Rethinking Federalism: ACA as a Case Study

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Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Healthcare For?*, 70 **Stan. L. Rev.** 1689 (2018).

Although federalism rhetoric has played a central role in debates over the Affordable Care Act (ACA), there has been little research on whether the ACA's implementation reinforced or stymied federalism values, including state autonomy, cooperation, experimentation, and variation. Professors Abbe Gluck and Nicole Huberfeld fill this void in their article *What is Federalism in Healthcare For?*. Extrapolating from data on the implementation of ACA's Medicaid expansion and health insurance exchanges, the authors challenge a longstanding assumption among federalism scholarship—that particular structural arrangements best serve federalism goals and values. They instead argue that federalism goals and values are not dependent on any particular architecture of state-federal separation or entanglement but find expression across a range of governance models.

Traditional theories of federalism view state power as derived from separation from the federal government, with federal authority negating state power. Modern federalism scholars characterize any state activity occurring within federal frameworks as subservient. Gluck and Huberfeld, however, find that the ACA's implementation supports neither view. Instead, they argue that ACA implementation is a story of states exerting power that checked federal authority from within the statute, not from outside it. Furthermore, this dynamic has resulted in extensive policy variation and experimentation within the ACA's national framework.

The history of the Medicaid expansion illustrates this point. Although the ACA mandated that all states expand their Medicaid programs to cover low-income adults, the Supreme Court declared this mandate unconstitutional in *National Federation of Independent Business v. Sebelius* (*NFIB*), re-interpreting the Medicaid expansion as optional for the states. As detailed in Part IV of the article, the *NFIB* decision led to dynamic intergovernmental state-federal negotiations. With the U.S. Department of Health and Human Services (HHS) eager for as many states as possible to opt for expanding their Medicaid program, states acquired leverage that they used to obtain concessions from HHS, such as permission to funnel their expansion population into the ACA insurance exchanges. Gluck and Huberfeld further note that these dynamic, pragmatic negotiations produced significant policy and legal diversity across states.

Implementation of the ACA's insurance exchanges reveals a similar dynamic. Under the ACA, states could establish their own state-run exchanges or default to federal-run exchanges. Traditional federalism would predict that the federalism values of state autonomy, experimentation and variation would flourish in the state-run exchanges and be absent from the federal-run exchanges. Yet actual implementation tells another story. To accommodate red states' desire to outwardly show resistance to the ACA while retaining some policy control over their exchanges, HHS quietly allowed states to retain authority over key components of the federally-run exchanges. This cooperative federalism "led to significant variation across states," both among those operating their own exchanges and those with nationally run exchanges. As Gluck and Huberfeld note, "national" exchanges ultimately did not mean "uniform." (P. 1731.)

While these "hybrid" national and state-level solutions promoted experimentation and variation, Gluck

and Huberfeld found that they also jeopardized transparency. For example, states with federal exchanges could "hide the fact they were getting federal help from their constituents," (P. 1700) displaying public resistance to the ACA while quietly working with the federal government to retain state control over key policies. This obfuscation of state cooperation muddles accountability, particularly at the local level.

Gluck and Huberfeld also call into question recent federalism scholarship that sees partisan politics as playing out within a nationalist narrative based on national party affiliation. Rather than finding state actors presenting a united front consistent with their national party's stand on ACA, legislators, governors, and insurance commissioners from the same party frequently held divergent views. Gluck and Huberfeld argue that the resulting intrastate negotiations among these players suggest "that state democracy itself—a key federalism attribute—is strengthened by these acts of differentiation from the national party." (P. 1751.)

Finally, Gluck and Huberfeld raise important questions about what purposes federalism serves in health policy. Should federalism in health care improve health policy goals such as improved access, higher quality care, and lower costs? Or is the goal to advance political or constitutional values independent of policy ends, such as maintaining a balance of power between states and the federal government in the healthcare policy arena? Gluck and Huberfeld caution that this lack of conceptual clarity makes it difficult to evaluate whether federalism in healthcare serves its ostensible purposes and is worth defending. Policymakers and scholars should be mindful of this difficulty when debating the future of the ACA and possible reforms such as a single-payor system.

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