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WHY HEALTH LAWYERS MUST BE PUBLIC-LAW LAWYERS: HEALTH LAW IN THE AGE OF THE MODERN REGULATORY STATE

ABBE R. GLUCK*

It is my deep privilege to deliver these remarks here at the University of Maryland, not only because the Law School has such a premier health-law faculty but, also, because it was in Maryland where I held my first three jobs. One of those former employers, the great Senator from Maryland, Paul S. Sarbanes, introduced me to Congress and inspired me to devote my career to the subjects of legislation, the political process and the law. And that is very much the topic of my remarks tonight, with health law as the context.

Health law is not often framed as part of the “public-law” landscape, and my goal is to explain why it should be. My aim is to convince the next generation of health lawyers, policymakers, and health-law scholars that they must see health law as a field that is intimately related to Congress, federal statutes, federal agencies, and federalism, in order to have an impact on it. I will then apply this public-law framework to some current events involving the 2010 health reform statute—the Affordable Care Act (“ACA”)¹—to illustrate how shaping health law today requires an understanding of the central roles now played in the field by the quintessential players in the public-law domain: Congress, federal agencies, the states, and the federal courts.

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* Professor of Law, Yale Law School. Many thanks to Diane Hoffmann for inviting me, to Senator Sarbanes for his continuing support and inspiration, and to *Journal of Health Care Law and Policy* editor-in-chief Lindsey Imus. These are edited remarks from the Stuart Rome Lecture, delivered at the University of Maryland School of Law on November 20, 2014.

1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

I. FROM PRIVATE LAW TO PUBLIC LAW

Why the need for this new framework? Health law has historically come from the states, local governments, and the medical profession itself. It was state courts and state law that decided most health-law matters, and it was the medical profession (through self-regulation) that largely controlled the physicians. So understood, health law was what law professors call a field of “private law”—a field of law made from the ground up, and which focused on regulating relationships among private parties. In the academy, health law is often still analyzed and taught this way—around the language of private actors or markets, or in terms of the special relationships that permeate the field.

It is very hard to look around today and think that this private, local, non-federal narrative still accurately describes the health care landscape. Of course, it is the case that states and the profession still have certain, localized areas of dominance (medical malpractice and licensing of practitioners being two important examples) but, as a general matter, health law has become a field of public law—by which I mean a field that is defined by the role of the government. The ACA is, of course, the culmination of this shift, but it is a transformation that has been underway at least since the enactment of Medicare and Medicaid, which celebrate their joint 50th anniversary this year.

Why does this matter? It matters because understanding the kind of law that health law has evolved into tells us something about the field’s modern mission—because the goals and interests of public law are different than private law. It also tells us who the key players now are and how and why policy change happens. Perhaps most importantly for lawyers, the *source* of health law is now different. Today, health law is made not through state or local law, but through the quintessential public law tool: big, complex, federal statutes passed by Congress and then implemented by federal agencies and courts, sometimes along with other actors, such as the states. Health law today is *national* and *statutory*.

This understanding should change at least some of the focus of health lawyers, scholars, and policy experts. For example, one rarely sees health-law literature about Congress, or about how Congress’s own pathologies that are completely unrelated to health law (such as its budget rules and gridlock problems) have a huge impact on the health policy that it generates.² Nor has there been deep study of health administrative law,³ and

2. Timothy Westmoreland is a rare exception and has called attention to this issue. See Abbe R. Gluck, *Symposium Issue Introduction: The Law of Medicare and Medicaid at Fifty*, 15 YALE J. HEALTH POL’Y, L. & ETHICS 1 (discussing recent Westmoreland lecture on these topics).

so we cannot readily answer important questions like the following: In which areas of health-law are federal agencies particular movers and shakers? In what areas do federal agencies have overlapping jurisdiction? In which areas do they have no jurisdiction at all? We also do not have a modern account of the very significant state-federal relationships that have been created under this new nationalized and statute-ized health-law umbrella.

Moreover, once we understand health law as federal public law, we also must think more about whether it makes a difference (and if so, what kind of difference) to now have the *federal courts* in the game. Congress's creation of a federal statutory landscape of health care creates a whole new role for the federal judiciary.⁴ Here, it is important to understand that the federal judiciary (similar to Congress) carries with it a lot of its own baggage that is completely separate from health law, but that will still have a huge effect on it. The current challenge to the ACA in the Supreme Court, as I will detail, is precisely such a case. It is case that is about the ACA, of course, but it is also about an ongoing feud within the federal courts about how federal statutory language should be interpreted, regardless of what the subject matter is.

This jurisprudential transformation of health law is obviously a big project, and one that I cannot fully address in a short lecture. Instead, my goal is to provide a framework to introduce these questions, and to begin to make the case about where health lawyers and law students should be directing their focus.

II. CONGRESS

Let's start with Congress. Every transformative statute has its own special story, and that includes the particulars of the path that the statute took through Congress. The ACA's story is very unique, and courts need to understand it before they can enforce it.⁵

The ACA is going to go down in history as a textbook example of what I am going to call "unorthodox lawmaking"—a term coined by

3. For two important exceptions to this lack of research, see Eleanor D. Kinney, *Administrative Law Protections in Coverage Expansions for Consumers under Health Reform*, 7 J. HEALTH & BIOMEDICAL L. 33, 34, 55, 60 (2011), and Timothy Stoltzfus Jost, *Health Law and Administrative Law: A Marriage Most Convenient*, 49 ST. LOUIS U. L.J. 1, 4, 5, 33 (2004).

4. See Abbe R. Gluck, *The Federal Statutory Law of Health Law: The Law of "Statutes in a Field" in the Statutory Era* (unpublished manuscript on file with author).

5. For more discussion of how relevant the unique legislative-process story of any one statute is to judicial interpretation, see Abbe R. Gluck et al., *Unorthodox Lawmaking, Unorthodox Rulemaking*, 115 COLUM. L. REV. (forthcoming 2015).

political scientist Barbara Sinclair to connote the end of the “Schoolhouse Rock” legislative process.⁶ I have written a lot about why unorthodox lawmaking is important for legal doctrine.⁷ One important reason is that the Supreme Court’s own doctrines of statutory interpretation are based on that now defunct Schoolhouse Rock model: the assumption that statutes go through a linear process, are internally coherent, and are meticulously and consistently drafted.⁸

The ACA is the first major statute that is the combined product of five congressional committees’ work: three in the House and two in the Senate.⁹ One result of this is that multiple drafts were produced and eventually merged.¹⁰ Another result is that the overlapping jurisdictions of the committees led to a great number of intersecting delegations to various federal agencies under the oversight of different congressional committees.

This legislative story also gives us a framework through which to understand the state-federal relationships that the ACA creates. Throughout the drafting process, the two chambers were divided over the ACA’s federalism structure; in particular, they disagreed about whether the Act’s new health insurance marketplaces (called “exchanges”) should be run by the federal government or by the states.¹¹ As is common, the Senate preferred a more state-oriented approach, offering the states the right of first refusal to run their own exchanges, and the House took a more nationalist approach, preferring a single federal exchange rather than state-run versions.

The Senate’s state-deferential bill passed the full Senate by 60–39 in 2009.¹² The House, however, was vigorously opposed to this bill,¹³ the plan

6. See BARBARA SINCLAIR, *UNORTHODOX LAWMAKING: NEW LEGISLATIVE PROCESSES IN THE U.S. CONGRESS* 8–9, 31 (3d ed. 2007).

7. See generally Abbe R. Gluck & Lisa Schultz Bressman, *Statutory Interpretation from the Inside—An Empirical Study of Congressional Drafting, Delegation, and the Canons: Part 1*, 65 *STAN. L. REV.* 901, 979 (2013) (highlighting the prevalence of laws developing outside of the traditional committee process); Gluck et al., *supra* note 5.

8. Gluck & Bressman, *supra* note 7.

9. See John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105 *LAW LIBR. J.* 131, 138 (2013) (stating that the ACA, prior to passage, was referred to the Education and Labor, Energy and Commerce, Ways and Means, Oversight, and Government Reforms Committees).

10. See *id.* at 140 (stating that the three versions of House Bill 3200 were merged into House Bill 3962, the Affordable Health Care for America Act).

11. See Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 *YALE L.J.* 534, 578 (2011).

12. H.R. 3590, 111th Cong. (2009) (enacted); see generally *U.S. Senate Roll Call Votes 111th Congress – 1st Session*, U.S. SENATE (Dec. 24, 2009, 7:05 AM), http://www.senate.gov/legislative/LIS/roll_call_lists/roll_call_vote_cfm.cfm?&congress=111&session=1&vote=00396 (listing the Senate votes on H.R. 3590).

was going to be for the House and the Senate to duke this out, and the Senate would then presumably change its bill to reflect whatever compromise emerged. But then something happened: Massachusetts Democratic Senator Ted Kennedy died, and Republican Scott Brown replaced him. This was the game changer, because the Senate now had only 59 ACA-friendly votes—not 60. If you learned in school that the Senate is a majoritarian body, and that 51 is the magic number, you learned wrong. The critical number in the Senate is 60, because 60 votes is what is required to stop a filibuster, close debate, and move to a vote.

As a result, the Senate bill could not change because any amendment to a bill, like any law itself, requires 60 votes to go anywhere in the U.S. Senate. The consequence of all of this is that the initial draft bill that was passed, which was intended to be just a starting offer, had to be the *final* bill.¹⁴ It was never subject to the two-chamber negotiation, and it was never cleaned up for ambiguities or redundancies in drafting (as most statutes are and as all had originally assumed the ACA would be) because it never went through the Conference Committee stage.¹⁵ Conference is the “clean up” stage, but occurs only where the House and the Senate are reconciling differences across two different bills. Here, the House bill never saw the light of day because of the ripple effect of Senator Kennedy’s death on the Democrats’ voting block. In the end, it should be clear that Nancy Pelosi is really an unsung hero of health reform. As Speaker, she twisted the arms she needed to twist and got the House to accept, essentially wholesale, a state-exchange oriented bill that the House had vowed never to accept.

One final important, procedural side note: there was a so-called “reconciliation bill”—a special budget measure that was deployed because the budget process has special rules that do not allow filibusters; as a result, the key number for reconciliation is 50, not 60, votes. The reconciliation bill was passed alongside the ACA to give the House a few items that it wanted. But reconciliation is no substitute for Conference. Bills generally do not get cleaned up in reconciliation, and reconciliation is limited only to budget-related changes, so most of the ACA could not be altered through that process. The changes that were adopted as part of that measure (called the Health Care and Education Reconciliation Act) were consolidated into

13. H.R. 3590, 111th Cong. (2009); see also *H.R. 3590 (111th): Patient Protection and Affordable Care Act*, GOVTRACK.US (Oct. 8, 2009), <https://www.govtrack.us/congress/votes/111-2009/h768>.

14. Gluck, *supra* note 11.

15. Gluck & Bressman, *supra* note 7.

the version of the ACA that appears in the statute books, so you have to read the notes to know which sections were added through that process.¹⁶

So why do I tell you all of this history? The history is important because the ACA is a *statute* and because it has already survived the constitutional challenge to its existence—the 2012 case, *National Federation of Independent Business v. Sebelius*¹⁷—which means that the *rest* of the ACA cases are going to be statutory interpretation cases. *Hobby Lobby* from last term, which was about the ACA’s contraception-mandate case, is one example.¹⁸ *King v. Burwell*, pending when this lecture went to press, is another.¹⁹ The ACA’s procedural history is critical to these kinds of cases because courts interpreting statutes make a lot of assumptions about how statutes are drafted—assumptions that tend to track the “textbook” model of the textbook legislative process. In the context of the ACA, however, some of those traditional assumptions are not only totally irrelevant, but arguably are malpractice.

Let me give you a simple example. In *Sebelius*, some of the early briefing had made a very big deal about the fact that the House version of the bill contained a so-called “severability clause”—a provision stating that if any part of the statute is ruled unconstitutional (as the Medicaid expansion ultimately was), Congress still intends the rest of the statute to stand.²⁰ Severability clauses are common but, based on the principle of legislative deference, the Court also has long applied its own default presumption that statutes are presumed severable even without such a clause unless they say otherwise.²¹ Because of that strong presumption, Congress often does not include explicit severability clauses, and the Senate version of the ACA did not contain one.

Back to *Sebelius*. There, the challengers argued that because the House version of the bill had a severability clause, the fact that the final bill did not have one meant something—i.e., the “dropping” of the clause was intentional and so if the Medicaid portion went down in Supreme Court, the entire statute should be struck down too.²²

16. H.R. 4872, 111th Cong. (2010) (enacted).

17. 132 S. Ct. 2566 (2012).

18. *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

19. *King v. Burwell*, 759 F.3d 358 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (2014).

20. See ESKRIDGE ET AL., *STATUTES, REGULATION AND INTERPRETATION* (2014).

21. *See id.*

22. *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1301 (N.D. Fla. 2011) (“The lack of a severability clause in this case is significant because one had been included in an earlier version of the Act, but it was removed in the bill that subsequently became law.”), *order clarified*, 780 F. Supp. 2d 1307 (N.D. Fla. 2011), *aff'd in part, rev'd in part sub nom. Florida ex rel. Atty. Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235 (11th

I hope even after this mini tutorial you can see what an irresponsible argument this was in light of the ACA's legislative context. The House bill means nothing here. Why? Because there was never a two-chamber integration of bills. The only bill that matters is the Senate bill because, unlike in the case of most legislation, the Senate never even had to negotiate with the House version because of Senator Kennedy and the freezing in time of the Senate text as *the* text when he died.

This is just one example of the new kind of analysis that health lawyers and policymakers will need to do if they are going to be effective players in this new era of federal statutory health law. *King v. Burwell* raises similarly important issues about understanding how the two drafts produced in the Senate merged into one, and what is relevant from that process.²³

Another reason it is important to understand health law as a federal statutory field is because this reconceptualization of the field has implications for policy reform. Today, health policy development must be grounded in the context of Congress's own internal structures and understood in the context of Congress's general lawmaking pathologies.²⁴ Statutory law experts are quite familiar with the institutionalized inertia of the legislative process and its tendencies toward incrementalism and path dependence, something that political scientists also have noted for years.²⁵ As a result, it is very unusual to expect big sweeping changes in a field that is dominated by an already-existing landscape of federal statutes. The ACA exemplifies this. Congress did not wipe the slate clean. Instead, Congress took the preexisting landscape of health law and built upon it. The reason this is significant is that the pre-existing landscape itself consisted of many different programs, built upon one another and also structured in many different ways. The ACA similarly builds upon Medicare—the national insurance program for the elderly, run by the federal government; Medicaid—the state-federal insurance program for low-income individuals that is run jointly by the states and the federal government; and also the private-employer insurance system. The ACA does improve on these preexisting structures but *it keeps them all*.²⁶ The result is not the kind of

Cir. 2011), *aff'd in part, rev'd in part sub nom.* Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012).

23. See 759 F.3d 358, 371 n.2 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (2014).

24. See Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 *FORDHAM L. REV.* 1749, 1751 (2013) (noting that in designing health reform, Congress was typically path-dependent).

25. See Charles E. Lindblom, *The Science of "Muddling Through"*, 19 *PUB. ADMIN. REV.* 79, 84 (1959) (noting how Western democracies do not change through large "leaps and bounds").

26. *Id.*

statute that any reformer would have drafted from scratch; and it further entrenches health law's structural fragmentation. But it is also not a surprise. Even as health policy wonks complained that the ACA had failed insofar as it did not ameliorate health law's fragmentation, experts on Congress found the statute's ultimate structure entirely predictable, even if not ideal.

III. AGENCIES

I have provided just a small taste of the ACA's legislative context. It is equally important, however, to understand the *administrative* context of any public-law regime that, like the ACA, leaves so much to implementation. The amount of space I shall devote to the agency context here is directly inverse to its importance. It is simply too complicated to capture in a brief discussion.

What I do want to point out, however, is that the complexity of the subject matter, the need for compromise, and the desire to allow variation in ACA implementation across the states led to an enormous amount of delegation in the ACA.²⁷ The statute has several hundred delegating provisions—an amount that some have surmised is unprecedented.²⁸ Further, these delegations themselves are highly complex and often involve multiple agencies, which are given overlapping jurisdiction. Take, for example, the new Accountable Care Organizations (“ACOs”)—the integrated health care concept that is one of the ACA's flagship innovations.²⁹ At least four different agencies (the Treasury, Health and Human Services, the Federal Trade Commission, and the Department of Justice) have some authority over ACO formation.³⁰ The result has been that the different administrators have had an extremely difficult time with coordination efforts because of different goals and different turf interests, and because of the fact that the administrators are overseen by different

27. See CURTIS W. COPELAND, CONG. RESEARCH SERV., R41180, REGULATIONS PURSUANT TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (P.L. 111-148) 2, 8 (2010) (documenting the array of agencies involved in the Affordable Care Act rulemaking process and mechanisms for collaboration).

28. *Id.*

29. See Jessica L. Mantel, *Accountable Care Organizations: Can We Have our Cake and Eat it Too?*, 42 SETON HALL L. REV. 1393, 1393 (2012) (highlighting the significance of accountable care organizations in the framework of the Affordable Care Act).

30. See Susan S. DeSanti, *ACO Antitrust Guidelines: Coordination Among Federal Agencies*, ANTITRUST SOURCE, Dec. 2011, at 1, 2, available at http://www.americanbar.org/content/dam/aba/publishing/antitrust_source/dec11_full_source.authcheckdam.pdf (describing inter-agency coordination of ACO guidelines).

congressional committees. As a result, the implementation process has not always produced the ideal level of clear guidance to the public.³¹

It is also worth noting that the ACA's administrative process, much like its legislative process, has had unorthodox features.³² The agencies have had to do an enormous amount of work under intense time constraints, public scrutiny and political division.³³ The consequence has been that agencies have used many unconventional regulating measures, such as proceeding through guidance rather than through notice-and-comment rulemaking,³⁴ that differ importantly from the "textbook" administrative law process one learns about in law school.³⁵ This is not a development unique to the ACA—it is a much broader trend, as I have illustrated elsewhere³⁶—but it is still a central feature of the ACA's story.

There are other unique aspects of ACA implementation that have received less attention. One of the most important, in my view, is the way that Congress changed and improved the process for obtaining Medicaid demonstration waivers under the Act.³⁷ The waiver process has become a subject of particular interest in recent years among lawyers and legal scholars who are focused on state-federal relationships in the context of major federal statutes.³⁸ In general, this process of state-federal negotiation and receive waivers from federal administrators has been described as a "black box," bereft of a formal framework that ensures notice and fairness to both states and the public. The ACA contains an important innovation in this area. As Sidney Watson has written, the ACA brings Medicaid demonstration waivers "into the light," with new requirements, including

31. See Thomas L. Greaney, *Regulators as Market-Makers: Accountable Care Organizations and Competition Policy*, 46 ARIZ. ST. L.J. 1, 35 (2014) (citing conflicts between health-care regulators and antitrust agencies that encumber ACO administration).

32. See Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL. POL'Y & L. 441, 442 (2014) (describing these unconventional methods).

33. *Id.*

34. *Id.*

35. Gluck et al., *supra* note 5.

36. *Id.*

37. See *Five Key Questions and Answers About Section 1115 Medicaid Demonstration Waivers*, HENRY J. KAISER FAMILY FOUND. 1, 2 (June 2011), <https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8196.pdf> (citing changes to obtaining demonstration waivers in the Affordable Care Act).

38. For a few of many recent examples, see Samuel Bagenstos, *Federalism by Waiver After the Health Care Case*, in *THE HEALTH CARE CASE* 227 (Nathaniel Persily et al. eds., 2013); David J. Barron & Todd D. Rakoff, *In Defense of Big Waiver*, 113 COLUM. L. REV. 265 (2013); Theodore Ruger, *Health Policy Devolution and the Institutional Hydraulics of the Affordable Care Act*, in *THE HEALTH CARE CASE: THE SUPREME COURT'S DECISION AND ITS IMPLICATIONS* 359 (Nathaniel Persily et al. eds., 2013).

public notice and comment at both the state and federal levels.³⁹ This is an important example of how health law is at the cutting edge of many public law issues, even if many people do not yet realize it.

Finally, there is a whole separate story to tell, which I detail in other work, about the extreme variety within health law itself when it comes to the role of federal agencies.⁴⁰ Some areas of health law are agency driven; others are much less so and, interestingly, this variety exists even across the different areas of health law that are all now included in within the same overarching statute of the ACA. For example, if one looks at federal court cases, one sees relatively few cases involving the Department of Labor's oversight of ERISA, but yet one will find many cases involving Health and Human Service's ("HHS") (specifically, the Centers for Medicare and Medicaid Services' ("CMS")) oversight of Medicare.⁴¹ Part of constructing the health law as a public law story is going to require understanding those differences.

IV. THE STATES

Federal agencies are not the only major implementers of health statutory law; states also play a central role.⁴² So, increasingly, do private actors, but I will not dwell on private actors here. Instead, I will briefly discuss what I and my coauthors in other work call the "New Health Care Federalism."⁴³

One of the most prominent books on health care federalism was written right after President Clinton's health reform effort failed in 1993.⁴⁴ The book predicted that health law would "move . . . toward a *reduced* federal role and an increased *state* role in setting policy, as well as in administering and financing it."⁴⁵ That is not what happened, but the opposite has not happened either. After 1993, we had HIPPA, the HITECH

39. Sidney D. Watson, *Out of the Black Box and Into the Light: Using Section 1115 Medicaid Waivers to Implement the Affordable Care Act's Medicaid Expansion*, 15 YALE J. HEALTH POL'Y L. & ETHICS 213 (2015).

40. Gluck, *supra* note 4.

41. *Id.*

42. *See generally* Gluck, *supra* note 11.

43. *See* Baker et al., *The New Health Care Federalism: An Empirical and Theoretical Assessment of How Federalism Has Changed in Health Care and Beyond* 3 (U. of Pa. Law School, Public Law Research Paper No. 14-34; Yale Law School, Public Law Research Paper No. 525, 2015), (unpublished manuscript) (on file with the author).

44. HEALTH POLICY, FEDERALISM, AND THE AMERICAN STATES (Robert F. Rich & William D. White eds., 1996).

45. *Id.* at 294 (emphases added).

Act, the new Medicare (parts C and D), and now the ACA. This steady stream of statutes effectuated a massive federalization of the field and *could have* displaced the states. But it didn't. Instead—and quite interestingly—Congress chose in these same statutes to retain and enlarge the state role in significant ways.⁴⁶

There is a whole industry of law professors currently fighting over whether the kind of state-federal relationships that statutes like the ACA set up actually advance “federalism”—our bedrock constitutional principle of a dual government, in which both the states and the federal governments have meaningful roles to play.⁴⁷ I take on that question elsewhere,⁴⁸ but for present purposes, I will note that I do think the ACA advances federalism. I reach this conclusion because, today, one has to understand federalism in light of the massive expansion of federal legislative power that has occurred since the New Deal.⁴⁹ Congress can now regulate almost anywhere it wishes, provided it designs its statutes correctly. States have little to gain anymore from insisting on total separation from federal law because if they do so insist, they will likely lose their chance to shape major questions of policy that have a direct effect on their citizens.⁵⁰

When it comes to the ACA, for example, the big mistake is to think that the alternative to Congress's intervention was *state* intervention—it wasn't. The alternative was just more federal government. The big federalism choice in the ACA was what divided the House and Senate—whether the federal government should regulate *with* the states, or acting alone. The states would have been rendered *irrelevant* to large swaths of health law had they been left out of the ACA altogether and now, because they were not left out, are instead central players in ACA policy. I call this “federalism from federal statutes,” to signify how state power today inures from *within* federal statutory schemes. And this is one fundamental way in which the concept of federalism in health care has changed dramatically in the modern era.⁵¹ To be sure, the idea that federalism is generated by

46. See, e.g., 42 U.S.C. § 1178 (2006) (allowing exceptions to the requirements under HIPAA as long as the state meets certain additional requirements under the section); 42 U.S.C. § 1321 (2010) (granting states “flexibility in operation and enforcement of Exchanges”).

47. Feature, *Federalism as the New Nationalism*, 123 YALE L.J. 1889 (2014).

48. Abbe Gluck, *Our [National] Federalism*, 123 YALE L.J. 1996 (2014).

49. *Id.*

50. *Id.*; Heather K. Gerken, *The Federalis(m) Society*, 36 HARV. J.L. & PUB. POL'Y 941, 942–43 (2013) (“If the federal government wants to invade a regulatory sphere, it will find a way to do it.”); Abbe Gluck, *Federalism From Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1755–56 (2013) (arguing that if states resist Congress's attempts to include them in federal policies, Congress will simply “legislate without states partners,” which will increase federal power).

51. Gluck, *supra* note 48.

Congress is counterintuitive at first and it is very different from traditional constitutional theories of federalism. This federalism is an option—not an entitlement—and it varies across statutory schemes.⁵² But that does not mean that there is not power in it for the states.⁵³

Let me illustrate this point with a few examples from the current landscape of ACA implementation. Most people are familiar with the basics. There are two large pieces of the ACA that rely on state implementation: (1) the Medicaid expansion, and (2) the insurance exchanges.

In the context of Medicaid, we have seen the states exert a lot of leverage and experimentation from the *inside* of this federal scheme—not by staying outside of it. We have seen the states negotiating with HHS to run Medicaid in unusual ways for instance, by essentially privatizing it, as Arkansas’s experience exemplifies.⁵⁴ Those states never could have reconfigured Medicaid in this way had they just washed their hands of the whole thing.

The insurance exchange federalism story has even more layers. Even as Senators and state advocates lobbied successfully in Congress to ensure that states would be given the right of first refusal to run the exchanges, politics have overcome initial policy preferences. In what has been mostly an act of political resistance to the ACA as a whole, thirty-four states have now refused to run their own exchanges.⁵⁵ The ACA requires the federal government to run the exchanges for states that decline to do so.⁵⁶ The big irony is evident. The states most opposed to the federalization of health care in the first place are the very same states that now have invited the federal government to take over their insurance markets.

Perhaps even more interesting from a federalism perspective is how the exchange story has confounded the traditional federalism categorizations. The ACA has either changed our understanding of federalism or is the most visible evidence yet of changes that were already underway. As most lawyers are well aware, federalism has several defining

52. *Id.*

53. *Id.*; see also Gerken, *supra* note 50, at 943 (stating that the interplay between the federal government and states under the Affordable Care Act offers states “meaningful opportunities for states to exercise power”).

54. *Medicaid Expansion in Arkansas*, HENRY J. KAISER FAMILY FOUND. (Feb. 12, 2015), <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-arkansas/>.

55. See Sarah Kliff, *It's Official: The Feds Will Run Most Obamacare Exchanges*, WASH. POST (February 18, 2013), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/02/18/its-official-the-feds-will-run-most-obamacare-exchanges/>.

56. See 42 U.S.C. § 18041(c)(1) (2010) (providing that if a state does not establish an exchange, the secretary and federal government shall establish an exchange within that state).

features. One of the most famous is the idea that we look to the states and not the federal government when we desire experimentation or local variation. This is the “states as laboratories” argument, most famously articulated by Justice Brandeis in 1932.⁵⁷ The new health care federalism inverts this assumption in important ways that have purchase for modern federalism in general.

As it turns out, the whole “states as laboratories” idea was not working—not only in health care, but in many other fields as well.⁵⁸ States often do not experiment at the level thought ideal for policy development. Experimentation is expensive and risky; states may lose business to neighboring states if they get too creative or protective on their own. Indeed, it may not be common knowledge that some of the most important state-led policy experiments of the modern age have come not through states acting alone, but rather through states acting through federally-funded regulatory schemes. In the environmental context, for instance, satisfactory levels of state innovation in the area of air-pollution control did not occur organically until Congress passed the major environmental statutes of the 1970s that effectively required the states to take the lead or have their air-quality laws preempted by federal statute. In the Medicaid context, it was states that first took advantage of that program’s flexibility to innovate and expand the benefits-eligible population beyond the federal statute’s initial target of children and their mothers. These state experiments, supported and incentivized by the federal government, formed the basis of Medicaid’s subsequent *national* expansions to cover those same populations. So, too, the philosophy behind the ACA’s own Medicaid expansion—eligibility based on an income threshold rather than demographic categories—was first pioneered as a Medicaid state option by a few aggressive states. The Massachusetts health reform law—the law on which much of the ACA was based—was not an independent state experiment but rather was done *through Medicaid*, specifically through a Medicaid waiver granted by the Bush Administration.⁵⁹ All of these are examples of experimentalism that

57. *New State Ice Co. v. Liebmann*, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (“It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”).

58. Susan Rose-Ackerman, *Risk Taking and Reelection: Does Federalism Promote Innovation?*, 9 J. LEGAL STUD. 593, 610–11 (1980); Edward L. Rubin & Malcolm Feeley, *Federalism: Some Notes on a National Neurosis*, 41 UCLA L. REV. 903, 924–26 (1994); Gluck, *supra* note 4, at 1764. See generally David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541 (2008).

59. See generally An Act Providing Access to Affordable, Quality, Accountable Health Care, 2006 Mass. Acts ch. 58, available at <https://malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58> (explaining the various

derives from national statutory law—from Congress getting in the game and not stepping aside, which is an inversion of the typical federalism account.

Another inversion is also worth emphasizing. In the traditional account, “nationalism” is associated with policy uniformity, and “federalism” with policy variation across the states. Statutes like the ACA turn those assumptions upside down by not only tolerating, but also incentivizing a wide variety of policy implementation across the states within a single federal law. Congress expected Utah’s exchange to look very different from Massachusetts’s, and it designed the ACA to allow for that difference.⁶⁰ The result is the kind of local policy tailoring that we traditionally associate with leaving states to their own devices, but which we actually get here by nationalizing health law.

Another common feature of federalism theory that the ACA calls into question goes to the way we tend to talk about state participation in federal law. Federalism theorists often measure federalism’s “success” in terms of state cooperation. Scholars identify and puzzle over “cooperative federalism,” “uncooperative federalism,” and countless variations on that concept. But the ACA has made it difficult to measure federalism’s success using this metric because statutes like the ACA dramatically complicate what it means to *cooperate* in this context.

Some states, like New York, are clearly cooperating even though they have not let the federal government in. These states have gone and implemented the exchanges on their own, and all is well. But consider Oregon. Oregon is a “blue” state that tried to be “cooperative” by implementing its own exchange, but it failed, and the federal government has had to step in.⁶¹ Now that the federal government is in Oregon, as a formal legal matter, Oregon’s exchange looks no different than Texas’s.

features and mechanisms put in place through the Massachusetts Health Law); Ryan Lizza, *Romney’s Dilemma*, NEW YORKER (June 6, 2011), <http://www.newyorker.com/magazine/2011/06/06/romneys-dilemma> (discussing how Governor Romney appealed for a waiver from the Bush Administration to expand state Medicaid benefits).

60. Cf. June M. Sullivan, *Health Insurance Exchanges: Contrasts Between Utah and Massachusetts*, ABA.HEALTH ESOURCE (May 2012), http://www.americanbar.org/content/newsletter/publications/aba_health_esource_home/aba_health_esource_0512_sullivan.html (discussing the differences in the health information exchanges between Utah and Massachusetts, as these two exchanges were formed before the ACA).

61. See Maria L. La Ganga, *Oregon Dumps Its Broken Healthcare Exchange for Federal Website*, L.A. TIMES (Apr. 25, 2014, 12:39 PM), <http://www.latimes.com/nation/politics/politicsnow/la-pn-oregon-drops-broken-healthcare-exchange-20140425-story.html> (discussing that despite Oregon’s early enthusiasm, officials had to drop its own exchange and use the federal website instead).

After all, the federal government is running the Texas exchange, too. Texas's decision not to cooperate, however, was an act of political defiance—not the result of a good-faith effort that fell short due to technological limitations.⁶² Are Oregon and Texas really to be viewed in the same way from a federalism perspective just because they both have a federally operated exchange? What if the federally operated exchange in both states looked exactly the same?

The point is that it now becomes very hard to determine what constitutes “a “success” for federalism, or, more existentially, to determine what federalism is *for*. Sometimes when it comes to the ACA, it seems like federalism is just a matter of *attitude*, and that can't be right.

A third defining feature of federalism is state sovereignty and autonomy, and the loss of that state power is always a looming fear in cooperative federalism schemes because states are implementing federal law instead of their own. To this fear, I want to offer two responses.

First, consider which states have had more “autonomy”; those that worked with the federal government to design their own exchanges or to come up with their own versions of Medicaid, or those that just refused to play and/or let the federal government take over?

Second, ask yourself what would happen to *state law* if some advocates had gotten their wish during the drafting of the ACA—i.e., if Congress had left the states out of the ACA altogether. In that case, the ACA would be completely federal, like a “Medicare for all” (which some had advocated). As for the states? State legislatures, courts, and administrators would now be largely irrelevant to health law and policy. But, because Congress chose the opposite path, there has instead been an enormous number of new state laws, state regulations, newly appointed state officials, and state court cases triggered *by* the ACA because the ACA sets in motion a new scheme that requires a lot of state lawmaking as part of its implementation.⁶³ In other words, the ACA *depends* on the states' legal apparatus, and so gives continuing relevance to that apparatus—to the state legislatures, courts, administrators, and so on, that a different statutory-design choice could have rendered irrelevant in the health care context.⁶⁴

62. See Letter from Rick Perry, Governor of Tex., to Kathleen Sebelius, Sec'y of Health & Human Serv. (July 9, 2012) (on file with Citizens' Council for Health Freedom), *available at* http://www.cchfreedom.org/pdf/HHS_Secretary_Sebelius-Rick_Perry.pdf (calling the ACA a “power grab” and emphasizing that its “unsound encroachments” into Texas' sovereignty would not occur).

63. Baker et al., *supra* note 43; Gluck, *supra* note 48.

64. See KATIE KEITH & KEVIN W. LUCIA, THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: THE STATE OF THE STATES (Jan. 2014), *available at*

The final point I want to make here is about the state-federal negotiations that have occurred. The ACA story substantiates a view that is emerging in the broader federalism literature, which is that this world of *administrative* negotiation is really where the action is located when it comes to federalism in general. One major concern has been that these negotiations in general have been largely lawless. Even the statutory waiver process, for instance, which is a central site of these interactions, has lacked legal rules to guide state-federal interactions and ensure fairness. This will be a very significant area for future law development, and as noted, the ACA's Medicaid provisions have a groundbreaking process innovation in this regard that people in other fields soon will notice.⁶⁵

Secondly, on this point, some have taken the view that the federal government is being too "wimpy," and the President has ceded too much ground to the states in these federalism negotiations. But I think real issue is that the interests and time horizons of the federal government are just very different from those of the states; this is an important difference that modern federalism theorists should recognize more than they currently do.⁶⁶

The whole philosophy of the ACA on the federal side is just to *get this thing in the door* and improve it down the line. It is a very pragmatic politics.⁶⁷ The President's interest—unlike that of many state officials—is long term. He wants to get the statute entrenched. HHS, therefore, is likely willing to do whatever it can within the limits of the law to let even resistant states adopt the ACA in some way, whether it is by restricting Medicaid, or doing something creative with the exchanges. To be clear, HHS is given very broad discretion within the statute, and is permitted by the statute to make the kinds of concessions that some wish it had not made. But each additional state action to implement the ACA, it is critical to remember, enmeshes the statute further in a state's legal, bureaucratic, and political web.

In other words, it is not that the federal government is desperate; rather, it is acting with a long term strategy of *federal statutory entrenchment*—a common story in the statutory-law literature that health

http://www.commonwealthfund.org/~media/files/publications/fund-report/2014/jan/1727_keith_implementing_aca_state_of_states.pdf.

65. Watson, *supra* note 39.

66. Baker et al., *supra* note 43.

67. See Ruger, *supra* note 38 (discussing how the Obama administration's goal of entrenching the ACA for the long term lends itself to flexibility in negotiations with states on mechanisms for implementation).

lawyers need to understand.⁶⁸ This is how to ensure that even if a Republican gets elected President, the statute is more likely to be tweaked than repealed.

V. COURTS

This brings me to my last topic—the ACA and the courts. This statute has been subject to court battle since literally the day it was signed.⁶⁹ It now has survived the 2012 constitutional challenge and the *Hobby Lobby* contraceptive-mandate dispute essentially intact, as well as other less significant court challenges.⁷⁰

Now we have the new challenge: *King v. Burwell*, pending at the time this lecture went to press.⁷¹ *King* brings together all of the themes of this lecture. It is about the legislative context of the ACA, its statutory interpretation, its agency implementation, and its federalism story. It is also inevitably a story about the unique politics of health reform—and one hopes it is not going to be a story about the next *Bush v. Gore*.⁷²

In November of 2014, the Supreme Court took the rare action of granting review in the case before the lower courts had finished deciding it.⁷³ There were four cases going through the federal circuits dealing with the same issue, but only one had been finally decided before the Court granted review.⁷⁴ The D.C. Circuit (widely viewed as the second most powerful court in the nation) had scheduled a full court review of its

68. See WILLIAM N. ESKRIDGE, JR. & JOHN FERREJOHN, *A REPUBLIC OF STATUTES* (2010) (detailing this process of administrative and statutory entrenchment).

69. See Nicole Huberfeld, *Federal-State Tensions in Fulfilling the ACA's Promises*, NAT'L CONST. CTR. (Oct. 7, 2013), <http://blog.constitutioncenter.org/2013/10/federal-state-tensions-in-fulfilling-the-acas-promises/> (stating that the day the law was signed, states challenged the mandated Medicaid expansion).

70. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566 (2012); *Burwell v. Hobby Lobby Stores, Inc.*, 134 S. Ct. 2751 (2014).

71. 759 F.3d 358 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (2014).

72. At the time I delivered the Stuart Rome lecture, I had not yet written an amicus brief in *King* and had not planned to do so. However, I did in fact write a brief shortly before these remarks went to press. These remarks should be taken as entirely separate from the brief and were finalized long before it was written.

73. *King*, 759 F.3d 358; *Halbig v. Burwell*, 758 F.3d 390 (D.C. Cir. 2014), *reh'g en banc granted and judgment vacated per curiam*, No. 14-5018, 2014 U.S. App. LEXIS 17099 (D.C. Cir. Sept. 4, 2014).

74. *Halbig*, 758 F.3d 390; *King*, 759 F.3d 358; *Indiana v. IRS.*, 38 F. Supp. 3d 1003 (S.D. Ind. 2014); *Oklahoma ex rel. Pruitt v. Burwell*, No. CIV-11-30-RAW, 2014 U.S. Dist. Lexis 139501 (E.D. Okla. Sept. 30, 2014), *appeal held in abeyance*, No. 14-7080, 2014 U.S. App. LEXIS 24498 (10th Cir. Nov. 19, 2014), *cert denied*, No. 14-586, 2015 U.S. LEXIS 773 (Jan. 26, 2015).

respective case for December 17, 2014.⁷⁵ Rather than wait for that decision—as is the Supreme Court’s usual practice—the Court plucked the Fourth Circuit’s completed case for early review.⁷⁶ This aggressive grant of certiorari raised concerns about the politicization of the case.

On the topic of politics, and to really understand what the case is about, we need to go back to 2010, when conservative scholar Michael S. Greve made the following speech about the ACA:

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, any dollar spent on that goal is worth spending; any brief filed toward that end is worth filing⁷⁷

Mr. Greve went on to urge a litigating strategy what would “concentrate on bits and pieces of this law.”⁷⁸ *King* is the direct result of that strategy. The case is brought by the same lawyers who brought the 2012 constitutional case and even one of the plaintiffs is the same.⁷⁹ The case seizes on four words of this 2,000 page statute to argue that the ACA’s insurance-purchase subsidies are not allowed on those exchanges that are operated by the federal government.⁸⁰

This reading is devastating to the statute. Without the subsidies, the exchanges will not function as they are supposed to in the three-dozen states that have federally-operated exchanges. The ACA sets out an intricate plan: it requires insurers to insure everyone, and to insure them at

75. No. 14-5018, 2014 U.S. App. LEXIS 17099 (D.C. Cir. Sept. 4, 2014).

76. *King*, 135 S. Ct. 475.

77. Michael S. Greve, Remarks at the American Enterprise Institute Conference: Who’s in Charge? More Legal Challenges to the Patient Protection and Affordable Care Act (Dec. 7, 2010), available at <https://www.aei.org/press/whos-in-charge-more-legal-challenges-to-the-patient-protection-and-affordable-care-act/>.

78. *Id.*

79. Nat’l Fed’n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2575 (2012); *King v. Burwell*, 759 F.3d 358, 358 (4th Cir. 2014), cert. granted, 135 S. Ct. 475 (2014).

80. See *King*, 759 F.3d. at 368 (summarizing plaintiffs’ argument and interpretation of statutory language in § 36B of the ACA).

essentially equal rates.⁸¹ The ACA then supports the insurance market, which otherwise could not absorb these requirements, by requiring everyone to get insured (the infamous “insurance mandate”), and it makes that insurance requirement affordable with the subsidies.⁸² Without the subsidies, insurance will be too expensive and thereby trigger certain statutory exemptions from the mandate. As a result, many individuals will be exempt from the requirement even as the insurers are still subject to their own requirements.⁸³ The consequence of all of this, as has been amply demonstrated by others, is that the insurance markets will likely collapse.⁸⁴

It should now be clear how *King* brings the story of this lecture together. *King* is about the clarity with which the statute is drafted. Remember that the ACA’s drafting history was highly unorthodox, and did not have the last stage cleanup process that statutes usually have.⁸⁵ *King* is also about the agency’s role in interpreting the statute. Specifically, what is being challenged in the case is a Treasury regulation that interprets the language in question authorizing the subsidies.⁸⁶ Finally, *King* is, of course, about federalism. *King* has legs because of the unexpected federalism twists in the ACA implementation, because many states unexpectedly decided not to operate the exchanges themselves even after they had insisted on that opportunity when the statute was being drafted.⁸⁷

But *King* is also about a huge, established landscape of black-letter federal statutory-interpretation law that existed before health reform that now must decide health reform’s future. After all, as I have emphasized, the

81. See, e.g., 42 U.S.C. § 300gg-1 (2012) (guaranteeing availability of coverage); 42 U.S.C. § 300gg-3 (2012) (prohibiting exclusion or discrimination based on preexisting conditions or health status).

82. See 26 U.S.C. § 5000A (2012) (requiring individuals to maintain minimum essential coverage for themselves and any dependents); 26 U.S.C. § 36B (2012) (allowing refundable tax credit for coverage under a qualified health plan).

83. See Brief of America’s Health Insurance Plans as Amicus Curiae in Support of Respondents at 9, *King v. Burwell*, No. 14-114 (Jan. 28, 2015) (explaining that when healthy individuals opt out of health insurance coverage, this drives up the risk profile and premium costs of insurance pools for all participants).

84. See *id.* at 10–12 (cautioning that “adverse selection” will destabilize insurance markets, noting several failed state-level market reforms that were implemented without requiring individuals to purchase insurance or pay a penalty, and without subsidizing premiums).

85. See *supra* Part II (reviewing the unique drafting history of the ACA).

86. See *King v. Burwell*, 759 F.3d 358, 365 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (2014) (“[P]laintiffs contend that the statutory language calculating the amount of premium tax credits according to the cost of the insurance policy that the taxpayer ‘enrolled in through an Exchange established by the State under [§ 1311]’ precludes the IRS’s interpretation that the credits are also available on national Exchanges.” (quoting 26 U.S.C. § 36B(b)(2)(A), (c)(2)(A)(i))).

87. See Brief for Professors Thomas W. Merrill et al. as Amici Curiae Supporting Respondents at 8–9, *King v. Burwell*, No. 14-114 (Jan. 28, 2015) [hereinafter *Merrill Brief*].

ACA is federal statutory law and so health reform now lives and dies by the legal doctrines that apply to statutes.

The scope of this lecture does not permit an exhaustive rehearsal of the statutory doctrines relevant to *King*, and I have written too much about them elsewhere to give justice here to the full range of argument. But let us just consider a few, by way of illustration.⁸⁸ One question in *King* is whether the Court should focus on the literal meaning of the four contested words in isolation or in the broader context of the statute. The Court's statutory doctrines answer this question, with countless cases in which Court's textualists, including Justice Scalia, have insisted that statutory language must be read in context and in light of surrounding statutory provisions. There are also settled doctrines to govern questions of statutory ambiguity when an agency regulation is at issue. Consider the third most cited Supreme Court case in history—the *Chevron* case—which holds that when a statute is ambiguous, the Court must defer to implementing the agency's interpretation of that statute.⁸⁹ Equally important is the long line of doctrine that holds that federal statutes will not be interpreted to intrude on the states without clear notice and crystal clear statutory language.⁹⁰

Instead, the *King* challengers are making an argument that rewrites history. Namely, they argue that Congress, at the time the ACA was drafted, needed some kind of incentive to push the states to operate their own exchanges, and so Congress wrote a statute that punishes the states if they refuse—namely, by denying the subsidies whenever the federal government has to operate an exchange. I have already described how the ACA's own legislative evolution and the statute's federalism design tell exactly the opposite story—that state-centered advocates *insisted* on giving states the right of first refusal and so no “stick” was needed.

88. For more detail, see generally Abbe 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/>; Brief for William N. Eskridge, Jr. et al. as Amici Curiae Supporting Respondents, *King v. Burwell*, No. 14-114 (Jan. 28, 2015).

89. *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984).

90. *Merrill Brief*, *supra* note 87; *Gregory v. Ashcroft*, 501 U.S. 452, 460–61 (1991) (“[I]f Congress intends to alter the ‘usual constitutional balance between the States and the Federal Government,’ it must make its intention to do so ‘unmistakably clear in the language of the statute.’” (quoting *Atascadero State Hospital v. Scanlon*, 473 U.S. 234, 242 (1985))); *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 24 (1981) (“Congress must express clearly its intent to impose conditions on the grant of federal funds so that the States can knowingly decide whether or not to accept those funds.”).

Additionally, the challengers' narrative is deeply undermined by the statutory text itself.⁹¹ As I have detailed in other venues, we need only look as far as the Medicaid provisions of the ACA—which in no uncertain terms withdraw federal funds for states that did not expand Medicaid as the ACA envisioned—to see that Congress knew how to punish states for nonparticipation when it wanted to, and that Congress knew how to make those consequences clear.⁹² The complete absence of anything analogous when it comes to the exchanges is the kind of damning textual evidence on which the Court routinely relies and it makes the government's point. This point is further buttressed by the Court's established legal doctrines on federalism, which require "unmistakably clear" notice required to the states of the consequences of their decision to be part of a federal statutory scheme. There are other textual supports. For instance, the statute repeats the phrase "state flexibility" more than five times in the context of describing the states' choice to operate an exchange and has a provision that expressly sets forth the consequences of the states' decision not to do so—a provision that nowhere contains the penalty that challengers would find buried, later in the law, in a section directed at how *individuals* should calculate their tax credits.

I cannot do justice to this complex case here, so by way of conclusion I will just walk through the primary textual debates in the case. The only definition of the exchanges in the ACA is in Section 1563, which defines "Exchange" as "an American Health Benefit Exchange established under section [1311]."⁹³ Section 1311 is the state exchange provision, and provides that the "state shall establish an American Health Benefit Exchange."⁹⁴ Section 1321 spells out the consequences of the state's failure to operate its own exchange.⁹⁵ Notably, that section is entitled "state flexibility"—not state punishment—and sits in a Part of the Act with the same title.⁹⁶ Section 1321 provides that if a state "will not have any required Exchange operational"—note the "capital E" in "Exchange"—". . . the Secretary shall . . . establish and operate *such* [capital E] Exchange

91. See 42 U.S.C. § 1396(c) (2012) (explaining the consequences of a state's noncompliance with the Medicaid Provision of the statute).

92. *Id.*

93. 42 U.S.C. § 300gg-91 (Supp. V 2012).

94. Patient Protection and Affordable Care Act of 2010 § 1311, 42 U.S.C. § 18031 (2012).

95. Patient Protection and Affordable Care Act of 2010 § 1321, 42 U.S.C. § 18041 (2012).

96. *Id.*

within the state.” (emphasis added).⁹⁷ The natural reading of this language is that the Secretary is establishing the state Exchange.⁹⁸

Now, it is true that when you get to Section 1401, the statute says that subsidies are calculated based on months enrolled in an “exchange established by the state under 1311,” which is the state exchange provision.⁹⁹ In a vacuum, this looks like only the state exchanges get the subsidies; but we know from the other sections of the ACA that the federal exchange is, by definition, establishing *such* a state exchange because the Act says that the only kind of exchange that exists is a state “Exchange.”

That’s confusing indeed, but this confusion clears up quickly when you read the rest of the 2,000 page statute. Throughout the statute, there are scores of other mentions of the (capital E) Exchange that apply clearly to both state and federal exchanges. At least six of those mentions are in the tax credit Section 1401 with no qualifying language, and which includes a provision that specifically requires both federal and state exchanges to report the subsidies that they have doled out to the IRS.¹⁰⁰ These provisions make no sense if the federal exchanges do not have subsidies.

The challengers in *King* have argued that they have the clear text on their side, and that all the government has is an amorphous congressional purpose. This is good strategic framing, but it is wrong. This is not a text vs. purpose case.¹⁰¹ One does not need to go beyond the text of the ACA itself to see the structure of the statute, and no one should because the ACA’s legislative history, as I have detailed, is too convoluted.

The text of the statute alone makes clear that the whole thing depends on the insurance subsidies. The text emphasizes “state flexibility”; contains many provisions that assume the federal exchanges will be giving out the tax credits and allows an easy comparison to the Medicaid provisions, which do explicitly threaten the states with rescinding federal funds if the states do not cooperate. At a minimum, these textual provisions make the statute ambiguous—even though the government goes farther to argue that the statutory text unequivocally supports its position.

In this regard, it is quite important to emphasize which side bears the legal burden and which side is benefitted by any finding of ambiguity. All

97. *Id.* (emphasis added).

98. *See King v. Burwell*, 759 F.3d 358, 369 (4th Cir. 2014), *cert. granted*, 135 S. Ct. 475 (2014) (explaining the defendant’s interpretation of the statute, who described “Exchange” as a state Exchange set up by the Secretary).

99. Patient Protection and Affordable Care Act of 2010 § 1401, 26 U.S.C. § 36B (Supp. IV 2011).

100. 26 U.S.C. § 36B.

101. Gluck, *supra* note 88.

of the relevant doctrines in this area favor the government if the statute is not clear. The *Chevron* doctrine requires deference to the agency if the statute is ambiguous. The federalism doctrines require “unmistakable clarity” before a statute will be read to impose dramatically on the states, as the challengers’ reading would. The Court also presumes that Congress does not make huge changes (especially ones that penalize states) without being clear, and also that Congress does not write statutes that are designed to fail. To effectuate these presumptions, courts apply the so-called “major questions rule,” which assumes—in Justice Scalia’s colorful phrasing of words—that Congress does not “hide elephants in mouseholes”—that it doesn’t sneak major things into statutes by burying them in indirect or unclear language.¹⁰² One should also not forget the doctrines of constitutional avoidance and severability, which direct courts—out of deference to the legislature—to construe statutes so as not to be dysfunctional.

In *King*, the challengers are arguing something totally implausible; namely, that Congress sowed the seeds of the statute’s own destruction intentionally into the act—that Congress set up its own federal exchanges to fail—and that it did so *intentionally* and without explicit language. This is an assumption that even the ACA dissenters in the 2012 case, *Sebelius*, flatly rejected. There, the Joint Dissent assumed the availability of the subsidies across all exchanges, and argued that the statute makes no sense without the subsidies and cannot function without them.¹⁰³ As the dissent put it there:

Congress provided a backup scheme; if a State declines to participate in the operation of an exchange, the Federal Government will step in and operate an exchange in that State.

. . .

That system of incentives collapses if the federal subsidies are invalidated. Without the federal subsidies, individuals would lose the main incentive to purchase insurance inside the exchanges, and some insurers may be unwilling to offer insurance inside of exchanges. With fewer buyers and even fewer sellers, *the exchanges would not operate as Congress intended and may not operate at all.*¹⁰⁴

102. *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 468 (2001).

103. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2674 (2012) (joint dissent).

104. *Id.* at 2665, 2674 (emphasis added).

VI. CONCLUSION

And so, here we are, in the middle of year five of the ACA's life, and with a statute that significantly transforms health law from a private law regime to a field of public law. We have a Congress that has tried to repeal the statute more than 40 times, we have state resistance, and we have another Supreme Court case.

We also have a Supreme Court that, as I detail elsewhere, does not have much health law experience, does not really understand the statutory schemes, and certainly does not take a coherent approach to the issues in the field.¹⁰⁵ This is why it is time to start thinking deeply about what it means to understand health law as federal statutory law, and to equip our health-law students with those doctrines. We need to start lawyering about health law in the public-law context in which it now unquestionable resides. I hope you will join me in doing so.

105. Gluck, *supra* note 4.