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## Nobody Knew How Complicated: Constraining the President's Power to Re(Shape) Health Reform

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SCHOOL OF LAW

UNIVERSITY *of* WASHINGTON

*Nobody Knew How Complicated:  
Constraining the President's Power  
to (Re)Shape Health Reform*

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# Nobody Knew How Complicated: Constraining the President’s Power to (Re)Shape Health Reform

Sallie Thieme Sanford<sup>†</sup>

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*Beginning on inauguration day, President Trump has attempted an executive repeal of the Affordable Care Act. In doing so, he has tested the limits of presidential power. He has challenged the force of institutional and non-institutional constraints. And, ironically, he has helped boost public support for the ACA’s central features. The first two sections of this article respectively consider the use of the President’s tools to advance and to subvert health reform. The final two sections consider the forces constraining the administration’s attempted executive repeal. I argue that the most important institutional constraint, thus far, is found in multifaceted actions by states – and not only blue states. I also highlight the force of public voices. Personal stories, public opinion, and 2018 election results – bolstered by presidential messaging – reflect growing support for government-grounded options and statutory coverage*

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*protections. Indeed, in a polarized time, “refine and revise” seems poised to supplant “repeal and replace” as the conservative focus countering liberal pressure for a common option grounded in Medicare.*

## I. INTRODUCTION

“I am not the first president to take up this cause,” President Obama said before a joint session of Congress, “but I am determined to be the last.”<sup>1</sup> He won’t be. And neither will President Trump. With a polarized Congress failing to refine, repeal, revise, or replace the Affordable Care Act (“ACA”), the executive branch has assumed an outsized role in shaping, and now reshaping, the contours of health reform. Beginning on inauguration day, President Trump has attempted an executive repeal of the ACA. In doing so, he has tested the limits of executive power. He has challenged the force of institutional and non-institutional constraints. And, ironically, he has helped boost public support for the ACA’s central features.

The first two sections of this paper respectively consider the uses of the president’s tools to advance and to subvert health reform. The presidential megaphone—the informal power of persuasion—has been central to the successful enactment of health reform legislation, notably including “Obamacare.” The century-long leadup to that historic legislation informs its structure, implementation challenges, and future options. In using the presidential megaphone to disparage the ACA and unsuccessfully rally Congress to repeal it, President Trump appears to have bolstered its legislative grounding.

In addition to a megaphone, the Resolute desk holds a landline and a pen. These formal tools of statutory implementation include the power to sign executive orders, oversee regulatory measures, and shape agency direction. President Trump has made extensive use of these tools to undermine the ACA’s coverage protections. Through a scattershot of complex managerial, regulatory, and litigative actions, his administration continues to threaten, but has not yet destroyed, the individual insurance marketplaces. The threat comes not only from specific executive-branch actions, but also from the general uncertainty they sow in an endeavor that depends upon voluntary private business involvement.

The final two sections of this paper consider the constraining forces on this attempted executive repeal. President Trump has, in effect, shot holes in the ACA-constructed dike that protects the individual coverage pool. Thus far, the fingers plugging those holes, and the feet bracing the dike, belong to the states. These are not only blue fingers and feet. Key state decisions, particularly intrastate managerial and regulatory responses,<sup>2</sup> have been distinctly bipartisan. In addition, Democratic-leaning

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<sup>1</sup> President Barack Obama, Remarks to a Joint Session of Congress on Health Care (Sept. 9 2009), <https://obamawhitehouse.archives.gov/video/President-Obama-Address-to-Congress-on-Health-Insurance-Reform#transcript> [<https://perma.cc/ERS4-APZA>].

<sup>2</sup> See, e.g., *A Bipartisan Blueprint for Improving Our Nation’s Health System Performance*, COLORADO OFFICIAL STATE WEB PORTAL (Feb. 23, 2018), [https://www.colorado.gov/governor/sites/default/files/bipartisan\\_governors\\_blueprint\\_022218final.pdf](https://www.colorado.gov/governor/sites/default/files/bipartisan_governors_blueprint_022218final.pdf) [<https://perma.cc/RJ3E-WZ7P>] (five state governors, two Democrat, two Republican, and one Independent, issued bipartisan “blueprint” outlining suggestions to preserve insurance coverage and improve the nation’s healthcare system performance).

states have instigated or intervened in several lawsuits,<sup>3</sup> taking a historically atypical position that aims to bolster federal power and nationally uniform rules.

Another significant and interwoven check on the president's power arises from Americans' stories about their health care challenges and their beliefs about the role of the federal government. With this issue, the personal readily becomes the political. Although the ACA remains highly polarizing, it now polls more favorably than not,<sup>4</sup> and central provisions enjoy strong, bipartisan support. This polling shift seems to have impacted campaign messaging in the 2018 elections. Furthermore, the results of that election evidence the expanding support for government-grounded coverage options.

"Now, I have to tell you it's an unbelievably complex subject," President Trump said as Republican Congressmembers struggled unsuccessfully to coalesce around an ACA replacement plan. "Nobody knew health care could be so complicated."<sup>5</sup> If that were ever true, it isn't now. Previously arcane health policy ideas are commonly bandied about. Health care and the means to pay for it continue to engage the public, as evidenced by the issue's ongoing prominence in state and national campaigns. There is increasing support for the proposition that the government should ensure health care access for all citizens and should maintain legal protections for those with pre-existing conditions.

Presidential efforts to the opposite end can be constrained, but not easily or completely. To date, state-level actions and public opinion expression have checked the president's power, but in a piecemeal and incomplete fashion. Similarly, judicial review might ultimately block one hole-in-the-ACA-dike regulation or another as a violation of administrative procedures or statutory authority. These legal challenges take time to wend their way through the courts, however, and they do not address the generalized threat to the ACA's coverage framework and the resulting implementation uncertainty. Ultimately, a robust constraint requires congressional action.

Indeed, the 116th Congress and subsequent Congresses may now have a pre-existing problem. Personal stories, public opinion, and 2018 election results—bolstered by presidential and campaign messaging—might have decisively shifted the legislative landscape. In a polarized time, "refine and revise" seems poised to supplant "repeal and replace" as the conservative focus countering liberal pressure for a common option grounded in Medicare.

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<sup>3</sup> Katie Keith, *Two New Lawsuits Challenge Trump Administration Actions on Health Reform*, HEALTH AFF. BLOG (Sept. 17, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180917.479910/full> [<https://perma.cc/8NX9-QRG8>] (Democratic attorneys general and governors intervened in *Texas v. United States* to argue in defense of the constitutionality of the ACA).

<sup>4</sup> Ashely Kirzinger et al., *Kaiser Health Tracking Poll – Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills*, KAISER FAMILY FOUND. (Sept. 5, 2018) <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills/> [<https://perma.cc/N2BR-F67P>] (finding that 50% of Americans view the ACA favorably and 40% view it unfavorably).

<sup>5</sup> Kevin Liptak, *Trump: "Nobody Knew Health Care Could Be So Complicated"*, CNN, (Feb. 28, 2017) <https://www.cnn.com/2017/02/27/politics/trump-health-care-complicated/index.html> [<https://perma.cc/7XBV-VU7D>].

## II. BEFORE MEDICARE AND BEYOND OBAMACARE, THE PRESIDENTIAL MEGAPHONE DIRECTS HEALTH REFORM LEGISLATION

The president gets one of the world's best megaphones.<sup>6</sup> History shows that this tool—the informal power of persuasion—has been critical to the enactment of health reform laws, including, notably, the ACA. Not for nothing is it routinely referred to as “Obamacare.” Originally used as a slur by opponents, and later embraced by proponents, this statutory nickname may before long be considered simply a neutral term that reflects the president's central role in the law's enactment.

The century-long leadup to the ACA's historic passage informs its structure, implementation challenges, and future options. Indeed, President Trump's megaphone use might have contributed to a left-ward shift in policy options. The future could harken back to the past, with something like President Nixon's plan the conservative option; President Truman's general framework the liberal vision; and a hybrid the possible compromise for a polarized country.

### A. THE CHIEF EXECUTIVE AND COVERAGE ADVOCACY

“[T]he power of the presidency is the power to persuade,” write political scientists David Blumenthal and James Morone, stressing that “in the debate over health care there is no greater force.”<sup>7</sup> They draw this conclusion from an in-depth study of the 11 presidents from Franklin D. Roosevelt<sup>8</sup> to George W. Bush and their struggles with “the health care octopus.” This octopus has been and continues to be “highly personal, politically perilous, technically complicated.”<sup>9</sup>

Franklin D. Roosevelt planned to add health coverage to the Social Security Act, a key legislative achievement of his tenure.<sup>10</sup> Doing so, he stressed, would require his full persuasive powers to rally the public and wrangle Congress.<sup>11</sup> In a harbinger of stalemates to come, FDR's proposal was scuttled by interest group opposition (the American Medical Association), politicized drafting challenges (the Social Security Act), and urgent national priorities (World War II).<sup>12</sup>

Years later, President Lyndon B. Johnson arrived in office with a public passion for health reform, the principled outlines of a plan, and the skill to quickly manage the Congressional process—all of which he used to secure the most important health care legislation of the last century.<sup>13</sup> The Medicare legislation established a federal health insurance system for all Americans over age 65.<sup>14</sup> That was and continues to be viewed by many advocates as a precursor to a truly universal system.

<sup>6</sup> DAVID BLUMENTHAL & JAMES A MORONE, *THE HEART OF POWER: HEALTH AND POLITICS IN THE OVAL OFFICE* 4 (U. of Cal. Press, 2d ed. 2010) (“Presidents control one of the world's great megaphones”).

<sup>7</sup> *Id.* at 7 (The authors acknowledge and draw on the work of “the dean of presidential studies,” Richard Neustadt).

<sup>8</sup> *Id.* at 11 (Republican Theodore Roosevelt is often credited as the first president to press for universal, government-grounded health care coverage, though he did so four years after vacating “the bully pulpit” and while campaigning unsuccessfully in 1912 to recapture the office. It is with his cousin, Democrat Franklin D. Roosevelt, that the president's role here takes shape). *See also* Obama Remarks on Healthcare, *supra* note 1 (“It has now been nearly a century since Theodore Roosevelt first called for health care reform.”).

<sup>9</sup> BLUMENTHAL & MORONE, *supra* note 6, at 11.

<sup>10</sup> *Id.* at 38.

<sup>11</sup> *Id.* at 11.

<sup>12</sup> *See generally* BLUMENTHAL & MORONE, *supra* note 6, at 21-56 (describing President Roosevelt's difficulties with health reform).

<sup>13</sup> *Id.* at 163.

<sup>14</sup> *Id.*

Its fraternal twin, Medicaid, established a joint federal-state program to provide coverage for certain categories of low-income Americans.<sup>15</sup>

Democrats Harry Truman and Bill Clinton both featured universal coverage in their successful presidential campaigns.<sup>16</sup> Truman, who followed FDR's 12 years in office, envisioned a comprehensive, government-administered program for all, conceptually similar to what would later be enacted as Medicare.<sup>17</sup> Clinton—by contrast and reflective of his post-Reagan era—envisioned a multi-faceted approach grounded in private insurance and employer-provided coverage.<sup>18</sup> Clinton's plan bore strong similarities to the national health coverage strategy that Republican Richard Nixon had unsuccessfully advanced decades earlier.<sup>19</sup> Both the Truman and Clinton electoral mandates floundered.<sup>20</sup>

Republicans Ronald Reagan and George W. Bush advocated in public and with Congresses for an expanded private-sector role in Medicare and ushered in the largest legislative expansions of that program.<sup>21</sup> Reagan's Catastrophic Coverage Act was repealed before it went into effect, largely because of protests from seniors who objected to bearing much of its costs.<sup>22</sup> Bush's Medicare Prescription Drug, Improvement, and Modernization Act, however, continues to thrive with strong public support for the privately run (and heavily government subsidized) Part D program.<sup>23</sup>

#### B. PRESIDENT OBAMA AND THE AFFORDABLE CARE ACT

President Obama drew on the lessons from his predecessors' successes and failures to enact the most significant health reform legislation since 1965. His passion for the topic animated his campaign, and he arrived in office with an outline grounded in key principles: near universality, pre-existing condition protection, and affordability.<sup>24</sup> He used the presidential megaphone to repeatedly make variations on this point: "In the wealthiest nation on Earth, no one should go broke just because they get sick."<sup>25</sup> Despite Obama's generally wonkish inclination, he avoided the policy weeds that dragged down the Clinton plan, leaving the details to Congress.<sup>26</sup>

<sup>15</sup> Sallie Thieme Sanford, *Health Care's Fraternal Twins at 50: The Birth and Development of Medicare and Medicaid*, JURIST: BLOG (Nov. 1, 2015, 7:03 AM), <https://www.jurist.org/commentary/2015/11/sallie-thieme-sanford-healthcare/>; see also Abbe R. Gluck, *The Law of Medicare and Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L. & ETHICS. 1, 2 (2015) (describing the similarities and differences between Medicare and Medicaid).

<sup>16</sup> BLUMENTHAL & MORONE, *supra* note 6, at 85, 355.

<sup>17</sup> *Id.* at 70.

<sup>18</sup> *Id.* at 85, 356.

<sup>19</sup> *Id.* at 356.

<sup>20</sup> *Id.* at 380.

<sup>21</sup> See *Id.* at 304, 387-98, 416-17 (discussing Reagan's and George W. Bush's Medicare reforms).

<sup>22</sup> *Id.* at 330.

<sup>23</sup> *Id.* at 393.

<sup>24</sup> See President Barack Obama, Remarks by the President in Town Hall Meeting on Health Care in Green Bay, Wisconsin (June 11, 2009), <https://obamawhitehouse.archives.gov/the-press-office/remarks-president-town-hall-meeting-health-care-green-bay-wisconsin> [https://perma.cc/E92P-7T6J] ("None of these plans, though, would be able to deny coverage on the basis of pre-existing conditions. Every plan should include an affordable, basic benefits package").

<sup>25</sup> President Barack Obama, Statement by the President on the Anniversary of the Affordable Care Act, (Mar. 23, 2013), <https://obamawhitehouse.archives.gov/the-press-office/2013/03/23/statement-president-anniversary-affordable-care-act> [https://perma.cc/3UTP-UVTC]; see also, President Barack Obama, Opinion, *Why We Need Healthcare Reform*, N.Y. TIMES, (Aug. 15, 2009), <https://www.nytimes.com/2009/08/16/opinion/16obama.html> [https://perma.cc/T367-JB6N]

He did so perhaps to a fault, as the House and Senate held dozens of hearings, advancing several bills, and taking amendments from both sides of the aisle.<sup>27</sup> It was during this time that Obama and the Democrats at times lost control of the narrative. As Morone describes it, “right-wing populists, self-styled Tea Party activists, roared into the health policy discussion with fury over supposed ‘government death panels.’<sup>28</sup> The claims—a variation on the old cry of ‘socialized medicine—were pungent, memorable, simple, and effective.”<sup>29</sup> This was grass roots opposition, grounded in anti-government and other perspectives, a distinct public voice with staying power.<sup>30</sup>

President Obama persisted despite a profound economic crisis and an election that seemed to doom the proposal’s chances. After the House and Senate had passed health reform bills, but before the needed reconciliation, Senator Kennedy died, and his elected replacement vowed to vote against the bill.<sup>31</sup> “Don’t walk away from reform,” the president urged in the 2010 State of the Union address. “Not now. Not when we are so close. Let us find a way to come together and finish the job for the American people.”<sup>32</sup> Spurred on by Obama’s speeches and televised, hours-long meetings with Republican and Democratic leadership, a work-around got an imperfect bill across the finish line, though with no Republican support.<sup>33</sup>

President Obama signed into law a vast, multifaceted statute that fundamentally aims to broaden access, improve quality, and lower costs through a variety of intertwined mechanisms. At its heart, though, is near universal access to comprehensive health insurance. The ACA advances this goal through its four M’s of Access: the mandate for individuals; the mandate for large employers; the Medicaid expansion; and the marketplace protections.<sup>34</sup>

The individual mandate – rendered toothless and perhaps unconstitutional by the 2017 federal tax law – requires most citizens to maintain qualified health insurance unless exempted (for financial or other reasons) or pay a tax penalty, which is set at \$0

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(describing the four main points of his plan: affordable for all, easing skyrocketing health costs, efficiency and accountability of insurance companies).

<sup>26</sup> See James Morone, *Presidents and Health Reform: From Franklin D. Roosevelt to Barack Obama*, 29 HEALTH AFF. 1097, 1098 (June 2010) (“A fatal mistake of the Clinton administration was its long delay in getting a health reform bill to Congress.”).

<sup>27</sup> See *id.* at 1097 (“Many observers have criticized the Obama administration for ‘over-learning’ the lessons of the Clinton administration and not sending a more fully fleshed plan to Congress.”).

<sup>28</sup> See *id.* at 1098.

<sup>29</sup> *Id.*; see also Julie Rovner, ‘You Can’t Have Perfection’: Lawmakers Who Forged ACA Look Back, KAISER HEALTH NEWS (June 27, 2018), <https://khn.org/news/you-cant-have-perfection-lawmakers-who-forged-aca-look-back/> [<https://perma.cc/46S5-CBYS>] (discussion with the five Congressional committee leaders: Max Baucus (D-Mont.), Chris Dodd (D-Conn.), Henry Waxman (D-Calif.), George Miller (D-Calif.) and Sander Levin (D-Mich.) who stewarded the ACA toward its passage in 2010).

<sup>30</sup> See Morone, *supra* note 26, at 1098 (regarding the impact of public voices).

<sup>31</sup> *Id.* at 1096.

<sup>32</sup> President Barack Obama, State of the Union Address (Jan. 27, 2010), <https://obamawhitehouse.archives.gov/photos-and-video/video/2010-state-union-address#transcript> [<https://perma.cc/Q876-2QRB>].

<sup>33</sup> See Lawrence R. Jacobs, *What Health Reform Teaches Us about American Politics*, 43 POL. SCI. & POL. 619, 622 (Oct. 1, 2010) (discussing Obama’s role in promoting health reform and refortifying the cause in early 2010); see also LAWRENCE R. JACOBS & THEDA SKOCPOL, *HEALTH CARE REFORM AND AMERICAN POLITICS: WHAT EVERYONE NEEDS TO KNOW* 101-121 (Oxford U. Press, 2d ed. 2012) (discussing impacts of Kennedy’s death and the election of Scott Brown).

<sup>34</sup> Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) [hereinafter Affordable Care Act] (codified as amended in scattered sections of the U.S. Code).



starting in 2019.<sup>35</sup> The employer mandate requires most large employers to provide adequate, affordable health insurance or pay a tax penalty.<sup>36</sup> The Medicaid expansion—made a state option by *NFIB v. Sebelius*—broadens that federal-state program from one that covers categories of low-income citizens to one that covers all otherwise uninsured citizens with incomes below 138% of the federal poverty level.<sup>37</sup> Finally, the marketplace protections provide regulatory and technical supports for those not offered statutorily adequate, affordable coverage by the government or an employer, and provide financial support for low- and middle-income purchasers.<sup>38</sup>

The ACA takes a fundamentally conservative approach grounded in support for private markets and employer-provided health insurance. Indeed, while the debate over the ACA legislation raged, Senator Kennedy allowed that one of his profound regrets was that he had opposed Nixon's health reform efforts while holding out for a single-payer approach.<sup>39</sup>

The Nixonian approach was like the ACA's, but broader, and overall more progressive, with more federal government regulation and subsidization.<sup>40</sup> It would have required most employers to provide health insurance for their full-time employees.<sup>41</sup> It would have federally defined the required benefits. And it would have established a government-grounded, subsidized program for all uninsured Americans, regardless of income.<sup>42</sup> That the ACA falls to the right of the Nixonian plan reinforces the practical difficulty—and likely impossibility—of replacing the ACA with a more market-oriented arrangement that achieves similar levels of access to comprehensive insurance. It also highlights the long-standing ideological hurdles to adoption of a single-payer, Medicare-for-all type model.

Indeed, President Trump's use of the chief executive's megaphone might, ironically, work to shift the conservative option in a Nixonian direction. "We have to

<sup>35</sup> Affordable Care Act § 1501, 26 U.S.C. § 5000A (2012), *amended by* Act to Provide for Reconciliation Pursuant to Titles II and V of the Concurrent Resolution on the Budget for Fiscal Year 2018, Pub. L. No. 115-97 § 11081, 131 Stat. 2054, 2092 (2017) (originally introduced as the Tax Cuts and Jobs Act of 2017); *see also Texas v. United States*, 352 F. Supp. 3d 665 (N.D. Tex. 2018), filing appeal (5th Cir. filed Jan. 7, 2019) (holding that without the tax penalty the individual mandate lacks constitutional grounding and that thus the entire law must fall, and entering a stay).

<sup>36</sup> 26 U.S.C. § 4980H (2012).

<sup>37</sup> Affordable Care Act § 2001(a)(4), 124 Stat. 119, 274 (codified as amended at 42 U.S.C. § 1396a(10)(A)(i)(VIII) (2012)) (amending § 1902 of the Social Security Act); Nat'l Fed'n of Indep. Bus. (NFIB) v. Sibelius, 567 U.S. 519, 575-88 (2012) (plurality opinion) (holding unconstitutional the requirement of Medicaid expansion).

<sup>38</sup> *See generally* Affordable Care Act §§ 1001-1563; Affordable Care Act § 1101, 42 U.S.C. § 18001 (2012) (establishing a temporary high-risk health insurance pool program); Affordable Care Act § 1201, 42 U.S.C. § 300gg-3 (2012) (prohibiting preexisting condition exclusions); *see also* Ctr. for Consumer Info. & Ins. Oversight, *Health Insurance Market Reforms*, CTRS. FOR MEDICARE & MEDICAID SERVS., <https://www.cms.gov/CCIOP/Programs-and-Initiatives/Health-Insurance-Market-Reforms/index.html> (last visited Dec. 3, 2018) (summarizing 13 market reforms).

<sup>39</sup> Jonathan Alter, *Teddy on Teddy*, NEWSWEEK, Aug. 27, 2009, at 74. *See also* THE BOSTON GLOBE, LAST LION: THE FALL AND RISE OF TED KENNEDY 323 (Peter S. Canellos ed., 2009).

<sup>40</sup> *See* Shanoor Seervai & David Blumenthal, M.D., *Lessons on Universal Coverage from an Unexpected Advocate: Richard Nixon*, COMMONWEALTH FUND: BLOG (Nov. 2, 2017), <https://www.commonwealthfund.org/blog/2017/lessons-universal-coverage-unexpected-advocate-richard-nixon> (noting that the "two main pillars of Nixon's plan were an employer mandate and expanded coverage for the poor").

<sup>41</sup> *Id.*

<sup>42</sup> BLUMENTHAL & MORONE, *supra* note 6, at 230-247 ("Nixon changed the health care discussion in the United States. Today's reformers all stand in his shadow. Ultimately, however, Nixon could not change himself. His health care plans went down with him amid the wreckage of Watergate.").

repeal Obamacare, and it can be—and— and it can be replaced with something much better for everybody,” candidate Trump said in 2015.<sup>43</sup> “Let it be for everybody. But much better and much less expensive for people and for the government.”<sup>44</sup>

As president, he has repeated these exhortations to repeal the ACA and replace it with something “terrific” that would cover everybody and save money all around.<sup>45</sup> To date he has been unsuccessful at wrangling Congress to repeal the law, apart from zeroing out the individual mandate’s tax penalty. “So,” President Trump told a Values Voter Summit, “we’re going a little different route.”<sup>46</sup> The following section describes that different, non-legislative route to repeal.

### III. WITH MEGAPHONE, LANDLINE, AND PEN, PRESIDENT TRUMP ATTEMPTS AN EXECUTIVE REPEAL

In addition to a megaphone, the Resolute desk also holds a landline and pen. In the current era, these tools—the president’s formal powers of statutory implementation—have assumed an outsized role in shaping the ACA. “I’ve got a pen and I’ve got a phone,” President Obama declared in early 2014. “And I can use that pen to sign executive orders and take executive actions and administrative actions that move the ball forward.”<sup>47</sup> He was referring to congressional gridlock generally, but as to the ACA specifically, the intransigence was profound. Following the 2010 shift in power, Congress has taken more than 50 votes to repeal the law; as of early 2019, the needed statutory refinement has not been in the offing.<sup>48</sup>

“Since Congress can’t get its act together on HealthCare,” President Trump tweeted after the failure of 2017 repeal effort, “I will be using the power of the pen to give great HealthCare to many people—FAST.”<sup>49</sup> As law professors Lisa Manheim and Kathryn Watts stress in their comprehensive book *THE LIMITS OF PRESIDENTIAL POWER*, the president’s tools of executive orders, regulatory oversight, and

<sup>43</sup> Ryan Koronowski, *68 Times Trump Promised to Repeal Obamacare: The White House Says It’s Already Moving On*, THINKPROGRESS (Mar. 24, 2017, 8:28 PM), <https://thinkprogress.org/trump-promised-to-repeal-obamacare-many-times-ab9500dad31e/> [<https://perma.cc/R79F-NGSY>].

<sup>44</sup> *Id.*

<sup>45</sup> Bob Bryan, *Trump Is Making a Massive Promise about His Obamacare Replacement*, BUS. INSIDER, (Jan. 26, 2017, 1:08 PM), <https://www.businessinsider.com/trump-obamacare-promise-2017-1> [<https://perma.cc/3ESD-M5L7>].

<sup>46</sup> President Donald J. Trump, Remarks by President Trump at the 2017 Values Voter Summit (Oct. 13, 2017) (transcript available at <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-2017-values-voter-summit/>).

<sup>47</sup> Tamara Keith, *Wielding a Pen and a Phone, Obama Goes It Alone*, NPR (Jan. 24, 2014, 3:36 AM), <https://www.npr.org/2014/01/20/263766043/wielding-a-pen-and-a-phone-obama-goes-it-alone> [<https://perma.cc/PD7E-WUKZ>]; *Obama on Executive Actions: ‘I’ve Got a Pen And I’ve Got A Phone’*, CBS WASH. (Jan. 14, 2014, 1:05 PM), <https://www.cbslocal.com/2014/01/14/obama-on-executive-actions-ive-got-a-pen-and-ive-got-a-phone/> [<http://cbsloc.al/JYNE7G>].

<sup>48</sup> See Tessa Berenson, *Reminder: The House Voted to Repeal Obamacare More than 50 Times*, TIME (Mar. 24, 2017), <http://time.com/4712725/ahca-house-repeal-votes-obamacare/> [<https://perma.cc/963D-DN3L>] (noting that the House has voted over 50 times on repealing or amending the ACA); Sean Sullivan, *Republicans abandon the fight to repeal and replace Obama’s health care law*, WASH. POST (Nov. 7, 2018), [https://www.washingtonpost.com/powerpost/republicans-abandon-the-fight-to-repeal-and-replace-obamas-health-care-law/2018/11/07/157d052c-e2d8-11e8-ab2c-b31dcd53ca6b\\_story.html?noredirect=on&utm\\_term=.71296deadb7f](https://www.washingtonpost.com/powerpost/republicans-abandon-the-fight-to-repeal-and-replace-obamas-health-care-law/2018/11/07/157d052c-e2d8-11e8-ab2c-b31dcd53ca6b_story.html?noredirect=on&utm_term=.71296deadb7f) [<https://perma.cc/V47Q-XW8K>] (discussing congressional Republicans’ efforts to repeal the ACA).

<sup>49</sup> Donald J. Trump (@realDonaldTrump), TWITTER (Oct. 10, 2017, 2:30 AM), <https://twitter.com/realdonaldtrump/status/917698839846576130?lang=en> [<https://perma.cc/JDB9-3UZ7>].

enforcement discretion are not magic wands.<sup>50</sup> They are bounded by Constitutional authority, statutory delegation, regulatory requirements, and other limiting forces. These limiting forces have a lot to contend with as President Trump has made robust use of the chief executive's toolkit to undermine a wide range of ACA provisions, particularly, as discussed here, the marketplace protections.

A. THE INDIVIDUAL COVERAGE POOL AND THE ACA'S PROTECTIVE DIKE

The ACA creates a dike protecting the individual coverage pool.<sup>51</sup> Behind the dike swim those without other coverage options such as an employer plan, Medicare, Medicaid, Tricare, or the Indian Health Service. Those in the pool include people who work for themselves, for small businesses, in the gig economy, and as independent contractors; it includes farmers, artists, students, and early retirees, among others. This is a relatively small group compared to those who have coverage through an employer or the government. But the pool is crucial, for the covered individuals and for the health care system.

The individual coverage dike is built with interlinked protective bricks. These varied bricks highlight the technical complexity of regulating the "health care octopus."<sup>52</sup> Foundationally, the ACA prohibits individual insurance plans from considering a person's health in the decision whether to offer them a plan, its coverage terms, or its price.<sup>53</sup> In addition to these pre-existing condition ("PEC") protections, the plans must cover a defined set of "essential health benefits," pay for preventative services without cost-sharing, limit out-of-pocket costs, and impose no annual or lifetime maximum.<sup>54</sup>

The federal financial supports and the individual mandate aim to ensure that the coverage pool is broad, including in any given year those who need a lot of health care and those who need only a little. A broad pool, with the sick and the well, should moderate premiums and support stable insurance options offered by private companies. Federal financial supports are of two types: sliding-scale premium subsidies and sliding-scale cost-sharing reductions ("CSRs").<sup>55</sup> The premium subsidies (technically they are advanceable, refundable tax credits) peter out at 400% of the federal poverty level (FPL).<sup>56</sup> In 2018, that was about \$50,000 for an individual or \$100,000 for a family of four.<sup>57</sup> The CSRs, which reduce out-of-pocket costs such as deductibles and co-pays, peter out at 250% FPL.<sup>58</sup>

<sup>50</sup> LISA MANHEIM & KATHRYN WATT, THE LIMITS OF PRESIDENTIAL POWER: A CITIZEN'S GUIDE TO THE LAW 58 (2018) ("The President's Toolkit").

<sup>51</sup> For this extended metaphor, I gratefully acknowledge Jane Beyer, Senior Health Policy Advisor, Washington State Office of the Insurance Commissioner. See also *infra* Section IV (regarding state fingers plugging the dike holes created by Trump administration actions).

<sup>52</sup> BLUMENTHAL & MORONE, *supra* note 6, at 11.

<sup>53</sup> Sallie Thieme Sanford, *The Struggle to Bury Pre-Existing Condition Consideration*, 7 ST. LOUIS J. HEALTH L. & POL'Y 405, 410-412 (2014).

<sup>54</sup> *Id.*

<sup>55</sup> 26 U.S.C. § 36B (2010); 42 U.S.C. § 18071.

<sup>56</sup> 26 U.S.C. § 36B (2010).

<sup>57</sup> Office of the Assistant Sec'y for Planning and Evaluation, *U.S. Federal Poverty Guidelines Use to Determine Financial Eligibility for Certain Federal Programs*, U.S. DEP'T. HEALTH & HUM. SERVS., <https://aspe.hhs.gov/poverty-guidelines> [<https://perma.cc/ZR9V-8TZJ>] (last visited Mar. 26, 2019).

<sup>58</sup> *Id.*

Although the average premium cost paid by a subsidized individual was about \$75 a month in 2018,<sup>59</sup> costs continue to be a serious problem for many purchasers. Deductibles are often high, sometimes approaching the maximum annual out-of-pocket costs, which in 2018 were about \$7,400 for an individual.<sup>60</sup> And for those who make too much or too little for a premium subsidy, purchasing a plan can be a huge financial burden.<sup>61</sup> This financial burden can be especially galling in regions where plan choices are few and characterized by a limited network of physicians and hospitals. And, of course, costs are a concern for the federal government; marketplace funding and Medicaid expansion are the two aspects of the ACA that impose the most costs on the federal government.

#### B. EXECUTIVE ORDERS AND MANAGERIAL ACTIONS

Throughout his presidential campaign, candidate Trump made a repeated, fervent pledge to “immediately repeal and replace Obamacare,”<sup>62</sup> promising action on day one of his administration. Indeed, shortly after being sworn in as president, while still at the Capitol, President Trump signed an executive order to “minimize the unwarranted economic and regulatory burdens” of the ACA.<sup>63</sup> It directed federal agencies to “exercise all authority and discretion available to them to waive, defer, grant exemptions from, or delay the implementation of any provision or requirement of the Act that would impose a fiscal burden.”<sup>64</sup> As discussed in this section and the next,

<sup>59</sup> *Health Insurance Exchanges 2018 Open Enrollment Period Final Report*, CTRS. FOR MEDICARE & MEDICAID SERVS. (APR. 3, 2018), <https://www.cms.gov/newsroom/fact-sheets/health-insurance-exchanges-2018-open-enrollment-period-final-report> [<https://perma.cc/U5EM-6XP9>] [hereinafter CMS.gov Final Report]; see also Rachel Fehr et al., *How ACA Marketplace Premiums Are Changing by County in 2019*, KAISER FAMILY FOUND. (Nov. 20, 2018), [https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2019/?utm\\_campaign=KFF-2018-The-Latest&utm\\_source=hs\\_email&utm\\_medium=email&utm\\_content=67700339&\\_hsenc=p2ANqtz-9Thx8hFjXer6rV84z5\\_G2oEsgFmkPqjRwgW7psV7tLBYvOaGVVWoeD7dNeGo3zkzdJPRMpQgv6brG42oAYOA6Cjlgbnw&\\_hsmi=67700339](https://www.kff.org/health-costs/issue-brief/how-aca-marketplace-premiums-are-changing-by-county-in-2019/?utm_campaign=KFF-2018-The-Latest&utm_source=hs_email&utm_medium=email&utm_content=67700339&_hsenc=p2ANqtz-9Thx8hFjXer6rV84z5_G2oEsgFmkPqjRwgW7psV7tLBYvOaGVVWoeD7dNeGo3zkzdJPRMpQgv6brG42oAYOA6Cjlgbnw&_hsmi=67700339) [<https://perma.cc/2WGS-JNWC>]; see *infra* Section IV.A. for a discussion of the complex reasons why the average monthly premium paid by a subsidized individual was lower (by about \$25) in 2017 and 2018 compared to the first years of the marketplaces.

<sup>60</sup> Stephen Miller, *HHS Sets 2018 Health Plan Out-of-Pocket Maximums*, HRNEWS (Dec. 22, 2016), <https://ezproxy.bu.edu/login?url=https://search.proquest.com/docview/1851717484?accountid=9676> [<https://perma.cc/7VTP-Q797>].

<sup>61</sup> Those with incomes below 100% FPL or above 400% FPL are not entitled to any premium subsidies (or cost-sharing reductions). The ACA as written intends that those at the lower income level be covered under a large employer plan or Medicaid, which the Supreme Court’s 2012 decision made a state option. As of mid-2018, 33 states and the District of Columbia had expanded their Medicaid programs; those that had not include populous Texas and Florida. See *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAMILY FOUND. (Nov. 26, 2018), <https://www.kff.org/health-reform/slide/current-status-of-the-medicare-expansion-decision/> [<https://perma.cc/S9G9-3ER8>]; see *infra* Section IV.B for discussion of Medicaid expansion and the 2018 mid-term election.

<sup>62</sup> Donald J. Trump (@realDonaldTrump), TWITTER (Feb. 9, 2016, 2:15 PM), [https://twitter.com/realDonaldTrump/status/697182075045179392?ref\\_src=twsrc%5Etfw%7Ctwcamp%5Eetweembed%7Ctwterm%5E697182075045179392&ref\\_url=https%3A%2F%2Fwww.washingtonpost.com%2Fnews%2Fpolitics%2Fwp%2F2017%2F03%2F24%2Fits-true-trump-didnt-pledge-obamacare-repeal-in-64-days-he-pledged-it-in-one%2F](https://twitter.com/realDonaldTrump/status/697182075045179392?ref_src=twsrc%5Etfw%7Ctwcamp%5Eetweembed%7Ctwterm%5E697182075045179392&ref_url=https%3A%2F%2Fwww.washingtonpost.com%2Fnews%2Fpolitics%2Fwp%2F2017%2F03%2F24%2Fits-true-trump-didnt-pledge-obamacare-repeal-in-64-days-he-pledged-it-in-one%2F) [<https://perma.cc/C8TR-PFMK>]; see also Philip Bump, *It’s True Trump Didn’t Pledge Obamacare Repeal in 64 Days. He Pledged It in One*, WASH. POST (Mar. 24, 2017), [https://www.washingtonpost.com/news/politics/wp/2017/03/24/its-true-trump-didnt-pledge-obamacare-repeal-in-64-days-he-pledged-it-in-one/?utm\\_term=.128a7927b2c5](https://www.washingtonpost.com/news/politics/wp/2017/03/24/its-true-trump-didnt-pledge-obamacare-repeal-in-64-days-he-pledged-it-in-one/?utm_term=.128a7927b2c5) [<https://perma.cc/H8AU-5FPC>] (noting President Trump’s repeated pledge to repeal ACA immediately).

<sup>63</sup> Exec. Order No. 13765, 3 Fed. Reg. 8351 (January 20, 2017).

<sup>64</sup> *Id.*

executive branch agencies have played a central role in advancing President Trump's anti-ACA agenda.

Health care is one of the most heavily regulated industries, and the ACA contains hundreds of sections directing that an agency head "may" or "shall" do one thing or another. Furthermore, as part of the complex dance of federalism, key aspects of the law's practical access functions are left to both federal and state agencies, often with broadly or awkwardly worded language. Primary federal agencies here are the Departments of Treasury, Labor, and Health and Human Services (HHS), especially the latter's Center for Medicaid and Medicare Services (CMS). The "M" in CMS is already a placeholder for two words, but given the center's workload, it really ought to be three and formally renamed the Center for Medicare, Medicaid, and Marketplace Services.

From its earliest days, HHS undertook managerial-type actions intended to discourage sign-ups through the marketplaces. President Trump appointed Representative Tom Price, a fierce critic of the ACA, to lead HHS.<sup>65</sup> In 2017, Price and then his successor, Alex Azar, slashed the budgets for marketplace advertising (by 90%) and consumer assistance (by 40%), shortened the time for the next open enrollment (from three months to 45 days), and removed helpful information from the CMS website. Indeed, the website came instead to feature videos of 23 people who described being harmed by the ACA.<sup>66</sup>

President Trump also destabilized the marketplaces by sowing uncertainty as to whether insurance companies would continue to receive CSR payments. In accordance with statutory direction, the IRS had made these payments monthly, reimbursing insurance companies to the tune of billions of dollars a year.<sup>67</sup> Just as frequently, the president and administration officials threatened to stop the reimbursements.<sup>68</sup>

They were empowered to do so by the outcome of a 2014 lawsuit brought by the Republican-controlled House of Representatives. The House argued that insurers could not lawfully be reimbursed for the CSR payments because Congress had not specifically appropriated the funds to do so.<sup>69</sup> The district court agreed.<sup>70</sup> The Obama administration appealed, and that appeal was pending when President Trump took office.<sup>71</sup> The appeal remained on hold as the president and agency officials publicly

<sup>65</sup> Amy Goldstein & Philip Rucker, *Trump names Rep. Tom Price as next HHS secretary*, WASH. POST (Nov. 29, 2016), <https://www.washingtonpost.com/news/powerpost/wp/2016/11/28/trump-to-name-rep-tom-price-as-next-hhs-secretary/> [<https://perma.cc/HB7Q-Z786>].

<sup>66</sup> Audrey Carlsen & Haeyoun Park, *The Same Agency That Runs Obamacare Is Using Taxpayer Money to Undermine It*, N.Y. TIMES, (Sept. 4, 2017), <https://www.nytimes.com/interactive/2017/09/04/us/hhs-anti-obamacare-campaign.html> [<https://perma.cc/9G2G-EEFW>]; see also Timothy Jost, *CMS Cuts ACA Advertising By 90 Percent Amid Other Cuts to Enrollment Outreach*, HEALTH AFF. BLOG (Aug. 31, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170901.061790/full/> [<https://perma.cc/F9N5-WL9Z>] (noting that CMS will focus outreach and marketing on digital messages).

<sup>67</sup> *President's Fiscal Year 2018 Health Care Proposals: Hearing Before the Comm. on Fin.*, 115th Cong. (2017). I DO NOT HAVE ACCESS TO THIS TO CONFIRM WHAT IT IS OR THE PINPOINT BELOW

<sup>68</sup> *Id.* at 59. CINDY IF YOU DON'T HAVE A WAY TO CONFIRM I CAN ASK THE EDITORS TO

<sup>69</sup> U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 174-176 (D.D.C. 2016).

<sup>70</sup> *Id.*

<sup>71</sup> Katie Keith, *States' Lawsuit Over Cost-Sharing Reductions is Dismissed*, HEALTH AFF. BLOG (July 19, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180719.822849/full/> [<https://perma.cc/5CQR-SLTD>]. One of the best resources for tracking the myriad federal implementation activities is this Health Affairs "following the ACA" blog, with its regular postings from Tim Jost, Katie Keith and others.

considered dropping it and stopping the payments (while also pressing Congress to repeal the ACA).<sup>72</sup>

“Obamacare is dead next month if it doesn’t get that money,” President Trump said in April 2017, as insurers were preparing to submit their rates for the fall enrollment season.<sup>73</sup> Premiums were already slated to go up substantially, with insurers exiting some markets. In no small part, insurers were responding to the chaos and uncertainty surrounding the then-pending repeal efforts and President Trump’s comments. Insurers also explained that previous enrollees had been sicker and older than predicted; and there is evidence that insurers may have underpriced their offerings in the first years, hoping to lock in purchasers. In addition, a transitional federal reinsurance program ended in 2016 — thus 2017 was the first year that insurers would lack a “safety net” for very high cost claims.<sup>74</sup>

After months of threats, on October 12, 2017, President Trump cancelled future CSR payments.<sup>75</sup> The Department of Justice dropped its appeal of the underlying district court decision. This was on the eve of open enrollment to purchase plans effective in 2018. As described in Section IV, creative actions by states cushioned the impact of this decision.

But states could not fully counter the uncertainty — *itself* a threat to coverage stability — sowed by this and contemporaneous federal agency regulatory and litigative actions. Uncertainty is itself a threat in part because the arrangement relies on private insurance company participation (there is no federal “public option”). In considering whether to offer a plan in an area during an upcoming open enrollment season, companies will weigh the financial risks and benefits, factoring in the number and characteristics of those likely to purchase a plan, as well as the expected payment streams and administrative work, among other factors.

### C. AGENCY REGULATION AND LITIGATION STRATEGY

Federal agencies play a key role in advancing the president’s agenda, as is evident here. By executive order in the fall of 2017, President Trump directed the revision of existing regulations to, among other changes, allow expanded access to short-term, limited duration plans (STLDs) and to association health plans (AHPs).<sup>76</sup> About a year later, final rules became effective, shooting significant holes in the dike.<sup>77</sup>

<sup>72</sup> Erin Raftery & Amy Lotven, *Court Grants House Wish to put CSR Case on Hold Until February*, INSIDEHEALTHPOLICY.COM’S DAILY BRIEF (Dec. 6, 2016).

<sup>73</sup> Michael C. Bender, Louise Radnofsky & Peter Nicholas, *Trump Threatens to Withhold Payments to Insurers to Press Democrats on Health Bill*, WALL ST. J. (Apr. 12, 2017, 5:06 PM), <https://www.wsj.com/articles/trump-threatens-to-withhold-payments-to-insurers-to-press-democrats-on-health-bill-1492029844> [<https://perma.cc/EU5P-RRRZ>].

<sup>74</sup> See Section IV B, *infra*, for a discussion of state attempts, using section 1332 waivers to reestablish reinsurance programs.

<sup>75</sup> Keith, *CSR*, *supra* note 72.

<sup>76</sup> Promoting Healthcare Choice and Competition Across the United States, Exec. Order No. 13,813, 82 Fed. Reg. 48385 (Oct. 12, 2017) [<https://perma.cc/9PMX-26JL>]. Other proposed changes to similar effect include revisions to the regulations concerning Health Reimbursement Arrangements.

<sup>77</sup> Katie Keith, *The Short-Term, Limited-Duration Coverage Final Rule: The Background, The Content, And What Could Come Next*, HEALTH AFF. BLOG (Aug. 1, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180801.169759/full/> [<https://perma.cc/AJN2-N55S>] hereinafter Keith *Short-Term, Limited-Duration Coverage*] (explaining STLD rule); see also Katie Keith, *Final Rule Rapidly Eases Restrictions On Non-ACA-Compliant Association Health Plans*, HEALTH AFF. BLOG (June 21, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180621.671483/full/> [<https://perma.cc/P2H3-ZS48>] (explaining AHP Rule).

Both coverage vehicles, which CMS promoted, would be expected to appeal to, and thus draw out, younger, healthier people, particularly those who do not qualify for subsidized coverage. With older, less healthy people remaining in the pool, premiums would be expected to soar.

STLD plans can exclude coverage for maternity, prescription medications, and mental health treatment (among other essential health benefits covered by marketplace plans).<sup>78</sup> They can have lifetime and annual limits.<sup>79</sup> And, in contravention of the PEC protections, can consider a person's health status in determining whether to offer a plan, its benefits, and its terms.<sup>80</sup> Under Obama-era regulations, STLD plans could last for only three months and could not be renewed; this jibed with an individual mandate provision that allowed for a three-month gap in qualifying coverage in any calendar year.<sup>81</sup>

Under the new rules, STLD plans can last for 364 days and can be renewed—at the insurer's option—two times (for a total term of just under three years).<sup>82</sup> In addition, nothing in the rules prevents a person from thereafter buying a new STLD plan, making these skimpier plans a potentially ongoing source of coverage. (Though, of course, pregnancy, disease or injury might mean a new plan is unavailable, unaffordable, or unhelpful.) To similar effect, the AHP rules both allow more people to form an “association” and reduce regulation of association-sponsored insurance plans.<sup>83</sup>

In late 2018, aiming to further expand the reach of these skimpier options, CMS relaxed the requirements for states to obtain waivers from compliance with key ACA provisions.<sup>84</sup> Waivers of this sort are known as “section 1332 waivers” in reference to the ACA provision that authorizes them. In a guidance document, CMS announced that for 2019 and subsequent years, the agency would be receptive to waiver requests that enabled federal subsidy support for the newly authorized, skimpier plans.<sup>85</sup> Notably, this action was not a rulemaking, but rather a form of subregulatory activity. Although a mechanically easier process for the agency, any subregulatory activity needs to comport with its statutory underpinnings. This guidance arguably violates the ACA's subsidy authorization and waiver criteria. Standing and ripeness questions, however, present challenges to litigating the legality of the waiver guidance or any subsequent waiver approvals.<sup>86</sup>

These and related agency actions shoot holes in the ACA's protective dike. If they persist, they can be expected to drive marketplace enrollment down and premiums

<sup>78</sup> Keith, *Short-Term, Limited-Duration Coverage*, [supra note 78](#) (explaining STLD rule).

<sup>79</sup> *Id.*

<sup>80</sup> *Id.*

<sup>81</sup> *Id.*

<sup>82</sup> *Id.* See also Zachary Tracer & Emma Ockerman, *It's Buyer Beware for Short-Term Health Plans Pushed by Trump*, BLOOMBERG LAW (Aug. 1, 2018, 9:20 AM) <https://news.bloomberglaw.com/health-law-and-business/its-buyer-beware-for-short-term-health-plans-pushed-by-trump> [<https://perma.cc/NU3C-4JFM>].

<sup>83</sup> Keith, *Short-Term, Limited-Duration Coverage*, [supra note 78](#) (explaining STLD rule). Keith, *Final Rule Rapidly Eases Restrictions*, [supra note 78](#) (explaining AHP Rule).

<sup>84</sup> Katie Keith, *Feds Dramatically Relax Section 1332 Waiver Guardrails*, HEALTH AFF. BLOG (Oct. 23, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20181023.512033/full> [<https://perma.cc/UCE3-4ZWW>].

<sup>85</sup> *Id.*

<sup>86</sup> *Id.*

up. This risks a “death spiral” of the type experienced in the 1990s when similar state-level reforms were undone, and insurers abandoned markets.<sup>87</sup>

The skimpier plans do address profound concerns about the unsustainably high cost of health coverage for many people, particularly those who are older, rural, and/or make more than \$50,000 a year.<sup>88</sup> But they do so to the detriment of those who will end up needing expensive health care because of illness, injury, or pregnancy. And they threaten the stability of the overall system. As discussed in Section IV, *infra*, states have emerged as a key institutional force working to constrain the president’s power, including by state-based measures to hold down premiums and encourage enrollment.

Finally, the administration’s litigation strategy further undermines the marketplace protections. As described above, the administration dropped the Obama-era appeal of the district court’s CSR decision. Moreover, beginning early 2018, in *Texas v. United States*, the administration has declined to defend the constitutionality of the ACA, arguing instead for a remedy that would strip PEC and related protections from the law.<sup>89</sup> Twenty Republican states’ attorneys general or governors filed *Texas v. United States* in response to the December 2017 tax law that zeroed out the individual mandate’s tax penalty.

Without the tax penalty, the plaintiffs argue, a key linchpin of the law lacks constitutional grounding and thus the *entire* ACA—from Medicaid expansion to menu labeling—must be thrown out.<sup>90</sup> Sixteen Democratic states’ attorneys general or governors intervened to argue for the law’s constitutionality and, as a fallback position, for a tailored approach to severability, limited to the mandate.<sup>91</sup> In late 2018, the district court ruled in favor of the plaintiffs, and then stayed, pending appeal, its decision to throw out the entire law.<sup>92</sup>

The individual mandate may not, in fact, prove to be operationally essential, at least at this point in the ACA’s implementation. Once results from the 2018 open enrollment season are analyzed, it is possible that the lack of a tax penalty will prove to have been a minor issue in purchasing decisions. Although enrollment is down overall, it is up in some states, and higher than many experts expected given the attempted executive repeal and tax penalty removal.<sup>93</sup> After several years of

<sup>87</sup> King v. Burwell, 135 S.Ct. 2480, 2482-2484 (2015). See also Sallie Thieme Sanford, *Mind the Gap: Basic Health Along the ACA’s Coverage Continuum*, 17 MD. J. HEALTH CARE L. & POL’Y 101, 103-105 (2014) (describing near-collapse of the individual market in Washington State in the late 1990’s after repeal of contentious mandates and retention of consumer protections).

<sup>88</sup> The ACA allows older people to be charged up to three times as much as younger people for the same policy. Those who receive a subsidy are largely shielded from this differential, because their subsidy rises to account for the age-adjusted premium for the benchmark plan. Rural people often face higher premium costs than city dwellers because there are typically fewer insurers competing for a smaller number of people, who are more expensively sick than average. These rural challenges were one argument in favor of a “public option” on the marketplaces. Vann Newkirk & Anthony Damico, *The Affordable Care Act and Insurance Coverage in Rural Areas*, KAISER FAMILY FOUND. (May 29, 2014), <https://www.kff.org/uninsured/issue-brief/the-affordable-care-act-and-insurance-coverage-in-rural-areas/> [https://perma.cc/PD96-VR4D].

<sup>89</sup> Katie Keith, *Texas Litigation: Where Are We Now and What Could Happen Next?*, HEALTH AFF. BLOG (Sept. 4, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180904.981573/full/> [https://perma.cc/7Z2G-PY57] [hereinafter Keith, *Texas Litigation*].

<sup>90</sup> *Texas v. United States*, -- or A SUPRA BACK TO THE INITIAL CITATION NO 35 AT PAGE 104.E

<sup>91</sup> *Id.*

<sup>92</sup> *Id.*

<sup>93</sup> CMS.gov FINAL REPORT, *supra* note 59.



dramatically reduced uninsurance rates, perhaps coverage has become the expectation and people are sticking with individual insurance. Marketplace affordability may prove to be the crucial factor. And that is promoted for low- and moderate- income purchasers by premium subsidies and cost-sharing reductions, which continue for now.

The attempted executive repeal did not destroy the marketplaces in 2018. That year all counties had at least one insurer offering coverage.<sup>94</sup> Costs, while higher than they would have been without the administration's destabilizing actions, appear generally manageable from a system perspective, if not as to many individuals and families.<sup>95</sup> However, the newly authorized cheaper, skimpier plans were not generally available in the fall of 2018. The tax penalty repeal had not yet gone into effect. And states have not yet acted upon the expanded 1332 waiver option.

Thus, it is too soon to know the ultimate impacts of President Trump's attempt to repeal and replace the ACA by "a little different route."<sup>96</sup> This uncertainty is compounded by the rising prominence of two constraining forces: the states, and the public.

#### IV. STATE ACTORS CONSTRAIN EXECUTIVE POWER WITH MANAGERIAL, LITIGATIVE, LEGISLATIVE, AND REGULATORY WORK

States have emerged as a key institutional force constraining the president's power to repeal the ACA's marketplace protections. As discussed in the prior section, the ACA establishes a dike protecting the individual coverage pool. The president continues to shoot holes in this dike. And by zeroing out the individual mandate tax penalty, Congress hammered a crack through it. The fingers plugging those holes and the feet bracing the crack belong, at least for now, to the states.

Notably, these are not only blue fingers and feet. Some of the actions have been distinctly bipartisan, such as the facilitation of "silver loading" to counter the president's withdrawal of CSR payments. Litigation brought by Democratic-leaning states takes a historically atypical position in aiming to bolster federal power and nationally uniform rules. As these lawsuits play out, the federal courts might patch a hole here and there or fashion a truss. Ultimately, though, it is hard to imagine the battered individual coverage dike holding strong without Congressional action to plaster and solidify the walls.

##### A. STATE MANAGEMENT AND LITIGATION

Within its federal framework, the ACA features a significant role for the states in marketplace management and Medicaid expansion. The Supreme Court's 2012 decision in *NFIB v. Sebelius* expanded these roles. After tracking the marketplace and Medicaid aspects of health care federalism from 2012–2017, law professors Abbe R. Gluck and Nicole Huberfeld conclude that "there have been waves of engagement and estrangement between states and the federal government" over

<sup>94</sup> Rachel Fehr, Cynthia Cox, & Larry Levitt, *Insurer Participation on ACA Marketplaces, 2014-2019*, KAISER FAMILY FOUND. (Nov. 14, 2018), <https://www.kff.org/health-reform/issue-brief/insurer-participation-on-aca-marketplaces-2014-2019/> [https://perma.cc/XJZ3-XR57].

<sup>95</sup> See CMS.gov, FINAL REPORT, [supra note 59](#). See also Fehr et al., *Changing by County*, [supra note 59](#).

<sup>96</sup> President Donald Trump, Remarks at the 2017 Values Voter Summit (Oct. 13, 2017), <https://www.whitehouse.gov/briefings-statements/remarks-president-trump-2017-values-voter-summit/> [https://perma.cc/FB8M-F7FK]. **THIS COULD HAVE A SUPRA, BUT MAYBE IT'S TOO FAR BACK IN THE PAPER**

ACA implementation.<sup>97</sup> The process, they write, has been dynamic, pragmatic, and negotiated; it has been marked by both intrastate politics and also intergovernmental creativity. Notably, state agency-level efforts to cooperatively support robust ACA coverage often belied political messaging from state leaders.<sup>98</sup>

The complicated dynamics of health care federalism also play out in many states' more recent role as a constraint on President Trump's efforts to undercut the marketplaces. One example revolves around the CSR saga described in Section III B. More than a dozen states intervened in the underlying lawsuit, taking up the Obama administration's advocacy in defense of continuing the payments.<sup>99</sup>

Days after President Trump announced he was cutting off the CSR payments to insurers, California and 18 other liberal-leaning states (including the District of Columbia) filed suit.<sup>100</sup> This action, the states argued, violated the ACA and would raise insurance premiums, destabilize the individual market, and harm state residents. Ruling quickly, the court denied a preliminary injunction to keep the payments flowing, concluding that much of the harm had been quickly offset by "silver loading."<sup>101</sup>

Silver loading is a creative, kludgy workaround adopted by state insurance commissioners across the country in response to the threatened, and then actual, CSR payment cut-off. Many insurance commissioners—in red states and in blue—allowed, or in some cases required, insurers to apply the full CSR-related premium increase to silver plans, rather than spreading the increase across their plans of all metal levels. Part of the logic is that the CSRs (the reduced out-of-pocket costs) are available only to income-eligible purchasers who buy a silver plan (rather than bronze, gold, or platinum). Much of the logic, though, is to hold down costs for other purchasers and to promote stability.

Thus, on the 2017 and 2018 marketplaces, silver plans in many markets had, counterintuitively, higher premiums than did gold plans. And, significantly, subsidized purchasers had higher federal premium subsidies, as these are pegged to a silver plan.<sup>102</sup> Those who made too much or too little to qualify for a subsidy and wanted a silver plan faced huge increases but could often find good rates for other plans (though perhaps with undesired tradeoffs). Marketplace pricing was quirky and complicated; but states' silver-loading decisions helped maintain viable markets.<sup>103</sup> In other managerial-type functions, many states increased their marketing and outreach in the face of drastic federal cuts in both those areas.

In addition, states and localities have been active litigators in defense of the ACA. As noted in the prior section, 16 Democratic attorneys general or governors intervened in *Texas v. United States* to argue in defense of the constitutionality of the

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<sup>97</sup> Abbe R. Gluck & Nicole Huberfeld, *The New Health Care Federalism on the Ground*, 15 IND. HEALTH L. REV. 1, 1 (2018). See also Abbe R. Gluck & Nicole Huberfeld, *What is Federalism in Health Care For?*, 70 STAN. L. REV. 1689, 1734 (2018).

<sup>98</sup> Gluck & Huberfeld, *New Health Care Federalism*, *supra* note 97, at 16–20.

<sup>99</sup> Keith, *CSR*, *supra* note 72.

<sup>100</sup> *Id.*

<sup>101</sup> *Id.*

<sup>102</sup> A purchaser's subsidy amount is designed to bring the age-adjusted full premium cost of the second cheapest silver plan down to a statutorily set percentage of the purchaser's income. For details on the complicated pricing in 2017 and 2018. See Fehr et al., *Changing by County*, *supra* note 59. There have been rumblings that the 2020 Notice of Benefit and Payment Parameter rule, expected to be published in early 2019, might attempt to prohibit silver loading.

<sup>103</sup> Fehr et al., *Changing by County*, *supra* note 59.

ACA, and for a tailored view of severability.<sup>104</sup> And in direct response to this case, the Maryland attorney general sued in federal court there seeking a declaration that the ACA remains constitutional and enforceable. The state is directly harmed, Maryland argues, by the administration's multifaceted actions to undermine the ACA.<sup>105</sup> Similar arguments are advanced by four cities—Baltimore, Chicago, Cincinnati and Columbus—in a lawsuit also filed in district court in Maryland. In a novel argument, the cities argue that President Trump is violating his constitutional duty to “take Care that the Laws be faithfully executed.”<sup>106</sup>

In addition, states have judicially challenged Trump administration regulations aimed at expanding the availability of less expensive, less comprehensive, less protective insurance plans through the AHP regulations. The plaintiffs argue that the regulations are arbitrary and capricious, violate the ACA, and violate the federal Employee Retirement Income Security Act (ERISA).<sup>107</sup>

As these cases wend their way through the federal courts, they will highlight the judicial system's role in checking the president's power. The question of the ACA's current constitutionality seems likely to be appealed, and perhaps taken up by the Supreme Court, spotlighting the odd situation of most of the states engaged in litigation, effectively against each other, over the authority of the federal government to regulate their citizens.

The regulatory challenges before the courts involve more typical questions of *Chevron* deference, statutory authority, and Administrative Procedures Act compliance. They also, though, feature the unusual situation of states arguing for federal rather than state regulation. This runs counter to states' more typical assertions of state authority and autonomy. It also reflects the reality that state-level backfilling here is a fragmented, piecemeal, and ultimately unsustainable endeavor.

## B. STATE LEGISLATION AND REGULATION

Several states also have enacted legislation or adopted rules aiming to plug executive branch-created holes in the individual marketplace dike. A couple of states have enacted individual mandates tied to state taxes, and others are considering doing so.<sup>108</sup> For states without an income tax, enforcement options are limited. And a key legislative question concerns what qualifies as satisfactory health insurance for purposes of a state mandate. To this point, states have enacted state law definitions of required benefits and pre-existing condition protections in line with the ACA.<sup>109</sup> The

<sup>104</sup> Keith, *Texas Litigation*, [supra note 89](#).

<sup>105</sup> Katie Keith, *Two New Lawsuits Challenge Trump Administration Actions on Health Reform*, HEALTH AFF. BLOG (Sept. 17, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180917.479910/full/> [<https://perma.cc/KY5V-6GJ4>].

<sup>106</sup> Complaint for Declaratory and Injunctive Relief at 3, *City of Columbus v. Trump*, No. 18-cv-2364 (D. Md. Aug. 2, 2018), [<https://perma.cc/W6VN-PEMH>]; U.S. CONST. art. II, § 3, cl. 5.

<sup>107</sup> Katie Keith, *ACA Round-Up: States Sue over AHP Rule; Wisconsin's 1332 Waiver Approved; House Votes To Repeal And Delay ACA Taxes, Authorize Copper Plans*, HEALTH AFF. BLOG (July 30, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180730.639187/full/> [<https://perma.cc/6MXU-KSRP>].

<sup>108</sup> Katie Keith, *Mandate Round-Up: Texas v. U.S., House Moves to Prevent D.C. Mandate, and New Report on Impact of State Mandates*, HEALTH AFF. BLOG (July 23, 2018), <https://www.healthaffairs.org/doi/10.1377/hblog20180723.634173/full/> [<https://perma.cc/G8Z8-VUZ7>].

<sup>109</sup> Kevin Lucia et al., *State Regulation of Coverage Options Outside of the Affordable Care Act: Limiting the Risk to the Individual Market*, THE COMMONWEALTH FUND (Mar. 29, 2018), [https://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-affordable-care-act?redirect\\_source=/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca](https://www.commonwealthfund.org/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-affordable-care-act?redirect_source=/publications/fund-reports/2018/mar/state-regulation-coverage-options-outside-aca) [<https://perma.cc/Q5AE-QFE8>].

reach of these statutes is complicated and limited by federal pre-emption under ERISA.

Regulation in some states also works to cabin the impact of the dramatically expanded federal rules regarding short-term limited duration (“STLD”) plans, which allow for PEC restrictions and limited benefits.<sup>110</sup> States retain the ability to regulate these plans. California banned them; Washington State allows them, but only for a non-renewable three-month term and with detailed notice to purchasers.<sup>111</sup>

There are also examples of states working with the Trump administration to shore up their marketplaces. Several states successfully obtained section 1332 waivers to use federal money for state-designed reinsurance arrangements.<sup>112</sup> These arrangements – modeled on the ACA’s temporary program that expired in 2016 – spread the financial burden of particularly high cost patients.<sup>113</sup> This reduces insurer risk, and thus moderates premiums.

Section 1332 waivers, a feature of the ACA also known as “Wyden Waivers,”<sup>114</sup> first became available in 2017. Alaska used one to draw down federal dollars in support of a reinsurance program; the program successfully reduced premiums on Alaska’s notoriously high-cost marketplace.<sup>115</sup> Other states have copied Alaska’s model and received similar 1332 waivers. (The financial arrangement is technically somewhat easier in Alaska than in other states; one reason is that nearly all of the Last Frontier’s marketplace purchasers receive a premium subsidy, a higher percentage than in other states.)<sup>116</sup>

In 2017, Senators Patty Murray (D-Wash.) and Lamar Alexander (R-Tenn.) worked on bipartisan legislation that featured several marketplace stabilization measures sought by the states. These included a federal reinsurance program, restoration of the CSR payments, and funding for advertising and assistance. Although there were indications of bipartisan and presidential support, the bill faltered and was not brought up for a vote.<sup>117</sup>

Pressure from state actors and the consequences of pending judicial decisions might spur Congressional revision and refinement of the ACA. This is somewhat more

<sup>110</sup> *Id.*

<sup>111</sup> Mary Ellen McIntire, *States Weigh Response to Proposed Short-Term Health Plan Rule*, ROLL CALL (Mar. 5, 2018, 5:00 AM), <https://www.rollcall.com/news/policy/states-weigh-response-proposed-short-term-health-plan-rule>. [<https://perma.cc/N4T3-QV3U>]; see also Lucia et al., *supra* note 109.

<sup>112</sup> Heather Howard & Galen Benshoof, *Section 1332 Waivers and the Future of State Health Reform*, HEALTH AFF. BLOG (Dec. 5, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20141205.043142/full> [<https://perma.cc/9LQ6-MC8F>].

<sup>113</sup> Joel Ario and Jessica Nysenbaum, *State Reinsurance Programs: Design, Funding, and 1332 Waiver Considerations for States*, MANATT HEALTH 1, 4 (2018), <https://www.shvs.org/wp-content/uploads/2018/03/Reinsurance-Brief-Update-FINAL.pdf> [<https://perma.cc/V6T6-JDYL>].

<sup>114</sup> <sup>114</sup> **XXWHY IS THIS FOOTNOTE NUMBER DOUBLED** See Heather Howard & Galen Benshoof, *Section 1332 Waivers and the Future of State Health Reform*, HEALTH AFF. BLOG (Dec. 5, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20141205.043142/full> [<https://perma.cc/9LQ6-MC8F>]. Senator Ron Wyden (D-OR) sponsored the amendment that allows states, with the approval of the federal government, to waive certain features of the ACA as long as their innovative approach would meet or exceed the quality, affordability, and reach of the ACA framework.

<sup>115</sup> Timothy Jost, *ACA Round-Up: CMS Approves Alaska 1332 Reinsurance Waiver, Ceases Premium Outlier Reviews*, HEALTH AFF. BLOG (July 12, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20170712.061031/full>. [<https://perma.cc/9XJQ-DJMN>].

<sup>116</sup> *Id.*

<sup>117</sup> Billy Wynne & Timothy Jost, *The Alexander-Murray Market Stabilization Package: What’s In It and Where’s It Going?*, HEALTH AFF. BLOG (Oct. 17, 2017), <https://www.healthaffairs.org/doi/10.1377/hblog20171022.680941/full> [<https://perma.cc/DXF8-9UTX>].

likely given Democratic control of the House in 2019-2020. And it is bolstered by public opinion, which is shifting towards solid support for government-grounded coverage options and pre-existing condition protections.

#### V. PUBLIC VOICES CONSTRAIN FUTURE OPTIONS, WITH GROWING SUPPORT FOR GOVERNMENT-GROUNDED COVERAGE AND PEC PROTECTIONS

Public voices present a growing constraint on the possibility of a full executive repeal of the ACA's access provisions. These voices do not directly limit executive action, as could institutional actors such as Congress, courts, and state governments. Indirectly, however, public opinion — particularly its expression at the ballot box — blunts the impacts of presidential pen and phone.

The ACA, despite polling more favorably than not in 2017 and 2018, remains highly polarizing. This polarization persists despite solidifying support, across party lines, for central features of the law, including pre-existing condition protections and government-grounded coverage options. This shift in opinion was reflected in political messaging during the 2018 midterm elections, and in its results. Voters in three states went around legislative and/or gubernatorial intransigence and adopted Medicaid expansion by initiative. In other states, voters elected governors who vowed to press for expansion.

#### A. PERSONAL STORIES AND PUBLIC OPINION

With this issue, the personal readily becomes political. Americans' stories about health care coverage and access challenges date back at least a century. Traditional and social media have amplified them, under both Presidents Obama and Trump. When "repeal and replace" seemed an imminent possibility under President Trump and a Republican Congress, the voices urging protection of the ACA reverberated from town hall attendees, expensively ill patients, media stars, and nascent politicians, among many others.

Tennessee teacher Jessi Bohon's Town Hall comments ricocheted around social media. "As a Christian," Bohon said, "my whole philosophy is to pull up the unfortunate."<sup>118</sup> She explained that this philosophy grounded her support for the individual mandate, and her concerns that the then-pending Republican replacement bill would mean that "[w]e are effectively punishing our sickest people."<sup>119</sup> Multiple sclerosis patient Kim Adams joined the chorus of activists who had gained health coverage because of the ACA and spoke out in various fora about what its repeal would mean to them. Describing her time of living with MS and without coverage, she said, "I lost three years of being able to care for my daughter, worrying the whole time, living in constant panic."<sup>120</sup>

Tonight Show host Jimmy Kimmel's on-air monologue about his infant son's frightening and expensive surgery for a congenital heart defect inspired the "Jimmy

<sup>118</sup> *Teacher's Town Hall Question Goes Viral*, CNN, (Feb. 9, 2017), <https://www.cnn.com/videos/politics/2017/02/10/republican-town-hall-diane-black-obamacare-question-sot.cnn/video/playlists/obamacare/> [https://perma.cc/MSQ7-E4DY].

<sup>119</sup> *Id.*

<sup>120</sup> Victoria Kim, *The Pitched Election Battle Over Healthcare Is Personal for Many Southland Voters*, L.A. TIMES, (Nov. 4, 2018, 2:00 AM), <http://www.latimes.com/local/lanow/la-pol-ca-midterms-healthcare-20181104-story.html> [https://perma.cc/ZEP8-8QK4].

Kimmel test” as a lodestar for evaluating ACA replacement options.<sup>121</sup> “If your baby is going to die and it doesn’t have to, it shouldn’t matter how much money you make,” Kimmel said. “I think that’s something that whether you’re a Republican or a Democrat or something else, we all agree on that, right?”<sup>122</sup> And the threat to the ACA inspired nascent politicians, including pediatrician and diabetic Kim Schrier (D-Wash.) who in 2018 successfully ran on health reform to win a previously Republican-held U.S. House seat.<sup>123</sup>

In some ways, the popular source and impacts of these stories mirror the Tea Party ascendance in the summer of 2009. At that time, nearly all major interest groups were allied in support of the key elements of what would become the ACA. The populist, conservative Tea Party movement amplified individual voices strongly opposed to an expanded government role in health care. Those voices helped deliver the Democratic shellacking in the 2010 mid-terms.<sup>124</sup>

Six months before this consequential election, and just after the ACA’s enactment, the Kaiser Family Foundation began asking Americans every few months whether they had a “generally favorable or generally unfavorable view” of the “health reform bill signed into law in 2010.”<sup>125</sup> What Americans have had, generally, is a divided view. Over the years, close to the same number disfavored the law as favored it, and few lacked an opinion.

Indeed, a notable feature of the Kaiser polls’ display graph over time is how closely the red line of unfavorability tracks the blue line of favorability. Over eight years of polling, the two are typically separated by no more than a few percentage points, occasionally meeting to reflect an even split in opinion. Between January 2013 and January 2015, the ACA was consistently viewed more unfavorably than not, the red line above the blue.<sup>126</sup>

As President Trump’s administration and the Republican Congress ramped up their threats to the law, however, public opinion decisively shifted. From February 2017, the month after President Trump’s inauguration, through at least 2018, more Americans have consistently expressed support for the ACA as a whole. In August 2018, 50% of those surveyed had a generally favorable view of the law as a whole, and 40% a generally unfavorable view.<sup>127</sup>

<sup>121</sup> Chris Cillizza, *How the 'Jimmy Kimmel test' became the health care fight's measuring stick*, CNN, (Sept. 20, 2017, 11:32 AM), <https://www.cnn.com/2017/09/20/politics/health-care-kimmel/index.html> [https://perma.cc/3Z8V-933N].

<sup>122</sup> Giovanni Russonello, *Jimmy Kimmel's Emotional Monologue: His New Son's Heart Condition*, N.Y. TIMES, (May 2, 2017), <https://www.nytimes.com/2017/05/02/arts/television/jimmy-kimmel-baby-son-wife.html> [https://perma.cc/Z3BW-XP4Q].

<sup>123</sup> Jim Brunner, *Kim Schrier, a Doctor, Makes Health Care a Centerpiece of Her 8th District Campaign for Congress*, SEATTLE TIMES, (July 26, 2018, 8:49 AM), <https://www.seattletimes.com/seattle-news/politics/kim-schrier-a-doctor-makes-health-care-a-centerpiece-of-her-8th-district-campaign-for-congress> [https://perma.cc/E4L6-PLZ2].

<sup>124</sup> Paul Harris and Ewen MacAskill, *US Midterm Election Results Herald New Political Era as Republicans Take House*, THE GUARDIAN, (Nov. 3, 2010), <https://www.theguardian.com/world/2010/nov/03/us-midterm-election-results-tea-party> [https://perma.cc/8WBJ-S7U8].

<sup>125</sup> See *Kaiser Health Tracking Poll: The Public's Views on the ACA*, KAISER FAMILY FOUND. (Mar. 1, 2019), <https://www.kff.org/interactive/kaiser-health-tracking-poll-the-publics-views-on-the-aca> [https://perma.cc/6WZS-3ASQ] (Kaiser’s periodic polling shows that there have been a few times in which the public’s overall opinion of the ACA has been favorable, but the most significant and steady favorability trend began in February 2017).

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

The Kaiser display graphs' use of blue for "favorable view" and red for "unfavorable view" tracks party affiliation. In the August 2018 poll mentioned above, for example, 77% of Democrats (and only 15% of Republicans) approved of the law overall. And in a mirror opposite 78% of Republicans (and 17% of Democrats) disapproved of the law overall.<sup>128</sup>

Many of the ACA's central aspects, though, poll as overwhelmingly and increasingly popular. Polling from late summer of 2018, for example, showed that 75% of Americans and including a majority of Republicans consider it "very important" to maintain the law's protections for those with pre-existing conditions.<sup>129</sup> Also quite popular among those from both parties were premium subsidies, the ability to keep children up to age 26 on large employer plans, and coverage of preventative services without cost-sharing.<sup>130</sup>

Polling about the government's role is also instructive. In 2013, as the four M's of Access were poised to go into effect, 56% of Americans said that it is not the government's responsibility to ensure that all citizens have health care.<sup>131</sup> In 2018, that had nearly flipped, with 60% averring that this is the government's responsibility.<sup>132</sup> Political divisions on this point remain significant and reflect complicated perceptions of government programs and citizen obligations.<sup>133</sup>

#### B. POLITICAL STATEMENTS AND POPULAR INITIATIVES

Ultimately, though, what impact does public opinion have, whether reflected in polling numbers or personal stories? Under conventional theory, it should shift policy. In the absence of linked political change, though, it might simply shift rhetoric. "[T]he influence of public opinion on government policy," concluded political scientists Lawrence R. Jacobs and Robert Y. Shapiro in 2000, "is less than it has been in the past and certainly less than commonly assumed by political pundits and some scholars."<sup>134</sup>

They wrote this prior to the battles over the ACA and the modern populist movements, but much of their analysis resonates. They argue that elected officials often use polling data and other indicia of public opinion more to shape their messaging than to shape their legislation.

The 2018 mid-term election campaigns provided a striking example of this. In a stark turn of campaign rhetoric, many Republicans dropped "repeal and replace"

<sup>128</sup> *Id.*

<sup>129</sup> Ashley Kirzinger et. al, *Kaiser Health Tracking Poll—Late Summer 2018: The Election, Pre-Existing Conditions, and Surprises on Medical Bills*, KAISER FAMILY FOUND. (Sept. 5, 2018), <https://www.kff.org/health-costs/poll-finding/kaiser-health-tracking-poll-late-summer-2018-the-election-pre-existing-conditions-and-surprises-on-medical-bills> [https://perma.cc/FT5J-D8WX].

<sup>130</sup> *Id.*

<sup>131</sup> Jeff Jones and Lydia Saad, *Gallup Poll Social Series: Health and Healthcare - Final Topline*, GALLUP, (Nov. 2-8, 2017), <https://news.gallup.com/poll/223391/majority-government-ensure-healthcare-coverage.aspx> [https://perma.cc/9PB2-7AYW].

<sup>132</sup> Jocelyn Kiley, *Most Continue to Say Ensuring Health Care Coverage Is Government's Responsibility*, PEW RES. CENTER: FACT TANK, (Oct. 3, 2018), <http://www.pewresearch.org/fact-tank/2018/10/03/most-continue-to-say-ensuring-health-care-coverage-is-governments-responsibility/> [https://perma.cc/DFZ9-PFND].

<sup>133</sup> See Atul Gawande, *Is Health Care a Right?*, NEW YORKER, Oct. 2, 2017, <https://www.newyorker.com/magazine/2017/10/02/is-health-care-a-right> [https://perma.cc/H2LR-6ELY].

<sup>134</sup> LAWRENCE R. JACOBS & ROBERT Y. SHAPIRO, *POLITICIANS DON'T PANDER: POLITICAL MANIPULATION AND THE LOSS OF DEMOCRATIC RESPONSIVENESS* xvi (Univ. of Chi., 1st ed. 2000).

calls and campaigned on support for PEC protections, historically the province of Democrats. In the weeks leading up to the 2018 midterms, President Trump echoed this messaging. “All Republicans support people with pre-existing conditions, and if they don’t, they will after I speak to them,” he tweeted. “I am in total support.”<sup>135</sup>

Consider, for example a campaign ad by a successful U.S. Senate candidate, Republican Josh Hawley, who was then Missouri’s attorney general. “Earlier this year, we learned our oldest has a rare chronic disease,” Hawley says in the ad. “Preexisting condition. We know what that’s like. I’m Josh Hawley. I support forcing insurance companies to cover all preexisting conditions.” At the same time, Hawley was a plaintiff in *Texas v. United States*,<sup>136</sup> which aims to throw out the entire ACA, or at least its PEC and related coverage protections; he also supported Trump administration rules to allow the sale of cheaper, limited-coverage, health status-rated plans which threaten the stability of the individual market. Hawley vowed to advance protective legislation outside the ACA framework, a drafting challenge that has eluded previous Congresses.<sup>137</sup>

Regardless whether public opinion ultimately matters, elections do. And this very much includes state-level elections. As discussed in Section IV of this paper, states have been a significant constraint on the president’s ability to undermine the ACA. In this regard, it is state officials, elected and appointed, that take the protective actions. It is also state officials, elected and appointed, that take resisting action. State legislatures, health care agencies, insurance commissioners, and governors are likely to be at the center of ACA implementation debates for the foreseeable future.

If nothing else, the successful 2018 state Medicaid expansion initiatives will ensure that centrality. Voters in Idaho, Nebraska, and Utah approved these direct-to-the-people measures during the midterm elections. And Maine elected a governor who vowed to implement a previous Medicaid expansion initiative that had been blocked by her predecessor. These four initiatives are notable examples of popular opinion going around gubernatorial and/or legislative ACA opposition.<sup>138</sup>

Medicaid is popular, even in states that had not expanded the program prior to 2018. In an October 2018 poll, 56% of people in the 17 non-expansion states said that they favored doing so.<sup>139</sup> Reflecting the insight that polling drives messaging, the 2018 initiative campaigns in Idaho, Nebraska and Utah downplayed the issue’s connection to the ACA, which polls much less positively in these Republican-leaning states than does Medicaid expansion.<sup>140</sup>

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<sup>135</sup> Donald J. Trump (@realDonaldTrump), TWITTER (Oct. 18, 2018, 11:43 AM), <https://twitter.com/realdonaldtrump/status/1053008701026693122?lang=en> [<https://perma.cc/LX5N-RVUK>].

<sup>136</sup> *Texas v. United States*, [supra note 91](#).

<sup>137</sup> Will Schmitt, *Hawley’s Balancing Act: Would Add Pre-existing Condition Protections after Suing to Remove*, SPRINGFIELD NEWS-LEADER, (Sept. 26, 2018, 3:00 PM), <https://www.news-leader.com/story/news/politics/elections/2018/09/26/mccaskill-hawley-obamacare-pre-existing-conditions-coverage-lawsuit/1431086002/> [<https://perma.cc/CAH9-H4EM>]; see also Margot Sanger-Katz, *Republicans Say They Will Protect Pre-existing Conditions; Their Records Say Something Else*, N.Y. TIMES, (Nov. 2, 2018), <https://www.nytimes.com/2018/11/02/upshot/republicans-pre-existing-conditions-.html> [<https://perma.cc/V4QX-YKJP>].

<sup>138</sup> Abby Goodnough, *Idaho, Nebraska and Utah Vote to Expand Medicaid*, N.Y. TIMES, (Nov. 7, 2018), <https://www.nytimes.com/2018/11/07/health/medicaid-expansion-ballot.html> [<https://perma.cc/6Q68-DRV9>].

<sup>139</sup> *Id.*

<sup>140</sup> *Id.*



Other states will also be grappling with Medicaid expansion in the 2019 legislative sessions. Montana voters rejected an initiative that would have taxed tobacco to pay for that state's expansion, which is set to sunset in July 2019 unless the legislature comes up with other funding.<sup>141</sup> The newly elected governors of Kansas and Wisconsin campaigned on expanding the program and might be legislatively positioned to do so. All told, in 2019 and 2020, hundreds of thousands more Americans are likely to be added to Medicaid from a half dozen red states.<sup>142</sup> Unless, of course, the plaintiffs prevail in *Texas v. United States* and the Medicaid expansion is thrown out with the rest of the ACA.

Writing in 2014, political scientist Lawrence Jacobs speculated that as ACA implementation proceeded, the law might "spur the formation of organized support for health reform from a broad coalition of Americans."<sup>143</sup> That appears to be happening.

## VI. CONCLUSION

The presidential megaphone has long been used, by Republicans and Democrats alike, to advocate with the public and with Congress for legislative solutions to expand access to high quality health care. President Obama's success in getting the Affordable Care Act enacted in 2010 marked the most consequential step towards universal coverage since the enactment of Medicare and Medicaid in 1965.

President Trump has attempted an executive branch repeal of the ACA, and particularly its marketplace protections. He has not yet succeeded, but the threat remains substantial. The threat comes not only from specific managerial, regulatory and other actions, but also from the general uncertainty they sow in an endeavor that depends upon voluntary private business involvement.

States are, for now, the crucial institutional constraint on the president's power to undermine the ACA's marketplace protections. With managerial, litigative, legislative, and regulatory actions they have, thus far, protected the individual coverage pool, and often in bipartisan ways. The states do so, though, in a piecemeal fashion. Similarly, as the state-led lawsuits wend their way through the judicial system, the courts might block one regulation or another as a violation of administrative procedures or statutory authority. But the courts, given their institutional posture, are unlikely to address the generalized threat presented by the executive branch's myriad destabilizing actions.

Public voices are a growing, non-institutional constraint, albeit an indirect one whose impacts are most profound at the ballot box. With this issue the personal readily becomes the political. Americans' stories about health care challenges seem to have shifted the political landscape. Although the ACA remains polarizing, there is increasing, solidifying support, across party lines, for central features of the law. These include pre-existing condition protections and government-grounded coverage options, including Medicaid expansion. This support is reflected in the 2018 elections, which saw passage of expansion initiatives, and election of state-level and national candidates from both parties who campaigned on these issues.

States, federal courts, and public opinion are important constraints, but robust protection against an attempted executive repeal of the ACA requires congressional

<sup>141</sup> *Id.*

<sup>142</sup> *Id.*

<sup>143</sup> Lawrence R. Jacobs, *Health Reform and the Future of American Politics*, 12 PERSPECTIVES ON POLITICS 631, 637 (2014).

action. And President Trump might, ironically, have contributed to a leftward shift in legislative options going forward. He has repeatedly used the presidential megaphone to urge replacement of the ACA with something better that covers everybody, protects people with pre-existing conditions, and reduces costs to individuals and families.

In doing so, President Trump appears to have reinforced a change in the public debate from *whether* the federal government ought to ensure health coverage for all Americans to *how* the federal government ought to do so. Indeed, “refine and revise” now seems poised to supplant “repeal and replace” as the conservative counterpoint to liberal pressure for a common option grounded in Medicare. Health reform’s future will be complicated — but everyone knows that.