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Too Clever by Half: Commanding the Nonuse of State Authority to Regulate Health Benefits in the ACA

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Too Clever by Half: Commanding the Nonuse of State Authority to Regulate Health Benefits in the ACA

Michael F. Ryan

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ABSTRACT

Prior to the enactment of the Patient Protection and Affordable Care Act (ACA), state legislatures routinely passed laws requiring health insurance carriers to cover certain health care services or providers. At the behest of the insurance industry, Congress attempted to use the health reform law as a vehicle to reign in state-specific “mandated benefit” laws. That being said, the ACA does not prevent states from enacting mandated benefit laws; in fact, the statute expressly permits states to enact such laws. Instead, Congress created a significant barrier to continued state-specific regulation of health insurance benefits. Specifically, 42 U.S.C. § 18031(d)(3)(B)(ii) (Section 1311(d)(3)(B)(ii) of the Act) requires states to “defray” the cost of any mandated benefit that exceeds the federally defined “essential health benefits” (EHB) package. In other words, were a state to enact a mandated benefit law that requires coverage for a benefit or service not included in the EHB package, the state would be legally obligated to appropriate state general revenue to either the individual subscribers or health plans to cover the cost of that benefit. In an apparent attempt to forestall state level health insurance regulation, Congress exacted a financial penalty from states for performing their essential role as the primary regulator of the insurance industry. This article will explore the constitutional implications of this ACA innovation.

AUTHOR NOTE

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INTRODUCTION

On April 7, 2016, the New York Assembly Standing Committees on Insurance and Health held a public hearing to explore the “[state] legislative role in modernizing state health insurance coverage under the Affordable Care Act.”¹ Prior to the passage of the ACA, such a hearing would not have been necessary because a state legislature’s role in modernizing state health insurance coverage was clear: enact laws requiring insurers to cover such benefits and services that the duly elected members of the legislature deem necessary to meet the needs of their constituents. The following passage from the Committees’ public hearing notice reflects a problem that state legislators across the country now face each time they consider mandated benefit legislation in the post-ACA world:

*The Affordable Care Act provided that states must pay the cost of new health insurance coverage “mandates” which were not included as [federal] “essential health benefits.” There has been almost no guidance to the state legislatures about what this means in practice... In practice this means that health care coverage has become frozen as reflected in the 2012 essential health benefits.*²

Simply put, states now must appropriate state general revenue dollars to subsidize the cost of any newly enacted mandated benefits that exceed the essential health benefits package.³

¹ *The Legislative Role in Modernizing State Health Insurance Coverages under the Affordable Care Act: Hearing Before the Joint Assembly Standing Committees on Insurance and Health, 2015-2016 Regular Sessions (NY 2016) (Public Hearing Notice),* <http://assembly.state.ny.us/write/upload/publichearing/20160318.pdf> [<https://perma.cc/TXS2-EAHQ>] [hereinafter NY Assembly Hearing Notice].

² *Id.* (emphasis added).

³ See 42 U.S.C. § 18031(d)(3)(B)(ii) (2012). See also CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULL., 1, 9 (Dec.16, 2011), https://www.cms.gov/CCIIO/Resources/Files/Downloads/essential_health_benefits_bulletin.pdf [<https://perma.cc/J6TT-X8UA>] [hereinafter EHB Bulletin] (“Section 1311(d)(3)(B) of the Affordable Care Act requires States to defray the costs of State-mandated benefits in excess of EHB for individuals enrolled in any qualified health plan either in the individual market or in the small group market.”).

State legislators are often confronted with constituents facing thousands of dollars in medical bills for treatments that work, but are not covered by their insurance plans.⁴ Prior to the ACA enactment, state lawmakers needed only to consider a mandated benefit bill on its policy merits—hardly an easy task—to address these constituent concerns.⁵ Now, in addition to evaluating competing policy considerations, legislators also must consider the *state* fiscal impact of mandated benefit legislation.⁶

Because general revenue dollars are scarce and in high demand,⁷ the ACA has created a significant impediment to state lawmakers' ability

⁴ See, e.g., *H. Finance Comm. Hearing on S.B. 791, S.D. 1, H.D. 1, Relating to Autism Spectrum Disorders*, 2015 Regular Session, 28th Leg. 179 (Haw. 2015) (written testimony of Michael Saines) http://www.capitol.hawaii.gov/session2015/testimony/SB791_HD1_TESTIMONY_FIN_04-08-15_.pdf (indicating that family had “been paying out of pocket medical expenses averaging over \$20,000 a year for [applied behavior analysis] services, speech therapy, and extra tutoring on top of regular medical bills). See also *id.* (“[W]e are at our limits financially and there are many other families who can’t afford basic services at all. This bill [requiring insurance coverage for autism spectrum disorders treatment] would give our children at very least, access to the same services that other insurers are offering in Hawaii.”).

⁵ See *infra* Part I.B.1.

⁶ See John Carroll, *States May Yet Regret Their Many Mandates*, *MANAGED CARE MAGAZINE* (March 2011), <http://www.managedcaremag.com/archives/2011/3/states-may-yet-regret-their-many-mandates> [https://perma.cc/WS8C-JKX6] (“It used to be that legislators would consider new mandates without any consideration of who winds up paying. Now [lawyer-lobbyist Keith Stover] says, ‘there will be a price for this.’”).

⁷ See, e.g., National Association of State Budget Officers, *The Fiscal Survey of States: An Update on State Fiscal Conditions: Spring 2016*, VII, <https://higherlogicdownload.s3.amazonaws.com/NASBO/9d2d2db1-c943-4f1b-b750-0fca152d64c2/UploadedImages/Reports/Spring%202016%20Fiscal%20Survey%20of%20States-S.pdf> [https://perma.cc/Q5P2-LBUQ] (“While state budget conditions have significantly improved and largely stabilized since the tough years during and immediately following the Great Recession, states across the country continue to face fiscal challenges in the short and long terms. Spending requirements on K-12 education, health care, and other critical areas continue to grow, often faster than state revenues.”); Kil Huh & Sarah Babbage, *Long Term Obligations Vary as a Share of State Resources*, *THE PEW CHARITABLE TRUSTS* (May 17, 2016), <http://www.pewtrusts.org/en/research-and-analysis/analysis/2016/05/17/long-term-obligations-vary-as-a-share-of-state-resources> [https://perma.cc/6UAG-R7QV] (“[States] still face some long-term spending commitments—such as debt and unfunded retirement costs—that they

to respond to their constituents' needs vis-à-vis health benefits. As the committee chairman noted in his opening remarks at the aforementioned New York legislative committee hearing: "In essence, health treatments and practices have been frozen at the level, the technology and protocols that were in the benchmark plans selected in 2012 . . . despite ongoing advances in health care. The legislature must have the ability to require new health coverages"⁸

By exacting a financial penalty from states for merely performing their role as the health insurance industry's primary regulator, this article argues that this ACA innovation "commandeers" the states' legislative processes in violation of the Tenth Amendment. Part I of this Article provides relevant substantive background information on the ACA and the current balance of federal-state health insurance regulation. Part II examines the Supreme Court's preeminent commandeering cases—*New York v. U.S.* and *Printz v. U.S.* Part III demonstrates that this ACA provision falls within the scope of the Supreme Court's prohibition on federal commandeering of state lawmaking. Part III argues that Congress has provided states with a false choice—either regulate health benefits "according to Congress' instructions"⁹ or risk losing scarce state general revenue dollars to a congressionally mandated state subsidy to the insurance industry. Part IV reviews (i) judicial and legislative options to bring this ACA section back into conformity with prevailing Constitutional norms and (ii) existing state options to avoid triggering the "defray the cost" provision.

must reckon with in the future. In 2013, states reported that they owed \$968 billion in unfunded pension benefits. . .States also reported \$587 billion in unfunded retiree health care liabilities").

⁸ *The Legislative Role in Modernizing State Health Insurance Coverages under the Affordable Care Act: Hearing Before the Joint Assembly Standing Committees on Insurance and Health, 2015-2016 Regular Sessions* 6 (NY 2016) (statement of Assembly Member Kevin Cahill, Chair, Assembly Standing Committee on Insurance)
http://nystateassembly.granicus.com/MinutesViewer.php?view_id=8&clip_id=3191&doc_id=ec712e4e-12e3-11e6-b3ab-00219ba2f017 [https://perma.cc/47NH-R69J].

⁹ *New York v. United States*, 505 U.S. 144, 162 (1992).

PART I. BACKGROUND

A. Historic Roles of Federal and State Government in Health Insurance Regulation

State governments have historically served as the primary regulator of the insurance industry.¹⁰ Insurance regulation has long been understood to be within states' "historic police powers."¹¹ However, in *U.S. v. South-Eastern Underwriters Association*, the Supreme Court ruled that the business of insurance fell within the scope of the Commerce Clause.¹² After this 1944 decision, Congress acted swiftly to restore state primacy in insurance regulation.¹³ With the enactment of the McCarran-Ferguson Act in 1945, Congress declared "that the continued regulation and taxation by the several States of the business of insurance is in the public interest"¹⁴ Moreover, "[n]o Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."¹⁵

On its face, the McCarran-Ferguson Act appears to give considerable deference to state governments in regulating the insurance industry.¹⁶ However, by preserving Congress' ability to enact laws "specifically relat[ing] to the business of insurance," the statute implicitly recognizes the essential holding of *South-Eastern Underwriters*, that in a modern economy, the business of insurance

¹⁰ Joshua Phares Ackerman, *The Unintended Federalism Consequences of the Affordable Care Act's Insurance Market Reforms*, 34 PACE L. REV. 273, 278-80 (2014); Meghan S. Stubblebine, Note, *The Federal Medical Loss Ratio: A Permissible Federal Regulation or an Encroachment on State Power?*, 55 WM. & MARY L. REV. 341, 354 (2013).

¹¹ *Hood v. Santa Barbara Bank & Trust*, 143 Cal. App. 4th 526, 536-37 (2nd Dist., 2006) (quoting *Smith v. Wells Fargo Bank, N.A.*, 135 Cal. App. 4th 1463, 1475 (Cal. Ct. App. 2005)). See also 44 C.J.S. *Insurance* §36 (2016).

¹² *United States v. Se. Underwriters Ass'n*, 322 U.S. 533, 553 (1944) (holding "No commercial enterprise of any kind which conducts its activities across state lines has been held to be wholly beyond the regulatory power of Congress under the Commerce Clause. We cannot make an exception of the business of insurance.").

¹³ Ackerman, *supra* note 10, at 280-81.

¹⁴ 15 U.S.C. § 1011 (2012).

¹⁵ 15 U.S.C. § 1012(b) (2012).

¹⁶ See *id.*

impacts interstate commerce and is therefore subject to federal regulation via the Commerce Clause.¹⁷ Accordingly, the McCarran-Ferguson Act is no impediment to congressional acts which specifically intend to regulate the business of insurance.¹⁸ Congress has used its authority to directly regulate the health insurance market on many occasions since McCarran-Ferguson's passage, most recently and dramatically with the ACA in 2010.¹⁹

B. Federal vs. State Regulation

1. State Mandated Benefit Laws

In exercising their traditional role as the primary insurance industry regulator, states have regulated the content of health insurance policies for several decades.²⁰ States began enacting mandated benefit laws in the 1970s.²¹ To counter insurers' attempts to manage costs by limiting services available to consumers, state legislatures enacted mandated benefit laws "by the hundreds."²² States have enacted mandated benefit laws to require coverage for a wide variety of treatments and services, including but not limited to: treatment of autism spectrum disorders,²³ diabetes,²⁴ alcoholism and substance abuse disorders,²⁵ and infertility

¹⁷ See Amy B. Monahan, *Federalism, Federal Regulation, or Free Market? An Examination of Mandated Health Benefit Reform*, 2007 U. ILL. L. REV. 1361, 1364 (2007) [hereinafter Monahan, *Federalism, Federal Regulation, or Free Market?*] ("However, section 1012(b) of the Act specifically provides that Congress may preempt state insurance law by specifically stating that federal legislation is intended to apply to the business of insurance.").

¹⁸ See *id.* (noting that, with respect to the McCarran-Ferguson Act, "Congress therefore retains the ability to regulate insurance so long as it makes its intentions explicit.").

¹⁹ See *infra* Part I.C.

²⁰ Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1365.

²¹ See *Metro. Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 728 n. 3 (noting that the "first mandated benefit statutes. . . appeared in 1971 and 1972 . . .").

²² Russell Korobkin, *The Battle Over Self-Insured Health Plans, or 'One Good Loophole Deserves Another'*, 5 YALE J. HEALTH POL'Y, L. ETHICS 89, 96-97 (2005).

²³ See, e.g., CAL. HEALTH & SAFETY CODE § 1374.73.

²⁴ See, e.g., GA. CODE ANN. § 33-24-59.2 (2016).

²⁵ See, e.g., 215 ILL. COMP. STAT. 5/370c (2016).

treatment.²⁶ All in all, there were approximately 1,600 state mandated benefit laws in effect at the time the ACA was enacted.²⁷

Mandated benefit laws have long been controversial.²⁸ Insurers argue that these laws increase costs and limit consumer choice.²⁹ Others object to mandated benefit laws as inappropriately interfering with freedom of contract.³⁰ Meanwhile, consumer advocates and other proponents of state content regulation contend that mandated benefit laws are needed to combat market inefficiencies and adverse selection.³¹ Whatever the pros and cons of state-specific mandated benefit laws may be, it is clear that mandated benefits were commonplace throughout the United States at the time the ACA was enacted.³² Moreover, it is apparent that mandated benefit laws and other state-specific insurance regulatory schemes have impacted employers' decision-making related to health and other benefits.³³

2. ERISA and the Limits of State Authority to Regulate Health Benefits

As its title indicates, the Employee Retirement Income Security Act of 1974 (ERISA) was enacted originally to provide minimum

²⁶ See, e.g., MASS. GEN. LAWS ch. 175, § 47H (2017).

²⁷ EHB Bulletin, *supra* note 3, at 7.

²⁸ Amy B. Monahan, *The ACA, the Large Group Market, and Content Regulation: What's a State To Do?*, 5 ST. LOUIS U. J. HEALTH L. & POL'Y 83, 89 (2011) [hereinafter Monahan, *The ACA, the Large Group Market, and Content Regulation*].

²⁹ See, e.g., AMERICA'S HEALTH INS. PLANS, STATEMENT ON ESSENTIAL HEALTH BENEFITS: SUBMITTED TO INSTITUTE OF MEDICINE COMMITTEE ON THE DETERMINATION OF ESSENTIAL HEALTH BENEFITS, 9 (Jan. 13, 2011), [https://www.nationalacademies.org/hmd/~media/Files/Activity%20Files/Health Services/EssentialHealthBenefits/2011-JAN-13%20and%202014/Carmella%20Bocchino%20Statement.pdf](https://www.nationalacademies.org/hmd/~media/Files/Activity%20Files/Health%20Services/EssentialHealthBenefits/2011-JAN-13%20and%202014/Carmella%20Bocchino%20Statement.pdf) [https://perma.cc/A4DH-X7HA] (arguing that "the inclusion of [state] mandates in the essential health benefits package is likely to have a significant impact on access to affordable coverage and limiting consumer choice.").

³⁰ See Amy Monahan, *Fairness Versus Welfare in Health Insurance Content Regulation*, 2012 U. ILL. L. REV. 139, 149-50 (2012) [hereinafter Monahan, *Fairness Versus Welfare*].

³¹ See *id.* at 148-49.

³² See *supra* text accompanying notes 19-27.

³³ Cf. Korobkin, *supra* note 22, at 97, 107-09 (noting that employers' "desire to avoid state benefits mandates and premium taxes can explain at least some of this increase in popularity [of opting to self-insure].").

protections to employees participating in private pension plans.³⁴ That being said, ERISA’s scope is broader than its title indicates. The statute governs all employee benefits, including health benefits.³⁵ Most importantly for the purposes of this limited exploration of ERISA, the statute “supersede[s] any and all State laws insofar as they may now or hereafter relate to any employee benefit plan.”³⁶ While ERISA protects state laws governing insurance from preemption,³⁷ the statute effectively bars states from regulating a substantial portion of employee benefit plans.³⁸

Employers that provide health benefits to their employees generally fall into two categories, fully-insured and self-insured (or self-funded). In a fully-insured arrangement, the employer purchases health insurance from an insurance carrier, and the carrier assumes the financial risk of providing the benefits.³⁹ In contrast, the employer generally assumes the financial risk for claims incurred in a self-insured arrangement.⁴⁰

³⁴ See 29 U.S.C. § 1001(c) (2012) (“It is hereby further declared to be the policy of this chapter to protect . . . the interests of participants in private pension plans and their beneficiaries by improving the equitable character and the soundness of such [private pension] plans . . .”). See also Daniel W. Sherrick, *ERISA Preemption: An Introduction*, 64 MICH. B. J. 1074, 1074 (1985) (“Faced with the rapid growth of private pension and benefit plans and the inability of the states to develop a comprehensive and uniform governing body of law, Congress enacted ERISA in 1974.”).

³⁵ 29 U.S.C. § 1002(1) (2012) (“The terms ‘employee welfare benefit plan’ and ‘welfare plan’ mean any plan, fund or program . . . to the extent that such plan, fund or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death . . .”).

³⁶ 29 U.S.C. § 1144(a) (2012).

³⁷ 29 U.S.C. § 1144(b)(2)(A) (2012).

³⁸ Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1371.

³⁹ BUREAU OF LABOR STATISTICS, NAT’L COMPENSATION SURVEY: GLOSSARY OF EMPLOYEE BENEFIT TERMS (Apr. 2016), http://www.bls.gov/ncs/eps/glossary20152016.htm#health_care [<https://perma.cc/HR8J-PHW3>].

⁴⁰ *Id.* Employers assume varying levels of risk in self-funded arrangements. “Stop-loss” insurance policies allow self-funded employers to limit their risk exposure. Some have characterized the ability of employers to purchase stop-loss insurance as a “loophole” in ERISA’s preemption of state insurance regulation. See

As alluded to above, ERISA bars states from categorizing self-funded health benefit plans as “insurance” for the purpose of subjecting them to state regulation.⁴¹ Thus ERISA’s application results in a complicated regulatory system for benefits that the average employee considers to be his or her “health insurance.”⁴² Simply put, fully-insured health benefit plans are subject to state-specific regulation while self-funded plans are not.⁴³ Moreover, ERISA does not regulate the content of self-funded plans in any significant way.⁴⁴ As one commentator noted, “self-insured plans operate rather happily in a ‘regulatory void.’”⁴⁵

Considering the significant benefits of self-insuring—namely avoiding state-specific regulation, mandated benefit laws, and premium

Korobkin, *supra* note 22, at 91 (“[T]he number [of self-funded plans] is surprisingly high, owing in part to the popularity of a loophole in ERISA that enables employers without sufficient resources to bear the risk of their employees’ health care costs to purchase ‘stop-loss’ insurance . . . and still qualify for ERISA’s protection from state regulatory requirements.”).

⁴¹ See 29 U.S.C. § 1144(b)(2)(B) (2012) (“Neither an employee benefit plan . . . nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.”). See also *Am. Med. Sec., Inc. v. Bartlett*, 111 F. 3d 358, 361 (4th Cir. 1997) (“Thus, a preempted law is saved from preemption if it regulates insurance and does not deem ERISA plans to be insurers for purposes of the state regulation of insurance.”).

⁴² Cf. Korobkin, *supra* note 22, at 93 (“Thus, ERISA preserves the traditional right of states to regulate the insurance industry, but those regulations may not extend to cover [employer health care benefits plans], even though [employer health care benefits plans] often serve an insurance function and might otherwise find themselves subject to state laws governing insurance.”).

⁴³ See Monahan, *Fairness Versus Welfare*, *supra* note 30, at 147 (“The end result of this regulatory structure is that individual insurance policies are regulated at the state level, insured employer plans are regulated both by the state and by ERISA, and self-insured employer plans are regulated solely by ERISA.”).

⁴⁴ See Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1372 (“[Plans] that are self-insured are subject only to the limited substantive requirements of ERISA, while plans that are funded through insurance contracts are subject to state insurance laws (including mandated benefit provisions), as well as any substantive requirements of ERISA . . .”).

⁴⁵ *Id.*

taxes⁴⁶—along with the availability of stop-loss insurance,⁴⁷ it is hardly surprising a significant portion of the market opts to self-fund.⁴⁸ Some 61% of employees receiving health benefits from their employers are in self-funded plans.⁴⁹ Thus 61% of employees receive health benefits that are by and large exempted from state regulation.⁵⁰ Indeed, the prospect of avoiding state-specific taxation and regulation appears to be a motivation for opting to self-fund for at least some employers.⁵¹ Thus, while states had traditionally acted as the primary regulator of the health insurance industry, the breadth of the ERISA preemption scheme has forestalled state-specific regulation of a majority of employer-sponsored health benefit plans.⁵²

C. State Authority to Regulate Health Insurance After the Patient Protection and Affordable Care Act

1. The Affordable Care Act

Perhaps the most comprehensive expression of Congress' intent to enact a law "specifically relate[d] to the business of insurance"⁵³ in recent memory is the ACA. According to President Obama, Congress passed the ACA because its "leaders . . . recognized that expanding coverage, reducing the level and growth of health care costs, and

⁴⁶ While state taxes on insurance premiums are generally not applicable to self-funded plans, state legislatures have looked for creative ways to generate revenue from self-insured employer plans that are, to date, permissible under ERISA. *See, e.g.,* MICH. COMP. LAWS §550.1731 et seq.

⁴⁷ *See generally* Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1372-73.

⁴⁸ *See* KAISER FAMILY FOUNDATION, EMPLOYER HEALTH BENEFITS: 2016 ANNUAL SURVEY, 188 (2016), <http://files.kff.org/attachment/Report-Employer-Health-Benefits-2016-Annual-Survey> [<https://perma.cc/7B2G-9S5M>].

⁴⁹ *Id.*

⁵⁰ *See* Monahan, *Fairness Versus Welfare*, *supra* note 30, at 147.

⁵¹ *See generally* Korobkin, *supra* note 22, at 107-09.

⁵² *See* Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1401 (discussing the "impotent role states currently play [in regulating health benefits] due to ERISA preemption . . ."). *See also* Timothy S. Jost & Mark A. Hall, *The Role of State Regulation in Consumer-Driven Health Care*, 31 AM. J. L. & MED. 395, 399 (2005) ("With respect to many issues where states see regulation as appropriate, self-insured plans are simply unregulated.").

⁵³ 15 U.S.C. § 1012(b) (2012).

improving quality was an urgent national priority.”⁵⁴ Throughout its 900 pages, the ACA seeks to increase the number of individuals with health insurance and reduce the cost of care.⁵⁵ Among the ACA reforms were the two provisions at issue in *NFIB v. Sebelius*: the requirement for individuals to purchase health insurance (the “individual mandate”)⁵⁶ and the expansion of the Medicaid program.⁵⁷ In addition, the Act requires insurers to “accept every employer and individual in the State that applies” for health insurance coverage regardless of an individual’s health status.⁵⁸ The health reform law requires the creation of health insurance “exchanges,” which are online marketplaces designed to “facilitate the purchase of qualified health plans.”⁵⁹ Finally, the Act provides tax credits to individuals at specified income levels to assist in covering the cost of health insurance.⁶⁰

2. Essential Health Benefits

The ACA requires carriers offering health insurance to small employers and individuals⁶¹ to include “essential health benefits”

⁵⁴ Barack Obama, *United States Health Care Reform: Progress to Date and Next Steps*, J. OF THE AM. MED. ASS’N. (Aug. 2, 2016) <http://jamanetwork.com/journals/jama/fullarticle/2533698> [<https://perma.cc/KVR3-C62Q>].

⁵⁵ *Nat’l Fed’n Indep. Buss. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012).

⁵⁶ *Id.* (citing 26 U.S.C. § 5000A (2012)).

⁵⁷ *Id.* at 2581-82 (citing 42 U.S.C. § 1396a(a) (2012)).

⁵⁸ 42 U.S.C. § 300gg-1 (2012).

⁵⁹ 42 U.S.C. § 18031(b)(1)(A) (2012).

⁶⁰ *King v. Burwell*, 135 S. Ct. 2480, 2488 (2015) (citing 26 U.S.C. § 36B (2012)).

⁶¹ The mandate to cover EHBs applies to individual and small employer plans regardless of whether the plan is purchased on or off of a health insurance exchange. *See* EHB Bulletin, *supra* note 3, at 1, n. 1 (“Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.”). *See also* Amanda Cassidy, *Health Policy Brief: Essential Health Benefits*, HEALTH AFFAIRS, 2 (Apr. 25, 2012), http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_68.pdf [<https://perma.cc/67SS-NSXU>] (“Beginning in 2014 health plans sold in the individual and small group markets, both within and outside the new state-based exchanges, must include essential health benefit These requirements do not apply to self-insured health plans, those in the large group market . . . or grandfathered health plans”).

(EHB) in their plans.⁶² The Act identifies ten broad categories of benefits⁶³ the plans must include and directs the Secretary of Health and Human Services (HHS) to further define the specific benefits insurers must offer via regulation.⁶⁴

The extent to which the Secretary would further define the EHB package was a high-stakes decision for the Obama Administration as it began implementing the ACA.⁶⁵ If the regulations implementing the EHB requirements were too prescriptive, administration critics' arguments that the ACA "[forced] a one-size-fits-all standard for health insurance and usurp[ed] state authority to regulate the industry" could have been bolstered.⁶⁶ However, if the regulations were not prescriptive enough, consumer groups that had championed the ACA would have been disappointed.⁶⁷

⁶² 42 U.S.C. § 300gg-6 (2012).

⁶³ 42 U.S.C. § 18022(b)(1) provides "the Secretary [of Health and Human Services] shall define the essential health benefits, except that such benefits shall include at least the following general categories and the items and services covered within the categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care."

⁶⁴ 42 U.S.C. § 18022(b)(1) (2012). The statute further requires that "The Secretary shall ensure that the scope of [essential health] benefits . . . is equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary." 42 U.S.C. § 18022(b)(2)(A) (2012).

⁶⁵ See Noam M. Levey, *Passing the Buck – Or Empowering States? Who Will Define Essential Health Benefits*, HEALTH AFFAIRS 31:4, 663, 663-64 (Apr. 2012) <http://content.healthaffairs.org/content/31/4/663> [https://perma.cc/QP8Q-SJTH] ("It is hard to overstate how important the notion of an essential health benefit package was to congressional Democrats and patient advocates as the law was being formulated.").

⁶⁶ Robert Pear, *Health Care Law Will Let States Tailor Benefits*, NY TIMES, Dec. 16, 2011, http://www.nytimes.com/2011/12/17/health/policy/health-care-law-to-allow-states-to-pick-benefits.html?_r=0 [https://perma.cc/Z72M-G3FC]. See Levey, *supra* note 65, at 663 (stating the Administration's approach to defining EHBs "dodg[ed] another noxious debate about a federal government 'takeover' of the health care and health insurance system.").

⁶⁷ See Jason Millman, *A Fine Line on Essential Benefits*, POLITICO (Dec. 18, 2011), <http://www.politico.com/story/2011/12/first-crack-at-essential-benefits-dodges-backlash-070616> [https://perma.cc/L6XJ-J6S2] ("[C]onsumer groups, who see the extension of comprehensive insurance coverage as health reform's most

Not surprisingly, interested parties had conflicting visions of what the EHB regulations should seek to accomplish.⁶⁸ For instance, the insurance industry saw the EHB requirements as an opportunity to provide a uniform regulatory standard for insurers rather than a patchwork of state mandated benefit regulations.⁶⁹ Further, America's Health Insurance Plans (AHIP), the leading health insurance industry trade association, saw no need to further specify the EHB package's scope beyond what the statute provided.⁷⁰ AHIP also believed this national standard could help insurers "get out from under" the weight of hundreds of state mandated benefit laws.⁷¹ In contrast, consumer advocates felt the EHB regulations needed to be detailed and strong in order to ensure the Act's promise of providing comprehensive health coverage to consumers.⁷² For their part, state government representatives sought to ensure the EHB requirements would not interfere with the ability of state governments to regulate the insurance industry in their respective states.⁷³

important promise, have been pushing for specific essential benefit requirements from HHS.").

⁶⁸ See *infra* text accompanying notes 69-73.

⁶⁹ See AMS. HEALTH INS. PLANS, NOW IS THE TIME FOR HEALTH CARE REFORM: A PROPOSAL TO ACHIEVE UNIVERSAL COVERAGE, AFFORDABILITY, QUALITY IMPROVEMENT AND MARKET REFORM, 10 (December 2008) <https://www.ahip.org/wp-content/uploads/2016/05/ComprehensiveReform.pdf> [<https://perma.cc/YP78-E3UH>] [hereinafter AHIP, NOW IS THE TIME] ("To maintain affordability, the essential benefits plan should not be subject to varying and conflicting state benefit mandates.").

⁷⁰ In a written statement to the Institutes of Medicine, AHIP noted the following: "Congress has already specified an appropriate set of 'essential' items or services that should be included in the essential health benefits package." AMS. HEALTH INS. PLANS, STATEMENT ON ESSENTIAL HEALTH BENEFITS SUBMITTED TO THE INSTITUTE OF MEDICINE COMMITTEE ON THE DETERMINATION OF ESSENTIAL HEALTH BENEFITS (January 13, 2011) [hereinafter AHIP, STATEMENT ON ESSENTIAL HEALTH BENEFITS] <https://www.nationalacademies.org/hmd/~media/B2B9D09B787E468398384FE879094981.ashx> [<https://perma.cc/U8UN-N6RF>].

⁷¹ Levey, *supra* note 65, at 664. See also *id.* (noting that insurers "had looked to Washington to create a national standard of benefits and clear away a web of burdensome state benefit mandates.").

⁷² See Millman, *supra* note 67.

⁷³ See *Healthcare Reform: Hearing Before the S. Comm. On Health, Educ., Labor and Pensions*, 111th Cong. 2009 WL 1653827 (2009) (statement of Ray Schepach, Exec. Dir., Nat'l Governors Ass'n) ("While states are supportive of

Ultimately, in drafting the EHB regulations, HHS provided states with a surprising degree of flexibility.⁷⁴ Rather than specifically delineate each and every benefit and service insurers must cover, the agency adopted a “benchmark” approach whereby states would, by and large, be permitted to define the EHB package applicable in their respective insurance markets.⁷⁵ According to the final rule, states have the option to designate one of four⁷⁶ “typical employer plans” as the state’s benchmark plan.⁷⁷ Thereafter, plans subject to the EHB requirements would have to cover the benefits and services – including state mandated benefits – that the benchmark plan covered.⁷⁸ While

having the federal government establish certain insurance market reforms on such issues as guaranteed issue, health care reform should not diminish or impede the long-standing establishment of state regulation of health insurance.”).

⁷⁴ See Pear, *supra* note 66 (describing the EHB benchmark approach as “a major surprise”).

⁷⁵ See Patient Protection and Affordable Care Act: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834, 12,841 (Feb. 25, 2013) (“The benchmark approach for defining EHB sought to balance the statutory ten benefit categories and affordability while providing states – the primary regulators of health insurance markets – with flexibility. The benchmark plan options for each state reflect the scope of benefits and services typically offered in the employer market in that state.”).

⁷⁶ See 45 C.F.R. § 156.100 (2015) (indicating that states may select one of the following insurance plans as its benchmark plan: “(1) *Small group market plan*. The largest health plan by enrollment in any of the three largest small group insurance products. . . in the State’s small group market . . . (2) *State employee health benefit plan*. Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State . . . (3) *FEHBP plan*. Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options . . . that is offered to . . . federal employees . . . (4) *HMO*. The coverage plan with the largest insured commercial . . . enrollment offered by a health maintenance organization operating in the state.”).

⁷⁷ Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. at 12,840 (“The EHB-benchmark plan would serve as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state.”).

⁷⁸ See EHB Bulletin, *supra* note 3, at 9 (“In the transitional years of 2014 and 2015, if a State chooses a benchmark [plan] subject to State mandates—such as a small group market plan—that benchmark should include those mandates in the State EHB package.”). See also Cassidy, *supra* note 61, at 3 (“Most of these [state] benefit mandates are typically included in the plans from which states will be able to select as the benchmark plan.”).

several key Democratic members of Congress strongly objected to the Department's delegation of authority to the states,⁷⁹ others applauded the administration's willingness to ensure that state governments would continue to have a key role in regulating the health insurance market.⁸⁰

3. Essential Health Benefits and State Mandated Benefit Laws

Consistent with the theme of providing states with flexibility in implementing its provisions, the ACA explicitly permits states to require health plans subject to the EHB provisions to cover benefits and services outside of the EHB package, as follows:

(B) States may require additional benefits

(i) In general

Subject to the requirements of clause (ii), a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title.⁸¹

The Act, however, is not as flexible as it appears at first glance. Subsection (3)(B)(ii) of the above-referenced ACA section provides:

(ii) State must assume cost

A State shall make payments –

⁷⁹ Letter from Rep. Henry A. Waxman, Ranking Member, House Committee on Energy and Commerce, et al. to The Honorable Kathleen Sebelius, Secretary of Health and Human Services (February 6, 2012) <https://wayback.archive-it.org/4949/20141224080853/http://democrats.energycommerce.house.gov/sites/default/files/documents/Sebelius-PPACA-Essential-Health-Benefits-2012-2-6.pdf> [<https://perma.cc/PH7M-PL5H>] (“When creating the EHB package, we intended this to be a federal decision. We had not anticipated your decision to delegate the definition of the EHB package to states [W]e would reiterate that one of the primary goals of the Affordable Care Act was to create a consistent and comprehensive level of coverage for people across the country. Without very careful protections, we have serious concerns about delegating the decision for the EHB to the States and providing even further discretion to insurers.”).

⁸⁰ See Levey, *supra* note 65, at 665 (“For their part, many state officials have welcomed the HHS directive [regarding the EHB benchmark approach]. ‘The big question for us was how prescriptive the federal government was going to be,’ says Iowa insurance commissioner Susan Voss. ‘We wanted to have some options.’”).

⁸¹ 42 U.S.C. § 18031(d)(3)(B)(i) (2012).

(I) to an individual enrolled in a qualified health plan offered in such State; or

(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;

*to defray the cost of any additional benefits described in clause (i).*⁸²

In short, this section of the ACA compels states to “defray” the cost of any health services the state requires insurers to provide outside of the federally defined EHB package.⁸³ Similar language had been included in several draft versions of the health reform legislation, with one key distinction: These earlier drafts had required states to assume costs attributable to state mandated benefits for only those individual and small-group market subscribers receiving federal premium assistance.⁸⁴

⁸² 42 U.S.C. § 18031(d)(3)(B)(ii) (2012) (“clause (i)” refers to the section of the statute permitting states to require benefits in addition to the EHB package).

⁸³ *Id.* See, e.g., Michelle Andrews, *Health Law Tempers New State Coverage Mandates*, KAISER HEALTH NEWS (Sep. 16, 2014), <http://khn.org/news/health-law-tempers-new-state-coverage-mandates/> [https://perma.cc/7T73-MHKG] (“[T]he law requires states, not insurers, to cover the cost of mandates passed after 2011 that apply to individual and small group plans sold on or off the state health insurance marketplaces. If a mandate increases a plan’s premium, states will be on the hook for the additional premium cost that’s attributable to the mandate.”).

⁸⁴ As indicated, early versions of the health care reform legislation required states to defray the additional costs attributable to mandated benefits only for subscribers who received advanced premium tax credits to subsidize the purchase of insurance. For instance, a preliminary House bill read:

(d) TREATMENT OF STATE BENEFIT MANDATES. – Insofar as a State requires a health insurance issuer offering health insurance coverage to include benefits beyond the essential benefits package, such requirement shall continue to apply to an Exchange-participating health benefits plan, if the State has entered into an arrangement . . . to reimburse the Commissioner for the amount of any net increase in affordability premium credits . . . as a result of an increase in premium

H.R. 3200, 111th Cong. § 203(d) (2009). Similarly, the Senate HELP Committee’s reform legislation included the following provision:

(F) ADDITIONAL BENEFITS – (i) NO ADDITIONAL FEDERAL COST. – A requirement by a state . . . that a qualified health plan cover benefits in addition to the essential health benefits required shall not affect the amount of a credit provided under section 1311 with respect to such plan. (ii) STATE MUST ASSUME COST. – A State shall make payments to or on behalf of

In contrast, the final version of the ACA includes this requirement for all individual and small-group market subscribers, regardless of whether they receive federal subsidies to help pay for their health coverage.⁸⁵ Because the legislative history of the ACA is murky at best, it is not clear what motivated Congress to make this significant change to the bill's language.⁸⁶ Whatever the motivation, the result appears to be that the ACA in its current form stands on less stable constitutional ground.⁸⁷

At least one observer correctly notes the “unusual” nature of this provision.⁸⁸ Rather than use its broad authority under the Commerce Clause to directly regulate the scope of insurance benefits available to the affected populations and preempt contradictory state mandated benefit laws, Congress opted to require states to expend scarce state general revenue dollars to subsidize the additional costs attributed to state mandated benefits.⁸⁹ In doing so, Congress apparently sought to discourage states from enacting these controversial mandated benefit laws.⁹⁰ Members of Congress apparently felt that if states had to assume the costs of these mandated benefits, they would be less likely to enact

an eligible individual to defray the cost of any additional benefits described in subparagraph (E).

S. 1679, 111th Cong. § 3101(c)(2)(F) (2009). *See also* Chapin White & Amanda E. Lechner, *State Benefits Mandates and National Health Reform*, Nat'l Inst. For Health Care Reform Policy Analysis No. 8, 1, 3 (Feb. 2012) http://nihcr.org/wp-content/uploads/2016/07/Policy_Analysis_No._8.pdf [<https://perma.cc/F2XT-BFEZ>] (“States will be allowed to mandate benefits that exceed the essential health benefits package, but they will have to pay for the cost of the additional benefits for all [qualified health plan] enrollees—not just those purchasing through the exchanges and receiving federal premium subsidies.”).

⁸⁵ Had the statutory language remain tied to federal expenditures (i.e. advance premium tax credits), this section arguably would have been enacted pursuant to Congress' spending clause power, thereby altering the commandeering analysis. *See infra* Parts II.A, III.D.

⁸⁶ *See generally* John Cannan, *A Legislative History of the Affordable Care Act: How Legislative Procedure Shapes Legislative History*, 105:2 LAW LIBRARY JOURNAL 131 (2013).

⁸⁷ *See infra* Part III.D

⁸⁸ Cassidy, *supra* note 61, at 3.

⁸⁹ *See supra* text accompanying notes 80-82.

⁹⁰ *See* Andrews, *supra* note 83 (“*To discourage states from passing mandates that go beyond essential health benefits requirements, the law requires states . . . to cover the cost of mandates passed after 2011 . . .*”) (emphasis added).

them in the first place.⁹¹ Some insurance industry representatives thought that this unique approach could help state leaders understand the true cost of mandated benefit law. As one insurance executive stated, “[Subsection (3)(B)(ii)] was a provision that we thought would really drive a discussion about what these benefit mandates cost.”⁹²

PART II. ENCOURAGEMENT, COERCION, OR COMMANDEERING?

The constitutional implications of the ACA have been discussed ad nauseam.⁹³ The Act’s individual mandate to purchase insurance and Medicaid expansion have been the primary subjects that the legal academy has analyzed.⁹⁴ Indeed, the Medicaid expansion called for the Supreme Court to assess the federalism implications of the Act.⁹⁵ Commentators have also discussed the federalism implications of other ACA provisions.⁹⁶ The next sections of this article will consider the constitutional permissibility of the provisions related to states’ authority to require health insurers to “offer benefits in addition to the essential health benefits.”⁹⁷ First, Part II will provide an overview of the Supreme Court leading cases prohibiting federal “commandeering” of state governments’ legislative and regulatory activity. Part III will make the case that the ACA’s limitation on state mandated benefit laws has resulted in states being coerced into enforcing a federal regulatory program in violation of the anti-commandeering principle.

⁹¹ *Id.*

⁹² Levey, *supra* note 65 at 664.

⁹³ See, e.g., Laurence H. Tribe, *The Constitutionality of the Patient Protection and Affordable Care Act: Swimming in the Stream of Commerce*, 35 HARV. J. L. & PUB. POL’Y 873 (Summer 2012).

⁹⁴ See, e.g., *id.* See also Alicia Ouellette, *Health Reform and the Supreme Court: The ACA Survives the Battle of the Broccoli and Fortifies Itself Against Future Fatal Attack*, 76 ALB. L. REV. 87, 90-99 (2012-2013); Nicole Huberfeld et al., *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1 (Jan. 2013).

⁹⁵ See Nat’l Fed’n Indep. Buss. v. Sebelius, 132 S. Ct. 2566, 2601-09 (2012).

⁹⁶ See, e.g., Huberfeld et al., *supra* note 94.

⁹⁷ 42 U.S.C. § 18031(d)(3)(B) (2012).

A. Congressional Encouragement of State Action Via the Spending Clause

While Congress has broad constitutional authority to regulate a wide range of issues, the Tenth Amendment prohibits Congress from “requir[ing] the States to govern according to Congress’ instructions.”⁹⁸ That being said, the Constitution permits a variety of ways in which Congress can encourage state policymakers to regulate in accordance with Congress’ wishes.⁹⁹ First, quite plainly, Congress may attach conditions to states’ receipt of federal funds.¹⁰⁰ In fact, until *NFIB v. Sebelius*, the Supreme Court had never invalidated Congress’ use of its spending power for being “unconstitutionally coercive.”¹⁰¹

Prior to *NFIB*, *South Dakota v. Dole* provided a four-factor test for determining whether a conditional spending program was constitutional:

*The conditions placed on federal grants to States must (a) promote the “general welfare,” (b) “unambiguously inform” States what is demanded of them, (c) be germane “to the federal interest in particular national projects or programs,” and (d) not “induce the States to engage in activities that would themselves be unconstitutional.”*¹⁰²

In *Dole*, the federal statute at issue authorized the Department of Transportation to withhold up to five percent of a state’s highway appropriation if the state did not raise its drinking age to 21 years.¹⁰³ In upholding the statute, the Court noted that states that opted not to raise their drinking age only stood to “lose a relatively small percentage of certain federal highway funds.”¹⁰⁴ This “relatively mild

⁹⁸ *New York v. United States*, 505 U.S. 144, 162 (1992).

⁹⁹ *See id.* at 166. *See also* Gregory P. Magarian, *Chief Justice Roberts’s Individual Mandate: The Lawless Medicine of NFIB v. Sebelius*, 108 NW. U. L. REV. COLLOQUOY 15, 27 (2013).

¹⁰⁰ *South Dakota v. Dole*, 483 U.S. 203, 206 (1987) (citing *Fullilove v. Klutznick*, 448 U.S. 448, 474 (1980)).

¹⁰¹ *Nat’l Fed’n Indep. Buss. v. Sebelius*, 132 S. Ct. 2566, 2630 (2012) (Ginsburg, J., concurring in part, concurring in the judgment in part, dissenting in part).

¹⁰² *Id.* (citing *South Dakota v. Dole*, 483 U.S. 203, 207-08, 210 (1987)).

¹⁰³ *Dole*, 483 U.S. at 211.

¹⁰⁴ *See id.* (“When we consider . . . that all South Dakota would lose if she adheres to her chosen course as to a suitable minimum drinking age is 5% of the funds

encouragement” was not enough for the Court to conclude that states had been coerced into enacting legislation to raise their respective drinking ages.¹⁰⁵

In *NFIB*, the Court distinguished the ACA Medicaid expansion¹⁰⁶ from *Dole*: “In this case, the financial ‘inducement’ Congress has chosen is much more than ‘relatively mild encouragement’ – it is a gun to the head.”¹⁰⁷ While the Chief Justice’s opinion discusses the *Dole* factors, ultimately his decision appears to turn on the degree of the Medicaid expansion’s impact on state budgets.¹⁰⁸ In doing so, the Chief Justice may have added a new requirement for conditions on state receipt of federal dollars to meet constitutional muster: these conditions must not represent a financial “gun to the [state’s] head.”¹⁰⁹ Notably, the *NFIB* decision departed from other federal court decisions by embracing the idea that courts can meaningfully assess whether a

otherwise obtainable under specified highway grant programs, the argument as to coercion is sown to be more rhetoric than fact.”).

¹⁰⁵ *Id.* at 211-12.

¹⁰⁶ The ACA expanded eligibility for Medicaid by requiring states to cover childless adults with incomes up to 133% of the federal poverty level. 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (2012). The Act provides federal funding to cover a substantial majority of the cost of the eligibility expansion. 42 U.S.C. § 1396d(y)(1) (2012). Initially, the Act provided 100% federal funding to cover the Medicaid expansion’s cost. *Id.* Over several years of implementation, states would eventually be required to provide 10% of the expansion’s cost. *Id.* “If a State [did] not comply with the Act’s new coverage requirements, it [could] lose not only the federal funding for those requirements, but all of its federal Medicaid funds.” Nat’l Fed’n Indep. Buss.v. Sebelius, 132 S. Ct. 2566, 2582 (citing 42 U.S.C. § 1396c (2012)).

¹⁰⁷ Nat’l Fed’n Indep. Buss.v. Sebelius, 132 S. Ct. 2566, 2604 (2012) (quoting *South Dakota v. Dole*, 483 U.S. 203, 211-12 (1987)).

¹⁰⁸ *See id.*

¹⁰⁹ *See* Mitchell N. Berman, *Coercion, Compulsion, and the Medicaid Expansion: A Study in the Doctrine of Unconstitutional Conditions*, 91 TEX. L. REV. 1283, 1297 (May 2013) (noting “It would have been easy enough for the *Dole* majority to plainly announce five requirements that any condition attached to federal spending grants to the states must satisfy: it must promote the general welfare, be unambiguous, be germane to the federal interest in the spending program, not induce the states to violate the Constitution, and not coerce the states into accepting. Instead, Chief Justice Rehnquist’s opinion listed the first four restrictions in a single paragraph and then, only after determining that none condemned the condition on highway funds at issue in that case, introduced Steward Machine’s ruminations on coercion almost as an afterthought.”).

spending condition is unduly coercive.¹¹⁰ In discussing the *NFIB* decision's reliance on "that single sentence"¹¹¹ in *Dole* which makes reference to the possibility that financial incentives offered by Congress could "be so coercive as to pass the point at which 'pressure turns into compulsion,'"¹¹² Magarian charges the Chief Justice with "inflat[ing] . . . a sketchy dictum into a pillar of Spending Clause doctrine."¹¹³ While the *NFIB* Court failed to offer clear guidelines as to what constitutes the proverbial "gun to the head,"¹¹⁴ it is apparent that the Roberts Court may have opened the door to more lawsuits challenging the coercive impact that federal laws may have upon states.¹¹⁵

B. Congressional Commandeering

In addition to the Spending Clause, Congress can use its authority to regulate "commerce among the states"¹¹⁶ to shape state policymaking.¹¹⁷ A primary example of this is the concept of

¹¹⁰ See *South Dakota v. Dole*, 483 U.S. 203, 211 (1987) ("As we said a half century ago in *Steward Mach. Co. v. Davis*: 'Every rebate from a tax when conditioned upon conduct is in some measure a temptation. But to hold that motive or temptation is equivalent to coercion is to plunge the law in endless difficulties.'") (citing *Steward Mach. Co. v. Davis*, 301 U.S. 548, 589-90 (1937)); *West Virginia v. U.S. Dept. of Health & Human Servs.*, 289 F.3d 281, 290 (4th Cir. 2002) (noting "most courts faced with the question [of where the line between encouragement and coercion is crossed] have effectively abandoned any real effort to apply the coercion theory.") (citations omitted).

¹¹¹ Magarian, *supra* note 99, at 27.

¹¹² *Dole*, 483 U.S. at 207-08, 211 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937)).

¹¹³ Magarian, *supra* note 99, at 28.

¹¹⁴ See Magarian, *supra* note 99, at 29-30 ("Chief Justice Roberts, in giving the [*Dole*] dictum serious legal effect for the first time, had a responsibility to provide guidance to Congress should it seek to repair or replace the PPACA's leverage provision The Chief Justice's failure to provide any legal insights as to these essential questions completes his *NFIB* opinion's catalog of descriptive lawlessness.").

¹¹⁵ See Huberfeld et al., *supra* note 94, at 46-47 ("The courthouse doors have now been thrown open to challengers seeking to explore the contours of the coercion doctrine.").

¹¹⁶ U.S. CONST. art. I, § 8.

¹¹⁷ *New York v. United States*, 505 U.S. 144, 167-68 (1992).

“cooperative federalism.”¹¹⁸ With cooperative federalism, Congress can provide state governments with the option of regulating a “private activity . . . according to federal standards or having state law preempted by federal regulation.”¹¹⁹ Notably, this rule applies to cases in which Congress has the authority to regulate *private activity* under the Commerce Clause.¹²⁰ In addition, when a generally applicable statute impacts a state government—even if the federal law effectively requires a state legislature to enact new legislation or amend existing statutes¹²¹—the federal statute does not run afoul of the Tenth Amendment as long as the statute “‘regulates state activities’ rather than ‘seek[ing] to control or influence the manner in which States regulate private parties.’”¹²²

While Congress’ power to regulate interstate commerce can be used to cajole states into pursuing certain policies, the Supreme Court has made it clear that Congress cannot “simply ‘commandeer the legislative processes of the States by directly compelling them to enact and enforce a federal regulatory program.’”¹²³ A federal statute that requires state officials merely to “consider[] . . . federal standards” when formulating state policies does not “commandeer” a state’s legislative process.¹²⁴ Likewise, when a state chooses not to regulate a field that is otherwise subject to federal preemption, there is no commandeering.¹²⁵ However, Congress cannot, under the guise of giving states a “choice,” coerce

¹¹⁸ *Id.* at 167 (citing *Hodel v. Va. Surface Mining & Reclamation Ass’n, Inc.*, 452 U.S. 264, 288 (1981)).

¹¹⁹ *New York*, 505 U.S. at 167. (citing *Hodel*, 452 U.S. at 288). *See Hodel*, 452 U.S. at 288 (noting that a federal statute governing the “activities of coal mine operators who are private individuals” was not impermissibly coercive where states were given the option to either propose a state regulatory scheme in accordance with the federal act or elect to have the federal government bear “the full regulatory burden.”).

¹²⁰ Where a federal law requires a state “in [its] sovereign capacity to regulate [its] own citizens” in accordance with said federal law, the analysis is markedly different. *See New York*, 505 U.S. at 166 (“The allocation of power contained in the Commerce Clause . . . authorizes Congress to regulate interstate commerce directly; it does not authorize Congress to regulate state governments’ regulation of interstate commerce.”).

¹²¹ *South Carolina v. Baker*, 485 U.S. 505, 513 (1988).

¹²² *Reno v. Condon*, 528 U.S. 141, 150 (2000) (quoting *Baker*, 485 U.S. at 514-15).

¹²³ *New York*, 505 U.S. at 161 (quoting *Hodel* 452 U.S. at 288).

¹²⁴ *New York*, 505 U.S. at 161-62 (citing *FERC v. Mississippi*, 456 U.S. 742, 764 (1982)).

¹²⁵ *See supra* text accompanying note 119.

states into enforcing a federal regulatory program.¹²⁶ As the Supreme Court stated in *New York v. U.S.*, its leading anti-commandeering case:

*In this provision, Congress has not held out the threat of exercising its spending power or its commerce power; it has instead held out the threat, should the States not regulate according to one federal instruction, of simply forcing the States to submit to another federal instruction. A choice between two unconstitutionally coercive regulatory techniques is not choice at all.*¹²⁷

The “two unconstitutionally coercive” choices that states were given in *New York* were: (1) enact and enforce a federal regulatory program to manage low-level radioactive waste or (2) “take title” to the privately owned low-level radioactive waste in one’s state and assume waste generators’ liability for any and all associated damages.¹²⁸ In discussing this false choice, the Court stated:

*[T]he Constitution would not permit Congress simply to transfer radioactive waste from generators to state governments. Such a forced transfer, standing alone, would in principle be no different than a congressionally compelled subsidy from state governments to radioactive waste producers. The same is true of the provision requiring States to become liable for the generators’ damages. Standing alone, this provision would be indistinguishable from an Act of Congress directing the States to assume the liabilities of certain state residents. Either type of federal action would ‘commandeer’ state governments into the service of federal regulatory purposes, and would for this reason be inconsistent with the Constitution’s division of authority between federal and state governments.*¹²⁹

¹²⁶ *New York*, 505 U.S. at 176, 188.

¹²⁷ *Id.* at 176.

¹²⁸ *Id.* at 174-75.

¹²⁹ *Id.* at 175.

The prohibition on federal commandeering applies regardless of how compelling a federal interest may be.¹³⁰ If a federal interest compels Congress to regulate, “it must do so directly; it may not conscript state governments as its agents.”¹³¹ Finally, as the Supreme Court made clear in *Printz v. U.S.*, a federal law need not directly command states to enact legislation or “make policy” to run afoul of *New York*’s commandeering principle.¹³² Requiring state executive branch officials to enforce a federal regulatory program is sufficient to constitute commandeering.¹³³

The *New York* Court was concerned about the impact of federal commandeering on the allocation of political accountability: “[W]here the Federal Government compels States to regulate, the accountability of both state and federal officials is diminished.”¹³⁴ In contrast to conditional spending and cooperative federalism, state citizens, practically speaking, cannot decline to obey Congress’ instructions.¹³⁵ “Where Congress encourages state regulation rather than compelling it, state governments remain responsive to the local electorate’s preferences; state officials remain accountable to the people.”¹³⁶ When Congress commandeers state governments, political accountability lines are blurred to such a great extent that “it may be state officials who will bear the brunt of public disapproval, while the federal officials who

¹³⁰ See *id.* at 178 (“No matter how powerful the federal interest involved, the Constitution simply does not give Congress the authority to require the States to regulate.”).

¹³¹ *Id.* at 178. See *id.* at 166 (“The allocation of power contained in the Commerce Clause . . . authorizes Congress to regulate interstate commerce directly; it does not authorize Congress to regulate state governments’ regulation of interstate commerce.”).

¹³² *Printz v. United States*, 521 U.S. 898, 926-31(1997). See *id.* at 935 (“The Federal Government may neither issue directives requiring the States to address particular problems, not command the States’ officers . . . to administer or enforce a federal regulatory program. It matters not whether policymaking is involved . . .”).

¹³³ *Id.* at 935.

¹³⁴ *New York*, 505 U.S. at 168.

¹³⁵ See *id.* at 168 (“If a State’s citizens view federal policy as sufficiently contrary to local interests, they may elect to decline a federal grant. If state residents would prefer their government to devote its attention and resources to problems other than those deemed important by Congress, they may choose to have the Federal Government rather than the State bear the expense of a federally mandated regulatory program, and they may continue to supplement that program to the extent state law is not pre-empted.”).

¹³⁶ *Id.* at 168.

devised the regulatory program may remain insulated from the electoral ramifications of their decision.”¹³⁷

PART III. THE UNEXPLORED COMMANDEERING FEATURES OF SECTION 1311

While state leaders and health policy experts have taken note of the ACA’s innovative approach to state mandated benefits,¹³⁸ few if any have explored the constitutional implications of this provision. It appears state policymakers have accepted the new reality: if they wish to enact new mandated benefit laws, they must subsidize the costs incurred by health insurers’ provision of those benefits.¹³⁹ While there are ways to draft mandated benefit legislation so as not to trigger the ACA “defray the cost” provision,¹⁴⁰ the practical benefit of drafting legislation in that manner is probably limited.¹⁴¹ To date, it does not appear that the federal government has enforced this provision in response to the enactment of a state mandated benefit law.¹⁴²

The requirement that a state defray the costs associated with mandated benefit laws is “unusual” to say the least.¹⁴³ It does not fit neatly within existing paradigms of federalism. This is not a case in which Congress has preempted contradictory state laws.¹⁴⁴ The plain

¹³⁷ *Id.* at 169.

¹³⁸ *See, e.g.*, NY Assembly Hearing Notice, *supra* note 1.

¹³⁹ *See, e.g.*, NY Assembly Hearing Notice, *supra* note 1. *See also* Millman, *supra* note 67 (describing some state officials as “particularly fearful that the state-required benefits will exceed the federal requirements, leaving them on the hook to make up the cost of premium subsidies derived from the mandates.”).

¹⁴⁰ *See infra* Part IV.B.

¹⁴¹ A substantial portion of the employer sponsored insurance market is already exempt from state regulation. *See supra* text accompanying notes 46-52. Therefore, drafting state mandated benefit legislation that only applies to the large group market, so as to avoid triggering the ACA “defray the cost” requirement, will likely have only minimal benefits for state citizens. *See infra* Part IV.B.

¹⁴² *See* Letter from Anne Marie Crosswell, Assistant Att’y Gen. for the State of South Carolina, to Michael W. Grambell, Member of the South Carolina House of Representatives (Dec. 18, 2015), 2015 WL 9581246 (S.C.A.G.) at *1 (“There is no history of a state triggering the reimbursements or precedents for state payments for expanded coverage requirements, and the responsibilities of a state with regard to this component of the ACA has not been established.”).

¹⁴³ Cassidy, *supra* note 61, at 3.

¹⁴⁴ *See* 42 U.S.C. § 18031(d)(3)(B)(i) (2012). *See also infra* Part III-A.

language of the statute in question explicitly reserves a state's authority to require insurers to cover benefits and services beyond the EHB package.¹⁴⁵ Nor is this a situation in which states are given a no-strings-attached option to either enforce a federal regulatory standard or allow the federal government to step in and enforce its own laws.¹⁴⁶ Nor are states faced with a "generally applicable" federal law that has incidental financial impacts on state governments.¹⁴⁷ Finally, while early drafts of the 2009-2010 health care reform legislation had tied this provision to federal subsidies,¹⁴⁸ the provision as enacted has no direct ties to federal spending.¹⁴⁹ Therefore, it cannot reasonably be argued that Congress was using its authority to attach conditions to federal spending when it enacted the defray-the-cost provision.¹⁵⁰

At first glance, the provision in question may not appear to fit within the Court's prohibition on commandeering of state government policymaking either. The principal commandeering case struck down federal laws that compelled *proactive* state government regulation of a theretofore unregulated issue.¹⁵¹ Here, rather than compelling proactive regulation, the federal law in question strongly discourages state regulatory activity by exacting a financial penalty from states should they engage in health plan content regulation.¹⁵² However, as indicated above, this strong discouragement falls short of preemption.¹⁵³ It appears Congress wanted to prevent states from enacting mandated benefit laws without dealing with the consequential political ramifications of expressly preempting state laws and, thus, advancing a "federal government takeover of health care."¹⁵⁴ While the Act's impact

¹⁴⁵ See 42 U.S.C. § 18031(d)(3)(B)(i). See also *infra* Part III-A.

¹⁴⁶ See 42 U.S.C. § 18031(d)(3)(B)(ii) (2012). See also *infra* Part III.B.

¹⁴⁷ *Contra* *Reno v. Condon*, 528 U.S. 141, 150-51 (2000). See *infra* Part III.C.

¹⁴⁸ See *supra* text accompanying note 84.

¹⁴⁹ See *infra* Part III.D.

¹⁵⁰ See *infra* Part III.D.

¹⁵¹ See *New York v. United States*, 505 U.S. 144, 174-77 (1992).

¹⁵² See 42 U.S.C. § 18031(d)(3)(B)(ii) (2012). See also *supra* Part I.C.3.

¹⁵³ See *supra* Part I.C.3.

¹⁵⁴ Pear, *supra* note 66. See Sam Solomon, *Health Exchange Federalism: Striking the Balance Between State Flexibility and Consumer Protection in ACA Implementation*, 34 *CARDOZO L. REV.* 2073, 2090-91 (June 2013) ("The political climate at the time the health reform bills were being considered was extremely hostile to what was being called, pejoratively, a federal 'takeover' of the health care system This [political] climate did not encourage legislation authorizing

on state content regulation may not fit neatly into existing precedent, the statute here features all of the principal ills that the *New York* and *Printz* Courts were most concerned with.¹⁵⁵ The ACA provision here does not preempt state law, nor does it permit states to regulate beyond the federal minimum standards without a financial penalty.¹⁵⁶ As such, the statute requires states to “govern according to Congress’ instructions”:¹⁵⁷ Enforce the federal EHB package as is, or else.

A. Section 1311(d)(3)(B) does not preempt state mandated benefit laws.

Even a cursory review of the statute in question confirms that the § 1311(d)(3)(B) does not preempt state mandated benefit laws. Indeed, in enacting the EHB package, Congress engaged in heretofore unprecedented *federal* content regulation of health plans.¹⁵⁸ However, throughout the ACA implementation process, perhaps for political reasons, federal officials appeared to bend over backward to ensure that states would continue to have an active role in regulating the health insurance market.¹⁵⁹ On its face, section 1311(d)(3) is no different in this regard. The statute reads, “a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 18022(b) of this title.”¹⁶⁰

the federal government to expand its direct rulemaking authority into areas traditionally regulated by the states, such as insurance law.”) (citations omitted).

¹⁵⁵ See *infra* Part III.E.

¹⁵⁶ See *supra* Part I.C.3.

¹⁵⁷ *New York v. United States*, 505 U.S. 144, 162 (1992).

¹⁵⁸ Historically, states have taken the lead on regulating health plan content. See Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1365 (“Using the authority granted by the McCarran-Ferguson Act, the states have actively regulated the health insurance industry, not only by regulating the business of insurance companies, but also in requiring health insurance contracts to contain certain substantive coverage provisions in the form of mandated benefit laws.”).

¹⁵⁹ See Kyle Thomas, *State-Run Insurance Exchanges in Federal Healthcare Reform: A Case Study in Dysfunctional Federalism*, 38 AM. J. L. & MED. 548, 550 (2012) (noting that “the federal government has gone to great lengths to continue to share power with the states” despite the federal government’s increased role in health care regulation). See also Pear, *supra* note 66 (discussing the Obama Administration’s decision to “giv[e] states the discretion to specify essential benefits”).

¹⁶⁰ 42 U.S.C. § 13031(d)(3)(B)(i) (2012).

Congress could have expressly preempted state laws requiring benefits above and beyond the EHB package.¹⁶¹ For whatever reason, Congress chose not to do this.¹⁶² In fact, Congress affirmatively did the exact opposite by permitting states to continue to enact laws requiring “benefits in addition to the essential health benefits.”¹⁶³ In construing the language of the statute, there can be no reasonable argument to the contrary.

B. Section 1311(d)(3)(B) is not an example of cooperative federalism.

Just as Congress could have expressly preempted state laws that conflicted with the federal EHB package, Congress could have used a cooperative federalism approach to defining the federal EHB package.¹⁶⁴ As it has done on so many other occasions, Congress could have defined the general parameters of its preferred regulatory scheme and thereafter permitted states to choose either to (1) enforce the federal regulatory scheme or (2) allow the federal government to step in and enforce its regulations.¹⁶⁵ Had it elected to utilize a so-called conditional preemption scheme to enforce the EHB package, Congress would not have run afoul of the anti-commandeering rule.¹⁶⁶ In cooperative federalist arrangements, the only penalty for opting not to enforce the federal regulatory program is federal preemption.¹⁶⁷ In contrast, here, there is a substantial financial penalty for regulating beyond the parameters of the federal standard.¹⁶⁸ If a state wishes to enact more stringent regulations than the federal EHB package, it must subsidize

¹⁶¹ Indeed, Congress has expressly preempted state laws regulating health benefits in other statutes. *See supra* Part I. B.2. A full analysis of the various forms of federal preemption is beyond the scope of this article. Thus, the article assumes *arguendo* that the statute in question, by not expressly preempting state mandated benefit laws, does not preempt state mandated benefit laws.

¹⁶² *See Pear, supra* note 66 (discussing the Obama Administration’s decision to “giv[e] states the discretion to specify essential benefits . . .”).

¹⁶³ 42 U.S.C. § 13031(d)(3)(B)(i).

¹⁶⁴ Some commentators have argued that §1311(d)(3)(B)(ii) does in fact represent a cooperative federalism approach. *See infra* text accompanying notes 256-57.

¹⁶⁵ *See supra* Part II.B.

¹⁶⁶ *See New York v. United States*, 505 U.S. 144, 167-68 (1992) (describing permissible cooperative federalism program features).

¹⁶⁷ *See supra* text accompanying notes 118-20.

¹⁶⁸ *See* 42 U.S.C. § 18031(d)(3)(B)(ii) (2012). *See also supra* Part I.C.3.

private party costs attributable to those more stringent state regulations.¹⁶⁹ Therefore, section 1311(d)(3)(B) cannot reasonably be construed as a cooperative federalist approach to health plan content regulation.

One of the cases upon which the *New York* court heavily relied in pronouncing the modern anti-commandeering rule illustrates permissible conditional preemption. In *Hodel v. Virginia Surface Mining and Reclamation Association, Inc.*, the Supreme Court considered a Tenth Amendment challenge to the federal Surface Mining Control and Reclamation Act of 1977.¹⁷⁰ This statute was intended to “establish a nationwide program to protect society and environment from the adverse effects of surface coal mining operations.”¹⁷¹ Among other provisions, the law provided states with the option of either developing and implementing a state regulatory program that met the standards established in the federal act or permit a newly created federal agency to enforce the federal standards.¹⁷² Because the statute’s provisions did not compel “the States . . . to enforce the [federal standards], to expend any state funds, or to participate in the federal regulatory program in any manner whatsoever,” the Court upheld the challenged sections.¹⁷³ The Court described the *Hodel* statute as “establish[ing] a program of cooperative federalism”¹⁷⁴ whereby “the full regulatory burden [would] be borne by the Federal Government”¹⁷⁵

¹⁶⁹ 42 U.S.C. § 18031(d)(3)(B)(ii).

¹⁷⁰ *Hodel v. Va. Surface Mining & Reclamation Ass’n, Inc.*, 452 U.S. 264, 268 (1981).

¹⁷¹ *Id.* (quoting 30 U.S.C. §1202(a) (1976 ed., Supp. III)).

¹⁷² *Id.* at 271-72 (“[A]ny State wishing to assume permanent regulatory authority over the surface coal mining operations . . . within its borders must submit a proposed permanent program to the Secretary for his approval. The proposed program must demonstrate the that state legislature has enacted laws implementing the environmental protection standards established by the Act and accompanying regulations In addition, the Secretary must develop and implement a federal permanent program for each State that fails to submit or enforce a satisfactory state program. In such situations, the Secretary constitutes the regulatory authority administering the Act within that State and continues as such unless and until a ‘state program’ is approved.”) (citations omitted).

¹⁷³ *Id.* at 288.

¹⁷⁴ *Id.* at 289.

¹⁷⁵ *Id.* at 288.

if a state chose not to adopt its own program.¹⁷⁶ In sum, cooperative federalism programs that provide states with the option to regulate in accordance with federally defined standards do not violate the Tenth Amendment, as long as there is no penalty for choosing not to enforce the federal program¹⁷⁷ and the federal program is otherwise within the federal government's power to regulate "private activities affecting interstate commerce."¹⁷⁸

Cooperative federalism is commonly used in health care policy.¹⁷⁹ One example of shared federal and state responsibility for health care regulation enforcement is the Health Insurance Portability and Accountability Act (HIPAA).¹⁸⁰ There, the statute permits but does not mandate states to "require that health insurance issuers that issue . . . health insurance coverage in the State in the individual or group market meet" HIPAA's requirements.¹⁸¹ Similar to other cooperative federalism programs, the consequence of a state failing to "substantially

¹⁷⁶ See *New York v. United States*, 505 U.S. 144, 167-68 (1992) (discussing other "programs of cooperative federalism" in existence at the time of the *New York* Court's decision).

¹⁷⁷ See *Fed. Energy Regulatory Comm'n. v. Mississippi*, 456 U.S. 742, 747 (1982) (noting that the statute in question "does not provide penalties for [a state's] failure to meet these deadlines [for compliance with federal standard]."); *Id.* at 748 (noting again that the statute in question did not provide for a "penalty . . . for failure to meet" another federal deadline). See also *Hodel*, 452 U.S. at 288 (noting that the federal act did not compel the state to "expend any state funds" in furtherance of the federal regulatory program).

¹⁷⁸ *Hodel*, 452 U.S. at 290.

¹⁷⁹ See Abbie R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 *YALE L. J.* 534, 584 (Dec. 2011) (describing Medicaid and the State Children's Health Insurance Program as "classic [examples of] 'cooperative federalism' programs."); Thomas, *supra* note 159, at 550 (describing Medicaid and the State Children's Health Insurance Program as examples of "cooperative federalism."). See also *id.* (noting that "the federal government has gone to great lengths to continue to share power with the states . . ." despite the federal government's increased role in health care regulation.); Solomon, *supra* note 154, at 2090 (discussing Congress' intent to pursue a "cooperative federalism approach" in enacting the ACA).

¹⁸⁰ See Alexander B. Blum et al., *Implementing Health Reform in an Era of Semi-Cooperative Federalism: Lessons from the Age 26 Expansion*, 10 *J. HEALTH & BIOMED. L.* 327, 330 (2015) (describing HIPAA as having "introduced the concept of preemptive federal regulatory standards that set minimum ground rules for health insurance conduct in the market.").

¹⁸¹ 42. U.S.C. § 300gg-22(a)(1) (2012).

enforce” the federal law’s provisions is direct federal enforcement.¹⁸² While the process for invoking federal enforcement is complicated,¹⁸³ it is apparent that states are not penalized for any failure to enforce the federal law’s provisions. In addition, states are permitted to “supplement” HIPAA’s provisions by enacting more stringent regulations.¹⁸⁴ As such, in enacting HIPAA, Congress appears to have respected the Supreme Court’s directive not to commandeer state legislative processes. The statute is carefully structured to permit but not command state enforcement activities.¹⁸⁵

The ACA builds on HIPAA’s shared enforcement model.¹⁸⁶ The ACA provisions related to health insurance exchanges provide a primary example of this shared enforcement model.¹⁸⁷ At first glance, the ACA language regarding health insurance exchanges appears to present a commandeering problem:¹⁸⁸ “Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange . . . for the State”¹⁸⁹ On its face, this ACA section appears to command state legislatures to enact a law establishing a marketplace for health insurance known as a health benefit exchange, squarely in violation of *New York’s* prohibition on commandeering.¹⁹⁰ However, “perhaps recognizing the potential commandeering problem,”¹⁹¹ the Act then provides a federal fallback option:

¹⁸² 42 U.S.C. § 300gg-22(a)(2).

¹⁸³ See generally Blum et al., *supra* note 180, at 340-46.

¹⁸⁴ Jost & Hall, *supra* note 52, at 399.

¹⁸⁵ See 42 U.S.C. § 300gg-22(a)(1) (“[E]ach State *may* require that health insurance issuers that issue, sell, renew, or offer health insurance coverage in the State in the individual or group market meet the requirements of this part with respect to such issuers.”) (emphasis added).

¹⁸⁶ See Blum et al., *supra* note 180, at 330 (noting that the ACA “borrow[ed] from the enforcement mechanism established under” HIPAA).

¹⁸⁷ See *id.*

¹⁸⁸ See Jonathan H. Adler, *Cooperation, Commandeering, or Crowding Out?: Federal Intervention and State Choices in Health Care Policy*, 20 SPG KAN. J. L. & PUB. POL’Y 199, 213 (Spring 2011) (“[By requiring states to establish a health exchange,] Section 1311 in isolation would unquestionably violate the constitutional prohibition on commandeering.”).

¹⁸⁹ 42 U.S.C. § 18031(b)(1) (2012).

¹⁹⁰ See Adler, *supra* note 188, at 213.

¹⁹¹ *Id.*

*If (A) a State is not an electing State under subsection (b); or (B) the Secretary [of Health and Human Services] determines, on or before January 1, 2013, that an electing State (i) will not have any required Exchange operational by January 1, 2014 . . . the Secretary shall . . . establish and operate such Exchange within the State*¹⁹²

Effectively, this provision renders the Act's requirement to establish a health exchange optional.¹⁹³ Here, similar to HIPAA, if a state fails to comply with Congress' wish, there is no penalty for the state. The only consequence for a state that fails to create a health benefit exchange is the federal government stepping in and creating an exchange for the noncompliant state's market.

Section 1311(d)(3)(B) stands in stark contrast to the variety of permissible cooperative federalism programs that Congress has enacted. Plainly, as it did elsewhere in the ACA and with HIPAA,¹⁹⁴ Congress could have defined the EHB package and given states the option to enforce the federal law. The constitutionality of such an approach is not in question.¹⁹⁵ Congress could have provided for a no-strings-attached federal enforcement fallback in the event that a state either chose not to enforce or otherwise "substantially failed" to enforce¹⁹⁶ the federal EHB requirements. Rather than use this established model of federal-state cooperation, Congress opted instead to levy a significant financial penalty on states that choose not to enforce the EHB package as defined by Congress.¹⁹⁷ Moreover, unlike HIPAA, which establishes a regulatory floor that states can supplement with more stringent regulations,¹⁹⁸ section 1311(d)(3)(B) establishes a de facto regulatory ceiling.¹⁹⁹ While states are not technically prohibited from exceeding

¹⁹² 42 U.S.C. § 18041(c)(1) (2012) (emphasis added).

¹⁹³ See Adler, *supra* note 188, at 213.

¹⁹⁴ See *supra* text accompanying notes 179-92.

¹⁹⁵ See *supra* text accompanying notes 170-78.

¹⁹⁶ See *supra* text accompanying notes 179-92.

¹⁹⁷ See 42 U.S.C. § 18031(d)(3)(B) (2012).

¹⁹⁸ See Blum et al., *supra* note 180, at 330-31.

¹⁹⁹ While the required subsidy will vary by benefit mandate and by state, the amount of the subsidy appears to be high enough to discourage states from enacting new mandated benefits. See Monahan, *The ACA, the Large Group Market, and Content Regulation*, *supra* note 28, at 98 ("Given most states' strained fiscal

the EHB floor, they can exceed the congressionally established floor only by providing a federally mandated subsidy to private insurance companies.²⁰⁰ Therefore, Congress' approach here is not at all consistent with constitutionally permissible cooperative federalism.

C. Section 1311(d)(3)(B) is not a generally applicable law with incidental impacts on state governments.

Congress may, consistent with the Tenth Amendment, enact generally applicable federal laws that incidentally burden state governments.²⁰¹ This is true even if the federal law requires states to enact new laws, promulgate new regulations, or amend existing laws and regulations.²⁰² Courts will seek to distinguish between federal statutes that regulate “state activities”²⁰³ and those that seek to “require the States in their sovereign capacity to regulate their own citizens.”²⁰⁴

In *Reno v. Condon*, the Court upheld the Driver's Privacy Protection Act of 1994, a federal statute that regulated the disclosure of “personal information contained in the records of state motor vehicle departments.”²⁰⁵ The statute was upheld in spite of South Carolina's argument that compliance with the statute “thrusts upon the States all of the day-to-day responsibility for administering its complex provisions”

position, it seems likely that state will simply eliminate any mandates in the individual and small group markets that exceed the essential health benefit requirements.”). *See also* Monahan, *Fairness Versus Welfare*, *supra* note 30, at 152 (“[T]he subsidy that would be required would often be substantial. As a practical matter, this direct cost to the state of mandated health benefits that exceed essential health benefits requirements makes it highly unlikely that states will regulate the content of coverage in the individual and small group market.”). For instance, at the time of implementation, the state of Maryland estimated that its then-existing mandates would require it to appropriate up to \$80 million annually to defray insurers' compliance costs. Cassidy, *supra* note 61, at 3-4.

²⁰⁰ See 42 U.S.C. § 18031(d)(3)(B)(ii).

²⁰¹ *See supra* text accompanying notes 121-22.

²⁰² *See, e.g.*, *South Carolina v. Baker* 485 U.S. 505, 514-15 (1988) (noting that the fact that a state “wishing to engage in certain activity” regulated by a generally applicable federal statute “must take administrative and sometimes legislative action to comply with federal standards regulating that activity is a commonplace that presents no constitutional defect.”).

²⁰³ *Reno v. Condon*, 528 U.S. 141, 150 (2000) (citing *South Carolina v. Baker*, 485 U.S. 505, 514-15 (1988)).

²⁰⁴ *Id.* at 151.

²⁰⁵ *Id.* at 143.

and would unreasonably “consume . . . state resources.”²⁰⁶ Rather than regulating the states “in their sovereign capacity,” the Court found that the statute regulated states as “owners of [motor vehicle information] databases.”²⁰⁷ Further, because the statute regulated “private resellers” of motor vehicle information as well as state governments, the generally applicable statute did not run afoul of the Court’s anti-commandeering rule from *New York*.²⁰⁸

Unlike the statute in *Reno*, section 1311(d)(3) is not generally applicable. It is a direct command upon the states “in their sovereign capacity.”²⁰⁹ The statute is directed squarely at “states.”²¹⁰ Unlike *Reno*, where private entities could have been subjected to the statute’s provisions, here there are no other entities that can take action to “require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits.”²¹¹ Enacting laws that require health insurers to cover specified benefits is a legislative function. This is in no way a generally applicable statute. Therefore, it cannot fall within Congress’ authority to enact generally applicable laws regulating *private* activity that have incidental impacts on state governments.²¹² The impact of the ACA’s requirement that states defray costs associated with state mandated benefit laws is far from incidental. Rather, section 1311(d)(3)(B)’s impact is direct, substantial, and intentional.

D. Section 1311(d)(3)(B) does not constitute conditional use of the Spending Power.

While the ACA features significant use of Congress’ authority under the Spending Clause,²¹³ section 1311(d)(3)(B) is not one of the Act’s Spending Clause provisions. By enacting this provision, Congress did not condition states’ receipt of new or existing federal grants on

²⁰⁶ *Id.* at 149-50 (citations omitted).

²⁰⁷ *Id.* at 151.

²⁰⁸ *Id.*

²⁰⁹ *Id.*

²¹⁰ See 42 U.S.C. § 18031(d)(3)(B)(i) (2012) (“[A] State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits”) (emphasis added); 42 U.S.C. § 18031(d)(3)(B)(ii) (2012) (“A State shall make payments”) (emphasis added).

²¹¹ 42 U.S.C. § 18031(d)(B)(i).

²¹² *Contra Reno* 528 U.S. at 151.

²¹³ See, e.g., *supra* text accompanying note 106.

refraining from enacting new state mandated benefit laws.²¹⁴ Here, rather than benefit from federal funds should they comply with a federally imposed condition, states are forced to spend state dollars if they choose not to enforce the federal regulatory program as instructed by Congress.²¹⁵ Should states continue to exercise their police power by regulating the insurance industry, Congress has forced them to subsidize private party costs.²¹⁶ As discussed above, at least two early drafts of the 2009-10 health care reform bills appeared to have had more direct ties to federal spending.²¹⁷ These drafts applied section 1311's "defray the cost" provision only to those plans purchased by subscribers receiving federally-funded subsidies to purchase insurance.²¹⁸ Had the final version of the law limited this provision in this way, a more thorough discussion of conditional spending would be warranted. However, the "defray the cost" provision applies to all plans offered on the individual and small group markets, regardless of the use of federal subsidies.²¹⁹ As such, the final version of this ACA provision does not implicate the Spending Clause in the way that the early drafts would have.

Prior to the ACA, Congress used its Spending Clause authority to attempt to influence state mandated benefit laws in a way that apparently did not implicate the commandeering doctrine.²²⁰ The Medicare Prescription Drug, Improvements, and Modernization Act of 2003, among other things, authorized the creation of "health savings accounts" (HSAs).²²¹ HSAs are "tax-free financial accounts that are designed to help individuals save for future health care expenses."²²² To use a tax-advantaged HSA, the individual must be covered by a "high deductible

²¹⁴ Cf. *supra* text accompanying notes 84-86.

²¹⁵ See 42 U.S.C. § 18031(d)(3)(B)(ii) (2012).

²¹⁶ *Id.*

²¹⁷ See *supra* text accompanying note 84.

²¹⁸ See *supra* text accompanying note 84.

²¹⁹ See Andrews, *supra* note 83.

²²⁰ See generally Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1401-05.

²²¹ *Id.* at 1401-02.

²²² NAT'L COUNCIL OF STATE LEGISLATURES, STATE ACTIONS ON HEALTH SAVINGS ACCOUNTS (HAS) AND CONSUMER DIRECTED HEALTH PLANS, 2004-2016 (Mar. 2016), <http://www.ncsl.org/research/health/hsas-health-savings-accounts.aspx> [<https://perma.cc/62XK-YFJ8>].

health plan.”²²³ At the time of the federal law’s enactment, many states had mandated benefit laws on the books that did not permit the imposition of a deductible on those specified benefits.²²⁴ As such, residents of those states could not establish HSAs until states amended their laws to permit the use of high deductible plans, notwithstanding contradictory state mandated benefit laws.²²⁵ As Monahan noted,

*In terms of its effect on mandated benefit reform, the health savings account legislation can perhaps best be described as incentive-based deregulation. While not requiring states to amend their mandated benefit laws, it does create a significant incentive to do so With the voluntary nature of the deregulation, states are able to weight to value of offering their residents health savings accounts against the value of the conflicting mandated benefit laws.*²²⁶

The HSA experience demonstrates yet another way in which Congress could have, but chose not to, incentivize “deregulation” of state mandated benefit laws.

E. Section 1311(d)(3)(B) commandeers state governments.

By exacting a financial penalty from state governments for regulating health benefits beyond the federal EHB standard, ACA section 1311(d)(3)(B) has commandeered state governments in violation of the Tenth Amendment. As established above, Congress did not utilize one of the several permissible strategies to encourage states to enforce the federal EHB regulations.²²⁷ Instead, Congress imposed a statutory straightjacket on states’ long-recognized authority to regulate health insurance plan content. While purportedly allowing states to continue to mandate health benefits not otherwise required by the EHB standards,²²⁸ Congress in fact imposed a significant, direct financial penalty on states that dare exceed the federally established regulatory

²²³ Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1402.

²²⁴ *Id.* at 1402-03.

²²⁵ *Id.*

²²⁶ *Id.* at 1405.

²²⁷ *See infra* Part IV.A–D.

²²⁸ *See* 42 U.S.C. § 18031(d)(3)(B)(i) (2012).

ceiling.²²⁹ This “defray the cost” scheme offers states a false choice: either enforce the federal EHB package as defined by Congress, or be forced to subsidize private insurers’ costs of complying with state laws in a non-preempted field.

1. “Congressionally compelled subsidy”

Section 1311(d)(3)(B) of the ACA is, in fact, on all fours with the “take-title” provision that the Supreme Court deemed unconstitutional in *New York*. As was the case there, neither of the two “choices” that states have in this instance are within Congress’ power to offer states. Quite clearly, Congress cannot mandate that state governments enforce its EHB scheme without violating the Tenth Amendment.²³⁰ Nor can Congress force states to “defray”—in other words subsidize—insurers’ costs of complying with mandated benefits laws.²³¹ The “defray the cost” requirement is no different from *New York*’s take title provision. In *New York*, the Supreme Court rejected the idea that Congress could force states to assume private nuclear waste producers’ liabilities if the states failed to enact and enforce the federally prescribed regulatory scheme.²³² Here, states are faced with the same type of “congressionally compelled subsidy from state governments” to private parties that the *New York* court rejected.²³³ In *New York*, the Supreme Court did not hesitate to declare that this attempt to “direct the States to assume the liabilities of certain residents” “commandeer[ed] state governments into the service of federal regulatory purposes.”²³⁴ Nor should federal courts hesitate to declare that section 1311(d)(3)(B) is “inconsistent with the Constitution’s division of authority between federal and state governments”²³⁵ and, thus, unconstitutional.

²²⁹ See 42 U.S.C. § 18031(d)(3)(B)(ii) (2012). See also *supra* text accompanying note 198.

²³⁰ See *supra* Part II.B.

²³¹ See *New York v. United States*, 505 U.S. 144, 175 (1992).

²³² *Id.*

²³³ *Id.*

²³⁴ *Id.*

²³⁵ *Id.*

2. Federal Regulation of State Governments' Regulation of Interstate Commerce

The fact that the ACA provision in question does not require states to proactively legislate in furtherance of a federal regulatory purpose is of no practical import.²³⁶ First, the *Printz* Court rejected the idea that there is a difference between making law and merely enforcing federal standards for commandeering purposes.²³⁷ As such, *New York's* prohibition on commandeering is applicable here, despite the fact that there is no “command” to *enact* new legislation or regulations.²³⁸ As the Court noted in *Printz*, to the extent that the federal law in question leaves little or no discretion to state governments to make policy, Congress' violation of the anti-commandeering rule is actually more egregious.²³⁹ Accordingly, unless states yield to the unconstitutional federally mandated subsidy discussed above, they are left with no discretion to regulate the content of health insurance plans issued in their states.

The *New York* decision unambiguously describes the crux of the commandeering inquiry: “The allocation of power contained in the Commerce Clause, for example, authorizes Congress to regulate interstate commerce directly; it does not authorize Congress to regulate state governments' regulation of interstate commerce.”²⁴⁰ The Court's commandeering precedent makes no distinction between congressional

²³⁶ See *Nat'l Collegiate Athletic Ass'n v. Governor of New Jersey*, 730 F.3d 208, 251 (3rd Cir. 2013) (Vanaskie, J. concurring in part, dissenting in part) (“[N]o legal principle exists for finding a distinction between the federal government compelling state governments to exercise their sovereignty to enact or enforce laws on the one hand, and restricting state governments from exercising their sovereignty to enact or enforce laws on the other.”). See also *id.* at 245 (“Rather, the general principle articulated by the Court in *New York* was that ‘even where Congress has the authority under the Constitution to pass laws requiring or prohibiting certain acts, it lacks the power to directly compel the States to require or prohibit those acts.’”) (quoting *New York*, 505 U.S. at 166).

²³⁷ *Printz v. United States*, 521 U.S. 898, 926-31 (1997).

²³⁸ *Id.*

²³⁹ *Id.* at 928 (“Even assuming, moreover, that the Brady Act leaves no ‘policymaking’ discretion with the States, we fail to see how that improves rather than worsens the intrusion upon state sovereignty. Preservation of the States as independent and autonomous political entities is arguably less undermined by requiring them to make policy in certain fields than . . . by ‘reduc[ing] [them] to puppets of a ventriloquist Congress.’”) (quoting *Brown v. EPA*, 521 F.2d 827, 839 (9th Cir. 1975)).

²⁴⁰ *New York*, 505 U.S. at 166.

acts which require proactive state regulatory or enforcement activity and “commanding the nonuse of state machinery to regulate.”²⁴¹ The question is, regardless of how compelling the federal interest at issue may be, has Congress regulated the several states’ regulation of interstate commerce?²⁴² As the Ninth Circuit observed, no Supreme Court precedent examining the scope of Congress’ authority to regulate interstate commerce “holds or even suggests that a state’s exercise of its police power with respect to an economic activity which affects interstate commerce is itself an economic activity . . . subject to regulation by Congress.”²⁴³ Unquestionably, section 1311(d)(3)(B) treats states’ exercise of their “police power with respect to an economic activity which affects interstate commerce” as an economic activity in and of itself “subject to regulation by Congress.”²⁴⁴ Regardless of the level of coercion at issue, there can be no question that this section of the ACA seeks to “regulate state governments’ regulation”²⁴⁵ of health insurance benefits.

3. Political Accountability

Among the Supreme Court’s primary concerns with the statute at issue in *New York* was the “diminish[ed]” political accountability that would result from federal commandeering of state governments.²⁴⁶ Under the permissible forms of federal encouragement of state regulatory activity, states “may choose to have the Federal Government rather than the State bear the expense of a federally mandated regulatory program” in the event that its “residents would prefer their government to devote its attention and resources to problems other than those deemed important by Congress.”²⁴⁷ Moreover, federal “encouragement” of state regulatory activity permits state elected

²⁴¹ *Nat’l Collegiate Athletic Ass’n*, 730 F.3d at 251 (Vanaskie, J. concurring in part, dissenting in part).

²⁴² *See New York*, 505 U.S. at 178 (“No matter how powerful the federal interest involved, the Constitution simply does not Congress the authority to require the States to regulate.”).

²⁴³ *Brown v. E.P.A.*, 521 F.2d 827, 838 (9th Cir. 1975), *vacated*, *E.P.A. v. Brown*, 431 U.S. 99 (1977).

²⁴⁴ *Id.*

²⁴⁵ *New York*, 505 U.S. at 166.

²⁴⁶ *Id.* at 168.

²⁴⁷ *Id.*

officials to “remain responsive to the local electorate’s preferences.”²⁴⁸ Where Congress coerces state officials into enacting and enforcing federal programs, however, voters cannot hold the responsible government officials accountable for their decisions.²⁴⁹ As the Court stated, when Congress commandeers state governments into action, “it may be state officials who will bear the brunt of public disapproval, while federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision.”²⁵⁰

Section 1311(d)(3)(B) presents the risk of misplaced public disapproval that the Supreme Court discussed in *New York*. At the very least, the lines of political accountability regarding state mandated benefit legislation will now be blurred. In the event that states leaders fail to respond to constituents that petition them to enact mandated benefit legislation, it is likely that these constituents will place “the brunt of public disapproval”²⁵¹ on said state leaders. Certainly, it ordinarily would not make sense for state citizens to hold federal officials accountable for a state legislature’s failure to enact state legislation. However, it is apparent that the “defray the cost” requirement may prove to be a substantial, if not predominant, factor in state leaders’ decision to refrain from enacting new mandated benefit laws.²⁵² As such, federal officials should share in any resultant political ramifications for a state’s failure to enact mandated benefit laws. Here, state leaders are not free to “remain responsive to the local electorate’s preferences”²⁵³ without incurring substantial financial costs.²⁵⁴

Had Congress simply precluded states from enacting mandated benefit legislation via federal preemption, there would be no confusion about who an aggrieved constituent should blame for their state legislature’s failure to respond to their advocacy. With federal preemption, “it is the Federal Government that makes the decision in full view of the public, and it will be federal officials that suffer the consequences if the decision turns out to be detrimental or

²⁴⁸ *Id.*

²⁴⁹ *See id.*

²⁵⁰ *Id.*

²⁵¹ *Id.* at 169

²⁵² *See supra* text accompanying note 198.

²⁵³ *New York*, 505 U.S. at 168.

²⁵⁴ *See* 42 U.S.C. § 18031(d)(3)(B)(ii) (2012).

unpopular.”²⁵⁵ That is not the case with section 1311(d)(3)(B). Here, Congress apparently sought to devise a way to prevent states from enacting mandated benefit laws without the risk of suffering the political consequences of “mak[ing] the decision” to preempt state laws “in full view of the public.”²⁵⁶ While innovative, Congress’ chosen path violates the Tenth Amendment’s prohibition on commandeering of state governments.

4. Administrative deference to states does not save the ACA from commandeering scrutiny.

Some commentators have suggested that the Obama administration’s initial incorporation of state mandated benefit laws into the EHB definition somehow alters the constitutional analysis of section 1311(d)(3)(B).²⁵⁷ This line of reasoning supposes that, regardless of what the statute says, one federal bureaucrat’s indication that she is willing to use her “discretion cooperatively to accommodate state regulatory preferences” is sufficient to render the statute an example of cooperative federalism.²⁵⁸ However, to accept the ACA’s “defray the cost” requirements as emblematic of cooperative federalism would be to ignore decades of Supreme Court decisions. Permissible cooperative federalism programs permit states to choose to either (1) regulate an activity in accordance with federal guidelines or (2) refrain from regulating the activity, thereby permitting “the full regulatory burden [to] be borne by the federal government.”²⁵⁹ Where the only alternative to enforcing the federal program is a congressionally mandated subsidy to private industry, as is the case with the “defray the cost” requirement, the Supreme Court has held that the federal law

²⁵⁵ *New York*, 505 U.S. at 168.

²⁵⁶ *Id.*

²⁵⁷ *See, e.g.*, Radha A. Pathak & Brendan S. Maher, *Health Insurance & Federalism-In-Fact*, 28 ABA J. LAB. & EMP. L. 73, 76-78 (Fall 2012).

²⁵⁸ *Id.* at 78. Moreover, the EHB Regulations are clear that the initial benchmark approach was intended to be temporary—to allow states to “transition.” *See* EHB Bulletin, *supra* note 3, at 9 (“In the *transitional* years of 2014 and 2015, if a State chooses a benchmark [plan] subject to State mandates—such as a small group market plan—that benchmark should include those mandates in the State EHB package.” (emphasis added)).

²⁵⁹ *Hodel v. Va. Surface Mining & Reclamation Ass’n, Inc.*, 452 U.S. 264, 288 (1981).

commandeers state governments.²⁶⁰ While it may be true that some ACA provisions “limit[] state power considerably less than its detractors suggest,”²⁶¹ that cannot be said of section 1311(d)(3)(B). The Obama Administration’s “benchmark” approach to defining the EHB package cannot and does not alter the commandeering analysis herein, nor does it transform section 1311(d)(3)(B) into something it is not – a model of cooperative federalism.²⁶²

5. Federal Coercion of State Governments and the Roberts Court

To the extent that the Roberts Court has opened the door to a more liberal treatment of federal financial “coercion” of state governments, the *NFIB* decision also provides support for the argument that section 1311(d)(3)(B) violates the Tenth Amendment. Obviously, the *NFIB* court considered the *withholding* of federal funds from states.²⁶³ Here, states are faced with the congressionally compelled *expenditure* of state funds. While admittedly a horse of a different color than the Medicaid expansion considered in *NFIB*, an unduly coercive financial inducement is an unduly coercive financial inducement regardless of which side of the ledger it applies to.

PART IV. REMEDYING THE COMMANDEERING PROBLEM

Having established that section 1311(d)(3)(B) unconstitutionally commandeers state governments, this section will explore (1) Congress’ options to bring this portion of the ACA back into conformance with prevailing constitutional norms and (2) states’ options to avoid triggering the “defray the cost” provision in the event that Congress does nothing.

A. What can Congress do to remedy § 1311(d)(3)(B)’s commandeering problem?

Congress has several options to amend the ACA to avoid violating the anti-commandeering rule. First and foremost, Congress could modify section 1311 by deleting subsection (d)(3)(B) in its entirety. This would restore the health plan content regulation to the pre-ACA

²⁶⁰ See *New York*, 505 U.S. at 175.

²⁶¹ Pathak & Maher, *supra* note 257, at 85.

²⁶² *Contra id.* at 78.

²⁶³ *Contra id.* at 73.

status quo. The federal EHB package would continue to exist. In pursuing this approach, Congress could devise a truly cooperative federalist arrangement to enforcing the EHB package.²⁶⁴ For example, Congress could amend the ACA to permit states to enforce the EHB package without a financial penalty.²⁶⁵ Under the cooperative federalism model, in the event a state chose not to enforce the EHB provisions, the statute could provide for a federal enforcement fallback option.²⁶⁶ With this approach, the EHB package would provide a federal regulatory floor rather than ceiling for states.²⁶⁷ As they are in so many other areas of the law, states would be free to enact more stringent laws and regulations.²⁶⁸ But, significantly, there would no longer be a financial penalty should a state exercise its traditional role as primary regulator of the health insurance industry.²⁶⁹

Congress could also amend the statute to expressly preempt state mandated benefit laws that conflict with the federal EHB package.²⁷⁰ While federal preemption of state law is far from unusual in the health care field,²⁷¹ this could be difficult to accomplish in the current political environment.²⁷² Moreover, there is disagreement among scholars regarding the wisdom of prohibiting states from engaging in health plan content regulation.²⁷³

To tie the “defray the cost” requirement to the line of cases permitting broad federal authority to attach conditions to the receipt of federal funds, Congress also could redraft the law to apply only this requirement to health plans purchased with federal subsidies. As discussed, early drafts of the ACA did just that.²⁷⁴ While the permissibility of conditional spending requirements is somewhat in flux

²⁶⁴ See *supra* Part III.B.

²⁶⁵ *Contra* 42 U.S.C. § 18031(d)(3)(B)(ii).

²⁶⁶ *Cf. supra* text accompanying notes 179-92

²⁶⁷ *Cf. supra* text accompanying notes 197-99.

²⁶⁸ *Cf. supra* text accompanying note 184.

²⁶⁹ See *supra* text accompanying notes 168-69.

²⁷⁰ *Cf. supra* text accompanying note 36.

²⁷¹ See *supra* text accompanying notes 36-45.

²⁷² See *supra* text accompanying note 154.

²⁷³ See generally Monahan, *Federalism, Federal Regulation, or Free Market?*, *supra* note 17, at 1375-88.

²⁷⁴ See *supra* text accompanying note 148.

in light of *NFIB*,²⁷⁵ surely this approach would put the “defray the cost” requirement on firmer constitutional ground than it currently rests.

B. What can States do to avoid triggering the “defray the cost” subsidy?

While states have enacted mandated benefit laws at a less frequent pace since the ACA’s implementation,²⁷⁶ they have not ceased enacting mandated benefit laws altogether.²⁷⁷ States can enact mandated benefit laws without triggering section 1311(d)(3)(B), because that section applies only to plans offered on the small group and individual insurance markets.²⁷⁸ As such, states can enact mandated benefit laws that apply only to the large group market without triggering subsection (d)(3)(B).²⁷⁹ That being said, the utility of drafting around section 1311(d)(3)(B) in this manner is limited due to the fact that the number of employers choosing to self-insure is substantial.²⁸⁰ As such, the

²⁷⁵ See *supra* text accompanying notes 108-115

²⁷⁶ By some accounts, the ACA’s treatment of state mandated benefit laws has significantly impacted state leaders’ approach to mandate legislation. See Andrews, *supra* note 83 (“Although some states are trying to sidestep having to pay for new mandates by limiting which plans are included, advocates say uncertainty about who is going to have to foot the bill is having a *chilling effect* overall.”) (emphasis added).

²⁷⁷ See *id.* (indicating that states have not “forego[ne] mandates altogether.”).

²⁷⁸ See *id.* (“[S]ome states are simply excluding from the mandates plans that the states would have to pay for. The result: Consumers who buy individual or small group plans may not get the mandated benefits that are required in large group plans.”).

²⁷⁹ For instance, states have enacted mandated benefit laws that specifically exempt health plans that are subject to the federal EHB requirements. See, e.g., 2012 Md. Laws Ch. 4 (S.B. 179), § 1 (“(c) This section does not apply to a policy or contract issued or delivered by an entity subject to this section that provides the essential health benefits required under § 1302(a) of the Affordable Care Act.”) (repealed by 2014 Md. Laws Ch. 67 (S.B. 641) § 1, codified at MD. CODE ANN., INS., § 15-846 (2011)). See also JUSTIN GIOVANNELLI ET AL., THE COMMONWEALTH FUND, IMPLEMENTING THE AFFORDABLE CARE ACT: REVISITING THE ACA’S ESSENTIAL HEALTH BENEFITS REQUIREMENTS 5 (October 2014) (“Some state have required new benefits only in plans not subject to the essential health benefit rules. Nebraska, for example, enacted a law mandating coverage of autism in the individual and group markets but exempted plans that are required to provide essential health benefits. Thus, in practice, the state’s requirement applies to large-group coverage and to plans in the individual and small-group markets that have grandfathered status.”) (citations omitted).

²⁸⁰ See *supra* text accompanying notes 48-50.

number of state residents that would benefit from a state mandated benefit law that only applies to the large group market would be correspondingly small.²⁸¹ Whether state leaders would be willing to accept the potential political consequences of enacting controversial mandated benefit legislation that only benefits a relatively small number of constituents remains to be seen.

The ACA also provides states with the option of applying for an innovation waiver.²⁸² If granted a waiver, states would be released from the requirements of some ACA provisions²⁸³ and would thus be permitted to experiment with policies not otherwise allowed under the ACA.²⁸⁴ The innovation waiver provisions require waiver applications to follow several broad guidelines. Waiver proposals must:

²⁸¹ Cf. *supra* text accompanying notes 48-50.

²⁸² See 42 U.S.C. § 18052(a) (“A State may apply to the Secretary of the waiver of all or any requirements described in paragraph (2) with respect to health insurance coverage within that State for plan years beginning after January 1, 2017.”).

²⁸³ See 42 U.S.C. § 18052(a)(2) (“The requirements described in this paragraph with respect to health insurance coverage within the State for plan years beginning on or after January 1, 2014, are as follows: (A) Part I of subtitle D. (B) Part II of Subtitle D. (C) Section 1402. (D) Sections 36B, 4980H, and 5000A of the Internal Revenue Code of 1986.”). These waivable provisions include those relating to “establishing qualified health plans,” health insurance exchanges, premium tax credits, and both individual and employer “shared responsibility.” CTR. FOR CONSUMER INFO. AND INS. OVERSIGHT, FREQUENTLY ASKED QUESTIONS ABOUT 1332 STATE INNOVATION WAIVERS [https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html#Frequently Asked Questions about 1332 State Innovation Waivers](https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html#Frequently%20Asked%20Questions%20about%201332%20State%20Innovation%20Waivers) [<https://perma.cc/5EFT-9KXZ>].

²⁸⁴ See Kevin Lucia et al., *Innovation Waivers and the ACA: As Federal Officials Flesh Out Key Requirements for Modifying the Health Law, States Tread Slowly*, THE COMMONWEALTH FUND (Feb. 17, 2016) <http://www.commonwealthfund.org/publications/blog/2016/feb/innovation-waivers-and-the-aca> [<https://perma.cc/F582-3HLC>] (“Starting in 2017, states can pursue ‘innovation waivers,’ . . . that allow them to modify key parts of the ACA. These waivers may propose ‘broad alternatives or targeted fixes’ to a number of the ACA’s private insurance provisions, so long as they stay true to the law’s goals and consumer protections.”) (citations omitted). *But see* Jonathan Ingram et al., *The ACA’s Section 1332: Escape Hatch or Straightjacket for Reform?*, HEALTH AFFAIRS BLOG (May 26, 2016), <http://healthaffairs.org/blog/2016/05/26/the-acas-section-1332-escape-hatch-or-straightjacket-for-reform/> [<https://perma.cc/VZ58-EUFX>] (describing overly broad characterizations of the scope of section 1332 waivers as “misleading” and, in some cases, “outlandish”).

*(1) . . . provide coverage to at least a comparable number of the state's residents as would be provided absent the waiver; (2) . . . provide coverage and cost-sharing protections against excessive out-of-pocket spending that are at least as affordable for the state's residents as would be provided absent the waiver; (3) . . . provide coverage for the state's residents that is at least as comprehensive for the state's residents as would be provided absent the waiver; (4) . . . not increase the Federal [budget] deficit.*²⁸⁵

Section 1311(d)(3)(B) appears to be waivable under the ACA.²⁸⁶ In theory, so long as the waiver application otherwise complies with the requirements for a § 1332 waiver, a state could apply for a waiver from section 1311(d)(3)(B) enabling the state to enact a specific mandated benefit law without being required to defray the costs associated with the mandate.²⁸⁷ However, the innovation waiver approval remains somewhat unclear.²⁸⁸ Whether a state could construct a waiver proposal that meets the requirements of § 1332 and whether the federal government would grant such a waiver is uncertain.²⁸⁹ Moreover, comparable waiver processes in other federal health care programs are cumbersome and resource-intensive.²⁹⁰ Given the other available means of avoiding section 1311(d)(3)(B),²⁹¹ the innovation waiver may not be an ideal way to avoid triggering section 1311(d)(3)(B).

²⁸⁵ Waivers for State Innovation, 80 Fed. Reg. 78131, 78132 (Dec. 16, 2015).

²⁸⁶ 42 U.S.C. § 13031 is included in Part 2 of Subtitle D of Title 1 of the Affordable Care Act, a section that is expressly included within the innovation waiver scheme. *See* 42 U.S.C. § 18052(a)(2).

²⁸⁷ *See* 42 U.S.C. § 18052(a)(2).

²⁸⁸ *See* Ingram et al., *supra* note 284 (“It is unclear how the Section 1332 approval process will be any better [than the Medicaid Section 1115 waiver approval process]. In fact, it could be much worse Given the complexity and newness of Section 1332 waivers, combined with the fact that they must be approved by two agencies . . . instead of one, it seems unlikely that the approval process will be short.”).

²⁸⁹ *See id.* (describing the “immense difficulty of fulfilling the ACA statutory requirements” for innovation waivers).

²⁹⁰ *See, e.g., id.* (“States frequently comment on the frustrating, time consuming, and seemingly ‘corrupt and opaque’ process of the Medicaid Section 1115 waiver route.”).

²⁹¹ *See supra* text accompanying notes 277-79.

PART V. CONCLUSION

As of the writing of this article, the ACA is still in effect. That being said, with President Donald Trump and Republican congressional leaders vowing to “repeal and replace” the ACA, it is once again facing significant political headwinds.²⁹² The ACA’s future is uncertain. Likewise, whether the section of the ACA discussed in this article will remain in effect is unclear.²⁹³ What is clear, however, is that the insurance industry fought long and hard to obtain a federal curb on the proliferation of state mandated benefit laws.²⁹⁴ Whether the industry will allow this provision to be repealed without a fight remains to be seen.

Whatever the fate of section 1311(d)(3)(B), it is now apparent that Congress stepped over the line that distinguishes congressional encouragement from commandeering when it enacted this requirement. Whether within the four corners of the ACA, a Republican health care reform plan, or some unrelated federal legislation, the ACA “defray the cost” approach must not be used as a model going forward.

²⁹² See, e.g., Amy Goldstein, *Obamacare’s Future in Critical Condition After Trump’s Victory*, WASH. POST (Nov. 9, 2016), https://www.washingtonpost.com/national/health-science/acas-future-in-critical-condition-with-trumps-victory/2016/11/09/7c5587e8-a684-11e6-ba59-a7d93165c6d4_story.html [https://perma.cc/Y9ZD-JSL3] (“According to lawmakers and health-policy analysts, the GOP majorities in both chambers are likely to employ Congress’s reconciliation process to reverse critical aspects of the [ACA] that involve federal spending But analysts said a political path is less clear to dismantling other parts of the law, such as its insurance marketplaces, or to instituting a set of conservative health-care approaches.”).

²⁹³ See *id.*

²⁹⁴ See, e.g., *supra* text accompanying notes 69-71.