High Stakes, Bad Odds: Health Laws and the Revived Federalism Revolution

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The Supreme Court's 2021 term produced a remarkable number of blockbuster decisions, nearly hiding an underlying federalism agenda that surfaced in health care, reproductive rights, administrative law, and public health related domains. Health law has been a vehicle for constitutional change before, but the stakes for older laws, most of which rely on states to accomplish national goals, have been raised. The Court has doubled down on interpretive methods that limit governmental power, using formalist tools like clear statement rules that demand specificity and offer little deference to lawmakers or regulators. These rules have constitutional dimensions, including separation of powers and federalism, and have substantive implications. Add the major questions doctrine, which is likely to have deregulatory impact across public laws of all stripes, and a pattern is developing in which the "New Roberts Court" is centering a formal, separate-spheres vision of federalism that favors states' rights, regardless of states' capacity to wield that power or evidence that they do not.

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The stakes could not be higher. Law is a determinant of health, controlling access to individual medical care and public health. For most social programs, Congress relies on federalism, which divides power and responsibility for designing and implementing policies across federal, state, and local governments. However, laws enacted before the Court's "Federalism Revolution" in the 1990s, like the Medicaid Act, the Public Health Service Act, and the National Emergencies Act, have no federal fallback if states refuse to partner. The politics of the COVID-19 pandemic illuminated state leaders' prioritization of party over partnering, stymieing federal laws needed to reach across state borders in an emergency, and demonstrating the dangers of states' veto of federal law when no fallback exists. Yet, state capacity to govern, to exercise power allocated by federalism, has been assumed by judges and theorists alike. The pandemic crystalized that the governance capacity assumption is out of step with evidence that many states have neglected public health and other social programs. Further, the inherent variability federalism invites impacts health inequitably, especially for racial and ethnic minorities and other vulnerable populations.

This article examines the Court's recent decisions elevating formalism through imposing clear statement rules on old laws, foregrounding dual sovereignty federalism, and discounting the ubiquity of federal/state partnerships. The article next questions theoretical assumptions about federalism's values and illustrates the risks through two key examples, Medicaid expansion and the COVID-19 public health emergency. The article then explores possible solutions, identifying legal and ethical principles courts, administrative agencies, states, and other policymakers could use given that the Court is not likely to change course anytime soon. Congress has authority to adopt fully federal laws, or to amend laws that have no fallback, either of which have the ironic effect of increasing federal presence in states that refuse to partner. Beyond legislative commitment, the traditional federalism values of state sovereignty and political accountability could be informed by concrete measures of governance capacity such as budgeting adequate funding. Likewise, the values of state experimentation and policy variation are more than theory, and I draw on ethical and legal principles for valid experimental design to explain how they might be evaluated. This article rings an alarm bell that many federal health laws are in danger of instability and dilution, but it may be possible to walk back from the precipice.

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INTRODUCTION

The Supreme Court's 2021 term produced a remarkable number and range of blockbuster decisions,[1] many of which exposed an underlying federalism agenda that popped up in health law, reproductive rights,

[1] For example, the Court changed analytical and doctrinal course on three fundamental rights. *See, e.g.*, Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2242 (2022) (Fourteenth Amendment privacy right protecting access to abortion); Kennedy v. Bremerton Sch. Dist., 142 S. Ct. 2407, 2426-29, 2432-34 (2022) (eliminating the *Lemon* test for unconstitutional establishment of religion while further protecting free exercise of religion); N.Y. State Rifle & Pistol Ass'n v. Bruen, 142 S. Ct. 2111, 2156 (2022) (strengthening Second Amendment right to bear arms).

administrative law, and other public health-related domains, weaving through cases where federalism was not obviously an issue, and appearing in "shadow docket" as well as regular decisions.[2] Health laws have been front and center at the Court many times before now. The Affordable Care Act ("ACA") has been litigated so much throughout its first decade, it is effectively a cottage industry.[3] While health law has been a vehicle for constitutional change in the past, the "New Roberts Court" is raising the stakes and creating bad odds for older health laws, most of which rely on states to achieve national goals.[4]

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[2] *See generally* William Baude, *Foreword: The Supreme Court's Shadow Docket*, 9 N.Y.U. J.L. & LIBERTY 1 (2015) (discussing the Court's 2013 Term and the growth of the procedurally irregular "shadow docket"); Stephen I. Vladeck, *The Solicitor General and the Shadow Docket*, 133 HARV. L. REV. 123 (2019) (exploring the phenomenon of the shadow docket and the Solicitor General's influence on it).

[3] Patient Protection and Affordable Care Act (ACA) litigation has been so abundant, one lawyer dedicated a blog to tracking federal courts' decisions. AFFORDABLE CARE ACT LITIGATION (Sept. 14, 2018), https://affordablecareactlitigation.com/ [https://perma.cc/RTQ6-E2JR]. The blog became a law review article surveying a decade of litigation. Abbe R. Gluck, Mark Regan & Erica Turret, *The Affordable Care Act's Litigation Decade*, 108 GEO. L.J. 1471 (2020). Another example is a major health policy journal that created a regular column on ACA litigation as well as regulatory updates. *See Following the ACA*, HEALTH AFFS., https://www.healthaffairs.org/topic/pt_bms010 (last visited Aug. 11, 2023) [https://perma.cc/5KHW-BA3F].

[4] The New Roberts Court refers to the post-Ruth Bader Ginsberg composition of justices, which includes three Trump appointees who created a conservative majority (Associate Justices Neil M. Gorsuch, Brett M. Kavanaugh, and Amy Coney Barrett). *See Current Members*, SUP. CT. OF THE U.S., https://www.supremecourt.gov/about/biographies.aspx (last visited Aug. 11, 2023) [https://perma.cc/TGM4-YKE3]. It is too early to say how Biden appointee Justice Ketanji Brown Jackson will vote, but oral argument questions indicate she will be more likely to side with Justices Sotomayor and Kagan, as Justice Stephen Breyer did. In other words, the "liberal" justices' balance has not changed, but the "conservative" justices in the October 2021 term rendered more 6-3 majority opinions and, statistically, a more divided court. *See* Angie Gou, *As Unanimity Declines, Conservative Majority's Power Runs Deeper Than the Blockbuster Cases*, SCOTUSBLOG (July 3, 2022, 8:21 PM), https://www.scotusblog.com/2022/07/as-unanimity-declines-conservative-majoritys-power-runs-deeper-than-the-blockbuster-cases/ [https://perma.cc/3ENR-FYQC] (reporting and assessing annual "stat pack" for October 2021 Term).

The Court also is doubling down on interpretive methods that limit government power,[5] often using formalist tools like clear statement rules that demand specificity and offer little or no deference to lawmakers or regulators.[6] These rules have constitutional dimensions, including separation of powers and federalism; as such, these structural rules have substantive implications. For example, in January 2022, during a post-holiday spike in COVID-19 infections and deaths, the Court blocked vaccine-or-test requirements for large employers — even though some governors and legislatures refused to implement such measures and obstructed local officials' disease containment efforts[7] — because the Court viewed the Federal Occupational Safety and Health Administration ("OSHA") as lacking authority.[8] The Court questioned whether OSHA has public health power at all while prioritizing state power to regulate health, and in so doing created a regulatory vacuum in pandemic containment policies. This was just one of many decisions demonstrating a turn toward formal line-drawing in governmental

[5] *See, e.g.*, Kristin E. Hickman, *The Roberts Court's Structural Incrementalism*, 136 HARV. L. REV. F. 75, 77-78 (2022) (describing the formalist tendencies of the Roberts Court: "in addition to being more inclined toward originalist and textualist methods of interpretation, the Roberts Court also is more structurally formalist and more skeptical of agency action than any of its predecessors since at least the New Deal era").

[6] For discussion of the major questions doctrine as a clear statement rule of consequence to administrative law, see Mila Sohoni, *The Major Questions Quartet*, 136 HARV. L. REV. 262, 264, 266, 272-76 (2022).

[7] 22 states limited emergency executive power: Alaska, Arizona, Arkansas, Florida, Idaho, Indiana, Kansas, Kentucky, Louisiana, Montana, New Hampshire, New Jersey, New York, North Carolina, North Dakota, Ohio, Pennsylvania, Texas, Utah, Virginia, West Virginia, and Wyoming. *See* NAT'L ASS'N OF CNTY. & CITY HEALTH OFFS. & THE NETWORK FOR PUB. HEALTH L., PROPOSED LIMITS ON PUBLIC HEALTH AUTHORITY: DANGEROUS FOR PUBLIC HEALTH 1, 5-9 (2021), https://www.naccho.org/uploads/downloadable-resources/Proposed-Limits-on-Public-Health-Authority-Dangerous-for-Public-Health-FINAL-5.24.21pm.pdf [https://perma.cc/DM68-44R9]; *see also* *Legislative Oversight of Emergency Executive Powers*, NAT'L CONF. OF STATE LEGISLATURES, https://www.ncsl.org/about-state-legislatures/legislative-oversight-of-emergency-executive-powers (last updated Sept. 26, 2022) [https://perma.cc/AR5W-YD7J].

[8] *See* Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin., 595 U.S. 109, 118-20 (2022) (per curiam opinion and questions posed during oral argument). *But see* Biden v. Missouri, 595 U.S. 87, 95-96 (2022) (where the Court upheld federal vaccine rules for Medicare and Medicaid providers).

authority that had the effect of increasing states' responsibility for protecting health.[9]

A pattern is emerging in which the Court is recentering a formal, separate-spheres vision of federalism that favors states' rights, regardless of state capacity to wield that power or evidence that they do not. Another piece of this pattern is the majority's skeptical approach toward administrative authority, which birthed the novel major questions doctrine that is poised to have deregulatory impact across public laws of all stripes.[10] Chief among them are federal health laws, which often rely on federalism governance structures and have been the means to achieve these ends in many instances.[11]

The stakes could not be higher. Law is a determinant of health, which means the structure and the substance of laws directly and indirectly control individual medical care, such as payment for, access to, and quality of care, as well as public health efforts in prevention, surveillance, and emergency and disaster responses.[12] Federal health laws have tended to flatten state heterogeneity in health policies to create a national baseline, while still relying on state uptake of federal funds to implement national policy goals. Indeed, Congress relies on federalism — which divides power and responsibility for designing and implementing policies across federal, state, and local governments — as the default governance structure for most social programs. Congress expects states to work within these statutory structures because historically they have done so, which means many older statutes contain no alternative approach for implementation. This reliance on federalism in laws that contain no fallback, in the face of the Court's use of health laws for doctrinal transformation, presents at least four challenges.

[9] Paradoxically, the Court also has tied state officials' hands in public health matters — for example, California and New York created COVID-19 containment measures limiting attendance at businesses and churches, but their efforts were struck down too. *See* Roman Cath. Diocese of Brooklyn v. Cuomo, 141 S. Ct. 63, 68-69 (2020).

[10] *See* Sohoni, *supra* note 6, at 264.

[11] *See* West Virginia v. Env't Prot. Agency, 142 S. Ct. 2587, 2614-16 (2022).

[12] *See Determinants of Health*, WORLD HEALTH ORG. (Feb. 3, 2017), https://www.who.int/news-room/questions-and-answers/item/determinants-of-health [https://perma.cc/92GJ-JH9J].

First, laws enacted before the Supreme Court's "Federalism Revolution" in the 1990s, like the amendments to the Social Security Act ("SSA") that are the Medicaid Act, most titles of the Public Health Service Act, the National Emergencies Act, and related social programs like the Supplemental Nutrition Assistance Program ("SNAP"), provide *no federal fallback*.[13] As amendments to the SSA,[14] such laws reflect New Deal Era thinking that states need money and therefore will avail themselves of federal laws implementing national baselines in exchange for stable, countercyclical funding.[15] Yet, when states refuse to participate in federal policies, federal programs become unimplementable, giving states what is effectively veto power over federal laws. Recent legislation is more likely to be drafted with federal fallbacks, often requiring a federal agency to act when states do not; for example, when states refused to create health insurance exchanges, the ACA required the federal government to create one.[16] On the other hand, the ACA's Medicaid eligibility expansion remains incomplete because the program never has had a fallback like the health insurance exchange, and eleven states are still vetoing expansion as of this writing.[17]

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[13] *See* Gregory v. Ashcroft, 501 U.S. 452, 457-61 (1991); JEFFREY TOOBIN, THE NINE: INSIDE THE SECRET WORLD OF THE SUPREME COURT 101 (2007) ("Throughout the 1990s, Rehnquist, Kennedy, and (as ever) O'Connor tried to revitalize the doctrine of states' rights, ruling that several federal laws impinged on aspects of state sovereignty. These developments were sometimes called a 'federalism revolution'. . . ."); Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 454-59 (2011) [hereinafter *Federalizing Medicaid*] (exploring the Rehnquist Court's Federalism Revolution and continuation by the Roberts Court in ACA-related litigation).

[14] *See generally* OFF. OF RSCH., EVALUATION & STAT., SOC. SEC. ADMIN., SSA PUBL'N NO. 13-11758, SOCIAL SECURITY PROGRAMS IN THE UNITED STATES 4-5, 51, 61 (1997), https://www.ssa.gov/policy/docs/progdesc/sspus/sspus.pdf [https://perma.cc/CJ2N-2UY2] (calling the SSA a "cornerstone" of social programs).

[15] *See id.* at 2-3 (explaining that the Great Depression necessitated federal intervention in social policy because states had no money, yet "[t]he intent of Federal participation was to encourage States to adopt such programs.").

[16] *See infra* Part I.A.1.

[17] The 11 states include Texas, Florida, Georgia, South Carolina, Mississippi, Wyoming, Wisconsin, Kansas, Alabama, Tennessee, and North Carolina. *Status of State Medicaid Expansion Decisions: Interactive Map*, KFF (July 27, 2023), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/ [https://perma.cc/V33F-AEB9]. North Carolina is moving concretely

Second, the heated politics of the COVID-19 pandemic displayed state leaders' prioritization of party over partnering and technocratic management,[18] undermining federal laws designed to reach across state borders in a national emergency, and demonstrating the dangers of states' *veto* of federal law.[19] Federal money and guidelines were offered to boost state capacity to manage the pandemic through existing federalism-based social programs, but some states did not participate as they have done in the past. Rather, they rejected federal aid, like Florida's governor refusing relief money to feed schoolchildren in the summer of 2021.[20] The ACA's Medicaid expansion politics previewed this phenomenon, and the Court's first ACA decision probably encouraged a take-no-prisoners political calculus.[21] However, COVID-19 seemed to prompt greater intensity in state officials' resistance, elevating rejection over negotiation.[22] Increased federal-state and state-

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toward expansion as of this writing. Press Release, N.C. Dep't of Health & Hum. Servs., NCDHHS Releases Statement on Medicaid Expansion, (Mar. 2, 2023), https://www.ncdhhs.gov/news/press-releases/2023/03/02/ncdhhs-releases-statement-medicaid-expansion [https://perma.cc/62KL-742U].

[18] Thanks to David Super for naming the technocratic management issue.

[19] This observation is consistent with political scientist Jake Grumbach's analysis that national party goals and cross-state party alignments are undermining traditional federalism values and the functioning of American democracy. *See generally* JACOB M. GRUMBACH, LABORATORIES AGAINST DEMOCRACY: HOW NATIONAL PARTIES TRANSFORMED STATE POLITICS (2022) (describing and analyzing data on state policies, public opinion, the flow of money in politics, voting, and responsive governance to show how state governmental authority is less responsive to residents and more responsive to national political parties).

[20] *See* Kate Santich, *Florida Missing Out on Millions of Dollars in Federal Aid for Childhood Hunger*, ORLANDO SENTINEL (Aug. 24, 2021, 2:09 PM), www.orlandosentinel.com/news/os-ne-florida-missing-out-on-millions-for-childhood-snap-benefits-20210824-drdik44j5zd6pfp34ymcx3id5e-story.html [https://perma.cc/C255-Q2BK].

[21] *See generally* Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012) (fractured decision upholding the constitutionality of the ACA except for Medicaid expansion, which was deemed unconstitutionally coercive and so gave power back to the states to decide who would be eligible to enroll).

[22] State veto is different from the "uncooperative federalism" theory, discussed in Part I. *See generally* Jessica Bulman-Pozen & Heather K. Gerken, *Uncooperative Federalism*, 118 YALE L.J. 1256 (2009) (arguing state resistance to federal policies benefits policymaking).

local conflict may have been fed by presidential leadership, but these seeds were planted long before the pandemic.[23]

Further, some states could not use federal relief money due to prior policy choices,[24] which points to the third challenge: lack of governance capacity. Theorists tend to overlook weaknesses in federalism being central to the success or failure of U.S. social programs. Experts traditionally conceive federalism's values as state autonomy, political accountability, policy experimentation, and variation. State *capacity* to exercise the power allocated by federalism is typically assumed to exist.[25] The pandemic crystalized how the governance capacity assumption is out of step with evidence of state lawmakers' choices being driven by national politics, interest organizations, and other factors, rather than data or a desire to conduct valid experiments. Federalism's layered governance can hide the effects of such policymaking, as it is harder for voters to discern responsibility for decisions, which is amplified by focus on presidential and national party politics rather than state and local elections.[26] Layers of power require more official action at each level of government, which can entrench a law when implementation works, but also foster room for error while obscuring accountability for failures. It is easier to kick the can down the road when voters cannot discern which actor is answerable for undesirable policies or outcomes.[27] For example, persistent defunding

[23] *See* Nicole Huberfeld, Sarah H. Gordon & David K. Jones, *American Public Health Federalism and the Response to the COVID-19 Pandemic*, *in* COVID-19 IN EUROPE AND NORTH AMERICA 25, 42-45 (Pierre-Alexandre Beylier & Véronique Molinari eds., 2022).

[24] *See* Sharon LaFraniere, *Why Mississippi, a Covid Hot Spot, Left Millions in Pandemic Aid Unspent*, N.Y. TIMES (Feb. 13, 2023), https://www.nytimes.com/2023/02/13/us/politics/covid-public-health-departments.html [https://perma.cc/45GA-YA2J].

[25] *See infra* Part I.B.

[26] *See* GRUMBACH, *supra* note 19, at 82-84 (stating accountability is diminished and exacerbated by the decline of local and state journalism on which both politicians and voters have relied historically, making the current devolution of power to the states different from past similar trends).

[27] *But see* New York v. United States, 505 U.S. 144, 168-69 (1992) (Justice O'Connor's majority opinion named "accountability" as a virtue of federalism). I have shown in other work with Abbe Gluck that this is a weak assumption based on extensive evidence from implementation of the ACA; voters demonstrated abundant confusion about which level of government is responsible for each policy choice in the ACA, which contains multiple kinds of federalism in the Public Law. Abbe R. Gluck & Nicole Huberfeld, *What*

of public health departments and programs[28] deeply affected management of the COVID-19 pandemic.[29] Nevertheless, the Court is returning such issues to states without evaluating whether states will take the reins or what it means for public health when they do.

Fourth, the inherent variability of federalism *impacts health inequitably*, especially for racial and ethnic minorities and other vulnerable populations such as rural communities.[30] Health inequities deepened during the COVID-19 pandemic response, but they are a long-term, well-documented problem.[31] Pushing policymaking down to the states will continue to expand health inequities. Medicaid expansion provides an example, but another decision from the blockbuster

Is Federalism in Healthcare For?, 70 STAN. L. REV. 1689, 1786 (2018) [hereinafter *What Is Federalism For*]; *see also* Abbe R. Gluck, *Federalism from Federal Statutes: Health Reform, Medicaid, and the Old-Fashioned Federalists' Gamble*, 81 FORDHAM L. REV. 1749, 1760 (2013).

[28] *See* Brian C. Castrucci & Monica Valdes Lupi, *When We Need Them Most, the Number of Public Health Workers Continues to Decline*, DEBEAUMONT FOUND. (May 19, 2020), https://debeaumont.org/news/2020/when-we-need-them-most-the-number-of-public-health-workers-continues-to-decline/ [https://perma.cc/C7BH-FNY2]. *But see* Irene Papanicolas, Liana R. Woskie, Duncan Orlander, E. John Orav & Ashish K. Jha, *The Relationship Between Health Spending and Social Spending in High-Income Countries: How Does the US Compare?*, 38 HEALTH AFFS. 1567, 1572-74 (2019).

[29] *See* Nason Maani & Sandro Galea, *COVID-19 and Underinvestment in the Public Health Infrastructure of the United States*, 98 MILBANK Q. 250, 251 (2020).

[30] *See, e.g.*, David K. Jones, *Political Participation in the Least Healthy Place in America: Examining the Political Determinants of Health in the Mississippi Delta*, 44 J. HEALTH POL., POL'Y & L. 505 (2019) (explaining that health in the Mississippi Delta is inequitable as a matter of state constitutional law); Robert A. Schapiro, *States of Inequality: Fiscal Federalism, Unequal States, and Unequal People*, 108 CALIF. L. REV. 1531 (2020) (finding that federalism can perpetuate social and economic inequality); Reva Siegel, *ProChoiceLife: Asking Who Protects Life and How — and Why It Matters in Law and Politics*, 93 IND. L.J. 207 (2018) (surveying mismatch between state abortion restrictions and family supportive state policies); David A. Super, *Laboratories of Destitution: Democratic Experimentalism and the Failure of Antipoverty Law*, 157 U. PA. L. REV. 541 (2008) [hereinafter *Laboratories of Destitution*] (analyzing the problems of decentralization and deregulation for antipoverty laws and exploring the inequitable impacts of state and local experimentation).

[31] *See generally* DAYNA BOWEN MATTHEW, JUST MEDICINE: A CURE FOR RAPID INEQUALITY IN AMERICAN HEALTH CARE (2015) (documenting how racism, meaning discrimination based on race or ethnicity, causes health disparities in America that measurably injure and kill Black and Brown populations and offering a view on solutions existing in federal civil rights laws that go unenforced).

October 2021 term also helps: returning regulation of abortion to the states after *Dobbs v. Jackson Women's Health*.[32] The *Dobbs* decision increased horizontal conflict between states and making access to many forms of health care more difficult, variable, and inequitable for people of reproductive age.[33] *Dobbs* is affecting not just the spotlighted issue of abortion, but also broader issues like where residents, physicians, and other health care providers are willing to practice medicine;[34] increasing fetal and maternal mortality disparities,[35] especially in states that limited access to abortion even before *Dobbs*; and growing conflicts between providers, patients, and restrictive states' laws.[36] When states have more control over health laws, inequitable impacts are a predictable outcome — some states will enact laws in the spirit of *salus populi*, but many have a history of the opposite approach.[37]

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[32] Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2284 (2022) (upholding a Mississippi law limiting abortion access to 15 weeks of gestation and overturning *Roe v. Wade* and *Planned Parenthood v. Casey*).

[33] *See* S. Marie Harvey, Annie E. Larson & Jocelyn T. Warren, *The* Dobbs *Decision — Exacerbating U.S. Health Inequity*, 388 NEW ENG. J. MED. 1444, 1445-46 (2023). For a pre-*Dobbs* take on horizontal federalism and the conflicts it fosters between states, see generally Heather K. Gerken, *The Taft Lecture: Living Under Someone Else's Law*, 84 U. CIN. L. REV. 377 (2018) (urging a coherent approach to horizontal federalism rooted in concepts of democratic representation rather than state sovereignty).

[34] *See* Kendal Orgera, Hasan Mahmood & Atul Grover, *Training Location Preferences of U.S. Medical School Graduates Post* Dobbs v. Jackson Women's Health Organization *Decision*, ASS'N OF AM. MED. COLLS. (Apr. 13, 2023), https://www.aamc.org/advocacy-policy/aamc-research-and-action-institute/training-location-preferences [https://perma.cc/5GET-PRAQ].

[35] *See, e.g.*, Roni Caryn Rabin, *Rural Hospitals Are Shuttering Their Maternity Units*, N.Y. TIMES (Feb. 26, 2023), https://www.nytimes.com/2023/02/26/health/rural-hospitals-pregnancy-childbirth.html [https://perma.cc/SU6A-MNMY] (explaining high levels of maternal and infant mortality and how rural hospital closures are making birthing more dangerous).

[36] *See* Michael Ollove, *Critics Fear Abortion Bans Could Jeopardize Health of Pregnant Women*, STATELINE (June 22, 2022, 12:00 AM), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2022/06/22/critics-fear-abortion-bans-could-jeopardize-health-of-pregnant-women [https://perma.cc/S9XD-SPWH]; Alice Miranda Ollstein, *Abortion Doctors' Post-Roe Dilemma: Move, Stay or Straddle State Lines*, POLITICO (June 29, 2022, 4:30 AM EDT), https://www.politico.com/news/2022/06/29/abortion-doctors-post-roe-dilemma-move-stay-or-straddle-state-lines-00040660 [https://perma.cc/8CWG-KRAC].

[37] Cicero's statement in *De Legibus*, "Salus populi suprema lex esto" typically is translated as "the good (or health) of the people should be the highest law." *See Cicero:*

This article rings an alarm bell. The renewed Federalism Revolution, channeled through decades-old health laws that were meant to decrease state variation yet rely on federalism without fallbacks for implementation, in combination with the state veto and questionable governance capacity, places many federal laws on a precipice. This danger did not come about because of political or policy debate, but rather because the Court is causing volatility that is likely to make reliance on old federal health laws difficult in the near future. Part I studies the New Roberts Court's decisions elevating formalism through interpretive tools such as clear statement rules, which affect the stability of health laws by imposing new standards on old laws and foregrounding dual sovereignty while disregarding how federal/state partnerships work. This Part also introduces problems posed by theoretical assumptions about federalism, which rely on values that are rarely evaluated in terms of their outcomes. The traditional values of autonomy and political accountability inform what I call "governance capacity," which impacts the leadership and expertise necessary for managing the responsibilities assigned by federalism. I also claim the values of state experimentation and policy variation should be informed by principles for valid experimental design. Part II makes the challenges of the Court elevating formal federalism more concrete with two examples of crucial health policies that lack federal fallbacks: Medicaid expansion and the public health emergency for COVID-19. These examples illustrate how state vetoes increase variability and stymie implementation of federal laws. Part III considers three possible approaches to managing the possible erosion of health laws.

I. REVITALIZING THE FEDERALISM REVOLUTION

Recent Supreme Court decisions have increased state authority over policymaking in public health, health care, and related domains, a structural devolution that substantively affects the lives of millions of people and raises important questions about the commonly named

de Legibus III, THE LATIN LIBR., https://www.thelatinlibrary.com/cicero/leg3.shtml (last visited Aug. 17, 2023) [https://perma.cc/9T9R-AE8D]. Interestingly, this is also the Missouri state motto. *Missouri State Motto*, MO. SEC'Y OF STATE, https://www.sos.mo.gov/symbol/motto (last visited Aug. 17, 2023) [https://perma.cc/N3NH-RHY5].

values of federalism.[38] If the 2021 term was a harbinger of things to come, then the courthouse doors are open to challenges to legislation addressing critical national issues, such as the Social Security Act, Voting Rights Act, environmental protection laws, and poverty reduction programs like SNAP and Temporary Assistance for Needy Families ("TANF"). Each statute relies on federalism-based state implementation that is more likely to fail the Court's new formalist take on old federal laws.

A. The Clear Statements Court

The New Roberts Court's beginning happened to coincide with major national events such as the COVID-19 pandemic, making health law a ready vehicle for doctrinal evolution through frequent litigation over political hot potatoes like disease containment policies. Early in the pandemic, the Court tended to defer to government officials, consistent with the historical tendency of courts to defer to governmental power to protect public health, safety, and welfare in the face of a health imperative.[39] But the Court soon turned in the opposite direction, limiting government power to protect public health while also displaying internal disagreement as to whether federal or state government should act to protect health.[40] The newly solidified conservative majority of justices has struck down federal actions for encroaching on traditional areas of state police power,[41] while also

[38] The word federalism is also represented by concerns for "state power," "state authority," or similar language. Even *NFIB v. Sebelius*, 567 U.S. 519 (2012) barely used the word federalism or referred to the Tenth Amendment though the concept undergirds the decision.

[39] *See, e.g.*, Jacobson v. Massachusetts, 197 U.S. 11 (1905) (upholding a mandatory smallpox vaccination law during a disease outbreak).

[40] *See* Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin., 595 U.S. 109, 118-20 (2022) (discussing OSHA's lack of authority to require vaccination or masking and testing for large employers); *cf.* Biden v. Missouri, 595 U.S. 87, 95-96 (2022) (upholding CMS vaccination requirements for health care workers under Medicare and Medicaid payment rules).

[41] *See, e.g.*, Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs., 141 S. Ct. 2485 (2021) (vacating the national moratorium instituted by the Director of CDC prohibiting evictions of financially needy tenants living in counties experiencing high levels of novel coronavirus transmission).

enjoining state containment measures for infringing civil rights.[42] These developments show the Court paradoxically limits federal power, even when state officials refuse to act, but also restrains state authority in favor of individual rights, a situation reminiscent of the Court's anti-regulatory posture during the *Lochner* Era.[43]

Jurists have expressed the desirability of federalism as a constitutional requirement while also maintaining it is good policy, promoting values such as experimentation through the "laboratory" of the states.[44] This line of thinking is traced to language in a 1932 dissent by Justice Louis Brandeis that rejected a laissez faire, anti-public regulation analysis and supported state power to regulate businesses to *protect* public health and welfare.[45] However, the Brandeis dissent gets remembered differently: the "laboratory" of the states often stands for an anti-federal, pro-state principle.[46] The Rehnquist Court's Federalism Revolution followed this approach, bounding federal power to devolve authority to states, a formalist approach the Court is now amplifying.

1. The Rehnquist Court's Federalism Revolution

A bit of background may be helpful. The Rehnquist Court issued several decisions curtailing Congress's commerce power while protecting state sovereignty, shaping a "Federalism Revolution"[47]

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[42] Tandon v. Newsom, 141 S. Ct. 1294, 1295 (2021) (preliminarily enjoining California's Blueprint System for containing novel coronavirus for impermissibly burdening free exercise of religion).

[43] Lochner v. New York, 198 U.S. 45, 64 (1905).

[44] New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting) (Oklahoma deemed ice producers to be public businesses that necessitated special regulation).

[45] *See id.* The Oklahoma ice licensure law read much like state certificate of need laws that limit constructing new hospitals and other expensive medical facilities. *See id.* at 272.

[46] For a recent example from the Supreme Court, see West Virginia v. Env't Prot. Agency, 142 S. Ct. 2587, 2618 (2022) (Gorsuch, J., concurring) (citing to *New State Ice Co.*, 285 U.S. at 536 (plurality opinion) for this idea).

[47] Erwin Chemerinsky, *The Federalism Revolution*, 31 N.M. L. REV. 7, 7 (2001) (asserting "I have no doubt that when constitutional historians look back at the Rehnquist Court, they will say that the greatest changes . . . were with regard to federalism" and documenting decisions comprising the Federalism Revolution).

during the 1990s that resulted from seeking to protect "traditional" areas of state power and restricting Congress's ability to seek state partnership in achieving national goals.[48] Two key decisions that happened to impede laws with public health goals were *New York v. United States*, which held the Low Level Radioactive Waste Act could not "commandeer" state legislatures, meaning force states to enact laws implementing federal statutes (to protect environmental health);[49] and *Printz v. United States*, which held Congress cannot "dragoon[]" state officials into implementing federal firearms laws (to prevent firearms injuries and deaths).[50] Other Rehnquist Court decisions also used public health laws as a vehicle for constitutional change, such as *United States v. Lopez* (gun safety) and *United States v. Morrison* (protections for domestic violence victims).

Statutes that post-date *Printz* tend to employ a structure commended by Justice O'Connor's majority opinion in *New York*, which instructed that Congress can nudge state action by offering monetary incentives with conditions, or preempt state law to implement federal goals, but federal law cannot require states to act.[51] Post-Federalism Revolution laws therefore tend to have a federal alternative, or "fallback," which is triggered by state nonparticipation in the national goal. This approach can increase federal power within states, though it was intended to protect state sovereignty.[52] For states to make the most of the

[48] The Federalism Revolution was foreshadowed by opinions such as Justice O'Connor's in *Federal Energy Regulatory Commission v. Mississippi*, 456 U.S. 742, 788 (1982) (O'Connor, J., concurring in part and dissenting in part), and scholars commonly describe it as beginning with *Gregory v. Ashcroft*, 501 U.S. 452 (1991), continuing with *New York v. United States*, 505 U.S. 144 (1992); *United States v. Lopez*, 514 U.S. 549 (1995); *Printz v. United States*, 521 U.S. 898 (1997); and *United States v. Morrison*, 529 U.S. 598, 627 (2000) (holding that private rights of action in the Violence Against Women Act were unconstitutional for abrogating state authority over family and criminal law).

[49] *New York v. United States*, 505 U.S. at 175 (establishing the anti-commandeering doctrine).

[50] *Printz*, 521 U.S. at 928 (describing the unconstitutionality of "dragoon[ing]" state officials to enforce federal laws).

[51] New York v. United States, 505 U.S. at 167-69.

[52] *See Printz*, 521 U.S. at 976-77 (Breyer, J., dissenting) (describing how other nations with federalist structures allow "commandeering" because they "believe that such a system interferes less, not more, with the independent authority of the 'state,' . . . or other subsidiary government").

Federalism Revolution, they must lean into federalism, especially cooperative federalism statutes, *i.e.*, seize offered partnerships (and money) in federal laws. If states do not "lean in," then federal implementation may be necessary, and thereby federal power extended, to make duly enacted laws work within opt-out states.

Throughout their tenure, Justices O'Connor and Kennedy lauded federalism's values.[53] For example, in *Gregory v. Ashcroft*, often cited for beginning the Federalism Revolution, former state legislator O'Connor described "dual sovereignty" and the virtues of federalism as "preserv[ing] to the people numerous advantages" including "decentralized government … more sensitive to the diverse needs of a heterogeneous society;" "opportunity for citizen involvement in democratic processes;" "experimentation in government;" and "responsive" government that competes for "mobile citizenry."[54] By the time *Gregory* was decided, most experts believed the U.S. had moved beyond the formal line-drawing of "layer cake" federalism, which strictly separates federal/state authority and responsibility.[55] Rather, the prevalence of cooperative federalism in New Deal Era legislation influenced the rise of a "marble cake" model that mixes federal and state power through partnerships that serve common goals.[56] Justice O'Connor's separate-spheres analysis in *Gregory*, and subsequent admonishment in *New York* that Congress should structure partnerships with states differently, signaled that the Court was not convinced that layer cake federalism had lost.[57]

Similarly, Justice Kennedy wrote in 1995: "Federalism was our Nation's own discovery. The Framers split the atom of sovereignty. It

[53] *See* Huberfeld, *Federalizing Medicaid*, *supra* note 13, at 455 n.114.

[54] *Gregory*, 501 U.S. at 457-58.

[55] *See* Morton Grodzins, *The Federal System*, *in* GOALS FOR AMERICANS 74, 74 (President's Commission on National Goals ed., 1960) (describing the layer cake metaphor for the federal system).

[56] *See* MALCOLM M. FEELEY & EDWARD RUBIN, FEDERALISM: POLITICAL IDENTITY AND TRAGIC COMPROMISE 75 (2008) (describing "marble cake" federalism); Edward S. Corwin, *The Passing of Dual Federalism*, 36 VA. L. REV. 1, 21 (1950).

[57] *See* Roderick M. Hills, Jr., *The Political Economy of Cooperative Federalism: Why State Autonomy Makes Sense and "Dual Sovereignty" Doesn't*, 96 MICH. L. REV. 813, 815 (1998) ("It is commonplace to observe that 'dual federalism' is dead, replaced by . . . 'cooperative federalism,' 'intergovernmental relations,' or 'marble cake federalism.'").

was the genius of their idea that our citizens would have two political capacities, one state and one federal, each protected from incursion by the other."[58] This "incursion" line of thinking reflected several assumptions: that state and federal governments have responsibility and policymaking capacity that can be separated; that these powers are complementary; that this separation is transparent; and that the separation would render effective governance. Yet, strictly separated governance has not been the predominant legislative approach since New Deal Era Supreme Court decisions expanded federal power to aid and guide state governments through spending, or to preempt their regulatory failures through commerce power exercises. Federal statutes from that point forward have generally exercised a limited version of available power by inviting state partnership, and sometimes negotiation, to implement national goals while continuing to allow some state preferences. These statutes have developed into long-running federal programs in the "cooperative federalism" mold. Some argue the federal government could be crowding out states,[59] but history shows the opposite, that states have not been able to entirely fund their own policy goals since the Great Depression.[60] States cannot develop the depth of expertise or capacity to act alone without federal support because they lack money and opportunity in short legislative sessions.

In other words, Congress has authority to regulate more broadly, without state participation, but Congress chooses to include states. More to the point here, Congress tends to be incremental in reforms in health care and public health, leaping to a broader federal model only when regulatory failures are clear, or an unusual event like war or another disaster occurs. In these moments, Congress occasionally

[58] U.S. Term Limits, Inc. v. Thornton, 514 U.S. 779, 838 (1995) (Kennedy, J., concurring).

[59] *See, e.g.*, Health & Hosp. Corp. of Marion Cnty. v. Talevski, 143 S. Ct. 1444, 1464 (2023) (Thomas, J., dissenting) (claiming that federal spending programs are not part of the General Welfare Clause and cannot exist because they unconstitutionally impose federal policies on states) (discussed below).

[60] *See* ROBERT STEVENS & ROSEMARY STEVENS, WELFARE MEDICINE IN AMERICA: A CASE STUDY OF MEDICAID 5-36 (1974) (explaining states' need for federal funding as social programs grew and how other historical events like World War I, the Great Depression, and World War II caused widespread need for more social programs and medical care in particular); Huberfeld, *Federalizing Medicaid*, *supra* note 13, at 444.

chooses reform that is purely federal, as it did with Medicare in 1965. But most of the time, Congress includes states. And, states can be desirable partners for a variety of reasons including localized management; developed expertise if a state has regulated an area (such as insurance) or served as a "policy laboratory" (such as Massachusetts's universal insurance coverage scheme providing a model for the ACA); and entrenchment of a federal policy through state leaders' buy-in.[61] But this federal invitation is not required, and it complicates the constitutional analysis as well as policy outcomes when states are part of a national program.

2. New Clear Notice Rules

The New Roberts Court's pattern arguably was foreshadowed by the Old Roberts Court's decision in *NFIB v. Sebelius*.[62] Five constitutional questions were taken up in this first blockbuster challenge to the ACA. A majority of justices accepted the novel theory that "inaction" cannot be regulated under the commerce power, in theory limiting Congress's commerce power but not striking down the individual mandate because the choice to purchase health insurance was analyzed as use of the taxing power to indirectly influence individual behavior.[63] Importantly, *NFIB* also articulated a formal view of federalism that launched the anti-coercion doctrine for limiting congressional spending power, which Justice Kennedy often advocated was vital to the Federalism Revolution.[64] Holding that Medicaid expansion was unconstitutionally

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[61] *See generally* Abbe R. Gluck & Nicole Huberfeld, *Federalism Under the ACA: Implementation, Opposition, Entrenchment* [hereinafter *Federalism Under the ACA*], *in* THE TRILLION DOLLAR REVOLUTION: HOW THE AFFORDABLE CARE ACT TRANSFORMED POLITICS, LAW, AND HEALTH CARE IN AMERICA 176 (Ezekiel J. Emanuel & Abbe R. Gluck eds., 2020) (showing how incremental federal health reforms like the ACA can become entrenched through state implementation).

[62] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519 (2012).

[63] *Id.* at 588-589 (summarizing the holding for all parts of the opinion). The Court rejected the theory that zeroing out the tax penalty for failure to purchase insurance under the Tax Cuts and Jobs Act of 2017 rendered the entire ACA invalid. *See* California v. Texas, 141 S. Ct. 2104, 2113 (2021) (denying standing for litigants who no longer would face a tax penalty).

[64] *Sebelius*, 567 U.S. at 576-77 ("'We have repeatedly characterized . . . Spending Clause legislation as 'much in the nature of a *contract*.' The legitimacy of Congress's

coercive signaled interest in limiting congressional authority in favor of states' rights, despite a history of state failures in regulating health insurance and health care markets as well as evidence of powerful national markets.[65] Justice Kennedy sought boundaries on the spending power for many years, just like the commerce power limits discovered during the Rehnquist Court.[66] *NFIB*'s limit on Medicaid expansion as a non-germane and overly compelling exercise of spending power left a regulatory vacuum where eleven states have not expanded Medicaid eligibility, discussed more below.

The New Roberts Court was formed with President Trump's appointments: Justices Brett Kavanaugh, Neil Gorsuch, and Amy Coney Barrett secured a conservative majority of six justices after Justice Ginsburg's death. The Court now demonstrates intent to curtail federal power, sometimes articulated as seeking "clear statements" — a formalist approach to legislative interpretation and administrative authority that has the potential to impact many areas of public law by imposing a newly stringent legislative analysis on old laws.[67] Evidence

exercise of the spending power 'thus rests on whether the State voluntarily and knowingly accepts the terms of the "contract."' Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system. That system 'rests on what might at first seem a counter-intuitive insight, that "freedom is enhanced by the creation of two governments, not one."' For this reason, 'the Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress' instructions.' Otherwise the two-government system established by the Framers would give way to a system that vests power in one central government, and individual liberty would suffer." (citations omitted)).

[65] *Id.* at 589-96 (Ginsburg, J., concurring in part and dissenting in part).

[66] *See* Huberfeld, *Federalizing Medicaid*, *supra* note 13, at 462 (documenting Justice Kennedy's desire to limit the spending power in the name of federalism, as the Court had done with the commerce power, through casual conversations and judicial opinions).

[67] *See, e.g.*, Ala. Ass'n of Realtors v. Dep't of Health & Hum. Servs., 141 S. Ct. 2485 (2021) (denying CDC authority to prevent evictions during the public health emergency associated with novel coronavirus after the CARES Act relief bill 120-day eviction moratorium expired); *see also* Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No. 116-136, 134 Stat. 281 (2020) (codified at 15 U.S.C. § 9058). Other important decisions include *Biden v. Missouri*, 595 U.S. 87, 96-97 (2022) (reaffirming that the power of federal agencies is limited while acknowledging that powers granted to them may not be limited) and *NFIB v. Occupational Safety and Health Administration*, 595 U.S. 109, 120

of this approach exists both in written opinions and in questions posed during oral arguments. For example, in 2021, the majority in *Alabama Association of Realtors* stated that Congress must give agencies specific, clear authority to act, in part to protect states from federal power.[68] The Court wrote: "We expect Congress to speak *clearly* when authorizing an agency to exercise powers of 'vast "economic and political significance"'. . . . The moratorium intrudes into an area that is the particular domain of state law: the landlord-tenant relationship."[69] And, in 2023, striking down EPA authority and citing its own 2020 decision in *US Forest Service v. Cowpasture*, the Court wrote: "[Our precedents] require[] Congress to enact *exceedingly clear* language if it wishes to significantly alter the balance between federal and state power and the power of the Government over private property."[70] This concept derives from dicta in *FDA v. Brown & Williamson*,[71] which held the Food and Drug Administration ("FDA") could not regulate tobacco products without specific congressional authority. The clear statement rule led the majority to strike down the Centers for Disease Control and Prevention ("CDC") moratorium on evictions during the COVID-19 public health emergency.[72]

A few months later, Justice Alito's questions during *Biden v. Missouri* oral arguments sought clear statements for states implementing Medicaid conditions on federal spending that set standards for safety in health care facilities.[73] In that case, the Department of Health and Human Services ("HHS") Secretary required Medicare and Medicaid participating providers to ensure employees were vaccinated for novel

(2022) (limiting Department of Labor and OSHA authority to require vaccination or masking and testing for large employers).

[68] *Ala. Ass'n of Realtors*, 141 S. Ct. at 2489.

[69] *Id.* (emphasis added) (quoting Utility Air Regul. Grp. v. Env't Prot. Agency, 573 U.S. 302, 324 (2014) (quoting Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 160 (2000))).

[70] Sackett v. Env't Prot. Agency., 598 U.S. 651, 679 (2023) (emphasis added) (citing U.S. Forest Serv. v. Cowpasture River Pres. Ass'n, 140 S. Ct. 1837, 1849-50 (2020)).

[71] Food & Drug Admin. v. Brown & Williamson Tobacco Corp., 529 U.S. 120, 160-61 (2000).

[72] *Ala. Ass'n of Realtors*, 141 S. Ct. at 2489-90.

[73] Oral Argument at 11:11, Biden v. Missouri, 595 U.S. 87 (2022) (No. 21A240), https://www.oyez.org/cases/2021/21A240 [https://perma.cc/9UU7-LZR4].

coronavirus. HHS attaches conditions to Medicare and Medicaid funds to safeguard facilities, professionals, and patients.[74] Most health care providers are privately-run entities, not state-run.[75] In other words, for most providers that are paid by Medicaid's federal and state moneys, federalism is not an issue. Even so, Justice Alito asked: "Did the states have *clear notice* that by accepting Medicaid funds they would be subject to vaccination requirements for staff at their state-run facilities? . . . . [I]f they read the statutes that you are now relying on primarily, that would provide them *clear notice* that they might be subject to something like this vaccination requirement?"[76]

This question dives right into clear statement rules as a tool for formal, process-oriented line-drawing. It echoed Justice Alito's majority opinion in *Arlington Central School District*, which demanded that Congress make conditions on spending clear and unambiguous to be valid.[77] Justice Alito wrote: "[W]e must view the [law] from the perspective of a state official who is engaged in the process of deciding whether the State should accept [] funds and the obligations that go with those funds. We must ask whether such a state official would clearly understand . . . obligations of the Act . . . ."[78] Ultimately, the Court upheld HHS's vaccination rule in *Biden v. Missouri*, but Justices Thomas and Alito, joined by Justices Gorsuch and Barrett, issued

[74] *Biden v. Missouri*, 595 U.S. at 89-92.

[75] Roosa Tikkanen, Robin Osborn, Elias Mossialos, Ana Djordjevic & George A. Wharton, *International Health Care System Profiles: United States*, THE COMMONWEALTH FUND (June 5, 2020), https://www.commonwealthfund.org/international-health-policy-center/countries/united-states#care-delivery-and-payment [https://perma.cc/9FJH-BZ83].

[76] Transcript of Oral Argument at 16-17, Biden v. Missouri, 595 U.S. 87 (2022) (No. 21A240) (emphasis added).

[77] Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy, 548 U.S. 291, 304 (2006). This decision affected the classic *Dole* test for conditions on federal spending, which required that conditions on spending to be unambiguous, by adding "clear" and unambiguous. *See* South Dakota v. Dole, 483 U.S. 203, 207 (1987) (describing that conditions on federal funds must be unambiguous to allow states to knowingly accept federal rules); Nicole Huberfeld, *Clear Notice for Conditions on Spending, Unclear Implications for States in Federal Healthcare Programs*, 86 N.C. L. REV. 441, 469-70 (2008) (exploring the implications of *Murphy* for federal health care programs in the context of the Federalism Revolution).

[78] *Arlington Cent. Sch. Dist.*, 548 U.S. at 296.

dissents calling for "clear statements" in statutory language, relying on *Alabama Realtors Association*.[79]

The Court echoed this expectation in the companion case, *National Federation of Independent Business v. OSHA*.[80] The Court held that OSHA's "vaccination or masking and testing" requirements for large employers exceeded the agency's authority because Congress did not clearly authorize this in the Occupational Safety and Health Act as enacted in 1970.[81] Oddly, the majority did not view OSHA as a public health agency, stating "The Act empowers the Secretary to set *workplace* safety standards, not broad public health measures."[82] (Of course, workplace safety *is* public health.) The Court wrote: "We expect Congress to speak *clearly* when authorizing an agency to exercise powers of vast economic and political significance. There can be little doubt that OSHA's mandate qualifies as an exercise of such authority."[83] The recent emphasis on clear statement rules is consistent with the rise of the major questions doctrine, which was identified in Justice Gorsuch's *NFIB v. OSHA* concurrence.[84]

The Supreme Court extended these concepts in two blockbuster cases that, on the surface may appear outside the field of public health. The last decision issued in the 2021 term, *West Virginia v. Environmental Protection Agency*, crystalized dicta into doctrine.[85] The Court evolved

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[79] *Biden v. Missouri*, 595 U.S. at 104 (Thomas, J., dissenting). Professor Sam Bagenstos expected the Old Roberts Court would favor this approach. Samuel R. Bagenstos, *Spending Clause Litigation in the Roberts Court*, 58 DUKE L.J. 345, 408 (2008) (predicting the Roberts Court would continue the line of thinking in *Arlington* to limit the spending power indirectly).

[80] Nat'l Fed'n of Indep. Bus. v. Dep't of Lab., Occupational Safety & Health Admin., 595 U.S. 109 (2022).

[81] Occupational Safety and Health Act of 1970, Pub. L. No. 91-596, 84 Stat. 1590 (codified as amended at 29 U.S.C. §§ 651-678).

[82] *NFIB v. OSHA*, 595 U.S. at 117 (emphasis in original).

[83] *Id.* (emphasis added).

[84] *See id.* at 121 (Gorsuch, J., concurring); *see also* Sohoni, *supra* note 6, at 264 (describing the conception of the major questions doctrine).

[85] West Virginia v. Env't Prot. Agency, 142 S. Ct. 2587, 2614 (2022); Allison Orr Larsen, *Becoming a Doctrine*, 76 FLA. L. REV. (forthcoming 2024) (manuscript at 2 n.1), https://ssrn.com/abstract=4374736 [https://perma.cc/5GMA-LMH7]; s*ee* Daniel T. Deacon & Leah M. Litman, *The New Major Questions Doctrine*, 109 VA. L. REV. 1009, 1011-12 (2023).

from citing *Brown & Williamson* dicta, to citing its own recent decisions' dicta reinterpreting the earlier dicta, to calling dicta a doctrine, thus creating a new statutory canon.[86] The majority wrote:

> [I]n certain extraordinary cases, both separation of powers principles and a practical understanding of legislative intent make us 'reluctant to read into ambiguous statutory text' the delegation claimed to be lurking there . . . . [S]omething more than a merely plausible textual basis for the agency action is necessary. The agency instead must point to '*clear* congressional authorization' for the power it claims.[87]

The Court continued, "As for the major questions doctrine 'label[],' it took hold because it refers to an identifiable body of law that has developed over a series of significant cases all addressing a particular and recurring problem: agencies asserting highly consequential power beyond what Congress could reasonably be understood to have

[86] *West Virginia v. Env't Prot. Agency*, 142 S. Ct. at 2608. The Court wrote:

> In *Brown & Williamson*, for instance, the Food and Drug Administration claimed that its authority over "drugs" and "devices" included the power to regulate, and even ban, tobacco products. We rejected that "expansive construction of the statute," concluding that "Congress could not have intended to delegate" such a sweeping and consequential authority "in so cryptic a fashion." In *Alabama Assn. of Realtors v. Department of Health and Human Servs.*, we concluded that the Centers for Disease Control and Prevention could not, under its authority to adopt measures "necessary to prevent the . . . spread of" disease, institute a nationwide eviction moratorium in response to the COVID-19 pandemic. We found the statute's language a "wafer-thin reed" on which to rest such a measure, given "the sheer scope of the CDC's claimed authority," its "unprecedented" nature, and the fact that Congress had failed to extend the moratorium after previously having done so.

Id. (citations omitted). The Court continued:

> Similar considerations informed our recent decision invalidating the Occupational Safety and Health Administration's mandate that "84 million Americans . . . either obtain a COVID–19 vaccine or undergo weekly medical testing at their own expense." We found it "telling that OSHA, in its half century of existence," had never relied on its authority to regulate occupational hazards to impose such a remarkable measure.

Id. at 2608-09 (citations omitted).

[87] *Id.* at 2609 (emphasis added) (citation omitted).

granted."[88] In striking down the EPA's authority, the Court effectively handed at least some environmental policy to the states unless Congress amends the Clean Air Act — limiting federal administrative power and serving a formal, dual sovereignty ("layer cake") vision of federalism. Indeed, Justice Gorsuch's concurrence pointedly underscored that clear statement rules serve federalism values, calling federalism a "longstanding clear-statement rule."[89]

Similarly, Justice Alito's majority opinion elevated state power in *Dobbs v. Jackson Women's Health Organization*, the June 24, 2022 decision that overturned *Roe v. Wade* and *Planned Parenthood v. Casey*.[90] No less than six times the Court stated it would "return the issue of abortion to the people's elected representatives."[91] This language reflects retrenchment in dual-sovereignty federalism that is consistent with the language and outcome in decisions described above — though the Court did not prescribe the areas in which state regulation must occur, its orientation toward process and structure has the effect of sketching out where state power is dominant in its view. Importantly, *Dobbs* does not mean *only* states may act to protect or restrict access to abortion and other reproductive care, though it is rightly read as a federalism decision at least in part. In 2007, *Gonzales v. Carhart* held that commerce power can be exercised to regulate abortion, power which is underscored now by the increasing numbers of patients traveling to other states to access medical services in the wake of *Dobbs*.[92] Federal response to *Dobbs* has

[88] *Id.*; *see also* Deacon & Litman, *supra* note 85, at 1011-12; Larsen, *supra* note 85, at 3.

[89] *West Virginia v. Env't Prot. Agency*, 142 S. Ct. at 2621 (Gorsuch, J., concurring).

[90] Dobbs v. Jackson Women's Health Org., 142 S. Ct. 2228, 2240-43(2022) (reviewing state authority over abortion as an introduction to overturning *Roe v. Wade* and *Planned Parenthood v. Casey*).

[91] *Id.* at 2243, 2259, 2277, 2279, 2284 (majority opinion referring to "returning" the issue of abortion to "the people's elected representatives"); *id.* at 2305, 2310 (Kavanaugh, J., concurring) (same language).

[92] Gonzales v. Carhart, 550 U.S. 124, 166-67 (2007) (upholding Federal Partial Birth Abortion Ban Act). But note Justice Thomas's concurrence, which expressed skepticism that the commerce power can reach abortion services. *Id.* at 168-69 (Thomas, J., concurring); *see also* SOC'Y OF FAM. PLAN., #WECOUNT REPORT, APRIL 2022 TO MARCH 2023, at 4 (2023), https://www.societyfp.org/wp-content/uploads/2023/06/WeCountReport_6.12.23.pdf [https://perma.cc/ZJ47-4LNQ]; *Change in Number of Abortions by State*, SOC'Y OF FAM. PLAN., https://societyfp.org/research/wecount/ (last visited Aug. 17, 2023) [https://perma.cc/P6GL-6L6N] (tracking and documenting increases and decreases in

been driven by executive branch action so far, as Congress has not enacted bills regarding reproductive care, such as the Women's Health Protection Act.[93] In the meantime, the variety of state actions in the wake of *Dobbs* have created chaos, conflict, and confusion — the exact reason that Congress normally would intervene and act to create a national baseline, especially in health policy. Federal statutory options are limited, at this point, however. For example, the Emergency Medical Treatment and Labor Act ("EMTALA") requires hospitals accepting Medicare reimbursement to treat *all* medical emergencies, even when the medical standard of care is providing an abortion, because EMTALA explicitly preempts conflicting state laws.[94] But even express preemption provisions may be jeopardized by this Court's clear statement rule.

Opportunities to solidify or expand the renewed Federalism Revolution continued in the 2022 term. For example, a sleeper Medicaid case resurfaced a recurring issue regarding state accountability to beneficiaries of federal spending programs.[95] In *Health and Hospital Corporation of Marion County v. Talevski*, the Court considered whether private parties can sue states in federal court under 42 U.S.C. § 1983 to enforce the Medicaid Act.[96] For decades, private actions against noncompliant states have relied on "Section 1983," a civil rights statute

abortions by state); Mallika Seshadri, *Out-of-Staters Are Flocking to Places Where Abortions Are Easier to Get*, NPR (Apr. 16, 2023, 5:08 AM EST), https://www.npr.org/2023/04/16/1168695321/out-of-staters-flocking-to-places-where-abortions-are-easier-to-get [https://perma.cc/GN93-PNTY].

[93] Women's Health Protection Act of 2022, H.R. 8296, 117th Cong. (2022) (as passed by the House, June 15, 2022); Women's Health Protection Act of 2022, S. 4132, 117th Cong. (2022) (as defeated by the Senate, May 11, 2022).

[94] Emergency Medical Treatment and Labor Act, 42 U.S.C. § 1395dd. District courts in Idaho and Texas had different outcomes, with Idaho's abortion restrictions being preempted, *United States v. Idaho*, 623 F. Supp. 3d 1096 (D. Idaho 2022), but the Texas administrative procedure challenge was successful in *Texas v. Becerra*, 623 F. Supp. 3d 696 (N.D. Tex. 2022).

[95] Health & Hosp. Corp. of Marion Cnty. v. Talevski, 143 S. Ct. 1444, 1454 (2023) (describing HHC's third-party beneficiary argument).

[96] *See generally* Nicole Huberfeld, *Bizarre Love Triangle: The Spending Clause, Section 1983, and Medicaid Entitlements*, 42 UC DAVIS L. REV. 413 (2008) (analyzing circuit courts' decisions in Medicaid-related § 1983 actions that pre-dated the *Talevski* decision, which shows how long parties have fought over private actions in Medicaid).

that allows relief in federal court against state officials for "deprivation[s] of any rights" under the "Constitution and laws."[97] Enacted during the Reconstruction Era as part of the Ku Klux Klan Act to provide a way to protect individuals when states would not, Section 1983 allows federal courts to tailor remedies to offending state actions and avoid interruptions to Medicaid coverage. Since 1980, federal courts have held consistently that Medicaid providers and patients can enforce statutory entitlements (as well as private parties in other social programs) under Section 1983.[98] The Court granted the HHC petition, which questioned whether Section 1983 actions are available in conditional spending programs.[99] This bold question may have reflected that states saw an opening because the Court demonstrated willingness to overturn settled precedent in the name of federalism. In fact, the advocate for the nursing home in *Talevski* began by quoting Justice Alito's clear notice rule from *Arlington*.[100]

However, on June 8, 2023, the Court affirmed 7–2 that Medicaid beneficiaries can seek relief in federal court, holding the Federal Nursing Home Reform Act of 1987 ("FNHRA"), which protects nursing home residents through amendments to Medicare and Medicaid, can be enforced under Section 1983.[101] *Talevski* could have affected federal social programs broadly, so simply maintaining the status quo could be called a victory for congressional spending power and the Medicaid program.[102] Justice Ketanji Brown Jackson's first majority opinion with high policy stakes reflected her oral argument questions, which engaged

[97] *Id.* at 427-28.

[98] *See* Brief of Indiana and Sixteen Other States as *Amici Curiae* in Support of Petitioner at 4, Health & Hosp. Corp. of Marion Cnty. v. Talevski, 143 S. Ct. 1444 (2023) (No. 21-806); *see also* Maine v. Thiboutot, 448 U.S. 1, 5-6 (1980).

[99] *Talevski*, 143 S. Ct. at 1451-52.

[100] Transcript of Oral Argument at 4, Health & Hosp. Corp. of Marion Cnty. v. Talevski, 143 S. Ct. 1444 (2022) (No. 21-806). Chief Justice Roberts seemed confounded by the breadth of the claim in this case. *Id.* at 21 ("I would contest that proposition since the whole premise is that the state has to be on unambiguous, clear notice. But how can that be with respect to a regulation that hasn't even been issued at the time of the statute?").

[101] *Talevski*, 143 S. Ct. at 1455.

[102] *See* Nicole Huberfeld, Opinion, *Private Actions to Protect Medicaid Live to See Another Day*, 330 JAMA 411 (2023).

with Section 1983's history and meaning as a critical civil rights law. Her majority opinion observed that Congress enacted Section 1983 to protect vulnerable individuals with plain language and rejected the argument that no federal spending program could be subject to Section 1983 actions, reiterating that state noncompliance could be enforced by private parties where the provision in question creates unambiguous rights.[103] Though some parts of the Medicaid Act do not meet the Court's "*Gonzaga* test" for private actions, the FNHRA does because it describes specific patient protections and "residents' rights."[104]

In separate concurrences, Justices Gorsuch[105] and Justice Barrett (joined by Chief Justice Roberts)[106] were open to more petitions like *Talevski*. Both concurring opinions found the FNHRA creates enforceable rights, but neither was willing to block the recurrent theory that Medicaid beneficiaries are "third-party beneficiaries" to a "contract" between HHS and states and cannot enforce federal law.[107] Going much farther, Justice Thomas's dissent expressed doubt that Congress has conditional spending power rooted in the General Welfare Clause *at all*, even though the Court has held the power to spend is a standalone enumerated power since 1936,[108] and called federal grants to states an "unprecedented threat[] to federalism."[109] Conspicuously, the Rehnquist Court found conditional spending unremarkable when it articulated the "*Dole* test," a four-part analysis for determining if

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[103] *Talevski*, 143 S. Ct. at 1452-54.

[104] *Id.* at 1457-58.

[105] *Id.* at 1462 (Gorsuch, J., concurring).

[106] *Id.* at 1463 (Barrett, J., concurring).

[107] *Id.* at 1462 (Gorsuch, J., concurring); *id.* at 1463 (Barrett, J., concurring).

[108] *See* United States v. Butler, 297 U.S. 1, 77-78 (1936) (holding that that Congress has the broad power to spend and collect taxes for the "general welfare" of the United States).

[109] *Talevski*, 143 S. Ct. at 1466 n.2 (Thomas, J., dissenting). Justice Thomas also called Reconstruction Era Amendments a federalism concern, even though they were adopted to constrain state authority in the wake of the Civil War. *Id.* at 1468 n.4. Justice Thomas furthered this point in *United States ex rel. Polansky v. Exec. Health Res., Inc.*, 143 S. Ct. 1720, 1741-42 (2023) (Thomas, J., dissenting).

Congress properly enacted conditions on spending.[110] Justice Thomas's approach would effectively force Congress to start over on most social programs, but was joined by no other justice, even though Justice Alito appeared receptive to such arguments in the past. Justice Alito's separate dissent (joined by Thomas) observed FNHRA administrative remedies should preclude Section 1983 actions.[111] The *Talevski* concurrences and dissents invite more litigation and keep the door open to further federalism questions in conditional spending programs.

This landscape sketch reveals patterns and momentum in the New Roberts Court's revival of the Federalism Revolution. This pattern has potential to be more restrictive for congressional power and more disruptive for health laws than the Rehnquist Court's was, in part because of heightened interest in spending programs, which has existed since *NFIB v. Sebelius*. Statutory clear notice does not specifically take on which government should be responsible for any policy matter,[112] consistent with federalism process theorists, who are more likely to focus on federalism as a protective structure than to delineate substantive areas for federal or state regulation.[113] However, this approach is inconsistent with, and does not consider, the fact that most federal health laws were enacted *decades* ago, and Congress continues to amend such statutes.[114]

In addition, state partnership in federal policies varies from law to law as well as within federal laws, yet the concept of federalism has been

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[110] South Dakota v. Dole, 483 U.S. 203, 207-08 (1987). Justice Thomas joined the Rehnquist Court in 1991, but he joined other opinions that relied on *Dole*, which did not articulate this more radical idea.

[111] *Talevski*, 143 S. Ct. at 1484-86 (Alito, J., dissenting).

[112] Another 2022 term decision calls for clear statement rules, this time in the context of abrogating the sovereignty of Native American Tribes. *See* Lac Du Flambeau Band of Lake Superior Chippewa Indians v. Coughlin, 143 S. Ct. 1689, 1695, 1699-1700 (2023); *see also id.* at 1704-05, 1712-13 (Gorsuch, J., dissenting).

[113] *See, e.g.*, Charles W. Tyler & Heather K. Gerken, *The Myth of The Laboratories of Democracy*, 122 COLUM. L. REV. 2187, 2228-29 (2022) (describing old and new "process federalism").

[114] *See* Abbe R. Gluck & Lisa Schultz Bressman, *Statutory Interpretation from the Inside — An Empirical Study of Congressional Drafting, Delegation, and the Canons: Part I*, 65 STAN. L. REV. 901, 972-74 (2013).

treated as if it is one kind of interaction between two fixed authorities.[115] The states are not a monolith, and their actions do not necessarily serve commonly articulated federalism values, as spotlighted in the aftermath of *Dobbs*. Yet, some jurists and experts have theorized about "the states" in a way that paradoxically treats all states the same way, contradicting the "local control" value of federalism for failing to recognize each state as different. This ignores abundant evidence that state variability can be either helpful or harmful and does not necessarily adhere to principles for valid experiments.[116]

The resurfacing dual sovereignty principle, while enforcing new clear statement rules, imposes a new requirement on old laws, approaching federalism as if states must be protected from the federal government reaching into their borders. Yet, Congress has authority to directly regulate matters related to health, such as public and commercial insurance as well as creating social programs.[117] Further, states are remarkably effective at negotiating their priorities, which Medicaid expansion under the ACA demonstrated plainly.[118] The New Roberts Court's approach is a mismatch for the longstanding practice of federal laws inviting state participation as a policy choice rather than constitutional command. Within a single public law different kinds of federalism can exist, especially where national goals are broad and have many methods to be achieved, like the ACA[119] or the laws that outline public health emergency response.[120] These old laws have hybrid federalism structures that are a poor fit for, and are jeopardized by, interpretive formalism.

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115 *See* Abbe R. Gluck, *Our* [*National*] *Federalism*, 123 YALE L.J. 1996, 1998-99, 2011-12, 2038 (2014) [hereinafter *Our* [*National*] *Federalism*].

116 *See infra* Part III.

117 The principle that Congress has power to place conditions on spending to legislate behavior dates to *Oklahoma v. Civ. Serv. Comm'n*, 330 U.S. 127, 137 (1947).

118 Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27, at 1737-43, 1745-47.

119 Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L.J. 534, 582, 584 (2011) [hereinafter *Intrastatutory Federalism*] (observing the ACA has five kinds of federalism).

120 *See supra* Part I.

B. Federalism's Values

Experts generally describe federalism's values as a closed set: state autonomy, political accountability, innovation or experimentation, and policy variation.[121] A more evidence-based understanding of what federalism does, and whether federalism impedes or facilitates any goal, should be developed through evaluating the values in this set. I argue that autonomy and political accountability together produce "governance capacity." Governance capacity can be measured through concrete factors, such as budgeting sufficient funds to implement chosen policies, which tangibly facilitates the leadership and expertise necessary for addressing policy questions adequately. Additionally, I argue that experimentation and policy variation should not be deemed meaningful values without adhering to standards for ethical scientific experimentation established in bioethical principles and federal laws.

Possible metrics for evaluating federalism's values are not explored much in the legal literature.[122] Typically, at least one of three assumptions are present. Some scholars describe federalism as a choice to maximize governmental expertise to address a certain issue. This assumes that a level of government both has such expertise and will act on it, *i.e.*, that capacity to act on allotted responsibilities already exists and can be further developed. The second assumption is that responsibilities allocated based on the first assumption — a certain level of government has expertise to act — will be carried out with evidence-based policymaking, knowledgeable staffing, and adequate funding.[123] A

[121] Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27, at 1694; *see also* Erin Ryan, *Negotiating Federalism*, 52 B.C. L. REV. 1, 12 (2011) ("[T]he fundamental principles that federalism brings to good governance, include[e] checks and balances, accountability and transparency, local innovation, and problem-solving synergy.").

[122] Some political scientists are trying. *See* JAMILA MICHENER, FRAGMENTED DEMOCRACY: MEDICAID, FEDERALISM, AND UNEQUAL POLITICS 26 (2018) (documenting how political participation, especially voting, is intertwined with Medicaid policy). *See generally* GRUMBACH, *supra* note 19 (explaining how national political and public health crises in 2020 exposed flaws of American federalism).

[123] Some legal scholars explore monetary aspects of federalism, or "fiscal federalism," but this is less about building capacity and more about the role money plays in federalism-based relationships. *See, e.g.*, Schapiro, *supra* note 30, at 1536 (calling for focus on money rather than constitutional federal questions); David A. Super, *Rethinking Fiscal Federalism*, 118 HARV. L. REV. 2544, 2549, 2652 (2005) [hereinafter *Rethinking Fiscal*

third assumption is that federal and state governments back one another up through overlapping expertise and shared policy goals facilitated by federal funding, because cooperative federalism creates redundancy, so if one layer of government fails, the other can act.

Some federalism experts call state experimentation valuable unto itself, arguing when states refuse federal offers of partnership, this is better for the system as a whole, and generally building on the premise that expertise is maximized by federalism. A prominent example by Professors Bulman-Pozen and Gerken posits that state resistance to federal policies benefits policymaking and that states build new policies through "dissent."[124] The "uncooperative federalism" theory is accurate in some circumstances but not always supported by evidence, such as the flipped federalism in the implementation of the ACA, discussed in the next Part.[125] A more comprehensive assessment would include what happens not only when states dissent and then do not follow through on the policy imperative but also when states *veto* federal policies that are meant to address national problems. The state veto acts as a blockade when there is no federal fallback and is not always an alternative pathway.[126]

Other scholars have explored certain aspects of governance capacity and related questions. For example, Professor Hills argued Congress is limited in both fiscal and regulatory capacity, leading it to opt for trading money and "scale" for state regulatory know-how.[127] Professor Rodriguez observed that conflict between states and the federal

Federalism] (stating that scholarship on federalism should be attentive to fiscal issues). *See generally* Matthew B. Lawrence, *Fiscal Waivers and State "Innovation" in Health Care*, 62 WM. & MARY L. REV. 1477 (2021) (exploring money's role in regulatory waivers in cooperative federalism programs). My point here is that capacity includes money, and that money is needed to build expertise, but expertise is also crucial for building successful public health responses.

[124] *See generally* Bulman-Pozen & Gerken, *supra* note 22 (exploring how "uncooperative federalism" may promote state autonomy and vocalization of state concerns).

[125] *See* Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27, at 1701-02.

[126] State veto is not the same as state nullification, embodied by laws like Texas's SB8, which defied federal constitutional and statutory law at the time it was enacted to eliminate abortion after six weeks gestation and prevented public enforcement of the law. Texas Heartbeat Act, S.B. 8, 87th Leg. (Tex. 2021).

[127] Hills, Jr., *supra* note 57, at 864-70, 884-86.

government in cooperative federalism schemes can expand federal "influence and capacities."[128] Professor Ryan explored "bargaining" between the federal government and states in environmental regulation, arguing federalism facilitates "good governance" (the Justice O'Connor model) through "checks and balances, accountability and transparency, local innovation, and problem-solving synergy."[129] She claimed states have "generally superior capacity for enforcement, implementation, and innovation"[130] and that state "regulatory capacity" provides leverage against federal funding and is a draw for the federal government, which she argues "trades federal fiscal capacity for state regulatory capacity to implement goals it lacks the expertise or resources to implement alone."[131] In each instance, the *capacity* to act on allocated responsibility is largely an assumed feature of divided governance.

Contrariwise, Professor Super studied decentralization and privatization as trends in poverty law and found that state and local governments lack fiscal capacity to effectively address the needs of low-income populations.[132] This approach most closely parallels the problem of governance capacity in health laws, which, for example, contain assumptions that state and local government will build public health capacity and respond to emergencies based on historical responsibility for the domain. As Professor Super observed, states do not have financial bandwidth.[133] As I have written, states have lacked financial

[128] Cristina M. Rodríguez, *Negotiating Conflict Through Federalism: Institutional and Popular Perspectives*, 123 YALE L.J. 2094, 2113 (2014).

[129] Ryan, *supra* note 121, at 11-12.

[130] *Id.* at 79.

[131] *Id.* at 90-91; *see also* Erin Ryan, *Secession and Federalism in the United States: Tools for Managing Regional Conflict in a Pluralist Society*, 96 OR. L. REV. 123, 154-55 (2017) (arguing the values of negotiated federalism include "the maintenance of (1) checks and balances between opposing centers of power that protect individuals, (2) governmental accountability and transparency that enhance democratic participation, (3) local autonomy that enables interjurisdictional innovation and competition, (4) centralized authority to manage collective action problems and vindicate core constitutional promises, and finally (5) the regulatory problem-solving synergy that federalism enables between the unique governance capacities of local and national actors for coping with problems that neither can resolve alone").

[132] Super, *Laboratories of Destitution*, *supra* note 30, at 547, 577.

[133] Super, *Rethinking Fiscal Federalism*, *supra* note 123, at 2652.

capacity for running social programs since the Great Depression.[134] In other words, the lack of state and local financial wherewithal is not new or surprising, but scholarship often bypasses states' inadequate budgets.

Other scholars have explored a different angle. For example, Professor Coan argued judicial decision-making serves goals like governmental self-regulation and workflow management, reflecting limited judicial capacity to mediate between government actors. He concludes this accounts for deferring to the political process or crafting rigid rules in decisions regarding federalism or separation of powers.[135] This assessment of the judiciary's ability to perform allocated work is arguably a different kind of capacity evaluation, positioning federalism as a boundary-drawing instrument separate from its constitutional dimensions.[136] This paper is less interested in whether the judicial branch can do the work and more concerned with judges' common assumption that devolving authority will net constructive results for autonomy, political accountability, experimentation, and policy variation.

Congress may enact laws in areas that once would have been the province of state or local governments, usually doing so out of national necessity and exercising constitutional authority in a way that includes states. When Congress has increased the federal role in health law particularly, it has also had to build federal capacity, and that capacity grows through agency implementation and partnership with states — both of which are in the sights of the New Roberts Court. More often than not, rather than relieve states of responsibility, Congress invites states to participate in national goals. Despite expert and judicial assumptions, states are not necessarily responsive to local interests — legal and political science scholars have shown that state politicians are more aligned with national politics and interest groups than their own

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[134] Huberfeld, *Federalizing Medicaid*, *supra* note 13, at 442-44.

[135] ANDREW COAN, RATIONING THE CONSTITUTION: HOW JUDICIAL CAPACITY SHAPES SUPREME COURT DECISION-MAKING 5-6, 208-09 (2019).

[136] Professor Ryan disagreed with the claim that judicial capacity drives federalism decisions, using the anti-coercion doctrine in *NFIB* to illustrate invitations for more litigation rather than less. Erin Ryan, *Rationing the Constitution vs. Negotiating It: Coan, Mud, and Crystals in the Context of Dual Sovereignty*, 2020 WIS. L. REV. 165, 172-73.

residents.[137] The dangers in assuming governance capacity and valid experimentation are exposed through the examples of the Medicaid expansion and the COVID-19 public health emergency, discussed below.

II. OLD LAWS, NEW RULES, NO FALLBACKS

The Court seems to be on a crash course with health laws, which rely on state partnership in federal efforts with the incentive of federal funding. The assumption that states will take up and manage federal spending and follow regulatory guardrails can thwart federal goals, because most older health care and public health laws have no federal alternative if states either fail or veto. Social program and health reform laws often are incremental, occasionally growing with large-scale efforts like Medicare, but usually Congress builds by amending existing laws. This reflects factors including historical decentralization of social programs; traditional federalism values; the political challenges of sweeping reform; and acclimating federal action in domains where states need assistance or collective action is necessary.[138] In addition, as noted in Part I, statutes enacted prior to the Rehnquist Court's Federalism Revolution have a different governance structure from more recently enacted laws.[139] In other words, many federal health laws predate the Federalism Revolution and have no federal fallback, so if a state vetoes participation in a federal law, or fails in implementing federal law, the federal goal cannot be achieved.

[137] *See, e.g.*, Tyler & Gerken, *supra* note 113, at 2221 ("The laboratories account views state policies as the output of officials working within state governments to promote local interests and working independently from officials in the federal government and in other states. In reality, ideas for many of the most significant state policy experiments come from outside of state governments, serve interests that are national in scope, and are advanced by coordinated political networks. . . . Many issues given the 'state' moniker are therefore better understood as 'national experiments carried out within state fora.'"); *see also* GRUMBACH, *supra* note 19, at 23-24.

[138] *See* Gluck, *Intrastatutory Federalism*, *supra* note 119, at 572 (explaining federalism facilitates "gradual field entry" by the federal government when it must take over for states).

[139] *See id.* at 573-74 n.109 (noting that federal laws with "opt out" provisions have the effect of "nationalizing statutory power" because Congress shifted the way that states are asked to implement federal laws after *Printz v. United States*).

This Part explores two examples of the dangers of federalism structures without fallbacks in this environment: Medicaid and public health emergencies. State power to stymie federal policies is not a new phenomenon, but when the judiciary is actively drawing boundaries around federal power over public health, state vetoes have real consequences.

A. *Medicaid and ACA Implementation*

The Medicaid program is a real-time experiment in health care federalism. As of publication, nearly a quarter of the U.S. population is enrolled in Medicaid, which is also vital to any public health emergency response.[140] Medicaid's recent history shows what happens when an old federal law is scrutinized by the Court for clear statements but has no fallback when such scrutiny finds it lacking. The Medicaid Act has been modified many times, but the ACA's statutory structure, litigation, and implementation, which were disrupted by the Supreme Court's 2012 decision in *NFIB v. Sebelius*, provide insights into current trends.

1. Flipped Federalism in Implementation

Medicaid is a federal-state program enacted in 1965 that is largely federally funded, the goal of which was to ensure comprehensive medical care for low-income people with specific federal rules protecting them.[141] Medicaid accounts for the distinct needs of its

[140] MEDICAID & CHIP PAYMENT & ACCESS COMM'N, MACSTATS: MEDICAID AND CHIP DATA BOOK 3 (2022) (showing in Exhibit 1 that 29% of U.S. population is covered by Medicaid and CHIP); Nicole Huberfeld & Sidney Watson, *Medicaid's Vital Role in Addressing Health and Economic Emergencies*, *in* ASSESSING LEGAL RESPONSES TO COVID-19, at 103, 107 (Scott Burris, Sarah de Guia, Lance Gable, Donna E. Levin, Wendy E. Parmet & Nicolas P. Terry eds., 2020); PowerPoint Presentation by Ctr. for Medicare & Medicaid Services on November 2022 Medicaid and CHIP Enrollment Trends 3, https://www.medicaid.gov/media/151121 [https://perma.cc/4A5Y-BXCG] (reporting that 84,815,742 enrolled in Medicaid, 6,970,515 enrolled in CHIP); *see also* Jennifer Tolbert & Meghana Ammula, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision*, KFF (June 9, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/ [https://perma.cc/JBY8-V23K] (noting estimates that predict a decline in Medicaid enrollment).

[141] 42 U.S.C. §§ 1396-1396w-7.

beneficiaries with requirements states must follow, like continuous open enrollment allowing individuals to qualify and enroll as soon as they meet statutory eligibility standards.[142] All states have accepted Medicaid funding, but if states do not accept the funding or implement the program, no federal alternative exists. This structure reflects two aspects of American health reform history: reliance on cooperative federalism in social programs as understood before the 1990s, and the idea from day one of the Medicaid program that it would be folded eventually into a national health insurance program, which was expected to fill gaps.[143] More than fifty-five years later, Medicaid has been repeatedly amended and extended, but a national universal insurance coverage system never arrived, so its deeply variable federal-state structure remains even after the ACA.[144]

Congress enacted the ACA to create a national baseline of near-universal insurance coverage, cobbled together from existing commercial and public insurance, which would improve care access because payment always has been a gateway to health care.[145] The ACA introduced a norm of "universality," a principle that set aside the long American history of private, transaction-based medicine that fostered exclusion of low-income people and people of color.[146] The Obama

[142] *Id.* § 1396a(a)(8).

[143] PAUL STARR, REMEDY AND REACTION: THE PECULIAR AMERICAN STRUGGLE OVER HEALTH CARE REFORM 51 (2011); STEVENS & STEVENS, *supra* note 60, at 315-19; *see also* Wilbur J. Cohen, *Reflections on the Enactment of Medicare and Medicaid*, HEALTH CARE FIN. REV., Dec. 1985, at 3, 3-5.

[144] *See* Huberfeld, *Federalizing Medicaid*, *supra* note 13, at 479-80 (exploring why Medicaid should be a national program and how the ACA moved in that direction).

[145] President Obama stated: "And we have now just enshrined, as soon as I sign this bill, the core principle that everybody should have some basic security when it comes to their health care." Barack Obama, President of the U.S., Remarks at the Signing of the Health Insurance Reform Bill (Mar. 23, 2010), https://www.obamalibrary.gov/sites/default/files/uploads/documents/Signing%20of%20the%20Health%20Insurance%20Reform%20Bill%202010%20%28TRANSCRIPT%29.pdf [https://perma.cc/AWZ8-L7TS]. I say "near universal" because undocumented immigrants are excluded and new immigrants face waiting periods.

[146] *See* Nicole Huberfeld, *The Universality of Medicaid at Fifty*, 15 YALE J. HEALTH POL'Y, L. & ETHICS 67, 72-73 (2015); *see also* Nicole Huberfeld & Jessica L. Roberts, *An Empirical Perspective on Medicaid as Social Insurance*, 46 U. TOL. L. REV. 545, 556 (2015) (describing

administration focused on health reform through universal insurance coverage because uninsurance reached a high of more than eighteen percent of the population in 2008, concentrated among people earning less than 250% of the federal poverty level ("FPL").[147] Since the late 1980s, employers decreased health insurance coverage and benefits; premiums and other out of pocket cost sharing increased, and employer sponsored health insurance ("ESI") was inaccessible to many. Other commercial insurance had high costs and exclusions like limited coverage of preexisting conditions. Low-income and part-time workers were rarely covered by ESI and other private insurance. Further, Congress amended Medicaid to expand eligibility over time, but nonelderly nondisabled adults with no children had no path to coverage.[148] In short, the ranks of the uninsured were increasing and access to care correspondingly was decreasing.[149]

The ACA involved many political and stakeholder compromises, making building on pre-existing statutes vital to negotiating its

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Medicaid expansion's universal approach as a form of social insurance rather than welfare).

[147] *See* Annual Update of the HHS Poverty Guidelines, 74 Fed. Reg. 4199, 4200 (Jan. 23, 2009) (reporting $10,830 FPL for one person); CARMEN DENAVAS-WALT, BERNADETTE C. PROCTOR & JESSICA C. SMITH, U.S. CENSUS BUREAU, REPORT NO. P60-238, INCOME, POVERTY, AND HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2009, at 22-28 (2010) (describing a continuous increase in the uninsured rate, with most uninsured earning less than $25,000 annually); INST. OF MED., AMERICA'S UNINSURED CRISIS: CONSEQUENCES FOR HEALTH AND HEALTH CARE 25-44 (2009) (describing trends of decreasing coverage); Andrew Villegas & Phil Galewitz, *Uninsured Rate Soars, 50+ Million Americans Without Coverage*, KFF HEALTH NEWS (Sept. 16, 2010), https://kffhealthnews.org/news/census-uninsured-rate-soars/ [https://perma.cc/T2U8-GXXS] (uninsured at "an all time high").

[148] STARR, *supra* note 143, at 79-80, 155-56; Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in* National Federation of Independent Business v. Sebelius, 93 B.U. L. REV. 1, 20-25 (2013) (explaining amendments expanding eligibility, some of which began as state demonstration waivers like expansion for pregnant women).

[149] Hospital emergency departments became a common place to seek care, where it is neither economically efficient nor ideal for care that requires any prevention, monitoring, or long-term attention — *i.e.*, most medical care. The Emergency Medical Treatment and Labor Act ("EMTALA") requires hospitals with emergency departments that accept Medicare as reimbursement for any services to treat or stabilize and transfer any person who presents with a medical emergency, so hospitals could not turn away the ranks of increasing uninsured. 42 U.S.C. § 1395dd.

substance.[150] Congress created new federal rules for already-existing health insurance plans through continued ESI, fortified individual and small group commercial insurance markets, and nationalized regulations that closed the gap in Medicaid eligibility. Specifically, Congress expanded Medicaid to cover individuals aged 18–64 earning up to 138% of the FPL, a population excluded historically as not "deserving."[151] The ACA offered states 100% federal funding for the newly eligible Medicaid population that phased down to a 90% match, a legislative choice reflecting confidence that states would walk the path established since 1982 and proceed with expanding eligibility.[152]

In addition to counting on states for administering Medicaid, Congress offered money and regulatory responsibility to states for implementing health insurance exchanges ("exchanges," later called "marketplaces") that would sell standardized commercial individual and small group health plans.[153] Congress had power to create one national exchange, which was part of the House bill, but instead gave states the option to create their own exchanges. As it had done with other health laws, Congress nationalized rules that had been left to state regulation while also inviting states to participate in implementing new federal law.[154] Congress assumed states would accept the offer to run exchanges with federal money because states have regulated insurance by congressional invitation under the McCarran-Ferguson Act since 1945.[155] The ACA used tools that some states already tried, such as forbidding lifetime caps and coverage exclusions for preexisting conditions, knowing that states had largely failed in implementing such

[150] *See* Gluck & Huberfeld, *Federalism Under the ACA*, *supra* note 61, at 178.

[151] The question of who deserves the support of social programs has long been tied to categories of deserving versus undeserving poor and questions of who is malingering. *See, e.g.*, Nicole Huberfeld, *Federalism in Health Care Reform*, *in* HOLES IN THE SAFETY NET: FEDERALISM AND POVERTY 197, 199-204 (Ezra Rosser ed., 2019) (exposing the history of the term "able bodied") [hereinafter *Federalism in Health Care Reform*].

[152] Holdout Arizona agreed to participate in Medicaid in 1982.

[153] 42 U.S.C. § 18031.

[154] *Id.* §§ 300gg to -28.

[155] 15 U.S.C. §§ 1011-1015 (enacted in 1945 after the Court's 1944 *South Eastern Underwriters Association* decision affirmed Congress's authority to regulate insurance as interstate commerce).

rules alone.[156] The ACA obligated HHS to create a federal exchange for states that did not do so[157] — a fallback that became a bigger operation than Congress envisioned after *NFIB v. Sebelius*.

Turmoil started when the ACA was signed, with an immediate state-led challenge that resulted in *NFIB v. Sebelius*.[158] The Court upheld the constitutionality of the individual mandate as an exercise of Congress's taxing power but also held that Medicaid expansion was an unconstitutionally coercive exercise of spending power; this effectively rendered expansion voluntary for states, even though the ACA's statutory language did not change.[159] *NFIB* flipped the ACA's federal/state balance and undercut the federal goal of universality by giving Medicaid eligibility back to states where Congress created a national baseline. If a state does not expand eligibility, Medicaid expansion cannot exist there, just like the rest of the Medicaid program. So, in non-expansion states, people who are eligible for Medicaid under the ACA but earn less than 100% of the FPL are ineligible for Medicaid and cannot get federal subsidies through the exchanges, which are only for people earning 100–400% of the FPL. This "coverage gap" has become geographically concentrated, existing in eleven states located in the Deep South and central Midwest as of this writing.[160]

Despite preserving the ACA, *NFIB* had the effect of amplifying political resistance. State vetoes of Medicaid, which included half of states in 2012, also extended to refusals to establish an exchange in many of the same states. This meant that Medicaid expansion *could not exist* in

[156] 42 U.S.C. §§ 300gg-3, -11; *see also* King v. Burwell, 576 U.S. 473, 479-81 (2015) (describing states' failed attempts in health insurance regulation).

[157] *Id.* § 18041(c)(1). This provision explicitly provides that if a state refuses or fails, HHS must step in: "If (A) a State *is not an electing State* under subsection (b); or (B) the Secretary determines, on or before January 1, 2013, that an electing State — (i) *will not have any required exchange operational* by January 1, 2014; . . . the Secretary *shall* (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements." *Id.* (emphasis added).

[158] Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 540 (2012).

[159] *Id.* at 588.

[160] Oklahoma and Missouri each had a successful ballot initiative to expand Medicaid in the summer of 2020, taking effect after the pandemic's economic recession impacted low-wage workers, and South Dakota had a successful ballot initiative in 2022.

those states, but the same resistance pushed responsibility for the exchange *to the federal government*.[161] HHS runs the federal exchange in two-thirds of states, often with input from state insurance officials.[162] This unanticipated "hybrid exchange model" has had the effect of operationalizing federal rules through state laws and regulations and may have helped to entrench the ACA despite flipped federalism produced by *NFIB*, but it does not affect Medicaid's lack of a fallback.[163]

Medicaid expansion has been extensively investigated — more than 600 studies indicate that, despite incomplete implementation, expansion has positive effects for individual and public health, health care providers, and state budgets.[164] The consistency of this data underscores the importance of the phenomenon of state vetoes, because it is no secret that states opting into expansion have gains in common measures, such as improved health insurance coverage[165] and decreased health disparities for Black, Hispanic, and other racial and ethnic populations, individuals with low educational attainment, and low-income people.[166] Medicaid expansion beneficiaries experience improvements in underlying determinants of health including income,

[161] *See generally* Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27 (describing irony that states ceded control and invited more federal power into their borders upon refusing to create exchanges because HHS had to create the Marketplace and regulate commercial insurers).

[162] *See id.* at 1768-72.

[163] Joel Ario, *Implementing the Insurance Exchanges: A View from the Trenches*, *in* THE TRILLION DOLLAR REVOLUTION, *supra* note 61, at 102, 114; Gluck & Huberfeld, *Federalism Under the ACA*, *supra* note 61, at 176, 178.

[164] Meghana Ammula & Madeline Guth, *What Does the Recent Literature Say About Medicaid Expansion?: Economic Impacts on Providers*, KFF (Jan. 18, 2023), https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/ [https://perma.cc/D9DY-U7EA]; MADELINE GUTH, RACHEL GARFIELD & ROBIN RUDOWITZ, KAISER FAM. FOUND., THE EFFECTS OF MEDICAID EXPANSION UNDER THE ACA: UPDATED FINDINGS FROM A LITERATURE REVIEW (2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/ [https://perma.cc/5BMT-CA5Q] (surveying over 400 studies' analyses of the impacts of the ACA's Medicaid expansion).

[165] EDWARD R. BERCHICK, JESSICA C. BARNETT & RACHEL D. UPTON, U.S. CENSUS BUREAU, REPORT NO. P60-267, HEALTH INSURANCE COVERAGE IN THE UNITED STATES: 2018, at 18-20 (2019), https://www.census.gov/library/publications/2019/demo/p60-267.html [https://perma.cc/V7K5-23NN].

[166] *See id.* at 15-16.

education, housing, food, and transportation.[167] Expansion increases voter registration and participation in elections, while Medicaid disenrollment decreases voting.[168] Health care providers have more financial stability with declines in uncompensated services and increased covered visits. Over 100 rural hospitals have closed since 2010, yet few are located in Medicaid expansion states.[169] States have budgetary savings from shifting the cost of the expansion population to HHS and report additional economic benefits.[170]

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[167] *See, e.g.*, Heidi L. Allen, Erica Eliason, Naomi Zewde & Tal Gross, *Can Medicaid Expansion Prevent Housing Evictions?*, 38 HEALTH AFFS. 1451, 1454 (2019) (discussing Medicaid's expansion in California leading to a reduction in evictions); Kevin Griffith, Leigh Evans & Jacob Bor, *The Affordable Care Act Reduced Socioeconomic Disparities in Health Care Access*, 36 HEALTH AFFS. 1503, 1506 (2017) (discussing increased insurance coverage of lower-income households); Luojia Hu, Robert Kaestner, Bhashkar Mazumder, Sarah Miller & Ashley Wong, *The Effect of the Affordable Care Act Medicaid Expansions on Financial Wellbeing*, 163 J. PUB. ECON. 99, 100 (2018) (discussing reductions in unpaid bills and bankruptcies with increased eligibility for Medicaid); Renuka Tipirneni, John Z. Ayanian, Minal R. Patel, Edith C. Kieffer, Matthias A. Kirch, Corey Bryant, Jeffrey T. Kullgren, Sarah J. Clark, Sunghee Lee, Erica Solway, Tammy Chang, Adrianne N. Haggins, Jamie Luster, Erin Beathard & Susan D. Goold, *Association of Medicaid Expansion with Enrollee Employment and Student Status in Michigan*, JAMA NETWORK OPEN, Jan. 2020, at 1 (discussing increased rates of employment and education among those who qualified for Medicaid); Naomi Zewde & Christopher Wimer, *Antipoverty Impact of Medicaid Growing with State Expansions over Time*, 38 HEALTH AFFS. 132, 135-36 (2019) (discussing Medicaid's impact on lowering out-of-pocket spending).

[168] Jake Haselswerdt & Jamila Michener, *Disenrolled: Retrenchment and Voting in Health Policy*, 44 J. HEALTH POL., POL'Y & L. 423, 426 (2019) (summarizing studies that indicate Medicaid and Medicaid expansion increase voting); *see also* Jake Haselswerdt, *Expanding Medicaid, Expanding the Electorate: The Affordable Care Act's Short-Term Impact on Political Participation*, 42 J. HEALTH POL., POL'Y & L. 667, 689 (2017); Margot Sanger-Katz, *When Medicaid Expands, More People Vote*, N.Y. TIMES (Nov. 8, 2018), https://www.nytimes.com/2018/11/08/upshot/medicaid-expansion-voting-increase.html [https://perma.cc/HWN3-UZ99].

[169] *See* Nicole Huberfeld, *Rural Health, Universality, and Legislative Targeting*, 13 HARV. L. & POL'Y REV. 241, 242 (2018) (documenting and exploring rural health disparities including the link between Medicaid expansion and hospital partial or complete closures); Press Release, KFF, Rural Hospitals Have Fared Worse Financially in States that Haven't Expanded Medicaid Coverage (Feb. 23, 2023), https://www.kff.org/health-costs/press-release/rural-hospitals-have-fared-worse-financially-in-states-that-havent-expanded-medicaid-coverage/ [https://perma.cc/HW3Q-TCBZ] (finding stronger finances at rural hospitals in expansion states compared to non-expansion states).

[170] GUTH ET AL., *supra* note 164, at 13-15.

Medicaid expansion varies from state to state like the rest of the program, but it has more variability than the ACA intended due to state vetoes and another significant, unintended outcome of *NFIB* — negotiations to get states to expand. Many states sought approval from HHS for demonstration project waivers under Section 1115 of the Social Security Act,[171] which gives the Secretary of HHS authority to waive certain statutory requirements if a state proposes a different way to further the purposes of the Medicaid program. Waivers are not specific to the ACA, but they were key to its implementation. Ultimately (and controversially) they included not just Medicaid expansion but also some known barriers to enrollment like premium payments under the Obama administration and work requirements under the Trump administration (for example, when Arkansas implemented work requirements in 2018, more than 18,000 people were disenrolled).[172]

The Obama administration was determined to make the ACA work and negotiated with states to get to yes on expansion after *NFIB*.[173] This opened the door to Section 1115 waivers that varied from the ACA's universality principle, allowing cost sharing and other hurdles to enrollment and access to care. The Obama administration aimed to achieve the ACA's goal of near-universal coverage, and the Secretary approved 1115 waivers only for states expanding Medicaid.[174] However,

[171] 42 U.S.C. § 1315(a) provides demonstration waiver authority in the SSA: "In the case of any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely to assist in promoting the objectives of subchapter . . . XIX . . . in a State . . . (1) the Secretary may waive compliance with any of the requirements of section . . . 1396a of this title, as the case may be, to the extent and for the period he finds necessary to enable such State or States to carry out such project."

[172] Benjamin D. Sommers, Lucy Chen, Robert J. Blendon, E. John Orav & Arnold M. Epstein, *Medicaid Work Requirements in Arkansas: Two-Year Impacts on Coverage, Employment, and Affordability of Care*, 39 HEALTH AFFS. 1522, 1522 (2020); *see also* Wendy E. Parmet, *The Trump Administration's New Public Charge Rule: Implications for Health Care & Public Health*, HEALTH AFFS. FOREFRONT (Aug. 13, 2019), https://www.healthaffairs.org/do/10.1377/hblog20190813.84831/full/ [https://perma.cc/Y3K7-BC4J]; Benjamin D. Sommers, Anna L. Goldman, Robert J. Blendon, E. John Orav & Arnold M. Epstein, *Medicaid Work Requirements — Results from the First Year in Arkansas*, 381 NEW ENG. J. MED. 1073, 1078-80 (2019).

[173] Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27, at 1733-57 (extensively documenting negotiations on Medicaid expansion and exchange implementation).

[174] *See id.*

the Trump administration built on these Obama-era waivers with an openly anti-ACA, anti-universality objective.[175] The Trump administration targeted the expansion population and allowed "community engagement" as a condition of eligibility (*i.e*. work requirements).[176] Both expansion states, like Kentucky, Indiana, Arkansas, New Hampshire, and Michigan, and non-expansion states, such as South Carolina, Tennessee, and Georgia, pursued such waivers.[177] Tennessee also gained the Secretary's approval for a block grant, which violates Medicaid law requiring open-ended federal funding for state expenditures, and is not waivable under Section 1115.[178] Every work requirement waiver was stayed by federal courts or halted during the COVID-19 pandemic pursuant to maintenance of effort requirements for federal relief funds.[179] The Biden administration HHS

[175] President Trump's first executive order, directing federal agencies to avoid implementing the ACA, is one example. Exec. Order No. 13765, 82 Fed. Reg. 8351 (Jan. 20, 2017).

[176] Letter from Ctrs. for Medicare & Medicaid Servs. to State Medicaid Dirs. Regarding Opportunities to Promote Work and Community Engagement Among Medicaid Beneficiaries (Jan. 11, 2018), https://affordablecareactlitigation.files.wordpress.com/2018/09/smd18002.pdf [https://perma.cc/9ZA4-RZS3]; *Healthy Adult Opportunity Fact Sheet*, CMS (Jan. 30, 2020), https://www.cms. gov/newsroom/fact-sheets/healthy-adult-opportunity-fact-sheet [https://perma.cc/W8G6-LNBJ] (federal policy guidance inviting block grant proposals from states for expansion population). A related block grant policy resulted in one demonstration waiver for Tennessee; an Oklahoma waiver application was withdrawn after a successful ballot initiative to expand Medicaid through a state constitutional amendment. *See Oklahoma Withdraws Medicaid Block Grant Proposal*, MOD. HEALTHCARE (Aug. 13, 2020, 8:07 PM), https://www.modernhealthcare.com/medicaid/oklahoma-withdraws-medicaid-block-grant-proposal [https://perma.cc/5Y56-7U92]. No prior administration allowed work requirements in Medicaid, though states tried, and Congress rejected proposals to add work to Medicaid, unlike other poverty-reducing programs like TANF or SNAP.

[177] *Medicaid Waiver Tracker: Approved and Pending Section 1115 Waivers by State*, KFF (Aug. 11, 2023), https://www.kff.org/report-section/section-1115-waiver-tracker-work-requirements/ [https://perma.cc/3WKD-7GSP].

[178] *See generally* Edward Alan Miller, Nicole Huberfeld & David K. Jones, *Pursuing Medicaid Block Grants with the Healthy Adult Opportunity Initiative: Dressing Up Old Ideas in New Clothes*, 46 J. HEALTH POL., POL'Y & L. 357 (2021) (exploring and analyzing the legal and policy implications of HHS approving Tennessee's waiver for block grants).

[179] The Supreme Court held the petition for certiorari in abeyance while the Biden administration handled the waivers through agency action, then reversed and remanded the circuit court's decision. *See* Case Docket, Gresham v. Azar, No. 20-37 (Apr. 5, 2021)

revoked work requirement waiver approvals. As an aggregated story, they show how more variability in Medicaid was made possible through the Court's federalism-based demand for clear statements in an old program with no fallbacks, increasing the likelihood that the federal law's goal of universal coverage could not be achieved.

Throughout 2017, Congress's Republican majority tried to repeal the ACA, with the last-ditch effort being a budget reconciliation bill called the Tax Cuts and Jobs Act of 2017, which zeroed out the penalty for not carrying insurance but left the ACA otherwise intact.[180] While Congress debated, the Trump administration used executive authority to weaken ACA-compliant commercial insurance markets, reduce state compliance with guardrails on state "innovation waivers,"[181] and undermine Medicaid by giving states more leeway to use federal money without oversight.[182] Rising uninsurance from 2017 through 2019 reflected such policies.[183] Uninsurance increased overall but especially in Medicaid non-expansion states in this timeframe.[184] The Centers for

(order holding the case in abeyance); *see also* Gresham v. Azar, 950 F.3d 93, 95 (D.C. Cir. 2020); Gresham v. Azar, 363 F. Supp. 3d 165, 169 (D.D.C. 2019) (Arkansas); Stewart v. Azar, 366 F. Supp. 3d 125, 130 (D.D.C. 2019) (2nd Kentucky decision); Stewart v. Azar, 313 F. Supp. 3d 237, 243 (D.D.C. 2018) (1st Kentucky decision).

[180] Tax Cuts and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054.

[181] 42 U.S.C. § 18052.

[182] Frank J. Thompson, *Six Ways Trump Has Sabotaged the Affordable Care Act*, BROOKINGS (Oct. 9, 2020), https://www.brookings.edu/articles/six-ways-trump-has-sabotaged-the-affordable-care-act/ [https://perma.cc/FB23-ZDMZ].

[183] Katie Keith, *CDC 2019 Coverage Numbers Show Increase in Uninsurance Rate, with Caveats*, HEALTH AFFS. FOREFRONT (Sept. 14, 2020), https://www.healthaffairs.org/do/10.1377/hblog20200914.60859/full/ [https://perma.cc/R5V8-B74H].

[184] This made it so approximately 30 million individuals were uninsured when the pandemic started, and nearly half of the uninsured were eligible for Medicaid or federal tax subsidies through an exchange. Munira Z. Gunja & Sara R. Collins, *Who Are the Remaining Uninsured, and Why Do They Lack Coverage?*, THE COMMONWEALTH FUND (Aug. 28, 2019), https://www.commonwealthfund.org/publications/issue-briefs/2019/aug/who-are-remaining-uninsured-and-why-do-they-lack-coverage [https://perma.cc/QU6B-D47M] (documenting the needs of the remaining uninsured before COVID's recession); *see also* ROBIN A. COHEN, AMY E. CHA, MICHAEL E. MARTINEZ & EMILY P. TERLIZZI, NAT'L CTR. FOR HEALTH STAT., HEALTH INSURANCE COVERAGE: EARLY RELEASE OF ESTIMATES FROM THE NATIONAL HEALTH INTERVIEW SURVEY, 2019, at 8 (2020), https://www.cdc.gov/nchs/data/nhis/earlyrelease/insur202009-508.pdf [https://perma.cc/5VBF-N3W9] (uninsurance of adults aged 18-64 rose to 14.7% in 2019 from 13.3% in 2018).

Medicare and Medicaid Services ("CMS") estimated 4 million people became eligible for Medicaid due to recession-related job loss and other financial hardships at the start of the pandemic, leading to a 6.2% increase in enrollment in 2020 alone.[185] These numbers were higher in non-expansion states, where close to two million individuals remain in the coverage gap.[186]

2. Implications of State Vetoes in the ACA Era

State officials were empowered by ACA implementation dynamics. Even after the ACA's nationalizing reforms, ZIP code dictates health because the federalism baked into the law's structure was susceptible to destabilization. Medicaid non-expansion is a poster child for the growing state veto phenomenon. Non-expansion was a litmus test for

[185] Press Release, Ctrs. For Medicare & Medicaid Servs., CMS Releases Medicaid and CHIP Enrollment Trends Snapshot Showing COVID-19 Impact on Enrollment (Sept. 30, 2020), https://www.cms.gov/newsroom/press-releases/cms-releases-medicaid-and-chip-enrollment-trends-snapshot-showing-covid-19-impact-enrollment [https://perma.cc/69NR-R85Z].

[186] Robin Rudowitz, Patrick Drake, Jennifer Tolbert & Anthony Damico, *How Many Uninsured Are in the Coverage Gap and How Many Could Be Eligible if All States Adopted the Medicaid Expansion?*, KFF (Mar. 31, 2023), https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/ [https://perma.cc/DK4E-6854]. Lawfully present immigrants must wait five years to be eligible for Medicaid. Lawfully present immigrants qualify for tax credits in the exchanges. *See Coverage for Lawfully Present Immigrants*, HEALTHCARE.GOV, https://www.healthcare.gov/immigrants/lawfully-present-immigrants/ (last visited Aug. 13, 2023) [https://perma.cc/YK6N-YW67]; *Immigration Status and the Marketplace*, HEALTHCARE.GOV, https://www.healthcare.gov/immigrants/immigration-status/ (last visited Aug. 13, 2023) [https://perma.cc/LK4V-G9BR]. Also, undocumented non-citizens are excluded, unable to enroll in Medicaid or to qualify for premium tax credits on an exchange, and thus more likely to be uninsured than lawfully present noncitizens (46% uninsurance rate as compared to 25%). *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1312(f)(3), 124 Stat. 119, 184 (2010); *see also Health Coverage and Care of Immigrants*, KFF (Dec. 20, 2022), https://www.kff.org/racial-equity-and-health-policy/fact-sheet/health-coverage-of-immigrants/ [https://perma.cc/AX7W-C6ZQ]. Before and after the ACA, undocumented noncitizens who could obtain coverage did so through ESI. Press Release, RAND Corp., Undocumented Immigrants Are Most Likely to Be Uninsured (Nov. 10, 2005), https://www.rand.org/news/press/2005/11/10.html [https://perma.cc/22YA-S9ZF]. Some public payment mechanisms exist, such as Medicaid's payments to hospitals for uninsured patients regardless of their immigration status ("emergency Medicaid"), but it is just a workaround.

Republican politicians at both federal and state levels,[187] but *state* politicians decide expansion. Congress appears to have abandoned "repeal and replace" efforts, but state vetoes continue and have concrete consequences.

NFIB empowered political-resistance dynamics that also complicated implementation in each state and call the traditional "value" of political accountability deeply into question. During the Obama administration, some states rejected Medicaid expansion and refused to implement an exchange, but other states were reluctant to reveal they were working with HHS, resulting in state-selected names that hid the ACA's national impact and made it harder for voters to know which officials were responsible.[188] This "secret boyfriend" federalism was impenetrable to an average person seeking health insurance or even voting, and it has concrete effects.[189] For example, studies showed in 2018 almost half of uninsured people qualified for federal subsidies to purchase insurance on an exchange but did not know it.[190]

On the other hand, ACA implementation dynamics fostered a popular movement for coverage that circumvents state vetoes: voter referenda.[191] Maine had the first successful ballot initiative to expand Medicaid in 2017, and others quickly followed, with Utah, Idaho, and Nebraska in 2018, Oklahoma and Missouri in 2020, and South Dakota in 2022.[192] The ballot initiatives demonstrate the lengths to which some

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[187] *See* Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27, at 1759.

[188] *Id.* We extensively discussed the confusion the law's dynamic federalism created and call this particular phenomenon "secret boyfriend" federalism, meaning HHS gave states cover to participate in the ACA even if it meant losing credit to states using new names meant to disguise their participation. *Id.* at 1700.

[189] *Id.* at 1700, 1767-68, 1770-71, 1780, 1786.

[190] This number has decreased slightly over time, though many people who are eligible for subsidies still do not know they can purchase insurance with support. *See* Jennifer Tolbert, Kendal Orgera, Natalie Singer & Anthony Damico, *Key Facts About the Uninsured Population*, KFF (Dec. 2019), https://files.kff.org/attachment//fact-sheet-key-facts-about-the-uninsured-population [https://perma.cc/B4LP-XG9S].

[191] Nicole Huberfeld, *Epilogue: Health Care, Federalism, and Democratic Values*, 45 AM. J.L. & MED. 247, 251 (2019) (discussing Maine, Montana, Utah, Idaho, and Nebraska ballot initiatives in the context of grassroots voter participation and state officials' undermining of the initiatives).

[192] Christopher Brown, *Medicaid Expansion Ballot Measures Brewing in Three More States*, BLOOMBERG NEWS (Jan. 26, 2021, 2:13 AM), https://news.bloomberglaw.com/

state leaders will go in their vetoes, as some legislatures, like Missouri, have resisted ballot initiative outcomes and tried not to implement expansion, requiring courts to intervene.[193] Some states, like Florida, made ballot initiatives more difficult after watching successful initiatives for expansion in other holdout states.[194] The grassroots

health-law-and-business/medicaid-expansion-ballot-measures-brewing-in-three-more-states [https://perma.cc/NC9X-KUU2].

[193] *See* Press Release, Mo. Governor's Off., State Outlines Next Steps for Medicaid Expansion After Court Ruling (Aug. 11, 2021), https://governor.mo.gov/press-releases/archive/state-outlines-next-steps-medicaid-expansion-after-court-ruling [https://perma.cc/FHD3-CAT8].

[194] In May of 2023, a resolution increased the constitutional amendment passage requirement to 67% of the vote when the amendment is proposed by citizen initiative. H.R.J. Res. 129, 2023 Leg., Reg. Sess. (Fla. 2023); *see also* Sophie Quinton, *GOP Works to Override Voters on Medicaid, Higher Wages, Pot*, STATELINE (Apr. 27, 2021, 12:00 AM), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2021/04/27/gop-works-to-override-voters-on-medicaid-higher-wages-pot [https://perma.cc/4RWA-R2R4].

movement of ballot initiatives, and state attempts to limit access to them,[195] is now spilling over into post-*Dobbs* reproductive care laws.[196]

[195] In 2022-2023, Arkansas, Arizona, Florida, Idaho, Missouri, North Dakota, Ohio, and Utah tried to limit voter ballot initiatives, either in reaction to Medicaid expansion, to voter support for abortion access, or both. For example, in 2022, Arkansas had a ballot initiative that would have created a supermajority voting requirement, but the initiative failed, with over 60% of voters opposing. PUB. POL'Y CTR. AT THE UNIV. OF ARK. SYS. DIV. OF AGRIC., 2022 VOTER GUIDE: ARKANSAS BALLOT ISSUES (2022), https://www.uaex.uada.edu/business-communities/voter-education/docs/2022-Arkansas-Ballot-Issue-Voter-Guide.pdf [https://perma.cc/HAH4-6QBX]; PUB. POL'Y CTR. AT THE UNIV. OF ARK. SYS. DIV. OF AGRIC., ISSUE 2 OF 2022 — REQUIRING 60% VOTER APPROVAL FOR CONSTITUTIONAL AMENDMENTS AND CITIZEN-PROPOSED STATE LAWS (2022), https://www.uaex.uada.edu/business-communities/voter-education/issue2.aspx [https://perma.cc/GLW7-GPFD]. In Arizona, two 2022 initiatives, Proposition 128 and 129, tried to alter ballot initiatives. 128 would have allowed the legislature to amend initiatives if they had "illegal or unconstitutional language," but allowed amending without limitation; Prop 128 failed. Proposition 129 limits citizens' initiative measures to single issues, and this proposition passed in 2022. ARIZ. SEC'Y OF STATE, ARIZONA 2022 GENERAL ELECTION PUBLICITY PAMPHLET: WHAT'S ON MY BALLOT? 40-71 (2022), https://azsos.gov/sites/default/files/azsos_2022_publicity_pamphlet_standard_english_web_version.pdf [https://perma.cc/9RRH-A72R]. A 2021 Idaho proposal would have required an increase from six percent of voters in 18 legislative districts to six percent in each of 35 legislative districts. This was voted down in 2023. S.J. Res. 101, 67th Leg., 1st Reg. Sess. (Idaho 2023); Clark Corbin, *Proposal to Change Idaho's Ballot Initiative and Referendum Process Voted Down*, IDAHO CAP. SUN (Mar. 30, 2023, 1:50 PM), https://idahocapitalsun.com/2023/03/30/proposal-to-change-idahos-ballot-initiative-and-referendum-process-voted-down/ [https://perma.cc/C9KY-CQ22]. In 2023, the Missouri House raised minimum signature requirements to a supermajority of 60%. Rudi Keller, *Four Bills Making Initiative Petition Process Harder Passed by Missouri House Committee*, MO. INDEP. (Jan. 26, 2023, 12:59 PM) https://missouriindependent.com/2023/01/26/four-bills-making-initiative-petition-process-harder-passed-by-missouri-house-committee/ [https://perma.cc/RF9W-5PHQ]. In North Dakota, a proposed constitutional amendment would require ballot initiatives to be single subject and to be approved in primary and general elections. S. Con. Res. 4013, 68th Legis. Assemb. (N.D. 2023). In Ohio, an August 2023 special election would require 60% of voters to amend the constitution (preventing upcoming abortion ballots from being decisive). Karen Kasler, *Ohio Election Officials Scramble Ahead of August Vote on State Constitution Changes*, NPR (May 25, 2023, 5:01 AM EST), https://www.npr.org/2023/05/25/1177921697/ohio-august-special-election-constitution-abortion-amendment [https://perma.cc/7E9P-HGKE]. In 2021, after the Medicaid expansion ballot initiative was successful, Utah amended rules for signature gatherers from per name to per hour payment methods. UTAH CODE ANN. § 20A-7-104 (2021).

The ACA serves as a model and a cautionary tale for federal health laws' fallback structure, with a blended approach that buoyed one aspect of universality while undermining another. When Congress amends old laws like the Medicaid Act that have no fallback, states and the Court can impede implementation. Exchanges were different because HHS was required to act, though the Trump administration approved a novel model for Georgia,[197] a non-expansion state that relies on the federal exchange, which sought an ACA section 1332 state innovation waiver to disband the federal exchange with no state-based replacement.[198] Georgia's application was approved just before the 2020 election.[199] The Biden administration and Georgia have been fighting ever since, but the Medicaid work requirements approved by the Trump administration as part of Georgia's package of reforms began late in 2023.[200] This reveals a slightly different aspect of the state veto, one in which federal rules

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[196] *See 2022 Abortion-Related Ballot Measures*, BALLOTPEDIA, https://ballotpedia.org/2022_abortion-related_ballot_measures (last visited Aug. 9, 2023) [https://perma.cc/U3SC-NKD3].

[197] *See* Letter from Seema Verma, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Frank W. Berry, Comm'r, Ga. Dep't. of Cmty. Health (Oct. 15, 2020), https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ga/ga-pathways-to-coverage-ca.pdf [https://perma.cc/A9ZN-VA35].

[198] Other states, such as Maine, relied on the federal exchange then implemented their own exchange, but none eliminated exchanges entirely. *See* Mark Barna, *More States Moving to Operate Their Own Health Exchanges: Uninsured Rising*, 50 THE NATION'S HEALTH, June 2020, at 1, 1.

[199] *See* Fact Sheet, Ctrs. for Medicare & Medicaid Servs., Georgia: State Innovation Waiver Under Section 1332 of the PPACA (Nov. 1, 2020), www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-/1332-GA-Fact-Sheet.pdf [https://perma.cc/C7VD-RYL8].

[200] *See* Letter from Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Grant Thomas, Dir., Off. of Health Strategy & Coordination, Ga. Governor's Off. of Plan. & Budget (Apr. 29, 2022), https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-GA-Suspension-Letter-GA-Access-Model.pdf [https://perma.cc/D4K7-D7DH] (requesting data); Letter from Chiquita Brooks-LaSure, Adm'r, Ctrs. for Medicare & Medicaid Servs., to Brian P. Kemp, Governor of Ga. (June 3, 2021), www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/1332-Request-Updated-GA-Analysis-Letter.pdf [https://perma.cc/BCZ6-MYZ9]; James C. Capretta, *An Update on the Disputes Leading CMS and Georgia to Court*, STATE OF REFORM (Aug. 26, 2022), https://stateofreform.com/commentary/2022/08/an-update-on-the-disputes-leading-cms-and-georgia-to-court/ [https://perma.cc/E3C5-6JTT].

should have prevented approving the waiver because no exchange would exist in the state, even though the law requires an exchange to be established by state or federal law — *i.e.*, the exchange's fallback cannot be waived (unlike Medicaid).[201]

In states that veto Medicaid expansion, health disparities remain stark, and many of these states made other policy choices that deepened the crises triggered by the pandemic, especially for populations already experiencing health inequities.[202] The next section explores the COVID-19 public health emergency to explore this phenomenon.

B. Public Health Emergencies

Congress enacted the Public Health Service Act in 1798 to provide an early version of health insurance for the merchant marine.[203] Congress later established the modern Public Health Service Act of 1944 ("PHSA"), which combined federal public health programs and supported state public health efforts better.[204] Structurally speaking, the PHSA is an extensive collection of amendments to the SSA that broadly delineate protections for physical and mental health. Some amendments regulate federal work, such as the Public Health Service itself, but the PHSA also instructs the HHS Secretary to include and train states and localities in most public health efforts like quarantine and disaster planning.[205] Volumes would be needed to evaluate the federal/state relationships existing throughout the PHSA; this part

[201] *See* Christen Linke Young & Jason Levitis, *Georgia's 1332 Waiver Violates the ACA and Cannot Lawfully Be Approved*, BROOKINGS INST. (Jan. 23, 2020), https://www.brookings.edu/research/georgias-1332-waiver-violates-the-aca-and-cannot-be-lawfully-approved/ [https://perma.cc/KBP2-YZCD].

[202] Richard A. Oppel Jr., Robert Gebeloff, K.K. Rebecca Lai, Will Wright & Mitch Smith, *The Fullest Look Yet at the Racial Inequity of Coronavirus*, N.Y. TIMES (July 5, 2020), https://www.nytimes.com/interactive/2020/07/05/us/coronavirus-latinos-african-americans-cdc-data.html [https://perma.cc/FCM7-EQGN].

[203] *See* Alanson W. Willcox, *The Public Health Service Act, 1944*, 7 SOC. SEC. BULL. 15, 15 (1944), https://www.ssa.gov/policy/docs/ssb/v7n8/v7n8p15.pdf [https://perma.cc/9URY-UYZX].

[204] Public Health Service Act, Pub. L. No. 78-410, 58 Stat. 682 (1944) (codified at 42 U.S.C. ch. 6A, §§ 201 to 300aaa-13).

[205] *See* 42 U.S.C. §§ 243 to 247d-12 (Federal-State Cooperation) (outlining and defining the HHS Secretary's authority to enforce quarantine regulations).

focuses on the example of the COVID-19 public health emergency response.

1. Federal Power to Address Public Health Emergencies

Federal executive and legislative public health emergency ("PHE") actions rely on states and localities. Like Medicaid, the PHSA has a pre-Federalism Revolution model — if a state does not accept federal money to implement an emergency response, no fallback exists to aid that state's residents or businesses.

Congress typically addresses national emergencies via "relief bills" that assist individuals, businesses, and state and local governments on a short-term basis, delivering economic aid, regulatory flexibilities, and other supports. Relief bills build on existing federal emergency and disaster laws, such as the Stafford Disaster Relief and Emergency Assistance Act of 1988, which amended the PHSA and provides authority for specific federal disaster response actions.[206] The federal government has limited, specific authority to act alone. In very particular circumstances, the President can order federal agencies to assist state residents directly; and PHSA section 361 authorizes the HHS Secretary to prevent the entry and spread of communicable diseases from foreign countries into the U.S. and between states.[207] CDC, an HHS sub-agency, can detain, examine, and release individuals crossing U.S. borders or traveling between states suspected of carrying communicable diseases during a PHE, but overall, the federal government has limited authority to force people to isolate or quarantine under the PHSA. The Surgeon General has power to prevent the spread of disease between states and to prevent disease from entering the nation.[208] Additionally, the ACA created the Prevention and Public Health Fund ("PPHF"), but this funding did not materialize as intended because the executive branch and Congress both redirected PPHF funds to other priorities, such as establishing the federal health insurance exchange.

[206] Disaster Relief and Emergency Assistance (Stafford) Act, Pub. L. No. 100-707, 102 Stat. 4689 (1988) (codified as amended at 42 U.S.C. ch. 68. §§ 5121-5208).

[207] 42 U.S.C. § 264.

[208] *See id.*; *see also* 42 C.F.R. pts. 70, 71 (2023) (explaining that the CDC also has some authority).

Federal/state partnership was built into congressional actions to address the COVID-19 PHE, starting with two relief bills enacted in March 2020. The Families First Coronavirus Response Act ("Families First Act")[209] and Coronavirus Aid, Relief, and Economic Security Act ("CARES Act")[210] offered loans to businesses, increased federal funding for health care services, and enhanced unemployment insurance benefits.[211] These COVID-19 relief bills followed a blueprint that uses pre-existing federal funding and programs to respond to unemployment surges and to relax regulatory standards to address increased demand on health care services. A later relief bill, the American Rescue Plan Act of 2021 ("ARPA"), had slightly more federal control than the CARES Act and Families First Act, directing funding for Biden administration priorities like implementation of the ACA.[212] ARPA provided new funding and directly addressed health matters like increased insurance coverage and testing and treatment for COVID-19.[213] Even with the stronger federal baseline, ARPA relied largely on states for implementation, such as an increased federal match for non-expansion

[209] Families First Coronavirus Response Act, Pub. L. No. 116-127, 134 Stat. 178 (2020) (codified at 42 U.S.C. § 1396d).

[210] Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, 134 Stat. 281 (2020).

[211] The Families First Act also required paid leave to care for COVID-positive relatives, the first federal law requiring paid leave. The FMLA of 1993 provides unpaid job protection and covers about 60% of the workforce, meaning full-time employees of large employers. Low-income and part-time workers remain unprotected, making it so they are much less likely to have job protection when a family member falls ill (or another such life event occurs). Families First Act protections ended December 31, 2020. *See* Families First Coronavirus Response Act § 3102, 134 Stat. at 189; *Families First Coronavirus Response Act: Employee Paid Leave Rights*, U.S. DEP'T OF LAB., https://www.dol.gov/agencies/whd/pandemic/ffcra-employee-paid-leave (last visited Oct. 12, 2023) [https://perma.cc/TAY7-FHCK]; *COVID-19 and the Family and Medical Leave Act Questions and Answers*, U.S. DEP'T OF LAB., https://www.dol.gov/agencies/whd/fmla/pandemic (last visited Oct. 12, 2023) [https://perma.cc/3PSK-PLGD].

[212] American Rescue Plan Act of 2021, Pub. L. No. 117-2, 135 Stat. 4.

[213] *See* Victor Reklaitis & Robert Schroeder, *All of President Biden's Key Executive Orders — in One Chart*, MARKETWATCH (Apr. 27, 2021, 11:50 AM EST), www.marketwatch.com/story/all-of-president-bidens-key-executive-orders-in-one-chart-2021-01-21?mod=mw_more_headlines [https://perma.cc/ZGC6-TRVL]; *The Biden-Harris Plan to Beat COVID-19*, THE WHITE HOUSE, www.whitehouse.gov/priorities/covid-19/ (last visited Aug. 12, 2023) [https://perma.cc/QB6A-3S5L].

states to opt-in to Medicaid expansion; increased SNAP funding; enhanced emergency rental assistance; and money for elementary and secondary schools to address pandemic-related conditions.[214] ARPA also enhanced navigator funding and federal subsidies in the exchanges, so people earning less than 150% of FPL had no premium to pay, and people earning more than 400% of FPL had capped costs, actions HHS could implement without states.[215] Likewise, paycheck protection was distributed to employers; and a child tax credit, which operated like Social Security, relied on federal implementation.[216]

Otherwise, the relief bills largely built on existing social programs, making state and local choices central to implementation. Depending on how they are counted, Congress enacted six relief bills during the COVID-19 PHE.[217] Like prior laws, they assumed state officials want both substantive and monetary federal assistance, and that the federal government could anticipate states would address collective needs with this assistance. Yet, after the first few months of the COVID-19 pandemic, some governors and other state officials started to veto federal relief, leading to disparate benefits from state to state. The lack of a federal fallback in emergency and disaster laws shows that state vetoes can amplify a crisis and exacerbate existing health, economic, and other inequities.[218]

[214] American Rescue Plan Act of 2021 § 9814, 135 Stat. at 215 (Medicaid); *id.* § 1103, 135 Stat. at 16 (SNAP); *id.* § 3201, 135 Stat. at 54 (rental assistance); *id.* § 2001, 135 Stat. at 19 (education).

[215] American Rescue Plan Act of 2021 § 9661; *see* Katie Keith, *HealthCare.gov Enrollment Up in First Two Weeks of COVID Special Enrollment Period*, HEALTH AFFS. BLOG (Mar. 3, 2021), https://www.healthaffairs.org/do/10.1377/hblog20210303.832465/full/ [https://perma.cc/32DF-493B].

[216] American Rescue Plan Act of 2021 § 5001, 135 Stat. at 81; *id.* § 9611, 135 Stat. at 144.

[217] *See, e.g.*, U.S. GOV'T ACCOUNTABILITY OFF., COVID-19 RELIEF: FUNDING AND SPENDING AS OF JAN. 31, 2023, at 1 (2023), https://www.gao.gov/assets/gao-23-106647.pdf [https://perma.cc/3QLN-7A4C] (summarizing six COVID-19 relief bills); *Here's Everything the Federal Government Has Done to Respond to the Coronavirus So Far*, PETER G. PETERSON FOUND. (Mar. 15, 2021), https://www.pgpf.org/blog/2021/03/heres-everything-congress-has-done-to-respond-to-the-coronavirus-so-far [https://perma.cc/EGZ6-BVMJ] (summarizing relief bills and tracking their funding).

[218] *See* Oppel et al., *supra* note 202.

2. Public Health Federalism — From State Management to State Vetoes

Emergency relief laws, in relying on federalism for implementation, build on states' prior policy choices. States with pre-existing social programs that are well run and funded are better equipped to take up federal emergency assistance because they have infrastructure that makes emergency aid easier to implement. States with underfunded or meager social programs have a harder path in responding to any emergency, even if they take up federal assistance, as they lack administrative capacity and often have health and economic disparities that make their populations less resilient. These dynamics existed before COVID but were exacerbated during the pandemic by state refusal to participate in programs like Medicaid expansion and state rules that made social program access harder, like work requirements for SNAP and TANF.[219]

In the case of responding to COVID, certain federal actions may have contributed to state vetoes. For example, President Trump undermined the ACA before the pandemic, as discussed above, and then avoided exercising unique power that federal law gives the President to respond quickly to national emergencies, devolving responsibilities to states and localities that the federal government should have addressed.[220] Federalism creates layers of governance, sometimes called "redundancy."[221] In theory, redundancy builds responsibility and expertise, providing backup so one official can pick up if another fails. However, these layers also can obfuscate accountability as well as necessitate constant horizontal and vertical coordination between local, state, and federal government officials, which creates more room for

[219] The Debt Ceiling deal that increased work requirement rules in SNAP will certainly impact the next PHE response. *See* Mary Clare Jalonick, *Changes to Food Aid in Debt Bill Would Cost Money, Far from Savings GOP Envisioned*, AP NEWS (May 31, 2023, 2:55 AM PDT), https://apnews.com/article/debt-bill-default-work-requirements-food-stamps-a42064f794b4466903ca06ca140b9013 [https://perma.cc/7VKD-3AWY].

[220] Michael D. Shear, Noah Weiland, Eric Lipton, Maggie Haberman & David E. Sanger, *Passing Off Virus Burden, White House Fueled Crisis*, N.Y. TIMES, July 19, 2020, at A1 (detailing the administration's goal and actions shifting pandemic responsibility to the states).

[221] *See* Hills, Jr., *supra* note 57, at 884.

error. Early redundancy was not possible despite the need for centralized decision-making and supports. Examples include the President telling governors "we're not a shipping clerk" and shifting purchasing and distributing personal protective equipment ("PPE") responsibility to state officials,[222] even though the federal government by law is responsible for disseminating stockpiled supplies.[223] The President also violated state and local containment orders, like mask-wearing, during public events.[224] As the pandemic advanced and the

[222] Quint Forgey, *"We're Not a Shipping Clerk": Trump Tells Governors to Step Up Efforts to Get Medical Supplies*, POLITICO (Mar. 19, 2020, 3:30 PM EDT), https://www.politico.com/news/2020/03/19/trump-governors-coronavirus-medical-supplies-137658 [https://perma.cc/36M3-FCED]; *see also* Jordan Fabian, *Trump Told Governors to Buy Own Virus Supplies, Then Outbid Them*, BLOOMBERG (Mar. 19, 2020, 1:42 PM PST), https://www.bloomberg.com/news/articles/2020-03-19/trump-told-governors-to-buy-own-virus-supplies-then-outbid-them [https://perma.cc/D5HJ-VLY3]; Olivia Rubin, Katherine Faulders, Soo Rin Kim & Laura Romero, *Despite Trump Claim, 13 States Say Some Orders for Coronavirus Supplies Still Unfilled*, ABC NEWS (July 23, 2020, 12:03 PM), https://abcnews.go.com/Health/trump-claim-12-states-orders-coronavirus-supplies-unfilled/story?id=71946598 [https://perma.cc/LF9U-HJX2].

[223] *See Bringing Resources to State, Local, Tribal & Territorial Governments*, FEMA, https://www.fema.gov/disasters/coronavirus/governments (last visited Aug. 12, 2023) [https://perma.cc/73DJ-H96Z] (describing FEMA's role and use of the Defense Production Act during a national emergency).

[224] Jess Bidgood, *"If He Believes He Doesn't Need a Mask, Good for Him": Despite Trump's Illness, Supporters Still Aren't Sure About Masks* (Oct. 5, 2020, 3:40 AM), BOS. GLOBE, https://www.bostonglobe.com/2020/10/04/nation/trumps-positive-covid-test-doesnt-change-views-some-supporters-wearing-masks/ [https://perma.cc/7SRB-2LRR] (reporting Trump supporters' refusal to wear masks and approval of the President's decision not to wear them); *see also* Teo Armus, *A GOP County Chair Asked Trump to Wear a Mask to His Rally. Instead, Trump Mocked Pandemic Restrictions*, WASH. POST (Sept. 9, 2020, 6:47 AM EDT), https://www.washingtonpost.com/nation/2020/09/09/trump-rally-masks-nc/ [https://perma.cc/7Y9E-7T5N]; Timothy Bella, *"Shameful, Dangerous and Irresponsible": Nevada Governor Blasts Trump for Indoor Rally Against State Rules*, WASH. POST (Sept. 14, 2020, 6:16 AM EDT), https://www.washingtonpost.com/nation/2020/09/14/trump-nevada-rally-coronavirus-sisolak/ [https://perma.cc/3YGP-B5VC]. The President had a COVID-19 infection in early October 2020 but did not share the information immediately, potentially making him contagious on the campaign trail. *See* Michael. C. Bender & Rebecca Ballhaus, *Trump Didn't Disclose First Positive Covid-19 Test While Awaiting a Second Test on Thursday*, WALL ST. J. (Oct. 4, 2020, 6:21 PM EST), https://www.wsj.com/articles/trump-didnt-disclose-first-positive-covid-19-test-while-awaiting-a-second-test-on-thursday-11601844813 [https://perma.cc/AL7S-LSX9].

virus mutated, he further encouraged resisting state and local containment orders.[225]

These actions had the legal effect of removing federal supports but also the expressive value of emboldening resistance to public health rules that had concrete ramifications; for example, a study found where less COVID testing occurred and local officials responsible for death certificates were politically less likely to name cause of death as COVID-19, COVID-19 deaths were undercounted.[226] An exclusively state-based response could not adequately address a national public health emergency, precisely the reason federal law creates resources such as a national stockpile under the Defense Production Act.[227]

In a parallel to federal law, state laws give governors special power during emergencies, which were used to contain viral transmission through measures such as closing schools, churches, and businesses.[228] But, after a couple of months of such measures, some governors followed President Trump's lead — echoing the politics surrounding implementation of the ACA. The FDA's emergency use vaccine approvals began December 11, 2020, so non-pharmaceutical interventions ("NPIs") like masking and social distancing were the primary tool for controlling spread of novel coronavirus throughout 2020 and into the early part of 2021.[229] Some state officials implemented

[225] President Trump tweeted "liberate Michigan," inspiring attempted kidnapping of the governor that was a protest against COVID containment measures. Lauren del Valle, *Man Pleads Guilty in Plot to Kidnap Michigan Gov. Gretchen Whitmer*, CNN (Jan. 27, 2021, 6:20 PM EST), https://www.cnn.com/2021/01/27/politics/gretchen-whitmer-kidnapping-plot/index.html [https://perma.cc/63K9-3YYJ].

[226] Olivia Goldhill, *Undercounting of Covid-19 Deaths Is Greatest in Pro-Trump Areas, Analysis Shows*, STAT NEWS (Jan. 25, 2021), https://www.statnews.com/2021/01/25/undercounting-covid-19-deaths-greatest-in-pro-trump-areas-analysis-shows/ [https://perma.cc/9M5V-MJRS].

[227] 50 U.S.C. § 4502.

[228] *See* JULIA RAIFMAN, KRISTEN NOCKA, DAVID K. JONES, JACOB BOR, SARAH KETCHEN LIPSON, JONATHAN JAY & PHILIP CHAN, COVID-19 US STATE POLICY DATABASE (2020), www.statepolicies.com [https://perma.cc/M5ZT-YT2E] (tracking a wide variety of state pandemic containment actions and related rules).

[229] *See* Press Release, Food & Drug Admin., FDA Takes Key Action in Fight Against COVID-19 By Issuing Emergency Use Authorization for First COVID-19 Vaccine (Dec. 11, 2020), https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-

NPIs and kept them in place as infection rates spiked, like Washington and California, while others like Texas and South Dakota reopened quickly from the original NPIs and then resisted further containment measures.[230] South Dakota had an outbreak after foregoing most NPI and hosting a motorcycle rally in the summer of 2020, causing infection spikes in neighboring states and demonstrating the need for collective action, not just state by state improvisation.[231] In some states, such as Missouri, governors refused to adopt containment measures suggested by federal experts, leaving decisions and implementation to local officials.[232] In others, like Mississippi and Texas, governors *limited local authority* for issuing containment rules, contrary to scientific evidence and creating a micro-federalism (or "new preemption") dimension of conflict.[233]

fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19 [https://perma.cc/U9XJ-ZNF3].

[230] Texas continued the pattern when Governor Abbott decided to eliminate mask wearing and other NPI requirements in March 2021, which President Biden denigrated as "Neanderthal thinking." *Covid: Biden Says "Neanderthal Thinking" Behind Lifting of Mask Rules*, BBC NEWS (Mar. 4, 2021), https://www.bbc.com/news/world-us-canada-56275103 [https://perma.cc/GEQ9-MYJ5]. Mississippi also made similar moves. Sarah Haselhorst, *In Mississippi, Gov. Tate Reeves Says Masks Will No Longer Be Mandatory. Just Encouraged.*, CLARION LEDGER (Mar. 2, 2021, 6:11 PM CDT), https://www.clarionledger.com/story/news/2021/03/02/reeves-new-executive-order-do-away-mississippi-mask-mandates/6892805002/ [https://perma.cc/N7FB-AAAY].

[231] Rosalind J. Carter, Dale A. Rose, Rebecca T. Sabo, Joshua Clayton, Jonathan Steinberg & Mark Anderson, *Widespread Severe Acute Respiratory Syndrome Coronavirus 2 Transmission Among Attendees at a Large Motorcycle Rally and their Contacts, 30 US Jurisdictions, August–September, 2020*, 73 CLINICAL INFECTIOUS DISEASES, July 2021, at S106.

[232] *See* Jim Salter, *Missouri's COVID-19 Response in Spotlight at Governor Forum*, U.S. NEWS (Oct. 9, 2020), https://www.usnews.com/news/best-states/missouri/articles/2020-10-09/missouris-covid-19-response-in-spotlight-at-governor-forum. Missouri's health department did not share studies indicating masking's efficacy. Rudi Keller, Derek Kravitz & Smarth Gupta, *Missouri Health Department Found Mask Mandates Work, But Didn't Make Findings Public*, MO. INDEP. (Dec. 1, 2021, 2:21 PM EST), https://missouriindependent.com/2021/12/01/missouri-health-department-found-mask-mandates-work-but-didnt-make-findings-public/ [https://perma.cc/4XEL-FXKP].

[233] *See* Adam Gabbatt, *Which States Have Done the Least To Contain Coronavirus?*, GUARDIAN (April 3, 2020, 4:11 PM EDT), https://www.theguardian.com/world/2020/apr/03/coronavirus-states-response-who-has-done-least-alabama-oklahoma-missouri [https://perma.cc/NA6R-VYGZ]; *see also* Richard Briffault, *The New Preemption: Placing*

Research has shown that states with the least stringent measures had the worst outbreaks,[234] and studies have documented that people of color who are low income and high exposure suffered more extreme disparities where states implemented less stringent NPI.[235] Temporal dissimilarities also contributed to the severity of COVID outbreaks. At first, states were in sync with "lockdown" in March and April 2020, but then state and local NPIs began to vary. By summer 2020, some states re-opened, contributing to a spike in infections across the Midwest and South and leading to another wave of stringent NPIs.[236] A third wave of containment measures occurred after Thanksgiving gatherings led to outbreaks that again flooded hospitals with COVID-19 cases through the end of 2020 and into early 2021.[237] The early 2021 Delta and Omicron variants had more inconsistent state and local responses. When vaccination became available in 2021, some states relaxed, or even limited, local NPI measures and some banned vaccine-related requirements.[238] These policy choices fueled infection and death spikes

Cities in American Federalism, *in* CITIES IN FEDERAL CONSTITUTIONAL THEORY 99, 99-103 (Erika Arban ed., 2022) (observing how state preemption of city policies has taken a punitive turn and using COVID-19 as an example); Richard Briffault, *The Challenge of the New Preemption*, 70 STAN. L. REV. 1995, 2004-05 (2018).

[234] *See Covid-19 Government Response Tracker*, UNIV. OF OXFORD BLAVATNIK SCH. OF GOV'T, https://www.bsg.ox.ac.uk/research/research-projects/coronavirus-government-response-tracker (last visited Aug. 13, 2023) [https://perma.cc/B3QU-W9CQ] [hereinafter *Coronavirus Tracker*]; *see also* Laura Hallas, Ariq Hatibie, Rachelle Koch, Saptarshi Majumdar, Monika Pyarali, Andrew Wood & Thomas Hale, *Variation in US States' Responses to COVID-19* 10-16 (Univ. of Oxford Blavatnik Sch. of Gov't, Working Paper No. 2020/034, version 3.0 2021), https://www.bsg.ox.ac.uk/sites/default/files/2021-05/BSG-WP-2020-034-v3.pdf [https://perma.cc/GU8T-KG9K].

[235] *See* Dielle J. Lundberg, Elizabeth Wrigley-Field, Ahyoung Cho, Rafeya Raquib, Elaine O. Nsoesie, Eugenio Paglino, Ruijia Chen, Mathew V. Kiang, Alicia R. Riley, Yea-Hung Chen, Marie-Laure Charpignon, Katherine Hempstead, Samuel H. Preston, Irma T. Elo, M. Maria Glymour & Andrew C. Stokes, *COVID-19 Mortality by Race and Ethnicity in US Metropolitan and Nonmetropolitan Areas, March 2020 to February 2022*, 6 JAMA NETWORK OPEN, May 2023, at 1, 2 (surveying early literature on disproportionate COVID deaths among racial minorities).

[236] *See* Hallas et al., *supra* note 234, at 20.

[237] *Id.* at 10-18.

[238] *See State Efforts to Limit or Enforce COVID-19 Vaccine Mandates*, NAT'L ACAD. FOR STATE HEALTH POL'Y, https://nashp.org/state-efforts-to-ban-or-enforce-covid-19-

into the summer and as the 2021-22 school year began, especially in Southern states, which had the lowest vaccination rates.[239] Contrary to CDC guidance, in September 2021 nine states prohibited school mask-wearing requirements or required school districts to allow families to opt out for any reason, some of which courts blocked or school boards ignored (Arizona, Arkansas, Florida, Iowa, Oklahoma, South Carolina, Tennessee, Texas, Utah); nineteen states including D.C. required masks; and the others left NPI decisions to local officials.[240] States limiting NPI also banned vaccination and verification requirements,[241] and they had spikes in coronavirus infections and deaths when Delta became dominant.[242] Arkansas's governor, among others, expressed regret for signing the bill banning mask-wearing as infection and death rates spiked in August 2021.[243]

Governors and attorneys general also challenged the federal eviction moratorium and vaccine rules for federal contractors,[244] workplaces,

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vaccine-mandates-and-passports/ (last updated June 30, 2023) [https://perma.cc/J3KZ-7Q4T].

[239] *See* Blake Farmer, *Why Are Southern States Lagging in Vaccinations?*, NPR (May 31, 2021, 3:50 AM EST), https://www.npr.org/2021/05/31/1001823407/why-are-southern-states-lagging-in-vaccinations [https://perma.cc/24V8-WBUZ]; *See How Vaccinations Are Going in Your County and State*, N.Y. TIMES (Oct. 20, 2022), https://www.nytimes.com/interactive/2020/us/covid-19-vaccine-doses.html [https://perma.cc/BND8-AYK2] (showing sortable data by state and county); *Vaccines*, JOHNS HOPKINS CORONAVIRUS RES. CTR., https://coronavirus.jhu.edu/vaccines (last visited Sep. 4, 2023) [https://perma.cc/9TFX-AENM] (providing data allowing comparisons among states for vaccine policies and infection rates).

[240] *See* Stacey Decker, *Which States Banned Mask Mandates in Schools, and Which Require Masks?*, EDUC. WK., www.edweek.org/policy-politics/which-states-ban-mask-mandates-in-schools-and-which-require-masks/2021/08 (last updated July 8, 2022) [https://perma.cc/FHW3-C5VX].

[241] *See State Efforts to Limit or Enforce COVID-19 Vaccine Mandates*, *supra* note 238.

[242] *Tracking Coronavirus Vaccinations and Outbreaks in the U.S.*, REUTERS, https://graphics.reuters.com/HEALTH-CORONAVIRUS/USA-TRENDS/dgkvlgkrkpb/ (last updated July 15, 2022) [https://perma.cc/3DWJ-UPTX].

[243] Josie Fischels, *Arkansas Governor Wants To Reverse a Law That Forbids Schools to Require Masks*, NPR (Aug. 4, 2021, 8:23 PM EST), www.npr.org/2021/08/04/1024939859/arkansas-governor-reverse-law-let-schools-require-masks [https://perma.cc/54C9-REAF].

[244] Georgia v. Biden, 574 F. Supp. 3d 1337, 1344 (S.D. Ga. 2021); Exec. Order No. 14042, 86 Fed. Reg. 50985 (Sept. 9, 2021).

and health care providers, as described in Part I.[245] These federal rules were issued because state officials would not promote or require vaccination. Nevertheless, the justices agreed with states' positions in many of these cases.[246]

This sketch shows how state responses grew beyond "uncooperative" through the course of the pandemic, developing into vetoes and stymieing policies designed to protect public health. Relatedly, from 2020–2022, nearly half of state legislatures limited executive emergency powers and/or added oversight to emergency actions.[247] Advocates claimed oversight served separation of powers and inter-branch balance, but limiting emergency powers also may contribute to a slower governmental response that will make public health officials' everyday jobs and emergency responses harder in the future. Some states also limited emergency executive authority for local governments (Utah), required review and approval of local NPI orders (Kansas), and created

[245] Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination, 86 Fed. Reg. 61555 (Nov. 5, 2021) (codified at 42 C.F.R. pts. 416, 418, 441, 460, 482, 483, 484, 485, 486, 491 and 494).

[246] In *Biden v. Missouri*, 595 U.S. 87 (2022), the majority sided with HHS to allow vaccination rules in health care settings, but the dissent would have left such issues to the states for failure of clear statements regarding vaccination rules in the Medicare and Medicaid Acts. *Id.* at 94-96 (finding HHS could require health care providers to be vaccinated during the pandemic and disagreeing with the dissenters' concern that such a rule requires congressional clear statements to protect federalism dynamics). In *NFIB v. Occupational Safety and Health Administration*, 595 U.S. 109 (2022), the Court sided with the OSHA vaccine rule's challengers, holding OSHA does not have general public health authority but that states do, made more pointed in Justice Gorsuch's concurrence. *Id.* at 121 (Gorsuch, J., concurring). Lower court decisions did not approve of either measure. *See* Missouri v. Biden, 571 F. Supp. 3d 1079, 1086-87 (E.D. Mo. 2021); Louisiana v. Becerra, 571 F. Supp. 3d 516, 537 (W.D. La. 2021).

[247] *See Legislative Oversight of Emergency Executive Powers*, NAT'L CONFERENCE OF STATE LEGISLATURES, https://www.ncsl.org/research/about-state-legislatures/legislative-oversight-of-executive-orders.aspx (last updated Sept. 26, 2022) [https://perma.cc/9QC7-MF9U]; NETWORK FOR PUB. HEALTH L. & NACCHO, PROPOSED LIMITS ON PUBLIC HEALTH AUTHORITY: DANGEROUS FOR PUBLIC HEALTH 1 (2021), https://www.naccho.org/uploads/downloadable-resources/Proposed-Limits-on-Public-Health-Authority-Dangerous-for-Public-Health-FINAL-5.24.21pm.pdf [https://perma.cc/F4VP-F5YG]; David A. Lieb, *State Lawmakers Are Pushing To Curb Governors' Virus Powers*, AP NEWS (Jan. 28, 2021, 2:40 PM MST), https://apnews.com/article/state-lawmakers-governor-coronavirus-7d5710f2d8aa4e659c0ec68400ad3d3c [https://perma.cc/68CW-KC2M].

civil actions to challenge local NPI measures for religious organizations (Kansas and Montana).[248]

Historically, public health in everyday and emergency circumstances relied on state and local funding and operationalization with federal guidance and money. However, state leaders made decisions during the pandemic that magnified prior policy decisions to neglect public health efforts, discussed next.

3. Fiscal Neglect and Governance Capacity

Public health spending increased 113.1% in 2020,[249] a remarkable increase possible only because public health has been underfunded for many years.[250] Public health professionals sometimes joke that the punchline when they succeed is "nothing happened." The idea is that public health delivers normal life for the ongoing effort required to prevent illnesses, injuries, and disasters. This "nothing happened" punchline makes it easier for state and local government to neglect funding because public health can be invisible — people tend not to think much about clean water, safe food, seatbelts in cars, easily

[248] NETWORK FOR PUB. HEALTH L. & NACCHO, *supra* note 247, at 6-7, 9; *Sentinel Surveillance of Emerging Laws Limiting Public Health Emergency Orders*, LAWATLAS (May 20, 2022), https://lawatlas.org/datasets/sentinel-surveillance-laws-limiting-public-health-authority [https://perma.cc/J37T-5P3A].

[249] Micah Hartman, Anne B. Martin, Benjamin Washington, Aaron Catlin & The Nat'l Health Expenditure Accts. Team, *National Health Care Spending in 2020: Growth Driven by Federal Spending in Response to the COVID-19 Pandemic*, 41 HEALTH AFFS. 13, 16-17 (2022). The Centers for Medicare and Medicaid Services Office of the Actuary defines "public health expenditure" to include federal, state, and local "provision of population-based health care services, including epidemiological surveillance, immunization and vaccination services, and disease prevention programs. In 2020 federal public health expenditures accounted for 57 percent of all public health spending, whereas typically the federal portion accounts for less than 15 percent of such spending overall." *Id.* at 20.

[250] Isabella Cueto, *"Disaster to Disaster": Underinvestment in Public Health Systems Obstructs Response to Covid, Monkeypox, Walensky Says*, STAT NEWS (Sept. 23, 2022), https://www.statnews.com/2022/09/23/disaster-to-disaster-underinvestment-in-public-health-systems-obstructs-response-to-covid-monkeypox-walensky-says/ [https://perma.cc/Z5X5-PNJ2] ("[T]he agency is still grappling with some of the same problems that slowed the response to Covid . . . . A major issue is infrastructure — the money states and cities have not spent on beefing up their public health departments, data systems and other essential services.").

available childhood vaccines, smoke free workplaces, etc. — because successes tend not to grab headlines.[251] Occasionally a crisis like the opioid epidemic draws public interest, and therefore money, but public health is easy for politicians to ignore in annual state budget cycles because it does not usually draw much attention.

Public health also has countercyclical economic traits: state budgets experience pressure at the same time that tax revenue declines during an emergency or disaster. With Congress's ability to deficit spend, federal public health funding is indispensable.[252] While public health activities have accounted for less than three percent of all national health expenditures, the U.S. spends roughly eighteen percent of its gross domestic product on individual medical care — more than any other Organisation for Economic Co-operation and Development ("OECD") nation[253] — yet the U.S. had poor health outcomes relative to other nations well before the pandemic, exacerbating the "worst outbreak in the world."[254] In evaluating public health spending at the national level, it can be difficult to separate public health from individual medical care because public health spending data sometimes contains payments for individual care. This makes the commonly cited

[251] *See Morbidity and Mortality Weekly Report: Ten Great Public Health Achievements — United States, 2001–2010*, CTRS. FOR DISEASE CONTROL & PREVENTION (May 20, 2011), https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6019a5.htm [https://perma.cc/4EPE-M5MU].

[252] *See* Super, *Rethinking Fiscal Federalism*, *supra* note 123, at 2586-88 (states' political and budgetary structures render them unable to support social services when economic and other emergencies occur).

[253] Munira Z. Gunja, Evan D. Gumas & Reginald D. Williams II, *U.S. Health Care from a Global Perspective, 2022: Accelerating Spending, Worsening Outcomes*, THE COMMONWEALTH FUND (Jan. 31, 2023), https://www.commonwealthfund.org/publications/issue-briefs/2023/jan/us-health-care-global-perspective-2022 [https://perma.cc/6Y9M-8EVE]; OECD, HEALTH AT A GLANCE 2021: OECD INDICATORS, HIGHLIGHTS FOR THE UNITED STATES (2021), https://www.oecd.org/unitedstates/health-at-a-glance-US-EN.pdf [https://perma.cc/AW8Y-CYZF].

[254] *See* Benjamin Mueller & Eleanor Lutz, *U.S. Has Far Higher COVID Death Rate than Other Wealthy Countries*, N.Y. TIMES (Feb. 1, 2022), https://www.nytimes.com/interactive/2022/02/01/science/covid-deaths-united-states.html [https://perma.cc/DG22-ZGK9].

figure that the U.S. directs 2.5% of all national health spending to public health an *over*estimate.[255]

Layers of public health governance facilitate this underfunding, as hidden policymaking allows for blame-shifting between federal, state, and local agencies. State and local governments historically piloted public health activities, so were the primary funders. However, every state must have a balanced annual budget, so lawmakers cut public health funding rather than items like education. Needless to say, public health spending varies greatly from state to state, within states, and across years; but, statistics show that public health has been widely deprioritized through state and local defunding, and spending has stagnated or declined.[256] National health expenditures climb upward year after year, increasing by 4.3% from 2008 to 2018; average economic growth was 3.3% in the same decade, but state public health expenditures on average decreased from $80.40 to $78.80 per person in the same timeframe, a trend critical to understanding the U.S. COVID-19 response.[257] One study estimated states spent $1.90 per person on

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[255] *See, e.g.*, Jonathon P. Leider, Beth Resnick, J. Mac McCullough, Y. Natalia Alfonso & David Bishai, *Inaccuracy of Official Estimates of Public Health Spending in the United States, 2000–2018*, 110 AM. J. PUB. HEALTH S194 (2020) (evaluating state public health expenditure data for accuracy of reporting and concluding that state public health spending is overstated by billions of dollars each year).

[256] TRUST FOR AMERICA'S HEALTH, THE IMPACT OF CHRONIC UNDERFUNDING ON AMERICA'S PUBLIC HEALTH SYSTEM: TRENDS, RISKS, AND RECOMMENDATIONS, 2020, at 3 (2020), https://www.tfah.org/report-details/publichealthfunding2020/ [https://perma.cc/KK4V-H9T3] [hereinafter TRUST FOR AMERICA'S HEALTH 2020]; *see also* TRUST FOR AMERICA'S HEALTH, THE IMPACT OF CHRONIC UNDERFUNDING ON AMERICA'S PUBLIC HEALTH SYSTEM: TRENDS, RISKS, AND RECOMMENDATIONS, 2022, at 4 (2022), https://www.tfah.org/wp-content/uploads/2022/07/2022PublicHealthFundingFINAL.pdf [https://perma.cc/J8T6-6F92] [hereinafter TRUST FOR AMERICA'S HEALTH 2022].

[257] Y. Natalia Alfonso, Jonathon P. Leider, Beth Resnick, J. Mac McCullough & David Bishai, *US Public Health Neglected: Flat or Declining Spending Left States Ill Equipped to Respond to COVID-19*, 40 HEALTH AFFS. 664, 668 (2021). "Flat public health spending coincided with observed declines in life expectancy, pervasive health disparities, and rising mortality rates, especially for White Americans ages 45–65. Public health spending remained flat despite the Trump administration's declaration in October 2017 that the opioid crisis was a public health emergency. Similarly, total public health spending showed no response to the decade's major public health events such as the emergence or reemergence of Ebola, Zika virus, West Nile virus, Middle East Respiratory Syndrome, measles, and other communicable diseases." *Id.* at 668-69.

public health preparedness in this ten-year time period but that COVID-19 cost nearly $50,000 per person.[258]

Longer-term trends show defunding affected the length of tenure for public health officials and limited the ability to do daily public health work. The National Association of County and City Health Officials ("NACCHO") issues regular reports on infrastructure, *i.e.* activities, workforce, funding, and priorities, for the nation's 2,800 local health departments ("LHD").[259] LHD employees decreased from 184,000 in 2008 to 153,000 in 2019, and average LHD expenditures decreased from eighty dollars per person in 2008 to fifty-six dollars in 2019, with some states having lower expenditures (thirty dollars per capita in seventeen states) and some higher (above seventy dollars in eight states).[260] NACCHO reports that LHD leadership resigned earlier: "Since 2013, the percentage of top executives who have been in their positions less than five years has increased, while the percentage of top executives who have been in their positions for six or more years has decreased."[261] Large LHDs, which serve more than half of the population, had shorter leadership tenures.[262] In addition, local health departments lost staff, with 5.2 full time employees ("FTE") per 10,000 people in 2008 declining to 4.1 FTE in 2019; large LHDs had greater workforce loss.[263] Less leadership, shorter tenures, fewer staff, and less funding meant maintaining a basic level of state and local public health capacity was near impossible.

Evidence indicates that the structure of health departments is also a factor. Four types of governance structure are common, and more variation exists within each structure. Some health departments are locally governed, meaning LHDs are run (funded and staffed) by local government; some are centrally run by state government (funded and

[258] *Id.* at 669.

[259] NAT'L ASS'N OF CNTY. & CITY HEALTH OFFS., 2019 NATIONAL PROFILE OF LOCAL HEALTH DEPARTMENTS (2019), https://www.naccho.org/uploads/downloadable-resources/Programs/Public-Health-Infrastructure/NACCHO_2019_Profile_final.pdf [https://perma.cc/N4VH-TMUM].

[260] *Id.* at 53, 69.

[261] *Id.* at 42-46.

[262] *Id.* at 22, 43.

[263] *Id.* at 54.

staffed); some are "shared," with a hybrid of both state and local authority, which can mean state funding and local staffing or state employees with some local decision-making; and some are mixed, which means more than one governance type exists within a state.[264] States with centralized health departments spend more on public health per capita ($186 compared with $69 in one study), though some decentralized states like Massachusetts report high per capita spending, in part due to robust funding and in part due to public hospital expenses being categorized as public health.[265] Such structural fragmentation and variability makes tracking public health spending challenging, and data often relies on self-reporting by public health officials.

Further, the U.S. does not have a centralized system for defining public health governance, structures, or funding, partly because public health authority is divided and subdivided for every task: horizontally among some twenty federal administrative agencies, and vertically between these federal agencies and 2,800 state and local public health departments. While federalism's divided governance is said to bring policy response closer to the people, federalism also poses a risk. Disuniform state structures and policies not only impacted local infection and mortality rates during COVID-19, but also states' heterogeneous decision-making affected neighboring states' efforts to contain coronavirus, suggesting state and local actions affected national efficacy in responding to a public health emergency.[266]

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[264] MICHAEL MEIT, ALANA KNUDSON, ILANA DICKMAN, ALEXA BROWN, NAOMI HERNANDEZ & JESSICA KRONSTADT, NORC, AN EXAMINATION OF PUBLIC HEALTH FINANCING IN THE UNITED STATES 19 (2013), https://www.norc.org/PDFs/PH%20Financing%20Report%20-%20Final.pdf [https://perma.cc/4HUQ-ZB83].

[265] *Id.* at 19-20.

[266] One study memorably calls this a "loss from anarchy." David Holtz, Michael Zhao, Seth G. Benzell, Cathy Y. Cao, M. Amin Rahimian, Jeremy Yang, Jennifer Allen, Avinash Collis, Alex Moehring, Tara Sowrirajan, Dipayan Ghosh, Yunhao Zhang, Paramveer S. Dhillon, Christos Nicolaides, Dean Eckles & Sinan Aral, *Interdependence and the Cost of Uncoordinated Responses to COVID-19* 1, 68 (Working Paper, 2020), https://osf.io/b9psy/ [https://perma.cc/NUX4-D5BE] ("[T]he contact patterns of people in a given region are significantly influenced by the policies and behaviors of people in other, sometimes distant, regions. When just one third of a state's social and geographic peer states adopt shelter in place policies, it creates a reduction in mobility equal to the state's own policy decisions. These spillovers are mediated by peer travel and distancing behaviors in those

As with Medicaid, states cannot go it alone in public health and increasingly rely on federal money and support. However, federal agencies responsible for public health do not have a large workforce and their mission often leads to indirect influence rather than direct actions.[267] For example, the CDC is tasked with scientific research, data collection, and surveillance. It was not created explicitly by statute but rather is a subagency that carries out HHS's statutory responsibilities for public health, though CDC now is referenced throughout laws pertaining to federal public health efforts.[268] CDC influences state and local officials' actions with scientific guidance and money but does not have power to compel action.[269] In the last decade CDC's funding was nearly flat, remaining close to 2008 levels.[270] CDC provides funding for projects and programs but not unlimited funding for states like Medicaid. In other words, CDC has money and expertise but no power to enforce its guidance or to correct state misdirection of federal money.[271] Other HHS agencies such as CMS, FDA, Health Resources and

states . . . . These results suggest a substantial cost of uncoordinated government responses to COVID-19 when people, ideas, and media move across borders.").

[267] David U. Himmelstein & Steffie Woolhandler, *Public Health's Falling Share of US Health Spending*, 106 AM. J. PUB. HEALTH 56, 57 (2016) (finding federal funding was decreasing, and sharing the concerns of the Institute of Medicine that public health funding was both disproportionate to individual medical care and inadequate to public health needs); see also Georges C. Benjamin, *The Future of Public Health: Ensuring an Adequate Infrastructure*, 101 MILBANK Q. 637, 644-48(2023) (describing and evaluating deficiencies in public health infrastructure, including personnel, structure, and funding).

[268] KAVYA SEKAR, CONG. RSCH. SERV., R47207, CENTERS FOR DISEASE CONTROL AND PREVENTION (CDC) FUNDING OVERVIEW 1 (2023).

[269] *See* Brenda Goodman, *CDC Announces Sweeping Reorganization, Aimed at Changing the Agency's Culture and Restoring Public Trust*, CNN (Aug. 17, 2022, 1:41 PM EDT), https://www.cnn.com/2022/08/17/health/cdc-announces-sweeping-changes/index.html [https://perma.cc/U5CU-V3VD].

[270] *New Report: Funding for Public Health Has Declined Significantly since the Great Recession*, TRUST FOR AM.'S HEALTH (Mar. 1, 2018), https://www.tfah.org/article/new-report-funding-for-public-health-has-declined-significantly-since-the-great-recession/ [https://perma.cc/Z5V8-6WTF].

[271] *See* Sharon LaFraniere & Noah Weiland, *Walensky, Citing Botched Pandemic Response, Calls for C.D.C. Reorganization*, N.Y. TIMES (Aug. 17, 2022), https://www.nytimes.com/2022/08/17/us/politics/cdc-rochelle-walensky-covid.html

Services Administration ("HRSA"), and Substance Abuse and Mental Health Services Administration ("SAMHSA") also are responsible for public health, but their efforts are underfunded too compared to money dedicated to individual medical care.

Another federal piece of the public health federalism puzzle is Medicaid, which offers funding and regulatory flexibilities that make it central to emergency response.[272] Medicaid's role in an emergency is supported by four features: eligibility rules that make coverage available whenever it is needed; comprehensive benefits that cover more medical care than other payers, including Medicare and commercial insurers; limited out-of-pocket payments, which are a barrier to coverage and care for low-income patients; and a statutory entitlement for beneficiaries and states.[273] Federal matching funds are guaranteed for states' Medicaid services and administration, and the poorest states receive the highest federal match. Additionally, Medicaid's countercyclical spending supports states during economic downturns. As described above, the blueprint for relief bills is to increase Medicaid's federal match,[274] like the Families First Act did by offering states a 6.2 percentage point increase in federal matching funds for non-expansion beneficiaries (expansion enrollees have the highest federal match, at ninety percent) for the duration of the PHE.[275] The enhanced match is conditioned on "maintenance of effort" ("MOE"), which means states must maintain eligibility and continuous enrollment for the duration of the federal PHE, which ended on May 11, 2023.[276] Because Medicaid has

[https://perma.cc/2HXP-VQRF]; *see generally* SEKAR, *supra* note 268 (describing CDC funding and how it relies on states and localities).

[272] Huberfeld & Watson, *supra* note 140, at 103-04.

[273] Nicole Huberfeld, Sidney Watson & Alison Barkoff, *Struggle for the Soul of Medicaid*, 48 J.L. MED. & ETHICS 429, 429-30 (2020).

[274] American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, 123 Stat. 115 (minimum increase of 6.2 percentage points); Jobs and Growth Tax Relief Reconciliation Act of 2003, Pub. L. No. 108-27, 117 Stat. 752 (increased Federal Medical Assistance Percentage ("FMAP") by 2.95 percentage points for a year and a quarter).

[275] Families First Coronavirus Response Act, Pub. L. No. 116-127, § 6008, 134 Stat. 178, 208 (2020) (codified at 42 U.S.C. § 1396d).

[276] Press Release, U.S. Dep't of Health & Human Servs., Fact Sheet: COVID-19 Public Health Emergency Transition Roadmap (Feb. 9, 2023), https://www.hhs.gov/about/news/

no federal fallback, states that have weaker programs, like non-expansion states, have less capacity to use additional federal supports during a PHE and appear likely to disenroll the most people when the PHE ends.[277]

If state and local public health departments are depleted, then public health response at the federal level is weakened, too, because PHE response cannot occur without state and local partnership. As the frontline officials and actors in public health activities,[278] state and local public health departments were key to containment of the spread of novel coronavirus.[279] Most states unevenly funded or defunded public health departments, so they did not have an adequate workforce to enforce containment efforts.[280] Defunded public health staff faced massive containment and vaccine rollout efforts without resources adequate to the tasks.[281] Rather than the redundancy some federalism

2023/02/09/fact-sheet-covid-19-public-health-emergency-transition-roadmap.html [https://perma.cc/4MGM-5ELV].

[277] Jennifer Tolbert & Meghana Ammula, *10 Things to Know About the Unwinding of the Medicaid Continuous Enrollment Provision*, KFF (June 9, 2023), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-the-unwinding-of-the-medicaid-continuous-enrollment-provision/ [https://perma.cc/RJZ7-4XAZ].

[278] WENDY K. MARINER, GEORGE J. ANNAS, NICOLE HUBERFELD & MICHAEL R. ULRICH, PUBLIC HEALTH LAW 18-20, 63-194 (3d ed. 2019); *see also Health Department Governance: State and Local Health Department Governance Classification Map*, CDC (Nov. 25, 2022), https://www.cdc.gov/publichealthgateway/sitesgovernance/index.html [https://perma.cc/KCN4-P9F3].

[279] *See* Lawrence O. Gostin & Lindsay F. Wiley, *Governmental Public Health Powers During the COVID-19 Pandemic: Stay-at-Home Orders, Business Closures, and Travel Restrictions*, 323 JAMA 2137 (2020).

[280] *See* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 4002, 124 Stat. 119, 541 (2010) (establishing the Prevention and Public Health Fund "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs," but as discussed in Part II.B.1, the fund was pillaged for other purposes, leaving states and localities in a precarious funding position); TRUST FOR AMERICA'S HEALTH 2020, *supra* note 256, at 29; Himmelstein & Woolhandler, *supra* note 267, at 56-57.

[281] President Trump's appointees reportedly resisted giving more money to states for vaccine rollout. Nicholas Florko, *Trump Officials Actively Lobbied to Deny States Money for Vaccine Rollout Last Fall*, STAT NEWS (Jan. 31, 2021), https://www.statnews.com/2021/01/31/trump-officials-lobbied-to-deny-states-money-for-vaccine-rollout/ [https://perma.cc/F7C6-59MU].

experts imagined, public health federalism seems to have made it easier for local, state, and federal government officials to make long term funding decisions that neglected everyday public health and left little time, money, or expertise for new threats. Infusion of resources does not automatically translate to effective action, but adequate funding improves the odds.

Fiscal neglect; fragmented, opaque, and decentralized authority; weakened public health departments; speeded turnover of leadership — all of these factors decreased the amount of public health work that could be done, now aggravated by the weakening of public health authority across nearly half of states.[282] This Part has explored the high stakes game old federal health laws with no fallbacks encounter with the New Roberts Court's new formalism. When Congress enacted Medicare and Medicaid as SSA amendments in 1965, Medicare was nationalized but Medicaid retained a federalist structure that offered more federal money and more stringent conditions.[283] Even after the federal government began to regulate health in comprehensive ways, state sovereignty has been invoked. In 1935, that meant excluding agricultural and domestic workers, a legacy of using enslaved people for such work.[284] Today, that legacy continues through policies such as work

[282] *See* Wendy E. Parmet & Faith Khalik, *Judicial Review of Public Health Powers Since the Start of the COVID-19 Pandemic: Trends and Implications*, 113 AM. J. PUB. HEALTH 280, 280 (2023); Lauren Weber & Anna Maria Barry-Jester, *Conservative Blocs Unleash Litigation to Curb Public Health Powers*, KFF HEALTH NEWS (July 18, 2022), https://khn.org/news/article/conservative-blocs-litigation-curb-public-health-powers/ [https://perma.cc/S3FH-XKDV]; Lauren Weber & Anna Maria Barry-Jester, *Over Half of States Have Rolled Back Public Health Powers in Pandemic*, KFF HEALTH NEWS (Sept. 15, 2021), https://khn.org/news/article/over-half-of-states-have-rolled-back-public-health-powers-in-pandemic/ [https://perma.cc/35HS-MM98].

[283] 42 U.S.C. §§ 1395 (Medicare); 42 U.S.C. § 1396 (Medicaid). *See generally* STEVENS & STEVENS, *supra* note 60 (providing extensive history of Medicaid's enactment, comparing it to prior social programs, and contrasting Congress's creation of the Medicare program).

[284] *See, e.g.*, IRA KATZNELSON, FEAR ITSELF: THE NEW DEAL AND THE ORIGINS OF OUR TIME (2013) (describing the tradeoffs that persuaded Southern Democrats to agree to New Deal legislation such as the SSA, which excluded predominantly Black agricultural and domestic workers); *see also* Jeneen Interlandi, *Why Doesn't the United States Have Universal Health Care? The Answer Has Everything to Do with Race*, N.Y. TIMES MAG. (Aug. 14, 2019), https://www.nytimes.com/interactive/2019/08/14/magazine/universal-health-care-racism.html [https://perma.cc/6UJ2-T7ZN].

requirements.[285] Because Congress does not usually start with a clean slate, rather building on what came before while also tending to political considerations, policy goals, and stakeholders' demands, health reform efforts tend to move in one direction, toward national standards that improve access and coverage. Yet these efforts allow health inequality to persist by continuing states' role in implementation and policymaking. Federal laws built around state policy choices can increase health disparities.[286]

III. RUBY SLIPPERS SOLUTIONS?[287]

This federalism tapestry was woven long before new drafting rules were imposed on old laws. Health laws in particular depend on statutory delegation of power to federal agencies for execution, and federal agencies rely on state and local partnership for implementation. The oldest laws have withstood tests of time with this configuration, but the Court has invited reevaluation of such structure and substance. Of course, federal laws are not crafted to exist at the single point in time in which they are enacted, but the Court's clear statement rules seem to expect infallible precision from the drafting Congress. The Court seems unlikely to change course soon, given how new the conservative majority is,[288] presenting challenges to previously durable health laws.

[285] Huberfeld, *Federalism in Health Care Reform*, *supra* note 151, at 208.

[286] One recent example was the Deficit Reduction Act of 2005 — in part a response to the devastation of Hurricane Katrina — which provided federal funding with one hand and reduced Medicaid spending with the other. Deficit Reduction Act of 2005, Pub. L. No. 109-171, tit. VI, 120 Stat. 4, 54-134 (2006); *see also* CONG. BUDGET OFF., COST ESTIMATE: S.1932 DEFICIT REDUCTION ACT OF 2005, at 35 (2006) (reporting that spending for Katrina recovery efforts was $2.2 billion but Medicaid spending was scheduled to decrease by $26.4 billion from 2006–2015).

[287] Thanks to Prof. Liz McCuskey for this turn of phrase.

[288] *See* John Gramlich, *How Trump Compares with Other Recent Presidents in Appointing Federal Judges*, PEW RSCH. CTR. (Jan. 13, 2021), https://www.pewresearch.org/fact-tank/2021/01/13/how-trump-compares-with-other-recent-presidents-in-appointing-federal-judges/ [https://perma.cc/V8NR-CULB] (studying ways the president reshaped federal courts). For the actions of lower federal court judges, some of whom pre-date the Trump presidency, that may have outsized impact on health law, see, for example, *Braidwood Management Inc. v. Becerra*, 627 F. Supp. 3d 624 (N.D. Tex. 2022), in which a federal district court judge declared the United States Preventive Services Taskforce ("USPSTF") unconstitutional and is preventing ACA-required access to PrEP

Admittedly, ringing alarm bells only does so much. So, this Part considers existing tools to think through what might come next.

A. A Legislative Approach

The collective action problems posed by health care and public health are long past strictly state and local action — the pandemic demonstrated the dangers and ineffectiveness of states acting alone.[289] Congress has not prioritized fixing old laws that lack a fallback structure, though these laws are crucial for most federal social programs; yet, Congress has authority to act, whether under the commerce power for direct regulation or spending power for indirect regulation.[290] So, Congress also has power to amend the laws that lack federal fallbacks, though amending old laws can have collateral consequences. For those committed to protecting state autonomy through formal federalism, one consequence is that federal fallbacks tend to expand federal authority within opt-out states. If they are a policy priority, federal programs are likely to pass constitutional muster, as federal laws that do not invite partnership are constitutionally more straightforward.[291] The Medicare program is a federal spending model, for example.[292] However, odds are that states will continue to be invited to stay in the game.

medication because it violates the religious beliefs of the challengers. *See also* All. for Hippocratic Med. v. U.S. Food & Drug Admin., No. 22-CV-223, 2023 WL 2825871 (N D. Tex. Apr. 7, 2023) (Trump appointed judge considered likely to strike down mifepristone 20 years after FDA approval, which could eliminate the primary form of medication abortion for the U.S.).

[289] *See generally* Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115, 115 (2010) (exploring when congressional authority should be exercised from the perspective of needing national, "collective" solutions).

[290] U.S. CONST. art. I, § 8, cl. 1, 3.

[291] Nicole Huberfeld, *Is Medicare for All the Answer? Assessing the Health Reform Gestalt As the ACA Turns 10*, 20 HOUS. J. HEALTH L. & POL'Y 69, 102-23 (2020).

[292] One exception is those people who are both elderly and poor, called dual eligibles, as they enrolled in Medicare (being elderly or permanently disabled) and Medicaid (being low income). Medicare does have a federalist structure, as it relies on regional contractors for administration, but they are commercial insurers operating on behalf of the federal government and do not implicate federalism doctrine.

Congress legislates this way by choice, not as a matter of constitutional obligation.[293] Politics raises questions about achievability, but not constitutional authority. Given likely political hurdles to broader, federally-based legislation, the next option is amending existing laws, which could have the consequence of fostering the redundancy expected of layered governance.[294] This approach has negative consequences, too, as layered governance increases opacity. In practice, the federal government creates redundancy for states, not the other way around, for reasons of funding but also because federal statutory goals usually elevate states' policies.[295] Nevertheless, some argue federalism is indispensable to implementing health policy goals, whether long term programs or short term responses, because localities and states are theoretically closer to the people and advance responsiveness and accountability.[296] This perspective underscores the need for finding an answer to the question: are federalism structures the problem, or is doing health care federalism badly the problem?[297] Federalism produces variability, which predictably results in different health outcomes that are often worse for racial and ethnic minorities and other vulnerable populations.[298] Low-income people, for example, cannot "vote with their feet" to move away if they do not like local law, even if they can discern who is responsible, but they are more likely to

[293] *See* Gluck, *Our* [*National*] *Federalism*, *supra* note 115, at 2003 (asserting most federalism occurs at the national level, legislatively, by the "grace" of Congress); *see also* Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27, at 1706-16 (explaining federalism is often a congressional choice, not constitutional requirement).

[294] *See* Erin Ryan, *Response to Heather Gerken's "Federalism and Nationalism: Time for a Détente?*," 59 ST. LOUIS U. L.J. 1147, 1163-64 (2015).

[295] Printz v. United States, 521 U.S. 898, 959 (1997) (Stevens, J., dissenting) ("By limiting the ability of the Federal Government to enlist state officials in the implementation of its programs, the Court creates incentives for the National Government to aggrandize itself. In the name of State's rights, the majority would have the Federal Government create vast national bureaucracies to implement its policies."); *see also* GRUMBACH, *supra* note 19, at 202-05 (describing why people were wrong to turn to the states when the Trump administration pursued undesirable policies).

[296] *See supra* Part I.

[297] *See* GRUMBACH, *supra* note 19, at 1703-24 (state politicians are more likely to follow national political cues than the policy preferences of their electorate).

[298] Jones, *supra* note 30, at 523-27; *see* MICHENER, *supra* note 122, at 48-56.

vote if they have Medicaid benefits.[299] The upshot is that Congress effectively condemns certain states' residents to worse health if it does not enact fallbacks — the very situation occurring with Medicaid expansion.

The ACA offers pragmatic and theoretical models but also warnings. In terms of structural models, certain features like the ACA's requirement for HHS to create a national exchange were crucial for implementation. However, the robust federal exchange may have encouraged states to engage in secret boyfriend federalism, which obstructs the accountability value, because HHS worked with states behind closed doors.[300] Conversely, Medicaid expansion is incomplete, and the New Roberts Court may allow testing other aspects of conditional spending programs, as concurrences and dissents invited in *Talevski*.

As for a theoretical model, research shows laws rooted in universal principles are more likely to succeed than programs targeted to one population or need.[301] The principle of universality was incorporated into the ACA, and it does not necessitate uniformity, but it has been undercut by variability.[302] This should not have been surprising: as enacted in 1935,[303] the SSA relied on states to implement new federal

[299] *See* Haselswerdt & Michener, *supra* note 168, at 443-44.

[300] Gluck & Huberfeld, *What Is Federalism For*, *supra* note 27, at 1767-72 (naming the phenomenon of secret boyfriend federalism).

[301] *See* Theda Skocpol, *Targeting Within Universalism: Politically Viable Policies to Combat Poverty in the United States*, *in* THE URBAN UNDERCLASS 411 (Christopher Jencks & Paul E. Peterson eds., 1991) (documenting the pattern showing that effective anti-poverty laws have been packaged not to look like special or "targeted" care for needy populations).

[302] Universalism is a central principle in international human rights standards, which facilitates protection of individual rights and collective civic, political, social, cultural, and economic purposes. The principle of universalism underlies the UN approach to human rights, but human rights are not typically part of the U.S. conversation, as the U.S. has resisted ratifying most multilateral human rights treaties. *Status of Ratification Interactive Dashboard*, U.N. HUM. RTS. OFF. OF THE HIGH COMM'R, https://indicators.ohchr.org/ (last visited August 16, 2023) [https://perma.cc/XQT4-L6Y7].

[303] Social Security Act, Pub. L. No. 74-271, 49 Stat. 620 (1935). The SSA is amended so often the GPO guide exceeds 900 pages. H. COMM. ON WAYS & MEANS, 113TH CONG., WMCP 113-3, COMPILATION OF THE SOCIAL SECURITY LAWS, INCLUDING THE SOCIAL

social programs, which extended existing disparities when states excluded domestic and agricultural workers.[304] In 1945, President Truman's special address to Congress proposed national public health insurance to overcome such gaps, which the ACA partially achieved.[305] Relatedly, how programs are funded, meaning the nature of the congressional appropriation, should be part of evaluating legislative amendments. Universally applicable programs like Medicare and Social Security are permanent appropriations, so Congress must allocate funds to support them. On the other hand, Medicaid is an appropriated entitlement, so it is partially subject to annual budget political processes.[306] A law's structure, core principles, and appropriation method combine to influence whether federal laws are durable.

In the post-*Dobbs* landscape, state variability has been heightened — a sort of health care federalism run amok. People regularly cross state lines to seek medical care, placing them within the reach of the commerce power.[307] After *Dobbs* allowed states to outlaw abortion, significantly more people are travelling to other states for medical

SECURITY ACT, AS AMENDED, AND RELATED ENACTMENTS THROUGH JANUARY 1, 2013 (Comm. Print 2013).

[304] The preamble states: "An Act [t]o provide for the general welfare by establishing a system of Federal old-age benefits, and by enabling the several States to make more adequate provision for aged persons, blind persons, dependent and crippled children, maternal and child welfare, public health, and the administration of their unemployment compensation laws; to establish a Social Security Board; to raise revenue; and for other purposes." Social Security Act, 49 Stat. at 620.

[305] This history reaches beyond the twentieth century; categorizations of who deserves government social program assistance trace to Elizabethan England and the colonies' policies to assist only "deserving" individuals without means to support themselves. Huberfeld, *Federalism in Health Care Reform*, *supra* note 151, at 199.

[306] Matthew B. Lawrence, *Disappropriation*, 120 COLUM. L. REV. 1, 20-23, 88 (2020); *see* Matthew B. Lawrence, *Congress's Domain: Appropriations, Time, and* Chevron, 70 DUKE L.J. 1057, 1065-68 (2021).

[307] Plenty of media reports document this phenomenon, and researchers are beginning to publish findings as well. *See, e.g.*, *Remaking America: Crossing State Lines for Abortion Care*, NPR (May 11, 2023, 3:42 PM EST), https://www.npr.org/2023/05/11/1175530713/remaking-america-crossing-state-lines-for-abortion-care [https://perma.cc/B2HZ-GAGH]; *see also* Benjamin Rader, Ushma D. Upadhyay, Neil K.R. Sehgal, Ben Y. Reis, John S. Brownstein & Yulin Hswen, *Estimated Travel Time and Spatial Access to Abortion Facilities in the US Before and After the* Dobbs v Jackson Women's Health *Decision*, 328 JAMA 2041, 2042 (2022).

care.[308] Some states protect access to reproductive care and others eliminated it, and within these categories many more variables exist and are constantly changing. The chaos, confusion, and conflict of the legal landscape directly affect clinicians' ability to practice medicine to the standard of care as well as increase the risk of injury and death for people of reproductive age. Congress has power to reduce these risks,[309] but political will is a different question.[310]

B. Federalism Values Revisited

Congress partners with states for legal, political, and policy reasons, such as engaging expertise in areas historically addressed through state police power; operationalizing funding; entrenching policy; and expeditious lawmaking. Federalism is entrenched in health laws, invites

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[308] Acacia Coronado, *Women Sue Texas over Abortion Ban, Say It Risked Their Lives*, AP NEWS (Mar. 7, 2023, 3:01 PM MST), https://apnews.com/article/women-sue-texas-over-abortion-ban-632fad72e0f5b255a3a55274cd097fa9 [https://perma.cc/2V2B-K9KM]; Kate Kelly, *How the Fall of Roe Turned North Carolina into an Abortion Destination*, N.Y. TIMES (Mar. 4, 2023), https://www.nytimes.com/2023/03/04/us/abortion-north-carolina.html [https://perma.cc/JR8C-JQP8]; *Abortion in the United States Dashboard*, KFF, https://www.kff.org/womens-health-policy/dashboard/abortion-in-the-u-s-dashboard/ (last visited Aug. 16, 2023) [https://perma.cc/FG98-GZD7].

[309] *See* United States v. S.-E. Underwriters Ass'n, 322 U.S. 533, 579 (1944) (finding that Congress has commerce clause authority to regulate national insurance markets); *see also* Helvering v. Davis, 301 U.S. 619, 645 (1937). The Court upheld the SSA in *Charles C. Steward Mach. Co. v. Davis*, 301 U.S. 548 (1937) (unemployment insurance) and *Helvering v. Davis* (old age benefits), recognizing need for federal collective action and affirming the spending power is a plenary enumerated power. *Davis*, 301 U.S. at 578, 599; *Helvering*, 301 U.S. at 640, 646. The Court rejected arguments that welfare for the elderly was reserved to the states. *Helvering*, 301 U.S. at 640-45. Emphasizing changes wrought by industrialization, the Court wrote: "The problem is plainly national. . . . Moreover, laws of the separate states cannot deal with it effectively. . . . States and local governments are often lacking in the resources that are necessary to finance an adequate program of security for the aged." *Id.* at 644.

[310] Compare the Hyde Amendment, which has prohibited Medicaid payment for abortion except to save the life or health of the pregnant woman, or in cases of incest or rape, since 1977. *See* Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, div. H, §§ 506-507, 134 Stat. 1182, 1547 (2020); Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 1994, Pub. L. No. 103-112 § 509, 107 Stat. 1082, 1113 (1993) (relaxing restriction slightly for rape and incest victims); Departments of Labor, and Health, Education, and Welfare Appropriation Act, 1977, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434 (1976).

heterogeneity in implementation, and may facilitate, complicate, or block response to nationwide problems.[311] This should be understood not just as theory but through evaluation of the commonly named values of federalism.

1. Autonomy, Political Accountability, and Governance Capacity

The traditional values of state sovereignty and political accountability operate in practice to affect governance capacity.[312] Through the example of major health laws, Part II illustrated that state sovereignty (or autonomy, I do not enter that theoretical debate here) is an entrenched feature of the oldest federal programs. One way to evaluate these values could be to consider whether the state has a well-functioning democracy that makes elections available to all eligible voters. Concrete facts such as whether state law fosters or restricts voting, and whether a state's laws reflect polling on the polity's policy preferences, would be two places to start. Political scientists and researchers in related disciplines have documented that states with stronger voting protections have healthier populations, and states with more restrictive voting laws have less healthy populations and laws that are less responsive to residents' policy preferences.[313] A third way to evaluate sovereignty and political accountability could be a state's path to ballot initiatives.[314] Some states by law must allow ballot initiatives to become law, some state laws allow the legislature to amend or block

[311] *See generally* Heather K. Gerken, *Federalism as the New Nationalism: An Overview*, 123 YALE L.J. 1889 (2014) (studying this question through a panel of federalism scholars with different views).

[312] *See infra* Part I.B.

[313] *See Health & Democracy Index*, HEALTHY DEMOCRACY, HEALTHY PEOPLE, https://democracyindex.hdhp.us/ (last visited Aug. 17, 2023) [https://perma.cc/BVC2-TBHT] (comparing public health indicators and voter turnout to the Cost of Voting Index for the 2020 general election and finding that civic participation correlates to healthier populations); *see also Election Administration at State and Local Levels*, NAT'L CONF. OF STATE LEGISLATURES (Nov. 1, 2022), https://www.ncsl.org/elections-and-campaigns/election-administration-at-state-and-local-levels [https://perma.cc/Y36J-RRNR] (tracking state and local election laws); *State Democracy Index*, JAKE GRUMBACH, https://sites.google.com/view/jakegrumbach/state-democracy-index (last visited Aug. 17, 2023) [https://perma.cc/66R6-EV9T].

[314] *See supra* notes 191–92 and accompanying text.

ballot initiatives, and as discussed above, some states have tried to make ballot initiatives more difficult to prevent Medicaid expansion (and abortion-related initiatives).[315]

Such measures could inform courts' and administrative agencies' analyses as to whether federalism facilitates sovereignty and accountability. Governance capacity is impacted by factors including state legislatures' budgeting, but also more, such as whether a state budget is adequate for fundamental civic necessities such as education, public health, and other underlying determinants of health like neighborhood safety. Legal theorists who study fiscal federalism have explored this path to some degree, such as Professor Schapiro, who argued that fiscal inequality between states undermines our constitutional commitment to federalism.[316] But fiscal inequality should also be studied because state legislatures' funding choices have concrete impacts on their implementation of federal laws, which affects either negatively or positively the national baseline rule set by federal law. If a state does not fund Medicaid adequately, for example, then beneficiaries will have less access to care because providers will refuse new patients, spend less time with existing patients, and even leave the program. Further, states with robust health systems, like Massachusetts, have experienced freeloading from neighbor states' residents. Additionally, Part II discussed the connection between funding and governance capacity — measures such as state and local taxes sufficient to support the state's population, and minimum wage sufficient to live above the poverty level, also offer upstream factors for evaluating a state's ability to exercise the responsibility assigned to it in federalism-based decisions, *i.e.*, whether states actually have governance capacity. These are measurable, evidence-based factors.

2. Variation and Experimentation

Federal agencies, institutional review boards, and other public and private entities must follow specific rules to conduct clinical research or

[315] *States with Initiative or Referendum*, BALLOTPEDIA, https://ballotpedia.org/States_with_initiative_or_referendum (last visited Aug. 17, 2023) [https://perma.cc/HA73-QWFK] (explaining each state's approach to voter referenda).

[316] *See* Schapiro, *supra* note 30, at 1535-36.

other experiments. International organizations started by drafting ethical codes to guide researchers and protect research subjects, the most important of which is arguably the Nuremberg Code, written in 1947 as a response to war crimes and crimes against humanity Nazi doctors committed.[317] The Nuremberg Code includes principles such as:

> "1. The voluntary consent of the human subject is absolutely essential. . . . 2. The experiment should be such as to yield fruitful results for the good of society, unprocurable by other methods or means of study, and not random and unnecessary in nature. 3. The experiment should be so designed . . . that the anticipated results will justify the performance of the experiment."[318]

In 1979, a special HHS commission issued the Belmont Report, which articulated three key bioethical principles for research: beneficence (duty to do good); autonomy (of the research subject); and justice.[319] Later, the Common Rule prescribed protections and processes for research on humans paid or conducted by federal agencies.[320] Taken together, these ethical and legal principles instruct that research should occur only if it follows "sound research design" and does not "unnecessarily expose subjects to risk."[321]

These principles could translate to evaluation of the "laboratory of the states" to determine whether states engage in experiments made valid through design rendering the policy experiment safe, effective, and beneficial. A full analysis of the meaning of these ethical standards

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[317] *Nuremberg Code: Directives for Human Experimentation*, U.S. DEP'T OF HEALTH & HUM. SERVS.: OFF. OF RSCH. INTEGRITY, https://ori.hhs.gov/content/chapter-3-The-Protection-of-Human-Subjects-nuremberg-code-directives-human-experimentation (last visited Aug. 17, 2023) [https://perma.cc/G8AC-W3KR]; *see also* George J. Annas & Michael A. Grodin, *Medical Ethics and Human Rights: Legacies of Nuremberg*, 3 HOFSTRA L. & POL'Y SYMP. 111, 113-14 (1999) (noting it has "never been formally adopted as a whole by the United Nations").

[318] Annas & Grodin, *supra* note 317, at 113 n.6.

[319] NAT'L COMM'N FOR THE PROT. OF HUM. SUBJECTS OF BIOMEDICAL & BEHAV. RSCH., THE BELMONT REPORT (1979), https://www.hhs.gov/ohrp/sites/default/files/the-belmont-report-508c_FINAL.pdf [https://perma.cc/ZZ4F-PMEF].

[320] *See* 45 C.F.R. §§ 46.101-46.505 (2023).

[321] *Id.* § 46.111.

would take another article, so I return to the Medicaid and COVID-19 examples to begin to illustrate the idea. The HHS Secretary has Section 1115 demonstration waiver authority to waive certain Medicaid requirements under SSA section 1902, if a state proposes to carry out an "experimental project" furthering the goals of the Medicaid program.[322] Medicaid's statutory purpose is to "furnish medical assistance" to low-income people, anchoring the Secretary's decisions.[323] This became part of the SSA in 1962, before Medicaid, and at first it did not foster much policy experimentation.[324] However, during the Clinton administration, states sought waivers more frequently to rework eligibility, benefits, and delivery systems.[325] Currently, Section 1115 waivers tend to involve programmatic reshaping, rather than precise research questions. As noted above, HHS and states negotiated Section 1115 waivers as a way to expand Medicaid, and more recently they were used to implement work requirements. However, HHS regulations state that demonstration waivers are *not* subject to the Common Rule, even though they are a recognized form of experiment.[326] If state experiments jeopardize enrollment, and disenrollment impacts access to care, then experimental principles are not met because such experiments *foreseeably* impact the health and lives of affected people.[327]

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[322] 42 U.S.C. § 1315.

[323] *Id.* § 1396-1; *see also* Stewart v. Azar, 313 F. Supp. 3d 237, 243 (D.D.C. 2018).

[324] *See* Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 122, 76 Stat. 172, 192 (1962) (codified at 42 U.S.C. § 1315).

[325] That is, until the Balanced Budget Act of 1997, Pub. L. No. 105-33, 111 Stat. 251, which permitted states to require most Medicaid beneficiaries to enroll in managed care plans without obtaining a waiver. *See also Waivers*, MEDICAID & CHIP PAYMENT & ACCESS COMM'N, https://www.macpac.gov/medicaid-101/waivers/ (last visited Aug. 17, 2023) [https://perma.cc/E6A6-PL79].

[326] Loans for Housing for the Elderly or Handicapped, 47 Fed. Reg. 9207 (1982) (to be codified at 24 C.F.R. pt. 885). The Secretary of HHS rendered this interpretation due to two-year cuts in Medicaid funding under the Omnibus Budget Reconciliation Act of 1981 to try to allow states to "experiment" in cost sharing waivers. *Id.*; *see also* Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357. When the Common Rule was updated, this interpretation became part of the revised regulations. 45 C.F.R. § 46.104(d) (2023) (research activities exempted from the Common Rule include Section 1115 waivers).

[327] *See* Harald Schmidt & Allison K. Hoffman, *The Ethics of Medicaid's Work Requirements and Other Personal Responsibility Policies*, 319 JAMA 2265, 2265-66 (2018)

Congress amended Section 1115 to ensure demonstration projects promote Medicaid's purpose and restrict invalid experiments to some degree, but more could be done. For example, in 1982, Congress restricted Section 1115 waivers that require paying premiums or cost-sharing, well-documented barriers to care.[328] The ACA required both state and federal public notice and comment periods before the HHS Secretary approves demonstrations so beneficiary and stakeholder input is possible (whereas they had no "consent" mechanism before 2010).[329] Regulations require that demonstration waivers serve a legitimate experimental purpose.[330] And, states must explain how they will evaluate waivers, including testable hypotheses, valid design plans, reliable data collection, and limiting beneficiary burdens.[331] These are important tools for evaluating states' Medicaid experiments, but HHS's original non-application of the Common Rule still haunts Medicaid and other similarly structured social programs. Further, the Secretary has not always adhered to sound experimentation principles, under which a "demonstration must yield new knowledge, be methodologically sound, and benefits should outweigh risks."[332]

Returning briefly to the PHE example: before COVID-19 began, state defunding correlated to higher turnover rates in public health departments, diminishing leadership and staffing and the ability to build expertise.[333] Some would argue this *is* the experiment of the states, to decide whether state budgets should fund public health or other policy priorities. However, this view of federalism as a "laboratory" overlooks existing evidence of harms caused by such choices, the opposite of

(arguing for ethical ways to implement work requirements but leaving aside the legality and ethics of approving such experiments).

[328] Tax Equity and Fiscal Responsibility Act of 1982, Pub. L. No. 97-248, § 131(b), 96 Stat. 324, 367 (codified at 42 U.S.C. § 1396o(f)).

[329] 42 U.S.C. § 1315(d)(2).

[330] *See* 42 C.F.R. §§ 431.400-431.428 (2023).

[331] *Id.* § 431.424.

[332] Brief for Deans, Chairs and Scholars as *Amici Curiae* in Support of Plaintiffs at 16, Philbrick v. Azar, 397 F. Supp. 3d 11 (D.D.C. 2019) (No. 19-773).

[333] *See* Theresa Spinner, *More than 9 in 10 Americans Are Endangered by the Underfunding of Local Public Health*, NAT'L ASS'N OF CNTY. & CITY HEALTH OFFS.: VOICE (Aug. 27, 2020), https://www.naccho.org/blog/articles/more-than-9-in-10-americans-are-endangered-by-the-underfunding-of-local-public-health [https://perma.cc/J5CY-6NE8].

principled experimental design. In other words, underfunding public health leads to the predictable, non-experimental outcome of worsening disasters and crises in certain places, measurable in illness, injury, and death.[334]

In short, ethical and legal principles indicate that courts, administrative agencies, and the states themselves are responsible for valid experimental design, even if the Court is more likely to protect states than people. The learning that is supposed to occur with any experiment should be evaluated, rather than assuming that American federalism is a "laboratory."[335]

CONCLUSION

The Court's clear statement rules on steroids have the potential to affect the interpretation, scope, and application of federal laws that fund and guide the public's health. Building on fifty to eighty year old laws suddenly seems to be a questionable approach, even though incrementalism was a politically practical approach in the past. This Article revealed patterns in the renewed Federalism Revolution that create high stakes for not just federal health laws but public laws of all stripes. Older health laws with no fallbacks, in combination with the Court's newfound formalism, and the rise of state vetoes, place many health laws on a precipice of dilution. Yet, the people reliant on social programs often are hindered from engagement in local democracy.[336]

Given the practice of building on what came before, Congress should prioritize federal fallbacks. In addition, deeper evaluation of what health care federalism actually does should occur. The Institute of Medicine defines public health as "fulfilling society's interest in assuring conditions in which people can be healthy."[337] Health policy disputes are being pushed more and more to the states. Because law is a determinant

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[334] TRUST FOR AMERICA'S HEALTH 2022, *supra* note 256, at 4, 10, 34.

[335] *See* Super, *Laboratories of Destitution*, *supra* note 30, at 614-16.

[336] *See* MICHENER, *supra* note 122, at 26; Haselswerdt & Michener, *supra* note 168, at 426; Jake Haselswerdt, *Expanding Medicaid, Expanding the Electorate: The Affordable Care Act's Short-Term Impact on Political Participation*, 42 J. HEALTH POL., POL'Y & L. 667, 670-73 (2017).

[337] INST. OF MED. COMM. FOR THE STUDY OF THE FUTURE OF PUB. HEALTH, THE FUTURE OF PUBLIC HEALTH 7 (1988).

of health, for the sake of *salus populi*, we should know what this devolution really means.