

# The Affordable Care Act’s Litigation Decade

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\* Professor of Law and Faculty Director, Solomon Center for Health Law and Policy, Yale Law School. © 2020, Abbe R. Gluck, Mark Regan & Erica Turret. We thank Andrew Pincus, the terrific editors at *The Georgetown Law Journal*, and Larry Gostin for helping to bring this Symposium issue together. The authors dedicate this Article, with our enduring thanks and admiration, to our incomparable colleague, Timothy Stoltzfus Jost.

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\*\*\* Yale Law School, J.D. 2020.

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#### INTRODUCTION

The decade of the Affordable Care Act (ACA) has been a decade in court.

The ACA is the most challenged statute in American history. The first lawsuits were filed moments after the law was enacted—on March 23, 2010—alleging that the ACA was unconstitutional.<sup>1</sup> Ten years later, the ACA is still under attack, being litigated in three Supreme Court cases within the current year alone<sup>2</sup>—for a collective total of seven Supreme Court challenges in a decade.<sup>3</sup> One of the

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1. See Complaint, Florida *ex rel.* Bondi v. U.S. Dep’t of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011) (No. 3:10-cv-00091-RV-EMT), 2010 WL 1038209; Complaint for Declaratory and Injunctive Relief, Virginia *ex rel.* Cuccinelli v. Sebelius, 702 F. Supp. 2d 598 (E.D. Va. 2010) (No. 3:10-cv-00188-HEH), 2010 WL 11240598.

2. Me. Cmty. Health Options v. United States, No. 18-1023, 2020 WL 1978706 (U.S. Apr. 27, 2020); Trump v. Pennsylvania, 140 S. Ct. 918 (2020) (mem.); California v. Texas, 140 S. Ct. 1262 (2020) (mem.).

3. The other four cases are *NFIB v. Sebelius*, 567 U.S. 519 (2012); *Burwell v. Hobby Lobby Stores*, 573 U.S. 682 (2014); *King v. Burwell*, 135 S. Ct. 2480 (2015); and *Zubik v. Burwell*, 136 S. Ct. 1557 (2016). This number does not include a recent emergency order staying a Second Circuit injunction in another ACA-related case concerning an immigration rule known as the public charge rule, Department

pending cases is another major challenge to the statute's entire existence.<sup>4</sup> Along the way, the statute has been rebelled against by the states charged with implementing it,<sup>5</sup> sabotaged by the second President to administer it,<sup>6</sup> and financially starved by Congress.<sup>7</sup> All of these events have fed a swirl of litigation and made for a story of unprecedented statutory resilience.

Everything about the ACA litigation—the stakes, the political and media attention, and even the number of hours of oral argument granted by the Supreme Court—has been “outsized,” as one former U.S. Solicitor General aptly put it.<sup>8</sup> The breadth of the more than 2,000 legal challenges has been staggering. The litigation reveals the extensive reach of the ACA into all areas of our economy and its effects far beyond healthcare. It shows the legal complexity of a federal law that does not rely solely on the federal government to administer it but relies on states and private actors as well. And it underscores the political and practical challenges of government intervention that aims to affect not only individual behavior but also private relationships, including those between employers and employees, and between patients and healthcare providers. For some, such interventions are an unacceptable overreach.

The ACA is the most significant healthcare legislation in recent American history, at least since Medicare and Medicaid were enacted in 1965. The cases it has generated in court have, of course, shaped American healthcare and the programs that comprise it. But they also have shaped constitutional law, federalism, statutory interpretation, administrative law, and our conceptualizations of the rights and duties of states and private actors charged with implementing federal statutes.

The legal challenges also underscore deep and longstanding philosophical tensions within American healthcare itself. The norms of solidarity and community—that everyone should contribute so everyone can receive good healthcare—have long stood in counterpoise to the libertarian and market-based position that one gets only the healthcare one can pay for (and that matches one's risk profile).<sup>9</sup> The fragmentation of American healthcare that preceded the ACA—a mix of government programs and substantial reliance on the private market—reflected

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of *Homeland Security v. New York*, 140 S. Ct. 599 (2020) (mem.) (order on application for a stay). The Supreme Court also stayed an Illinois-specific injunction of the same rule. *Wolf v. Cook County*, 140 S. Ct. 681 (2020) (mem.) (order on application for a stay). See *infra* Section III.D.2.

4. *California v. Texas*, 140 S. Ct. 1262 (2020) (mem.).

5. See *infra* Section II.B.

6. See *infra* Sections III.A, III.D.2.

7. See *infra* Section III.A.

8. Paul Clement, *The ACA and the Courts: Two Perspectives, Part Two*, in *THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA* 163, 163 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020).

9. See Wendy K. Mariner, *Social Solidarity and Personal Responsibility in Health Reform*, 14 *CONN. INS. L.J.*, 199, 200–01 (2008); Deborah Stone, *The Struggle for the Soul of Health Insurance*, 18 *J. HEALTH POL., POL'Y & L.* 287, 290 (1993). Before the ACA, most insurers distinguished among prospective customers, in terms of both eligibility and pricing, based on their risk of disease.

that normative ambivalence.<sup>10</sup> And the structure of the ACA for the most part does not change that. The ACA retains the mixed system of federal, state, and private healthcare that came before it, but seeks to make the system more generous and accessible across every dimension. As a result, the ACA in some places advances solidarity—requiring that we all participate and that everyone gets covered—and in other places retains individualism and the market structure. The litigation has largely centered around solidarity—both challenging it and protecting it.

And yet, litigation has transformed the ACA and the public’s understanding of it and its goals. Whereas the ACA came into the world as an uneasy political compromise between solidarity and market norms that frustrated some reformers wishing to see more,<sup>11</sup> it has emerged from a decade of litigation much more closely aligned with the norms of solidarity and universal coverage than it was in 2010.

Take, for example, the significant choices that the ACA puts to the states. Some of those choices are the direct result of litigation, including the Supreme Court’s own interpretation of the law and its decision to allow states to opt out of the Medicaid expansion. Those choices are essentially choices about how much of the population to cover and so they elevate the salience of that issue. Efforts to strangle and repeal the law have failed largely because of the people who would be thrown off the rolls. The ongoing litigation about access to medicine, nondiscrimination, and immigrants’ right to healthcare is also about the population’s ability to access care. Even the many significant cases involving insurers are about the promises the government made to the industry to convince it to implement the law, and how easily the government can walk back those promises. Those cases, too, are in a sense about the struggle between a market model and a model that puts special obligations and responsibilities on the federal government.

Even prominent conservatives have observed how this decade of fighting over the ACA has changed what the law stands for and how we understand our healthcare system. As former Republican House Majority Leader Eric Cantor has noted, most significantly, the “baseline” has changed; a replacement that does not cover the same number of people is now widely viewed as politically unacceptable.<sup>12</sup> That is an enormous shift. Consider that when the ACA was enacted, a “public option”—a government-run insurance program that would compete with others—was viewed as too radical;<sup>13</sup> now it is one of the more moderate proposals on the table for future reform.

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

11. LAWRENCE R. JACOBS & THEDA SKOCPOL, HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO KNOW 78–82 (3d ed. 2012); PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 239 (2011).

12. See Eric Cantor, *The ACA and the Republican Alternative*, in THE TRILLION DOLLAR REVOLUTION, *supra* note 8, at 139; accord Joseph Antos & James C. Capretta, *The Road Not Taken*, in THE TRILLION DOLLAR REVOLUTION, *supra* note 8, at 72 (discussing how “[t]he ACA established policy objectives that set a base for future reforms”).

13. See Abbe R. Gluck & Thomas Scott-Railton, *Affordable Care Act Entrenchment*, 108 GEO. L.J. 495, 501 (2020) (“The Party position has now shifted so much that a ‘public option’ [in 2008] has gone

This Article documents in one place (the first to our knowledge) the sheer breadth and volume of the decade of litigation about the ACA, covering the period from the day the law was enacted, March 23, 2010, until April 2020. The relentless and multipronged legal attacks on the ACA, and the ACA's survival and transformation through and in large part because of them, are an important part of the history of not only the ACA but the law of the decade itself.

After a brief overview in Part I of the ACA and the political context in which the ACA was challenged and implemented, Part II turns to the so-called "existential challenges" to the law—the challenges that have threatened the entire ACA. Part III then moves to narrower challenges to specific aspects of the law: those brought by insurers, those challenging the ACA's contraception and nondiscrimination provisions, those seeking to defend the law against a new and hostile President, and many more challenges in state and federal courts. We conclude in Part IV with some additional reflections on what the litigation landscape reveals about the ACA and the many areas of law, regulation, and American behavior that it has touched.

### I. BRIEF OVERVIEW OF THE ACA

The ACA's governance structure has provided the impetus for much of the litigation. In this vein, the most important thing to emphasize is that the ACA largely built on what came before it—namely, a highly fragmented American healthcare system in which different swaths of the population received their health benefits from different programs. The elderly and disabled had Medicare, a federal government program; certain categories of low-income individuals had Medicaid, a government program jointly administered by states and the federal government;<sup>14</sup> veterans had their federal healthcare system; about half the population obtained health insurance through their employers (who benefitted from a tax deduction collectively worth \$200 billion a year);<sup>15</sup> and the rest either bought insurance in the (expensive, hard-to-navigate, and often-discriminatory) private individual market or rolled the dice, went uninsured, and relied on emergency rooms and charity care.<sup>16</sup>

The politics of enactment—including President Obama's (ultimately unachieved) desire to get a bipartisan bill<sup>17</sup> and stinging memories of the failed healthcare reform effort by the Clinton Administration in 1993–1994<sup>18</sup>—meant that the ACA would not wipe the slate clean and build a unified program. Instead, the law

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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.”).

14. Two ACA provisions assisting Medicare–Medicaid “dual eligibles” are sections 2601 and 2602.

15. See Abbe R. Gluck & Nicole Huberfeld, *What Is Federalism in Healthcare For?*, 70 STAN. L. REV. 1689, 1708–09 (2018).

16. See Gluck & Scott-Railton, *supra* note 13, at 503–04.

17. See Timothy S. Jost, *Health Care Reform and a Failed Vision of Bipartisanship*, 35 HEALTH AFF. 1748, 1748–49 (2016) (describing failed efforts to create a bipartisan reform bill).

18. See generally Theda Skocpol, *The Rise and Resounding Demise of the Clinton Plan*, 14 HEALTH AFF. 66 (1995) (describing the Clinton Administration's inability to pass healthcare reform).

kept the fragmented structure of the system but increased access and benefits at every level. Medicare saw a significant increase in its drug benefits,<sup>19</sup> and co-pays for many preventive services were eliminated.<sup>20</sup> Medicaid was to be expanded to populations long excluded from categorical eligibility (namely, nonelderly childless adults, including men, with incomes up to 138% of the federal poverty level (FPL)).<sup>21</sup> Individuals in the private market with incomes up to 400% FPL (approximately \$100,000 for a family of four) would receive subsidies to make the purchase of insurance more affordable and would buy that insurance on newly created and regulated insurance markets—the “exchanges”—designed to make options more transparent for consumers and to ensure that insurance so met a minimum standard of coverage.<sup>22</sup> To support these dramatic changes, the ACA also included a series of stabilization payments to insurers designed to smooth the transition and keep the out-of-pocket costs to consumers relatively low.<sup>23</sup> Litigation would develop around both the Medicaid expansion and the concept of the single unified insurance pool that the exchanges were designed to create, as well as around the payments the law promised to insurers.

The ACA also included significant new insurance protections regardless of what program individuals were in. Insurers could no longer deny<sup>24</sup> or rescind<sup>25</sup> coverage for a pre-existing health condition, impose lifetime or annual caps,<sup>26</sup> or

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19. The ACA closed the Medicare prescription drug “doughnut hole,” in which beneficiaries previously faced a gap in coverage for prescription drug costs. See JULIETTE CUBANSKI ET AL., KAISER FAMILY FOUND., WHAT ARE THE IMPLICATIONS OF REPEALING THE AFFORDABLE CARE ACT FOR MEDICARE SPENDING AND BENEFICIARIES? 2 (2016), <http://files.kff.org/attachment/Issue-Brief-What-Are-the-Implications-of-Repealing-the-Affordable-Care-Act-for-Medicare-Spending-and-Beneficiaries> [<https://perma.cc/5W9C-S2EH>]. Previously, Medicare covered prescription drug costs up to a certain cost threshold, and then beneficiaries had to pay the rest of their yearly drug costs out of pocket until reaching a certain level of catastrophic prescription drug costs. KAISER FAMILY FOUND., EXPLAINING HEALTH CARE REFORM: KEY CHANGES TO THE MEDICARE PART D DRUG BENEFIT COVERAGE GAP 1 (2010), <https://www.kff.org/wp-content/uploads/2013/01/8059.pdf> [<https://perma.cc/9RB6-3QDS>].

20. See CUBANSKI ET AL., *supra* note 19, at 2.

21. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271 (2010) (codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012)) (creating a new Medicaid eligibility category for those with incomes up to 133% FPL). 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 Pub. L. No. 111-152, § 1004(e)(2), 124 Stat. 1029, 1036 (codified at 42 U.S.C. § 1396a(e)(14)(I)(i) (2012)).

22. See, e.g., Patient Protection and Affordable Care Act § 1321(a) (codified at 42 U.S.C. § 18041(a) (2012)) (detailing the exchange structure); *id.* § 1401(a) (codified at 42 U.S.C. § 36B (2012)) (detailing the structure and eligibility levels for premium tax credits to make exchange coverage more affordable); see also TIMOTHY STOLTZFUS JOST, THE COMMONWEALTH FUND, HEALTH INSURANCE EXCHANGES AND THE AFFORDABLE CARE ACT: KEY POLICY ISSUES 6 (2010), [https://www.commonwealthfund.org/sites/default/files/documents/\\_\\_\\_media\\_files\\_publications\\_fund\\_report\\_2010\\_jul\\_1426\\_jost\\_hlt\\_insurance\\_exchanges\\_aca.pdf](https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_fund_report_2010_jul_1426_jost_hlt_insurance_exchanges_aca.pdf) [<https://perma.cc/7EEZ-425D>].

23. See *infra* Part III for further discussion of these provisions of the ACA (known as the “three Rs”): risk corridor payments, risk-adjustment payments, and transitional reinsurance.

24. Patient Protection and Affordable Care Act § 1201(4) (codified at 42 U.S.C. § 300gg-1).

25. *Id.* § 1001(5) (codified at 42 U.S.C. § 300gg-12).

26. *Id.* (codified at 42 U.S.C. § 300gg-11).

charge a co-pay for important preventive care.<sup>27</sup> One such service for which co-pays were eliminated, and which would prove a focal point for litigation, was contraception.<sup>28</sup>

Finally, to strengthen the insurance markets and help pay for all of these reforms, the ACA imposed a “shared responsibility requirement”—the requirement that all individuals, with some exceptions,<sup>29</sup> obtain insurance coverage or pay a tax.<sup>30</sup> Bringing as many additional people as possible into the shared risk pool was intended to stabilize the insurance markets—which cannot function if only the sick obtain insurance—and lower prices for all. Colloquially known as the “individual mandate,” this requirement became the focus of ACA resistance, the main target of legal challenges, and the primary symbol of government overreach.

The ACA is a 2,000-page law and has many other provisions aimed at system reform, including incentives for physicians to move to new payment models and improve quality,<sup>31</sup> medical workforce training provisions,<sup>32</sup> a prevention and public health fund,<sup>33</sup> and much more. But the main structural components outlined above have, thus far, been the most fertile terrain for litigation.

## II. THE EXISTENTIAL CHALLENGES: *NFIB*, *KING*, AND *TEXAS*

Thus far, there have been three significant “existential” challenges to the ACA—lawsuits that threaten the existence of the entire 2,000-page law. The first lawsuit was partially successful, the second was unsuccessful, and the third is pending.

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27. *Id.* (codified at 42 U.S.C. § 300gg-13).

28. *See infra* Section III.C.1.

29. Those exempted from the individual mandate penalty include those with income-related exemptions (when the lowest-priced plan available, either a marketplace or job-based plan, would cost more than 8.05% of one’s household income, or when one’s income is below the tax filing threshold); hardship exemptions (including homelessness, eviction, domestic violence, filing for bankruptcy, and natural or human-caused disasters); a temporary lack of insurance for no more than two months out of the year; an income below 138% FPL for individuals who live in a state that did not expand Medicaid; members of a federally recognized tribe or those eligible for services through an Indian Health Services provider; members of a recognized healthcare-sharing ministry; members of a recognized religious sect with religious objections to insurance including Social Security and Medicare; incarcerated individuals; U.S. citizens living abroad; certain types of noncitizens; and those not lawfully present. *See Health Coverage Exemptions, Forms & How to Apply*, HEALTHCARE.GOV, <https://www.healthcare.gov/health-coverage-exemptions/forms-how-to-apply/> [<https://perma.cc/B853-D8RZ>] (last visited Mar. 20, 2020); *see also* 26 U.S.C. § 5000A(d)–(e) (2017) (providing statutory exemption provisions), *invalidated by Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020) (mem.).

30. 26 U.S.C. § 5000A (creating a requirement to maintain minimum essential health coverage).

31. *See, e.g.*, Patient Protection and Affordable Care Act § 3021(a) (codified as amended at 42 U.S.C. § 1315a (2012)) (creating the Center for Medicare and Medicaid Innovation (CMMI)).

32. These provisions can be found in Title V of the Patient Protection and Affordable Care Act, which is named “Health Care Workforce.” *See, e.g., id.* §§ 5102, 5301 (codified at 42 U.S.C. §§ 294r, 293k (2012)) (establishing state healthcare workforce-development grants and supporting and developing primary care training programs).

33. *Id.* § 4002 (codified at 42 U.S.C. §300u-11 (2012)).

A. *NFIB*: A CONSTITUTIONAL CHALLENGE TO THE INDIVIDUAL MANDATE AND THE MEDICAID EXPANSION

The focus of the challenge filed by fourteen states on the date of the ACA's enactment<sup>34</sup> (eventually twenty-six states total) was the constitutionality of the individual mandate.<sup>35</sup> Although the mandate was originally the brainchild of the Heritage Foundation and pioneered on the ground by former Republican Governor (and later presidential candidate) Mitt Romney in Massachusetts, it quickly became the focal point of ACA opposition, offensive to conservatives and libertarians as “an attack on freedom.”<sup>36</sup>

The opponents' legal argument was 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—they argued this was regulating “inaction,” not “commerce.”<sup>37</sup> Initially dismissed as a nonstarter, the politics of the moment and extremely successful messaging by the suit's supporters moved the claims (filed in federal district courts in Florida, Michigan, Pennsylvania, Virginia, and Washington, D.C.<sup>38</sup>) from being, as Professor Jack Balkin put it at the time, “off the wall to on the wall.”<sup>39</sup> Proponents of these lawsuits relentlessly compared the

34. Thirteen states sued together in Florida. See Complaint, Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., *supra* note 1, at 1–2; The states included Alabama, Colorado, Florida, Idaho, Louisiana, Michigan, Nebraska, Pennsylvania, South Carolina, South Dakota, Texas, Utah, and Washington. *Id.* Virginia sued on its own. See Complaint, Virginia *ex rel.* Cuccinelli v. Sebelius, *supra* note 1.

35. Nat'l Fed'n of Indep. Bus. v. Sebelius (*NFIB*), 567 U.S. 519, 520 (2012).

36. Michael Cooper, *Conservatives Sowed Idea of Health Care Mandate, Only to Spurn It Later*, N.Y. TIMES (Feb. 14, 2012), <https://www.nytimes.com/2012/02/15/health/policy/health-care-mandate-was-first-backed-by-conservatives.html>; see Paul Starr, *A Health Insurance Mandate with a Choice*, N.Y. TIMES (Mar. 3, 2010), <https://www.nytimes.com/2010/03/04/opinion/04starr.html>.

37. See *NFIB*, 567 U.S. at 552–61.

38. Florida *ex rel.* Bondi v. U.S. Dep't of Health & Human Servs., 780 F. Supp. 2d 1256 (N.D. Fla. 2011), *aff'd in part, rev'd in part sub nom.* 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); Thomas More Law Ctr. v. Obama, 720 F. Supp. 2d 882 (E.D. Mich. 2010), *aff'd*, 651 F.3d 529 (6th Cir. 2011); Goudy-Bachman v. U.S. Dep't of Health & Human Servs., 811 F. Supp. 2d 1086 (M.D. Pa. 2011); Liberty Univ., Inc. v. Geithner, 753 F. Supp. 2d 611 (W.D. Va. 2010), *vacated*, 671 F.3d 391 (4th Cir. 2011), *vacated*, 568 U.S. 1022 (2012), and *aff'd sub nom.* Liberty Univ., Inc. v. Lew, 733 F.3d 72 (4th Cir. 2013); Virginia *ex rel.* Cuccinelli v. Sebelius, 728 F. Supp. 2d 768 (E.D. Va. 2010), *vacated*, 656 F.3d 253 (4th Cir. 2011); Mead v. Holder, 766 F. Supp. 2d 16 (D.D.C. 2011), *aff'd sub nom.* Seven-Sky v. Holder, 661 F.3d 1 (D.C. Cir. 2011).

Some cases were dismissed on standing grounds. See, e.g., Bellow v. U.S. Dep't of Health & Human Servs., No. 1:10-CV-165, 2011 WL 2462205, at \*1 (E.D. Tex. June 20, 2011); Kinder v. Geithner, No. 1:10-cv-101-RWS, 2011 WL 1576721, at \*4–5, \*7–8 (E.D. Mo. Apr. 26, 2011), *aff'd*, 695 F.3d 772 (8th Cir. 2012); Purpura v. Sebelius, No. 10-04814, 2011 WL 1547768, at \*9 (D.N.J. Apr. 21, 2011), *aff'd*, 446 F. App'x 496 (3d Cir. 2011); Peterson v. United States, 774 F. Supp. 2d 418, 420 (D.N.H. 2011); N.J. Physicians, Inc. v. Obama, 757 F. Supp. 2d 502, 510 (D.N.J. 2010), *aff'd sub nom.* N.J. Physicians, Inc. v. President of the U.S., 653 F.3d 234 (3d Cir. 2011); Shreeve v. Obama, No. 1:10-CV-71, 2010 WL 4628177, at \*4 (E.D. Tenn. Nov. 4, 2010); Baldwin v. Sebelius, No. 10CV1033-DMS-(WMC), 2010 WL 3418436, at \*4–5 (S.D. Cal. Aug. 27, 2010), *aff'd*, 654 F.3d 877 (9th Cir. 2011).

39. 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/>.



individual mandate to a hypothetical requirement that Congress could “make people buy broccoli,”<sup>40</sup> an analogy that resonated. Early victories in Virginia and Florida lent momentum to the litigation, and although the ACA survived in the U.S. Courts of Appeals for the Fourth, Sixth, and D.C. Circuits,<sup>41</sup> the U.S. Court of Appeals for the Eleventh Circuit ruled the mandate unconstitutional in August 2011 but left the rest of the ACA in place.<sup>42</sup> (The challengers had argued that the mandate was essential to the entire 2,000-page law and the entire ACA had to fall with it, but the Eleventh Circuit found the mandate completely severable from the rest of the law.<sup>43</sup>) Some of these cases had their own outsized political valence; two Republican-appointed judges who wrote opinions that did not strike down the ACA were said at the time to be blacklisted from possible nomination to the U.S. Supreme Court.<sup>44</sup> One of these judges was now-Justice Brett Kavanaugh.<sup>45</sup>

The Supreme Court granted review of three cases in 2011, consolidated under the name *National Federation of Independent Business v. Sebelius (NFIB)*,<sup>46</sup> and accorded the case an unprecedented three days of oral argument.<sup>47</sup> The Court's grant of review also surprised some experts by asking the parties to brief not only

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40. See James B. Stewart, *How Broccoli Landed on Supreme Court Menu*, N.Y. TIMES (June 13, 2012) (quoting Justice Antonin Scalia), <https://www.nytimes.com/2012/06/14/business/how-broccoli-became-a-symbol-in-the-health-care-debate.html>.

41. The Sixth and D.C. Circuits upheld the individual mandate under Congress's commerce power. See *Seven-Sky*, 661 F.3d at 4, 18, 20, *abrogated by NFIB*, 567 U.S. 519; *Thomas More Law Ctr.*, 651 F.3d at 549, *abrogated by NFIB*, 567 U.S. 519. The Fourth Circuit found that the challenge was barred by the Anti-Injunction Act. See *Liberty Univ., Inc.*, 671 F.3d at 401–03 (4th Cir. 2011), *abrogated by NFIB*, 567 U.S. 519.

42. *Florida ex rel. Att'y Gen.*, 648 F.3d at 1328.

43. See *id.* at 1323 (“In light of the stand-alone nature of hundreds of the Act's provisions and their manifest lack of connection to the individual mandate, the plaintiffs have not met the heavy burden needed to rebut the presumption of severability. We therefore conclude that the district court erred in its wholesale invalidation of the Act.”).

44. See, e.g., Scott Lemieux, *Brett Kavanaugh's Supreme Court Nomination Is the Result of Years of Unopposed Conservative Organizing*, NBC NEWS (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>] (claiming that Judge Jeff Sutton of the Sixth Circuit “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 (Jul. 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 then-Judge Brett Kavanaugh's avoidance of taking a position on the ACA in the D.C. Circuit).

45. See *Seven-Sky*, 661 F.3d at 21 (Kavanaugh, J., dissenting) (arguing the D.C. Circuit lacked jurisdiction and offering no opinion on the merits of the constitutional claim about the individual mandate).

46. The Supreme Court granted certiorari for three cases from the Eleventh Circuit: *National Federation of Independent Business v. Sebelius*, *Florida v. Department of Health & Human Services*, and *Department of Health & Human Services v. Florida*, all at 565 U.S. 1033 (2011).

47. See Clement, *supra* note 8, at 167; Donald B. Verrilli, *The ACA and the Courts: Two Perspectives, Part One*, in THE TRILLION DOLLAR REVOLUTION, *supra* note 8, at 145, 154.

the mandate question but also the question of whether the ACA's Medicaid expansion was unconstitutional—an issue that had received little legal attention up to that point.<sup>48</sup> The Medicaid expansion sought to end the patchwork across states that had left many Americans completely uninsured.<sup>49</sup> Before the ACA, states did not have to cover childless adults under Medicaid if they did not wish to do so, a choice that left gaping holes in the insured population when it came to adult men in particular.<sup>50</sup> The ACA gave states a choice between expanding Medicaid to cover all individuals up to 138% of the federal poverty level or losing all their existing Medicaid funding.<sup>51</sup>

The ACA's challengers won in part and lost in part. Five Justices agreed that Congress did not have power under the Commerce Clause to enact the mandate, largely accepting the challengers' view that the mandate was forcing entry into a market and regulating inaction instead of regulating commerce.<sup>52</sup> One of those five was Chief Justice Roberts, who did not join the dissent. Even though Roberts refused to accept the principle that healthcare was a unique good, or that Congress could “compel citizens to act as the Government would have them act” because the failure to purchase insurance detrimentally affects others in the healthcare market,<sup>53</sup> he found different grounds on which to uphold the law. Specifically, the Chief Justice saved the ACA by reasoning that the mandate was a permissible exercise of Congress's taxing power, if not (as his dicta implied) its Commerce Clause power.<sup>54</sup> The four dissenting justices refused to accept the Chief Justice's saving construction of the mandate as a tax.<sup>55</sup> The remaining four Justices would have upheld the mandate under Congress's commerce power.<sup>56</sup>

The Medicaid holding was more dramatic and stunned many. Seven Justices concluded that the threat to withhold Medicaid funding from states that did not

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48. See, e.g., Sara Rosenbaum & Timothy M. Westmoreland, *The Supreme Court's Surprising Decision on the Medicaid Expansion: How Will the Federal Government and States Proceed?*, 31 HEALTH AFF. 1663, 1663 (2012), <https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2012.0766> [<https://perma.cc/BL2B-864V>] (calling the NFIB Medicaid holding “a move that shocked almost everyone”).

49. See Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y L. & ETHICS 67, 82–83 (2015).

50. See Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 450 (2011).

51. See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 2001(a)(1), 124 Stat. 119, 271 (2010) (codified at 42 U.S.C. § 1396a(10)(viii) (2012) (creating a new Medicaid eligibility category).

52. See *NFIB*, 567 U.S. 519, 558 (2012). A majority likewise found Congress lacked the power to do so under the Necessary and Proper Clause. See *id.* at 560.

53. *Id.* at 554.

54. See *id.* at 574. Some have since argued that the mandate was more precisely understood as a tax penalty to ensure compliance with maintaining health insurance, especially because the Department of Justice stated that no one could sue a person to make him or her maintain minimum essential coverage. See Opening Brief of Intervenor the U.S. House of Representatives at 12–20, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), 2019 WL 1458855; State Defendants' Opening Brief at 28–29, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), 2019 WL 1458854.

55. *NFIB*, 567 U.S. at 656, 668 (Scalia, Kennedy, Thomas & Alito, J.J., dissenting) (“[T]o say that the individual Mandate merely imposes a tax is not to interpret the statute but to rewrite it.”).

56. *Id.* at 589 (Ginsburg, J., concurring in part, concurring in the judgment, and dissenting in part).

expand the program was unconstitutional. The Chief Justice's plurality opinion<sup>57</sup> found that even though Congress had the right to amend the Medicaid program, the ACA's change was too big—it was one of “kind, not merely degree.”<sup>58</sup> Moreover, given the centrality of Medicaid to many state budgets, the Court held that the choice between expanding and losing all Medicaid funds was not a choice at all but, rather, a “gun to the head”—an “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion”—and, as such, was unconstitutionally coercive on the states in violation of the Tenth Amendment and Congress's spending power.<sup>59</sup> The four Justices who found the mandate unconstitutional would have struck the entire Medicaid expansion, too, as a coercive offer “no states could refuse.”<sup>60</sup> But as to the remedy, there were five justices total (the plurality plus Justices Ginsburg and Sotomayor, who would have upheld the expansion) in agreement that the proper remedy was not to strike down the Medicaid expansion but to allow states to opt out of it without penalty.<sup>61</sup>

The litigation itself, and then the ruling, has had enormous implications. At the level of legal practice, the case not only had an unprecedented number of hours of oral argument, but it also had two appointed amici and a level of media attention that surprised and overwhelmed even the two U.S. Solicitors General arguing it: President Obama's Solicitor General Donald Verrilli and former Solicitor General Paul Clement, who argued the other side.<sup>62</sup> *NFIB* also has influenced the shape of other prominent cases outside of healthcare. As Verrilli and Clement each have noted, the *NFIB* litigation largely pioneered the now-common practice of orchestrated writings on blogs and opinion pages before an important Supreme Court case, designed to influence the framing and outcome.<sup>63</sup> Clement has further observed that the twenty-six-state challenge to the Medicaid expansion “was likewise the precursor to a series of high-profile constitutional challenges by states against major federal-government initiatives,” and that the Chief Justice's vote on the individual mandate “has shaped the perception that he is the new ‘swing Justice’ on the current Court.”<sup>64</sup>

The ruling itself had constitutional significance on several fronts. First, although only four Justices dissented to hold that the mandate was impermissible under the Commerce Clause, the Chief Justice went out of his way to say that he agreed with the dissenters on that front—arguably in many pages of dicta—

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57. Justices Breyer and Kagan joined this part (Part IV) of Roberts's opinion. *See id.* at 529 (plurality opinion).

58. *Id.* at 583.

59. *Id.* at 575–85.

60. *Id.* at 689 (Scalia, Kennedy, Thomas & Alito, J.J., dissenting).

61. *Id.* at 585–88 (plurality opinion); *id.* at 645–46 (Ginsburg, J., dissenting). Justices Ginsburg and Sotomayor disagreed with the seven Justices who found the mandatory expansion unconstitutional, but joined the Chief Justice, and Justices Breyer and Kagan, on severability to save the statute.

62. *See* Clement, *supra* note 8, at 167–70; Verrilli, *supra* note 47, at 154–55.

63. *See* Clement, *supra* note 8, at 174–75; Verrilli, *supra* note 47, at 150.

64. Clement, *supra* note 8, at 175.

before finding an alternative basis for the mandate in the taxing power.<sup>65</sup> Consequently, as a practical matter, there now appear to be five votes on the Court for the proposition that Congress cannot use its commerce power to compel entry into a market, and perhaps also for the proposition that healthcare is not a unique good or unique kind of market that can overcome that proposition.

There also is now a precedent for the proposition that whether an act of Congress falls within the taxing power is a question of law for the courts to decide for themselves, rather than a question that Congress itself decides. ACA supporters affirmatively did not label the ACA a tax; President Obama promised the law would not bring new taxes, and Democratic drafts in the Senate actually deleted the word “tax” or converted it to “penalty” at least a dozen times in the individual mandate section of the Senate finance bill.<sup>66</sup> At least one lower court judge—Judge Vinson of the U.S. District Court for the Northern District of Florida, who would have struck down the ACA in its entirety—held that the mandate could not be construed as a tax for precisely those reasons: to do so would allow Congress to enact a tax with no accountability for doing so.<sup>67</sup> But the Chief Justice concluded the construction was within the Court’s power.

Finally, the Medicaid holding appears to be the first time that the Court has invalidated a federal spending program on grounds of coercing the states.<sup>68</sup> Still, the Court refused to articulate a new legal standard. The Chief Justice wrote: “We have no need to fix a line . . . . It is enough for today that wherever that line may be, this statute is surely beyond it. Congress may not simply ‘conscript state [agencies] into the national bureaucratic army’ . . . .”<sup>69</sup> Since *NFIB*, litigants have used the Court’s Medicaid holding to argue that other federal programs, particularly in the area of immigration, violate the Court’s anticoercion and anticommandeering principles with mixed success.<sup>70</sup> Scholars have observed that the

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65. *NFIB*, 567 U.S. at 563, 574. For scholars of statutory interpretation, the Chief deployed an interpretive method that some thought extinct—“classic” constitutional avoidance—in which the Court states one reading of a law would be unconstitutional and so chooses a different one. See WILLIAM N. ESKRIDGE JR., ABBE R. GLUCK & VICTORIA F. NOURSE, STATUTES, REGULATION, AND INTERPRETATION 517 (2014). Modern cases have eschewed this approach due to the dicta and advisory opinion problems it raises and instead prefer a formulation that one reading might raise constitutional concerns, thereby making an alternate reading preferable. *Id.* at 517–18.

66. Compare S. 1796, 111th Cong. § 5000A (2009) (using the term “tax”), with H.R. 3590, 111th Cong. § 5000A (2009) (using the term “penalty”).

67. See *Florida ex rel. McCollum v. U.S. Dep’t of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1142 (N.D. Fla. 2010).

68. See KAISER FAMILY FOUND., A GUIDE TO THE SUPREME COURT’S AFFORDABLE CARE ACT DECISION 6 (2012), <https://www.kff.org/wp-content/uploads/2013/01/8332.pdf> [<https://perma.cc/3N45-58F3>]; Rosenbaum & Westmoreland, *supra* note 48, at 1663, 1667; see also *NFIB*, 567 U.S. at 625 (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part) (“The Chief Justice therefore—for the first time ever—finds an exercise of Congress’ spending power unconstitutionally coercive.”). Prior to *NFIB*, the Supreme Court struck down federal laws on the grounds that they impermissibly commandeered state and local officials in violation of federalism principles. See *Printz v. United States*, 521 U.S. 898, 935 (1997); *New York v. United States*, 505 U.S. 144, 188 (1992).

69. *NFIB*, 567 U.S. at 585 (plurality opinion) (alteration in original).

70. See, e.g., *Mayhew v. Burwell*, 772 F.3d 80, 91 (1st Cir. 2014) (holding that the ACA’s Medicaid maintenance-of-effort requirement was not unconstitutionally coercive); *New York v. U.S. Dep’t of*

*NFIB* holding “casts a constitutional pall” and presents problems for future social policy that relies on the use of conditional spending to achieve Congress’s goals.<sup>71</sup>

Right after *NFIB*, there were a few new constitutional challenges to the individual mandate and the employer mandate based on the Court’s new tax theory.<sup>72</sup> Employers face an insurance mandate under the ACA, too. Under ACA section 1513, a large employer—employing fifty people or more—must pay a penalty if it does not offer full-time employees an opportunity to enroll in affordable minimum essential coverage, i.e., coverage that would satisfy the individual mandate.<sup>73</sup> Some plaintiffs alleged that if both of these mandates were now to be understood as part of a revenue-raising statute, the ACA would have been enacted in violation of the Constitution’s Origination Clause (which states in part that “[a]ll Bills for raising Revenue shall originate in the House of Representatives”<sup>74</sup>) because the ACA did not begin in the House of

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Health & Human Servs., 414 F. Supp. 3d 475, 566 (S.D.N.Y. 2019) (finding HHS “conscience” rule violated the requirement established in *NFIB* that the “financial inducement offered by Congress” must not be “impermissibly coercive”); *Tennessee v. U.S. Dep’t of State*, 329 F. Supp. 3d 597, 626–29 (W.D. Tenn. 2018) (granting federal government’s motion to dismiss Tennessee’s challenge to federal laws requiring states to provide Medicaid to refugees or risk losing all their Medicaid funding, finding the laws did not coerce the state in violation of the Tenth Amendment), *aff’d sub nom. Tennessee ex rel. Tenn. Gen. Assembly v. U.S. Dep’t of State*, 931 F.3d 499 (6th Cir. 2019).

The New York district court judge who recently vacated the Trump Administration’s “conscience” rules, which will be discussed in greater detail in section III.B., based his finding that the rules violated the Spending Clause on the *NFIB* Medicaid holding. See *New York v. U.S. Dep’t of Health & Human Servs.*, 414 F. Supp. 3d at 566. Several cases have challenged Trump’s immigration policies, such as the Administration’s threats to cut funding for sanctuary cities, as unconstitutionally coercive against the states. See, e.g., *City of Los Angeles v. Barr*, 929 F.3d 1163, 1176 (9th Cir. 2019); *New York v. Dep’t of Justice*, 343 F. Supp. 3d 213, 225, 237 (S.D.N.Y. 2018), *rev’d*, 951 F.3d 84 (2d Cir. 2020); *City of Chicago v. Sessions*, 321 F. Supp. 3d 855, 861, 867 (N.D. Ill. 2018); *California ex rel. Becerra v. Sessions*, 284 F. Supp. 3d 1015, 1034–35 (N.D. Cal. 2018), *reconsideration denied sub nom. California ex rel. Becerra v. Sessions*, No. 17-cv-04701-WHO, 2018 WL 3399214 (N.D. Cal. Apr. 24, 2018); *County of Santa Clara v. Trump*, 275 F. Supp. 3d 1196, 1201 (N.D. Cal. 2017), *aff’d in part, vacated in part, remanded sub nom. City & County of San Francisco v. Trump*, 897 F.3d 1225 (9th Cir. 2018); *City of Philadelphia v. Sessions*, 280 F. Supp. 3d 579, 651 (E.D. Pa. 2017).

71. Andrew B. Coan, *Commandeering, Coercion, and the Deep Structure of American Federalism*, 95 B.U. L. REV. 1, 13, 17 (2015); Michael J. Graetz & Jerry L. Mashaw, *Constitutional Uncertainty and the Design of Social Insurance: Reflections on the Obamacare Case*, 7 HARV. L. & POL’Y REV. 343, 364 (2013).

72. See *infra* note 75 for constitutional challenges to the individual mandate based on the Origination Clause. In other post-*NFIB* cases, courts rejected other constitutional challenges to the individual mandate including takings and substantive due process claims. See *Coons v. Lew*, 762 F.3d 891 (9th Cir. 2014), *cert denied*, 575 U.S. 935 (2015) (mem.) (rejecting a substantive due process claim that the individual mandate violated rights to medical autonomy and nondisclosure of personal medical information); *Ass’n of Am. Physicians & Surgeons v. Sebelius*, 901 F. Supp. 2d 19 (D.D.C. 2012), *aff’d*, 746 F.3d 468 (D.C. Cir. 2014) (rejecting takings and substantive due process challenges to the individual mandate).

73. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1513(a), 124 Stat. 119, 253 (2010) (codified at 26 U.S.C. § 4980H(a) (2012)). At least one employee must have been certified to the employer as qualifying for premium tax credits. *Id.*

74. U.S. CONST. art. I, § 7, cl. 1.

Representatives.<sup>75</sup> The bill that became the ACA, H.R. 3590, had indeed originated in the House, but the Senate stripped out the bill's original language and replaced it with its own ACA language. In one case regarding the individual mandate, *Sissel v. United States Department of Health and Human Services*, this raised enough of an Origination Clause issue that the D.C. Circuit split over how to handle it. One group of judges relied on the theory that the individual mandate's purpose was not actually to raise revenue and so did not implicate the Origination Clause.<sup>76</sup> A group of en banc denial dissenters, led by then-Judge Kavanaugh, would have dismissed the Origination Clause claim on the quite different ground that H.R. 3590 in its original form was a bill for raising revenue.<sup>77</sup>

In 2013, the Fourth Circuit rejected a Commerce Clause challenge to the employer mandate, concluding that Congress had authority under the Commerce Clause to enact the employer mandate as a regulating condition of employment for large employers.<sup>78</sup> In *Hotze v. Burwell*, a case raising Origination Clause and Takings Clause challenges to both the individual and employer mandate, the Fifth Circuit held that the challenge was barred by the Tax Anti-Injunction Act, a statute that bars pre-enforcement challenges to tax statutes.<sup>79</sup> The courts have also held, as a matter of Commerce Clause and Tenth Amendment jurisprudence, that state and local governments, as large employers, are subject to the employer mandate.<sup>80</sup>

B. STRIKING AT "BITS AND PIECES OF THE LAW": A NEW LEGAL STRATEGY AND  
*KING V. BURWELL*

In the normal trajectory of a controversial statutory enactment followed by legal challenge, a successful Supreme Court ruling followed by reelection of the party supporting the law tends to end the existential threats to the law and allow the government to move onto implementation. Many states halted ACA implementation in the run-up to *NFIB*, a development that dramatically complicated the launch of the law for the U.S. Department of Health and Human Services (HHS). The *NFIB* ruling mostly upheld the law and the subsequent 2012 reelection of President Obama, as well as Democratic gains in the Senate and House,<sup>81</sup> seemed to put the question of the ACA's future to rest.

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75. *Bank v. U.S. Dep't of Health & Human Servs.*, 708 F. App'x 43, 44 (2d Cir. 2018) (mem.); *Hotze v. Burwell*, 784 F.3d 984, 989–90 (5th Cir. 2015); *Sissel v. U.S. Dep't of Health & Human Servs.*, 760 F.3d 1, 4 (D.C. Cir. 2014); *Ass'n of Am. Physicians & Surgeons v. Sebelius*, 746 F.3d 468, 470–71 (D.C. Cir. 2014).

76. *Sissel*, 760 F.3d at 10.

77. *Sissel v. U.S. Dep't of Health & Human Servs.*, 799 F.3d 1035, 1049 (D.C. Cir. 2015) (Kavanaugh, J., dissenting from denial of rehearing en banc) (mem.).

78. *Liberty Univ., Inc. v. Lew*, 733 F.3d 72, 76 (4th Cir. 2013).

79. 784 F.3d at 986. The court had held that Dr. Hotze himself lacked standing to challenge the individual mandate, even on Origination Clause grounds, but that his employer did have standing to challenge the employer mandate on those and other grounds. *Id.*

80. *See, e.g., Indiana v. IRS*, 309 F. Supp. 3d 603, 609 (S.D. Ind. 2018); *Oklahoma ex rel. Pruitt v. Sebelius*, No. CIV-30-RAW, 2013 WL 4052610, at \*9 (E.D. Okla. Aug. 12, 2013).

81. *See Gluck & Scott-Railton, supra* note 13, at 522.

But the ACA is no average law. As former Solicitor General Verrilli—who argued *NFIB* for the Obama administration—has written, the ACA's opponents refused to accept the decision as legitimate and did not come around to the political advantages of working with the law.<sup>82</sup> Instead, the ACA's challengers largely moved away from constitutional challenges to the ACA and utilized a different legal strategy to try to eliminate the law nonetheless. The new strategy was to pull the statute apart by focusing on “bits and pieces of the law.”<sup>83</sup>

At one widely reported critical strategy meeting following *NFIB*, opponents focused on what became a theme: destruction of the ACA at all costs. A key speaker exhorted the crowd to use any technical weaknesses or loopholes in the law, to “kill” it “any which way.”<sup>84</sup>

The next major Supreme Court case, *King v. Burwell*, was the direct result of this strategy. The case turned on four words in the ACA that had ambiguous meaning.<sup>85</sup> The case's architects aimed, in their words, to “exploit[]” four isolated words in the 2,000-page law—which they called a “monster” filled with “contradictions and incongruities.”<sup>86</sup> The goal was to achieve a do-over of the failed constitutional challenge in *NFIB* by pulling at a small string in the ACA in the hopes it would all come loose.

*NFIB* aimed at two of the three main strategies the ACA uses to expand insurance access: the individual mandate and the Medicaid expansion.<sup>87</sup> *King* was about the third: the ACA's new insurance marketplaces.<sup>88</sup> These marketplaces—called “exchanges”—were for the purchase of insurance by individuals and small businesses and would serve as quality control clearinghouses, places where consumers could compare health plans, plans could compete, and importantly, the

82. Verrilli, *supra* note 47, at 157 (“That these attacks came so swiftly after the *NFIB* decision was not surprising, especially given the leak. Many on the right refused to accept *NFIB* as legitimate and treated the opinion of the chief justice with scorn.”); cf. JOAN BISKUPIC, *THE CHIEF: THE LIFE AND TURBULENT TIMES OF CHIEF JUSTICE JOHN ROBERTS* 229–48 (2019) (reporting leaked information that the Chief Justice had initially voted with the dissenters but later changed his vote to uphold the ACA).

83. Abbe R. Gluck, *Imperfect Statutes, Imperfect Courts: Understanding Congress's Plan in the Era of Unorthodox Lawmaking*, 129 HARV. L. REV. 62, 64 (2015) (quoting Am. Enter. Inst., *Who's in Charge? More Legal Challenges to the Patient Protection and Affordable Care Act* at 1:31:45, YOUTUBE (Mar. 11, 2014), <http://www.youtube.com/watch?v=C7nRpJURvE4>).

84. Only a YouTube recording of the remarks is available. The main speaker exhorted:

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. . . .

Am. Enter. Inst., *supra* note 83, at 1:30:55–1:31:15 (remarks of Michael Greve at a Dec. 7, 2010 panel).

85. 135 S. Ct. 2480, 2492 (2015) (“Petitioners and the dissent respond that the words ‘established by the State’ would be unnecessary if Congress meant to extend tax credits to both State and Federal Exchanges.”); see also Gluck, *supra* note 83, at 69–71 (explaining the genesis of the question in *King v. Burwell*).

86. Am. Enter. Inst., *supra* note 84, at 1:32:50–1:33:16.

87. *NFIB*, 567 U.S. 519, 530–31 (2012).

88. *King*, 135 S. Ct. at 2485.

access point for new subsidies for those under 400% FPL to make insurance more affordable.<sup>89</sup> *King* targeted those subsidies.

The political context is an important part of the story. By 2012, ACA opposition had become a red-state “litmus test.”<sup>90</sup> It was viewed as a betrayal of the Republican Party for state leadership to do anything to implement the ACA.<sup>91</sup> The problem for ACA implementation was that the ACA was drafted to rely heavily on the states to run the new insurance exchanges—indeed the states’ right of first refusal to do so was negotiated by Republicans in the Senate to maintain traditional state control over insurance.<sup>92</sup> Although the ACA does provide that the federal government must operate an exchange for a state that declines to run its own, the federal government did not anticipate operating most of the exchanges in the nation.<sup>93</sup> And yet the political resistance that *NFIB* bred led to the surprising result that, by the ACA’s 2014 launch deadline, more than half the states had refused to implement their own exchanges.<sup>94</sup>

Enter *King*. The challenged provision 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 [a qualified health plan] through an Exchange established by the State under [section] 1311 of the Patient Protection and Affordable Care Act.”<sup>95</sup> Because section 1311 of the ACA establishes the state-run exchanges, the challengers argued that, on a strictly literal reading of the ACA, consumers on federally run exchanges could not benefit from the subsidies—an outcome that would have made insurance unaffordable in the thirty-four states with federal exchanges at the time, most likely leading the ACA markets to collapse in those states.<sup>96</sup>

In 2015, the Supreme Court rejected the challenge—but this time more decisively with a unified opinion of six Justices (Justice Kennedy voted with the ACA, unlike in *NFIB*).<sup>97</sup> The decision was based entirely on statutory interpretation reasoning, because *King* was not a constitutional case. But the ruling was still significant.

*King* broke new statutory interpretation ground because the Court departed from its ordinary mode of interpretation to give the ACA a more forgiving reading. The challengers had urged a hyper-literal reading of the ACA’s text. Strict textualism was the dominant approach the Court took to statutes, including statutory mistakes, at the time, and largely still is. The challengers took advantage of

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89. *See id.* at 2487.

90. Gluck & Huberfeld, *supra* note 15, at 1759.

91. *Id.* at 1759–60.

92. *Id.* at 1727–30.

93. *Id.* at 1730–31.

94. *See id.*

95. 26 U.S.C. § 36B(b)(2)(A) (2012); *King v. Burwell*, 135 S. Ct. 2480, 2495 (2015).

96. *See, e.g., King*, 135 S. Ct. at 2487, 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>].

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



that approach and portrayed the ACA as a “law that no one understands,” arguing that the Court could not possibly do more than give it the most literal interpretation.<sup>98</sup>

Instead, the Court read the words in the broader context of the ACA as a whole, adopted a more forgiving view of Congress, and held that the Court “must do [its] best” to construe the ACA in accordance with “the legislative plan.”<sup>99</sup> For the first time in a Supreme Court case in modern history, the Court also looked to a statute’s convoluted enactment process as part of its reasoning whether to cut the statutory language some slack. It was a groundbreaking opinion for modern statutory interpretation, harkening back to the “legal process” interpretive approach from decades earlier that conceptualized courts as helpful partners to the legislature.<sup>100</sup> In *King*, the Court gave Congress—and the ACA—the benefit of the doubt.<sup>101</sup>

The majority’s refusal to apply its more literal mode of interpretation prompted Justice Scalia to complain of ACA exceptionalism: “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.”<sup>102</sup>

After *King*, Court watchers wondered if the Roberts Court would continue down this new path of Congress-oriented, cooperative, statutory interpretation. Thus far it has not, lending support to Justice Scalia’s view that the opinion was a special opinion for a special statute. Lower state and federal courts, however, had invoked *King* in more than 400 cases at the time of this Article.

### C. USING THE MANDATE TO PULL THE WHOLE ACA DOWN: *CALIFORNIA V. TEXAS*

For the three years after *King*, ACA opponents focused on attacking parts of the law rather than the entire law. We detail those challenges, including challenges to the ACA’s contraception-coverage requirements and its new civil rights provisions, in the next Part.

ACA opponents looked outside of courts, too, to Congress and the political process. That in turn gave rise to new court cases. Many of those cases involved the insurance industry, which we also discuss in the next Part. But one of those cases gave rise to the third existential challenge to the law: *California v. Texas*, in which the Supreme Court has granted certiorari and will hear oral argument in the fall of 2020.<sup>103</sup>

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98. See Gluck, *supra* note 83, at 69–70 (internal quotation marks omitted).

99. *King*, 135 S. Ct. at 2492, 2496 (quoting *Utility Air Regulatory Grp. v. EPA*, 573 U.S. 302, 320 (2014)).

100. See 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).

101. *King*, 135 S. Ct. at 2495.

102. *Id.* at 2497 (Scalia, J., dissenting).

103. 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020) (mem.).

*California v. Texas* has its genesis in Congress. After *King*, ACA opponents' focus turned to the presidential election of 2016. Candidate Trump, however, surprised many by promising that he would replace the ACA with "something better" rather than simply repeal it.<sup>104</sup> He assured voters that his health plan would offer universal coverage, too, saying: "I am going to take care of everybody" and "[t]he government's gonna pay for it."<sup>105</sup> These promises put pressure on the now-Republican-controlled Congress not to repeal the ACA without a replacement bill. After some seventy attempts—and some close calls in the spring and summer of 2017—repeal efforts collapsed.<sup>106</sup>

Eager for even a symbolic "win," at the end of 2017, Congress was able to eliminate the tax penalty associated with the individual mandate as part of the 2017 Tax Cuts and Jobs Act.<sup>107</sup> The tax-reform package, which constituted the Republican-controlled 115th Congress's only significant legislative accomplishment after months of unsuccessful attempts to repeal the ACA, made it through the gridlocked Congress via a special legislative procedure known as "reconciliation."<sup>108</sup> This procedure bypasses the filibuster in the Senate. Reconciliation can only be used for budget measures, however, and so Republicans were able to use this fast-track procedure to repeal only the penalty; they could not use it to repeal the rest of the ACA and they did not have the votes to otherwise repeal the ACA in the Senate, where it takes sixty votes (which the Republicans did not have) to end a filibuster.<sup>109</sup> Because the mandate was the focal point of *NFIB* and the highest profile example of what critics said was the ACA's overreach, repealing the penalty was still a symbolic victory.

The Tax Cuts and Jobs Act gave rise to the third existential challenge. Texas, leading a group of twenty states,<sup>110</sup> sued in 2018 on the ground that, without a tax penalty, the mandate—which the Court had sustained as a tax in *NFIB*—lacks a

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104. Sarah Kliff, *Donald Trump Is Very Committed to Taking Away Your Health Insurance*, VOX (Mar. 27, 2019, 8:00 AM), <https://www.vox.com/2019/3/27/18282509/trump-obamacare-lawsuit-health-care> [<https://perma.cc/NH2N-DWGE>].

105. Linda Qiu, *Ted Cruz's False Claim that Trump, Clinton and Sanders 'Have the Identical Position on Health Care'*, POLITIFACT (Jan. 31, 2016), <https://www.politifact.com/truth-o-meter/statements/2016/jan/31/ted-cruz/ted-cruzs-false-claim-trump-clinton-and-sanders-ha/> [<https://perma.cc/3D2P-7GVE>].

106. 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>].

107. 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(a)–(c) (2017)), *invalidated by Texas v. United States*, 945 F.3d 355 (5th Cir. 2019).

108. See Tara Golshan, *The Republican Tax Reform Bill Will Live and Die by This Obscure Senate Rule*, VOX (Nov. 14, 2018, 8:40 AM), <https://www.vox.com/policy-and-politics/2017/11/14/16634200/republican-tax-reform-byrd-rule> [<https://perma.cc/J8WH-ECPB>].

109. Indeed, the Senate could not even muster fifty votes to repeal the ACA under the so-called "skinny repeal" bill famously rejected with Senator John McCain's thumbs down gesture in 2017. See 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>.

110. Now eighteen states—Wisconsin and Maine withdrew from the lawsuit following the 2018 midterm elections. Katie Keith, *Texas v. United States: Where We Are Now and What Could Happen*

constitutional basis in the taxing power and is therefore unconstitutional.<sup>111</sup> The suit went further, however, and argued that without the mandate the entire ACA—all 2,000 pages of it—cannot stand.<sup>112</sup> The argument is an extreme application of a legal doctrine (that applies to all kinds of statutes, not just health laws) known as “severability,” which asks courts to consider what to do with the rest of a statute if one part is struck down. Applying the severability doctrine, the challengers argued that all 2,000 pages of the ACA are inextricably intertwined with the mandate, and so must fall with it.<sup>113</sup> Adding to the drama and raising the threat level, the Trump Administration’s Department of Justice took the unusual position of refusing to defend a federal law, and refused to defend the ACA.<sup>114</sup>

*California v. Texas* has many of the same features of *King*, most saliently its shared strategy of using a thin string to pull the entire statute loose.<sup>115</sup> It also shares a feature with several of the cases we discuss in the next part: judge shopping. ACA opponents filed the case in the Fort Worth Division of the Northern District of Texas which, at the time, had only one judge who was not semi-retired and who had already issued several anti-ACA decisions.<sup>116</sup>

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Next, HEALTH AFF. BLOG (July 9, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20190709.772192/full/> [<https://perma.cc/TNA7-9VCC>].

111. *Texas v. United States*, 340 F. Supp. 3d 579, 619 (N.D. Tex. 2018), *aff’d in part, vacated in part* by 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020) (mem.).

112. *Id.* at 373.

113. *Texas v. United States*, 945 F.3d at 373.

114. Initially, the federal government only refused to defend guaranteed issue and the prohibition on preexisting conditions exclusions, arguing that those provisions were not severable from the mandate. Letter from Jefferson B. Sessions III, Att’y Gen., to Paul Ryan, Speaker, U.S. House of Representatives (June 7, 2018), <https://www.justice.gov/file/1069806/download> [<https://perma.cc/M73T-GSXP>]. Now on appeal, the federal government has refused to defend the ACA in its entirety. 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*, 945 F.3d 355 (5th Cir. 2019) (No. 00514887530), <https://s3.amazonaws.com/wvmetro-uploads-prod/2019/03/DOJ-Obamacare-letter.pdf> [<https://perma.cc/FVK5-THEE>].

115. See generally 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 *California v. Texas*).

116. Manny Fernandez, *In Weaponized Courts, Judge Who Halted Affordable Care Act Is a Conservative Favorite*, N.Y. TIMES (Dec. 15, 2018), <https://www.nytimes.com/2018/12/15/us/judge-obamacare-reed-oconnor.html> (“[T]he Texas attorney general, Ken Paxton, filed some of his major cases challenging Obama Era policies in Wichita Falls, Tex., where [Judge Reed O’Connor] is the only district judge who hears cases, and in Fort Worth, where he is the only district judge who is not semiretired.”); see also Ashley Lopez, *Judge Who Invalidated Obamacare Has Been A ‘Go-To Judge’ For Republicans*, *Critics Say*, NPR (Dec. 19, 2018, 4:20 PM), <https://www.npr.org/sections/health-shots/2018/12/19/677965547/aca-judge> [<https://perma.cc/TAH3-9ZXC>] (detailing Judge O’Connor’s record of overturning Obama Era policies). Judge O’Connor has heard four cases concerning the ACA: the Medicaid managed care fees case, *Texas v. United States*, 336 F. Supp. 3d 664 (N.D. Tex. 2018) (filed in October 2015); the Franciscan Alliance 1557 case, *Franciscan Alliance, Inc. v. Burwell*, 414 F. Supp. 3d 928 (N.D. Tex. 2019) (filed in August 2016); the Global Challenge, *Texas v. United States*, 945 F.3d 355 (N.D. Tex. 2018) (filed in February 2018); and a contraceptive-mandate case, *DeOtte v. Azar*, 332 F.R.D. 173 (N.D. Tex. 2019) (filed in October 2018).

In December 2018, the district court agreed with the challengers and struck down the *entire* ACA, ruling the individual mandate without a penalty could not be sustained as a tax and that nothing in the rest of the ACA could be severed from the now-unconstitutional individual mandate.<sup>117</sup> The judgment was stayed pending the decision on appeal from the Fifth Circuit Court of Appeals, which, in December 2019 affirmed the lower court in large part but remanded for more detailed proceedings on the severability question.<sup>118</sup> In March 2020, the Supreme Court granted certiorari and will hear the case close to the time of the presidential election.

But one important difference in *California v. Texas* is the political valence of the case. The anti-severability legal arguments in the case are widely viewed as weak—a fact that has produced another significant ACA turning point: unprecedented opposition to an ACA lawsuit from many prominent conservative legal experts, including heretofore ACA opponents.

The test for the legal doctrine at issue—severability—has long been settled. The question is “legislative intent,” and usually the best the courts can do when striking down part of a law is guess what Congress would have wanted to do about the rest of the statute.<sup>119</sup> As the Court has explained, it “must next ask: Would the legislature have preferred what is left of its statute to no statute at all?”<sup>120</sup> and “[u]nless it is ‘evident’ that the answer is no, [a court] must leave the rest of the Act intact.”<sup>121</sup> In *California v. Texas*, and the reason the challengers’ claims appear specious to legal experts of all political stripes, it was a Republican-controlled Congress that passed the Tax Cuts and Jobs Act. The elimination of the mandate penalty was the only aspect of the ACA that Congress 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 and before. Even legal experts associated with ACA opposition have argued that it blinks reality to argue that Congress intended to repeal the entire ACA with the mandate penalty when in fact, Congress is the one that left the rest of the ACA in place. Congress did not repeal the ACA and Congress did not have the votes to do so.<sup>122</sup>

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117. See *Texas v. United States*, 340 F. Supp. 3d 579, 619 (N.D. Tex. 2018); see also *Texas v. United States*, 352 F. Supp. 3d 665, 669 (N.D. Tex. 2018) (staying judgment pending appeal).

118. See *Texas v. United States*, 945 F.3d at 403.

119. See Brief of Amici Curiae Jonathan H. Adler, Nicholas Bagley, Abbe R. Gluck, and Ilya Somin in Support of Intervenor-Defendants-Appellants at 6, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019) (No. 19-10011), <https://affordablecareactlitigation.files.wordpress.com/2019/04/5c-adler-bagley-gluck-somin-amicus.pdf> [<https://perma.cc/7SCP-SLTN>].

120. *Ayotte v. Planned Parenthood of N. New Eng.*, 546 U.S. 320, 330 (2006).

121. *NFIB*, 567 U.S. 519, 587 (2012) (plurality opinion) (quoting *Champlin Ref. Co. v. Corp. Comm'n of Okla.*, 286 U.S. 210, 234 (1932)).

122. Nor did the functional disappearance of the tax penalty convert the remainder of the mandate statute into a command to purchase insurance; the government cannot compel people to purchase insurance now, and any argument that Congress intended to turn the mandate into an even stronger command when it repealed the penalty—at the same moment it was trying to defang the ACA—makes no sense.

This new alignment of legal scholars is significant because it indicates that unqualified ACA opposition may no longer be a GOP litmus test.<sup>123</sup>

It remains to be seen whether the challenge will gain more prominent supporters, like the other existential attacks on the ACA. Now that the Supreme Court has granted certiorari, it may also be an opportunity for the Court to speak more broadly on the doctrine of severability, which could have an impact on areas of the legal landscape far beyond healthcare.<sup>124</sup> And if the ACA is ultimately invalidated in whole or in large part, there is an entirely different set of legal questions concerning how a statute of this complexity, which has transformed the system so much, could even be unwound.

### III. HUNDREDS OF OTHER CHALLENGES IN FEDERAL COURT: INSURANCE, CIVIL RIGHTS, AND ACA DEFENSE

*NFIB*, *King*, and *Texas* are just the tip of the iceberg. More than 100 cases have been filed challenging aspects of the ACA since it was enacted. Space does not permit as complete an exegesis of these cases as we have offered for the existential challenges, but we think capturing the landscape is important not only to document the history but also to convey how many areas of law the ACA touches and the range of challenges to it.

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123. Prominent Republican legal experts, including several who were architects of the earlier major ACA challenges, have argued the lawsuit is meritless; some have filed bipartisan amicus briefs. See Brief of Amici Curiae Jonathan H. Adler, Nicholas Bagley, Abbe R. Gluck, and Ilya Somin in Support of Intervenors-Defendants-Appellants, *supra* note 119; Brief of Amici Curiae Samuel L. Bray, Michael W. McConnell, and Kevin C. Walsh in Support of Intervenors-Defendants-Appellants, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), <https://affordablecareactlitigation.files.wordpress.com/2019/04/5c-bray-mcconnell-walsh-amicus.pdf> [<https://perma.cc/Q36R-9S93>]; Brief for Amici Curiae Walter Dellinger and Douglas Laycock in Support of Intervenors-Defendants-Appellants Supporting Remand and Dismissal, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), <https://perma.cc/9SB7-9VME>.

Some Republican elected officials have spoken out against the suit. Two Republican attorneys general even filed an amicus brief opposing the district court's severability ruling, while more still have distanced themselves from it. See Brief of Amicus Curiae States of Ohio and Montana in Support of Neither Party, *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), <https://www.ohioattorneygeneral.gov/Files/Briefing-Room/News-Releases/Appeals/Tex-v-US-Amicus-Brief-FOR-FILING-4-1.aspx> [<https://perma.cc/2AFL-PX8Z>]. 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." 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>].

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 that "even the right-leaning Fifth Circuit Court of Appeals judges will overturn" the decision. Editorial, *Texas ObamaCare Blunder*, WALL ST. J. (Dec. 16, 2018, 4:40 PM), <https://www.wsj.com/articles/texas-obamacare-blunder-11544996418>.

124. See Brief for Jonathan H. Adler, Nicholas Bagley, Abbe R. Gluck, and Ilya Somin as Amici Curiae Supporting Petitioners, *California v. Texas*, 140 S. Ct. 1262 (2020) (mem.).

The main groups of cases can be roughly divided into three categories: cases involving the insurers the ACA relies on, cases about the ACA's new civil rights protections (including its contraception protections), and cases challenging the Trump Administration's efforts to weaken the law. There are also hundreds of other cases on a wide range of topics, from standing, to ERISA,<sup>125</sup> to intergovernmental disputes, which we briefly summarize at the end of this Part.

The insurer cases raise important questions about Congress's relationships with private statutory implementers and the intersection of appropriations law with statutory commands. The civil rights cases, and the cases challenging the Trump Administration's efforts to weaken the law, all address how far the ACA reaches to require or induce or encourage individuals, employers, and insurers to participate in the new system. The *NFIB* struggle over the Commerce Clause was, at bottom, about the same point.

All of these cases might have an impact on how government programs are structured in the future—in particular, the extent to which the ACA challenges might chill future efforts to embed reforms in private implementers (like insurers and employers) and favor instead more direct national regulation, which would be harder to challenge. It would be an ironic legacy for a law that began as a market-oriented compromise, and then was challenged as government overreach, to pave the way toward nationalization.

#### A. INSURERS

After the ACA opponents lost in the Supreme Court in *NFIB*, they looked for other ways to weaken the law, and they looked outside the courts as well as within them. One venue was Congress, which has been under at least partial Republican control since 2010. Congressional Republicans, later aided by President Trump, not only tried to repeal the law but alternatively tried to weaken the ACA by financially starving it. Some of these efforts, for example, when President Trump cut funds for insurance “navigators”—critical outreach personnel for exchange enrollment—harmed insurers indirectly (through depressed enrollment).<sup>126</sup> But in other instances, Congress's actions were targeted directly at funding streams that the ACA promised insurers.<sup>127</sup>

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125. ERISA stands for Employee Retirement Income Security Act of 1974.

126. *See, e.g.*, KAREN POLLITZ ET AL., KAISER FAMILY FOUND., DATA NOTE: CHANGES IN 2017 FEDERAL NAVIGATOR FUNDING (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]; Shanoor Seervai, *Cuts to the ACA's Outreach Fund Will Make It Harder for People to Enroll*, COMMONWEALTH FUND (Oct. 11, 2017), <https://www.commonwealthfund.org/publications/other-publication/2017/oct/cuts-acas-outreach-budget-will-make-it-harder-people-enroll>.

127. *See infra* pp. 1494–1500.

Insurers have filed approximately 50 to 100 cases concerning the ways in which the ACA relies on them and what the ACA promises them. Here, it is critical to remember how much the ACA built on what came before. The ACA retains the preexisting private insurance system, employer-based and individual, which accounted for more than 50% of Americans' insurance at the time the ACA was drafted and continued to do so ten years later.

As such, the ACA relies heavily on the private insurance system to help implement its reforms. But the ACA also fundamentally changes that system by imposing new national restrictions on how insurers do business. Insurers can no longer “medically underwrite”—reject<sup>128</sup> or rescind<sup>129</sup> coverage due to preexisting conditions or health status. The ACA also makes insurance more affordable and transparent by eliminating lifetime and annual caps<sup>130</sup> and co-pays for certain preventive services.<sup>131</sup> The ACA further requires all plans on the new insurance exchanges to meet minimum quality standards and cover ten essential health benefits.<sup>132</sup>

To make these changes affordable for insurers, the ACA both increased the customer pool (with the insurance purchase mandate) and provided three critical funding streams, known as the “three Rs”: risk corridors,<sup>133</sup> risk adjustment,<sup>134</sup> and reinsurance.<sup>135</sup> These are financial mechanisms designed to stabilize the insurance markets during the transition to the new regime and encourage plans to serve high-cost patients. Each of these programs involves some type of redistribution from plans that on average have fewer high-cost patients to plans that cover more people with chronic conditions and other higher cost medical needs. The philosophy underlying them is that plans that serve higher cost patients should be rewarded for doing so while plans that serve lower-cost patients should give up a portion of the money they are saving by paying less expensive claims.

The ACA also attempts to make coverage affordable for relatively low-income people by requiring insurers to reduce “cost sharing” (for example, deductibles and copays) charged to individuals, and the law attempts to encourage insurers to enroll those low-income patients by reimbursing plans for the money they lose by reducing cost-sharing for those patients.<sup>136</sup> These “cost-sharing reduction” payments (CSRs) are another funding stream in addition to the three Rs.

Recognizing the importance of all these payments to the ACA, opponents targeted them for attack. The result was more litigation. These cases have a different feel from *NFIB*, *King*, and *California v. Texas*. They are less directly about

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128. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1001(5), 124 Stat. 119, 130 (2010) (codified at 42 U.S.C. § 300gg-1 (2012)).

129. *Id.* (codified at 42 U.S.C. § 300gg-12).

130. *Id.* (codified at 42 U.S.C. § 300gg-11).

131. *Id.* (codified at 42 U.S.C. § 300gg-13).

132. *Id.* § 1302 (codified at 42 U.S.C. § 18022).

133. *Id.* § 1342 (codified at 42 U.S.C. § 18062) (in effect for plan years 2014, 2015, and 2016).

134. 42 U.S.C. § 18063.

135. *Id.* § 18061.

136. *Id.* § 18071.

concerns about government overreach, and more about government promises not kept. The cases tee up important questions that extend beyond the ACA itself, namely, about Congress's obligations to private implementers who are made integral parts of statutory schemes. Here, Congress and the Executive took political action to disrupt payments that the private sector had been counting on based on the text of the ACA. How strictly Congress is required to adhere to those promises, and what exactly is the nature of the relationship between Congress and its private sector partners are key questions—some of which the Supreme Court answered just as this Article went to print.

## 1. The “Three Rs”

### *a. Risk Corridors.*

By statute, the risk corridors program was a three-year program, covering plan years 2014 through 2016.<sup>137</sup> The statutory formula called for HHS to make risk corridor payments to plans whose costs were more than 103% of a target amount, and for HHS to collect from plans whose costs were less than 97% of the target amount.<sup>138</sup> In 2013, HHS suggested that this formula called for the agency to make payments to higher-cost plans that exceeded the amounts it would be collecting from lower-cost plans. In other words, the program would not be budget neutral. The federal government would have to put additional money in to make up for higher costs experienced by the plans that served higher-cost patients.<sup>139</sup>

ACA opponents seized on the announcement, and labeled the proposed formula a “taxpayer-funded bailout for insurance companies.”<sup>140</sup> Senator Marco Rubio proposed an appropriations rider to block the transfer of such payments, which—after two years of trying to get it through Congress—was enacted at the end of 2014 as part of the 2015 appropriations bill.<sup>141</sup> Insurers had already set their premiums for 2014 and 2015 relying on the risk corridor formula.

Insurers filed more than fifty cases to challenge the rider.<sup>142</sup> They argued that they had an entitlement under the statutory formula to get the payments the

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137. Patient Protection and Affordable Care Act § 1342(a).

138. *Id.* § 1342(b)(1)(A), (b)(2)(A).

139. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 70 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013) (codified at 45 C.F.R. pts. 153, 155, 156–58).

140. *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>.

141. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (“None of the funds made available by this Act from [CMS trust funds], or transferred from other accounts funded by this Act to the ‘Centers for Medicare and Medicaid Services—Program Management’ account, may be used for payments under section 1342(b)(1) of Public Law 111-148 [*i.e.*, 42 U.S.C. 18062(b)(1)] (relating to risk corridors).”).

142. This started with the class action of *Health Republic Ins. Co. v. United States*, No. 1:16-cv-259 (Fed. Cl. Filed Feb. 24, 2016). *See Risk Corridors and Risk Adjustment*, AFFORDABLE CARE ACT LITIG., <https://affordablecareactlitigation.com/risk-corridors-and-risk-adjustment/> [https://perma.cc/XWF4-EA4L] (last visited Mar. 25, 2020). The cases are in the Court of Federal Claims because under the Tucker Act, that is where cases claiming money from the Federal Government are supposed to be filed.



formula promised, and that the rider could not effectively repeal that promise in the ACA.<sup>143</sup> The Government responded that “[t]he ACA did not impose an obligation, enforceable through private actions for damages, to make risk-corridor payments in excess of appropriations.”<sup>144</sup> In 2018, after mixed results in the Court of Federal Claims, the Federal Circuit Court of Appeals held that the ACA gave insurers the right to the risk corridor payments, but that this right was revoked by the appropriations rider.<sup>145</sup>

In June of 2019, however, the Supreme Court surprised some onlookers when it granted review of the Federal Circuit’s decisions in several of these cases, consolidated as *Maine Community Health Options v. United States*.<sup>146</sup> The question on which the Court granted cert implicates much more than the ACA: “Whether Congress can evade its unambiguous statutory promise to pay health insurers for losses already incurred simply by enacting appropriations riders restricting the sources of funds available to satisfy the government’s obligation.”<sup>147</sup> Another interesting shift: Former Solicitor General Paul Clement, who argued *against* the ACA in *NFIB*, argued to *enforce* the ACA in *Maine Community Health Options*. Before the argument, Clement had observed: “The stakes of the risk corridor cases underscore the ACA’s outsized impact. . . . [E]ven the Supreme Court does not get many \$12 billion cases. Similarly, it is the rare statute that occupies as much of the Supreme Court’s time and attention as the ACA.”<sup>148</sup>

The Court decided the case on April 27, 2020, in an 8–1 opinion for the insurers, requiring Congress to stand by the obligations it created for itself in the text of the ACA and not permitting an implied repeal of those obligations through an appropriations rider.<sup>149</sup> At oral argument, the Justices evinced their understanding of the important role of the risk corridor program within the ACA’s statutory scheme.<sup>150</sup> A series of questions also centered on whether the insurers would have participated in the markets or made different pricing decisions but for the government’s promise to

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143. Brief for Petitioners at 27–30, *Me. Cmty. Health Options v. United States*, No. 18-1023, 18-1028, and 18-1038 (Aug. 30, 2019).

144. Brief for the Respondent at 19–43, *Me. Cmty. Health Options*, No. 18-1023, 18-1028, and 18-1038 (Oct. 21, 2019); *see also id.* at 51 n.10 (elaborating on the argument and responding to petitioners’ contentions).

145. *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1320, 1324 (Fed. Cir. 2018), *cert. granted*, 139 S. Ct. 2743 (2019) (mem.), *and argued*, No. 18-1028 (Dec. 10, 2019); *see also* *Land of Lincoln Mut. Health Ins. Co. v. United States*, 892 F.3d 1184 (Fed. Cir. 2018), *cert. granted*, 139 S. Ct. 2744 (2019) (mem.), *and argued*, No. 18-1038 (Dec. 10, 2019).

146. 892 F.3d at 1320, 1324. In granting certiorari, the Supreme Court consolidated *Moda, id.*, and *Blue Cross and Blue Shield of North Carolina v. United States*, 729 F. App’x 939 (Fed. Cir. 2018) (mem.).

147. Brief for Petitioners at i, *Me. Cmty. Health Options*, No. 18-1023, 18-1028, and 18-1038 (Aug. 30, 2019); *see also* Petition for Writ of Certiorari at i, *Me. Cmty. Health Options*, No. 18-1023, 18-1028, and 18-1038 (Feb. 4, 2019).

148. Clement, *supra* note 8, at 174.

149. *Me. Cmty. Health Options*, No. 18-1023, 2020 WL 1978706 (U.S. Apr. 27, 2020).

150. Transcript of Oral Argument at 37–41, *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://www.supremecourt.gov/oral_arguments/argument_transcripts/2019/18-1023_m648.pdf) [<https://perma.cc/9JVX-XFZY>].

pay—further demonstrating the importance of the case for the growing number of statutes that involve private implementers.<sup>151</sup>

*b. Risk Adjustment.*

The risk adjustment program also spreads costs among insurers participating in the exchanges. Specifically, it prompts states to assess charges on health plans whose patients have below-average actuarial risks and provide payments to health plans whose patients have above-average actuarial risks.<sup>152</sup> Contrary to its risk corridor policy at the outset, the Obama Administration promulgated revenue-neutral risk adjustment regulations, where money was redistributed among insurers and no new money came from the federal government. Lawsuits were filed and lower courts split over whether the Obama Administration's position was permissible.<sup>153</sup> In December 2019, the Court of Appeals for the Tenth Circuit upheld the federal government's methodology.<sup>154</sup> Another risk adjustment case pending appeal concerns whether the ACA's risk adjustment provisions preempt formulas that a state—in this case, New York—might prefer to employ.<sup>155</sup>

*c. Reinsurance.*

Reinsurance occurs when one insurer takes on part of the responsibility for risks originally handled by another insurer, thereby enabling the original insurer's rates to remain lower. The ACA's transitional reinsurance program has been phased out over time, and did not lead to major litigation. However, the program did prompt states to establish ways to continuously reinsure the risks associated with insurance plans that serve particularly high-cost patients. Many states—red and blue alike—have obtained “state innovation waivers” under section 1332 of the ACA.<sup>156</sup> For instance, Alaska has implemented its own version of a

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151. *Id.* at 58–59.

152. The ACA expected the system to be modeled on the Medicare Part D risk adjustment system for charging prescription drug plans whose patients have less-than-average actuarial risks and paying prescription drug plans whose patients have greater-than-average actuarial risks.

153. *Compare* N.M. Health Connections v. U.S. Dep't of Health & Human Servs., 312 F. Supp. 3d 1164, 1170 (D.N.M. 2018) (“The [c]ourt concludes that: . . . HHS' use of statewide average premiums in its risk adjustment methodology . . . is arbitrary and capricious . . .”), *rev'd*, 946 F.3d 1138 (10th Cir. 2019), *with* Minuteman Health v. U.S. Dep't of Health & Human Servs., 291 F. Supp. 3d 174, 201 (D. Mass. 2018) (“The question then becomes whether HHS's decision to attempt to operate the risk-adjustment program in a budget-neutral way was unreasonable or arbitrary. It was not.”).

154. N.M. Health Connections v. U.S. Dep't of Health & Human Servs., 946 F.3d 1138, 1167 (10th Cir. 2019) (“HHS did not violate the APA when it designed the risk adjustment program as budget neutral”).

155. *Unitedhealthcare of N.Y. v. Vullo*, 323 F. Supp. 3d 470 (S.D.N.Y. 2018), *appeal filed sub nom. Unitedhealthcare of N.Y. v. Lacewell*, No. 18-2583 (2d Cir. Aug. 28, 2018).

156. *See Tracking Section 1332 State Innovation Waivers*, KAISER FAMILY FOUND. (Jan. 7, 2020), <https://www.kff.org/health-reform/fact-sheet/tracking-section-1332-state-innovation-waivers/> [<https://perma.cc/B6LL-UBUF>]. As of January 2020, the federal government had approved section 1332 reinsurance waivers in thirteen states. *Id.*

reinsurance program, which has already helped reduce premiums.<sup>157</sup>

#### B. COST SHARING REDUCTION PAYMENTS

Another set of cases focuses on the cost-sharing reduction payments (CSRs). Those cases, combined with the 2020 risk corridors case decided by the Supreme Court in *Maine Community Health Options*, reveal the ACA—and its litigation—to have become an important part of the development of modern appropriations law. As noted, the ACA also attempts to make marketplace coverage more affordable for low-income individuals by reimbursing insurers for money they spend on reducing how much consumers pay out-of-pocket (“cost-sharing”).<sup>158</sup> Litigation about these CSR payments has taken unexpected turns.

Before the ACA, there were no reported cases in which a litigant had challenged the federal government’s expenditure of funds as a violation of the Constitution’s Appropriations Clause.<sup>159</sup> Nor were there any reported cases holding that an express congressional failure to appropriate money could give rise to a cause of action under the Appropriations Clause. Furthermore, neither Congress—nor the House or Senate individually—had ever sued the Executive Branch for an alleged violation of the Appropriations Clause.

*United States House of Representatives v. Burwell* is the ACA case that changed this history.<sup>160</sup> At issue were the CSR payments to insurers, which reduce how much money low-income patients pay out of pocket.<sup>161</sup> The CSRs can be found in section 1402 of the Act.<sup>162</sup> The CSRs are programmatically linked to the premium tax credits (the subsidies that lower premiums for marketplace coverage), which are found in section 1401.<sup>163</sup> Premium tax credits, however, are paid from a Treasury fund whose governing statute expressly mentions them, but does not mention CSRs.<sup>164</sup> In 2014, the Obama Administration made a request for a specific appropriation for CSR payments, but Congress refused to appropriate the funding.<sup>165</sup>

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157. Alaska has a section 1332 waiver allowing a state agency to cover claims for individual market users who have one or more of thirty-three high-cost conditions, including HIV/AIDS, chronic hepatitis, hemophilia, cerebral palsy, and end-stage renal disease. See 3 ALASKA ADMIN. CODE tit. 3, § 31.540 (2019). Alaska has projected that the reinsurance will reduce premiums by 20% of what they would have been without the reinsurance. AFFORDABLE CARE ACT LITIG., ALASKA: STATE INNOVATION WAIVER UNDER SECTION 1332 OF THE PPACA ( 2017), <https://affordablecareactlitigation.files.wordpress.com/2018/09/alaska-1332-waiver-fact-sheet-final-7-11-17.pdf> [<https://perma.cc/4U8Q-VMEG>].

158. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1402, 124 Stat. 119, 220 (2010) (codified at 42 U.S.C. § 18071 (2012)).

159. U.S. CONST. art. I, § 9, cl. 7 (“No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law . . .”).

160. 185 F. Supp. 3d 165 (D.D.C. 2016), *appeal held in abeyance*, 676 F. App’x 1 (D.C. Cir. 2016) (per curiam).

161. *Id.* at 165.

162. Patient Protection and Affordable Care Act § 1402.

163. “Premium tax credits” are government subsidies that lower premiums for marketplace coverage for those with incomes under 400% FPL. *Id.* at § 1401.

164. 31 U.S.C. § 1324(b)(2) (2012).

165. Doug Badger, *Panic Prompted ObamaCare Lawlessness*, HILL (July 15, 2016 11:47 AM), <https://thehill.com/blogs/pundits-blog/healthcare/287906-panic-prompted-obamacare-lawlessness> [<https://perma.cc/H7XC-FYWF>].

The Administration decided to make the payments out of the Treasury fund.<sup>166</sup> The House of Representatives sued, claiming that disbursing CSRs absent a specific appropriation violated the Appropriations Clause of the Constitution.<sup>167</sup> Once filed, the litigation proved surprisingly successful on several fronts. First, the federal district court in Washington, D.C. ruled that the House had standing to pursue an Appropriations Clause claim—a ruling that broke new ground given the Supreme Court’s historically narrow approach to the question of when legislatures or legislators can sue to enforce laws they pass.<sup>168</sup> The theory in *United States House of Representatives v. Burwell* was in part based on the argument that because the Constitution requires all appropriations legislation to originate in the House, the House had a special legal interest in enforcing that aspect of its authority.<sup>169</sup> In a subsequent order, the district court found that there was no express appropriation supporting the CSR payments and enjoined further payments from being made, but stayed the order pending appeal.<sup>170</sup>

Then, the Trump Administration took office. The Administration reversed course, disputing the Obama Administration’s position on the legality of the CSR payments.<sup>171</sup> Democrat-led states intervened on appeal to defend the law.<sup>172</sup>

Simultaneously, President Trump made public statements threatening to halt the payments himself nearly every week, throwing insurance markets into a state of uncertainty.<sup>173</sup> Insurers and states had to make decisions about rates for the 2018 year without knowing if the payments would continue. Some insurers even supplied regulators with two different rate schedules, one to apply if CSR

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166. One House staff report suggests the Obama Administration did not want CSR payments to go through appropriations because it did not want them to be subject to the budget sequester. AFFORDABLE CARE ACT LITIG., JOINT CONGRESSIONAL INVESTIGATIVE REPORT INTO THE SOURCE OF FUNDING FOR THE ACA’S COST SHARING REDUCTION PROGRAM 63 (2016), [https://affordablecareactlitigation.files.wordpress.com/2018/09/20160707joint\\_congressional\\_investigative\\_report-2-1.pdf](https://affordablecareactlitigation.files.wordpress.com/2018/09/20160707joint_congressional_investigative_report-2-1.pdf) [<https://perma.cc/54CQ-DTV3>].

167. Complaint, *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165 (D.D.C. 2016) (“Defendants . . . have violated, and are continuing to violate, the Constitution by directing, paying, and continuing to pay, public funds to certain insurance companies to implement a program authorized by the ACA, but for which *no funds* have been appropriated.”).

168. *House v. Burwell*, 130 F. Supp. 3d at 58 (Collyer, J.). Judge McFadden took a contrary view and, in *United States House of Representatives v. Mnuchin*, 379 F. Supp. 3d 8, 11 (D.D.C. 2019), ruled that the House did not have standing to enforce the Appropriations Clause.

169. *House v. Burwell*, 130 F. Supp. 3d at 74.

170. *House v. Burwell*, 185 F. Supp. 3d at 168.

171. See Letter from Jeff Sessions, Att’y Gen., to Steven Mnuchin, Sec’y of the Treasury, and Don Wright, Acting Sec’y of Health & Human Servs. (Oct. 11, 2017), <https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf> [<https://perma.cc/7BZE-N5TV>].

172. *House v. Price*, No. 16-5202 (D.D.C. Aug. 1, 2017).

173. See, e.g., Lydia Ramsey & Bob Bryan, *Trump Is Threatening a Move That Could Make Obamacare Explode and Hurt Lawmakers’ Coverage*, BUS. INSIDER (July 31, 2017), <https://www.businessinsider.my/trump-obamacare-cost-sharing-payments-2017-7/> (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/8LFG-UZC9>] (describing how “President Donald Trump has been threatening to end the payments . . . for months”).

payments were made, the other to apply if they were not.<sup>174</sup>

In October 2017, the Administration halted the payments entirely.<sup>175</sup> Seventeen states sued in the Northern District of California to get a preliminary injunction to reverse the decision.<sup>176</sup> They were unsuccessful, partly because most states, including California, had already raised insurers' overall rates in order to compensate for the loss of CSR payments.<sup>177</sup> The court held that, without irreparable harm to the insurers, a preliminary injunction was inappropriate.<sup>178</sup>

A number of insurers then filed cases in the Court of Federal Claims seeking reimbursement for CSR payments that the federal government had not made.<sup>179</sup> So far, the Court of Federal Claims has ruled in favor of the insurers in six cases. The most significant ruling came in *Common Ground*, an opt-in class action, where on October 22, 2019, the court entered a \$1,587,108,397.81 judgment for the 2017 and 2018 plan years.<sup>180</sup> Several CSR cases were appealed to the Federal Circuit, which held oral argument on January 9, 2020.<sup>181</sup> Other CSR cases are

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174. See, e.g., RABAH KAMAL ET AL., KAISER FAMILY FOUND., HOW THE LOSS OF COST-SHARING SUBSIDY PAYMENTS IS AFFECTING 2018 PREMIUMS (2017), <https://www.kff.org/health-reform/issue-brief/how-the-loss-of-cost-sharing-subsidy-payments-is-affecting-2018-premiums/> [<https://perma.cc/5N8A-36WD>].

175. See Notice at 1, *United States House of Representatives v. Hargan*, No. 16-5202 (D.C. Cir. Oct. 13, 2017), <https://separationofpowerslaw.files.wordpress.com/2017/12/us-house-v-hargan-sessions-opinion-letter.pdf> [<https://perma.cc/N524-TAUP>].

176. *California v. Trump*, 267 F. Supp. 3d 1119 (N.D. Cal. 2017). The states seeking preliminary included California, Connecticut, Delaware, Illinois, Maryland, Massachusetts, Minnesota, Vermont, Oregon, Pennsylvania, New York, Washington, Virginia. *Id.* at 1121. The District of Columbia, Iowa, Kentucky, and New Mexico joined pro se. *Id.*

177. *Id.* at 1134–38. The states generally used a practice known as “silver loading”—shifting the weight of the rate increases into the ACA’s middle level, silver plans, which are subsidized. The effect is that the individual subsidized purchaser does not feel the effect of the rate increase, because the federal subsidy increases as the silver rate does (meaning, ironically, that the federal government winds up paying at least as much to the plans as it would have done if it had made the CSR payments in the first place).

178. *Id.* at 1134–39.

179. See, e.g., Complaint, *Emblemhealth, Inc., v. United States*, No. 19-1164-C (Fed. Cl. Aug. 12, 2019); Complaint, *Common Ground Healthcare Coop. v. United States*, 142 Fed. Cl. 38 (2019), *appeal filed*, No. 20-1286 (Fed. Cir. Dec. 23, 2019); Complaint, *Noridian Mutual Ins. Co. v. United States*, No. 18-1983-C (Fed. Cl. Dec. 27, 2018); Complaint, *Local Initiative Health Authority for Los Angeles Cty. v. United States*, 145 Fed. Cl. 746 (2018); Complaint, *Sanford Health Plan v. United States*, 139 Fed. Cl. 701 (2018), *appeal filed*, No. 19-1290 (Fed. Cir. Dec. 11, 2018); Complaint, *Blue Cross & Blue Shield of Vt. v. United States*, No. 18-373-C (Fed. Cl. Mar. 9, 2018); Complaint, *Health All. Med. Plans, Inc. v. United States*, No. 18-334-C (Fed. Cl. Mar. 5, 2018); Complaint, *Mont. Health Co-Op v. United States*, 139 Fed. Cl. 213, *appeal filed*, No. 19-1302 (Fed. Cir. Dec. 12, 2018); Complaint, *Molina Healthcare of Ca., Inc., v. United States*, 133 Fed. Cl. 14 (2017).

180. *Common Ground Healthcare Coop. v. United States*, No. 1:17-cv-877-MMS, slip op. at 1 (Fed. Cl. Oct. 22, 2019).

181. In ascending order of Federal Circuit docket number, they are *Sanford Health Plan*, 139 Fed. Cl. 70 (2018), *appeal docketed*, No. 19-1290 (Fed. Cir. Dec. 11, 2018); *Montana Health Co-Op*, 139 Fed. Cl. 213, *appeal docketed*, No. 19-1302 (Fed. Cir. Dec. 12, 2018); *Community Health Choice*, 141 Fed. Cl. 744 (2019), *appeal docketed*, No. 19-1633 (Fed. Cir. March 8, 2019); *Common Ground Healthcare Cooperative*, 142 Fed. Cl. 38 (2019), *appeal docketed*, No. 20-1286 (Fed. Cir. Dec. 23, 2019); and *Local Initiative Health Authority for Los Angeles County*, 145 Fed. Cl. 746 (2019), *appeal docketed*, No. 20-1393 (Fed. Cir. Jan. 27, 2020). The United States raised complex damages-computation issues, and asks whether

stayed at the Court of Federal Claims, pending a decision by the Federal Circuit regarding whether or not there is a right to recovery, and if so whether there must be limits on how much insurers may recover.<sup>182</sup>

For its part, the *House v. Burwell* litigation itself was dismissed via settlement,<sup>183</sup> and Congress has not reinstated CSR payments through a separate appropriation.

### C. CONTRACEPTION AND CIVIL RIGHTS

Social and cultural issues have also been a focus of ACA litigation. Two provisions of the ACA, sections 1557 and 2713, broaden protection for civil rights and preventive services respectively. These sections have received particular scrutiny, and have become the subject of intense litigation because they have been applied to extend protection to contraception, to women who have terminated pregnancies, and to transgender individuals. One arm of that litigation—the cases concerning the ACA’s requirement that insurance plans provide contraception without cost-sharing (the so-called “contraceptive mandate”)—has already been taken up by the Supreme Court twice and the Court in May 2020 heard oral argument in a third case on the issue.<sup>184</sup> Another arm—civil rights—is implicated by three consolidated cases pending before the Court at the time of this Article.

#### 1. Contraception

Section 2713 of the ACA requires coverage of certain preventive healthcare services without cost sharing—i.e., without paying anything at the point of service.<sup>185</sup> The preventive services were defined as including, among other things: “evidence-based items or services that have in effect a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force,”<sup>186</sup> a category that includes services like blood pressure screenings and colonoscopies, and “with respect to women, such additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration for purposes of this paragraph.”<sup>187</sup>

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insurers who successfully sued for CSRs would get an impermissible double recovery given that states have already raised their rates to compensate for the CSR loss. The day after oral argument, the Federal Circuit ordered supplemental briefing “addressing in more detail the question of whether, assuming liability under the appellees’ statutory and/or implied-in-fact contract theories, a reduction in damages is available to the appellant if the appellees’ loss was diminished as a result of increases in premiums and tax credits.” *Cnty. Health Choice v. United States*, No. 19-1633 (Fed Cir. Jan. 10, 2020).

182. See, e.g., *Blue Cross & Blue Shield of Vt. v. United States*, No. 18-373-C (Fed. Cl. Sep. 25, 2019); *Noridian Mutual Ins. Co. v. United States*, No. 18-1983-C (Fed. Cl. July 9, 2019); *Health All. Med. Plans, Inc. v. United States*, No. 18-334-C (Fed. Cl. Mar. 28, 2019).

183. *House v. Azar*, No. 14-1967 (RMC) (D.D.C. May 18, 2018).

184. *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 918 (2020) (mem.), consolidated with *Trump v. Pennsylvania*, 140 S. Ct. 918 (2020) (mem.).

185. 42 U.S.C. § 300gg-13(a) (2012).

186. *Id.* § 300gg-13(a)(1). For the list of preventive services the U.S. Preventive Services Taskforce has given an A or B grade, see *USPSTF A and B Recommendations*, U.S. PREVENTIVE SERVICES TASK FORCE (Dec. 2019), <https://perma.cc/P9KT-ME9B>.

187. 42 U.S.C. § 300gg-13(a)(4).

After the ACA's passage, HHS, relying on the Health Resources and Services Administration guidelines, interpreted this to include coverage for all Food and Drug Administration approved methods of contraception.<sup>188</sup> Because all plans, including employer plans, are required to provide preventive health services without cost-sharing,<sup>189</sup> HHS's interpretation meant that these employers had to provide health insurance that included contraceptive coverage.

There were no exceptions in the ACA for employers who had religious objections to providing required preventive services, including contraception for employees. However, relying on the Religious Freedom Restoration Act (RFRA)—which prohibits the government from substantially burdening a person's exercise of religion except if the government is acting to further a compelling government interest and is using the least restrictive means of doing so<sup>190</sup>—the Obama Administration exempted certain religious employers, including houses of worship, from the requirement through its 2011 Interim Final Rule.<sup>191</sup> Employers with religious objections who did not qualify as religious employers under the 2011 Interim Final Rule filed lawsuits under RFRA.<sup>192</sup> The Administration eventually announced it would delay enforcement of the Interim Final Rule against certain religious nonprofits pending additional rulemaking regarding religious exceptions and accommodations.<sup>193</sup> Thus, many of these initial lawsuits challenging some religious nonprofits' exclusion from the initial exemption were dismissed as unripe.<sup>194</sup>

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188. *Women's Preventive Services Guidelines*, HEALTH RES. & SERVS. ADMIN., <https://www.hrsa.gov/womens-guidelines-2016/index.html> (last updated Oct. 2019) [<https://perma.cc/95W9-J4X4>]. While the Act does not use the word "contraception," contraception is a principal subject of the guidelines that the ACA cross-references. HHS relied on recommendations from the Institute of Medicine to determine what would constitute preventive care for the purpose of required coverage without cost-sharing. *See Women's Preventive Services*, DEP'T OF HEALTH AND HUMAN SERVS., <https://www.hhs.gov/opa/title-x-family-planning/preventive-services/womens-services/index.html> [<https://perma.cc/RC5C-DECZ>] (last updated May 3, 2017).

189. 42 U.S.C. § 300gg-13(a)(4).

190. *See Religious Freedom Restoration Act of 1993*, Pub. L. No. 103-141, § 3, 107 Stat. 1488, 1488–89 (codified at 42 U.S.C. § 2000bb-1(a)–(b) (2012)).

191. *See Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act*, 76 Fed. Reg. 46,621, 46,625–26 (Aug. 3, 2011) (to be codified at 45 C.F.R. pt. 147). A religious employer for the purposes of the exemption is "one that: (1) has the inculcation of religious values as its purpose; (2) primarily employs persons who share its religious tenets; (3) primarily serves persons who share its religious tenets; and (4) is a nonprofit organization under section 6033(a)(1) and section 6033(a)(3)(A)(i) or (iii) of the [Internal Revenue] Code." *See id.* at 46,623. Sections 6033(a)(3)(A)(i) and (iii) refer to churches, churches' integrated auxiliaries, and conventions or associations of churches, as well as to the "exclusively religious activities of any religious order." *See* 26 U.S.C. § 6033(a)(3)(A) (2012).

192. *See, e.g., Eternal Word Tel. Network v. Sebelius*, 935 F. Supp. 2d 1196, 1207–08 (N.D. Ala. 2013); *Belmont Abbey Coll. v. Sebelius*, 878 F. Supp. 2d 25, 29 (D.D.C. 2012).

193. *See* DIPTI SINGH, NATIONAL HEALTH LAW PROGRAM, CONTRACEPTIVE COVERAGE REQUIREMENT TIMELINE (July 23, 2013), <https://healthlaw.org/resource/contraceptive-coverage-requirement-timeline/> [<https://perma.cc/FF3Y-PUZA>] (noting a safe harbor from the 2011 Interim Final Rule for religious affiliated nonprofit groups pending the Administration's development of an accommodations process).

194. *See Eternal Word*, 935 F. Supp. 2d at 1223 (granting motion to dismiss based on lack of ripeness); *Belmont Abbey*, 878 F. Supp. 2d at 37, 39 (granting motion to dismiss based on lack of standing and ripeness).

In 2013, the Administration promulgated a rule that created a regulatory mechanism for other nonprofit organizations with religious objections—employers not covered by the 2011 exemption—developing an accommodations process to make sure female employees still had access to the full spectrum of cost-free contraception while taking into account employers' religious objections.<sup>195</sup>

For-profit companies owned by individuals with religious objections, however, were not eligible for either the exemption under the 2011 Interim Final Rule or the accommodation under the 2013 Final Rule.<sup>196</sup> They sued, asserting that the contraceptive mandate violated RFRA. This gave rise, in 2014, to the second ACA case in the Supreme Court—*Burwell v. Hobby Lobby Stores*—decided between *NFIB* and *King*.<sup>197</sup>

In *Hobby Lobby*, the Court held that the government could not require closely held for-profit corporations with religious objections to provide contraceptive coverage.<sup>198</sup> As part of its analysis, the Court found that applying the contraceptive mandate to these employers was not the least restrictive means of achieving the government interest due to the existence of the accommodations process for religious nonprofits.<sup>199</sup> The Court posited that this accommodations process could be extended to closely held for-profits with religious objections, without explicitly deciding whether the accommodations process itself was consistent with RFRA.<sup>200</sup> By finding that certain for-profit businesses had free exercise rights under RFRA, *Hobby Lobby* provided a new roadmap for litigants, especially for-profit businesses, with religious objections seeking to gain exemptions from generally applicable laws, even when those exemptions would work to the detriment of third parties. Businesses with religious objections have used the case, for example, to argue they need not comply with state and local antidiscrimination laws that protect against discrimination on the basis of sexual orientation, extending the reasoning of *Hobby Lobby* even beyond the RFRA context.<sup>201</sup>

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195. See Coverage of Certain Preventive Services Under the Affordable Care Act, 78 Fed. Reg. 39,870, 39,873–82 (July 2, 2013) (to be codified at 45 C.F.R. pts. 147, 156). Under the accommodation, eligible employers would notify their insurer of their objection and the insurer or administrator would then directly ensure that employees received the required contraceptive coverage without cost-sharing. See *id.* at 39,876.

196. See *id.* at 39,875 (“[T]he definition of eligible organization[s] in these final regulations does not extend to for-profit organizations.”).

197. See 573 U.S. 682 (2014).

198. *Id.* at 736. For other cases dealing with religious objections from for-profit employers, see, for example, *Gilardi v. United States Department of Health & Human Services*, 733 F.3d 1208 (D.C. Cir. 2013), vacated, 573 U.S. 956 (2014).

199. See *Hobby Lobby*, 573 U.S. at 692.

200. *Id.* at 731.

201. For example, *Masterpiece Cakeshop v. Colorado Civil Rights Commission*, 138 S. Ct. 1719 (2018), used *Hobby Lobby*'s reasoning but was not a RFRA case. For more on the role of *Hobby Lobby* in LGBT rights and nondiscrimination cases, see Olivia Brown et al., *Religious Exemptions*, 20 GEO. J. GENDER & L. 397, 407–08 (2019); Ira C. Lupu, *Moving Targets: Obergefell, Hobby Lobby, and the Future of LGBT Rights*, 7 ALA. C.R. & C.L. L. REV. 1, 63–69 (2015); Jennifer C. Pizer, *Navigating the Minefield: Hobby Lobby and Religious Accommodation in the Age of Civil Rights*, 9 HARV. L. & POL'Y REV. 1, 5 (2015).



Nonprofit employers with religious objections continued to challenge the accommodations process.<sup>202</sup> In 2014, the federal government issued another Interim Final Rule that provided another alternative accommodation for employers with religious objections: rather than submit a form to the insurer or administrator, they could instead inform HHS in writing of their objection.<sup>203</sup> Objecting employers continued to argue that the requirement made them complicit in the provision of contraceptive coverage (or certain forms of contraception they believed amounted to abortion), violating their religious beliefs. The lower courts divided on the issue<sup>204</sup> and the Supreme Court granted review in *Zubik v. Burwell*.<sup>205</sup> In a May 2016 per curiam opinion, the Court vacated all of the lower court decisions, declined to reach the merits of the issue, and directed the government and the challengers to again attempt to resolve the dispute through the administrative process.<sup>206</sup>

The 2016 election, just six months after the Court's decision in *Zubik*, produced an administration much more hostile to the contraceptive mandate. The Trump Administration promulgated interim final rules in October 2017<sup>207</sup> and

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202. See, e.g., *Wheaton Coll. v. Burwell*, 573 U.S. 958, 958–59 (2014); *Little Sisters of the Poor Home for the Aged v. Sebelius*, 134 S. Ct. 1022, 1022 (2014). In 2014, shortly after announcing its decision in *Hobby Lobby*, the Court decided that *Wheaton College* did not have to submit a self-certification form to its third-party administrator, a component of the regulatory accommodation that the religious nonprofit objected to, in order to obtain an injunction pending appeal. *Wheaton Coll.*, 573 U.S. at 959. The Supreme Court also granted emergency relief to *Little Sisters of the Poor* in its lawsuit challenging the accommodation, but it did not decide the merits. *Little Sisters of the Poor*, 134 S. Ct. at 1022.

203. Coverage of Certain Preventive Services Under the Affordable Care Act, 79 Fed. Reg. 51,092, 51,094 (Aug. 27, 2014) (to be codified at 45 C.F.R. pt. 147). This alternative accommodation was created in response to the Supreme Court's order in *Wheaton*. See *id.* The Final Rule was issued in July 2015. Coverage of Certain Preventive Services Under the Affordable Care Act, 80 Fed. Reg. 41,318 (July 14, 2015) (to be codified at 45 C.F.R. pt. 147).

204. Several district courts granted preliminary and subsequently permanent injunctions finding that complying with the accommodation posed a substantial burden on employers' religious beliefs. See *Catholic Diocese of Beaumont v. Sebelius*, 10 F. Supp. 3d 725, 736 (E.D. Tex. 2014); *E. Tex. Baptist Univ. v. Sebelius*, 988 F. Supp. 2d 743, 772 (S.D. Tex. 2013); *S. Nazarene Univ. v. Sebelius*, No. CIV-13-1015-F, 2013 WL 6804265, at \*11 (W.D. Okla. Dec. 23, 2013); *Reaching Souls Int'l, Inc. v. Sebelius*, No. CIV-13-1092-D, 2013 WL 6804259, at \*8 (W.D. Okla. Dec. 20, 2013); *Roman Catholic Archbishop of Wash. v. Sebelius*, 19 F. Supp. 3d 48, 82 (D.D.C. 2013) (finding at least one plaintiff was entitled to summary judgment on its RFRA claim); *Zubik v. Sebelius*, 983 F. Supp. 2d 576 (W.D. Pa. 2013); *Geneva Coll. v. Sebelius*, 960 F. Supp. 2d 588 (W.D. Pa. 2013).

The courts of appeals that heard these cases were united in finding that the accommodations process did not violate RFRA. See *Little Sisters of the Poor Home for the Aged v. Burwell*, 794 F.3d 1151, 1160 (10th Cir. 2015); *E. Tex. Baptist Univ. v. Burwell*, 793 F.3d 449, 452 (5th Cir. 2015); *Geneva Coll. v. Sec'y U.S. Dep't of Health & Human Servs.*, 778 F.3d 422, 427 (3d Cir. 2015); *Priests for Life v. U.S. Dep't of Health & Human Servs.*, 772 F.3d 229, 237 (D.C. Cir. 2014).

205. 136 S. Ct. 1557 (2016) (per curiam).

206. See *id.* at 1560.

207. Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,792 (Oct. 13, 2017) (to be codified at 45 C.F.R. pt. 147); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 82 Fed. Reg. 47,838 (Oct. 13, 2017) (to be codified at 45 C.F.R. pt. 147).

final rules in November 2018<sup>208</sup> that expanded the exemption to a much broader range of employers with religious, or even nonreligious, moral objections.<sup>209</sup> This time, several states challenged this exemption as *too* broad. In 2019, the Third Circuit held that the 2018 Final Rule violated the APA and upheld a nationwide injunction enjoining the rule.<sup>210</sup> The Supreme Court heard the case in the spring of 2020.<sup>211</sup>

At the same time, a different federal court—in a matter intentionally brought to the same judge, Judge Reed O'Connor, who has presided over several ACA challenges including *California v. Texas*—issued a permanent injunction against the Obama Administration's accommodations process and the underlying contraceptive mandate.<sup>212</sup> The court enjoined the mandate against two nationwide classes which include all employers and individuals who object to contraceptive coverage based on sincerely held religious beliefs<sup>213</sup>—a far broader employer class than the closely held corporations represented in *Hobby Lobby*.<sup>214</sup> The result? Conflicting nationwide injunctions are currently in place, creating a unique situation in which the courts have both enjoined the Trump Administration's policy and the Obama Administration's policy, and different rules apply depending on whether the employer is covered by the Texas court's injunction or not. The Fifth Circuit stayed the appeal of the Texas district court decision pending the Supreme Court's decision in the upcoming Pennsylvania challenge to the Trump rules.<sup>215</sup>

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208. Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,536 (Nov. 15, 2018) (to be codified at 45 C.F.R. pt. 147); Moral Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. 57,592 (Nov. 15, 2018) (to be codified at 45 C.F.R. pt. 147). The Administration expanded the availability of an exemption to those with nonreligious moral objections with no apparent statutory basis.

209. The new rules take the position that the government lacks a compelling interest in women having access to contraception through employers with objections to providing comprehensive contraceptive coverage and that any nongovernmental employer with such an objection should not have to provide that coverage. *See* Religious Exemptions and Accommodations for Coverage of Certain Preventive Services Under the Affordable Care Act, 83 Fed. Reg. at 57,546–48.

210. *See* *Pennsylvania v. President United States*, 930 F.3d 543, 556 (3d Cir. 2019). Courts previously granted preliminary injunctions enjoining the 2017 Interim Final Rules. *See* *California v. Dep't of Health & Human Servs.*, 281 F. Supp. 3d 806 (N.D. Cal. 2017); *Pennsylvania v. Trump*, 281 F. Supp. 3d 553 (E.D. Pa. 2017).

211. *See* *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 918 (2020) (mem.), *consolidated with* *Trump v. Pennsylvania*, 140 S. Ct. 918 (2020) (mem.). Argument was to take place May 6, 2020.

212. *See* *DeOtte v. Azar*, 393 F. Supp. 3d 490, 514 (N.D. Tex. 2019).

213. *See id.* at 513–14.

214. This class includes every employer, regardless of size or corporate form, that objects to contraceptive coverage. *See id.* at 508 n.8.

215. *See id.*, *appeal docketed*, No. 19-10754 (5th Cir. July 5, 2019), and *stayed granted*, No. 19-10754 (5th Cir. Jan. 29, 2020) (granting stay of appeal pending the Supreme Court's rulings in *Little Sisters of the Poor Home for the Aged v. Pennsylvania* and *Trump v. Pennsylvania*).

Yet another case regarding the contraceptive mandate is currently moving forward in the Seventh Circuit.<sup>216</sup> The claims are against both the federal government—challenging the Trump rules—and the University of Notre Dame, challenging a settlement agreement between Notre Dame and the Trump Administration that exempts the university from all current and any future requirements with respect to the contraceptive mandate.<sup>217</sup>

These cases, in an important sense, relate to the ongoing theme of disputes relating to the ACA's efforts toward solidarity. By establishing benefits that *all* plans must cover, the ACA envisions a framework in which everyone, regardless of the plan type they enroll in, would have access to core, uniform healthcare services. The contraceptive-mandate cases raise the question of whether, in an employment-based healthcare system, employers should be permitted to decline to provide their employees with healthcare services the employers object to.

Further, it remains to be seen whether the Court's broad conception of free exercise rights under RFRA in these cases will extend to other types of healthcare services, like vaccines or blood transfusions, which some object to, or whether matters of women's health (particularly contraception and abortion) are treated *sui generis* by the Court. The majority in *Hobby Lobby* did recognize that access to contraception is a constitutional right,<sup>218</sup> but it did not seem to grasp the importance of access to contraception as *preventive* care within the ACA's statutory scheme. Now that the Court has agreed to hear its third contraceptive-mandate case, it might be forced to answer questions it has long seemed to avoid: Is the accommodations process itself a burden on employers' free exercise rights under RFRA, and, ultimately, which rights will prevail when in conflict—employers' rights under RFRA or women's rights to access to contraception under the Court's fundamental rights precedents and the ACA?

## 2. Civil Rights

Section 1557 of the ACA prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs and activities.<sup>219</sup> Preexisting nondiscrimination law had applied to some healthcare programs, and section 1557 extended its protection to individuals participating in any health program or activity that receives funding from HHS, in full or in part, any health program or activity that HHS itself administers, any health insurance marketplaces, and all plans offered by insurers that participate in the marketplace.<sup>220</sup> Cases filed under section 1557 have included allegations of disability discrimination against

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216. *Irish 4 Reproductive Health v. United States Dep't of Health & Human Servs.*, No. 3:18-CV-491-PPS-JEM, 2020 WL 248009 (N.D. Ind. Jan. 16, 2020).

217. *Id.* The issues are distinct from the issues presented in *Trump v. Pennsylvania*. One difference is that, in the dispute over the Notre Dame settlement agreement, women needing contraception are participating as parties. See *infra* note 381.

218. *Burwell v. Hobby Lobby Stores, Inc.* 573 U.S. 682, 727 (2014).

219. See 42 U.S.C. § 18116(a) (2012).

220. See *id.*

people with hearing loss,<sup>221</sup> discriminatory failure to provide comprehensive breastfeeding and lactation support services,<sup>222</sup> disability discrimination over plan limitations on specialty medications for HIV/AIDS,<sup>223</sup> discriminatory overpricing of drugs to treat Hepatitis C,<sup>224</sup> and sex discrimination in failure to prescribe fentanyl for Global Diffuse Adenomyosis.<sup>225</sup>

Although section 1557 has been in effect since the passage of the ACA, the HHS Office for Civil Rights issued the Final Rule to implement the provision in May 2016.<sup>226</sup> That rule interpreted discrimination on the basis of sex to include discrimination based on gender identity and pregnancy termination. Several states and religious healthcare providers, including the Catholic hospital system Franciscan Alliance, challenged this aspect of the rule under the Administrative Procedure Act (APA) and RFRA—again before Judge O'Connor in Texas. In December 2016, Judge O'Connor granted a nationwide preliminary injunction to prevent enforcement of the provision.<sup>227</sup>

Other litigants have brought cases concerning the same issue and other courts have found that the statutory language in section 1557 does indeed protect against discrimination in healthcare based on gender identity.<sup>228</sup> Some of these cases rely on the theory that failure to provide gender-confirmation surgery is discrimination based on a disability: gender dysphoria.<sup>229</sup>

221. Complaint at 3, E.S. by and through R.S. v. Regence Blueshield, No. 2:17-cv-1609, 2018 WL 4566053 (W.D. Wash. Sept. 24, 2018) (alleging discrimination in plans' failure to provide hearing aids); Complaint at 3, Schmitt v. Kaiser Found. Health Plan of Wash., No. 2:17-cv-1611, 2018 WL 4385858 (W.D. Wash. Sept. 14, 2018) (alleging discrimination in plans' failure to provide treatment of hearing loss); Complaint at 3, Audia v. Briar Place, Ltd., No. 1:17-cv-6618, 2018 WL 1920082 (N.D. Ill., Apr. 24, 2018) (settled); Complaint at 2, Esparza v. Univ. Med. Ctr. Mgmt. Corp., No. 2:17-cv-4803, 2017 WL 4791185 (E.D. La. Oct. 24, 2017) (alleging providers' failure to provide interpreter) (settled).

222. See, e.g., York v. Wellmark, Inc., No. 4:16-cv-00627-RGE-CFB, 2019 WL 1493715, at \*1 (S.D. Iowa Feb. 28, 2019); Condry v. UnitedHealth Grp., Inc., No. 17-cv-00183-VC, 2018 WL 3203046, at \*1 (N.D. Cal. June 27, 2018); Briscoe v. Health Care Serv. Corp., 281 F. Supp. 3d 725, 728 (N.D. Ill. 2017).

223. See, e.g., Doe v. BlueCross BlueShield of Tenn., Inc., 926 F.3d 235, 238 (6th Cir. 2019).

224. See Se. Pa. Transp. Auth. v. Gilead Scis., 102 F. Supp. 3d 688, 693, 701 (E.D. Pa. 2015) (dismissed for failure to state a section 1557 claim).

225. See Weinreb v. Xerox Bus. Servs., LLC Health & Welfare Plan, 323 F. Supp. 3d 501, 504, 522 (S.D.N.Y. 2018) (dismissed for failure to state a section 1557 claim).

226. Nondiscrimination in Health Programs and Activities, 81 Fed. Reg. 31,376 (May 18, 2016) (to be codified at 45 C.F.R. pt. 92).

227. Franciscan All., Inc. v. Burwell, 227 F. Supp. 3d 660, 670 (N.D. Tex. 2016).

228. Other cases could be brought because section 1557 includes a private right of action and Judge O'Connor's ruling applied only to HHS. See, e.g., Tovar v. Essentia Health, 342 F. Supp. 3d 947, 956 (D. Minn. 2018) (settled); Boyden v. Conlin, 341 F. Supp. 3d 979, 998 (W.D. Wis. 2018).

Other section 1557 cases challenging discrimination against transgender people include: *Flack v. Wisconsin Department of Health Services*, 395 F. Supp. 3d 1001 (W.D. Wis. 2019) (concerning failure by Medicaid program to provide appropriate treatment for gender dysphoria); *Edmo v. Idaho Department of Correction*, 358 F. Supp. 3d 1103 (D. Idaho 2018) (concerning an inmate seeking gender-confirmation surgery), *aff'd in part, rev'd in part sub nom.* *Edmo v. Corizon, Inc.*, 935 F.3d 757 (9th Cir. 2019); *Prescott v. Rady Children's Hospital—San Diego*, 265 F. Supp. 3d 1090 (S.D. Cal. 2017) (concerning failure by hospital to provide appropriate treatment for gender dysphoria) (settled); and *Rumble v. Fairview Health Services*, No. 14-cv-2037, 2015 WL 1197415 (D. Minn. Mar. 16, 2015).

229. See, e.g., *Flack*, 395 F. Supp. 3d at 1003–10.

The Trump Administration declined to defend the 2016 Final Rule and, in June 2019, issued a proposed rule amending the Obama Era rule to exclude protection for discrimination on the basis of gender identity and termination of pregnancy.<sup>230</sup> Four months later, Judge O'Connor issued a final judgment in *Franciscan Alliance, Inc. v. Azar*,<sup>231</sup> vacating the provisions of the 2016 rule prohibiting discrimination on the basis of gender identity and termination of pregnancy and holding that they violated the APA and RFRA.<sup>232</sup> At the time of this writing, the appeal—*Franciscan Alliance* itself is appealing, asserting that Judge O'Connor's decision did not go far enough to protect it from 1557—is pending in the Fifth Circuit.<sup>233</sup>

At the same time, the Supreme Court in October 2019 heard a consolidated case that presented the question of whether the word “sex” in Title VII of the Civil Right Act includes sexual orientation and gender identity.<sup>234</sup> The Court's ruling in that case may affect the future construction of “sex” in section 1557 of the ACA by the courts of appeals.

Another significant question concerns whether section 1557 strengthens various existing antidiscrimination statutes, such as the Americans with Disabilities Act, and harmonizes them with each another or whether it merely makes the existing statutes more applicable to health insurance.<sup>235</sup> For example, one emerging question is whether litigants can bring disparate impact, disability discrimination cases under section 1557. Lower courts have divided on the question as have the Obama and Trump Administrations.<sup>236</sup> At the time of this writing, the Ninth Circuit is considering the disparate impact issue in two cases about alleged discrimination on the basis of hearing loss by health plans.<sup>237</sup>

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230. The proposed rule makes additional changes to the 2016 rule. Aside from eliminating the gender identity and termination of pregnancy provisions, it includes a relaxation of the Obama Administration's language-access requirements. See *Nondiscrimination in Health and Health Education Programs or Activities*, 84 Fed. Reg. 27,846 (proposed June 14, 2019) (to be codified at 42 C.F.R. pts. 438, 440, 460).

231. 414 F. Supp. 3d 928, 946–47 (N.D. Tex. 2019).

232. *Id.* at 945–46.

233. The district court granted the ACLU's and the River Gender City Alliance's motion to intervene, thus allowing those organizations to participate in the appeal. See *id.* at 936–37.

234. See *Bostock v. Clayton County*, No. 17-1618 (argued Oct. 8, 2019); *Altitude Express, Inc. v. Zarda*, No. 17-1623 (argued Oct. 8, 2019); *R.G. & G.R. Harris Funeral Homes, Inc., v. EEOC*, No. 18-107 (argued Oct. 8, 2019) (cases consolidated).

235. The antidiscrimination statutes giving rise to section 1557 are Title VI of the Civil Rights Act (race, color, and national origin), Title IX of the Education Act Amendments (sex), the Age Discrimination Act, and section 504 of the Rehabilitation Act (handicap discrimination).

236. Compare *Rumble*, 2015 WL 1197415, at \*11 n.6 (holding the ACA did align the various statutes) and *Nondiscrimination in Health Programs and Activities*, 81 Fed. Reg. 31,376, 31,439–41 (to be codified at 45 C.F.R. pt. 92) (May 18, 2016), with *Doe v. BlueCross BlueShield of Tenn., Inc.*, 926 F.3d 235, 238–43 (6th Cir. 2019), and *Nondiscrimination in Health and Health Education Programs or Activities*, 84 Fed. Reg. at 27,850–51.

237. See *Schmitt v. Kaiser Found. Health Plan of Wash.*, No. C17-1611RSL, 2018 WL 4385858 (9th Cir. Oct. 12, 2018); *E.S. by and through R.S. v. Regence BlueShield*, C17-01609, 2018 WL 4566053 (W.D. Wash. Sept. 24, 2018), *appeal filed*, No. 18-35892 (9th Cir. Oct. 23, 2018); see also *E.S. by and through R.S. & J.S. v. Regence BlueShield*, No. 18-35892, slip op. at 1 (9th Cir. Oct. 15 2019).

In May 2018, the HHS Office for Civil Rights (OCR) finalized a series of so-called “conscience” rules to implement what OCR characterized as a series of statutory provisions (including sections of the ACA<sup>238</sup>) protecting individual and entity rights not to participate in healthcare to which the individuals or entities objected.<sup>239</sup> Under the new rules, medical providers could refuse care that they disagreed with for religious or moral reasons.<sup>240</sup> States, local governments, and providers sued, objecting to the new system for cutting off all federal funds to a provider that required employees to violate the rules.<sup>241</sup> As of this writing, district courts in New York, California, and Washington had vacated the rule.<sup>242</sup> In the New York case, the court held that the new rules made unjustified changes in prior policy and coerced providers and states in violation of the *NFIB* anticoercion holding.<sup>243</sup> The federal government is appealing.<sup>244</sup>

Interestingly, antidiscrimination litigation has also challenged tensions within the ACA itself. For example, the ACA promotes “wellness programs,” which reward individuals for healthy behaviors and lifestyles by establishing “rewards” of up to 30% of the cost of employee-only coverage.<sup>245</sup> Commentators have noted the tension between these provisions and the ACA’s broader principle of no discrimination based on health status.<sup>246</sup> The EEOC’s regulations implementing wellness programs have been successfully challenged under the APA. A federal district court in Washington, D.C. found that the agency did not adequately

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238. The ACA was among the statutes that the Administration stated it was implementing. In its rules, OCR cited sections 1553 (banning discrimination by entities receiving federal funding against providers that do not provide assisted suicide), 1303 (requiring that qualified health plans segregate funds for abortion services), and 1411 (discussing the availability of hardship exemptions from the penalty for failure to comply with the individual mandate). *See Protecting Statutory Conscience Rights in Health Care; Delegations of Authority*, 84 Fed. Reg. 23,170, 23,172 (May 21, 2019) (to be codified at 45 C.F.R. pt. 88).

239. *See id.* at 23,170.

240. *See id.*

241. *See, e.g., California v. Azar*, No. 4:19-cv-02769 (N.D. Cal. filed Nov. 19, 2019); *County of Santa Clara v. U.S. Dep’t of Health & Human Servs.*, No. 3:19-cv-02916 (N.D. Cal. May 28, 2019); *City & County of San Francisco v. Azar*, No. 3:19-cv-02405 (N.D. Cal. filed May 2, 2019); *see also Washington v. Azar*, No. 2:19-cv-00183-SAB, 2019 WL 6219541 (E.D. Wash. Nov. 21, 2019); *New York v. U.S. Dep’t of Health & Human Servs.*, No. 1:19-cv-04676-PAE, 2019 WL 3531960 (S.D.N.Y. Nov. 6, 2019); *Planned Parenthood v. U.S. Dep’t of Health & Human Servs.*, No. 1:19-cv-05435-PAE (S.D.N.Y. Nov. 6, 2019).

242. *City & County of San Francisco v. Azar*, No. 411 F. Supp. 3d 1001 (N.D. Cal. 2019); *New York v. U.S. Dep’t of Health & Human Servs.*, 2019 WL 3531960; *Washington v. Azar*, 2019 WL 6219541.

243. *See New York v. U.S. Dep’t of Health & Human Servs.*, 2019 WL 3531960.

244. Notice of Appeal, *Washington v. Azar*, No. 2:19-cv-00183-SAB (E.D. Wash. Jan. 17, 2020); Notice of Appeal, *New York v. U.S. Dep’t of Health & Human Servs.*, No. 1:19-cv-04676-PAE (S.D.N.Y. Jan. 3, 2020); Notice of Appeal, *City & County of San Francisco v. Azar*, No. 19-cv-2405-WHA (N.D. Cal. Mar. 6, 2020); Notice of Appeal, *County of Santa Clara v. U.S. Dep’t of Health & Human Servs.*, No. 19-cv-02916-WHA (N.D. Cal. Mar. 6, 2020).

245. *See* 42 U.S.C. § 300gg-4(j) (2012).

246. *See, e.g., Tom Baker, Health Insurance, Risk, and Responsibility After the Patient Protection and Affordable Care Act*, 159 U. PA. L. REV. 1577, 1603–07 (2011).

explain how the programs would avoid discrimination against those with disabilities and health conditions and be truly “voluntary” as the ACA requires.<sup>247</sup> An antidiscrimination lawsuit against a private employer that operates a wellness program—Yale University—is also pending.<sup>248</sup>

D. DEFENDING AGAINST A NEW ADMINISTRATION HOSTILE TO THE LAW: MEDICAID WORK REQUIREMENTS, IMMIGRANT ACCESS, AND EFFORTS TO UNDERMINE THE INSURANCE POOLS

The most recent phase of the ACA's litigation story has been one of shifting momentum in the courts. Since 2018, lawsuits have been filed more frequently “not to challenge the law but to affirmatively defend and enforce it.”<sup>249</sup> Of course, that momentum has been spurred in part by mirroring changes in the Executive Branch. The Trump Administration arrived with open hostility to the ACA—President Trump's first executive order 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.<sup>250</sup> President Trump has repeatedly stated that the defeat of ACA repeal in Congress “doesn't matter” because “[w]e gutted it anyway”<sup>251</sup> and that, “[W]e're doing it a different way. We have to go a different route.”<sup>252</sup>

These actions galvanized a new wave of affirmative defensive litigation in support of the ACA. Not only did almost two dozen states intervene to defend the ACA in *California v. Texas*, but the House of Representatives intervened as well as soon as the Democrats regained control in 2018.<sup>253</sup> And dozens of other lawsuits have also been filed in support of the law. Among these are the many important insurance-payment-related cases already discussed.<sup>254</sup>

In addition, cases have been brought by states and consumer organizations challenging the legality of the Trump Administration's new rules that aim to undermine the ACA's universal access goals. Those rules include new rules that would allow states to impose work requirements on Medicaid recipients, new

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247. *AARP v. EEOC*, 267 F. Supp. 3d 14 (D.D.C. 2017); *see also* *AARP v. EEOC*, 92 F. Supp. 3d 238, 238 (D.D.C. Dec. 2017).

248. *See* First Amended Complaint ¶¶ 1–8, *Kwesell v. Yale Univ.*, No. 3:19-cv-01098 (KAD) (D. Conn. Oct. 17, 2019).

249. *See* Gluck & Scott-Railton, *supra* note 13, at 529.

250. Exec. Order No. 13,765, 82 Fed. Reg. 8351, 8351 (Jan. 24, 2017); *see also* Complaint for Declaratory and Injunctive Relief ¶ 108, *City of Columbus v. Trump*, No. 1:18-cv-02364-DKC (D. Md. Aug. 2, 2018), 2018 WL 3655066.

251. Laura Litvan (@LauraLitvan), TWITTER (June 23, 2018, 1:04 PM), <https://perma.cc/27Z3-77BA>.

252. *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/Y7JW-BQT8>].

253. *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. 2019), 2019 WL 114796.

254. *See supra* Section III.A.

rules aimed to dissuade immigrants from accessing healthcare, and rules that offer pathways out of the ACA insurance markets and protections.<sup>255</sup>

### 1. Chipping Away at Medicaid

Congress drafted the ACA to make Medicaid expansion mandatory for all states, creating a new federal floor to allow individuals with incomes of up to 138% of the FPL to be eligible for Medicaid in every state.<sup>256</sup> In this way, Congress took a large step toward “universalizing” Medicaid, shifting the program from one based on categorical eligibility and the concept of the “deserving poor” to a program that would cover all low-income Americans based on their socioeconomic status alone.<sup>257</sup> The Supreme Court’s decision in *NFIB* changed that. By in effect transforming Medicaid expansion into a state option to opt out, the Supreme Court not only undermined the universality of the Medicaid expansion as Congress drafted it, but also gave states new leverage in negotiations with the federal government over their Medicaid programs.

The Obama Administration’s goal was to get as many states to expand as possible.<sup>258</sup> Thus, it allowed states to implement their preferred policies by generously approving administrative waivers under section 1115 in exchange for Medicaid expansion.<sup>259</sup> Section 1115 of the Social Security Act, which predates the ACA, gives the Secretary of the Department of Health and Human Services the authority to approve state demonstration projects that “promot[e] the objectives” of the Medicaid program.<sup>260</sup>

To bring states on board, the Obama Administration allowed more conservative states to expand Medicaid in ways not always popular with progressives, including by expanding coverage through premium assistance in the private market rather than with traditional Medicaid, increasing cost-sharing requirements (co-pays) above the levels allowed by the statute, eliminating the requirement to provide nonemergency medical transportation, and instituting lockout periods for nonpayment of premiums.<sup>261</sup> However, the Administration drew the line at partial expansion—it refused to approve waiver requests that would have allowed states failing to cover all individuals under the ACA’s 138% FPL threshold to receive the full financial benefits of the Medicaid expansion<sup>262</sup>—and at work

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255. *Ass’n for Cmty. Affiliated Plans v. U.S. Dep’t of Treasury*, 392 F. Supp. 3d 22 (D.D.C. 2019) (challenging the Short-Term Plans rule), *appeal filed*, No. 19-5212 (D.C. Cir. July 30, 2019); *New York v. Dep’t of Labor*, 363 F. Supp. 3d 109 (D.D.C. 2019) (challenging the Association Health Plans Rule), *appeal filed*, No. 19-5125 (D.C. Cir. Apr. 30, 2019).

256. *See* 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) (2012).

257. Huberfeld, *supra* note 49, at 69, 86.

258. Gluck & Huberfeld, *supra* note 15, at 1734.

259. *Id.*

260. 42 U.S.C. § 1315(a).

261. *See Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KAISER FAMILY FOUND. (Mar. 10, 2020), <https://perma.cc/ZW29-VHXM>.

262. The Obama Administration’s 2012 guidance on this subject (and others) stated that it would consider waivers that included a partial expansion, but only if funded “subject to the regular federal matching rate.” CTR. FOR MEDICARE & MEDICAID SERVS., FREQUENTLY ASKED QUESTIONS ON



requirements, refusing requests from states seeking to add a requirement that non-disabled, non-elderly adult Medicaid recipients work.<sup>263</sup>

The Trump Administration walked into this atmosphere of negotiations and concession-making and went further. Although it has continued to discourage requests for partial expansion,<sup>264</sup> it reversed the longstanding position of the Center for Medicare and Medicaid Services (CMS) that work requirements are impermissible under the Medicaid program.<sup>265</sup>

Just one day after issuing the new guidance, CMS approved Kentucky's section 1115 waiver, which included a work requirement—the first approval of its kind.<sup>266</sup> Individual beneficiaries of Kentucky's Medicaid expansion quickly sued.<sup>267</sup> In June 2018, a federal court in Washington, D.C. found that the approval of the waiver was arbitrary and capricious because the agency failed to adequately consider whether the waiver would actually help furnish medical assistance, Medicaid's core statutory objective.<sup>268</sup>

The agency conducted a new notice and comment period and re-approved Kentucky's waiver.<sup>269</sup> The plaintiffs successfully challenged the re-approval,

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EXCHANGES, MARKET REFORMS AND MEDICAID 11 (2012), <https://www.medicaid.gov/federal-policy-guidance/downloads/FAQ-12-10-2012-Exchanges.pdf> [<https://perma.cc/TT3U-PPDC>].

263. *See, e.g.*, Letter from Vikki Wachino, Dir., Ctr. for Medicare & Medicaid Servs., to Jeffrey A. Myers, Comm'r, N.H. Dep't of Health & Human Servs. (Nov. 1, 2016), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/nh/health-protection-program/nh-health-protection-program-premium-assistance-cms-response-110116.pdf> [<https://perma.cc/6SMY-BFR8>] (denying New Hampshire's request to add a work requirement, which "could undermine access, efficiency, and quality of care provided to Medicaid beneficiaries and [does] not support the objectives of the Medicaid program").

264. *See, e.g.*, Letter from Seema Verma, Adm'r, Ctr. for Medicare & Medicaid Servs., to Gary R. Herbert, Governor of Utah (Aug. 16, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ut/per-capita-cap/ut-per-capita-cap-correspondence-ltr-20190816.pdf> [<https://perma.cc/7A65-7S7P>] (stating that CMS would continue its policy of only granting the enhanced match under the ACA to states that fully expand their Medicaid programs).

265. *See* Letter from Brian Neale, Dir., CMS, to State Medicaid Directors (Jan. 11, 2018), <https://www.medicaid.gov/federal-policy-guidance/downloads/smd18002.pdf> [<https://perma.cc/SQ9W-4VDR>] (issuing new guidance encouraging states to submit waiver requests that would condition Medicaid eligibility for able-bodied adults on completing work or work-related activities). Notably, the guidance followed a year of failed attempts in Congress to repeal and replace the Affordable Care Act that would have created a statutory state option to add work requirements to Medicaid. *See, e.g.*, American Health Care Act of 2017, H.R. 1628, 115th Cong.

266. *See* Letter from Demetrios L. Kouzoukas, CMS Principal Deputy Adm'r, to Stephen P. Miller, Comm'r, Kentucky Cabinet for Health and Family Services (Jan. 12, 2018), <https://khn.org/wp-content/uploads/sites/2/2018/01/kentucky-1115-memo-and-approval-ltr.pdf> [<https://perma.cc/K6EX-J3CG>] (approving Kentucky's section 1115 waiver that included a work requirement.)

267. *See* Class Action Complaint for Declaratory and Injunctive Relief, *Stewart v. Azar*, 308 F. Supp. 3d 239 (D.D.C. 2018), 2018 WL 525491.

268. *Stewart*, 313 F. Supp. 3d 237, *appeal after remand*, 366 F. Supp. 3d 125, 156 (D.D.C. 2019), and *appeal filed*, No. 19-5095 (D.C. Cir. 2019). In particular, CMS failed to consider the impact on coverage despite Kentucky's estimate in its waiver application that 95,000 Kentuckians would lose Medicaid coverage due to the change in policy. *Id.* at 265.

269. *See* Letter from Paul Mango, Chief Principal Deputy Adm'r and Chief of Staff, CMS, to Carol H. Steckel, Comm'r, Ky. Dep't for Medicaid Servs., Cabinet for Health and Family Servs. (Nov. 20, 2018), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ky/ky-health-ca.pdf> [<https://perma.cc/CVD4-4FSW>].

with the judge relying on *NFIB*, of all cases, to hold that providing health coverage to the expansion population is just as much a Medicaid objective as is providing health coverage to the traditional Medicaid population.<sup>270</sup>

On the same day, the same judge also vacated CMS's approval of Arkansas's section 1115 waiver, which similarly included work requirements.<sup>271</sup> Unlike Kentucky's work requirement, which had not yet been implemented before vacatur, Arkansas's had gone into effect beginning in June 2018.<sup>272</sup> By the end of 2018, more than 16,000 Arkansas residents had lost their Medicaid coverage.<sup>273</sup> The same judge vacated the approval of New Hampshire's work requirement in July 2019.<sup>274</sup> A lawsuit was filed challenging Indiana's work requirement in September 2019, and the requirement has been suspended while the dispute is ongoing.<sup>275</sup>

In February 2020, the D.C. Circuit issued a unanimous opinion, written by a noted conservative judge David B. Sentelle, affirming the district court's decision in *Gresham*, the Arkansas case.<sup>276</sup> The court of appeals agreed that it "is indisputably correct that the principal objective of Medicaid is providing health care coverage" and that the Secretary impermissibly disregarded this purpose in his decision to approve the waiver.<sup>277</sup> The same district court vacated the approval of Michigan's work requirement shortly thereafter.<sup>278</sup> As of this Article, CMS has approved work-requirement waivers in ten states and another ten states have work-requirement waivers pending at CMS.<sup>279</sup> However, as of April 2020, no

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270. *Stewart*, 366 F. Supp. 3d at 145, 146–47 (finding the approval arbitrary and capricious and contrary to the Medicaid Act, and once more vacating the approval and remanding to the agency).

271. *Gresham v. Azar*, 363 F. Supp. 3d 165, 185 (D.D.C. 2019), *aff'd*, 950 F.3d 93 (D.C. Cir. 2020).

272. Medicaid beneficiaries between the ages of nineteen and forty-nine had to complete eighty hours of work or approved community engagement activities per month to remain eligible.

273. *Gresham v. Azar*, 363 F. Supp. 3d at 172.

274. *See Philbrick v. Azar*, 397 F. Supp. 3d 11, 16 (D.D.C. 2019), *appeal filed*, 19-5295 (D.C. Cir. 2019).

275. *Rose v. Azar*, No. 1:19-cv-02848 (D.D.C. filed Sept. 23, 2019). Pending resolution of federal lawsuit, FSSA will temporarily suspend Gateway to Work reporting requirements. Press Release, Ind. Family & Soc. Servs. Admin., Pending Resolution of Federal lawsuit, FSSA Will Temporarily Suspend Gateway to Work Reporting Requirements (Oct. 31, 2019) [https://www.in.gov/fssa/files/Gateway\\_to\\_Work\\_suspension\\_announcement.pdf](https://www.in.gov/fssa/files/Gateway_to_Work_suspension_announcement.pdf) [<https://perma.cc/G53N-U7BR>].

276. *Gresham v. Azar*, 950 F.3d 93 (D.C. Cir. 2020). Kentucky had reversed its decision to implement a work requirement following the election of Democratic Governor Andy Beshear in November 2019, thus mooted out the *Stewart* case.

277. *Id.* at 99, 104.

278. *Young v. Azar*, No. 1:19-cv-03526 (D.D.C. Mar. 4, 2020).

279. Maine withdrew its waiver following the election of a Democrat as governor in 2018. Letter from Janet T. Mills, Governor of Me., to Seema Verma, Adm'r, CMS (Jan. 22, 2019), <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/mainecare/me-mainecare-approval-reponse-ltr-01222019.pdf> [<https://perma.cc/WHX7-MMHL>]. On December 12, 2019, CMS approved South Carolina's work-requirement waiver—the first approval of its kind for a state that did not expand Medicaid under the Affordable Care Act. But South Carolina's requirement has not yet been implemented at the time of this Article. Letter from Seema Verma, Adm'r, CMS, to Joshua Baker, Dir., S.C. Dep't of Health & Human Servs. (Dec. 12, 2019) [hereinafter Letter from Seema Verma to Joshua Baker], <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/sc/sc-healthy-connections-works-ca.pdf> [<https://perma.cc/RC6F-733C>].

state had a work requirement currently in force with all having been vacated by a court, suspended by the state, or not yet implemented.<sup>280</sup>

Another percolating issue may be Medicaid block grants, which would convert Medicaid's funding structure into a lump-sum payment to the states, allowing participating states to skirt certain federal Medicaid requirements. In January 2020, CMS issued guidance inviting states to apply for section 1115 waivers using a block-grant or per-capita-cap funding model aimed at the expansion population.<sup>281</sup> Because Medicaid's funding formula is not waivable under section 1115, lawsuits would likely immediately follow any federal approval of this type of waiver.

## 2. Efforts to Undercut Access for Immigrants

The Trump Administration has also sought to limit Medicaid eligibility by discouraging immigrants from accessing health services. In August 2019, the Department of Homeland Security finalized the "public charge" rule, which redefines the term "public charge" in the Immigration and Nationality Act to make the receipt of certain federal benefits, including Medicaid, grounds for denying an immigrant's application for admission or a green card.<sup>282</sup> Twenty-two states and local governments, in addition to several advocacy groups, challenged the rule in at least nine separate lawsuits.<sup>283</sup> The plaintiffs variously argued that the rule was arbitrary and capricious in violation of the APA, discriminated against those with disabilities<sup>284</sup> in violation of the Rehabilitation Act of 1973, and violated the Equal Protection Clause.<sup>285</sup> Before the rule went into effect, five district

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280. Utah, the only state with a remaining active work requirement as of April 2020, suspended its work requirement due to the COVID-19 pandemic. Harris Meyer, *Utah Suspends Medicaid Work Requirement Due to COVID-19*, MOD. HEALTHCARE (Apr. 2, 2020, 2:05 PM), <https://www.modernhealthcare.com/medicaid/utah-suspends-medicaid-work-requirement-due-covid-19>.

In March 2020 in response to the COVID-19 pandemic, Congress passed the Families First Coronavirus Response Act, which included a maintenance-of-effort requirement that forbids states from making Medicaid eligibility more stringent than it was in January 2020 if they accepted the Act's enhanced federal Medicaid funding. Pub. L. No. 116-127, § 6008(b), 134 Stat. 178, 208–09 (2020).

281. Letter from Calder Lynch, Dir., Ctrs. for Medicaid & Medicare Servs., to State Medicaid Director (Jan. 30, 2020), <https://www.medicaid.gov/sites/default/files/Federal-Policy-Guidance/Downloads/smd20001.pdf> [<https://perma.cc/G4FF-VBQK>].

282. See Inadmissibility on Public Charge Grounds, 84 Fed. Reg. 41,292 (Aug. 14, 2019) (to be codified in scattered sections of 8 C.F.R.).

283. Wendy E. Parmet, *Five Victories for Public Health: Courts Enjoin the Public Charge Rule*, HEALTH AFF. BLOG (Oct. 18, 2019), <https://www.healthaffairs.org/doi/10.1377/hblog20191018.747447/full/> [<https://perma.cc/V3X4-5TFM>].

284. The Rule's new criteria are so broad that they will exclude some persons with significant disabilities solely on that basis. In addition to the already-existing health criteria, the Rule now requires immigration officials to consider whether the applicant "has any physical or mental condition . . . significant enough to interfere with the person's ability to care for himself or herself." Inadmissibility on Public Charge Grounds, 84 Fed. Reg. at 41,407 (footnote omitted).

285. See, e.g., Complaint ¶¶ 7, 23, 281–305, 338–43, *California v. Dep't of Homeland Sec.*, No. 19-cv-04975 (N.D. Cal. Aug. 16, 2019); Complaint ¶¶ 9, 297, *New York v. Dep't of Homeland Sec.*, 408 F. Supp. 3d 334 (S.D.N.Y. 2019).

courts issued preliminary injunctions, three of which applied nationwide.<sup>286</sup>

The rule also raises concerns about chilling immigrants from applying for and receiving healthcare benefits for which they and their children are eligible.<sup>287</sup> If immigrant and mixed-status families disenroll from healthcare programs like Medicaid due to the new rule, this could undermine much of the progress made since the ACA in decreasing the rate of uninsured, especially for children.<sup>288</sup>

The cases proceeded to appeal and on January 27, 2020, the Supreme Court stayed the Southern District of New York's nationwide injunction against the public charge rule and thus, allowed the rule to go into effect while the litigation proceeds.<sup>289</sup> Due to the COVID-19 pandemic, in March 2020 the Department of Homeland Security announced it would suspend enforcement of the healthcare aspects of the rule for an undetermined period of time.<sup>290</sup>

Another recent attempt to use the healthcare system to restrict legal immigration was the "Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System," issued on October 4, 2019.<sup>291</sup> The Proclamation moves beyond the Medicaid population targeted by the public charge rule to also bar immigrants receiving ACA insurance subsidies on the exchanges from entering the country.<sup>292</sup> At the same time, the Proclamation seeks to require legal immigrants to obtain health

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286. See, e.g., *Casa de Md., Inc. v. Trump*, 8:19-cv-02715-PWG, slip op. at 1–2 (D. Md. Oct. 14, 2019) (granting a nationwide preliminary injunction); *Cook County v. McAleenan*, 19-cv-06334, slip op. at 1–2 (N.D. Ill. Oct. 14, 2019) (granting a preliminary injunction); *Washington v. Dep't of Homeland Sec.*, No. 4:19-cv-05210-RMP, slip op. at 2 (E.D. Wash. Oct. 11, 2019) (granting a nationwide preliminary injunction); *City & County of San Francisco v. U.S. Citizenship & Immigration Servs.*, No. 19-cv-04717-PJH, slip op. at 1–2 (N.D. Cal. Oct. 11, 2019); *New York v. Dep't of Homeland Sec.*, No. 1:19-cv-07777-GBD, slip op. at 3 (S.D.N.Y. Oct. 11, 2019) (granting a nationwide preliminary injunction).

The plaintiffs argued that the Administration's revised definition of the term "public charge" was inconsistent with the term's longstanding definition: an individual who is likely to become primarily and permanently dependent on the government for subsistence rather than someone who is temporarily in need of aid. The plaintiffs also argued that DHS failed to adequately consider the costs and benefits of the revised definition also rendering the rule arbitrary and capricious under the APA.

287. See *City & County of San Francisco v. U.S. Citizenship & Immigration Servs.*, No. 4:19-cv-04975-PJH, slip op. at 4 n.1 ("When plaintiffs refer to harms caused by those who will disenroll from public benefits in addition to those who will forego enrollment. This order considers the two categories together, and refers to them interchangeably.").

288. See *Washington v. Dep't of Homeland Sec.*, No. 4:19-cv-05210-RMP, slip op. at 17.

289. *Dep't of Homeland Security v. New York*, 140 S. Ct. 599 (2020) (mem.) (order on application for a stay). The Supreme Court also stayed the Illinois-specific injunction. *Wolf v. Cook County*, 140 S. Ct. 681 (2020) (mem.) (order on application for a stay).

290. Public Charge, U.S. CITIZENSHIP & IMMIGRATION SERVS., <https://www.uscis.gov/greencard/public-charge> [<https://perma.cc/9E7U-FXDP>] (last updated Mar. 27, 2020).

291. President Donald J. Trump, *Presidential Proclamation on the Suspension of Entry of Immigrants Who Will Financially Burden the United States Healthcare System*, WHITE HOUSE (Oct 4, 2019), <https://www.whitehouse.gov/presidential-actions/presidential-proclamation-suspension-entry-immigrants-will-financially-burden-united-states-healthcare-system> [<https://perma.cc/PTP9-NXMN>].

292. See *id.* Specifically, the Proclamation bars those who were going to rely on "health plan[s] offered in the individual market within a State" from entering unless those plans were "unsubsidized." *Id.*

insurance within thirty days of entering the country.<sup>293</sup> A federal district court in Oregon stopped the rule from going into effect by granting a nationwide TRO<sup>294</sup> and a subsequent nationwide injunction.<sup>295</sup> In its order, the court noted that “[t]he ACA is . . . explicit in its support of legal immigrants, affirmatively allowing newly arrived legal immigrants to use premium tax credits to buy insurance offered on [exchanges].”<sup>296</sup> The government appealed.<sup>297</sup>

These efforts, like the Medicaid work-requirement cases, have an undercurrent that is at odds with the ACA’s core principle of universal coverage and its norm of solidarity. All of these actions look to reinstate an individual “merit” model and the concept of the “deserving poor”—the notion that only some categories of individuals, for example, citizens or those who work, should receive government benefits.

### 3. Efforts to Disrupt the Risk Pool

*NFIB* was, at bottom, a case about the insurance risk pool. The risk pool concept is central to the ACA because it helps to finance the significant new requirements that the ACA imposes on insurers. To make its new insurance rules financially viable, the ACA expands the insurance market—bringing healthy individuals into the insurance pool to both spread risk and bring additional revenue to insurers who now bear more risk than before.

The insurance mandate at issue in *NFIB* was about this principle—whether unwilling individuals could be prompted to be part of a region-wide risk pool, on pain of paying a tax penalty if they refused to maintain minimum essential coverage. Other early efforts to police the boundaries of the primary risk pool include the Obama Administration’s unsuccessful attempts to discourage people from signing up for fixed indemnity plans.<sup>298</sup> On the other hand, the Obama Administration did undermine the risk pool somewhat by “grandmothering” exemptions for some plans that had been in effect at the time of the ACA’s passage<sup>299</sup> (the result of President Obama’s infamous promise: “[i]f you like your

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293. *Id.*

294. *See Doe #1 v. Trump*, 414 F. Supp. 3d 1307 (D. Or. 2019).

295. *See Doe #1 v. Trump*, 418 F. Supp. 3d 573 (D. Or. 2019).

296. *Id.* at 581–82.

297. *See Doe #1 v. Trump*, 944 F.3d 1222 (9th Cir. 2019) (denying stay pending appeal).

298. *See, e.g., Cent. United Life, Inc. v. Burwell*, 128 F. Supp. 3d 321, 323 (D.D.C. 2015) (enjoining enforcement of an HHS rule that barred fixed indemnity plan sellers from “selling . . . to individual consumers unless those consumers certify[ed] that they ha[d] ‘minimum essential coverage’ under the Affordable Care Act”), *aff d sub nom. Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70 (D.C. Cir. 2016).

299. These Obama Administration exemptions are called transitional plans, and at least one court has referred to them as the “Administrative Fix.” *See West Virginia v. U.S. Dep’t of Health & Human Servs.*, 145 F. Supp. 3d 94, 96 (D.D.C. 2015), *aff d sub nom. West Virginia ex rel. Morrissey v. U.S. Dep’t of Health & Human Servs.*, 827 F.3d 81 (D.C. Cir. 2016). Courts dismissed the two principal challenges for lack of standing. *See West Virginia v. U.S. Dep’t of Health & Human Servs.*, 145 F. Supp. 3d at 105, 110–11; *Am. Freedom Law Ctr. v. Obama*, 106 F. Supp. 3d 104, 112 (D.D.C. 2015), *aff d*, 821 F.3d 44 (D.C. Cir. 2016).

health care plan, you'll be able to keep [it].").<sup>300</sup>

The Trump Administration has imposed new policies to further split and undermine the pool. First, the Administration issued a rule that would expand the category of eligible employers who are authorized to sponsor Association Health Plans (AHPs), which under the ERISA statute are exempt from important ACA consumer protections including the essential-health-benefits requirement.<sup>301</sup> Under prior rules, associations of employers had to consist of bona fide employers with a commonality of interest beyond simply offering insurance for employees, and participating employers had to actually be employers, not simply one-person businesses. Under the new rule, an expanded universe of loosely connected individuals could form AHPs and by doing so, avoid ACA protections. Eleven states and the District of Columbia sued over the new rules and won in federal district court in 2019.<sup>302</sup> The court found the rule to be an intentional “end-run around the ACA” and also a violation of ERISA.<sup>303</sup> The case is currently on appeal, where a major issue will be how much discretion a federal agency has to set—and change—policy in this area.

A second similar attempt involved “short-term, limited duration” plans.<sup>304</sup> Under the ACA, everyone is required to obtain minimum essential coverage, which includes individual health insurance coverage. However, the ACA carries forward the definition of “individual health insurance coverage” from the 1996 HIPAA law,<sup>305</sup> which definition did not include short-term, limited duration insurance.<sup>306</sup> The Obama Administration interpreted short-term limited duration insurance to mean insurance coverage that would be in effect for no more than three months,<sup>307</sup> relying in part on an exception in the individual mandate statute for “short coverage gaps.”<sup>308</sup> In 2018, the Trump Administration changed course and adopted rules that would allow short-term, limited duration plans that do not have to comply with many ACA consumer protections like essential health

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300. *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 Mar. 26, 2020).

301. Definition of “Employer” Under Section 3(5) of ERISA—Association Health Plans, 83 Fed. Reg. 28,912 (June 21, 2018) (to be codified at 29 C.F.R. pt. 2510).

302. *New York v. U.S. Dep't of Labor*, 363 F. Supp. 3d 109, 116–17, 141 (D.D.C. 2019), *appeal filed*, No. 19-5125 (D.C. Cir. Apr. 30, 2019). It reasoned the rule would “allow[] virtually any association of disparate employers connected by geographic proximity to qualify” and that an association could “form solely for the purpose of creating an AHP.” *Id.* at 117.

303. *Id.*

304. *See Ass'n for Cmty. Affiliated Plans v. U.S. Dep't of Treasury*, 392 F. Supp. 3d 22, 25 (D.D.C. 2019), *appeal filed*, No. 19-5212 (D.C. Cir. July 30, 2019).

305. *See* 42 U.S.C. § 300gg-91(b)(5) (2012) (“The term ‘individual health insurance coverage’ means health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.”).

306. *See* 26 U.S.C. § 5000A(e)(4) (2017).

307. *See* Excepted Benefits; Lifetime and Annual Limits; and Short-Term, Limited-Duration Insurance, 81 Fed. Reg. 75,316, 75,317–18 (Oct. 31, 2016) (to be codified at 45 C.F.R. pts. 144, 146, 147, and 148).

308. *See* 26 U.S.C. § 5000A(e)(4).

benefits to continue for 364 days and to be renewable or extendable for a total of three years.<sup>309</sup>

Organizations that included a nonprofit insurer, a health-professional organization, and consumer advocacy groups sued to challenge the rule. They lost in the district court, which held that the Trump Administration's interpretation deserved deference under the *Chevron* rule—the important Supreme Court precedent requiring deference to reasonable agency interpretations of ambiguous statutes.<sup>310</sup> The appeal was heard by the D.C. Circuit in March 2020.

In addition to bringing challenges to these rules under the APA and as in violation of the ACA, cities brought a constitutional claim against the President. Specifically, they argued that President Trump's expressed, intentional Executive sabotage of the ACA violates the Take Care Clause of the Constitution, which directs the President to "take Care that the Laws be faithfully executed."<sup>311</sup> Although the Take Care Clause is rarely invoked because the President enjoys enormous implementation and enforcement discretion, the cities argued that the ACA story offers the extreme case: that President Trump has made no pretense of engaging in good faith implementation and so if there is any action that could ever violate the Take Care Clause, the kind of intentional sabotaging in which the President is engaged with respect to the ACA satisfies that standard.<sup>312</sup> In April 2020, the district court refused to let the Take Care claim go forward but did not dismiss the rest of the case.<sup>313</sup>

Finally, the Trump Administration has considered using waivers to undercut private insurance. In fall 2018, it published guidance stating that as long as one of several plans an insurer offers includes the full ACA scope of coverage—for example, essential health benefits—the Administration could grant a section 1332 waiver under the ACA (the ACA waiver section with parallels to section 1115 waivers under Medicaid<sup>314</sup>) for plans to be offered that provide less-than-full coverage. If such waivers are granted, more court challenges may follow.

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309. See Short-Term, Limited-Duration Insurance, 83 Fed. Reg. 38,212, 38,214–15 (Aug. 3, 2018) (to be codified at 45 C.F.R. pts. 144, 146, 148). The rule would also make these plans stackable, meaning they could last even beyond three years.

310. See *Ass'n for Cmty. Affiliated Plans*, 392 F. Supp. 3d at 41–42, 44–45.

311. See U.S. CONST. art. II, § 3; Complaint for Declaratory and Injunctive Relief, *City of Columbus v. Trump*, *supra* note 250, ¶¶ 1–5.

312. See U.S. CONST. art. II, § 3; Plaintiffs' Opposition to Defendants' Motion to Dismiss Plaintiffs' Amended Complaint at 49–68, *City of Columbus v. Trump*, No. 18-cv-2364 (D. Md. May 31, 2019), 2019 WL 2526482.

313. *City of Columbus v. Trump*, No. DKC-18-2364, slip op. at 58–67 (D. Md. Apr. 10, 2020).

314. Section 1115 waivers and 1332 waivers are not precisely parallel. Among other things, section 1332 waivers neither have to satisfy a test for promoting the objectives of the Act, 42 U.S.C. § 1315(a) (2012), nor do they need to be phrased in terms of experimental protocols. *Id.* However, they do have to satisfy four federal guardrails, 42 U.S.C. § 18052(b)(1)(A)–(D), the first of which requires that coverage be at least as comprehensive as coverage under the ACA absent the 1332 state innovation waiver, 42 U.S.C. § 18052(b)(1)(A).

## IV. ALMOST 2,000 OTHER FEDERAL AND STATE CHALLENGES

Apart from the cases we have discussed, a staggering 1,700-plus cases involving the ACA have been heard by the federal courts, more than 300 of which have come before the federal courts of appeals. These cases not only challenge the law, but they also invoke rights under it and contest administrative enforcement of it. They also include individual challenges and challenges to state implementation decisions. Another several hundred have been brought in the state courts, the most significant of which involve intragovernmental disputes within states over how or whether to implement the ACA. Although we cannot possibly digest all of those cases here, we offer some broad strokes to help paint the picture.

## A. ENFORCING NEW RIGHTS UNDER THE ACA

One set of cases aims to enforce new benefits and obligations provided by the ACA. For example, several cases in the courts of appeals concern the changes the ACA made to survivorship benefits for coal miners' widows under the Black Lung Benefits Act.<sup>315</sup> Another group of cases concerns the ACA's amendments to Medicare's payments to teaching hospitals for residents.<sup>316</sup> Other cases concern the ACA's amendments to the False Claims Act and other issues surrounding healthcare fraud.<sup>317</sup> The Federal Trade Commission recently brought a case to enforce the ACA against a healthcare indemnity provider for engaging in deceptive trade practices in which the provider sold indemnity plans under the false pretense that the plans offered comprehensive coverage and were in compliance with the ACA.<sup>318</sup>

## B. MORE CHALLENGES TO ADMINISTRATIVE ACTION IMPLEMENTING THE ACA

There are more cases challenging the Trump Administration's regulations, too. One set of cases challenges the Administration's new Title X rule—the so-called “gag rule”—which imposes additional restrictions on providers in the Title X

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315. *See, e.g.*, *W. Va. CWP Fund v. Bender*, 782 F.3d 129 (4th Cir. 2015); *Peabody Coal Co. v. Dir., Office of Workers' Comp. Programs*, 577 F. App'x 469 (6th Cir. 2014); *Jim Walter Res., Inc. v. Dir., Office of Workers' Comp. Programs*, 766 F.3d 1333 (11th Cir. 2014); *E. Associated Coal Co. v. Dir., Office of Workers' Comp. Programs*, 578 F. App'x 165 (4th Cir. 2014); *Westmoreland Coal Co. v. Dir., Office of Workers' Comp. Programs*, 540 F. App'x 152 (4th Cir. 2013); *Mountaineer Coal Dev. Co. v. Dingess*, 538 F. App'x 367 (4th Cir. 2013); *Marmon Coal Co. v. Dir., Office of Workers' Comp. Programs*, 726 F.3d 387 (3d Cir. 2013); *U.S. Steel Mining Co., LLC v. Dir., OWCP*, 719 F.3d 1275 (11th Cir. 2013); *Harlan-Cumberland Coal Co. v. Farmer*, 518 F. App'x 445 (6th Cir. 2013); *Vision Processing, LLC v. Groves*, 705 F.3d 551 (6th Cir. 2013); *Helen Mining Co. v. Fairman*, 490 F. App'x 459 (3d Cir. 2012); *B & G Constr. Co. v. Dir., Office of Workers' Comp. Programs*, 662 F.3d 233 (3d Cir. 2011); *Morrison v. Tenn. Consol. Coal Co.*, 644 F.3d 473 (6th Cir. 2011).

316. *See Covenant Med. Ctr., Inc. v. Burwell*, 603 F. App'x 360 (6th Cir. 2015); *Rush Univ. Med. Ctr. v. Burwell*, 763 F.3d 754 (7th Cir. 2014); *Henry Ford Health Sys. v. Dep't of Health & Human Servs.*, 654 F.3d 660 (6th Cir. 2011).

317. *See, e.g.*, *United States v. Dehaan*, 896 F.3d 798, 804 (7th Cir. 2018); *Cooper v. Pottstown Hosp. Co. LLC*, 651 F. App'x 114, 115 (3d Cir. 2016).

318. *FTC v. Simple Health Plans LLC*, 379 F. Supp. 3d 1346, 1352, 1354 (S.D. Fla. 2019), *appeal filed*, *FTC v. Dorfman*, No. 19-11932 (11th Cir. May 15, 2019).



family-planning program.<sup>319</sup> The challengers rely in part on section 1554 of the ACA, the “noninterference mandate,” which prevents HHS from issuing any rule that interferes with the patient–provider relationship.<sup>320</sup> The first Bush Administration promulgated a similar gag rule, which the Court upheld in 1991 in *Rust v. Sullivan*.<sup>321</sup> The Clinton Administration immediately withdrew the rule.<sup>322</sup> A question now raised is whether the ACA—with its prohibitions on creating unreasonable barriers to healthcare access and on interfering with patient–provider communications about a full range of treatment options in section 1554—has superseded or undermined *Rust*, and thus prevents the rule from being reimposed. Several district courts have taken this position,<sup>323</sup> but the Fourth Circuit (a panel) and the Ninth Circuit (a panel and en banc) disagreed.<sup>324</sup> As of April 2020, an injunction was in place for the state of Maryland, but the rule was in effect everywhere else.<sup>325</sup>

In another challenge to the Trump Administration’s healthcare regulations, hospitals have sued HHS over its new rule requiring hospitals to disclose publicly the prices they pay to different payers.<sup>326</sup> The hospitals argue that the Final Rule<sup>327</sup> falls outside of the standard charges they are required to disclose under section 2718(e) of the ACA and thus is not within the agency’s statutory authority.<sup>328</sup> States have also challenged the Trump Administration’s rule requiring insurance plans that include abortion coverage to send separate bills and

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319. See *California by and through Becerra v. Azar*, 927 F.3d 1068 (9th Cir. 2019) (granting a motion for a stay pending appeal after district courts in California, Oregon, and Washington granted preliminary injunctions to prevent the Trump Administration’s Title X rule), *reh’g en banc granted*, 927 F.3d 1045 (9th Cir. 2019) (mem.), *vacated*, 950 F.3d 1067 (9th Cir. 2020); *Mayor of Baltimore v. Azar*, 392 F. Supp. 3d 602 (D. Md. 2019).

320. See *California by and through Becerra*, 927 F.3d at 1075–76; *Mayor of Baltimore*, 392 F. Supp. 3d at 615.

321. 500 U.S. 173, 203 (1991).

322. The Title X “Gag Rule,” 58 Fed. Reg. 7455 (Feb. 5, 1993) (President Clinton directing his Secretary of Health and Human Services to “suspend the Gag Rule pending the promulgation of new regulations in accordance” with the APA).

323. *Mayor of Baltimore v. Azar*, 392 F. Supp. 3d 602, 617 (D. Md. 2019); *Oregon v. Azar*, 389 F. Supp. 3d 898, 920 (D. Or. 2019); *California by and through Becerra*, 385 F. Supp. 3d at 1022; *Washington v. Azar*, 376 F. Supp. 3d 1119, 1132 (E.D. Wash. 2019).

324. *California ex rel. Becerra v. Azar*, 928 F.3d 1153, 1155 (9th Cir. 2019) (en banc) (denying emergency motions for a stay of the panel decision allowing the rule to go into effect); *Mayor of Baltimore v. Azar*, 778 F. App’x 212 (4th Cir. 2019) (mem.) (granting stay).

325. *Mayor of Baltimore v. Azar*, No. CV RDB-19-1103, 2020 WL 1043728 (D. Md. Mar. 4, 2020) (enjoining the rule in the state of Maryland on the grounds that the rule was arbitrary and capricious in violation of the APA). The Fourth Circuit en banc denied the government’s motion to stay the district court’s permanent injunction and granted the plaintiffs’ request for an initial hearing en banc. *Mayor of Baltimore v. Azar*, No. 19-1614, 2020 WL 1514779 (4th Cir. Mar. 27, 2020).

326. Complaint ¶¶ 3–4, *Am. Hosp. Ass’n v. Azar*, No. 1:19-cv-3619, 2019 WL 6534522 (D.D.C. Dec. 4, 2019).

327. *Medicare and Medicaid Programs: CY 2020 Hospital Outpatient PPS Policy Changes and Payment Rates and Ambulatory Surgical Center Payment System Policy Changes and Payment Rates. Price Transparency Requirements for Hospitals To Make Standard Charges Public*, 84 Fed. Reg. 65,524 (Nov. 27, 2019) (to be codified at 45 C.F.R. subchap. E).

328. Complaint, *Am. Hosp. Ass’n v. Azar*, *supra* note 326, ¶¶ 5, 40–51.

collect separate payments for the portion of a premium attributable to that coverage.<sup>329</sup> The first district court decision in these cases, in March 2020, invalidated the rule as “hav[ing]e little to do with providing efficient and effective medical coverage and everything to do with trying to prevent Washington’s State recognition of a women’s right to access safe and legal abortions.”<sup>330</sup>

Over the years, health insurance industry stakeholders have filed several lawsuits challenging other aspects of HHS’s implementing regulations and rules. The pharmaceutical industry’s trade group challenged HHS’s interpretation of the ACA’s changes to two important federal laws regarding prescription drugs, the 340B program and the Orphan Drug Act focusing on circumstances in which an orphan drug (a drug used to “treat rare diseases or conditions”) must be offered at a discount price under the Public Health Service Act.<sup>331</sup> Insurers offering fixed indemnity policies successfully sued to challenge HHS’s regulation that limited the sale of these policies to those who already had minimum essential coverage under the ACA.<sup>332</sup> Insurers also unsuccessfully challenged the charge imposed on them by the Exchange for the District of Columbia in order to fund the exchange,<sup>333</sup> and providers unsuccessfully challenged the ACA’s changes to Medicare billing.<sup>334</sup>

Challenges to the Obama Administration’s grandmothing policies (“[i]f you like your health care plan, you’ll be able to keep [it]”<sup>335</sup>) were unsuccessful.<sup>336</sup> Another case involved Obama Administration regulations on payments to out-of-network emergency physicians; the parties settled after it was remanded for further consideration.<sup>337</sup> A challenge to the Medicare Independent Payment Advisory Board (IPAB)—the commission charged with keeping Medicare

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329. Patient Protection and Affordable Care Act; Exchange Program Integrity, 84 Fed. Reg. 71,674 (December 27, 2019) (to be codified at 45 C.F.R. pt. 155, 156). The states argue that the rule penalizes states that choose to offer plans including coverage for abortion, has the potential to confuse consumers and result in the termination of their coverage, and violates sections 1554, 1557, and 1303 of the ACA, which represent a legislative compromise between federal restrictions on funding for abortion and access to reproductive healthcare. Complaint ¶¶ 7–8, *California v. U.S. Dep’t of Health & Human Servs.*, No. 3:20-cv-00682-LB (N.D. Cal. Jan. 30, 2020).

330. *Washington v. Azar*, No. 4:20-cv-00047-SAB, slip op. at 11–12 (E.D. Wash. Apr. 10, 2020).

331. *Pharm. Research & Mfrs. of Am. v. U.S. Dep’t of Health & Human Servs.*, 138 F. Supp. 3d 31, 32, 34 (D.D.C. 2015).

332. *Cent. United Life Ins. Co. v. Burwell*, 827 F.3d 70, 72–73 (D.C. Cir. 2016).

333. *Am. Council of Life Insurers v. D.C. Health Benefit Exch. Auth.*, 815 F.3d 17, 18–19 (D.C. Cir. 2016).

334. *Ass’n of Am. Physicians & Surgeons, Inc. v. Sebelius*, 901 F. Supp. 2d 19, 26–27 (D.D.C. 2012), *aff’d sub nom. Ass’n of Am. Physicians & Surgeons v. Sebelius*, 746 F.3d 468 (D.C. Cir. 2014). This case also included constitutional challenges based on the Origination Clause and the Takings Clause. *Id.* at 37–38.

335. *See Obama: ‘If You Like Your Health Care Plan, You’ll Be Able to Keep Your Health Care Plan,’ supra* note 300.

336. *See, e.g., West Virginia v. U.S. Dep’t of Health & Human Servs.*, 145 F. Supp. 3d 94 (D.D.C. 2015), *aff’d sub nom. West Virginia ex rel. Morrissey v. U.S. Dep’t of Health & Human Servs.*, 827 F.3d 81 (D.C. Cir. 2016); *Am. Freedom Law Ctr. v. Obama*, 106 F. Supp. 3d 104 (D.D.C. 2015), *aff’d*, 821 F.3d 44 (D.C. Cir. 2016).

337. *Am. Coll. of Emergency Physicians v. Price*, 264 F. Supp. 3d 89, 90–91 (D.D.C. 2017).

spending under specified growth levels—was dismissed as unripe<sup>338</sup> and Congress eventually abolished the IPAB in the 2018 budget agreement.<sup>339</sup> Senator Ron Johnson and members of his staff unsuccessfully challenged OPM's rule implementing the ACA provision that requires members of Congress and their staff to obtain health insurance through the exchange.<sup>340</sup>

Additional challenges brought by states include, among others, a challenge to HHS's certification rule, which required states to pay the ACA's health insurance provider fee.<sup>341</sup> Maine brought a lawsuit challenging the ACA's Medicaid maintenance-of-effort requirement, which required states to maintain their levels of Medicaid eligibility for children for a set period following the ACA's enactment.<sup>342</sup> Ohio challenged the application of the transitional reinsurance program and the associated fees to health plans for state employees.<sup>343</sup> Nonprofit-organization plaintiffs challenged Missouri's state law restricting navigators (outreach officials who help match individuals to insurance plans).<sup>344</sup> Finally, physicians opposed to Vermont's law requiring them to disseminate information regarding physician-assisted suicide sued, relying on the ACA provision prohibiting state agencies from discriminating against those who object to physician-assisted suicide.<sup>345</sup>

### C. INDIVIDUAL SUITS

Individual plaintiffs have filed other lawsuits. One suit was a challenge to the individual mandate's religious exemption as violating the Establishment Clause, as well as a challenge to the transitional-policy requirement as violating the Equal Protection Clause.<sup>346</sup> A group of enrollees brought a lawsuit claiming that their insurer violated the medical loss ratio (MLR) provision of the ACA—the provision that requires insurers to spend at least 80 or 85%, depending on the plan, of premium dollars on medical care and issue rebates to consumers if the percentage spent on medical care falls below that threshold—by miscalculating the MLR.<sup>347</sup> Plaintiffs also have filed cases challenging insurers' lack of adequate coverage for lactation services in violation of the ACA.<sup>348</sup>

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338. *Coons v. Lew*, 762 F.3d 891, 900–01 (9th Cir. 2014).

339. Margot Sanger-Katz, *Another of Obamacare's Unloved Provisions Is Gone*, N.Y. TIMES (Feb. 9, 2018), <https://www.nytimes.com/2018/02/09/upshot/obamacare-ipab-medicare-congress.html>.

340. *Johnson v. U.S. Office of Pers. Mgmt.*, 783 F.3d 655, 658 (7th Cir. 2015).

341. *See Texas v. United States*, 336 F. Supp. 3d 664, 667 (N.D. Tex. 2018).

342. *See Mayhew v. Burwell*, 772 F.3d 80, 82–83 (1st Cir. 2014).

343. *Ohio v. United States*, 154 F. Supp. 3d 621, 632 (S.D. Ohio 2016), *aff'd*, 849 F.3d 313 (6th Cir. 2017).

344. *St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1019–20 (8th Cir. 2015).

345. *Vt. All. for Ethical Healthcare, Inc. v. Hoser*, 274 F. Supp. 3d 227, 232 (D. Vt. 2017), *appeal dismissed sub nom. Vt. All. for Ethical Healthcare, Inc. v. van de Ven*, No. 17-1481, 2017 WL 3429397 (2d Cir. May 22, 2017).

346. *Cutler v. U.S. Dep't of Health & Human Servs.*, 797 F.3d 1173, 1175 (D.C. Cir. 2015). The plaintiff objected to the individual mandate for personal reasons rather than religious reasons. *Id.*

347. *See Morris v. Cal. Physicians' Serv.*, 918 F.3d 1011, 1012–13, 1017 (9th Cir. 2019).

348. *See Briscoe v. Health Care Serv. Corp.*, 281 F. Supp. 3d 725, 728–29 (N.D. Ill. 2017); *Condry v. UnitedHealth Grp., Inc.*, No. 17-cv-00183-VC, 2017 WL 7420997, at \*1–2 (N.D. Cal. Aug. 15, 2017);

There also have been some additional cases involving the employer mandate. With respect to where the employer mandate applies and how it works, a federal district court in Wyoming held that it applies to tribal enterprises,<sup>349</sup> while a federal district court in New York held that employees whose hours were being artificially held below the thirty-hours-per-week threshold could pursue claims against their employer.<sup>350</sup> The Obama Administration had delayed immediate imposition of the employer mandate, and that prompted legal challenges too. The courts, however, found that the litigants lacked standing to challenge the delay and so the issue was never heard on the merits.<sup>351</sup>

D. CHALLENGES TO ASPECTS OF STATE IMPLEMENTATION OF THE ACA OR EFFORTS TO REGULATE ALONGSIDE THE ACA

Other lawsuits involve the relationship between the ACA and the states. In 2015, a group of states sued—again before Judge O’Connor in Texas—to challenge the ACA’s Health Insurance Providers Fee, and an HHS rule requiring that contributions by state Medicaid managed-care plans toward that fee be assessed with reference to standards set by the Actuarial Standards Board, a private entity.<sup>352</sup> The court agreed with the challengers on their claim that the rule violated the nondelegation doctrine, impermissibly giving control of decisions as to who would pay the ACA’s health insurance providers fee to this private organization.<sup>353</sup> The case is unusual because most nondelegation cases are about statutes that do not adequately guide agency discretion; nondelegation cases about agency regulations are rare. The appeal was pending at the time of this Article.

One important case that made it to the Supreme Court involved the potential intersection of the ACA, ERISA, and state regulation. In trying to rationalize healthcare at the state level, Vermont required all insurers and insurer-equivalents to report payment information to an all-payer state database. In *Gobeille v. Liberty Mutual Insurance Co.*, the Court held that the ERISA statute, which governs employee benefit plans and continues to do so despite the ACA’s reforms to employer-sponsored insurance, preempted Vermont’s all-payer database law for all insurers.<sup>354</sup> The Court expressly declined to

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Ferrer v. CareFirst, Inc., 265 F. Supp. 3d 50, 51–52 (D.D.C. 2017), *reconsideration denied*, 278 F. Supp. 3d 330 (D.D.C. 2017).

349. N. Arapaho Tribe v. Burwell, 118 F. Supp. 3d 1264, 1269–70 (D. Wyo. 2015), *appeal filed sub nom.* N. Arapaho Tribe v. Azar, No. 15-8099 (10th Cir. Aug. 28, 2015), *appeal dismissed*, No. 15-8099 (10th Cir. Mar. 4, 2019).

350. Marin v. Dave & Buster’s, Inc., 159 F. Supp. 3d 460, 461 (S.D.N.Y. 2016). The parties settled in 2019. See Perry Cooper, *Dave & Buster’s \$7.4M Health Coverage Class Deal Wins Final Nod*, BLOOMBERG LAW (July 22, 2019, 12:37 PM), [https://news.bloomberglaw.com/class-action/dave-busters-7-4m-health-coverage-class-deal-wins-final-nod?utm\\_source=rss&utm\\_medium=CLNW&utm\\_campaign=0000016c-1a78-dd4e-a36c-5f78fa960001](https://news.bloomberglaw.com/class-action/dave-busters-7-4m-health-coverage-class-deal-wins-final-nod?utm_source=rss&utm_medium=CLNW&utm_campaign=0000016c-1a78-dd4e-a36c-5f78fa960001).

351. See *Kawa Orthodontics, LLP v. Sec’y, U.S. Dep’t of Treasury*, 773 F.3d 243, 248 (11th Cir. 2014); *Ass’n of Am. Physicians & Surgeons v. Koskinen*, 768 F.3d 640, 642–43 (7th Cir. 2014).

352. *Texas v. United States*, 300 F. Supp. 3d 810 (N.D. Tex. 2018), *appeal filed*, No. 18-10545 (5th Cir. May 7, 2018).

353. *Id.* at 846–48.

354. 136 S. Ct. 936, 947 (2016).

address whether the ACA itself also preempted—or saved—state reporting requirements, so the question remains open.<sup>355</sup>

E. STATE COURT CASES: INTRAGOVERNMENTAL DISPUTES AND MORE

The state courts appear to have seen about 200 ACA-related cases, many of which involve the statute only tangentially. One important set of cases involves the *intragovernmental* disputes generated by political divisions over the ACA and the Supreme Court's decision in *NFIB*. By allowing states to choose whether to opt out of the ACA's Medicaid expansion, *NFIB* set the stage for legal disputes *within* state governments over whether or not to expand. In many states, the governor and legislature disagreed over Medicaid expansion, even in states like Ohio and Arizona that had both a Republican legislature and governor.<sup>356</sup> In Alaska, Ohio, and Kentucky, legislators argued that the governor impermissibly accepted federal funds for Medicaid expansion without the legislature's agreement.<sup>357</sup> Courts mostly upheld the processes those states used to expand Medicaid, even when governors acted on their own in the face of opposition in state legislatures.<sup>358</sup> In North Carolina, legislators successfully sued to keep the governor from submitting a Medicaid state-plan amendment implementing the expansion.<sup>359</sup> In Arizona, legislators asserted that fees assessed against providers—necessary components of Arizona's expansion financing—were really taxes that should not have been adopted without a legislative supermajority.<sup>360</sup>

In Maine, the first state to adopt Medicaid expansion through a ballot initiative, litigation was filed contesting the way in which the state government, at many times

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355. *Id.* (“This anti-pre-emption provision might prevent any new ACA-created reporting obligations from pre-empting state reporting regimes like Vermont’s, notwithstanding the incorporation of these requirements in the heart of ERISA. The Court has no need to resolve this issue.” (citation omitted)). The question may become relevant as well to the AHP cases, which involve the interplay between ERISA and the ACA.

356. *See* *Biggs v. Betlach*, 404 P.3d 1243, 1244–45 (Ariz. 2017). *State ex rel. Cleveland Right to Life v. Ohio Controlling Bd.*, 3 N.E.3d 185, 189–90 (Ohio 2013).

357. *Alaska Legislative Council v. Walker*, No. 3AN-15-09208CI, 2016 WL 4073651, at \*1–4 (Alaska Super. Ct. Mar. 1, 2016); *State ex rel. Cleveland Right to Life*, 3 N.E.3d at 190–91; *Adams v. Commonwealth*, No. 13-CI-423, slip op. at 2–4 (Franklin Ky. Cir. Ct. Sept. 3, 2013).

358. *See Ohio ex rel. Cleveland Right to Life*, 3 N.E.3d at 191–92. The Ohio court held that the state Controlling Board did not violate legislative intent by approving the state Department of Medicaid's request for additional appropriation authority to expand Medicaid. *Id.* Republican Governor Kasich used the Controlling Board to expand Medicaid in the face of opposition by Republicans in the state legislature. *Id.* at 190. In Arizona, the court held that the hospital assessment that the Arizona legislature passed to fund the state portion of the funding for expansion was not a tax and, therefore, did not require a supermajority vote in the legislature. *Biggs*, 404 P.3d at 1248. In Alaska, the court held that the governor and the commissioner of the state Department of Health and Social Services did not violate the law by accepting federal funding for Medicaid expansion without legislative approval. *Alaska Legislative Council*, 2016 WL 4073651, at \*9. Similarly, in Kentucky, a state court held that the Governor acted in accordance with the law when he accepted federal funding for Medicaid expansion on his own. *Adams*, No. 13-CI-423, slip op. at 3–4.

359. *Berger v. Burwell*, No. 5:17-cv-25-FL, 2017 WL 2709769, at \*1 (E.D.N.C. Jan. 14, 2017).

360. *Biggs*, 404 P.3d at 1245.

hostile to expansion, chose to implement or not to implement the initiative.<sup>361</sup> Other states adopted the expansion through voter initiative in 2018, only to see the legislature and governor impose limits below what voters had approved. It does not appear that these cutbacks have led to any litigation yet.

Earlier in the statute's lifetime, there were more intragovernmental challenges focused on the existential attacks on the law, including challenges to the validity of ballot initiatives that prohibited states from implementing the ACA,<sup>362</sup> or challenges to a state attorney general's authority to unilaterally make a state a party to cases arguing that the ACA was unconstitutional.<sup>363</sup>

With respect to other cases in the states, looking to the approximately fifty cases that have reached the highest courts of the states, examples of the more relevant cases include: (1) cases that challenge the ability of members of Congress to get insurance via the District of Columbia small business insurance exchange;<sup>364</sup> (2) cases that concern whether worker's compensation is subject to the same protections as insurance under the ACA;<sup>365</sup> (3) disputes over whether certain medical treatments would be covered under Medicaid post-ACA,<sup>366</sup> and (4) debates about whether a wife would qualify under an ACA-subsidized exchange plan if her husband did not sign up for employer-provided insurance for which he was eligible.<sup>367</sup>

## V. BROADER SIGNIFICANCE FOR PUBLIC LAW

This final Part briefly reflects on the broader significance of the decade of ACA litigation for public law—constitutional, statutory, and administrative law—beyond healthcare.

With respect to constitutional law, the past ten years of ACA litigation made new law about the Commerce Clause, the taxing power, the Appropriations Clause, the spending power, and the Tenth Amendment. These cases, as we have discussed, were about Congress's own powers but especially about its relationships with the state and private implementers of its laws. The ACA also pushed boundaries in administrative law—again in large part due to the law's relationships with its implementers—and charted new paths in statutory interpretation.

### A. CONSTITUTIONAL LAW

One lesson from the ACA's litigation decade is that it would have been much simpler and cleaner, as a legal matter, for Congress to have federalized the entire

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361. *See, e.g.*, *Me. Equal Justice Partners v. Hamilton*, No. BCD-AP-18-02, 2018 WL 3702245 (Me. Bus. & Consumer Ct. June 4, 2018).

362. *Hoffman v. State*, 328 P.3d 604, 605 (Mont. 2014); *State ex rel. Ohio Liberty Council v. Brunner*, 928 N.E.2d 410, 412 (Ohio 2010).

363. *See City of Seattle v. McKenna*, 259 P.3d 1087, 1088 (Wash. 2011) (en banc).

364. *Vining v. Exec. Bd. of D.C. Health Benefit Exch. Auth.*, 174 A.3d 272, 276 (D.C. 2017).

365. *Frith v. N.D. Workforce Safety & Ins.*, 845 N.W.2d 892, 893–94 (N.D. 2014).

366. *Pruncun v. Del. Dep't Health & Human Servs.*, 201 A.3d 525, 527–28 (Del. 2019) (holding skin-shocking treatment in community-based settings was not covered).

367. *In re J.H.*, 160 A.3d 1023, 1024 (Vt. 2016).

healthcare landscape. Politically, however, a full-scale federal takeover was not palatable—and many viewed it unwise as a health policy matter, too. But a fully federalized healthcare system would not have implicated the majority of constitutional provisions that were subsequently litigated in court.

The next time the country needs a big, national social program, Supreme Court decisions deriving from the ACA may change the strategies Congress uses. Mandates might be eschewed, for instance. The irony is that one of the least risky schemes from a constitutional perspective would be a government tax-and-spend program—the kind of big-government design that conservatives loathe and that the ACA, with its grounding in the private market, was a policy compromise to avoid. The RFRA cases too might have the same paradoxical effect of encouraging the kind of policy design that ACA opponents despise most—if religious carve-outs interfere too much with services, maybe Congress will just have the government provide those services to the public directly.

There are many other reasons why experts believe the ACA has paved the way for even more ambitious reforms—reforms committed to government-provided, centralized universal coverage. As one of us has detailed elsewhere, the legal and political challenges themselves have changed the national conversation about and expectations for our healthcare system in ways that point toward more government involvement and more solidarity.<sup>368</sup> But the ACA cases also show us where Congress treads on most solid authority and the kinds of government demands that private implementers and the states are likely to resist.

The litigation has also continuously implicated the standing doctrine—that is, who has the right to sue, and when controversies are ripe. There were a number of cases in which courts declined to review parts of the ACA, or agency action based on the statute, because they concluded that the parties challenging the statute or the agency action lacked standing to sue. This was true of many of the early challenges to the individual mandate, where courts assessed some general taxpayer-standing-type challenges as simply being “generalized grievances” about the ACA as opposed to concrete individual claims of financial harm or disruption due to individuals’ needing to prepare for the mandate. Some courts also concluded that because the shared responsibility requirements were not yet operating, and individuals did not yet know what their financial and health coverage circumstances would be in 2014, it could not safely be said that individual plaintiffs had standing to challenge the mandate.<sup>369</sup>

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368. See Gluck & Scott-Railton, *supra* note 13, at 558–66.

369. Before *NFIB*, courts dismissed many individual challenges to the individual mandate, largely on standing grounds. See, e.g., *Boyle v. Sebelius*, No. 2:11-cv-07868-GW-AJW, slip op. at 5 (C.D. Cal. Feb. 3, 2012); *Bryant v. Holder*, 809 F. Supp. 2d 563, 571–72 (S.D. Miss. 2011) (finding no standing to raise state employee claims, but finding standing to raise medical privacy claims); *Bellow v. U.S. Dep’t of Health & Human Servs.*, No. 1:10-cv-165, 2011 WL 2462205, at \*1 (E.D. Tex. June 20, 2011); *Kinder v. Geithner*, No. 1:10-cv-101-RWS, 2011 WL 1576721, at \*4–8 (E.D. Mo. Apr. 26, 2011), *aff’d*, 695 F.3d 772 (8th Cir. 2012); *Purpura v. Sebelius*, No. 10–04814, 2011 WL 1547768, at \*9 (D.N.J. Apr. 21, 2011), *aff’d*, 446 F. App’x 496 (3d Cir. 2011); *Peterson v. United States*, 774 F. Supp. 2d 418, 420 (D.N.H. 2011); *N.J. Physicians, Inc. v. Obama*, 757 F. Supp. 2d 502, 510–11 (D.N.J. 2010), *aff’d*, 653

Lack of standing also ruled out challenges to the Obama Administration's decision to delay the ACA's employer mandate,<sup>370</sup> to its decision to expand 'grandmother' status to particular health plans that may not have qualified under the precise terms of the grandfathering statute,<sup>371</sup> and to the policy of allowing members of Congress and congressional staff to qualify for coverage under the SHOP small employer system.<sup>372</sup>

The most important standing decision was probably *House v. Burwell*, the CSR case, because it was a rare occasion of standing being granted to members of Congress.<sup>373</sup> The opinion is nonprecedential, however, because the case settled before appeal, and no court to date has relied on it to find legislator standing.<sup>374</sup>

On the other hand, at least where *individuals* have tried comprehensively to challenge the ACA, courts have been fairly liberal with respect to individual standing. *NFIB* reached the merits, apparently based purely on individual plaintiffs' projections that they would be subject to the individual mandate eventually<sup>375</sup>—the *NFIB* opinions themselves do not mention standing anywhere. *King* involved an even more attenuated claim to individual standing. The individual plaintiffs there alleged that they should qualify for an exemption from the individual mandate because, as residents of states where the federal government operated the exchanges, they should not be treated as eligible for premium tax credits.<sup>376</sup> From that refusal to accept a benefit that the federally operated exchange would have offered them, the individual plaintiffs had standing to try to collapse the entire premium subsidy system.

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F.3d 234 (3d Cir. 2011); *Van Tassel v. United States*, No. 1:10-cv-00310-TDS-PTS, slip op. at 4–5 (M.D.N.C. Nov. 15, 2010); *Shreeve v. Obama*, No. 1-10-cv-71, 2010 WL 4628177, at \*4 (E.D. Tenn. Nov. 4, 2010); *Baldwin v. Sebelius*, No. 3:10-cv-1033, 2010 WL 3418436, at \*4–5 (S.D. Cal. Aug. 27, 2010), *aff'd*, 654 F.3d 877 (9th Cir. 2011).

370. See *Kawa Orthodontics, LLP v. Sec'y, U.S. Dep't of the Treasury*, 773 F.3d 243, 248 (11th Cir. 2014); *Ass'n of Am. Physicians & Surgeons v. Koskinen*, 768 F.3d 640, 642 (7th Cir. 2014).

371. See *West Virginia v. U.S. Dep't of Health & Human Servs.*, 145 F. Supp. 3d 94, 95–96 (D.D.C. 2015), *aff'd*, 827 F.3d 81 (D.C. Cir. 2016).

372. See *Johnson v. U.S. Office of Personnel Mgmt.*, 783 F.3d 655, 658 (7th Cir. 2015).

373. See *U.S. House of Representatives v. Burwell*, 130 F. Supp. 3d 53, 58 (D.D.C. 2015).

374. Only three cases have cited *House v. Burwell* in the context of legislator standing, and all have distinguished it. See *Tennessee v. U.S. Dep't of State*, 931 F.3d 499, 501–02, 512–14 (6th Cir. 2019) (holding that the Tennessee General Assembly lacks standing to challenge federal law requiring states to provide Medicaid to refugees: "The General Assembly has not identified an injury that it has suffered, such as disruption of the legislative process, a usurpation of its authority, or nullification of anything it has done, unlike in . . . *Burwell*."); *U.S. House of Representatives v. Mnuchin*, 379 F. Supp. 3d 8, 11, 18 (D.D.C. 2019) (holding that the House has no standing to challenge President Trump's plans to use funds for his border wall that were appropriated for other purposes and referring to *Burwell* as a "slender reed"); *Cummings v. Murphy*, 321 F. Supp. 3d 92, 95–96, 116, 117 n.9 (D.D.C. 2018) (finding that individual members of the House Oversight Committee lacked standing to challenge federal agency's failure to respond to members' records request in contrast to the institutional injury present in *Burwell*).

375. See, e.g., *Fla. ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1270–71 (N.D. Fla. 2011), *aff'd in part, rev'd in part*, 648 F.3d 1235 (11th Cir. 2011, and *aff'd in part, rev'd in part, NFIB*, 567 U.S. 519 (2012); *Goudy-Bachman v. U.S. Dep't of Health & Human Servs.*, 764 F. Supp. 2d 684, 690–91 (M.D. Pa. 2011).

376. See Complaint ¶¶ 11–14, *King v. Sebelius*, 997 F. Supp. 2d 415 (E.D. Va. 2013).



In *California v. Texas*, the question was whether two individual Texans have standing to challenge what remains of the individual mandate even though, because Congress zeroed out the tax penalty amount, the individual Texans' failure to maintain minimum essential coverage no longer triggers a tax penalty or any other tangible, adverse legal consequence for them. Nevertheless, Judge O'Connor found that these plaintiffs had standing—that even an allegedly toothless command nevertheless qualifies as “inherently binding” law, and the Fifth Circuit affirmed.<sup>377</sup>

It should be noted that in the three major challenges to the ACA as a whole, and in the *House v. Burwell* litigation about cost-sharing reduction payments, and in most of the contraception cases, individuals who wanted to *keep* the benefits the ACA offered did not participate as parties. In *NFIB*, the litigation was brought by individuals and states, challenging the individual mandate and the Medicaid expansion, against the United States, which defended the ACA. In *King*, the litigation was between individuals who claimed to want *exemptions* from the individual mandate that they would not get if they received subsidies, and the United States, again defending the ACA; people who wanted and would qualify for premium tax credits did not participate as parties.<sup>378</sup> In *House v. Burwell*, low-income people who were getting cost-sharing reductions and wanted them to continue tried to intervene on appeal, but the D.C. Circuit denied intervention.<sup>379</sup> In the *DeOtte* contraception litigation, even though the district court certified nationwide classes of employers who do not want to promote contraception and individuals who do not want to contribute to other individuals' contraception,<sup>380</sup> the district court did not consider forming a corresponding defense class of people who wanted to get contraception from their objecting employers.<sup>381</sup>

State standing has also been important. *NFIB* implicitly found that individuals had standing to challenge the individual mandate and so did not reach the state standing issue. States were not parties in *King v. Burwell* itself either, but they were parties in that case's Oklahoma and Indiana counterparts. Although the district judge rejected the idea that Oklahoma had standing as a sovereign to impose its preference for exempting Oklahoma employers from the employer mandate

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377. *Texas v. United States*, 340 F. Supp. 3d 579, 593–95 (N.D. Tex. 2018), *aff'd in part, vacated in part*, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020) (mem.). The district court spread its individual-standing analysis over two opinions, the first granting partial summary judgment, *Texas v. United States*, 340 F. Supp. 3d at 585, the second entering judgment under Federal Rule of Civil Procedure 54(b), *Texas v. United States*, 352 F. Supp. 3d 665, 672–78 (N.D. Tex. 2018); and it made standing arguments in each opinion. The Fifth Circuit's affirmance on individual standing is at *Texas v. United States*, 945 F.3d at 378–83.

378. And in *Texas v. United States*, people who benefit from the ACA's provisions, did not participate as parties, even though the United States was no longer defending the ACA.

379. See U.S. House of Representatives v. *Burwell*, No. 16-5202 (D.C. Cir. Jan. 12, 2017).

380. *DeOtte v. Azar*, 393 F. Supp. 3d 490, 499 (N.D. Tex. 2019).

381. An exception to this pattern is *Irish 4 Reproductive Health v. United States Department of Health and Human Services*, No. 3:18-cv-491-PPS-JEM, 2020 WL 248009 (N.D. Ind. Jan. 16, 2020), where Notre Dame students and employees seeking contraception have affirmatively challenged Notre Dame's agreements with the United States. See *supra* note 217 for further discussion.

over low-income Oklahomans getting subsidies,<sup>382</sup> the judge did find that Oklahoma could raise its challenge in its role as a large employer,<sup>383</sup> which was also the standing theory supporting the Indiana case as well.<sup>384</sup>

In *California v. Texas*, the Fifth Circuit determined that the plaintiff states had standing to challenge what remained of the individual mandate, because “the state plaintiffs in this case have suffered fiscal injuries as employers,” having to fill out and submit forms about employees’ health insurance status.<sup>385</sup> The court found that the federal defendants had standing to appeal because the federal government’s continued enforcement of the ACA was sufficient to give the government a necessary stake in the litigation, even though they were no longer defending it.<sup>386</sup> The coalition of states led by California as interveners to defend the ACA also had standing to appeal because they demonstrated the requisite showing of injury resulting from the judgment of the district court.<sup>387</sup> The Fifth Circuit did not reach the question of whether the House of Representatives as intervenor had independent standing to sue.<sup>388</sup>

One question about state standing to challenge federal interpretations of the ACA is whether states may obtain injunctions that apply nationwide. This question has arisen in a number of ACA-related cases. The Ninth Circuit has twice held, for example, that although states should get preliminary relief against federal rules limiting contraceptive coverage, an injunction geographically limited to the plaintiff states would prevent the economic harm appearing in the record.<sup>389</sup> The Third Circuit’s economic-harms justification for a nationwide injunction on the same subject included the consideration that “[m]any individuals work in a state that is different from the one in which they reside. . . . Out-of-state college attendance further exacerbates the States’ injury.”<sup>390</sup> In *California v. Texas*, the

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382. Oklahoma *ex rel.* Pruitt v. Sebelius, No. 6:11-cv-30, 2013 WL 4052610, at \*6–7 (E.D. Okla. Aug. 12, 2013).

383. *Id.* at \*9.

384. *Indiana v. IRS*, 38 F. Supp. 3d 1003, 1009–11 (S.D. Ind. 2014).

385. 945 F.3d 355, 384; *see id.* at 384–87. The case was called *Texas v. United States* at this stage.

386. *Id.* at 375–76. The Fifth Circuit relied on the Supreme Court’s standing analysis in *United States v. Windsor*, 570 U.S. 744 (2013).

387. *Texas v. United States*, 945 F.3d at 376–77.

388. The court seemed skeptical of this theory of standing, writing that the Supreme Court’s recent decision in *Virginia House of Delegates v. Bethune-Hill*, 139 S. Ct. 1945, 1953 (2019), “call[ed] the House’s standing to intervene into doubt.” *Texas v. United States*, 945 F.3d at 377.

389. *California v. U.S. Dep’t of Health & Human Servs.*, 941 F.3d 410, 431 (9th Cir. 2019); *California v. Azar*, 911 F.3d 558, 584 (9th Cir. 2018).

390. *Pennsylvania v. President United States*, 930 F.3d 543, 576 (3d Cir. 2019), *cert. granted sub nom.* *Trump v. Pennsylvania*, 140 S. Ct. 918 (2020) (mem.), *consolidated with* *Little Sisters of the Poor Saints Peter & Paul Home v. Pennsylvania*, 140 S. Ct. 918 (2020) (mem.). An alternative way to challenge federal interpretations of the ACA would be through a nationwide class action by individuals, including employers, affected by the policy. That justified Judge Reed O’Connor’s nationwide permanent injunction in the *DeOtte v. Azar* objections-to-contraception case, 393 F. Supp. 3d 490, 513–14 (N.D. Tex. 2019), and it has justified Judge Michael Simon’s nationwide preliminary injunction in the *John Doe #1 v. Trump* visa-denial case. *See John Doe #1 v. Trump*, No. 3:19-cv-1743-SB, slip op. at 43–46 (D. Or. Nov. 26, 2019). Judge Simon later certified a class. *John Doe #1 v. Trump*, 3:19-cv-01743-SI (D. Or. Apr. 7, 2020).

United States eventually argued that enforcement of the ACA should be enjoined only in the plaintiff states, an argument the Fifth Circuit commended to the attention of the district court.<sup>391</sup> Courts also issued nationwide preliminary injunctions in the case concerning the public charge rule, all of which were stayed by the Supreme Court. These cases play into the broader emerging debate about the validity of such injunctions across all fields of law.<sup>392</sup> In the Supreme Court's order lifting the nationwide injunction of the public charge rule, for instance, Justice Gorsuch, with Justice Thomas concurring, wrote separately to criticize nationwide injunctions in general.<sup>393</sup>

#### B. ADMINISTRATIVE AND STATUTORY LAW

The ACA litigation has also influenced doctrinal development in administrative law and statutory interpretation. The Religious Freedom Restoration Act cases, as discussed, have broad potential implications for government regulation of religious employers. The many Administrative Procedure Act cases that have been brought to defend the ACA have not yet broken much new doctrinal ground about the APA itself, but they have—especially the Medicaid work-requirement cases—expanded the meaning of some of the public programs that are part of the ACA. For instance, the work-requirement decisions describe Medicaid's core objective, from which administrative waivers now cannot deviate, as “granting health care coverage to those who cannot afford it”<sup>394</sup> and “providing health care coverage without any restriction geared to healthy outcomes, financial independence or transition to commercial coverage”<sup>395</sup>—a significant characterization of Medicaid under a solidarity and universality principle of coverage that may limit what administrators can do to narrow the program in the future.

Also notable about the Medicaid work requirements cases is they help settle a longstanding question about whether section 1115 waivers are reviewable. The ACA also broke new ground in transparency of waiver applications, by adding notice and comment requirements for section 1115 that are not replicated in other federal waiver provisions.<sup>396</sup> These transparency requirements have provided litigators with an administrative record, making section 1115 waiver cases,

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391. 945 F.3d at 402–03.

392. Compare, e.g., Samuel L. Bray, *Multiple Chancellors: Reforming the National Injunction*, 131 HARV. L. REV. 417, 418 (2017), with Mila Sohoni, *The Lost History of the “Universal” Injunction*, 133 HARV. L. REV. 920, 922 (2020). See also *Trump v. Hawaii*, 138 S. Ct. 2392 (2018). (Thomas, J., concurring) (“These injunctions are beginning to take a toll on the federal court system—preventing legal questions from percolating through the federal courts, encouraging forum shopping, and making every case a national emergency for the courts and for the Executive Branch. I am skeptical that district courts have the authority to enter universal injunctions.”).

393. *Dep’t of Homeland Sec. v. New York*, 140 S. Ct. 599 (2020) (mem.) (granting application for a stay).

394. *Stewart v. Azar*, 313 F. Supp. 3d 237, 261 (D.D.C. 2018) (quoting *W. Va. Univ. Hosps., Inc. v. Casey*, 885 F.2d 11, 20 (3d Cir. 1989)).

395. *Gresham v. Azar*, 950 F.3d 93, 102 (D.C. Cir. 2020).

396. 42 U.S.C. § 1315(d)(2)(A), (C) (2012).

including the work requirements cases, easier to litigate successfully and more like the typical APA case.

We already have discussed the significance of the Court's statutory interpretation decision in *King v. Burwell*—in particular, its refusal to apply the Court's preferred interpretive method of strict textualism to a likely mistake in the ACA. But as noted, the Court has not returned to that approach since *King*. Nor did *King* explicitly answer the question of what courts should do about obvious statutory mistakes, even as the case itself made clear how unappealing the Court's basic approach to that question was at the time—that is, to interpret the statute literally and let the chips fall where they may.<sup>397</sup> In *King*, the Court found a way around that problem with its special interpretive approach—what it called interpreting the ACA in the broader context of “the legislative plan.”<sup>398</sup>

*King* more definitively addressed another important interpretation question, one about administrative deference. Before *King*, the Court generally applied *Chevron* deference to interpretations of statutes by agencies charged with administering them, especially where those interpretations were made with the force of law,<sup>399</sup> but had begun to develop some exceptions. One such exception was for so-called “major questions”—matters of major economic, political, or policy significance, that the Court on a handful of occasions doubted Congress meant to commit to agency discretion.<sup>400</sup> But the applicability of the major questions exception remained in question before *King*. Another open question was whether an agency deserves more or less interpretive deference depending on whether the issue is within its area of expertise. Until *King*, the Court had never explicitly so held.

In *King* the Court shed light on both doctrines. It did not make express, however, whether its decision not to defer to the agency was because the agency (there, the IRS) lacked expertise, or because the question was too important, or both:

The tax credits are among the Act's key reforms, involving billions of dollars in spending each year and affecting the price of health insurance for millions of people. Whether those credits are available on Federal Exchanges is thus a question of deep “economic and political significance” that is central to this statutory scheme; had Congress wished to assign that question to an agency, it surely would have done so expressly. It is especially unlikely that Congress would have delegated this decision to the *IRS*, which has no expertise in crafting health insurance policy of this sort.

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397. See generally Richard A. Posner, *Comment on Professor Gluck's “Imperfect Statutes, Imperfect Courts,”* 129 HARV. L. REV. F. 11 (2015).

398. *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015).

399. See *United States v. Mead Corp.*, 533 U.S. 218 (2001).

400. See *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120 (2000); *MCI Telecomms. Corp. v. Am. Tel. & Tel. Co.*, 512 U.S. 218 (1994).

It is instead our task to determine the correct reading of Section 36B.<sup>401</sup>

*King* was also significant for being the first modern Supreme Court case to seriously consider the circumstances of a statute's enactment in interpreting it—and, then, for cutting the statute some slack as a result of its unorthodox legislative process.<sup>402</sup> Even before the Supreme Court decision, the *King* litigation had opened the door to new advances in this vein of statutory interpretation theory. For example, one idea introduced by one of us during the litigation that took root at the time and has since grown legs is the “CBO Canon”—the proposition that ambiguities in a statute should be construed in light of the Congressional Budget Office's score of the bill.<sup>403</sup> The ACA was drafted in the shadow of a clear budget target from the President and continuously tweaked to remain within that target. The CBO Canon argument is that any interpretation wholly inconsistent with the assumptions on which the CBO score depended is presumptively a misconstruction of the law and of congressional intent. Since *King*, there has been robust academic debate on whether and when the circumstances of a statute's enactment, or specifics of congressional procedure—whether the CBO score, or other features, like the budget process—should affect a statute's interpretation.<sup>404</sup>

*NFIB*, even though a constitutional case, also made significant statutory rulings. One was simply the way in which the Court interpreted Medicaid. In the Court's view, the centrality and scale of Medicaid made unacceptably severe any threat of losing Medicaid funds if a state did not fully expand under the ACA. In retrospect, however, this very aspect of *NFIB* forecast the extent to which Medicaid would become such an important part of the ACA's story. The Chief Justice's opinion in *NFIB* emphasized how the ACA had tried to change Medicaid: “It is no longer a program to care for the neediest among us, but rather an element of a comprehensive national plan to provide universal health insurance coverage.”<sup>405</sup> He thought that the expansion was expendable in a way the mandate was not—that is, the Court could gut the mandatory nature of the expansion without destabilizing the entire ACA. Ironically, the basis of that holding—

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401. *King*, 135 S. Ct. at 2489 (citations omitted).

402. See Gluck, *supra* note 83, at 96–99.

403. Abbe Gluck, *The “CBO Canon” and the Debate Over Tax Credits on Federally Operated Health Insurance Exchanges*, BALKINIZATION (July 10, 2012), <https://balkin.blogspot.com/2012/07/cbo-canon-and-debate-over-tax-credits.html> [<http://perma.cc/VM2X-ATU3>] (introducing the concept). For elaboration, see also Abbe R. Gluck, *Congress, Statutory Interpretation, and the Failure of Formalism: The CBO Canon and Other Ways That Courts Can Improve on What They Are Already Trying to Do*, 84 U. CHI. L. REV. 177, 187–91 (2017) [hereinafter Gluck, *Congress, Statutory Interpretation, and the Failure of Formalism*].

404. Compare, e.g., Gluck, *Congress, Statutory Interpretation, and the Failure of Formalism*, *supra* note 403; Gluck, *supra* note 91; Abbe R. Gluck & Jesse M. Cross, *The Congressional Bureaucracy*, 168 U. PA. L. REV. (forthcoming 2020) (detailing the legislative-drafting-related work of the nonpartisan institutions inside Congress and how it should affect interpretation); and Abbe R. Gluck, Anne Joseph O'Connell & Rosa Po, *Unorthodox Lawmaking, Unorthodox Rulemaking*, 115 COLUM. L. REV. 1789 (2015); with John F. Manning, *Inside Congress's Mind*, 115 COLUM. L. REV. 1911 (2015); and Ryan D. Doerfler, *Who Cares How Congress Really Works?*, 66 DUKE L.J. 979 (2017).

405. 567 U.S. 519, 583 (2012) (plurality opinion).

Medicaid's centrality to state healthcare systems and its new universality principle—was ultimately the main reason why the ACA was not repealed and replaced in 2017, even after the Court allowed states to opt out without penalty.<sup>406</sup> 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 in effect optional, the Court not only handed the states' leverage vis-à-vis the federal government, but, at the same time, unwittingly created new pathways for the ACA's entrenchment. The seven years since *NFIB* was decided have seen uninterrupted state–federal negotiation over the Medicaid program that have invested many state officials, including Republicans, with the role of tailoring and entrenching Medicaid in their various states.<sup>407</sup> Another kind of statutory 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—and more generally whether everyone should be covered—front and center as a matter of public deliberation in each state. The question whether to expand Medicaid has become the stuff of front-page news, gubernatorial elections, and even ballot initiatives.<sup>408</sup> It has become the topic of state legislation and executive orders that have sought to bypass opposing factions of state government to accomplish the expansion.<sup>409</sup>

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406. See *supra* Section II.C; see also Gluck & Scott-Railton, *supra* note 13, at 500 (further explaining the central role of Medicaid in the defeat of Republican efforts to repeal and replace the ACA in 2017).

407. In the very 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* from state legislatures moving “toward liberalization of abortion statutes” to reenergized 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).

408. 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> (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. (Nov. 4, 2015), <https://www.healthaffairs.org/doi/10.1377/hblog20151104.051634/%20%20full/> [<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 healthcare was at least a very important issue in 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/5WPH-FENF>] (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/9JJQ-2DD8>] (attributing a Republican governor's popularity partly to expansion of Medicaid).

409. See Gluck & Scott-Railton, *supra* note 13, at 518–21.

It is a constant conversation about coverage and who is and should be left out. All of that has contributed to the ACA's entrenchment and normative transformation from a statute that once was thought to be an uneasy compromise with the market into one that now stands for universal health coverage.<sup>410</sup>

*NFIB* also introduced new ideas about severability, the statutory interpretation doctrine now at issue in *Texas*. The four dissenting Justices would have struck down the entire statute; they viewed any part of the law ruled invalid—whether the Medicaid expansion or the mandate—as inextricably intertwined with the rest. That was an aggressive and unusual position to take, given that the Court has consistently applied a presumption in favor of severability, grounded in the notion that the goal should be to preserve as much of the statute as possible.<sup>411</sup>

As discussed, the Chief Justice's opinion in *King* broke new ground in considering the unorthodox circumstances of the ACA's enactment in interpreting it. But the portion of the *NFIB* dissent on severability was arguably a forerunner, because it was the first time that members of the Court addressed the question of whether the particular features of a statute or its legislative process—in the case of the ACA, a long, omnibus law with many titles and provisos of different significance—should have a special severability doctrine. The dissent explained:

The Court has not previously had occasion to consider severability in the context of an omnibus enactment like the ACA, which includes not only many provisions that are ancillary to its central provisions but also many that are entirely unrelated—hitched on because it was a quick way to get them passed despite opposition, or because their proponents could exact their enactment as the *quid pro quo* for their needed support. When we are confronted with such a so-called “Christmas tree,” a law to which many nongermane ornaments have been attached, we think the proper rule must be that when the tree no longer exists the ornaments are superfluous.<sup>412</sup>

This twist on the doctrine was in tension with current precedent and has not been mentioned in a case since *NFIB*. It may resurface when the Supreme Court hears the *Texas v. United States* appeal, *California v. Texas*, although the severability question is presented quite differently there.<sup>413</sup>

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410. As this Article went to press, the ACA's solidary-enhancing features—in particular its robust safety net, including the Medicaid expansion and the insurance subsidies—were being deployed as frontline defenses to insure the population in the face of the COVID-19 pandemic and the accompanying economic downturn.

411. See Brief of Amici Curiae Jonathan H. Adler, Nicholas Bagley, Abbe R. Gluck, and Ilya Somin in Support of Intervenor-Defendants-Appellants, *supra* note 119, at 20; see also *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 509 (2010); *Ayotte v. Planned Parenthood of N. New England*, 546 U.S. 320, 329 (2006).

412. *NFIB v. Sebelius*, 567 U.S. 519, 705 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting).

413. See *supra* note 119. In *California v. Texas*, Congress's intent to preserve the rest of the ACA is so clear—because Congress itself repealed the mandate penalty and left the rest of the ACA standing—that it would be a strange application of any new principle about omnibus statutes to invalidate the whole ACA there.

## CONCLUSION

There is a lot more that we could say about the decade of ACA litigation, but space permits just two concluding points. First, the statute's resilience has been extraordinary. No law in American history has survived such an onslaught, and this Article has only discussed one prong of it. The ACA has also been relentlessly attacked in the political sphere, by the states, and by the President himself. How and why the statute survived—and became even more normatively transformative—is the subject of another paper by one of us in this journal.<sup>414</sup>

Second, from the moment when Florida and other states filed suit to invalidate the law, much of the ACA litigation has not been about only invalidating a federal policy as applied to a particular plaintiff but rather about invalidating benefits the government would like to award to people *other* than the plaintiff and the structures through which those benefits are delivered. As to the latter, obligations the ACA puts to the states and private actors—most importantly the insurance industry—are front and center in court throughout the decade. As to the former, *NFIB* was about much more than halting Medicaid expansion in the plaintiff states; it was about halting it everywhere. *King* was a case about someone seeking an exception from the insurance requirement to try to bring down the law's entire subsidy structure.

The crux of almost all of these cases is the extent to which government should be involved in the assurance, payment and delivery of healthcare for the broader citizenry. That once again reflects the tension and ongoing struggle between a universal and community-oriented approach to healthcare on the one hand and an individual, market model on the other. Indeed, this tension, at its core, is what the ACA is about.

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414. Gluck & Scott-Railton, *supra* note 13.