut welfare rights with a new framework that turned on notions of individual deservingness. One scholar described the welfare program as "legally entrenched" but not "morally entrenched."[383]

Studies also have found that receipt of government assistance does not translate neatly into support for federal benefits programs or votes for the party supporting those programs.[384] Nor is the perception that one has benefited from a policy independent of ideology. For example, in 2014, 27% of Americans—and almost half of Republicans—claimed their families had been directly hurt by the ACA—nearly double the number who said they had been helped by the law.[385] Part of the problem, as noted, was poor education by the Obama Administration

381. Pub. L. No. 104–193, 110 Stat. 2105 (codified as amended in scattered sections of the U.S.C.). President Clinton declared in his 1994 State of the Union address that it was necessary to "revolutionize our welfare system" not only because it "[i]t doesn't work" but because it "[i]t defies our values as a nation." *January 25, 1994: State of the Union Address*, UVA MILLER CENTER, https://millercenter.org/the-presidency/presidential-speeches/january-25-1994-state-union-address [https://perma.cc/5JJS-RQCH] (last visited Dec. 28, 2019). The replacement program, Temporary Assistance for Needy Families (TANF), reflected this ascendant norm wherein benefits were meant to be short-term and linked to employment. *See* Noah Zatz, *Welfare to What?*, 57 HASTINGS L.J. 1131, 1138–39 (2006).

382. *See* Michele Estrin Gilman, *Legal Accountability in an Era of Privatized Welfare*, 89 CALIF. L. REV. 569, 578–81, 588–91 (2001) (describing the mounting criticism of the welfare program on both normative and pragmatic grounds); *see generally* Jonathan Zasloff, *Children, Families, and Bureaucrats: A Prehistory of Welfare Reform*, 14 J.L. & POL. 225 (1998) (describing in detail the normative and empirical debates surrounding the Aid to Families with Dependent Children (AFDC) program and arguing that the failure of supporters to advocate a normative vision with sufficient widespread appeal played a crucial role in the eventual demise of the program).

383. Thomas F. Burke, *The Rights Revolution Continues: Why New Rights Are Born (and Old Rights Rarely Die)*, 33 CONN. L. REV. 1259, 1262–63, 1267–68 (2001).

384. *See* RICH MORIN ET AL., PEW, A BIPARTISAN NATION OF BENEFICIARIES 1, 5 (2012), https://www.pewsocialtrends.org/2012/12/18/a-bipartisan-nation-of-beneficiaries/ [https://perma.cc/L2DE-VTSW]; Dean Lacy, *Moochers and Makers in the Voting Booth: Who Benefits from Federal Spending, and How Did They Vote in the 2012 Presidential Election?*, 78 PUB. OPINION Q. 255, 257–71 (2014); *see also* Binyamin Appelbaum & Robert Gebeloff, *Even Critics of Safety Net Increasingly Depend on It*, N.Y. TIMES (Feb. 11, 2012), http://www.nytimes.com/2012/02/12/us/even-critics-of-safety-net-increasingly-depend-on-it.html; Eduardo Porter, *Where Government Is a Dirty Word, But Its Checks Pay the Bills*, N.Y. TIMES (Dec. 21, 2018), https://www.nytimes.com/2018/12/21/business/economy/harlan-county-republican-welfare.html; Catherine Rampell, *How Do the 47% Vote?*, N.Y. TIMES: ECONOMIX (Sept. 18, 2012, 2:28 PM), https://economix.blogs.nytimes.com/2012/09/18/how-do-the-47-vote/; Jeremy White et al., *The Geography of Government Benefits*, N.Y. TIMES (Feb. 11, 2012), http://www.nytimes.com/interactive/2012/02/12/us/entitlement-map.html.

More generally, some survey research has found that self-interest is not always the primary motivator in political preferences. *See generally* Richard R. Lau & Caroline Heldman, *Self-Interest, Symbolic Attitudes, and Support for Public Policy: A Multilevel Analysis*, 30 POL. PSYCH. 513 (2009) (finding "symbolic" political dispositions more important than self-interest in views on national health insurance); David O. Sears, *The Impact of Self-Interest on Attitudes—A Symbolic Politics Perspective on Differences Between Survey and Experimental Findings: Comment on Crano (1997)*, 72 J. PERSONALITY & PSYCH. 492 (1997); David O. Sears & Carolyn L. Funk, *The Limited Effect of Economic Self-Interest on the Political Attitudes of the Mass Public*, 19 J. BEHAV. ECON. 247 (1990).

385. Blendon & Benson, *supra* note 248, at tbl.3.

as to what the ACA actually does.[386] Mothers might have noticed that they no longer paid a co-pay on their children's vaccines but likely did not know the new benefit, like many others, comes directly from the ACA.

1. Interest Group Creation

Some experts worried when the ACA was enacted that it did not have a concentrated interested group to support it; that its benefit to "health" was too diffuse. Public-choice scholars argue that, because many broadly public-regarding statutes—such as infrastructure laws or environmental laws—have widespread public benefits, they do not attract the kind of intense stakeholder support observed in statutes with direct tangible benefits to a specific group.[387] Broad but more direct benefits—like the federal mortgage deduction—can be more easily politically locked in.

We disagree with the arguments that the lack of a core beneficiary group in the ACA was a bug, rather than a feature of the law.[388] The ACA has a key advantage that only will grow stronger over time as people come to really understand it: the population served *directly* by the law is much broader than the populations served by many other safety-net programs. In other words, the ACA is more like the mortgage-tax deduction than like infrastructure. Almost everyone benefits tangibly from the insurance reforms that prevent discrimination based on health status, remove lifetime coverage caps, remove copays for certain services, allow young adults to remain on their parents' plans, and require coverage for basic treatments and screenings. Those ACA benefits apply to *all* plans and not just the subsidized ACA plans or even just the exchange plans for the individual market. Those who obtain insurance through their employer get these ACA benefits too.[389]And everyone who reaches sixty-five also ultimately benefits from the ACA's much more generous Medicare coverage.

But even subsidized ACA plans have unusually broad reach. The government subsidies to make insurance more affordable reach up to 400% of the poverty line—that is $49,960 for an individual and $103,000 for a family of four.[390] By comparison, Medicaid—even as expanded by the ACA—only covers individuals up to 138% FPL; TANF primarily covers families with dependent children under

386. *See* Sage, *supra* note 378, at 2146.

387. *See generally* MANCUR OLSON, THE LOGIC OF COLLECTIVE ACTION: PUBLIC GOODS AND THE THEORY OF GROUPS (1971) (arguing that the interests of large, diffuse groups will tend to be overshadowed by those of smaller, concentrated groups, including in the legislative process).

388. *E.g.*, Brown, *supra* note 102, at 470 (noting that people without insurance are not a stable and cohesive interest group); *cf.* Super, *supra* note 104, at 898–900 (arguing that "the ACA's supporters" had a "very incomplete understanding of the politics of entrenching social benefits").

389. *Potential Impact of* Texas v. U.S. *Decision on Key Provisions of the Affordable Care Act*, KAISER FAMILY FOUND. (Nov. 27, 2019), [https://perma.cc/9G2G-D7NY].

390. Office of the Assistant Sec'y For Planning & Evaluation, *HHS Poverty Guidelines for 2019*, U.S. DEP'T OF HEALTH & HUMAN SERVS, https://aspe.hhs.gov/poverty-guidelines [https://perma.cc/8428-YKHE] (last visited Dec. 28, 2019).

eighteen and limits the period of aid to five years,[391] and even the state with the most generous benefits (New Hampshire) limits maximum assistance at 60% FPL, whereas in the least generous state (Mississippi) it is 9.6%.[392]

It cannot be irrelevant to the entrenchment story that the ACA provides direct—not diffuse—personal benefits to such a large and diverse portion of the population, or at least holds out benefits many people know they themselves may need someday.[393] Political scientists have observed that, in the context of entitlement programs, "political dynamics . . . vary according to the social construction of targeted groups"; some have posited that, "as targeted programs become more inclusive and the targeted boundaries more ambiguous, this notion of a cultural entitlement itself becomes a salient object of moral debate and ideologically charged political conflict."[394] The new protections the ACA offers to virtually every swath of the population has helped to redefine the boundaries of who benefits from government healthcare (and make more salient support that existed before). The ACA is a statute for the less fortunate but it also is most certainly a statute for the *middle class*.

The broad beneficiary base also appears to have prevented the ACA, thus far, from being pejoratively depicted as a "welfare" program or being racialized; the two, as Dorothy Brown notes, often go together.[395] It has also prevented the ACA from falling victim to normative or moral retrenchment based on a new narrative of deservingness, as happened in the welfare context—although President Trump's approval of Medicaid work requirements (recently stymied by the D.C. Circuit) threatened to do just that.[396] In the Medicaid context, there is indeed a

391. GENE FALK, CONG. RESEARCH SERV., R43634, TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF): ELIGIBILITY AND BENEFIT AMOUNTS IN STATE TANF CASH ASSISTANCE PROGRAMS 2 & n.5 (2014), https://fas.org/sgp/crs/misc/R43634.pdf [https://perma.cc/R9PC-SU6T] (noting that TANF also covers families with children who are eighteen years old if they are enrolled full-time in secondary school, and that there are also certain exceptions that render individuals ineligible).

392. ASHLEY BURNSIDE & IFE FLOYD, CTR. ON BUDGET & POLICY PRIORITIES, TANF BENEFITS REMAIN LOW DESPITE RECENT INCREASES IN SOME STATES app. tbl.2 (2019), https://www.cbpp.org/sites/default/files/atoms/files/10-30-14tanf.pdf [https://perma.cc/6WCT-CQW5].

393. Sociologist Theda Skocpol has argued that "when U.S. antipoverty efforts have featured policies targeted on the poor alone, they have not been politically sustainable, and they have stigmatized and demeaned the poor." THEDA SKOCPOL, SOCIAL POLICY IN THE UNITED STATES: FUTURE POSSIBILITIES IN HISTORICAL PERSPECTIVE 253 (1995). On the other hand, "more universal policies that have spread costs and visibly delivered benefits across classes and races have recurrently flourished" in part because "[b]road political coalitions have developed to protect and extend these policies." *Id.* at 259.

394. Colleen M. Grogan & Eric M. Patashnik, *Universalism Within Targeting: Nursing Home Care, the Middle Class, and the Politics of the Medicaid Program*, 77 SOC. SERV. REV. 51, 68–69 (2003).

395. Dorothy A. Brown, *Race and Class Matter in Tax Policy*, 107 COLUM. L. REV. 790, 812–17 (2007) (arguing that "welfare is a code word for race," and that it is critical to stop using the term and to illustrate the true demographics of those benefitted by such programs); *see also* David A. Super, *The Quiet "Welfare" Revolution: Resurrecting the Food Stamp Program in the Wake of the 1996 Welfare Law*, 79 N.Y.U. L. REV. 1271, 1291–95 (2004) (describing as one of several features of maligned "welfare" programs that they are perceived as being for the benefit of "an unpopular and unemployed population that seems foreign to much of the middle-class").

396. This parallel is not solely theoretical. In invalidating Medicaid work requirements in Kentucky, the district court rejected the State's express attempt to draw an analogy to TANF and AFDC, explaining that the purpose of Medicaid was to expand health coverage, not individual responsibility. *See* Stewart v. Azar, 366 F.

long history of under-implementation or even full-out resistance to social programs that are motivated by racism or prejudice against the poor. Advocates of the ACA have seized instead on its much broader benefits base and framed the quintessential ACA beneficiaries as individuals with preexisting conditions[397], a population that, to date, enjoys a broad moral consensus from across the aisle for their "right" to care.[398] This contrasts with other social programs that conservatives successfully undermined by portraying them as benefitting only low-income individuals or racial minorities.[399] In this sense, the ACA has more in common with broad programs like Social Security or Medicare—programs that are paradigmatic examples of resistance to shifting political winds[400]—even though it lacks the same kind of nationalizing, sweeping structure.

Finally, another new interest group that must be noted is the healthcare industry itself. In a major turnaround from the failed Clinton health reform effort, almost every major health industry and stakeholder organization, and even the insurance industry, rallied against repeal of the ACA.

B. POLITICAL AND EXPRESSIVE CHANGE

Benefits are only part of the story. The narrative that politics is little more than a process by which voters and interest groups vie for more benefits out of self-interest[401] fails to account for how individuals come to recognize the need for *others* outside their own communities to obtain government benefits. We focus in this section on how the ACA's principle of universal coverage came to overshadow its other, more market-based principles and shifted federal political baselines. Implementation and resistance did more than entrench the ACA—they changed it. We discuss how that process in turn triggered even more legal changes at the state level in the next section.

It is not that everyone now fully embraces single-payer healthcare or Medicare for All. It is, rather, that the range of politically acceptable healthcare policy ideas

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Supp. 3d 125, 147–48 (D.D.C. 2019), *appeal filed*, No. 19-5095 (D.C. Cir. Apr. 11, 2019). The D.C. Circuit expressly agreed that, unlike TANF Medicaid was not intended to "transition[] benficiaries away from government benefits." Gresham v. Azar, No. 19-5094, 2020 WL 741278, at *6 (D.C. Cir. Feb. 14, 2020).

397. *See supra* note 288 and accompanying text. For an argument that such groups have come to be understood as "deserving," see Peter B. Edelman, *Toward a Comprehensive Antipoverty Strategy: Getting Beyond the Silver Bullet*, 81 GEO. L.J. 1697, 1703–04 (1993).

398. Part of this is, of course, the fact that 57% of Americans report that they or someone in their household has a preexisting condition. Ashley Kirzinger et al., *6 Charts About Public Opinion on the Affordable Care Act*, KAISER FAMILY FOUND. (Nov. 27, 2019), [https://perma.cc/RP67-FVY4].

399. *See, e.g.*, Brown, *supra* note 395, at 793–96, 811–16; Super, *supra* note 395, at 1289–95.

400. Sage, *supra* note 104, at 1098 (comparing the ACA to Social Security and Medicare because of its model of more broad-based benefits); *see also* Jill Gaulding, Note, *Race, Sex, and Genetic Discrimination in Insurance: What's Fair?*, 80 CORNELL L. REV. 1646, 1689 (1995) (noting the "widespread public support" for such "programs such as Medicare, Food Stamps, and Social Security" (citing THEODORE R. MARMOR ET AL., AMERICA'S MISUNDERSTOOD WELFARE STATE: PERSISTENT MYTHS, ENDURING REALITIES 47–48 (1990))).

401. *See* William N. Eskridge, Jr., *Politics Without Romance: Implications of Public Choice Theory for Statutory Interpretation*, 74 VA. L. REV. 275, 283–95 (1988) (describing the public choice theory in the context of legislation); Daniel A. Farber & Philip P. Frickey, *The Jurisprudence of Public Choice*, 65 TEX. L. REV. 873, 883–90 (1987) (describing models of interest group politics, particularly as they relate to legislating).

has shifted significantly to include those concepts. This shift has occurred on both the left and the right. It is not a shift (as political scientists sometimes posit with political change) that has merely occurred as a moderating response to what was at one point thought extreme rhetoric or policy positions.[402] The Republicans did not embrace preexisting conditions because of Bernie Sanders, notwithstanding the important role Senator Sanders may have played in the Democratic Party.[403] This is a shift that has occurred as a result of the ACA as lived facts on the ground—benefits doled out, healthcare systems irrevocably changed, new constituencies created. These lived experiences have evolved into new understandings of rights.

Norms are abstract things and tracing them is difficult. A complete theory of how normative change occurs is outside the scope of this Article. But in the case of the ACA, we now have almost a decade of public statements, polls, elections, and legislative action. At the most mundane level, the statute has continued to gain support, is now viewed more favorably than unfavorably by a meaningful margin, and since 2017, has surpassed its enactment-year popularity.[404] It is easy to attribute that gain to more people receiving benefits with the passage of time. But what has changed is more than the view that popular benefits cannot be taken away; it is, rather, a view of what people now think a healthcare system *should be*.

Remember, the ACA built on what was already there—a mix of systems, with much healthcare left to the free market and some important government-run programs for specific populations. The idea of single-payer healthcare or Medicare for All was too radical in 2008. Those ideas embody solidarity and universality that extend well beyond the initial normative ambivalence of the ACA—a statute whose design straddled the debate between solidarity and individual responsibility.

Things have changed.[405] Recent polling now shows meaningful support for universal coverage or some version of government-guaranteed healthcare for all

402. *Cf. The Overton Window*, MACKINAC CTR. PUB. POL'Y, https://www.mackinac.org/OvertonWindow [https://perma.cc/ZVD4-BVU5] (last visited Dec. 29, 2019) (describing the "window" as a range of policies acceptable to the public at any given time, typically between two extreme positions).

403. *See, e.g.*, Draper, *supra* note 20 (discussing the role of Bernie Sanders and union organizers, particularly from National Nurses United, in bringing the idea of Medicare for All into the mainstream).

404. *Kaiser Health Tracking Poll: The Public's Views on the ACA*, KAISER FAMILY FOUND. (Nov. 20, 2019), [https://perma.cc/VB5S-NADE] (showing that, beginning in mid-2017, the population has held consistently more favorable views of the ACA than at any point since its enactment).

405. While polling continues to shift based in part on how policies are framed, majorities now support large expansions of government health coverage. *See* KAISER FAMILY FOUND., PUBLIC OPINION ON SINGLE-PAYER, NATIONAL HEALTH PLANS, AND EXPANDING ACCESS TO MEDICARE COVERAGE (2019), https://www.kff.org/slideshow/public-opinion-on-single-payer-national-health-plans-and-expanding-access-to-medicare-coverage/ [https://perma.cc/8REV-KKC6]. Public support for a single government plan was at close to 40% from 1998 to 2004, 46% in 2008 to 2009, and then rose to almost 60% in 2018 before slipping to slightly over 50% at the time of the writing of this Article. *Id.* at figs.2 & 3. When described as "Medicare for All," 63% have a positive reaction, compared to 34% negative. *Id.* at fig.5. When Medicare for All is described as optional, 74% support it, compared to only 24% in opposition. *Id.* at fig.15. These results are impressive, though it is important to caveat there is also uncertainty about the details of such plans. *Id.* at figs.10 & 12–13.

across voters in both parties and the population as a whole.[406] Some versions retain private market options, some do not. Support for increasing government responsibility for health insurance does not come solely, or even primarily, from individuals who see themselves as having benefited from the ACA.[407] The same goes for the proposition that more people should have health insurance even if it costs the government more money.[408]

In the Republican Party itself, President Trump's own signature healthcare initiatives—including piloting payment reform and his ten-year plan to end the HIV epidemic—depend on the ACA's own provisions and benefits.[409] Virtually no Republican is now willing to state a desire to return to the pre-ACA landscape of discrimination based on health status,[410] and there is new Republican legislation that proposes to protect individuals with preexisting conditions, albeit with less generous protections than the ACA.[411]

The big point is that the *baseline has shifted*. Eric Cantor, House Majority leader until 2014, recently wrote that "after Obamacare's enactment, the test for

406. *See id*. at figs.5 & 7 (reporting findings that 56% of all Americans would support a plan in which the government was the sole provider of insurance, while 63% have a positive opinion of both Medicare for All and universal coverage); *see also* Daniel Marans, *Bernie Sanders' "Medicare for All" Online Town Hall Draws Over 1 Million Live Viewers*, HUFFPOST (Jan. 24, 2018, 1:14 AM) https://www.huffingtonpost.com/entry/bernie-sanders-medicare-for-all-town-hall_us_5a680274e4b0dc592a0dbcf6 [https://perma.cc/BS9L-K8WM]; Yusra Murad, *Majority Backs "Medicare for All" Replacing Private Plans, if Preferred Providers Stay*, MORNING CONSULT (July 2, 2019, 12:01 AM), https://morningconsult.com/2019/07/02/majority-backs-medicare-for-all-replacing-private-plans-if-preferred-providers-stay/ [https://perma.cc/5JFR-85CB] (finding that Medicare for All polls at 53% among all voters, but with some variation on support depending on which features of Medicare for All are highlighted); Dylan Scott, *The "Pleasant Ambiguity" of Medicare-for-All in 2018, Explained*, VOX (July 2, 2018, 8:30 AM), https://www.vox.com/policy-and-politics/2018/7/2/17468448/medicare-for-all-single-payer-health-care-2018-elections [https://perma.cc/QV8V-7UZS] (finding that Medicare for All polls at 62% and single payer at 48%); Letitia Stein et al., *Inside the Progressive Movement Roiling the Democratic Party*, REUTERS (Aug. 23, 2018, 1:00 PM), https://www.reuters.com/investigates/special-report/usa-election-progressives/ [https://perma.cc/VQC2-26YS] (reporting a poll showing that 84.5% of Democrats, 51.9% of Republicans, and 70.1% of the total population support a policy of Medicare for All).

407. Robert J. Blendon & John M. Benson, *Public Opinion About the Future of the Affordable Care Act*, 377 NEW ENG. J. MED. e12(1), e(12)(2) tbl.2, fig.1. (2017). For example, in 2017, 8% of Republicans said they had been directly helped by the ACA, but 30% of Republicans said that the government is responsible for making sure all Americans have health coverage. *Id*.

408. *Id*.

409. *See The Trump Administration's Attack on the ACA: Reversal in Court Case Threatens Health Care for Millions of Americans*: *Hearing Before the H. Comm. on Oversight & Reform*, *supra* note 379, at 11 (written statement of Abbe R. Gluck, Professor of Law, Yale Law School).

410. *See The Trump Administration's Attack on the ACA: Reversal in Court Case Threatens Health Care for Millions of Americans*: *Hearing Before the H. Comm. on Oversight & Reform*, Committee Hearing Transcript at 3, https://docs.house.gov/meetings/GO/GO00/20190710/109761/HHRG-116-GO00-Transcript-20190710.pdf [https://perma.cc/KE7T-975Y] (statement of Ranking Member Jim Jordan: "There is no one on this committee who would support denying coverage to Americans with preexisting conditions.").

411. Paige Winfield Cunningham, *The Health 202: Republicans Want to Look Like Pioneers on Preexisting Conditions*, WASH. POST POWERPOST (April 12, 2019), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/04/12/the-health-202-republicans-want-to-look-like-pioneers-on-preexisting-conditions-protections/5caf95bfa7a0a475985bd402/?utm_term=.294e825313aa.

an alternative was a comparison of coverage numbers."[412] In other words, any Republican replacement plan that did not contain the preexisting conditions protections and also that did not cover substantially the same number of people would be unacceptable. Joseph Antos and James Capretta, two noted conservative scholars who have opposed the ACA, likewise have written that, in addition to the preexisting conditions protections, "[t]he exchange system, premium subsidies, and other ACA provisions have been in place since 2014. . . . It is unrealistic to imagine upending those structural changes."[413] The significance of these baseline shifts cannot be overstated. Remember, even the basic right to be covered regardless of health status was not the baseline a decade ago.

Our discussion of the 2017 repeal-and-replace fight makes clear how concerns over reduced coverage fractured Republican efforts to repeal the law.[414] And although the individual mandate was eventually repealed, the repeal was accomplished only by attacking the mandate in isolation from the ACA as a whole via a single provision in a broader tax bill,[415] a sharp break from previous attempts to bring down the whole law. In April 2019, Senate Majority Leader Mitch McConnell announced that ACA repeal before the 2020 election would be a nonstarter.[416]

We have already alluded to the shift among Democrats. In 2016, presidential candidate Hillary Clinton argued that debates over single-payer healthcare irresponsibly drew attention away from realistic solutions,[417] a sentiment repeated by various Democratic congresspersons[418] and influential liberal media voices.[419]

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412. *See* Eric Cantor, *The Policy and Politics of the Affordable Care Act: A Republican View from the Hill*, *in* THE TRILLION DOLLAR EXPERIMENT, *supra* note 238.

413. *See* Joseph Antos & James C. Capretta, *The Road Not Taken*, *in* THE TRILLION DOLLAR EXPERIMENT, *supra* note 84; *cf.* TIM ALBERTA, AMERICAN CARNAGE 170 (2019) (describing how, as early as 2013, Republicans worried that the ACA would change the public's perception of the role of government).

414. *See supra* Part II.

415. *See* Timothy Jost, *The Tax Bill and the Individual Mandate: What Happened, and What Does It Mean?*, HEALTH AFF. BLOG (Dec. 20, 2017), https://www.healthaffairs.org/do/10.1377/hblog20171220.323429/full/ [https://perma.cc/R9XP-J77Y].

416. Ashley Turner, *Mitch McConnell Tells Trump the Senate Will Not Revisit Obamacare Repeal Before 2020 Elections*, CNBC (Apr. 3, 2019, 9:45 AM), https://www.cnbc.com/2019/04/02/mitch-mcconnell-tells-trump-the-senate-will-not-revisit-obamacare-repeal-before-2020-elections.html [https://perma.cc/7WFS-NBCR].

417. *See* Condon, *supra* note 17.

418. *See, e.g.*, Ferrechio, *supra* note 17 (quoting Nancy Pelosi: "[Bernie Sanders is] talking about a single-payer system and that's not going to happen"); Caitlin Owens, *Congressional Democrats Aren't Feeling the Single-Payer Bern*, MORNING CONSULT (Feb. 15, 2016, 4:55 PM), https://morningconsult.com/2016/02/15/congressional-democrats-arent-feeling-the-single-payer-bern/ [https://perma.cc/CY25-4554] ("Everyone who's supporting [Sanders] needs to take a sober look at what would actually happen with these proposals[.]" (alteration in original) (quoting Senator Claire McCaskill)).

419. *See* Henry J. Aaron, *The Impossible (Pipe) Dream—Single-Payer Health Reform*, BROOKINGS (Jan. 26, 2016), https://www.brookings.edu/opinions/the-impossible-pipe-dream-single-payer-health-reform/ [https://perma.cc/E4RH-NKUM]; Johnathan Chait, *Bernie Sanders's Health-Care Plan Does Not Add Up*, N.Y. MAG. (Feb. 3, 2016), http://nymag.com/daily/intelligencer/2016/02/bernie-sanders-health-care-plan-does-not-add-up.html (stating that Sanders' bill had problems that could only be overlooked in "a world where a massive popular uprising has given democratic socialists control of both chambers of Congress"); Paul Krugman, Opinion, *Health Reform Is Hard*, N.Y. TIMES (Jan. 18, 2016),

The DNC platform committee rejected a plank supporting single-payer healthcare in 2016.[420] This decision reflected the view that, as Clinton put it, "[t]he last thing we need is to throw our country into a contentious debate about healthcare again."[421] Some said that talk of universal coverage would undermine Democrats' ability to defend the incremental gains of the ACA,[422] that the ACA needed to be entrenched before the party could start talking about single-payer.

As the repeal efforts progressed, all of that changed. The public began mobilizing around even broader government involvement in healthcare, such as Medicare for All, as key to locking in the ACA's aims.[423] Opposition to the law thus not only helped to further entrench the ACA's core principles, it *changed* those principles. It tipped the scales of the ACA's tightrope-walking ambivalence between solidarity and individual responsibly to bring the law to stand largely for the universality principle. In contrast to Clinton's comment in 2016, the *first* thing Democrats have wanted since 2017 is a debate about healthcare.

In the 2017–2018 Congress, one third of Democratic senators and a majority of Democratic representatives endorsed Medicare-for-All proposals,[424] including Democratic elected officials from states or districts that the party had lost in 2016, or from swing districts.[425] Dozens of Democratic mayors across the country

https://krugman.blogs.nytimes.com/2016/01/18/health-reform-is-hard/ [https://perma.cc/P4BG-TZMV] ("But the Sanders plan in a way reinforces my point that calls for single-payer in America at this point are basically a distraction. Again, I say this as someone who favors single-payer—but it's just not going to happen anytime soon."); Paul Starr, *The False Lure of the Sanders Single-Payer Plan*, AM. PROSPECT (Feb. 1, 2016), http://prospect.org/article/false-lure-sanders-single-payer-plan [https://perma.cc/5LES-765H]; Paul Starr, *Why Democrats Should Beware Sanders' Socialism*, POLITICO MAG. (Feb. 22, 2016), https://www.politico.com/magazine/story/2016/02/bernie-sanders-2016-socialism-213667 [https://perma.cc/4BB5-BXJF] ("Sanders' single-payer health plan shows . . . indifference to real-world consequences.").

420. *See* Draper, *supra* note 403.

421. Gibson, *supra* note 54.

422. *See* Owens, *supra* note 418.

423. *See, e.g.*, Stein, *supra* note 291 (detailing how Medicare for All became a battle cry in rallies held to defend the ACA); *see also* KAISER FAMILY FOUND., *supra* note 405, at fig.1 (showing that support for a single government plan rose precipitously during the fight over ACA repeal); Draper, *supra* note 20 (noting how ACA repeal fight led to increased support for solutions like Medicare for All).

424. *See, e.g.*, Expanded & Improved Medicare for All Act, H.R. 676, 115th Cong. (2017) (124 cosponsors in the House); Medicare for All Act of 2017, S. 1804, 115th Cong. (16 cosponsors in the Senate); Haeyoun Park & Wilson Andrews, *One-Third of Democratic Senators Support Bernie Sanders's Single-Payer Plan*, N.Y. TIMES (Sept. 13, 2017), https://www.nytimes.com/interactive/2017/09/13/us/sanders-medicare-for-all-plan-support.html.

425. *See* Alexander Burns & Jennifer Medina, *The Single-Payer Party? Democrats Shift Left on Health Care*, N.Y. TIMES (June 3, 2017), https://www.nytimes.com/2017/06/03/us/democrats-universal-health-care-single-payer-party.html ("Representative Rick Nolan of Minnesota, a populist Democrat whose district voted for President Trump by a wide margin, said he had rarely seen core Democratic voters as enthusiastic about an issue as they were about single-payer health care."); Colby Itkowitz, *The Health 202: Medicare for All Is New Democratic Mantra in Congressional Races*, WASH. POST POWERPOST (July 9, 2018), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2018/07/09/the-health-202-medicare-for-all-is-new-democratic-mantra-in-congressional-races/5b3e2b291b326b3348addd0f/ ("Of the 57 Democrats, like Eastman, who have won primaries and will challenge GOP incumbents in swing districts this fall, 33 support some form of Medicare for all, according to data from the Progressive Change Campaign Committee (PCCC). Nearly two-thirds of that group use the term in their campaign materials and just over a quarter are running in districts that Trump won."); *see also* Rachel Roubein, *Centrist Dem: Maybe We Should Look at*

signaled their support for that concept or similar ones.[426] Even Senate Minority Leader Chuck Schumer, who famously said the Democrats "blew" it by focusing on healthcare in the 2014 midterm elections, said in the summer of 2017 that single-payer healthcare was "on the table."[427] As one commentator put it: "Not since the Great Society era has so ambitious a social program been so actively promoted by influential Democrats."[428]

Indeed, how to expand government healthcare further has become *the* issue of the 2019 Democratic presidential primary.[429] A wide array of different plans have now been put forward that reflect the new policy baseline, including full single-payer,[430] Medicare for All, Medicaid and Medicare buy-in bills (through which government insurance would compete in health insurance markets with private plans),[431] plans that would automatically enroll everyone in Medicare unless they opted out to retain private insurance,[432] and two-step plans that would begin with a public option that would then transition to Medicare for All.[433] There are

Single-Payer Health Care, HILL (Sept. 6, 2017, 3:36 PM), https://thehill.com/policy/healthcare/349493-centrist-dem-maybe-we-should-look-at-single-payer-healthcare [https://perma.cc/HL9Z-DCXM] ("Sen Jon. Tester (D-Mont.) on Wednesday said Congress should perhaps take a 'solid look' at a single-payer health care system.").

426. Sarah Gamard, *Cities Fear Obamacare Repeal, Warm to Single-Payer*, POLITICO MAG. (July 24, 2017), http://www.politico.com/magazine/story/2017/07/24/mayors-support-obamacare-single-payer-health-care-215414 [https://perma.cc/64YZ-GVZS].

427. Charlie May, *Chuck Schumer Says Single-Payer Health Care Is "On the Table" for Democrats*, SALON (July 23, 2017, 3:49 PM), https://www.salon.com/2017/07/23/chuck-schumer-says-single-payer-health-care-is-on-the-table-for-democrats/ [https://perma.cc/G238-BJT8]; *cf.* Sullivan, *supra* note 252.

428. Draper, *supra* note 20.

429. Paige Winfield Cunningham, *The Health 202: Health Care Is the Central Divide in the Democratic Primary*, WASH. POST POWERPOST (Sept. 13, 2019), https://www.washingtonpost.com/news/powerpost/paloma/the-health-202/2019/09/13/the-health-202-health-care-is-the-central-divided-in-the-democratic-primary/5d7a77e6602ff171a5d73594/ ("Health care is the 2020 presidential candidates' marquee issue").

430. Sarah Kliff, *Bernie Sanders's New Medicare-for-All Plan, Explained*, VOX (Sept. 13, 2018, 8:12 AM), https://www.vox.com/policy-and-politics/2017/9/13/16296656/bernie-sanders-single-payer [https://perma.cc/G97Q-ZW9K].

431. Such as, for example, Joe Biden's plan, *Health Care*, BIDEN FOR PRESIDENT, https://joebiden.com/healthcare/ [https://perma.cc/ZG7P-T3PZ] (last visisted Jan. 19, 2020), or Pete Buttigieg's "Medicare for All Who Want It" plan, *Medicare for All Who Want It*, PETE FOR AMERICA, https://peteforamerica.com/policies/health-care/ [https://perma.cc/RN5R-SZV7] (last visisted Jan. 19, 2020); *see also* Sarah Kliff, *Democrats Now Have 5 Competing Plans to Expand Government Health Care*, VOX (Apr. 18, 2018, 2:52 PM), https://www.vox.com/policy-and-politics/2018/4/18/17252714/democrats-medicare-buy-in-chris-murphy-jeff-merkley [https://perma.cc/NSR5-PKN8]; Sarah Kliff, *Medicare X: The Democrats' Supercharged Public Option Plan, Explained*, VOX (Oct. 20, 2017, 11:00 AM), https://www.vox.com/health-care/2017/10/20/16504800/medicare-x-single-payer [https://perma.cc/K7DT-95PL].

432. *See The Medicare for America Act of 2019*, OFFICE OF CONGRESSWOMAN ROSE DELAURO, https://delauro.house.gov/sites/delauro.house.gov/files/Medicare%20for%20America%20of%202019%20Summary.pdf [https://perma.cc/W6TF-ZAZ2] (last visited Jan. 19, 2020); Dylan Scott, *Medicare for America, Beto O'Rourke's Favorite Health Care Plan, Explained*, VOX (Mar. 18, 2019, 3:00 PM), https://www.vox.com/policy-and-politics/2019/3/18/18270857/medicare-for-all-beto-orourke-2020-policies-voxcare [https://perma.cc/2ZMQ-JCKH].

433. *See My First Term Plan for Reducing Health Care Costs in America and Transitioning to Medicare For All*, WARREN FOR PRESIDENT, https://elizabethwarren.com/plans/m4a-transition [https://perma.cc/Q5D6-NKBH] (last visited Jan. 19, 2020).

meaningful differences among these policies, especially when it comes to the role of government and how much of a role private insurance would retain. But all of the options build on and beyond the ACA.[434] Notably, all embrace some version of expanded access to Medicare or an alternative that would still significantly expand the government's role in guaranteeing coverage, such as a "public option."[435] A public option is a government public health insurance plan that would compete with private plans in the market. It has long been a goal of progressives,[436] but it did not make it into the final draft of the ACA because it did not have the votes.[437] Now, it is among the more modest options being considered.[438]

Even the 2020 Democratic candidates with more incremental proposals often present their proposals, including the public option, as a pragmatic bridge toward an ultimate goal of a government guarantee of universal coverage.[439] While debates over the wisdom of "full" Medicare for All as a matter of policy and politics have been fraught,[440] the terrain on which this conversation is taking place has shifted perceptibly. And despite real differences in opinion over the specific preferred policy, nearly 85% of Democrats agree that a government-run healthcare plan should be universally available.[441] Kaiser reports finding

434. House Speaker Pelosi, for instance, has argued in favor of building on the ACA rather than rushing to Medicare for All. *See, e.g.*, Sahil Kapur, *Nancy Pelosi is Worried 2020 Candidates Are on Wrong Track*, BLOOMBERG (Nov. 2, 2019, 6:00 AM), https://www.bloomberg.com/news/articles/2019-11-02/nancy-pelosi-is-worried-2020-candidates-are-on-wrong-track.

435. *See, e.g.*, *How the Democratic Candidates Responded to a Health Care Policy Survey*, *supra* note 95 (detailing positions on healthcare of nineteen of the Democratic 2020 presidential candidates); Uhrmacher et al., *supra* note 21.

436. *See* Helen A. Halpin & Peter Harbage, *The Origin and Demise of the Public Option*, 29 HEALTH AFF. 1117, 1117 (2010); Margot Sanger-Katz, *The Difference Between a 'Public Option' and 'Medicare for All'? Let's Define Our Terms*, N.Y. TIMES: THE UPSHOT (Feb. 19, 2019), https://www.nytimes.com/2019/02/19/upshot/medicare-for-all-health-terms-sanders.html.

437. *See* Halpin & Harbage, *supra* note 436, at 1117.

438. *See How the Democratic Candidates Responded to a Health Care Policy Survey*, *supra* note 95; Uhrmacher et al., *supra* note 21.

439. Amy Klobuchar's campaign stated that she "wants to see universal health care and there are many ways to get there" and "[s]he believes the smartest transition right now would be to do a public option." *How the Democratic Candidates Responded to a Health Care Policy Survey*, *supra* note 95. Beto O'Rourke's campaign described Medicare for America as the "surest, quickest way" to get to "universal, guaranteed, high-quality health care." *Id.* Tim Ryan described "Medicare for all" as the "ultimate goal," and the public option as the "realistic" way to get there. *Id.* Eric Swalwell described a public option as the way to provide universal coverage. *Id.* Jay Inslee stated that a public option "should be a key first step toward delivering universal health care." *Id.* Pete Buttigieg's plan is to start with a public option that would eventually lead to Medicare for All. *Id.*; Abby Goodnough & Trip Gabriel, *'Medicare for All' vs. 'Public Option': The 2020 Field Is Split, Our Survey Shows*, N.Y. TIMES (June 23, 2019), https://www.nytimes.com/2019/06/23/us/politics/2020-democrats-medicare-for-all-public-option.html.

440. *See, e.g.*, Thomas Kaplan, *'Medicare for All': Elizabeth Warren and Pete Buttigieg Clash at Debate*, N.Y. TIMES (Oct. 15, 2019), https://www.nytimes.com/2019/10/15/us/politics/medicare-for-all-elizabeth-warren.html.

441. Ben Casselman, *Democrats Love Free College, Until You Offer Them More Options*, N.Y. TIMES (Dec. 21, 2019), https://www.nytimes.com/2019/12/19/business/economy/democratic-voters-free-college.html?searchResultPosition=1.

majority support for a single-payer national health plan for the first time in 2016.[442]

Shifting political positions have been accompanied by a shift in the vocabulary —notably, in a language of rights. Candidates in the Democrat presidential primary speak of healthcare as a "right, not a privilege."[443] At the time of the writing of this Article, former or current 2020 presidential candidates Michael Bennet,[444] Joe Biden,[445] Michael Bloomberg,[446] Cory Booker,[447] Pete Buttigieg,[448] Kirsten Gillibrand,[449] Kamala Harris,[450] Jay Inslee,[451] Beto O'Rourke,[452] Bernie Sanders,[453] Elizabeth Warren,[454] and Andrew Yang[455] have echoed that phrase, or called healthcare a "human right." In the context of other statutes, as Eskridge and Ferejohn have pointed out, a shift in language toward entitlement

442. *Public Opinion on Single-Payer, National Health Plans, and Expanding Access to Medicare Coverage*, KAISER FAMILY FOUND. (Nov. 26, 2019), [https://perma.cc/95XA-TDAH].

443. *See* Kamala Harris (@KamalaHarris), TWITTER (June 25, 2017, 5:00 PM), https://twitter.com/kamalaharris/status/879081783375122435?lang=en [https://perma.cc/A8HL-V8E9].

444. *2019 Democratic Debates, Night 2: Full Transcript*, N.Y. TIMES (June 28, 2019), https://www.nytimes.com/2019/06/28/us/politics/transcript-debate.html ("It is a right. Healthcare is a right.").

445. Joe Biden (@JoeBiden), TWITTER (July 15, 2019, 10:47 AM), https://twitter.com/joebiden/status/1150778836482699266 [https://perma.cc/V5N2-BE8B] (declaring that "[i]n America, health care is a right—not a privilege dependent on your gender, race, sexual orientation, income or zip code").

446. Steve Cotorno, *Michael Bloomberg Talks About Health Care and Capitalism Like No Other Democrat*, TAMPA BAY TIMES (Jan. 27, 2020), https://www.tampabay.com/florida-politics/buzz/2020/01/27/michael-bloomberg-talks-about-healthcare-and-capitalism-like-no-other-democrat/ [https://perma.cc/Q2XT-YRTN].

447. *How the Democratic Candidates Responded to a Health Care Policy Survey*, *supra* note 95 ("The most important thing is to keep the ultimate goal in mind: affordable health care for every American, because health care is a human right.").

448. *Medicare for All Who Want It*, PETE FOR AMERICA, *supra* note 431.

449. Jessica Taylor, *New York Sen. Kirsten Gillibrand Announces 2020 Presidential Run*, NPR (Jan. 15, 2019, 6:34 PM), https://www.npr.org/2019/01/15/678292493/new-york-sen-kirsten-gillibrand-announces-2020-presidential-run [https://perma.cc/UW9Y-S9XX] ("I'm going to run for president of the United States, because as a young mom, I'm going to fight for other people's kids as hard as I would fight for my own . . . . Which is why I believe that health care should be a right and not a privilege.").

450. Harris, *supra* note 443.

451. *How the Democratic Candidates Responded to a Health Care Policy Survey*, *supra* note 95 ("I believe that health care is a right for all Americans. As president, I am committed to achieving the goal of universal coverage.").

452. *Beto O'Rourke Says Universal Healthcare Is a "Human Right,"* WASH. POST (Mar. 16, 2019, 7:03 PM), https://www.washingtonpost.com/video/politics/beto-orourke-says-universal-healthcare-is-a-human-right/2019/03/16/e9905884-13e1-4d42-9b6c-dcf72e5b8729_video.html?utm_term=.3853504f6d06 ("Yes, I believe it is a human right. And, yes, I believe that every American should be able to have healthcare—mental healthcare, primary healthcare, women's healthcare.").

453. *How the Democratic Candidates Responded to a Health Care Policy Survey*, *supra* note 95 ("Bernie is running for president because the time is long overdue for the United States to join every other major country on Earth and guarantee health care to all people as a right, not a privilege, through a Medicare-for-all program. Health care is not a commodity. It is a human right.").

454. *Id.* ("I support Medicare-for-All so that everyone is covered, no one goes broke because of a medical bill, and we start treating health care like the basic human right that it is.").

455. *Medicare for All*, YANG2020, https://www.yang2020.com/policies/medicare-for-all/ [https://perma.cc/CU45-6QGY] ("As Democrats, we all believe in healthcare as a human right.").

is a critical step toward entrenchment.[456] Democrats have sometimes used this language before,[457] but never before in combination with such overt support for a universal guarantee of government coverage.[458] It was thus a major shift when President Obama, who took pains for more than a decade to defend the ACA as a market-based compromise, spoke favorably of Medicare for All—a development some believe signals the definitive move of Medicare for All from being a "pet project" to within the mainstream of Democratic policy.[459]

C. LEGAL ENTRENCHMENT OUTSIDE THE ACA ITSELF

The ACA's reforms have spread beyond the statute itself. They are now features of state law and state political discourse, and they also appear in other aspects of federal law and even the private sector. This extra-statutory legal influence is a classic attribute of special-statute theory as well.

1. State Initiatives and Other Political–Legal Action

States have held successful ballot initiatives and other electoral actions on whether to expand Medicaid, as in Maine, or shore up the existing expansion, as in Oregon.[460] They have elected slates of candidates who ran on expanding Medicaid, as in Virginia.[461] The election activity generated public debate about healthcare access.

The state-level initiatives were supported by grassroots, nonpartisan campaigns involving intensive community outreach, often spearheaded by individuals who had

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456. *See generally* Karen M. Tani, *Welfare and Rights Before the Movement: Rights as a Language of the State*, 122 YALE L.J. 314 (2012) (describing how concepts of rights emerged in the development of Social Security and other social welfare programs). ESKRIDGE & FEREJOHN, *supra* note 98, at 175–76.

457. *See In Their Own Words: Transcript of Speech by Clinton Accepting Democratic Nomination*, N.Y. TIMES, July 17, 1992, at A14, https://www.nytimes.com/1992/07/17/news/their-own-words-transcript-speech-clinton-accepting-democratic-nomination.html (quoting candidate Bill Clinton saying that he stood for "[a]n America in which health care is a right, not a privilege"); *The Second Presidential Debate*, N.Y. TIMES (Oct. 7, 2008), https://www.nytimes.com/elections/2008/president/debates/transcripts/second-presidential-debate.html (quoting candidate Barack Obama saying that healthcare "should be a right for every American").

458. Thus, for example, the 2008 Democratic Platform emphasizes that "*affordable* health care is a basic right," rather than that the government should guarantee health coverage. *2008 Democratic Party Platform*, AM. PRES. PROJ. (Aug. 25, 2008) (emphasis added), https://www.presidency.ucsb.edu/documents/2008-democratic-party-platform [https://perma.cc/4ZVG-VZ4Y].

459. David Lazarus, *Column: With A Single Sentence, Obama Moves Medicare-for-All Into the Political Mainstream*, L.A. TIMES (Sept. 11, 2018, 3:00 AM), https://www.latimes.com/business/lazarus/la-fi-lazarus-obama-medicare-for-all-20180911-story.html ("Democrats aren't just running on good old ideas like a higher minimum wage, they're running on good new ideas like Medicare for all . . . .").

460. Matthew Bloch & Jasmine Lee, *Election Results: Maine Medicaid Expansion*, N.Y. TIMES (Dec. 20, 2017, 9:15 PM), https://www.nytimes.com/elections/results/maine-ballot-measure-medicaid-expansion; Lynne Palombo, *Measure 101 County Breakdown (Maps)*, OREGONIAN, https://www.oregonlive.com/data/2018/01/measure_101_county_breakdown.html [https://perma.cc/HA73-RWE9] (last visited Dec. 30, 2019).

461. *See* Abby Goodnough, *After Years of Trying, Virginia Finally Will Expand Medicaid*, N.Y. TIMES (May 30, 2018), https://www.nytimes.com/2018/05/30/health/medicaid-expansion-virginia.html (highlighting how Republicans who were previously opposed to Medicaid dropped their opposition after almost losing control of the House of Delegates).

not previously been politically active.[462] The campaigns drew on several core arguments, including bringing federal tax dollars back to states,[463] and consistently emphasized the stories of individuals who would gain coverage if the measures passed.[464] One overarching strategy was to put a human face to the idea that no people should be left out of healthcare coverage because they cannot afford it.[465] These initiatives sometimes articulated the moral importance of Medicaid expansion in a traditionally conservative register; pro-expansion Republicans worked to depict Medicaid expansion—once pilloried as the worst kind of socialism—as not an exclusively Democratic issue.[466] As one Republican legislator in Idaho put it: "Idaho is a conservative, Christian and right-to-life state, and Medicaid expansion fits right in with our morals and values we have."[467] Utah has not voted for a Democrat for president since 1964.[468] Yet its Medicaid initiative is expected to bring coverage to 120,000 more Utah citizens.[469] One commentator stated: "if it wins approval here, it could happen almost anywhere."[470]

Some state Medicaid expansions are more generous than others. States pushing Medicaid work requirements are arguably less committed to universality than states not doing so, and create a danger that at least some ACA benefits could be morally framed, like welfare, to depend on particular notions of deservingness. In states like Utah, some governors have tried to cut down on the expansion the

462. *See* Paul Demko, *The Ballot Revolt to Bring Medicaid Expansion to Trump Country*, POLITICO (Oct. 19, 2018, 5:48 PM), https://www.politico.com/story/2018/10/19/medicaid-expansion-trump-country-864421 [https://perma.cc/JS3T-GHBC] (describing the grassroot campaign in Idaho in support of Medicaid).

463. *See, e.g.*, UTAH DECIDES HEALTHCARE, [https://perma.cc/Z5V4-N29N] (last visited Dec. 30, 2019) ("Nearly $800 million in federal funding per year is already set aside for Utah that we aren't getting back. It's money 33 other states already get, but Utah has lost out on for years.").

464. *See, e.g.*, Phil Galewitz, *Republican Gun Store Owner and Legislator Campaigns for Medicaid Expansion in Idaho*, NPR (Oct. 23, 2018, 5:01 AM), https://www.npr.org/sections/health-shots/2018/10/23/659576261/republican-gun-store-owner-and-legislator-campaigns-for-medicaid-expansion-in-id [https://perma.cc/YU3C-NGCJ]; Gabrielle Gurley, *How Maine's Medicaid Expansion Campaign Got to Yes*, AM. PROSPECT (Nov. 13, 2017), http://prospect.org/article/how-maine%E2%80%99s-medicaid-expansion-campaign-got-yes [https://perma.cc/9KKZ-DTJU]; Amanda Schaffer, *The Grassroots Activists Who Got Medicaid on the Ballot in Utah*, NEW YORKER (Nov. 1, 2018), https://www.newyorker.com/news/dispatch/the-grassroots-activists-who-got-medicaid-on-the-ballot-in-utah; *Our Fight*, INSURE THE GOOD LIFE, https://web.archive.org/web/20181108110419/https://insurethegoodlife.com/our-fight/ [https://perma.cc/46AH-Z2PB] (last visited Dec. 30, 2019).

465. As the spokesman for Mainers for Healthcare put it, the goal was to bring out the "faces and families behind those numbers." Gurley, *supra* note 464.

466. *See* Noam N. Levey, *How Medicaid Broke Through in Three Deep-Red States, and Could Do the Same in More*, L.A. TIMES (Nov. 16, 2018, 10:15 AM), https://www.latimes.com/politics/la-na-pol-medicaid-ballot-measures-20181116-story.html.

467. Galewitz, *supra* note 464.

468. Schaffer, *supra* note 464.

469. Utah Dep't of Health, *Medicaid Expansion*, UTAH.GOV, https://medicaid.utah.gov/expansion/ [https://perma.cc/AQC2-5C8B] (last visited Jan. 19, 2020).

470. Robert Pear, *Medicaid Expansion Finds Grass-Roots Support in Conservative Utah*, N.Y. TIMES (Sept. 9, 2018), https://www.nytimes.com/2018/09/09/us/politics/utah-medicaid-expansion.html/.

voters enacted.[471] In December 2019, South Carolina became the first state that did not expand Medicaid under the ACA to receive federal approval for a work requirement.[472] But an undoubtable domino effect of some form of Medicaid expansion continues. One salient example emerged at the time of this Article: New Hampshire's Republican administration announced it would delay enforcement of its work requirement due to concerns about a lack of reporting from the majority of those affected, which would lead to large coverage losses.[473] The Governor, Republican Chris Sununu, also signed a bill passed by the Democrat-controlled legislature placing additional safeguards on the requirement, should it go into effect.[474]

2. State Law Entrenchment

Equally as important, more than half the states have codified ACA reforms as *their own state law*. That is, states entrenched these reforms by enacting laws outside the ACA and in the body of individual state statute books by enacting laws that are parallel to, but distinct from, the ACA. This is perhaps the ultimate form of formal entrenchment because it gives the ACA reforms legal permanence even if the ACA itself is repealed.

Seven states have passed a full suite of guaranteed-issue, preexisting-conditions, and community-ratings standards that are analogous to the ACA's.[475] Another fourteen states have adopted some mix of these protections.[476] Four

471. Rachana Pradhan, *Trump Administration Approves Partial Utah Medicaid Expansion to Replace Voter-Approved Plan*, POLITICO (Mar. 29, 2019, 3:18 PM), https://www.politico.com/story/2019/03/29/cms-utah-medicaid-expansion-1243501 [https://perma.cc/7U8Y-GS77] (describing attempts to undertake a more limited expansion that would cost Utah "tens of millions of dollars more" than the initial full expansion, a sign that the intensity of the ideological resistance to the ACA remains). Utah ultimately adopted a full Medicaid expansion up to 138% FPL, but with work requirements for some of the expansion population. *See* Utah Dep't of Heath, *supra* note 469.

472. *See* Abby Goodnough, *South Carolina is the 10th State to Impose Work Requirements*, N.Y. TIMES (Dec. 12, 2019), https://www.nytimes.com/2019/12/12/health/medicaid-work-requirements-SC.html. This is an example of how the ACA's post-*NFIB* bargaining dynamic could actually lead to a retrenchment of the protections of the preexisting Medicaid program.

473. Harris Meyer, *New Hampshire Delays, Alters Its Medicaid Work Requirement*, MOD. HEALTHCARE (July 8, 2019, 3:50 PM), https://www.modernhealthcare.com/medicaid/new-hampshire-delays-alters-its-medicaid-work-requirement.

474. *Id*. (providing that New Hampshire would halt the requirement "if a substantial number of beneficiaries can't be contacted, there aren't adequate work opportunities available in particular areas, or transportation or other supportive services are lacking" and requiring future evaluation of the "work mandate program").

475. *See* Corlette, *supra* note 9 (identifying Colorado, Massachusetts, New York, and Virginia as having passed such laws in 2018); Sabrina Corlette & Emily Curran, *Can States Fill the Gap if the Federal Government Overturns Preexisting-Condition Protections?*, COMMONWEALTH FUND (Oct. 29, 2019), https://www.commonwealthfund.org/blog/2019/can-states-fill-gap-preexisting-condition-protections [https://perma.cc/VAJ8-P72R] (identifying Maine, New Mexico, and Washington as having passed all three sets of standards since 2018).

476. *See* Corlette, *supra* note 9 (identifying fourteen states as having passed preexisting condition protections, including the seven states that passed comprehensive protections).

states and the District of Columbia have adopted individual mandates since the passage of the ACA.[477]

Moving even further beyond the "four corners"[478] of the ACA, Washington state has enacted a limited form of a public option; it is the first state to do so.[479] Three other states have passed laws to study and develop potential public options, and fourteen other states are actively considering such legislation.[480] Oregon voters recently overwhelmingly approved a tax increase to support the state's Medicaid expansion.[481] California Governor Gavin Newsom, describing healthcare as a "fundamental right," [482] announced an ambitious package of proposals to expand healthcare access and affordability, making healthcare a priority from the beginning of his term.[483] California enacted a state-level individual mandate, putting the projected revenue toward an expansion of subsidies to purchase exchange plans to include those with incomes between 400% and 600% FPL, making exchange coverage more affordable for a larger number of middle-class families.[484] The state was also the first to pass a law offering low-income, undocumented individuals under twenty-five access to Medicaid.[485] New York City Mayor Bill de Blasio announced a plan to guarantee healthcare for all residents, including the undocumented immigrants the ACA does not cover at all,[486] to

477. *See* JENNIFER TOLBERT, MARIA DIAZ, CORNELIA HALL & SALEM MENGISTU, KAISER FAMILY FOUND., STATE ACTIONS TO IMPROVE THE AFFORDABILITY OF HEALTH INSURANCE IN THE INDIVIDUAL MARKET 3 (2019), https://www.kff.org/wp-content/uploads/2019/07/Issue-Brief-State-Actions-to-Improve-the-Affordability-of-Health-Insurance-in-the-Individual-Market.pdf [https://perma.cc/4A5E-FSWM].

478. Eskridge & Ferejohn, *supra* note 97, at 1216.

479. Austin Jenkins, *Will Washington State's New 'Public Option' Plan Reduce Health Care Costs?*, NPR (May 16, 2019, 12:11 PM), https://www.npr.org/sections/health-shots/2019/05/16/723843559/will-washington-states-new-public-option-plan-reduce-heath-care-costs [https://perma.cc/CVL7-PGZB].

480. Harris Meyer, *States Giving Public Option Health Plans a Hard Look*, MOD. HEALTHCARE (June 1, 2019, 1:00 AM), https://www.modernhealthcare.com/governance/states-giving-public-option-health-plans-hard-look.

481. Palombo, *supra* note 460.

482. David Lazarus, *Column*: *Newsom on Why Paying for the Healthcare of Immigrants in the Country Illegally Makes Sense*, L.A. TIMES (Jan. 17, 2019, 5:00 AM), https://www.latimes.com/business/lazarus/la-fi-lazarus-newsom-healthcare-interview-20190117-story.html; *see also* Gavin Newsom (@GavinNewsom), TWITTER (Jan. 9, 2019, 7:09 PM), https://twitter.com/GavinNewsom/status/1083153698161917952 [https://perma.cc/FTG2-9WVE].

483. *In First Act as Governor, Gavin Newsom Takes on Cost of Prescription Drugs & Fights for Health Care for All*, OFFICE OF GOVERNOR GAVIN NEWSOM (Jan. 7, 2019), https://www.gov.ca.gov/2019/01/07/first-acts-as-governor/ [https://perma.cc/PCQ4-KEKU].

484. *See* Victoria Colliver, *California Goes Even Bigger on Obamacare*, POLITICO (June 16, 2019, 6:51 AM), https://www.politico.com/story/2019/06/16/california-obamacare-health-care-1530461 [https://perma.cc/LSQ8-D6LM].

485. Bobby Allyn, *California Is 1st State to Offer Health Benefits to Adult Undocumented Immigrants*, NPR (July 10, 2019, 3:41 AM), https://www.npr.org/2019/07/10/740147546/california-first-state-to-offer-health-benefits-to-adult-undocumented-immigrants [https://perma.cc/B82G-6Z3C]; Catherine Kim, *California Is About to Be the First State to Expand Health Care to Young Unauthorized Immigrants*, VOX (June 12, 2019, 1:55 PM), https://www.vox.com/2019/6/12/18653901/california-expand-health-care-unauthorized-immigrants [https://perma.cc/J6B2-TVHG].

486. Amy Goldstein, *New York City Mayor Vows Health Care for All – Including Undocumented Immigrants*, WASH. POST (Jan. 8, 2019, 6:29 PM), https://www.washingtonpost.com/national/health-science/

ensure that "health care is not just in theory a right" but also "in practice a right."[487] Other states have considered ambitious state proposals to regulate healthcare prices or enact state-level, single-payer programs.[488]

The court decisions involving state Medicaid waivers have also invoked the universality principle. For example, in the series of decisions striking down Kentucky and Arkansas's Medicaid waivers allowing for work requirements, one federal court noted that "the primary purpose of [M]edicaid is to achieve the praiseworthy social objective of granting healthcare coverage to those who cannot afford it."[489] It also quoted the ACA itself for the proposition that "the Affordable Care Act was designed to provide 'quality, affordable healthcare for all Americans,' including by expanding the 'role of public programs—like Medicaid—in achieving that goal'" and quoted *NFIB*, of all cases, for the proposition that "[t]hrough the ACA, Congress made Medicaid an 'element of a comprehensive national plan to provide universal health insurance coverage.'"[490] The D.C. Circuit opinion, authored by conservative jurist David Sentelle, said the lower court was "indisputably correct that the principal objective of Medicaid is providing health care coverage."[491]

Ironically, without the relentless GOP attack on all aspects of the law, these acts of extra-statutory entrenchment likely would never have occurred. States have codified ACA reforms into their own laws precisely because they are in jeopardy on the federal level. The Supreme Court's own case-by-case acceptance and acknowledgement of the ACA is important too and has been possible only because the ACA *keeps coming back to the Court*.

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new-yorks-mayor-de-blasio-vows-health-care-for-all–including-undocumented-immigrants/2019/01/08/415db55a-1358-11e9-b6ad-9cfd62dbb0a8_story.html?utm_term=.dbf552a5159f; Paul Waldman, *On Health Care, Democrats Aren't Messing Around*, WASH. POST (Jan. 9, 2019, 2:40 PM), https://www.washingtonpost.com/opinions/2019/01/09/health-care-democrats-arent-messing-around/?utm_term=.f562e2805e5b; *see also De Blasio Administration Launches NYC Care in the Bronx, Key Component of Mayor's Guaranteed Health Care Commitment*, NYC.GOV (Aug. 1, 2019), https://www1.nyc.gov/office-of-the-mayor/news/376-19/de-blasio-administration-launches-nyc-care-the-bronx-key-component-mayor-s-guaranteed-health [https://perma.cc/LU6K-9VG8].

487. Aaron Katersky, *New York City Mayor Bill de Blasio Unveils Health Care Program for City Residents, Including Undocumented Immigrants*, ABC NEWS (Jan. 8, 2019, 12:27 PM), https://abcnews.go.com/Politics/york-city-mayor-bill-de-blasio-unveil-health/story?id=60229872 [https://perma.cc/Z98M-A8CT].

488. Sarah Kliff, *California's Ambitious Plan to Regulate Health Prices, Explained*, VOX (Apr. 11, 2018, 4:20 PM), https://www.vox.com/policy-and-politics/2018/4/11/17226574/california-health-care-pricing-regulation [https://perma.cc/N5JS-KPT5]; *State Single Payer Legislation*, HEALTHCARE-NOW!, https://www.healthcare-now.org/legislation/state-single-payer-legislation/ [https://perma.cc/AML9-SC4R] (last visited Dec. 31, 2019).

489. Stewart v. Azar, 313 F. Supp. 3d 237, 261 (D.D.C. 2018), *appeal after remand*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019), *and appeal filed*, No. 19-5095 (D.C. Cir. 2019) (quoting W. Va Univ. Hosps., Inc. v. Casey, 885 F.2d 11, 20 (3d Cir. 1989)) (internal quotation marks omitted).

490. *Id.* (quoting Pub. L. No. 111–148, 124 Stat. 119, 130, 271 (2010)); *Id.* (quoting NFIB, 567 U.S. 519, 583 (2012)); *see also* Gresham v. Azar, 363 F. Supp. 3d 165, 175 (D.D.C. 2019), *appeal filed*, No. 19-5094 (D.C. Cir. Apr. 11, 2019) (making similar statements in the Arkansas work requirement case, which the court described as "*déjà vu* all over again")

491. Gresham v. Azar, No. 19-5094, 2020 WL 741278, at *4–*6 (D.C. Cir. Feb. 14, 2020).

3. New Federal and Private Market Reforms

There has been movement outside the confines of the ACA on the federal side, too. Drug pricing provides a salient example of a way in which both state and federal lawmakers are attempting to build on the ACA's goal of making healthcare more accessible by going even further than the ACA does. In 2019, Maryland became the first state to create a Prescription Drug Affordability Board to attempt to regulate what state and local governments pay for high-cost drugs.[492] Louisiana is using an innovative new payment model for Hepatitis C drugs in its Medicaid program.[493] At the time of this Article, in addition to the Trump Administration's prioritization of the issue within its health policy agenda,[494] Congress was discussing numerous drug-pricing proposals.[495]

Even on the private-market side, there has been a sense of the inevitability of even the ACA's pilot reforms, which in turn caused system-wide change. As one prominent example, the ACA itself does not have provisions compelling industry integration. Instead (in line with its ambivalent structure), it allows the preexisting structural and pricing fragmentation to continue but creates several experimental programs designed to encourage providers to integrate and coordinate the delivery of medical care and to move away from the dominant fee-for-service payment model. But many providers interpreted the pilots as writing on the wall as early as 2010 and moved accordingly to make those kinds of changes anyway.[496] The first few years of the ACA's existence saw an unprecedented degree

492. MD. CODE ANN., HEALTH—GEN. § 21-2C-08, 09 (West 2019); Jane Horvath, *Maryland Passes Nation's First Prescription Drug Affordability Board Legislation*, NAT'L ACAD. FOR STATE HEALTH POLICY (Apr. 15, 2019), https://nashp.org/maryland-passes-nations-first-prescription-drug-affordability-board-legislation/ [https://perma.cc/W7N3-KZXQ] (noting that this Prescription Drug Affordability Board is the first board of its kind in the nation).

493. Press Release, Ctrs. for Medicare & Medicaid Servs., CMS Approves Louisiana State Plan Amendment for Supplemental Rebate Agreements Using a Modified Subscription Model for Hepatitis C Therapies in Medicaid (June 26, 2019), https://www.cms.gov/newsroom/press-releases/cms-approves-louisiana-state-plan-amendment-supplemental-rebate-agreements-using-modified [https://perma.cc/62RM-FV7T].

494. *See, e.g.*, DEP'T OF HEALTH & HUMAN SERVS., AMERICAN PATIENTS FIRST: THE TRUMP ADMINISTRATION'S BLUEPRINT TO LOWER DRUG PRICES AND REDUCE OUT-OF-POCKET COSTS (2019), https://www.hhs.gov/sites/default/files/AmericanPatientsFirst.pdf [https://perma.cc/4ANV-P6N2].

495. Berkeley Lovelace Jr., *Senate Finance Committee Unveils Bipartisan Bill to Lower Prescription Drug Prices for Seniors*, CNBC (July 23, 2019, 3:43 PM), https://www.cnbc.com/2019/07/23/key-senate-panel-unveils-bipartisan-bill-to-lower-drug-prices-for-seniors.html [https://perma.cc/2RX9-C22D]; Susannah Luthi, *Congress Revives Flurry of Drug Pricing Legislation*, MOD. HEALTHCARE (Jan. 10, 2019, 12:00 AM), https://www.modernhealthcare.com/article/20190110/TRANSFORMATION04/190119992/congress-revives-flurry-of-drug-pricing-legislation. Congress has also considered several proposals to end the practice of surprise billing to build on ACA efforts to make health care more affordable by preventing out-of-network providers from sticking patients with high bills in situations in which the patient did not know the provider was out of network. Many viewed the staunch opposition of the health care industry to these proposals as a cautionary tale for the likelihood of political success for Medicare for All or even a public option. *See, e.g.*, Margot Sanger-Katz, *Doctors Win Again, in Cautionary Tale for Democrats*, N.Y. TIMES (Dec. 17, 2019), https://www.nytimes.com/2019/12/17/upshot/surprise-billing-democrats-2020.html.

496. The New Health Care Industry: Integration, Consolidation, Competition in the Wake of the Affordable Care Act, Event at Yale Law School (Nov. 12, 2015) (discussing the dramatic increase in

of mergers and other forms of healthcare consolidation across the entire industry, as well as an uptick in new payment models based on the whole person or the whole episode of care rather than fee-for-service.[497] These payment models, including accountable-care organizations and bundled payments, focus on paying for value rather than volume. All of these private industry changes will be extremely difficult, if not impossible, to unwind regardless of what happens to the ACA.

President Trump's Secretary of HHS at the time of this Article, Alex Azar, also has reversed the Administration's prior position by supporting mandatory payment models that use the government's power to force providers to focus on value rather than fee-for-service.[498] The ACA incentivizes those changes and allows pilot projects for them; both the private market and the regulators have responded.[499] All of these moves are important precursors, both structurally and philosophically, to a more universal system.

D. STATUTORY DESIGN: FEDERALISM AND FINANCIAL ARCHITECTURE AS TOOLS OF RESISTANCE

Finally, there is the ACA's federalism and its financing structure. On federalism, scholars have argued that deep entrenchment typically occurs through the expansive and ambitious post-enactment implementation of the law by administrative agencies or courts "loyal" to the values the law embraces.[500] The ACA's trajectory is similar in only some ways to this account. The most important difference is the one this Article has repeatedly emphasized: states are far more prominent players in the ACA story than in other accounts of entrenchment, which center around federal actors.[501] The concessions that the ACA made to federalism

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mergers and acquisitions post-ACA and how it incentivized these changes even as it did not require them).

497. *See* Martin Gaynor, *New Health Care Symposium: Consolidation and Competition in US Health Care*, HEALTH AFF. BLOG (Mar. 1, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160301.053529/full/ [https://perma.cc/XNB2-TJXD] (detailing mergers and consolidation before and after the ACA); Abbe, R. Gluck, *Symposium: The New Health Care Industry—Consolidation, Integration, Competition in the Wake of the ACA*, HEALTH AFF. BLOG (Feb. 24, 2016), https://www.healthaffairs.org/do/10.1377/hblog20160224.053315/full/ [https://perma.cc/XNB2-TJXD]; *see also* NAT'L CONF. OF STATE LEGISLATURES, EPISODE-OF-CARE PAYMENTS (2010), http://www.ncsl.org/portals/1/documents/health/EPISODE_of_CARE-2010.pdf [https://perma.cc/9AXZ-GWLC]; David Blumenthal & David Squires, *The Promise and Pitfalls of Bundled Payments*, COMMONWEALTH FUND (Sept. 7, 2016), https://www.commonwealthfund.org/blog/2016/promise-and-pitfalls-bundled-payments [https://perma.cc/F2P4-EUU7]; *Bundled Payments for Care Improvement (BPCI) Initiative: General Information*, CMS.GOV (Nov. 26, 2019), https://innovation.cms.gov/initiatives/bundled-payments/ [https://perma.cc/3E36-8NXD].

498. *Mandatory Payment Models Are Making a Comeback*, *Azar Says*, ADVISORY BD. (Nov. 9, 2018, 8:30 AM), https://www.advisory.com/daily-briefing/2018/11/09/payment-models [https://perma.cc/62BY-8AD2].

499. *See* Abby Goodnough & Robert Pear, *After Obama, Some Health Reforms May Prove Lasting*, N.Y. TIMES, (Jan. 2, 2017), https://www.nytimes.com/2017/01/02/us/politics/obama-health-care-affordable-care-act.html?module=inline.

500. ESKRIDGE & FEREJOHN, *supra* note 98, at 26–28, 166–67, 186–96; Eskridge & Ferejohn, *supra* note 97, at 1270–71.

501. *See* Gluck, *supra* note 109, at 560–64 (noting the absence of states as implementers of federal law from theories of special statutes).

have proved to be perhaps the most crucial avenues for the stability of the law. In this final section, we detail another positive feature of the ACA's federalist structure: it has allowed for effective resistance against the arrival of a new Administration hostile—not loyal—to the law.

Another feature of the law that was lamented for not being sufficiently transformative is its non-federal financing structure. But it is precisely because at least part of the ACA's financial architecture has remained separate from the federal government that cooperative states have been able to use the ACA's flexible financing to stabilize their markets in the face of the Executive Branch's sabotage.

It is impossible to know what the counterfactual would be. Full-scale nationalization of the healthcare system would never have passed Congress in 2008. Would a more uniform Medicaid expansion (had the Court not intervened) or the House model of an all-federal exchange have occasioned the same buy-in as the ACA's actual path has? Or might healthcare by fiat instead have unhelpfully obviated the kind of public debate, engagement, and state legal entrenchment that the ACA's incremental and federalist structure inspired? Could implementers have resisted attacks as well as they have if the ACA's structure was fully nationalized? We cannot answer those questions, but we can show how entrenchment through the opposite scenarios occurred.

1. Entrenchment Through Oppositional Federalist Implementation

We have not seen other entrenchment theorists focusing on state implementation as a tool of statutory resilience. True, the ACA's reliance on the states created significant instability in the early years and has provided avenues for new creative attempts to curtail some of the ACA's expansions in access and reforms under an Administration hostile to the law. But implementation through the states also gave the states ownership over ACA reforms, put states in constant negotiations with HHS, created a need to pass state laws and build out state agencies to implement the law, forced public deliberation over how far to embrace the law, and allowed state officials to manipulate the ACA's financing regime to stabilize the law.

a. Entrenchment Via Negotiation, Concessions, and "Secret Boyfriends."

As one former federal official who implemented the ACA put it: "federalism is everything [we] did."[502]

Eskridge and Ferejohn posit that eager federal administrators using their powers to expand statutory rights are typical in transformative laws.[503] In contrast, Obama Administration officials entrenched the ACA by *giving in* to states even when states had a cramped vision of the ACA's reforms.

The Gluck and Huberfeld study documents how the Administration made an enormous number of concessions on Medicaid waivers—including in areas

502. Gluck & Huberfeld, *supra* note 327, at 7 (discussing a conversation with an anonymous former Executive Branch official).

503. *See* Eskridge & Ferejohn, *supra* note 97, at 1231.

generally disfavored by Medicaid advocates, such as privatizing Medicaid markets—just to get resisting states to adopt some form of expansion.[504] The Obama Administration played a long game: The theory was that once the door was open it would remain so.[505] Those Obama Medicaid administrators were proven right in 2017 when Medicaid's popularity in states that had expanded it formed the most important bulwark against ACA repeal.

Insurance exchange implementation proceeded in parallel. Going into *NFIB*, as noted, red states were politically shamed if they "cooperated" with the Obama Administration by operating state exchanges.[506] As a result, most of the blue states appeared to be running their own exchanges while most of the red states appeared to be defaulting to the federal government. That very architecture—allowing for a federal fallback exchange in the case of state refusal—provided one obvious pathway to ACA entrenchment. The federal government took over state insurance markets for the first time ever in those resisting states.

But less obviously and more complexly, as the Gluck and Huberfeld study documents, many of the ostensibly ACA-hostile states were actually engaged in significant (often behind-the-scenes) participation in and direction of their new ACA markets.[507] State officials were eager to maintain control over their own markets while "saving face" with the Republican Party by at least *appearing* to resist implementation.

The Obama Administration was happy to cooperate with this subterfuge to serve its long-term goals. Administration officials labored furiously behind the scenes to innovate new models of state–federal partnership and give even publicly resisting states as much de facto ownership over their exchanges as they wished—simply to get the statute entrenched.[508] One official colorfully called this the "Secret Boyfriend Model" of state–federal relations: the federal government was a sought-after partner, but one that states were embarrassed to reveal to their friends.[509]

The Obama Administration did not call these states out for their political obfuscation, demand accountability, or even take credit for the ACA's success in those states. Instead, the Administration saw these moments as *opportunities* to solidify the law in the long term.

b. Entrenchment Through State Implementation and Choice.

Hundreds of state laws and regulations had to be passed to implement the ACA,[510] and state employees had to be hired. None of that would have happened

504. Gluck & Huberfeld, *supra* note 8, at 1735–46.

505. *See* Gluck & Huberfeld, *supra* note 327, at 9.

506. *See supra* notes 118–19 and accompanying text.

507. *See* Gluck & Huberfeld, *supra* note 327, at 14–19; Gluck & Huberfeld, *supra* note 8, at 1759–76.

508. Gluck & Huberfeld, *supra* note 8, at 1737–40, 1758–72.

509. *Id.* at 1767–72.

510. KATIE KEITH & KEVIN M. LUCIA, COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: THE STATE OF THE STATES, 12–17 (2014), https://www.commonwealthfund.org/sites/default/

if the ACA had been designed as a full-scale federal takeover instead of as a statute that depended on state leadership and legal infrastructure—state law would have been preempted and so there would be no room for state legal action.[511] Similarly, the fact that the ACA left policy room for the states, rather than occupying the entire healthcare landscape, opened the door to the other powerful kind of legal entrenchment we have already discussed: states retained and took advantage of the legal freedom to pass parallel versions of the ACA's requirements as their own state law or to pass laws that complement the ACA. All of these kinds of legal and bureaucratic actions will be hard to undo.

But more profoundly, federalist implementation structures in general typically put states to a choice. The ACA's statutory design was no exception, especially after *NFIB*. In the ACA's case, having those state choices made the ACA the stuff of constant public debate. States had to choose whether to operate their own exchanges or expand Medicaid. Sometimes these choices produced massive public showdowns. GOP governors in some states used executive authority to expand ACA reforms even over the objection of legislatures controlled by their own party.[512] Some legislatures sought to muscle recalcitrant governors the other way.[513] And, as detailed, the voters themselves came forward in several states to ratify expansion or force resisting state governments to do so.[514]

State attorneys general had to decide whether to join the constitutional opposition to the law in *NFIB* almost as soon as the ACA was enacted. New state officials elected in 2018 felt pressure to make pronouncements in their first weeks in office about whether they were going to follow their predecessors' ACA litigating positions. Two states withdrew from the current ACA challenge in Texas;[515] others decided to join the ACA defense.[516] Some new Democratic governors announced their intent to reverse decisions made by Republican governors on Medicaid.[517] Some states made decisions to switch from the federal exchange to

files/documents/___media_files_publications_fund_report_2014_jan_1727_keith_implementing_aca_state_of_states.pdf [https://perma.cc/GZJ6-SKZE].

511. *See generally* Abbe R. Gluck, *Our [National] Federalism*, 123 YALE L.J. 1996 (2014) (arguing that federal laws with state implementation baked in give states real sovereign power by virtue of the state lawmaking they allow and require).

512. Gluck & Huberfeld, *supra* note 327, at 13–15.

513. Gluck & Huberfeld, *supra* note 8, at 1735–36, 1745–51.

514. *See supra* notes 460–70 and accompanying text.

515. Katie Keith, *Texas v. United States: Where We Are Now and What Could Happen Next*, HEALTH AFF. BLOG (July 9, 2019) https://www.healthaffairs.org/do/10.1377/hblog20190709.772192/full/ [https://perma.cc/TNA7-9VCC] ("Two plaintiff states—Maine and Wisconsin—withdrew from the case.").

516. Motion of the States of Colorado, Iowa, Michigan, and Nevada to Intervene at 6, Texas v. United States, 945 F.3d 355 (5th Cir. 2019), https://www.michigan.gov/documents/ag/CO_IA_MI_NV_Motion_to_Intervene-ACA_645014_7.pdf [https://perma.cc/7QEW-J4TR] (showing new attorneys general moving to intervene on the side of the ACA).

517. *See, e.g.*, Letter from Janet T. Mills, Governor of Maine, to Seema Verma, Administrator, Ctrs. for Medicare & Medicaid Servs. (Jan. 22, 2019), https://www.maine.gov/governor/mills/sites/maine.gov.governor.mills/files/inline-files/01-22-19%20CMS%201115%20Waiver.pdf [https://perma.cc/XDA9-MYB9].

state-based exchanges.[518]

In other words, the choices that the ACA continuously puts to the states as part of its federalism architecture virtually ensure that the ACA remains in the public consciousness. And those choices almost entirely center around the basic question of healthcare for all.

2. Federalism and Financial Resilience Under a Hostile Administration

The federalist structure of the ACA was a compromise offered in exchange for Republican votes (which never materialized). The idea was that a state-led implementation full of choices, rather than a purely national or uniform program, would make the statute seem less transformative, less of a federal takeover, and more politically palatable. The ACA's financial architecture—which leaves the private-insurance marketplace intact but adds new guardrails and supports the market with a flexible spectrum of subsidies and plans—likewise emerged from a desire for incrementalism and retention of the status quo.

But enter an Administration hostile to the law, and these two apparent compromises, put together, become powerful weapons of resistance and entrenchment.

The Gluck and Huberfeld study documents how, under the Obama Administration, the particular state-versus-federal architecture mattered little to healthcare outcomes or even to cooperation with the federal government, because the Administration was eager to make the ACA work regardless of a state's exchange structure.[519] Things are different under the Trump Administration. Ironically, it has proved easier for the Administration to suffocate the ACA in red states because most of those states are on the federal exchange where the Administration has more control than in the state-run exchanges. As a result, exchanges have performed worse in the red states and enrollment is down more in those states than in blue states.[520]

The ACA's federalism structure, for the states that exercised their federalism choices, baked this resilience into the law. States that chose to run their own exchanges have been able to increase enrollment efforts even as the Trump Administration tried to decrease them. They also have been able to reject the Administration's new policy options designed to weaken the ACA insurance markets. New Jersey's governor expressly noted, when announcing his decision

518. *See* N.J. REV. STAT. § 17B:27A-58 (2019); 40 PA. CONS. STAT. § 9301, 9302 (2019); *Governor Murphy Signs Legislation to Establish State-Based Health Exchange in New Jersey*, NJ.GOV (June 27, 2019), https://www.nj.gov/governor/news/news/562019/approved/20190628a.shtml [https://perma.cc/QN9V-6FMJ] (New Jersey Governor's Office announcing that this move "will allow New Jersey greater control over its health insurance market and the ability to establish stronger protections against the Trump Administration's sabotage of the Affordable Care Act").

519. Gluck & Huberfeld, *supra* note 8, at 1765.

520. Shelby Livingston, *State-Based Exchange Enrollment Holds Steady, HealthCare.gov Drops*, MOD. HEALTHCARE (Mar. 25, 2019, 8:13 PM), https://www.modernhealthcare.com/insurance/state-based-exchange-enrollment-holds-steady-healthcaregov-drops.

to switch New Jersey to a state exchange, that his motivation was to enable the exchange to resist executive branch sabotage.[521]

States have also been able to take advantage of the ACA's nonfederal, private financing mechanisms to stabilize their markets. The ACA's financing structure does not draw a straight line to universal coverage, but its flexibility and separation from the federal government have proven a strong defense against sabotage. Jeanne Lambrew, who was President Obama's deputy director of health reform, has pointed out how the Act's structure—which allows for a range of different plans, with different prices and subsidy levels—has allowed the ACA to resist much of the economic undermining to which it has been subjected.

As lawsuits and administrative efforts have weakened the insurance markets, premiums have risen, but individuals have not necessarily felt those increases. Creative state administrators and insurers have been able to use their flexibility across plan structures to shift more of their populations into the middle-level ACA plan, the so-called "silver plan," because under those plans individuals pay only a fixed percentage of their income, with tax credits absorbing the rest.[522] Thus, by shifting the increased costs due to ACA sabotage to silver-plan premiums (a practice now known as "silver loading"), the federal government paradoxically winds up picking up most of the tab for its own sabotage because the federal government provides the subsidies.[523] One recent study found that silver loading actually "increased enrollment by about 8[%]" in exchange plans among individuals with incomes over 200% FPL, "largely offsetting the effects of other, simultaneous federal changes in policy and practice that depressed participation levels."[524] Notably, silver loading has become such a critical ACA stabilization strategy that Congress in the 2020 Consolidated Appropriations Act prevented the Trump Administration from prohibiting or restricting it.[525]

This subsidy structure has also been an important reason why the exchanges have largely withstood the impact of the repeal of the individual mandate (although the full effect of this remains to be seen). Insurers can raise premiums in response to changes in the risk pool and the government foots the bill. As noted, the exchanges became more competitive in 2019 and the individual market was profitable for insurers.[526]

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521. *See Governor Murphy Signs Legislation to Establish State-Based Health Exchange in New Jersey*, *supra* note 518.

522. Jeanne Lambrew, *No "ObamaCare Implosion" from Trump Payment Freeze*, CENTURY FOUND. (Apr. 19, 2018), https://tcf.org/content/commentary/no-obamacare-implosion-trump-payment-freeze/?session=1 [https://perma.cc/TVG8-V2F3]; *cf.* Robert I. Field, *Even After Political Assaults, Obamacare Is Looking Much Healthier*, PHILA. INQUIRER (Aug. 13, 2018), https://www.inquirer.com/philly/health/health-cents/even-after-political-assaults-obamacare-is-looking-much-healthier-20180813.html.

523. RAO & NOWAK, *supra* note 245 at 1 (noting that while the federal government "no longer pays the cost of CSRs, most of those costs are covered by increased federal spending on the [advance premium tax credits]").

524. Stan Dorn, *Silver Linings for Silver Loading*, HEALTH AFF. BLOG (June 3, 2019) https://www.healthaffairs.org/do/10.1377/hblog20190530.156427/full/ [https://perma.cc/9LM7-4FR3].

525. Further Consolidated Appropriations Act, 2020, H.R. 1865, 116th Cong. § 609 (2019).

526. Livingston, *supra* note 361.

Numerous states, with numbers increasing almost daily, have also gained federal approval of ACA waivers to establish "reinsurance" programs—which allow them to shift more funds to insurers with very high-cost customers, keeping premiums down and markets stable.[527] These waivers, which are being sought and obtained by blue and red states alike,[528] are yet another example of the resilience the ACA obtains through its fiscal "flexibility" (a word mentioned more than a dozen times in the law itself),[529] untethered from federal control and its menu of state options.

Political scientists David Epstein and Sharyn O'Halloran famously argued that in times of divided government Congress is more likely to delegate outside of the federal government—including to the states—because it does not trust the Executive Branch fully to carry out statutory goals.[530] That concern did not animate the Congress that enacted the ACA, but the statute's federalism architecture, ten years in, substantiates it.

CONCLUSION

We are far from the first to tell a story of major legal and normative change through statutes. But the ACA's entrenchment and the way it is changing the national perspective about healthcare has been made possible by a particularly interesting, motley crew of strategies—some intentional, some unexpected, and others forced upon the law by external forces, including the Supreme Court. These strategies included granting direct benefits to a broad base, policy incrementalism, and structural federalism—and were complemented, ironically, by unprecedented and unexpected resistance to the law.

No one can predict the future. The ACA remains under perpetual attack and may be for years to come. And the healthcare system, of course, has not (yet) fully transformed. But what we can do is describe and situate the ACA's remarkable resilience and trajectory in theories of statutory design, political theory, and constitutional governance structure. We can recognize the emergence of new legal regimes, new political baselines, new constituencies, and even new vocabularies, attributable to the ACA's norms and influences. We can think about how rights emerge, in and through debate on a national stage as well as through statutory design and implementation, and how they take hold and remain.

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527. *Tracking Section 1332 State Innovation Waivers*, KAISER FAMILY FOUND. (Nov. 6, 2019), [https://perma.cc/V4PC-LXEQ]; Dylan Scott, *2020 Obamacare premiums Are on Track for Smallest Increases Ever*, VOX (Oct. 28, 2019, 1:30 PM), https://www.vox.com/policy-and-politics/2019/10/28/20936573/obamacare-health-insurance-open-enrollment-2020 [https://perma.cc/5W5W-9U8A].

528. *See Tracking Section 1332 State Innovation Waivers*, *supra* note 527.

529. "Flexibility" is mentioned in the text of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), in sections 1311(f), 1321, 1331, 1441(4)(B), 1412(e), 3129, 4108(D), 5403(f), 6402(j)(1)(C), and in the headings of Title I, Subtitle D, Parts III, and IV. It is also mentioned in the Table of Contents five times and in the Short Title Table of Contents another five times.

530. *See* DAVID EPSTEIN & SHARYN O'HALLORAN, DELEGATING POWERS: A TRANSACTION COST POLITICS APPROACH TO POLICY MAKING UNDER SEPARATE POWERS 157 (1999) ("[N]on-executive actors . . . receive a greater percentage of delegations during divided government.").