

OF ICEBERGS AND GLACIERS: THE SUBMERGED CONSTITUTION OF AMERICAN HEALTHCARE

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I

INTRODUCTION

The United States is presently in the midst of a fractious and polyphonic debate about the future shape of its healthcare finance and delivery system. Spurred in significant part by the controversial passage of a major federal health insurance statute two years ago, this debate implicates foundational questions of government authority and constitutional limitation that have transcended the traditional boundaries of health law. Although in many respects it is an incomplete and unfinished reform, the Patient Protection and Affordable Care Act (ACA)¹ manifests a new congressional focus on insurance regulation and expanded access and raises significant questions about, and opposition to, the increased role of the federal government and the new federal and state bureaucracies that the Act creates.

As with other episodes of transformative legal restructuring in the United States and elsewhere, the ACA (or more accurately, the future transformation of medical care delivery that it may portend) has provoked vigorous opposition in legal and political discourse. And also, as with earlier episodes of constitutional transformation, this dissent sounds in multiple registers and employs different oppositional vernaculars and diverse institutional levers in an effort to thwart the full implementation of the ACA's regulatory measures. The most visible strand of this opposition is the multifaceted litigation against the constitutionality of the individual mandate that has proceeded in various federal courts around the country and is presently before the U.S. Supreme Court. Couched within the familiar decisional forum of the federal courts, the litigation offers the prospect of a determinate institutional statement on the question of the individual mandate's constitutionality within a reasonably predictable time frame.

No such institutional centrality or prospect of finality exists in the roiling popular opposition to the ACA and related health reforms that are playing out in various extrajudicial fora. Clearly the ACA's wisdom and its constitutionality

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1. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.).

will be a major issue in the national popular election of 2012 and most likely those of 2014 and 2016 as well. Opposition to the Act has already manifested in profligate state legislative and referendum activity: By my count, in the fall of 2011 there were 197 separate state statutes or referenda pending in the fifty states, many bearing evocative titles like Missouri's "Big Government Get Off My Back Act,"² which purports to exempt small businesses from enforcement of various state and federal mandates. This immediate popular opposition is important and interesting, and treated in nuanced fashion in several other papers in this symposium.³

My aim in this short article is to place the current constitutional litigation in an even broader frame of reference than that of the present day's popular constitutionalism. Taking a much longer temporal view, it is possible to regard the current debate over the ACA as but one episode in an ongoing process of legal and normative construction and contestation about the proper locus of authority in American medicine that stretches back well into the nineteenth century. Like the small portion of an iceberg visible above the waters, the current ACA litigation is merely the most visible and immediately salient manifestation of much more enduring public concerns about institutional intrusion on individualistic choice in medical care.

The embrace of highly diffuse authority over medical decisions has long been prioritized by patients and physicians, and will continue to hold a powerful sway over public attitudes long after the dust has settled on this episode of litigation. Yet the fragmentation and resistance to institutional control—whether public or private institutions—that has for years characterized the healthcare delivery system in the United States is becoming increasingly unsustainable and problematic. As imperatives of cost control and quality assurance necessarily demand public and private reordering that will be much more extensive than the individual mandate in the decades ahead, we can regard the current constitutional litigation, however heated within its institutional bounds, as a rather mild precursor to the real battle over authority in medicine that will unfold over the next few decades.

In the following pages I will describe the broad historical and legal contours of this traditional authority structure in American medicine and relate it to the instant litigation; a later section more specifically examines the long development of healthcare federalism in the context of today's Commerce Clause challenge.

2. MO. ANN. STAT. § 1.310 (West 2011) (providing that "[t]his section shall be known and may be cited as the "Big Government Get Off My Back Act").

3. See, e.g., Bryan Leitch, *On the Difficulty of Separating Law and Politics: Federalism and the Affordable Care Act*, 75 LAW & CONTEMP. PROBS., no. 3, 2012 at 203; Ernest A. Young, *Popular Constitutionalism and the Underenforcement Problem: The Case of the National Healthcare Law*, 75 LAW & CONTEMP. PROBS., no. 3, 2012 at 157.

II

HISTORICAL AND LEGAL CONTOURS IN AMERICAN MEDICINE

As I have written in more detail elsewhere, two centuries of health law development—in all its multiple forms and multiple institutional architects—have played a crucial role in the construction of a deeply entrenched but increasingly unsustainable structure of medical authority. From its early appearances in congressional constitutional discourse through the late nineteenth century flourishing of common law doctrines and into the twentieth century statutory regimes, the hydraulic push of American health law has been, until very recently, relentlessly centrifugal, pushing therapeutic authority to the individualized discretion of physicians and their patients. In the nineteenth and early twentieth centuries, constitutional federalism, licensure statutes, and a bevy of particularized common law rules all operated sequentially and cumulatively to disable other forms of decisional authority, whether from government actors or from private institutions such as hospitals or insurers. The multiple legal institutions that operated to create the health law regime of the United States fostered, enhanced, and gave specific shape to the diffusion and individuation of medical authority. Well through the middle of the twentieth century, the state law institutions that controlled health law rules operated to enshrine and solidify the authority of individual physicians and to deter standardization or institutional centrality in American medicine. And even after health law's strong-form restrictions have receded in recent decades, the normative and organizational structure of American healthcare remains.

This regime of diffuse authority in American medicine was constructed primarily of “ordinary” law forms—although it has proven at least as durable and entrenched as the stuff of high-status constitutional doctrine—and has exerted a powerful trumping effect on public and private reordering that is functionally similar to the role played by more recognizable constitutional law. The common law doctrines that state courts crafted and applied from the late nineteenth century onward in the health law area reflect courts' eclectic borrowing and modification from the fields of tort, contract, fiduciary duty, and others, creating what some scholars have called a “chaotic, dysfunctional patchwork” of diverse legal forms.⁴ Despite this patchwork dynamic, it is conceptually possible to lump broad swaths of health law's traditional canon into two general functional clusters. In the first basket are first-order specificity rules, which articulated and enforced legal doctrines that encouraged and protected therapeutic individuation. For instance, the customary standard of care in medical malpractice was in actuality a cluster of multiple standards of care with courts permitting meaningful therapeutic variation along variables such as type of medical training, mode of practice, geographic location, and other factors. Doctors in different locations were privileged by thin-sliced

4. See M. Gregg Bloche, *The Invention of Health Law*, 91 CALIF. L. REV. 247, 250 (2003).

liability rules (for example, the “locality rule,”⁵ which was an American common law invention never adopted in English law) to practice medicine differently from physicians in other towns in the same state. Even to the present day, medical liability rules serve to render a certain rough compensatory justice in some cases but do little or nothing to promote optimal methods of care between various therapeutic alternatives.⁶

A second set of legal doctrines framed a century ago by state courts and legislatures operated primarily as displacing rules, acting to preserve therapeutic individualization indirectly (although no less significantly) by blocking or trumping other forms of private institutional ordering that might otherwise have exerted a standardizing influence on medical authority. Courts framed and employed doctrines such as the prohibition on the “corporate practice of medicine” to preserve the traditional diffuse structures of medical authority against incursion from new organizational forms of private control, particularly the rise of the corporation in the late nineteenth century United States and the nonprofit hospital in the twentieth. Such trumping rules were actively sought by doctors, and willingly extended by common law courts, with the result that the practice of medicine developed and expanded without meaningful public or private control through much of the twentieth century. The health delivery system’s development through the century was shaped by these constraints on institutional ordering.

Throughout the past century, observers have noted the pernicious policy effects of these displacing rules. In 1938, a *Yale Law Journal* commenter presciently declared that the prohibition on institutional control of physicians stifled “extensive experimentation with methods of medical organization” and thus frustrated “[e]fforts to obtain adequate medical care at reasonable costs.”⁷ Mark Hall wrote much more recently that the rule against corporate employment of physicians was a “puzzling doctrine . . . clouded with confused reasoning and . . . founded on an astounding series of logical fallacies,” and comprehensively cataloged the doctrine’s “long history of suppressing needed innovation” throughout the twentieth century.⁸ The core doctrines of American health law did not create the original diffusion of authority in nineteenth century medicine, but were instrumental in calcifying and extending that

5. See Jon R. Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Litigation*, 18 DEPAUL L. REV. 408, 410 (1969) (describing the rule’s origins and noting that “the English courts never developed such a principle”).

6. Several recent medical malpractice reform proposals seek to alter this dynamic: For instance, by expressly incorporating evidence-based standards as safe harbors against malpractice liability. See, e.g., Linda L. LeCraw, *Use of Clinical Practice Guidelines in Medical Malpractice Litigation*, 3 J. ONCOL. PRAC. 254 (Sep. 2007).

7. See Note, *Right of Corporation to Practice Medicine*, 48 YALE L.J. 346, 346–47 (1938).

8. Mark A. Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431, 510 (1998) (noting specific episodes of hospital and insurance industry innovation at different periods in the twentieth century that were thwarted by judicial invocation of the doctrine and lamenting that “courts were entirely unresponsive in tempering” its dampening effect on innovation).

individuated authority regime throughout the twentieth century. Although most of these doctrines have been modified or abandoned by state courts in recent decades, they did more than enough work earlier in the century to lock in the basic regime of medical authority that persists today.

Finally, the mid-twentieth century's most important doctrinal innovation relative to physician authority did nothing to alter the general diffusion of healthcare decisions even as it worked a sea change in the relative power balance between physicians and patients. Legal scholars, ethicists, and common law judges coalesced after 1960 to articulate a new emphasis on informed patient consent and the cognate principle that medical decisionmaking ought to be shared between doctor and patient rather than dictated by the former. This produced a crucial shift in health law doctrine, and worked a dramatic legal and normative change in the relationships between physicians and patients. Yet the real legal changes fostered by the informed consent ideal did nothing to reduce the diffuse character of medical decisionmaking in the United States. Medical decisions were now binary rather than unitary, but remained devolved to the most particularized level of the delivery system, with predictable consequences in the morally hazardous context of third-party insurance.

With this individuated authority structure entrenched and protected by various doctrinal levers, important legal and financial developments in the middle of the twentieth century acted to accelerate and entrench the individuated authority structures of American medicine through greater resource inputs channeled into the preexisting regime. Favorable tax laws and wartime wage restrictions fueled a vast expansion in the number of Americans with employment-based private health insurance between 1940 and 1960, and the passage of Medicare in 1965 added millions of seniors to the public insurance rolls. These developments channeled tens of billions of dollars into the growing health system, yet these resources were injected into the preexisting structure of diffuse therapeutic individualism, with institutional effort from public or private payors to control physician discretion until the twentieth century's end.

Importantly for current and future debates and efforts at restructuring, this individuated conception of medical authority in the United States has proven significantly more durable than the original constitutional understandings and common law rules that helped create it in the first place. Since the middle of the twentieth century, the formal constitutional barriers to federal involvement in the healthcare enterprise have largely evaporated, and likewise state courts have diluted or abandoned many of the common law doctrines that protected physician autonomy from institutional control. Yet even as the formal legal structures that created and enforced our fragmented medical decisionmaking regime have fallen away, support for this foundational authority structure remains deep, exerting important constraints on public and private attempts to reorder the healthcare delivery system. In this sense the health law system in the United States is glacial in at least two ways: first in its remarkably slow pace

of change, reform, and systematic federal involvement relative to other economic areas, but also in the sedimentary or residual dynamic described here. Even as problematic formal rules in the health law area receded, the fragmented and diffuse organization of American healthcare remains as a sedimentary legacy of this prior legal regime very much relevant in institutional form and public and physician attitudes.

The structure of the Medicare program, particularly as designed and implemented originally in the 1960s, is a prime example of this dynamic of powerfully rooted old authority structures shaping (or warping) newer federal interventions. Medicare was, and is, a massive federal budgetary commitment to health security that was, in its earliest decades, a blank check subsidizing traditional physician and patient behavior. Even today it only weakly serves to monitor physician activity, with consequent substantial variation in treatment and utilization costs.

The unsustainable nature of this authority model is evident: The simultaneous embrace of a health security ideal for seniors and traditional therapeutic individualism in the Medicare context has been rendered workable only by pouring more and more money into the system. In 1960, just before the passage of Medicare and Medicaid, total health spending in the United States accounted for only 5.2% of Gross Domestic Product (GDP).⁹ Since then, it has more than tripled as a percentage of GDP, at about 17% by recent estimates. This cost growth is not due solely, or primarily, to government largesse—private health insurance cost growth in the past decade has been greater than that of the major public insurance programs. But neither public nor private payors have succeeded in containing cost growth. The Congressional Budget Office (CBO) forecasts that, if present trends continue, overall healthcare spending will account for 25% of GDP by 2025, 37% by 2050, and 49% by 2082.¹⁰

This trend is clearly unsustainable going forward and has catalyzed a growing scholarly consensus that the individuated diffusion of therapeutic authority in American medicine and medical law is problematic from the perspective of both patient outcomes and systemic cost. Medical errors remain commonplace in the United States, and many studies suggest that implementing evidence-driven standards of care and systems-based approaches would reduce error rates and improve outcomes.¹¹ Moreover, the variations in individual treatment protocols produced by the devolution of medical decisionmaking to the bedside have been major drivers of cost increases, particularly when coupled with the moral hazard of third-party insurance, which allows individual patients and their doctors to shift the costs of their particularized decisions to

9. See CONG. BUDGET OFFICE, PUB. NO. 3085, *THE LONG-TERM OUTLOOK FOR HEALTH CARE SPENDING* (2007), available at <http://www.cbo.gov/ftpdocs/87xx/doc8758/11-13-LT-Health.pdf>.

10. See *id.*

11. See, e.g., Elliott S. Fischer et al., *The Implications of Regional Variations in Medicare Spending, Part 2: Health Outcomes and Satisfaction with Care*, 138 ANN. INT. MED. 288, 297–98 (2003).

public or private risk pools.¹² Yet efforts to promulgate guidelines or otherwise standardize care, whether driven by public or private institutional actors, are often met by fierce public and physician resistance borne out of deep normative entrenchment of this older constitution of therapeutic individualism.

For all of this imperative for systemic change, the ACA is influenced by the hydraulic push of health law's traditional constitution just as its predecessor federal statutes were. The ACA's architecture is clearly and profoundly solicitous of the extant structures of the medical delivery system. Despite its infamous length and its allegedly transformative nature, the ACA is—at bottom—a gap-filling statute aimed at closing significant loopholes in the complex existing architecture of public and private health insurance in the United States, and it does little to simplify or make more coherent the fragmented healthcare delivery system that already exists. The Act cures two major shortfalls in current access to health insurance: By expanding Medicaid dramatically to cover tens of millions more people at or near the poverty line, and also through its insurance exchange provisions that will help many Americans with preexisting conditions gain access to health insurance. But in the immediate term it does little to rework the basic structure of the medical delivery system, which is replete with high levels of individual variation in physician practice and dramatic annual cost increases. The ACA does evince an awareness that business as usual in the operation of the nation's major public and private insurance programs is unsustainable and creates some new institutions that might improve upon system performance (for instance, the controversial Independent Payment Advisory Board¹³ to propose Medicare cost reductions), but these reforms are incomplete and nascent at this time.

Viewed in this broader context, it is possible, with a few points of emphasis, to regard the current ACA litigation in a different light. First, the attacks on the individual mandate within and outside of the courts, particularly in that they are grounded in opposition to a perceived intrusion on individual choice, are conceptually derivative of this deeply entrenched set of norms that is contained in the traditional constitution of American health law. Polls show that the individual mandate provision is by far the most unpopular insurance regulation provision in the ACA. The public favors, by a wide margin, many of the underwriting restrictions in the Act, particularly the ban on preexisting conditions exclusions, but is much less keen on the mandate itself.¹⁴ A more

12. High-profile examples of this feature of healthcare delivery abound. A set of studies by both the Dartmouth Atlas of American Health Care and the Congressional Budget Office have found dramatic variations in Medicare cost per patient in different regions of the country, even after controlling for all relevant health, population, and price index variables. *See, e.g., id.*

13. *See* Patient Protection and Affordable Care Act § 3403.

14. Mollyann Brodie et al., *Liking The Pieces, Not The Package: Contradictions In Public Opinion During Health Reform*, 29 HEALTH AFFAIRS 1125, 1127 (2010); Louise Radnofsky, *Poll: Voters Like Much of Health Care Law—But Not Individual Mandate*, WALL ST. J. (Nov. 30, 2011, 7:00 AM), <http://blogs.wsj.com/washwire/2011/11/30/poll-voters-like-much-of-health-care-law-but-not-the-individual-mandate/>.

nanced framing study demonstrates that the perceived intrusion on individual autonomy in healthcare decisions in particular makes the mandate unpopular: Polling questions that reference “choice” when asking about the mandate produce the highest levels of public opposition.¹⁵

These studies illuminate one conceptual incongruity between the imperatives of formal constitutional doctrine and the realities of public opposition. The case for the mandate’s Commerce Clause invalidity hinges on its characterization as a regulation of pure inactivity. Yet the public opposition to the mandate derives from concerns about government intrusion into the more active choices that individuals have traditionally made about their medical care. There is an irony as well for supporters and proponents of the Act, in that the mandate provision is most unpopular precisely when framed as a mandatory incursion on choice. Had the ACA’s architects given the provisions the functionally more accurate label of a tax (on a kind of free riding) or an “EMTALA risk adjustment payment,”¹⁶ presumably they would have faced an immediate political hit in late 2009 and 2010 for raising a new tax, but might be facing less ongoing opposition over this provision after the Act’s passage.

Second, given the deep public unease about systemic reordering that threatens individual choice, the present opposition to the individual mandate is best seen as an early salvo in what promises to be a recurring series of conflicts over the reshaping of the American health insurance and delivery systems, whatever shape eventual reform takes. There is no public–private distinction in this contest of authority regarding the submerged constitution of traditional healthcare authority—both private and public efforts to manage, standardize, and optimize the allocation of medical care will create conflict with the older diffuse model of authority.

This latter point—about the constraining effect of the public’s embrace of the individualized authority regime over even private reform efforts—was illustrated by the collapse of managed care in the last decade. In the years following the demise of the Clinton plan in 1994, many health policy scholars and industry analysts put great faith in the growth of “managed care” delivery systems, which sought to centralize care management through prospective utilization review, payment reform, and, in some cases, direct employment of physicians. Due to ERISA preemption¹⁷ of state insurance regulations and other permissive factors in the legal and economic landscape of the 1990s, managed

15. See David Asch et al., *Polling Analysis: Public Support for Health Reform Was Broader Than Reported and Depended on How Proposals Were Framed*, 30 HEALTH AFFAIRS 1242, 1245 (2011).

16. Emergency Medical Treatment and Active Labor Act, 42 U.S.C. § 1395dd (2006); see generally Neil S. Siegel, *Free Riding on Benevolence: Collective Action Federalism and The Minimum Coverage Provision*, 75 LAW & CONTEMP. PROBS., no. 3, 2012 at 29.

17. Employee Retirement Income Security Act of 1974, Pub. L. No. 93-406, 88 Stat. 829 (codified as amended in scattered sections of 5 U.S.C., 18 U.S.C., 26 U.S.C., 29 U.S.C., and 42 U.S.C.). On ERISA preemption in the context of a leading Supreme Court case, see Theodore W. Ruger, *The Supreme Court Federalizes Managed Care Liability*, 32 J. L. MED. & ETHICS 528 (2004) (describing the *Aetna v. Davila* case which preempted state tort remedies for insurance company negligence in health plan administration).

care organizations appeared poised to reshape the delivery of healthcare in the United States and achieve meaningful cost control in the process. According to one leading scholar of this episode, the managed care wisdom of the decade was the same one that “imbued President Clinton’s Health Security Act and continued to influence public and private decision-making for several years thereafter” and was driven by a belief that on insurance and delivery matters “one size fit all or could be made to fit all.”¹⁸ Many insurance companies, most notably Aetna, made huge investment-backed strategic decisions to position themselves for the new era of managed care.

Yet despite no regulation or restriction from the federal government, and only weak and incomplete legal responses from the states, the strong-form managed care practiced by large insurers in the 1990s proved a disaster for the companies themselves, largely due to intense patient and physician opposition. Patient enrollees left managed care organizations in droves in many states, balking at the notion of more centralized decisionmaking (even as studies showed that actual patient satisfaction in such arrangements was as high, or higher, than in ordinary fee-for-service insurance). Providers resisted vehemently and predictably to threatened incursions on their individuated autonomy and refused to negotiate the concessions insurance companies expected they could extract. Aetna, the insurance company that had bet most heavily on managed care, was hit the hardest, seeing its stock price fall from a high of \$82 per share in 1997 to \$25 in 2001 as it became apparent that the heavily managed care model would not work in the institutional and normative context of the 1990s.¹⁹ Today’s reform imperatives, encouraged in part by some of the ACA’s provisions supporting “Accountable Care Organizations,”²⁰ augur a return to private ordering in favor of greater institutional control of care, and thus similar opposition can be expected to recur repeatedly.

To the extent it likewise concerns misgivings about centralized intrusions on individual choice in the healthcare area, the individual mandate litigation thus both echoes prior disputes over medical authority and presages the coming battles that will take much longer to resolve. Packaged as it is in the specialized vernacular of formal doctrine, and sited in the hierarchical setting of the federal courts, the mandate litigation presents a much simpler prospect of resolution. It is far more difficult to imagine the manner in which reformed public and private healthcare institutions will—across many years and thousands of points of institutional conflict—succeed in reordering and rationalizing the longstanding patterns of fragmented authority in the medical system.

Finally, that the individual mandate litigation is a minor skirmish in a much broader process of reframing authority in American medicine does not render it

18. James C. Robinson, *From Managed Care to Consumer Health Insurance: The Fall and Rise of Aetna*, 23 HEALTH AFFAIRS 43, 44 (2004).

19. *Id.* at 53.

20. *See generally* Health Policy Brief, Accountable Care Organizations, HEALTH AFFAIRS (July 27, 2010).

unimportant. To the contrary, precisely because there is so much work to be done—work that is much harder than anything framed so far under the ACA—it is important to put the current controversy behind us and move to more difficult and relevant questions of implementing the ACA and other necessary public and private sector reforms. A Supreme Court ruling against the mandate’s constitutionality would not long obviate the increasing public and private institutional control that many of the ACA’s opponents fear, for the resource imperative of systemic reform cannot long be held at bay. But a ruling against the mandate might produce another cycle of delay in beginning the process of reform that is already well overdue.

III

THE ACA AND THE LONG PATH OF HEALTHCARE FEDERALISM

The above pages have given a general overview of the manner in which current litigation and public opposition to the ACA interacts with, and relates to, broader patterns of individualized authority contained within the submerged constitution of American healthcare. Given the current litigation’s core doctrinal emphasis on federalism limitations, it is also useful to consider the current litigation in the broader frame of the long history of healthcare federalism in the United States. Viewed from the perspective of the earliest institutional behavior, the doctrinal opposition to the ACA paints an anomalous picture of Congress as an overreaching institution in the healthcare context: In reality the long pattern of congressional behavior has been to exercise considerably less than the full extent of its formal commerce power when regulating on matters of health.

Likewise, when viewed from the perspective of the past half century’s explosion of cooperative or joint federalism—where key federally funded programs are primarily administered by the states (for example, Medicaid)—the ACA litigation’s suggestion of an oppositional or mutually exclusive federalism is misleading. The ACA’s architecture adopts and extends the cooperative federalism model, leaving substantial discretion for the states in implementing the Act’s requirements. There is a substantial and ongoing federalism debate to be had over the ACA, but it is different from, and institutionally and temporally much broader than, the formalist debates over the Commerce Clause taking place in the federal courts today. As the state health insurance exchange provisions of the ACA are implemented beginning in 2014, the more important federalism questions will be prioritized, as states will exercise broad discretion and variation in regulating insurers within and outside of their exchange, with real consequences for patients’ rights and optimal system design. Federal administrative practice has encouraged such state experimentation in the context of predecessor cooperative programs like Medicaid and the State Children’s Health Insurance Program (SCHIP), and the current administration appears to have adopted this posture for the ACA’s implementation. The federal department of Health and Human Services (HHS) issued regulations in

July 2011 that signaled a willingness to give states high levels of discretion to variously interpret and implement the ACA's provisions on exchanges.²¹ Experience with Medicaid suggests HHS will continue to permit dramatic state variability, and the shape and scope of this devolution in implementation will generate recurring questions about uniform standards and state prerogatives to administer different insurance regulation regimes. These federalism disputes will be ongoing and will reside not in the federal courts but primarily in the nuanced context of state and federal administrative practice and congressional oversight of the Act's implementation.

A more detailed glimpse of the historical development of healthcare federalism in the United States illustrates several of these themes. The earliest contests of different visions of national authority, which played out first in explicit congressional debate described below, are interesting as a comparative exercise of heated debate over the same topics subject to current litigation. But throughout the nineteenth century, the institutional valence was reversed from the premise of current ACA opponents—in that epoch it was Congress that was reluctant to exercise even a minimal amount of regulatory authority in the health area. Other coordinate branches (various Presidents and the Supreme Court) consistently articulated a broader view of the national authority over health matters, like the power to quarantine, than Congress was willing to operationalize through statutory lawmaking. This pattern of congressional declension carried through much of the twentieth century. Put in the language of constitutional theory, Congress dramatically overenforced perceived federalism limitations (relative to contemporaneous understandings by other branches) regarding its power to regulate health matters for almost two centuries.

This pattern of congressional overenforcement (and underactivity) has two implications for the Commerce Clause litigation now pending before the Supreme Court. First, it would be ironic, and not a little unfortunate, if the modern Supreme Court chooses to thwart Congress when it has finally exercised regulatory authority in the health field similar to what it has exerted in other areas of economic life. The long legislative failure to exercise the full scope of congressional authority over health matters should not now be interpreted to work a diminution of power in Congress. To the extent objections to the ACA are founded in the long tradition of vesting health matters to the states, this tradition ought to be recognized for what it is—a deferential congressional choice to underregulate rather than a fixed and judicially enforceable outer boundary. Relatedly, slipperly slope arguments against the ACA's validity that are premised on a parade of hypothetical follow-on laws from Congress (like the famous imaginary broccoli mandate) are grounded in a presumption of Congressional profligacy regarding health regulation that is directly contrary to the history of two centuries of institutional

21. See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 C.F.R. pt. 155 and 156).

reticence in this area.

Second, it is important to note that the ACA, although an important new assertion of federal regulatory authority and federal budgetary commitment, nonetheless architecturally reflects the sensitivity to state authority that has long been evinced by prior Congresses. States retain primary regulatory authority over healthcare financing and delivery under the ACA.²² The statute's form, and its likely impact once implemented, extends and supports state regulatory authority over healthcare rather than subverting it.

The first great debate over the national government's role in public health, which would recur throughout the nineteenth century, was over federal quarantine authority. In this institutional dynamic a reluctant Congress repeatedly declined to exercise the authority that several Presidents, and even the Supreme Court, opined that it held. John Adams was the first American President to implore Congress to enact a national health statute,²³ although he would hardly be the last. He did so in his second annual address to Congress, in 1798.²⁴ Although the subject was finite (quarantine legislation for ports of entry to the United States), the federal government's authority to act was hotly debated, and Adams came down squarely in favor of national power.²⁵ He began his major address to Congress not with the growing hostilities with France (he would turn to that later) but with an ardent description of the "alarming and destructive pestilence with which several of our cities and towns have been visited."²⁶ He noted the "magnitude of the evils arising from the interruption of public and private business, whereby the national interests are deeply affected," and described his "duty to invite the Legislature of the Union" to consider federal legislation on quarantines. Adams was aware of the constitutional doubts surrounding his proposal, and offered his assurances of the validity of such federal legislation. Since "contagious sickness may be communicated through the channels of commerce," said the President, it was necessary and appropriate that Congress "should frame a system which, while it may tend to preserve the general health, may be compatible with the interests

22. On the states' substantial ongoing role in implementing the ACA, see Abbe R. Gluck, *Intrastatutory Federalism and Statutory Interpretation: State Implementation of Federal Law in Health Reform and Beyond*, 121 YALE L. J. 534, 576–95 (2011).

23. Of tangential interest perhaps in the current litigation is the fact that the very first federal statute relating to healthcare was itself a mandate to purchase healthcare, applied to ship owners who were required to provide medicine and insure merchant seamen against the costs of treatment. All ships were required to "provide[] a chest of medicines, put up by some apothecary of known reputation, and accompanied by directions for administering the same." See An Act for the Government and Regulation of Seamen in the Merchants Service, ch. 24, § 8, 1 Stat. 131, 134 (1790). Masters of ships were also required to "provide[] . . . for all such advice, medicine, or attendance of physicians, as any of the crew shall stand in need of case of sickness . . . without deduction from the wages of such sick seaman or mariner." *Id.* at 135.

24. John Adams, Second Annual Message to Congress (Dec. 8, 1798), available at <http://www.presidency.ucsb.edu/ws/index.php?pid=29440#axzz1k3T2LYIT> (last visited Mar. 17, 2012).

25. *Id.*

26. *Id.*

of commerce and the safety of the revenue.”²⁷

In proposing such a national quarantine law for seaports, and vouching for its constitutional validity, Adams endorsed a view of federal authority over such matters that was entirely respectable and widely shared at the time. Key members of Congress had recently supported the constitutionality of a similar quarantine authority to be vested in the President in the context of a bill debated on the floor of the House of Representatives two years earlier. William Smith of South Carolina described such power as “perfectly within the Federal jurisdiction,” since “if the performance of quarantine was neglected such neglect naturally tended to affect the lives as well as the revenue and the commerce of the citizens throughout the United States.”²⁸ Samuel Smith of Maryland concurred, arguing that this bill was “a commercial regulation, and, therefore, the business of the General Government.”²⁹ Reflecting the mutually exclusive attitude toward federal–state authority held by many in the early nineteenth century, Samuel Sitgreaves of Pennsylvania was even more assertive, arguing that it was a “matter of very serious doubt whether, upon this subject [of maritime quarantines], the States had any authority at all” since the power was “vested by the Constitution in the Congress, under their general authority to regulate commerce and navigation.”³⁰

Even Thomas Jefferson, Adams’ successor in office and no friend of expansive national power, would similarly endorse the latent authority of the federal government over quarantine in a speech to Congress a few years later. In his annual address to that body in 1805, Jefferson acknowledged the possibility that federal quarantine legislation might one day prove desirable, and defended its constitutional validity (although he declined to propose specific action). He proposed a cautious cooperative approach:

As we advance in our knowledge of this disease, as facts develop the source from which individuals receive it, the State authorities charged with the care of the public health, and Congress with that of the general commerce, will become able to regulate with effect their respective functions in these departments. . . . Although the health laws of the States should be found to need no present ³¹revisal by Congress, yet commerce claims that their attention be ever awake to them.

Despite such unlikely consanguinity between Adams and Jefferson as to the federal commerce power over quarantine laws, these two were merely the first in a long line of Presidents to witness Congress acting on a different, and sharply diminished, view of national authority in the health law field. In a series of legislative decisions that reverberated into the twentieth century, Congress, from the late eighteenth century forward, repeatedly declined invitations to regulate even minimally in the health field such as by enacting commercial

27. *Id.*

28. 5 ANNALS OF CONG. 1357 (1796).

29. *Id.* at 1352.

30. *Id.* at 1350.

31. Thomas Jefferson, Fifth Annual Address to Congress (Dec. 3 1805), *available at* <http://www.presidency.ucsb.edu/ws/index.php?pid=29447#axzz1kyw3cmML> (last visited Mar. 17, 2012).

quarantine laws. Such early legislative incapacity produced a pattern of unexercised authority and a corresponding dearth of institutional development at the federal level.

In 1796, the Fourth Congress was the first one to debate the topic extensively when it considered a bill similar to the one Adams proposed two years later that would have given the President limited maritime quarantine authority over incoming ships and their cargo and passengers. In response to the claims of constitutional validity summarized above, opponents argued vehemently that quarantine laws were “by no means a commercial regulation, but a regulation which respected the health of our fellow-citizens” and thus within the sphere of state authority.³² Other members raised policy arguments favoring individualized state authority, claiming that states “were the best judges” of their own situation, and that federal rules would “interfer[e] with state policy.”³³

Exasperated at such claims and other statements that a federal quarantine would be “imperious” and an “injudicious interference” with the states, William Smith, a supporter of federal quarantine authority, questioned his colleagues’ denigration of national authority in terms that presaged today’s debates over national power and perhaps would resonate with various defenders of the ACA against current Commerce Clause challenges. “Who are we?” Smith asked, speaking of Congress, “Are we a foreign government?” He also chided opponents who had on other topics supported robust federal authority for having “already forgotten their arguments on former occasions, when speaking of the power of the House, they could then do anything and everything.”³⁴

Ultimately such arguments in favor of federal legislative action failed in 1796, as they would after John Adams’s speech in 1798 and then repeatedly over the following century. Congress refused to enact national quarantine legislation in 1796. Instead, they passed what would be the template for federal activity with respect to quarantines through most of the nineteenth century. Federal authority was made subservient to the states: The President was ordered to “direct the [federal] revenue officers and the [federal] officers commanding forts and revenue cutters, to aid in the execution of quarantine” in accordance with state law.³⁵ Statutes embodying this deferential reverse-*Printz*³⁶ dynamic were reenacted with minor variations several times in the following decades.³⁷ So, for instance, Congress in 1798 and 1830 reenacted the same

32. 5 ANNALS OF CONG. 1352 (1796).

33. *Id.* at 1354; *see also id.* at 1351 (statement of Rep. Giles) (noting that Savannah, Georgia was one thousand miles from the national capitol and that too much time would elapse before the Presidential quarantine order would reach that port to effectively limit disease).

34. *See id.* at 1356.

35. An Act Relative to Quarantine, ch. 31, 1 Stat. 474 (1796).

36. *See Printz v. United States*, 521 U.S. 898 (1997) (involving a federal law that temporarily sought to implement the opposite dynamic, whereby state officials would participate in implementing a federal background check rule for firearms purchases).

37. *See Joint Resolution Respecting Quarantine and Health Laws*, ch. 42, 14 Stat. 357 (1866); An

statute it had in 1796. Congress did establish a tentative national program to produce and distribute effective cowpox vaccine in 1813, and appointed federal vaccine agents to effectuate the plan.³⁸ But nine years later the national legislators opted to discontinue the program, deciding to leave the issue of vaccine production and dissemination to the states.³⁹ As late as 1879, Congress was still legislating tentatively and inconsistently in the health area: In that year it belatedly established a National Board of Health with authority to investigate diseases and impose quarantines, but permitted the new agency to lapse four years later based on arguments that such authority ought to remain with the states.⁴⁰ Not until the very last decades of the nineteenth century, and after express prodding from the Supreme Court, would Congress exercise substantive and permanent federal authority over quarantines.⁴¹

By now the pattern is clear enough: From the late eighteenth century onward, Congress evidenced a consistent trend of legislating on healthcare topics with less than what others within and outside of government thought its full Commerce Clause authority would permit. In so doing, Congress appears to have been acting on a perception of its own power in this area that was more cramped than that shared by other branches. The pages above detail various episodes of Presidential endorsement of a federal power over public health in the form of quarantine laws. The Supreme Court would have its say on the matter in 1886 in an extraordinary bit of dicta. If any doubts remained by then about whether Congress's doctrinal Commerce Clause power was capacious enough to accommodate greater federal health legislation, they were put to rest in a case involving a railroad's challenge to a state quarantine statute. Although it upheld Louisiana's power to quarantine, the Court, in an extraordinarily directive bit of dicta, was clear about the latent power that rested with Congress in that area:

But it may be conceded that whenever congress shall undertake to provide for the commercial cities of the United States a general system of quarantine . . . all state laws on the subject will be abrogated, at least so far as the two are inconsistent; but until this is done, the laws of the State on the subject are valid.

. . . .

For the period of nearly a century since the government was organized congress has passed no quarantine law, nor any other law to protect the inhabitants of the United States against the invasion of contagious and infectious disease from abroad; and yet,

Act to Enforce Quarantine Regulations, ch. 204, 4 Stat. 577 (1832); An Act Respecting Quarantines and Health Laws, ch. 12, 1 Stat. 619 (1799).

38. See An Act to Encourage Vaccination, ch. 37, 2 Stat. 806 (1813); see generally Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Legislation*, 35 LAW & CONTEMP. PROBS. 334 (Spring 1970).

39. See An Act to Repeal the Act, Entitled "An Act to Encourage Vaccination," ch. 50, 3 Stat. 677 (1822).

40. See An Act to Prevent the Introduction of Infections or Contagious Diseases Into the United States, and to Establish a National Board of Health, ch. 202, 20 Stat. 484 (1879).

41. See generally Michael Les Benedict, *Contagion and the Constitution: Quarantine Agitation from 1859 to 1866*, J. HIST. MED., Apr. 1970, at 177, 177.

during the early part of the present century, for many years, the cities of the Atlantic Coast, from Boston and New York to Charleston, were devastated by Yellow Fever. In later times the cholera has made similar invasions; and the yellow fever has been unchecked in its fearful course in the southern cities During all this time the congress never attempted to exercise this or any other powers to protect the people from the ravages of these dreadful diseases. No doubt they believe that the power to do this belonged to the states.⁴²

Congress during this era seemed less keen than the Court in asserting its authority—in 1879 it did finally create a National Board of Health with supervisory quarantine authority, but allowed that statute to lapse without renewal four years later.⁴³

The *Morgan* opinion's explicit judicial dictum is merely a high profile coda to an institutional pattern that recurred throughout the nineteenth century, from President Adams's speech onward. First, Congress repeatedly exercised less federal authority in the field of health regulation than coequal branches thought it held and ought to exercise. Second, congressional reluctance was motivated in significant part by constitutional arguments articulated by its members about the scope of their body's power. Finally, this pattern of inaction reverberated through the end of the nineteenth century and into the twentieth by virtue of settled patterns of institutional allocation and institutional competency that persisted long after the constitutional doubts over federal power subsided. That it did so with respect to health matters suggests a particular congressional solicitude for the regulatory prerogatives of states in that field, even compared with other regulatory areas with similar effects on interstate commerce. Well after anyone could seriously claim a Commerce Clause disability precluded federal action over healthcare issues, the basic structures of federal and state allocation had ossified, with a corresponding poverty of federal institutions relating to health regulation. This original principle of allocation adopted by Congress still echoes today in the shape of major federal statutes as well as the institutional structures that govern healthcare in the United States.

The distance between limited potential federal regulation in the nineteenth century was extended and compounded by additional regulatory devolutions that took place at the state level. Under the state licensure laws that were established by the end of the nineteenth century, the standard model was for states to devolve gatekeeping authority to the profession itself in the form of state-sanctioned medical boards.⁴⁴ Authority over medical practice was thus

42. See, e.g., *Morgan's La. & Tex. R.R. Co. v. La. Bd. of Health*, 118 U.S. 455 (1886). Modern observers of institutional interaction between the Court and Congress over the scope of federal authority will recognize this episode of judicial advice giving as a curious inversion of the institutional posture of the late twentieth century. Whereas the Rehnquist Court, in famously schoolmarmish tones, frequently scolded Congress for what the Court saw as Commerce Clause overreaching, the Justices a century before impatiently waited for Congress to act where the Court saw no doctrinal barrier.

43. See Carleton B. Chapman & John M. Talmadge, *Historical and Political Background of Federal Health Care Legislation*, 35 LAW & CONTEMP. PROBS. 334, 337–38 (1970).

44. On the rise and operation of state licensure boards in the nineteenth century, see generally RICHARD H. SHRYOCK, *MEDICAL LICENSING IN AMERICA, 1650–1965* 3–43 (The Johns Hopkins

doubly diffused from the general government to the states⁴⁵ and then again to a collective board of practitioners. Beyond a generalized gatekeeping authority, these boards, well into the twentieth century, exerted almost no actual control over the particularities of medical practice, effectively producing yet another diffusion from these collective professional structures down to the individual bedside.

This fragmentation of authority that derived from the nineteenth century Congress's crabbed sense of its own Commerce authority mattered in two different, related ways that remain relevant today. First, because health regulation was vested entirely in the states, the national government of the United States was largely absent from the field of public health and health policy until the twentieth century. This federal passivity suppressed national institutional development of federal bodies that might have played a more enhanced role in the twentieth century, and it relatedly shaped the contours of major twentieth century health statutes that perversely disabled the federal government from exercising its constitutionally permissible authority over the practice of medicine.

On the institutional front, in other nations—even where authority over therapeutic treatment was delegated to the professions—a host of ancillary health policy and public health functions, such as sanitation, vaccination, and quarantine, fell to the national government and led to the development of national institutions that would, in the twentieth century, take a more active role in regulating the practice of medicine. For instance, nineteenth century Britain permitted the medical profession a substantial degree of self-regulation like the United States, but in Britain this pattern of diffusion was anchored by various national bodies established by Parliament that exerted certain forms of centralizing control. In 1836 Parliament created the Office of Registrar General in Great Britain, which was vested with the power to collect health statistics from local authorities, and in 1848 instituted a General Board of Health.⁴⁶ The British Medical Act of 1858 created a General Council of Medical Education and required all practitioners in the nation to register with the council.⁴⁷ Although the actual controls over practice exercised by these early boards were slight, they reflect an emerging institutional presence at the national level that was lacking in the contemporaneous United States.⁴⁸

By centering medical regulation in the states, the parsimonious

Press 1967).

45. To say that the federal government has “devolved” authority to the states in this area is a modern functionalist view; it is of course more accurate historically to say that the states possessed, and retain, primary jurisdiction over such regulation under their inherent police powers. As discussed below, however, the federal government has assiduously refrained from entering this field of regulation even in the past half century when no formal constitutional barrier exists.

46. JERRY L. GAW, *A TIME TO HEAL: THE DIFFUSION OF LISTERISM IN VICTORIAN BRITAIN* 20 (1999).

47. *Id.* at 8

48. *Id.* at 8–9.

interpretations of federal power over health that early Congresses embraced decentered the institutional structures that might otherwise have developed alongside the growth of the healthcare system through the twentieth century. Congress deferred assiduously to the states even where, as in the case of communicable diseases, the interstate dimensions of a problem would have permitted Congress to address it, declining to develop any systemic national public health regulation during the nineteenth century. This stunted the development of national public health institutions that, in recent periods, might have taken a more active institutional voice in promulgating and disseminating optimal standards of care and otherwise might have acted to counter the decentralizing trends in American medicine. Moreover, this normative pressure on Congress to avoid incursions on state authority over medicine became calcified over this long course of development such that congressional practice through the twentieth century continued to enshrine the diffuse authority structures of medical regulation even long after doctrinal constitutional limits on federal power had eroded. What was originally perceived as a doctrinal imperative became converted into a powerful rhetorical trope that channeled behavior within Congress and without—the practice of medicine was to be regulated primarily, and exclusively, by the states.

The twentieth century would see a continuation of this long pattern even when Congress did enact statutes funding or regulating in the healthcare field. The result, which reverberates today, is a set of major federal health statutes intentionally filled with jurisdictional holes that disable federal institutions from meaningfully controlling therapeutic decisions even where such intervention might further safety or cost-control goals. This allocation was originally an imperative of perceived constitutional limits, but now persists due to a combination of regulatory path dependence and congressional deference to states over the proper locus of authority over medical care. Major federal statutory interventions like the Federal Food, Drug, and Cosmetic Act in 1938⁴⁹ and Medicare and Medicaid in 1965⁵⁰ expressly disclaimed federal authority over the actual practice of medicine (perceived to be within the states' sphere of regulation) even while expanding the federal role in crucial ways over the safety and security of the medical system. For instance, Congress disclaimed any intent to regulate medical practice despite becoming a major funder of new hospitals in the Hill–Burton Act in the 1940s, which provided that “nothing in this title shall be construed as conferring on any Federal officer or employee the right to exercise any supervision or control over the administration, personnel, maintenance, or operation of any hospital with respect to which any funds have been or may be expended under this title.”⁵¹ Likewise, the Medicare statute

49. Pub. L. No. 75-717, 52 Stat. 1040 (1938) (codified as amended in scattered sections of 21 U.S.C.).

50. Both were created by the Social Security Amendments of 1965, Pub. L. No. 89-97, 79 Stat. 286 (codified as amended in scattered sections of 42 U.S.C.).

51. See Hospital Survey and Construction Act, Pub. L. No. 79-725, § 2, 60 Stat. 1040, 1049 (1946).

commits the federal government as the guarantor of medical access for older Americans and others, but nonetheless states that “[n]othing in this title shall be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided.”⁵²

In repeatedly adopting a more parsimonious view of federal power over health issues than it might have exercised within the bounds of judicial constitutional doctrine, Congress has for the past two centuries engaged in a kind of legislative constitutionalism that has occurred in the context of other lawmaking episodes. But in this area of health policy the institutional valence regarding federal authority was inverted: Congress clung to a more narrowly crabbed sense of federal power than the Supreme Court or the Executive Branch. The result for healthcare has been a statutory “constitution” of negation, devolution, and underenforced authority at the federal level. To be clear, this long history evinces a recognizable strand of legislative constitutionalism, but to say that much does not mean that such patterns of congressional behavior are or ought to be imbued with controlling weight when raised in judicial constitutional litigation. Recognition that Congress has tended to overenforce federalism concerns in its own consideration of healthcare legislation ought not to compel similar judicial overenforcement in this area.

What is more, even as Congress has authorized the federal government to take a gradually larger role in the financing and regulation of healthcare delivery, its statutory architecture has consistently preserved a major role for state discretion in implementing federal programs. The ACA itself embodies this dynamic of cooperative federalism. In the past half century, as the national government has become more involved in funding healthcare, Congress has often enlisted states as front-line administrators, with vast discretion over policy variation of programs such as Medicaid and SCHIP, which cover tens of millions of Americans. The existing Medicaid statute permits states to select dramatically different levels of funding and coverage, alter and experiment with different financing and delivery modes, and opt to cover (or not to cover) a range of particular procedures and therapies.⁵³ States have leveraged this policy discretion to generate a myriad of dramatically different Medicaid programs over the past several decades.⁵⁴

The increasing state role in health governance has been fostered and encouraged not only by Congress in its basic statutory enactments but at least as

52. Health Insurance for the Aged Act, Pub. L. No. 89-97, § 102(a), 79 Stat. 290, 291 (1965).

53. See Jonathan R. Bolton, *The Case of the Disappearing Statute: A Legal and Policy Critique of the Use of Section 1115 Waivers to Restructure the Medicaid Program*, 37 COLUM. J. L. & SOC. PROBS. 91, 96–97 (2003) (describing the “great flexibility” Medicaid’s statutory scheme grants to states).

54. See, e.g., John Holohan, *State Variation in Medicaid Spending: Hard to Justify*, 26 HEALTH AFFAIRS 667, 667 (2007) (noting variance in 2004 state spending per Medicaid enrollee ranging from \$10,199 in New Jersey to \$3,664 in California); John Holohan and David Liska, VARIATIONS IN MEDICAID SPENDING AMONG STATES (The Urban Institute 1997) (mapping variations of both spending and treatments offered between states).

much by Presidents of both parties through increasingly lenient uniformity enforcement by the federal administrative bureaucracy. The past twenty years, particularly under Presidents Clinton and Bush, saw an explosion in the number of Medicaid and SCHIP demonstration waivers granted by the federal government to the states. Federal administrative philosophy under both Presidents appears to have been to permit substantial variation and experimentation by state policymakers in administering joint programs.

Unsurprisingly, the pervasiveness of this model of shared federalism in the healthcare area is particularly manifested in the fact that state government size and policy relevance has increased substantially faster than federal government over the past fifty years. In the aftermath of the major health program expansions such as Medicaid and Medicare, state government employees play an increasingly important role in the line-level implementation of national public policy. There are today about as many federal government employees as there were fifty years ago—roughly 2.5 million.⁵⁵ Over the same period, the number of state and local public employees has expanded dramatically: from about 3 million in 1943 to about 16 million today. Put differently, the proportion of public employees who work for the national government as opposed to subsidiary governments has declined from thirty-seven percent in 1953 to about fifteen percent today. Budget numbers indicate an increasing number of these state employees are working on health matters: By 2003, close to one-half of all federal grant money to state and local governments involved health initiatives as their subject matter.⁵⁶ There may well be valid concerns about a “government takeover” of healthcare, but in today’s regulatory climate of shared state–federal government responsibility, which the ACA’s provisions embody, talk of a Washington takeover is clearly misguided.

IV

CONCLUSION

The ACA builds on this framework of cooperative federalism, and its architecture mimics Medicaid and other enactments in putting states on the front lines of policy formulation and enforcement. Parts of the ACA provide significantly more federal funding for Medicaid by pouring federal money into the existing state regimes that currently implement that program. Other sections of the ACA direct each state to set up a new health insurance exchange through which individuals and small businesses can purchase regulated insurance. The Act leaves open or ambiguous many policy choices regarding the structure and functioning of the exchanges and their regulatory posture toward private insurers. And whatever state policy discretion is built into the Act’s statutory language has been stretched further by the Obama

55. Thomas Gais & James Fossett, *Federalism and the Executive Branch*, in *INSTITUTIONS OF AMERICAN DEMOCRACY: THE EXECUTIVE BRANCH* 503, Table 2 (Joel Aberbach & Mark Peterson eds., 2005).

56. *See id.* at 499.

Administration in its rulemaking behavior: in July 2011 HHS issued lengthy regulations on the state health insurance exchanges that permit “maximum flexibility” to the states in establishing and operating these new regulatory entities.⁵⁷ Contrary to much of the rhetoric surrounding the Commerce Clause litigation before the Supreme Court, state authority remains vital even in the new world of the ACA.

In light of all of this, the true federalism issues involving the ACA are those in this realm of cooperative and overlapping federalism, not those of absolute limitation as articulated by opponents in the Commerce Clause litigation. Recurring federalism issues, with real consequences for patients’ rights, will play out after the litigation dust settles and states start establishing and implementing very different visions of insurance regulation under the ACA’s exchange provisions. The ACA does create profound federalism questions, including risks of state and individual coercion, but the most important institutional contestation will take place on fault lines much more complex than those of formal Commerce Clause doctrine.

57. See Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41866 (proposed July 15, 2011) (to be codified at 45 C.F.R. pt. 155 and 156).