
ARTICLE

LEGAL LIMITS AND THE IMPLEMENTATION OF THE AFFORDABLE CARE ACT

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INTRODUCTION

Accusations of illegality have dogged the Obama Administration’s efforts to implement the Affordable Care Act (ACA),¹ the most ambitious piece of social legislation since the advent of Medicare and Medicaid. Some of the accusations have merit; indeed, it would be surprising if they did not. Even

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¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029. For ease of reference, and unless otherwise noted, citations will be to the scattered provisions of the U.S. Code codifying the ACA.

as the ACA's rollout has exposed unanticipated difficulties in the statutory design, congressional antipathy to health reform has precluded looking to the legislature to iron out those difficulties. To secure his principal achievement, President Obama has repeatedly tested the limits of executive authority in implementing the ACA.

Six years after its enactment and two years after its full implementation, now is an auspicious time to take stock. Moving past the partisan bickering, to what extent has the Obama Administration skirted the law or broken conventions to implement the ACA? In what ways, if any, has the messy implementation process set worrisome precedents? How troubled should we be if the Administration has at times brushed up against and even exceeded the limits of its power?

To get traction on these questions, this Article takes a close look at the most hotly debated legal questions surrounding the ACA's rollout. The selections reflect my own judgments about the most serious allegations of executive impropriety, but they are not idiosyncratic: they closely track—and indeed go beyond—the selections made by those seeking to demonstrate the President's disregard for law.² My hope is that a holistic and even-handed examination of the Administration's purported legal excesses will provide a useful focal point for understanding how law restrains executive discretion in a time of polarized politics. The Article closes with some thoughts about the status of executive lawbreaking in American constitutional culture and how to discipline such lawbreaking when it occurs.

I. TESTING LEGAL LIMITS

A. *Essential Health Benefits*

To ensure access to a comprehensive roster of basic services, the ACA requires health insurance for individuals and small businesses to cover the “essential health benefits.”³ The ACA, however, does not define what those benefits are. Instead, it instructs the Secretary of the Department of Health and Human Services (HHS) to specify what counts as essential, subject to some general guidelines.⁴ Essential benefits must include, for example,

² See, e.g., Senator Ted Cruz, *The Obama Administration's Unprecedented Lawlessness*, 38 HARV. J.L. & PUB. POL'Y 63, 100-07 (2015) (discussing “six major” legal violations committed by the Obama Administration with respect to its implementation of the ACA); see also Brief of Amici Curiae Cato Institute and Prof. Josh Blackman in Support of Petitioners at 2-3, *King v. Burwell*, 135 S. Ct. 2480 (2015) (No. 14-114) (arguing that the Obama Administration effectively rewrote the ACA by improperly modifying, delaying, and suspending the ACA's coverage rules, mandates, and subsidies).

³ 42 U.S.C. § 300gg-6(a) (2012).

⁴ *Id.* § 18022(b)(1).

emergency services, hospitalization, prescription drugs, and the like.⁵ The scope of the benefits must also be “equal to the scope of benefits provided under a typical employer plan, as determined by the Secretary.”⁶ The Secretary is otherwise afforded wide discretion to decide which treatments and services are essential.

Actually making those decisions promised to be both delicate and controversial. Too expansive a definition would drive up the cost of coverage, burdening working families and discouraging healthy people from buying insurance. But a narrower definition would deprive patients of access to care deemed nonessential, which would infuriate hospitals, physicians, and drug manufacturers that wished to offer that care. Whatever the ultimate outcome, the Secretary’s decision would “influence the nature of coverage available to millions of people in the United States.”⁷

When Congress enacted the ACA, the universal expectation was that the Secretary would specify a uniform, nationwide roster of benefits. It was thus front-page news—“a major surprise”⁸—when, late in 2011, HHS released a terse, thirteen-page Internet bulletin announcing that it would punt the decision to the states.⁹ Per the bulletin, each of the states would identify a “benchmark” plan from among existing plans sold to small businesses or government employees.¹⁰ Whatever benefits that the benchmark plan covered would then be considered “essential” within the state.¹¹ For states that declined to select a plan, the benchmark would be the largest small-group plan in the state.¹² After President Obama’s 2012 reelection, HHS proposed and finalized a rule adopting the benchmark approach.¹³

Politically, the decision was shrewd. It allowed the Obama Administration to sidestep a fractious rulemaking, avoid disruption to state insurance markets, and signal that the ACA was not a national takeover of the health insurance markets. As a policy matter, the approach also held appeal. The bulletin explained that even across different states, health plans “do not differ significantly in the range of services they cover.”¹⁴ Because no state could

⁵ *Id.*

⁶ *Id.* § 18022(b)(2)(A).

⁷ CHERYL ULMER ET AL., INST. OF MED. OF THE NAT’L ACADS., PERSPECTIVES ON ESSENTIAL HEALTH BENEFITS: WORKSHOP REPORT 17 (2012) (internal quotation marks omitted).

⁸ Robert Pear, *Health Care Law Will Let States Tailor Benefits*, N.Y. TIMES, Dec. 17, 2011, at A1.

⁹ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, ESSENTIAL HEALTH BENEFITS BULLETIN 8-9 (2011).

¹⁰ *Id.* at 9.

¹¹ *Id.*

¹² *Id.*

¹³ 45 C.F.R. § 156.100 (2015).

¹⁴ CTR. FOR CONSUMER INFO. & INS. OVERSIGHT, *supra* note 9, at 4.

select a barebones plan and deny vital services to their residents,¹⁵ deferring to the states appeared reasonable.

But is the benchmark approach legal?¹⁶ Nothing in the ACA explicitly prohibits the Secretary from adopting a state-specific, non-uniform approach to essential health benefits. As a first cut, the ACA's silence suggests that HHS, per *Chevron*,¹⁷ can fill the gap as it sees fit.

The lack of an outright prohibition, however, does not necessarily mean that HHS can allow the essential health benefits to vary from state to state.¹⁸ The question under *Chevron* “is always whether the agency has gone beyond what Congress has permitted it to do,”¹⁹ and it is difficult to square the benchmark approach with many features of the ACA's design. The implication is that, although Congress gave HHS broad discretion to define the essential health benefits, it may not have conferred the discretion to define them in this state-specific manner.²⁰

The most obvious objection to the Agency's approach is actually the least persuasive. The ACA delegates to HHS—not the states—the power to define the essential health benefits.²¹ Under D.C. Circuit case law, the Agency can't subdelegate that power to the states unless the ACA says it can²²—and the ACA says no such thing. At first blush, HHS's pre-commitment to adopting state-selected benchmarks looks like that kind of prohibited subdelegation.

But is that really what's going on? Under the same D.C. Circuit case law, an agency can properly “turn to an outside entity for advice and policy recommendations, provided the agency makes the final decisions itself.”²³ To my mind, that's the more accurate way to characterize what HHS has done. The Agency made the final decision about essential health benefits when it identified a narrow set of presumptively acceptable benchmark plans. Having

¹⁵ See *supra* notes 4–5 and accompanying text.

¹⁶ The following discussion draws on my prior work on the question. See generally Nicholas Bagley & Helen Levy, *Essential Health Benefits and the Affordable Care Act: Law and Process*, 39 J. HEALTH POL., POL'Y & L. 441 (2014).

¹⁷ *Chevron U.S.A. Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984).

¹⁸ See *Ry. Labor Execs.' Ass'n v. Nat'l Mediation Bd.*, 29 F.3d 655, 671 (D.C. Cir. 1994) (en banc) (“To suggest . . . that *Chevron* step two is implicated any time a statute does not expressly *negate* the existence of a claimed administrative power (*i.e.* when the statute is not written in ‘thou shalt not’ terms), is both flatly unfaithful to the principles of administrative law . . . and refuted by precedent.”).

¹⁹ *City of Arlington v. FCC*, 133 S. Ct. 1863, 1869 (2013).

²⁰ *Cf., e.g., Brown v. Gardner*, 513 U.S. 115, 120 (1994) (rejecting an agency interpretation that was a “poor fit” with the statute); *Cal. Indep. Sys. Operator Corp. v. FERC*, 372 F.3d 395, 401 (D.C. Cir. 2004) (same).

²¹ 42 U.S.C. § 18022(a)(1), (b)(1)(4) (2012).

²² See *U.S. Telecom Ass'n v. FCC*, 359 F.3d 554, 565 (D.C. Cir. 2004) (holding that the FCC could not delegate its regulatory authority to an outside entity without “an affirmative showing of congressional authorization”).

²³ *Id.* at 568.

made that critical decision, HHS can heed a state's choice about which particular plan, among acceptable alternatives, should serve as the benchmark.

A much more serious objection is that the benchmark approach renders a number of provisions of the ACA inscrutable or unnecessary. Consider, for example, how the ACA treats state coverage mandates. Such mandates are common: states variously require health plans to cover benefits like in vitro fertilization or applied behavior analysis for autism.²⁴ But Congress did not want federal taxpayers, who heavily subsidize individual health plans, to foot the bill for state-mandated treatments beyond those deemed essential.²⁵ The ACA thus limits federal subsidies to covering the essential health benefits²⁶ and requires states “to defray the cost of any additional benefits.”²⁷

The benchmark approach throws this carefully considered allocation of financial responsibility out the window. By dint of state law, any state-selected benchmark plan will necessarily cover state-mandated benefits. Such benefits will thus be folded into the definition of essential health benefits within the state. The upshot is that even a state with extravagant coverage mandates will never have to assume any additional costs to cover them. In effect, the benchmark approach allocates more federal subsidies to states with more extensive coverage mandates—contrary to Congress's deliberate attempt to avoid that result.

The difficulties run deeper. For example, the Office of Personnel Management (OPM) is supposed to contract with insurers to provide at least two “multi-State” plans on each state's exchange.²⁸ But those plans, by statute, must “offer[] a benefits package that is uniform in each State and consists of the essential benefits.”²⁹ A benefits package cannot be uniform across states if the essential health benefits vary from state to state.

OPM has tried to avoid the problem by reading the phrase “uniform in each State” to mean that the benefits “must be uniform within a State, but not necessarily uniform among States.”³⁰ That interpretation is linguistically plausible, but it leaves the uniformity requirement with no work to do. A given health plan's benefits are uniform in the state in which it is sold; if an insurer wished to offer a different benefits package, it would create and market a different health plan. Because the benefits package of a given multistate health plan will thus never vary within a state, Congress had no

²⁴ Bagley & Levy, *supra* note 16, at 451.

²⁵ 26 U.S.C. § 36B(b)(3)(D)(ii) (2012).

²⁶ *Id.*

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

²⁸ *Id.* § 18054(a)(1).

²⁹ *Id.* § 18054(c)(1)(A).

³⁰ Patient Protection and Affordable Care Act; Establishment of the Multi-State Plan Program for the Affordable Insurance Exchanges, 77 Fed. Reg. 72,582, 72,589 (proposed Dec. 5, 2012).

need to insist on uniformity “within a State,” as OPM would have it.³¹ The provision is meaningful only if it requires uniformity *across* states. OPM’s interpretation also trivializes a related provision allowing states to impose their coverage mandates on multistate plans, but only if they pay the increased expense.³² This deliberate and limited carve-out from the uniformity requirement would have been totally unnecessary if state plans must only be “uniform within a State.”

All told, the benchmark approach is in tension with several ACA provisions. The hard question is whether that tension is substantial enough to justify the inference that the adoption of such an approach exceeded HHS’s delegated authority. In my judgment, it is not, although the question is close. This is not a case where the agency has exploited statutory silence to intrude on a regulatory domain that Congress never meant for it to enter.³³ HHS instead interpreted a provision that the ACA gave it wide latitude to interpret. Nor is this a case where the chosen interpretation is completely incompatible with the statutory design.³⁴ At most, the interpretation is awkward and generates some statutory surplusage. But interpretations of complicated and complex statutes will almost always generate some awkwardness.³⁵ And since HHS can always revisit its benchmark approach—and indeed, it plans on doing so³⁶—provisions that are extraneous today may not be extraneous tomorrow. Something more definitive—something closer to out-and-out irreconcilability—would be necessary to demonstrate that Congress foreclosed the Obama Administration from adopting a state-centered approach to the essential health benefits.

³¹ *Id.*

³² 42 U.S.C. § 18054(c)(2)–(4).

³³ *See, e.g.*, *ABA v. FTC*, 430 F.3d 457, 470 (D.C. Cir. 2005) (invalidating an FTC interpretation regulating attorneys as “financial institutions” because it was a “poor fit” with the statutory language and the FTC based its interpretation merely on the fact that the statute did not specifically exempt attorneys).

³⁴ *See, e.g.*, *FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 160–61 (2000) (construing the “overall regulatory scheme” of the Federal Food, Drug, and Cosmetic Act to deprive the FDA of the authority to regulate tobacco products).

³⁵ *See, e.g.*, *Babbitt v. Sweet Home Chapter of Cmty. for a Great Or.*, 515 U.S. 687, 722 (1995) (Scalia, J., dissenting) (criticizing the Court’s decision to uphold agency’s interpretation of the Endangered Species Act and arguing that its interpretation “makes superfluous (or inexplicable)” other provisions of the Act).

³⁶ *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,813 (Feb. 27, 2015) committing to the benchmark approach through 2017 but expressing a willingness to reconsider at that point).

B. Administrative Delays

Under the ACA's employer mandate, midsize and large employers must offer qualifying health coverage to their employees or pay a tax penalty.³⁷ The mandate was supposed to take effect on January 1, 2014.³⁸ In July 2012, however, the Obama Administration made a surprise announcement that it would provide one year of "transition relief" from the mandate.³⁹ "In our ongoing discussions with businesses," the Administration explained, "[W]e have heard that you need the time to get this right. We are listening."⁴⁰

This was to be the first in a series of high-profile administrative delays. A few months before the ACA's new insurance rules were to take effect on January 1, 2014, a number of out-of-compliance health plans issued cancellation letters to their enrollees. President Obama came in for searing criticism for violating his oft-repeated claim that "if you like your health care plan, you can keep it." Members of Congress, including leading Democrats, proposed legislation to contain the political damage.⁴¹ The Administration believed, however, that the proposed bills would compromise the effectiveness of the ACA.⁴² To quell the controversy and forestall congressional action, the Obama Administration announced that certain existing health plans "will not be considered to be out of compliance with the market reforms" for at least another year.⁴³

These were not the only delays. More quietly, the Administration announced in early 2013 that, for a subset of insurers, it would delay for one year a requirement that they cap the amount their enrollees paid out of pocket for their care.⁴⁴ In February 2014, the Administration offered a second one-year

³⁷ 26 U.S.C. § 4980H (2012).

³⁸ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1513(d), 124 Stat. 119, 256 (2010).

³⁹ Mark J. Mazur, *Continuing to Implement the ACA in a Careful, Thoughtful Manner*, U.S. DEP'T TREASURY: TREASURY NOTES (July 2, 2013), <https://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx> [<https://perma.cc/WEK4-AC86>].

⁴⁰ Valerie B. Jarrett, *We're Listening to Businesses About the Health Care Law*, WHITE HOUSE BLOG (July 2, 2013, 6:00 PM), <https://www.whitehouse.gov/blog/2013/07/02/we-re-listening-businesses-about-health-care-law> [<https://perma.cc/4YHN-SKGT>].

⁴¹ Manu Raju, *Landrieu: Save Current Health Plans*, POLITICO (last updated Oct. 31, 2013, 7:00 AM), <http://www.politico.com/story/2013/10/mary-landrieu-vanishing-health-plans-099101> [<https://perma.cc/MDJ2-N37L>].

⁴² *Id.*

⁴³ Letter from Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight, to Ins. Comm'rs 1 (Nov. 14, 2013), <https://www.cms.gov/ccio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf> [<https://perma.cc/V456-38PT>].

⁴⁴ *Affordable Care Act Implementation FAQs - Set 12*, CMS.GOV (Feb. 20, 2013), http://www.cms.gov/CCHIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs12.html [<https://perma.cc/9EYQ-HBMT>].

delay of the employer mandate for midsize firms.⁴⁵ The following month, the Administration extended the “like it, keep it” fix for an additional two years.⁴⁶

Delays in rolling out large government programs are of course common. The ACA has been plagued with them.⁴⁷ But none of these delays were the result of an agency’s failure to meet a deadline or its inability to implement a congressional instruction. Instead, they resulted from conscious decisions to delay the dates on which congressional statutes directed at private actors would take effect.

The Obama Administration appears to justify the delays as routine exercises of the executive branch’s traditional authority to choose when, where, and under what circumstances to enforce statutes.⁴⁸ A federal agency, as the Supreme Court explained in *Heckler v. Chaney*, “[G]enerally cannot act against each technical violation of the statute it is charged with enforcing.”⁴⁹ Agencies must instead pick and choose. In the Administration’s telling, the ACA delays are of a piece with that longstanding practice. They merely postpone enforcement of certain provisions of the ACA that, in the Administration’s judgment, are not yet prudent to enforce.

This defense, however, runs counter to legal conventions governing the President’s duty to “take Care that the Laws be faithfully executed.”⁵⁰ Most notably, the administrative delays are not “discretionary judgment[s] concerning the allocation of enforcement resources” that, according to

⁴⁵ See Juliet Eilperin & Amy Goldstein, *White House Delays Health Insurance Mandate for Medium-Size Employers Until 2016*, WASH. POST (Feb. 10, 2014), https://www.washingtonpost.com/national/health-science/white-house-delays-health-insurance-mandate-for-medium-sized-employers-until-2016/2014/02/10/ade6b344-9279-11e3-84e1-27626c5ef5fb_story.html [<https://perma.cc/V426-6DS9>] (explaining that employers with fifty to ninety-nine employees will be given until 2016 to comply with the employer mandate).

⁴⁶ Press Release, U.S. Dep’t of Health & Human Servs., HHS 2015 Health Policy Standards Fact Sheet (Mar. 5, 2014), <http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-03-05-2.html> [<https://perma.cc/4PYV-V4HN>].

⁴⁷ See generally Memorandum from C. Stephen Redhead, Coordinator, Cong. Research Serv. et al. (Apr. 21, 2014), http://freebacon.com/wp-content/uploads/2014/04/aca_deadlines_memo_update.pdf [<https://perma.cc/3MI8-D4LT>] (providing overview of various ACA agency-action deadlines and describing agency actions taken to meet those deadlines).

⁴⁸ See Greg Sargent, *White House Defends Legality of Obamacare Fix*, WASH. POST: THE PLUM LINE (Nov. 14, 2013), <https://www.washingtonpost.com/blogs/plum-line/wp/2013/11/14/white-house-defends-legality-of-obamacare-fix/> [<https://perma.cc/KBZ5-Z8YB>] (quoting an HHS spokesperson saying that “[t]he Supreme Court held more than 25 years ago [in *Heckler v. Chaney*] that agencies charged with administering statutes have inherent authority to exercise discretion to ensure that their statutes are enforced in a manner that achieves statutory goals and are consistent with other administrative policies”). I say “appears” since the Administration has not offered a thoroughgoing public defense of the delays.

⁴⁹ 470 U.S. 821, 831 (1985).

⁵⁰ U.S. CONST. art. II, § 3. I canvassed some of these arguments in Nicholas Bagley, *The Legality of Delaying Key Elements of the ACA*, 370 NEW ENG. J. MED. 1967 (2014).

Heckler, lie at the heart of the nonenforcement power.⁵¹ The delays are instead bald efforts to avoid unwanted consequences associated with full implementation of the ACA. The delay of the employer mandate, for example, was meant to “give employers more time to comply with the new rules,”⁵² not to preserve the resources of the Internal Revenue Service (IRS). And the “like it, keep it” fix couldn’t have conserved federal resources because the states, not the federal government, have primary responsibility for enforcing the ACA’s insurance rules.⁵³

If the Administration wished to deprioritize enforcement, it could have kept quiet about its plans. The regulated community would still have felt obliged to comply even if the likelihood of enforcement was low. For policy reasons, however, the Administration wanted to relieve employers and health plans of certain obligations. The Administration thus used the public announcements of its nonenforcement policies to encourage the regulated community to disregard provisions of the ACA. Prospectively licensing large groups of people to violate a congressional statute for policy reasons is inimical to the Take Care Clause.⁵⁴ As the D.C. Circuit has cautioned, “[A]n agency’s pronouncement of a broad policy against enforcement poses special risks that it ‘has consciously and expressly adopted a general policy that is so extreme as to amount to an abdication of its statutory responsibilities.’”⁵⁵ The ACA delays embody that kind of abdication.

Indeed, the delays’ critics find support in an unusual place: the Obama Administration itself. In November 2014, the Office of Legal Counsel (OLC) released a careful analysis of the Department of Homeland Security’s (DHS) plans to deprioritize the removal of unauthorized aliens with children in the United States and grant them “deferred action” status, which would enable them to work.⁵⁶ In considering the legality of DHS’s plans, OLC discussed at length the limits that the Take Care Clause places on the exercise of enforcement discretion.⁵⁷ Although OLC eschewed bright-line rules, it reasoned that nonenforcement is most likely to be constitutionally permissible where it reflects a genuine, case-by-case effort to devote scarce resources to the most

⁵¹ *Edison Elec. Inst. v. EPA*, 996 F.2d 326, 333 (D.C. Cir. 1993).

⁵² Jarrett, *supra* note 40.

⁵³ See 42 U.S.C. § 300gg-22(a)(2) (2012) (allowing the federal government to enforce only where “a State has failed to substantially enforce” those rules).

⁵⁴ For a comprehensive and compelling defense of this view, see Zachary S. Price, *Enforcement Discretion and Executive Duty*, 67 VAND. L. REV. 671, 676 (2014).

⁵⁵ *Crowley Caribbean Transp., Inc. v. Peña*, 37 F.3d 671, 677 (D.C. Cir. 1994) (quoting *Heckler v. Chaney*, 470 U.S. 821, 833 n.4 (1985)).

⁵⁶ The Department of Homeland Security’s Authority to Prioritize Removal of Certain Aliens Unlawfully Present in the United States and to Defer Removal of Others, 38 Op. O.L.C., 2014 OLC Lexis 2 (Nov. 19 2014).

⁵⁷ *Id.* at *8-19.

urgent priorities.⁵⁸ At the same time, however, “the Executive cannot, under the guise of exercising enforcement discretion, attempt to effectively rewrite the laws to match its policy preferences.”⁵⁹

Due to their breadth and categorical nature, DHS’s enforcement plans presented a hard case. With respect to the parents of citizens and lawful permanent residents, OLC sustained DHS’s approach for three reasons: (1) acute resource constraints required prioritization; (2) immigration officers retained discretion to deport low-priority individuals when the circumstances warranted it; and (3) a number of statutory enactments suggested a congressional policy of promoting family unity when a child was a U.S. citizen or a lawful permanent resident.⁶⁰ None of these factors applies to the ACA delays. They were not driven by resource constraints; they did not preserve discretion to enforce against egregious offenders; and they found no support in congressional enactments. The Administration simply suspended parts of the ACA for policy reasons.

With respect to the delays of the employer mandate—but not to the other delays—the Obama Administration joined its general nonenforcement argument to a specific claim that Congress has acquiesced to a longstanding, bipartisan IRS practice of delaying the effective dates of tax statutes.⁶¹ For support, the IRS collected ten examples extending back to 2000.⁶² In 2007, for instance, the IRS gave tax preparers an extra six months to prepare for a new set of rules governing the improper preparation of a tax return.⁶³ And in 2011, the IRS declined to apply an excise tax on airline fuel for a sixteen-day period where Congress had specified an earlier effective date.⁶⁴

These past delays, according to the Administration, demonstrate that Congress has acquiesced to the IRS’s assertion of authority to delay new tax statutes. My kids make this kind of argument all the time. When I tell my son to stop jumping on the couch, he’s apt to say that he’s jumped on it before. For him, my earlier failure to tell him to stop means there is no rule against jumping on the couch. The Administration’s argument is as weak as my son’s

⁵⁸ *Id.* at *17-19.

⁵⁹ *Id.* at *15.

⁶⁰ *Id.* at *81-82. Since OLC could find no similar congressional solicitude for the parents of children who were neither citizens nor legally permanent residents, it concluded that DHS’s effort to grant them deferred action was impermissible. *Id.* at *82-86.

⁶¹ See Letter from Mark J. Mazur, Assistant Sec’y for Tax Policy, Dep’t of the Treasury, to Fred Upton, Chairman, House Comm. on Energy and Commerce (July 9, 2013), <http://waysandmeans.house.gov/wp-content/uploads/2015/10/Treasury-Letter-20140408HL.pdf> [<https://perma.cc/Z9JF-483Q>] (characterizing the delays as an “exercise of the Treasury Department’s longstanding administrative authority to grant transition relief when implementing new legislation like the ACA”).

⁶² *Id.* at 2 & n.2.

⁶³ *Id.* at 2.

⁶⁴ *Id.*

argument. Congress's failure to rebuke the IRS is not especially good evidence of congressional acquiescence. Maybe Congress never caught wind of the practice. ("I didn't see you jumping on the couch.") Maybe it heard about the practice but didn't think it was worth intervening. ("You're going to bed in five minutes anyhow.") Maybe it was distracted. ("I'm on the phone.")⁶⁵

The limited number and scope of past IRS delays underscores that it would be improper to make too much of Congress's silence. It's one thing to delay an airline excise tax for a little more than two weeks. Congress probably paid little or no attention to such a modest delay—or even to a dozen others like it. It's another thing altogether to delay for a full year (and for midsize employers, two years) a substantial tax applying to employers that forms an integral part of a statute aimed at providing near-universal health-care coverage.

The ACA delays thus appear to invade Congress's prerogative to specify when its laws come into force. The delays also set a worrisome precedent for future Presidents. Are all effective dates up for grabs? Are they to be treated as congressional suggestions that the President can revise, at least for a year or two? Given the Obama Administration's willingness to use past extensions of tax relief as precedent for delaying the employer mandate, the risk seems especially serious in the tax context. Consider, for example, the ACA's Cadillac Tax, which, beginning in 2018, will impose a 40% excise tax on employer contributions to jumbo insurance plans.⁶⁶ Although the tax is unpopular across the political spectrum—indeed, Congress recently suspended it until 2020 in a bipartisan budget bill⁶⁷—it arguably holds more promise for reducing long-term health spending than any other ACA provision.⁶⁸ Could a future President suspend it again for a couple of years? The OLC memo suggests not⁶⁹ but the pattern of interim delays suggests the contrary. And when it comes to precedent in the executive branch, deeds matter more than words.

C. *Hardship Exemptions*

By December 2013, it had become clear that some insurers were still canceling health plans that were out of compliance with the ACA's insurance rules, notwithstanding the Administration's effort to temporarily relieve them of their

⁶⁵ For a less cheeky elaboration of this point, see Curtis A. Bradley & Trevor W. Morrison, *Historical Gloss and the Separation of Powers*, 126 HARV. L. REV. 411 (2012).

⁶⁶ 26 U.S.C. § 4980I (2012).

⁶⁷ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. P, tit. I, § 101(a), 129 Stat. 2242, 3037 (2015).

⁶⁸ See Peter R. Orszag & Ezekiel J. Emanuel, *Health Care Reform and Cost Control*, 363 NEW ENG. J. MED. 601, 602 (2010) (explaining how the tax will "help to bend the long-term cost curve" and "put downward pressure on the growth of healthcare costs").

⁶⁹ See *supra* notes 56–60 and accompanying text.

obligations to comply.⁷⁰ Confronted by a restive Congress, the Administration again took action. In a letter to Virginia Senator Mark Warner, Kathleen Sebelius, then-Secretary of HHS, sympathized with “those with canceled plans who might be having difficulty” purchasing a health plan.⁷¹ The same day, HHS released a memorandum confirming that anyone whose plan had been canceled would be eligible for a hardship exemption from the individual mandate if replacement coverage on the exchange would be more expensive.⁷² A few months later, the Administration quietly announced that the same hardship exemption would be available until October 2016.⁷³

The move has come under serious criticism. How could the Administration argue to the Supreme Court that the individual mandate was essential to making the ACA work when it so blithely waived it for those with canceled plans?⁷⁴ Even supporters of the ACA were nervous. As Ezra Klein pointed out, “Normally, the individual mandate applies to anyone who can purchase qualifying insurance for less than 8 percent of their income. Either that threshold is right or it’s wrong. But it’s hard to argue that it’s right for the currently uninsured but wrong for people whose plans were canceled.”⁷⁵

As a policy matter, these arguments have force. As a legal matter, however, they ring hollow. The ACA does exempt from the individual mandate any person who would have to pay more than 8% of her income for coverage.⁷⁶ But it also authorizes separate exemptions for anyone who “is determined by the Secretary of Health and Human Services . . . to have suffered a hardship with respect to the capability to obtain coverage under a qualified health plan.”⁷⁷ Plan cancellations plausibly give rise to such a “hardship” when it comes to the “capability” of getting coverage. For many people, the cancellation notices were a rude surprise, especially given the President’s

⁷⁰ Letter from Kathleen Sebelius, Sec’y, U.S. Dep’t of Health & Human Servs., to Senator Mark R. Warner, 2 (Dec. 19, 2013), http://media.cmgdigital.com/shared/news/documents/2013/12/19/Sebelius_letter.pdf [<https://perma.cc/H4ZY-M39J>].

⁷¹ *Id.*

⁷² Memorandum from the Ctr. for Consumer Info. & Ins. Oversight 1 (Dec. 19, 2013), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-12-19-2013.pdf> [<https://perma.cc/899E-T34U>].

⁷³ Memorandum from Gary Cohen, Dir., Ctr. for Consumer Info. & Ins. Oversight 3 (Mar. 5, 2014), <https://www.cms.gov/ccio/resources/regulations-and-guidance/downloads/transition-to-compliant-policies-03-06-2015.pdf> [<https://perma.cc/LH65-GBPK>].

⁷⁴ See Opinion, *ObamaCare’s Secret Mandate Exemption*, WALL ST. J., Mar. 12, 2014, at A18 (criticizing the Obama Administration for extending various hardship exemptions from the individual mandate).

⁷⁵ Ezra Klein, *The Individual Mandate No Longer Applies to People Whose Plans Were Canceled*, WASH. POST: WONKBLOG (Dec. 19, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/12/19/the-obama-administration-just-delayed-the-individual-mandate-for-people-whose-plans-have-been-canceled/> [<https://perma.cc/U2W2-Y6CF>].

⁷⁶ 26 U.S.C. § 5000A(e)(1)(A) (2012).

⁷⁷ *Id.* § 5000A(e)(5).

promise that they could keep their insurance under the ACA. Those who structured their affairs in anticipation of retaining their coverage—by stretching their budget to lease a car, for example—unexpectedly found themselves in the position of having to scrape up extra money to buy a health plan.

Indeed, characterizing plan cancellation as a hardship is consistent with a guidance document—issued months before the “like it, keep it” fiasco⁷⁸—explaining that a qualifying hardship would include a “significant, unexpected increase in essential expenses that prevented [an individual] from obtaining coverage.”⁷⁹ The fact that this particular hardship exemption is temporary reinforces the conclusion that it does not supersede the ACA’s specific 8% exemption governing the unaffordability of health insurance. The exemption for those with canceled plans is, instead, a temporary patch to avoid the financial disruption that switching to a more expensive health plan would entail. The ACA authorizes precisely such a patch.

D. *Premium Subsidies*

To subsidize the purchase of health plans on the new exchanges, the ACA extends “premium tax credits” to certain low- and middle-income individuals who buy insurance through the new state-specific exchanges.⁸⁰ The ACA invited the states to establish the exchanges themselves; if a state declined, the Secretary of HHS would establish a fallback exchange on the state’s behalf.⁸¹

The initial expectation was that most of the states opposed to the ACA would prefer to establish their own exchanges, if for no other reason than to keep the federal government out of their business. For thirty-four states, however, the decision of whether to establish an exchange got caught up in the political furor surrounding Obamacare, and they defaulted to the federal fallback.⁸²

At the time, the states did not anticipate that their refusal to establish exchanges might affect their residents’ eligibility for tax credits.⁸³ It turns out, however, that a complex statutory formula links the amount of those credits to the length of time the individual is enrolled in “an Exchange established by

⁷⁸ See *supra* notes 41–43 and accompanying text.

⁷⁹ Memorandum from Gary Cohen, Deputy Adm’r and Dir., Ctrs. for Medicare & Medicaid Servs. 1 (2013), <https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/exemptions-guidance-6-26-2013.pdf> [<https://perma.cc/QR47-BSN7>].

⁸⁰ 26 U.S.C. § 36B.

⁸¹ 42 U.S.C. § 18041(c)(1) (2012).

⁸² *State Decisions on Health Insurance Marketplaces and the Medicaid Expansion*, HENRY J. KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/state-decisions-for-creating-health-insurance-exchanges-and-expanding-medicaid/> [<https://perma.cc/7SXV-HS5U>].

⁸³ Brief of the Commonwealths of Virginia et al. as Amici Curiae in Support of Affirmance at 1-2, *King v. Burwell*, 135 S. Ct. 2480 (2015) (No. 14-114).

the State.”⁸⁴ Read literally, the provision suggests that no one in the thirty-four states that refused to establish their own exchanges is eligible for premium subsidies. The IRS, however, was not inclined to read the provision literally. Instead, it adopted a rule clarifying that tax credits would be available nationwide.⁸⁵

Pilloried as unlawful, the IRS’s rule led to the legal challenge that culminated in *King v. Burwell*, where the Supreme Court, in a 6-3 decision, upheld the validity of the rule.⁸⁶ Although the Court acknowledged the literal text of the statute supported the challengers’ position, it doubted that Congress would have used such an elliptical way to communicate that it meant to withhold tax credits from the residents of states that declined to establish their own exchanges.⁸⁷ The Court also pointed to other provisions of the ACA that would make little sense if it were construed as the challengers suggested.⁸⁸ In particular, the ACA requires those “qualified individual[s]” who are eligible to purchase health plans on an exchange to “reside[] in the State that established the Exchange.”⁸⁹ On the challengers’ theory, there would be no qualified individuals in states that declined to establish an exchange, meaning that no one could buy health plans at all on the federally established exchange.⁹⁰ Provisions like these, the Court reasoned, “suggest that the Act may not always use the phrase ‘established by the State’ in its most natural sense.”⁹¹

What appeared to clinch the case for the Court was the mismatch between the ACA’s design and the consequences of accepting the challengers’ interpretation. Without tax credits, the Court noted, relatively healthy people would drop coverage they could no longer afford, even as relatively unhealthy people would keep paying their premiums.⁹² Insurers would have to then raise their premiums to reflect the cost of their sicker enrollees, leading more healthy people to shed their coverage, resulting in still-higher premiums.⁹³ The loss of tax credits would thus “likely create the very ‘death spirals’ that

⁸⁴ 26 U.S.C. § 36B(b)(2)(A).

⁸⁵ 45 C.F.R. § 155.20 (2013).

⁸⁶ 135 S. Ct. 2480, 2496 (2015).

⁸⁷ *See id.* at 2495 (“Had Congress meant to limit tax credits to State Exchanges, . . . [i]t would not have used such a winding path of connect-the-dots provisions about the amount of the credit.”).

⁸⁸ *See id.* at 2491-92 (describing “several provisions that assume tax credits will be available on both State and Federal Exchanges”).

⁸⁹ *Id.* at 2490 (internal quotation marks omitted) (quoting 42 U.S.C. § 18032(f)(1)(A) (2012)).

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.* at 2493.

⁹³ *Id.*

Congress designed the Act to avoid.”⁹⁴ Because the statute could be read to avoid that “calamitous” result, the Court reasoned that it should be.⁹⁵

Although the challengers’ arguments in *King* were not frivolous, the Supreme Court’s decision should lay to rest the most extravagant claims of presidential overreach. The dispute reflected a legitimate difference of views about the proper interpretation of a complex statute—the sort of everyday disagreement that would have attracted little attention if the stakes were not so high.

E. *Cost-Sharing Subsidies*

For low-income people, making insurance affordable requires more than subsidizing their premiums. Most of the health plans on the exchanges have very high deductibles and require other out-of-pocket expenditures.⁹⁶ To help those who would otherwise struggle with steep cost-sharing obligations, the ACA requires health plans on the exchanges to reduce cost-sharing levels for enrollees who make less than 250% of the poverty level.⁹⁷ The ACA then instructs the Treasury Secretary to “make periodic and timely payments to the [health plan] equal to the value of the reductions.”⁹⁸ The cost-sharing payments are essential to the ACA’s overall scheme to provide affordable, near-universal coverage. Without them, health plans would have to bear the full costs of reductions, an estimated \$167 billion over ten years.⁹⁹

But there’s a problem. Although the ACA directs the Treasury Secretary to issue cost-sharing payments, it’s black-letter law that “a direction to pay without a designation of the source of funds is not an appropriation.”¹⁰⁰ Yet the ACA nowhere designates a source of funds to make the cost-sharing payments. The Obama Administration’s 2014 budget request therefore asked Congress for an annual appropriation to cover the payments.¹⁰¹ Congress declined.

⁹⁴ *Id.*

⁹⁵ *Id.* at 2496.

⁹⁶ See Matthew Rae et al., *Patient Cost-Sharing in Marketplace Plans, 2016*, HENRY J. KAISER FAM. FOUND. (Nov. 13, 2015), <http://kff.org/health-costs/issue-brief/patient-cost-sharing-in-marketplace-plans-2016/> [<https://perma.cc/VB8G-NE5J>] (noting that an average silver plan in 2016 requires enrollees to pay a \$3,064 deductible).

⁹⁷ 42 U.S.C. § 18071(c)(2)(A)-(C) (2012).

⁹⁸ *Id.* § 18071(c)(3)(A).

⁹⁹ CONG. BUDGET OFFICE, *THE BUDGET AND ECONOMIC OUTLOOK: 2014 TO 2024* app. at 107 (2014).

¹⁰⁰ 1 U.S. GOV’T. ACCOUNTABILITY OFFICE, GAO-04-261SP, *PRINCIPLES OF FEDERAL APPROPRIATIONS LAW 2-17* (3d ed. 2004) [hereinafter RED BOOK]; see also *Guam & V.I.*, B-114808, 1979 WL 12213, at *3 (Comp. Gen. Aug. 7, 1979) (concluding that a statutory instruction that the Secretary of the Treasury “shall remit” funds “merely establish[es] permanent authority for the program rather than a permanent indefinite appropriation”).

¹⁰¹ See *CTRS. FOR MEDICARE & MEDICAID SERVS., U.S. DEP’T OF HEALTH & HUMAN SERVS., JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES: FISCAL YEAR*

The Administration then quietly determined that it did not need an annual appropriation.¹⁰² It instead concluded that 31 U.S.C. § 1324 already appropriates the money to pay for both premium tax credits and cost-sharing reductions.¹⁰³ Enacted prior to the ACA, § 1324 is a permanent appropriation for tax refunds, including refunds arising as a result of tax credits.¹⁰⁴ Although cost-sharing reductions are not tax credits, the Administration believes that the ACA, in providing for insurance subsidies in § 36B of the Internal Revenue Code,¹⁰⁵ created a single program to make advance payments of both the premium tax credits and the cost-sharing reductions.¹⁰⁶ In the Administration's words, credits and reductions are both "properly regarded as 'refunds due from' Section 36B because [they] are compensatory payments made to subsidize an individual's insurance coverage based on that individual's satisfaction of the eligibility requirements in Section 36B."¹⁰⁷ To demonstrate that credits are "inextricable" from reductions, the Administration observes that an individual is eligible for reductions only if she receives credits, that advance credits and reductions are both paid to health plans, and that both serve to defray the cost of health insurance.¹⁰⁸

In addition, the Administration points to ACA provisions and post-ACA enactments as evidence that Congress believed that it had permanently appropriated

2014 7 (2013) (describing the Administration's request for an "annually-appropriated account[]" to cover the cost-sharing payments).

¹⁰² The first hint of the Administration's change of heart came when it quietly withdrew the cost-sharing payments from the list of funds subject to the budget sequester, which applies only to discretionary—not permanent—appropriations. Compare OFFICE OF MGMT. AND BUDGET, EXEC. OFFICE OF THE PRESIDENT, OMB REPORT TO THE CONGRESS ON THE JOINT COMMITTEE REDUCTIONS FOR FISCAL YEAR 2015 app. at 6 (2014) (omitting the cost-sharing payments from the list of sequestered funds), with OFFICE OF MGMT. AND BUDGET, EXEC. OFFICE OF THE PRESIDENT, OMB SEQUESTRATION PREVIEW REPORT TO THE PRESIDENT AND CONGRESS FOR FISCAL YEAR 2014 AND OMB REPORT TO THE CONGRESS ON THE JOINT COMMITTEE REDUCTIONS FOR FISCAL YEAR 2014 app. at 23 (2013) (including cost-sharing payments in the list).

¹⁰³ See Letter from Sylvia M. Burwell, Dir., Office of Mgmt. and Budget, to Senator Ted Cruz & Senator Michael S. Lee 4 (May 21, 2014), http://www.cruz.senate.gov/files/documents/Letters/20140521_Burwell_Response.pdf [<https://perma.cc/H6AP-3Y43>] (noting that cost-sharing subsidy payments are "made through the advance payments program and will be paid out of the same account from which the premium tax credit portion of the advance payments for that program are paid").

¹⁰⁴ 31 U.S.C. § 1324 (2012).

¹⁰⁵ 26 U.S.C. § 36B (2012).

¹⁰⁶ See 42 U.S.C. § 18082(a)(3) (2012) (directing the Secretary of the Treasury to make advance payments of tax credits and cost-sharing reductions to qualified health plans); *id.* § 18082(c)(2) (directing the Secretary of the Treasury to make advance payments of premium tax credits to qualified health plans); *id.* § 18082(c)(3) (same with respect to cost-sharing reduction payments).

¹⁰⁷ Defendants' Memorandum in Support of Their Motion for Summary Judgment at 12, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2016 WL 2750934 (D.D.C. May 12, 2016) [hereinafter Defendants' Summary Judgment Brief].

¹⁰⁸ *Id.* at 13.

money for the cost-sharing payments. For example, in dozens of places the ACA “authorized” federal spending without supplying an appropriation.¹⁰⁹ Later Congresses were expected to appropriate funds for that authorized spending on an annual basis.¹¹⁰ There is no similar authorizing language in the ACA provision governing cost-sharing reductions. In the Administration’s view, “There is no such . . . language . . . because Congress understood that the ACA itself provided a permanent appropriation.”¹¹¹

The ACA also contains a restriction on using premium tax credits and cost-sharing subsidies to pay for abortions.¹¹² Since language restricting the use of federal funds for abortions—the so-called Hyde Amendment—typically appears in annual appropriations, the provision was thought necessary only because the ACA’s core subsidy provisions required no such appropriations.¹¹³ Similarly, in 2013, Congress passed an appropriations bill conditioning payment of the premium tax credits and cost-sharing reductions on HHS certifying that an antifraud program was in place.¹¹⁴ Such a certification, according to the Administration, would have been unnecessary if the cost-sharing reductions had not already been appropriated.¹¹⁵

How does the Administration’s argument stack up? Without question, the premium tax credits and the cost-sharing reductions form essential parts of the same program. And the government is right that it’s hard to understand why Congress would have deliberately created a permanent appropriation for one and not the other. It’s not as if requiring an annual appropriation for cost-sharing reductions would have given Congress more control over federal spending. Even without an appropriation, the ACA creates an entitlement to cost-sharing reductions.¹¹⁶ Health plans can vindicate that entitlement before the Court of

¹⁰⁹ *Id.* at 14–15 (quoting Patient Protection and Affordable Care Act, Pub. L. No. 111–148, § 2705(f), 124 Stat. 119, 325 (2010)).

¹¹⁰ *Id.* at 15.

¹¹¹ *Id.*

¹¹² 42 U.S.C. § 18023(b)(2)(A) (2012).

¹¹³ See 155 CONG. REC. S12,660 (daily ed. Dec. 8, 2009) (statement of Sen. Hatch) (“[T]his bill is not subject to appropriations.”).

¹¹⁴ Continuing Appropriations Act, 2014, Pub. L. No. 113–46, § 1001(a), 127 Stat. 558, 566 (2013).

¹¹⁵ Defendants’ Summary Judgment Brief, *supra* note 107, at 32.

¹¹⁶ Cf. 2 U.S.C. § 622(9)(A) (2012) (defining “entitlement authority” as the authority “to make payments . . . the budget authority for which is not provided for in advance by appropriation Acts, to any person or government if, under the provisions of the law containing such authority, the United States is obligated to make such payments to persons or governments who meet the requirements established by such law”); *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472 (2003) (“[A] statute creates a right capable of grounding a claim within the [Tucker Act’s] waiver of sovereign immunity if, but only if, it ‘can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained.’” (quoting *United States v. Mitchell*, 463 U.S. 206, 217 (1983))); *Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (“We have repeatedly recognized that the use of the word ‘shall’ generally makes a

Federal Claims.¹¹⁷ Payment would then come from the Judgment Fund—a permanently appropriated fund to pay court judgments where “payment is not otherwise provided for.”¹¹⁸

The question is thus not whether the government will pay, but when. Given that premium tax credits have been appropriated, it’s sensible to construe the ACA (if at all possible) to avoid the possibility that health plans might have to bring thousands of duplicative lawsuits to obtain similar subsidies that form part of the same program. That’s especially so given that in 1997, Congress enacted a statute to discourage the creation of entitlements that would have to be funded annually—so-called “backdoor spending.”¹¹⁹ If Congress meant to create a new entitlement without a permanent appropriation, the government is right that it probably would have spoken more clearly.¹²⁰

Taking a highly functional approach, the government can reasonably maintain that fidelity to the legislative plan requires paying cost-sharing reductions out of the same appropriation that already exists for premium tax credits.¹²¹ The trouble is that appropriations law eschews that kind of functionalism. By statute, “[a] law may be construed to make an appropriation out of the Treasury . . . only if the law specifically states that an appropriation is made.”¹²² Nothing in the ACA specifically appropriates money for cost-sharing reductions.

statute money-mandating.” (internal quotation marks omitted) (quoting *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003))).

¹¹⁷ See *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) (“It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute.”); RED BOOK, *supra* note 100, at 2-49 (“A failure to appropriate . . . will prevent administrative agencies from making payment, but . . . is unlikely to prevent recovery by way of a lawsuit.”). Under *Bowen v. Massachusetts*, 487 U.S. 879 (1988), a suit seeking payment of mandatory cost-sharing reductions could technically be brought against the Treasury in federal district court under the Administrative Procedure Act (APA). Like the plaintiff in *Bowen*, health plans would be seeking equitable relief—specifically, money promised under a statute—not money damages “to remedy particular categories of past injuries or labors.” *Id.* at 904 n.39. The APA supplies the right vehicle for that kind of equitable relief. But, without an appropriation to make cost-sharing payments, the Treasury would have no funds to draw on to comply with an order to make such payments. *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 424 (1990). Therefore, to recover, plans would have to file suit in the Court of Federal Claims for money damages equivalent to what Treasury was obliged to pay.

¹¹⁸ 31 U.S.C. § 1304(a)(1) (2012).

¹¹⁹ See Balanced Budget Act of 1997, Pub. L. No. 105-33, § 10106(c)(1)(A), 111 Stat. 251, 682 (amending the Congressional Budget Act of 1974 to allow Congress to provide “new budget authority for any fiscal year”).

¹²⁰ Defendants’ Summary Judgment Brief, *supra* note 107, at 31-32.

¹²¹ See *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015) (“A fair reading of legislation demands a fair understanding of the legislative plan.”).

¹²² 31 U.S.C. § 1301(d) (2012).

Although the ACA links § 36B's premium tax credits to § 1324,¹²³ cost-sharing reductions aren't established in § 36B and they also aren't tax refunds. They are payments to insurers to reimburse them for reducing their low-income customers' cost-sharing burden. It's an enormous stretch to read an appropriation governing refunds for individual taxpayers to also cover payments to insurers.

As for the evidence of congressional meaning, it does suggest that Congress operated on the assumption that the ACA permanently appropriated money for the cost-sharing reductions. But that assumption appears to have been misplaced. Inferring an appropriation from statutory context and congressional purpose would seem to countermand the requirement that an appropriation be "specifically state[d]."¹²⁴ What's more, the contextual evidence that Congress meant to permanently appropriate money for the cost-sharing payments is far from conclusive. It's still possible (albeit unlikely) that Congress really did mean for the cost-sharing reductions to depend on annual appropriations for

¹²³ See Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1401(d)(1), 124 Stat. 119, 220 (2010) (amending 31 U.S.C. § 1324(b)(2) to include reference to § 36B of the Internal Revenue Code).

¹²⁴ 31 U.S.C. § 1301(d) (2012); see also RED BOOK, *supra* note 100, at 2-16 ("An appropriation cannot be inferred or made by implication."). The Administration has argued that this clear-statement rule applies only to *whether* a particular statute appropriates money, not to the *scope* of an appropriation. Defendants' Summary Judgment Brief, *supra* note 107, at 29. But the Government Accountability Office (GAO) appears to treat the clear-statement rule as applying to both questions, perhaps because that parsimonious interpretation would undercut § 1301(d)'s effort to afford Congress tight control over appropriations. See Architect of the Capitol, B-303961, 2004 WL 2793171 (Comp. Gen. Dec. 6, 2004) (applying the clear-statement rule to limit the scope of an appropriation covering employee fringe benefits); U.S. Postal Serv., 50 Comp. Gen. 863 (1971) (deploying the clear-statement rule to ascertain the temporal scope of a postal appropriations statute).

The case law, slim as it is, is to the same effect. Consider *Stitzel-Weller Distillery v. Wickard*. Pursuant to a marketing order adopted under the Agricultural Adjustment Act (AAA), whiskey distillers deposited money with the federal government for later redistribution. *Stitzel-Weller Distillery v. Wickard*, 118 F.2d 19, 21 (D.C. Cir. 1941). Like exchange plans, they operated on the assumption that the government would honor its obligations. *Id.* But after the AAA was declared partly unconstitutional in *United States v. Butler*, 297 U.S. 1 (1936), the government determined it could no longer pay up. *Id.* The distillers naturally sought to force payment of the funds. *Id.* To make their case, they pointed to an existing, permanent appropriation—much like the Obama Administration has pointed to an existing, permanent appropriation—allowing Treasury officials to disburse "trust funds" that had been deposited with the government. *Id.* at 22-23 (citing 31 U.S.C. § 725r (1940)).

The government agreed that Congress had appropriated money to disburse "trust funds" but argued that the specific list of trust funds to which it applied did not include money deposited under AAA marketing orders. *Id.* at 23. The distillers insisted that the statutory omission was a congressional oversight that the court should correct. *Id.* at 23. The court sided with the government: "We are of opinion that the Act does not confer this authority, for there is certainly nothing in . . . the Act which can be said specifically to declare the purpose of Congress to appropriate the sum in issue here for repayment to the distillers; and without such 'specific' appropriation, there can be no withdrawal of the money." *Id.* (quoting 31 U.S.C. § 627 (1940)). For the court, the specificity requirement applied not only to whether a statute was an appropriations statute—everyone agreed that it was—but also to the scope of that appropriation.

reasons that do not appear in the record. After all, many programs—even mandatory spending programs, including Medicaid—are funded through annual appropriations.¹²⁵ In contrast to *King*, where powerful statutory evidence indicated that Congress could not have meant quite what it said, the most natural reading of § 1324 is consistent with a plausible and coherent legislative plan.

Even accepting the premise that Congress meant to permanently appropriate money to cover the cost-sharing reductions, it doesn't follow that Congress meant § 1324 to serve as that appropriation. Indeed, it would have been odd for Congress to fund cost-sharing reductions out of an appropriation governing tax credits. That oddity suggests another possibility: that Congress, in the frantic negotiations over the ACA, simply overlooked the absence of language appropriating the money for the cost-sharing reductions.¹²⁶

The argument for reading § 1324 to appropriate money for the cost-sharing reductions is therefore thin. Indeed, the Obama Administration's apparent legal violation prompted the Republican-controlled House of Representatives to file a federal lawsuit to enjoin further spending in connection with the cost-sharing reductions. In May of this year, a Washington, D.C. district court sided with the House.¹²⁷ The court's conclusion that the House has standing to pursue the case is problematic;¹²⁸ indeed, *House v. Burwell* is likely to be dismissed on appeal. But the court's decision on the merits of the Appropriations Clause dispute appears correct.¹²⁹

The Obama Administration's willingness to bend the law here is to some extent understandable. Congress's refusal to meet the financial obligations that it assumed in prior legislation is a breach of a longstanding convention that Congress will appropriate the money to satisfy those obligations.¹³⁰ That breach of convention in turn imperils the Administration's signature legislative

¹²⁵ See William C. Fay & Michelle D. Rodgers, Appropriations for Mandatory Expenditures supplemental app. 5 (Mar. 30, 2008) (unpublished seminar paper, Harvard Law School), [http://www.law.harvard.edu/faculty/hjackson/MandatorySpending_17\(rev\).pdf](http://www.law.harvard.edu/faculty/hjackson/MandatorySpending_17(rev).pdf) [<https://perma.cc/49E3-MYEL>] (detailing the nature of appropriations for Medicare, Medicaid, and other mandatory spending programs).

¹²⁶ Cf. *Guam & V.I.*, B-114808, 1979 WL 12213, at *2 (Comp. Gen. Aug. 7, 1979) (“[W]e would agree that Congress probably did not anticipate that appropriations would be needed Nevertheless, . . . we must conclude that [the statutory provisions in question] do not constitute permanent indefinite appropriations.”).

¹²⁷ *U.S. House of Representatives v. Burwell*, No. 14-1967, 2016 WL 2750934 (D.D.C. May 12, 2016).

¹²⁸ Compare *U.S. House of Representatives v. Burwell*, 130 F. Supp. 3d 53, 81 (D.D.C. 2015) (finding standing), with Nicholas Bagley, *Oh Boy. Here We Go Again*, INCIDENTAL ECONOMIST (Sept. 9, 2015, 9:34 PM), <http://theincidentaleconomist.com/wordpress/oh-boy-here-we-go-again/> [<https://perma.cc/N24Q-XS94>] (criticizing the court's reasoning).

¹²⁹ Nicholas Bagley, *A Legal Setback for the Affordable Care Act*, 374 NEW ENG. J. MED. 2307 (2016).

¹³⁰ See Kate Stith, *Congress' Power of the Purse*, 97 YALE L.J. 1343, 1380 (1988) (“[I]n the case of statutory entitlement programs, even where Congress has not provided for a permanent appropriation—and instead, formally enacts a new appropriation each year—internal congressional rules and practice treat such appropriations as permanent and mandatory.”).

achievement. Without cost-sharing payments, health plans will have to pursue expensive and time-consuming litigation to recover what they are owed under the ACA. The plans will pass on the costs of the litigation, delay, and uncertainty to their customers, leading to higher premiums across the board. Those higher premiums will strain middle-income pocketbooks, increase federal outlays on premium tax credits, and drive healthy people from the exchanges. In the face of committed resistance from a Republican-controlled Congress that wishes to undermine the ACA in any way possible, the Administration may have felt that it had little choice but to find an appropriation where none exists.

Its decision nonetheless sets a troubling precedent for future battles over the appropriations power. Indeed, it may provide an opening to reevaluate the formalism that has long characterized appropriations law, at least where Congress has refused to appropriate money that it has already committed to pay. It's impossible to anticipate the full consequences of weakening the legislature's power of the purse; indeed, there's much to be said for a practice that refuses to countenance Congress's stubborn unwillingness to honor its debts. But the Administration's efforts to put the ACA on surer financial footing may embolden the next President to further slip the reins of legislative control—a dynamic that could have especially serious consequences for foreign affairs, where the appropriations power “remains one of the Congress's few effective legal tools to regulate presidential initiatives.”¹³¹

F. *Risk Corridor Appropriations*

A similar appropriations question surrounds the Administration's funding of the risk corridor program.¹³² The program serves as a financial buffer for health plans that might otherwise be reluctant to participate on the exchanges. For three years, beginning in 2014, health plans with gains that exceed a given target must return some of that money to HHS.¹³³ By the same token, plans that rack up substantial losses get money back from the Agency.¹³⁴

Without an appropriation, however, HHS cannot hand money to those health plans that should receive it. And, as with the cost-sharing reductions, the ACA contains no explicit appropriation for the risk corridor program. As a result, the Congressional Research Service concluded in January 2014 that HHS could not make any payments to insurers.¹³⁵ In the meantime, Congress

¹³¹ HAROLD HONGJU KOH, *THE NATIONAL SECURITY CONSTITUTION* 128-31 (1990).

¹³² See 42 U.S.C. § 18062 (2012) (establishing the program).

¹³³ *Id.* § 18062(b)(2).

¹³⁴ *Id.* § 18062(b)(1).

¹³⁵ See Memorandum from Edward C. Liu, Legislative Attorney, Cong. Research Serv., to House Energy and Commerce Comm. 3 (Jan. 23, 2014), <https://energycommerce.house.gov/sites/republishers.energycommerce.house.gov/files/20140123CRSMemo.pdf> [<https://perma.cc/384Q-YJKG>]

has declined to appropriate funds for the risk corridor program, which a number of leading Republicans have decried as an insurer “bailout.”¹³⁶

But the tempest over the risk corridor program is overdrawn. In September 2014, the Government Accountability Office, which is vested with responsibility for offering formal opinions on appropriations questions, concluded that an existing appropriation covered HHS’s risk corridor payments.¹³⁷ Specifically, appropriations bills covering fiscal years 2014 and 2015 allow the Centers for Medicare and Medicaid Services (CMS)—which runs the risk corridor program—to spend “user fees” it collects to carry out its various “responsibilities.”¹³⁸ In GAO’s view, the money that CMS collects from the risk corridor program is properly characterized as a user fee.¹³⁹ As GAO explained, the health plan “is paying for the certainty that any potential losses related to its participation in the Exchanges are limited to a certain amount, thus minimizing risk and maximizing business stability for the plan.”¹⁴⁰

GAO’s reasoning is not unassailable. Typically, a user fee is a charge imposed on those who take advantage of a given resource. A toll for crossing a bridge, for example, is a user fee. The risk corridor program operates differently. It’s a pooling arrangement: health plans that make more than a target amount share their profits with those that make less. Many health plans will thus never pay anything to participate. It’s a little odd to call something a user fee if many users never have to pay it.

Nonetheless, GAO’s conclusion appears basically sound. Its preexisting definition of a user fee—“[a] fee assessed to users for goods or services provided by the federal government”¹⁴¹—is broad enough to capture collections from the risk corridor program. Up front, every health plan commits to returning certain excess profits to the federal government. Those commitments have financial value even if no money changes hands. When some insurers

(finding that “it does not appear that a revolving fund exists for purposes of receipts and payments under [the risk corridor program]”).

¹³⁶ See Letter from Senator Marco Rubio et al., to John Boehner, Speaker, U.S. House of Representatives 2 (Oct. 8, 2014), http://www.rubio.senate.gov/public/index.cfm/files/serve/?File_id=7dc96d2f-1256-4816-bb06-025ed3d3363b [<https://perma.cc/CG6W-GE6Y>] (criticizing the President for “ignor[ing] Congress’s explicit and exclusive authority by spending money on the risk corridor program without an appropriation from Congress”).

¹³⁷ See Dep’t of Health & Human Servs., B-325630, 2014 WL4825237 (Comp. Gen. Sept. 30, 2014) (concluding that section 1342 of the ACA directs HHS to make risk corridor program payments to health plans).

¹³⁸ Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, 128 Stat. 2130, 2477 (2014); Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, div. H, tit. II, 128 Stat. 5, 374.

¹³⁹ Dep’t of Health & Human Servs., 2014 WL 4825237, at *4.

¹⁴⁰ *Id.*

¹⁴¹ *Id.* (alteration in original) (quoting U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-05-734SP, A GLOSSARY OF TERMS USED IN THE FEDERAL BUDGET PROCESS 100 (2005)).

end up giving some of their excess profits to the federal government, those payments reflect the liquidated amount of those earlier commitments. Seen that way, it is not anomalous to treat the after-the-fact payments as user fees.¹⁴²

Putting the legal question to one side, however, the Administration's justification has created an enormous problem. Treating collections as user fees allows CMS to disburse only as much as it receives in collections. Initially, CMS anticipated that collections would more than cover expenses.¹⁴³ If that didn't turn out to be the case, the Agency said that it would use any excess money collected for 2014 and 2015 to cover 2016 shortfalls.¹⁴⁴ And, "in the unlikely event that risk corridor collections . . . are insufficient to make risk corridors payments" for 2016, the Agency vaguely said that it "will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."¹⁴⁵

It's looking more and more likely that the risk corridor program will run out of money. On October 1, 2015, HHS announced that, for 2014, health plans were owed substantially more under the risk corridor program than they paid in. Unprofitable plans have therefore received just 12.6% of the amount due to them.¹⁴⁶ Those plans could still recover what they're owed for 2014 if collections in 2015 and 2016 far exceed outlays,¹⁴⁷ but most observers anticipate that the program will end up in the red. In the meantime, the demise of many new cooperative health plans has been attributed to low risk corridor payments.¹⁴⁸

Congress, however, has signaled that it won't appropriate new risk corridor funding. Although an appropriations bill for fiscal year 2015 continues to allow CMS to spend the risk corridor money that it collects, a rider prohibits the Administration from using newly appropriated funds to

¹⁴² For an argument that the ACA can perhaps be read to establish a revolving fund on which the Administration could draw to make risk corridor payments, see Nicholas Bagley, *Does the Risk Corridor Program Have a Fatal Technical Flaw?*, INCIDENTAL ECONOMIST (May 1, 2014, 6:22AM), <http://theincidentaleconomist.com/wordpress/does-the-risk-corridor-program-have-a-fatal-technical-flaw/> [<https://perma.cc/EL4V-GM5G>].

¹⁴³ Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70,674, 70,700 (proposed Nov. 26, 2014).

¹⁴⁴ *Id.*

¹⁴⁵ *Id.*

¹⁴⁶ Memorandum from the Ctr. for Consumer Info. & Ins. Oversight, Ctrs. For Medicare & Medicaid Servs. (Nov. 19, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf [<https://perma.cc/Y4SW-KD6Z>].

¹⁴⁷ *See id.* ("The remaining 2014 risk corridors payments will be made from 2015 risk corridors collections, and if necessary, 2016 collections.")

¹⁴⁸ *See, e.g.*, Timothy Jost, *Risk Corridor Payments, UnitedHealth, Cooperatives, and the Marketplaces*, HEALTH AFFAIRS BLOG (Nov. 20, 2015), <http://healthaffairs.org/blog/2015/11/20/risk-corridor-payments-unitedhealth-cooperatives-and-the-marketplaces/> [<https://perma.cc/S8V4-AQEU>] (describing the "devastating" effect of the risk corridor program on health insurance cooperatives).

make up for any shortfall.¹⁴⁹ The same rider appears in the 2016 appropriations bill.¹⁵⁰ Senator Marco Rubio has claimed credit for the rider—indeed, his presidential campaign said that he “[k]ill[ed] Obamacare”¹⁵¹—which raises the political heat over the risk corridor program and reduces the chances that Congress will quietly appropriate the money that health plans are entitled to. Although health plans may eventually recover what they are owed through lawsuits in the Court of Federal Claims,¹⁵² thinly capitalized plans that can’t withstand the loss of anticipated risk corridor funds may struggle to stay in the market.

G. *The Hill Fix*

As is typical for American workers, most federal employees receive health coverage as a fringe benefit. When an employee selects her health plan through the Federal Employees Health Benefits Program (FEHBP), she chooses from a list that OPM has supplied.¹⁵³ To keep costs down and quality high, OPM includes on the list only those plans with which it has contracted directly.¹⁵⁴ The federal government is then empowered by statute to make contributions for “an employee . . . enrolled in a health benefits plan under this chapter,”¹⁵⁵ which is to say, the chapter of the U.S. Code governing the FEHBP. Under this arrangement, the government only pays for the costs of those plans with which OPM has contracted directly.

The ACA upsets this scheme for a tiny group of federal employees, members of Congress and their staffers. Members and staffers can no longer secure coverage through the FEHBP. Instead, “the only health plans that the

¹⁴⁹ See Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, § 227, 128 Stat. 2130, 2491 (2014) (prohibiting various funds made available by the Act from being used for risk corridor program payments).

¹⁵⁰ Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, tit. II, § 225 (2015).

¹⁵¹ Marco Rubio (@TeamMarco), TWITTER (Nov. 24, 2015, 10:29 AM), https://twitter.com/TeamMarco/status/669221349403983872?ref_src=twsrc%5Etfw [<https://perma.cc/FC8S-QXMS>]. However, Senator Rubio played no part in getting the rider into the appropriations bill. See Glenn Kessler, *Rubio’s Inaccurate Claim that He “Inserted” a Provision Restricting Obamacare “Bailout” Funds*, WASH. POST: FACT CHECKER (Dec. 23, 2015), <https://www.washingtonpost.com/news/fact-checker/wp/2015/12/23/rubios-inaccurate-claim-that-he-inserted-a-provision-restricting-obamacare-bailout-funds/> [<https://perma.cc/C8GW-UNHT>] (crediting Representative Jack Kingston for the rider and noting that Kingston was not influenced by Rubio).

¹⁵² See Nicholas Bagley, *Did Marco Rubio Kill Obamacare?*, INCIDENTAL ECONOMIST (Dec. 1, 2015, 8:00 AM), <http://theincidentaleconomist.com/wordpress/did-marco-rubio-kill-obamacare/> [<https://perma.cc/WMS9-5UZA>] (explaining why damages lawsuits are likely to be viable). As this Article goes to press, at least six such lawsuits have been filed. See, e.g., Class Action Complaint ¶ 13, *Health Republic Ins. Co. v. United States*, No. 16-259 C (Fed. Cl. filed Feb. 24, 2016).

¹⁵³ 5 U.S.C. §§ 8903, 8903a, 8905(a) (2012).

¹⁵⁴ *Id.* §§ 8903, 8903a.

¹⁵⁵ *Id.* § 8906(b)(1).

Federal Government may make available to Members of Congress and congressional staff . . . shall be health plans that are . . . offered through an Exchange established under this Act.”¹⁵⁶

The ACA’s spare text presents a question. Now that members and staffers must go on the exchanges, can their employer—the federal government—still make contributions toward their health insurance? Since those contributions are a substantial part of members’ and staffers’ overall compensation packages, their elimination would effectively impose a large pay cut.

To avoid that result, OPM issued a rule—often called “the Hill fix”—allowing the federal government to keep contributing to the health coverage of their members and staffers.¹⁵⁷ Within months, Senator Ron Johnson of Wisconsin, together with one of his staffers, filed a high-profile lawsuit challenging the rule.¹⁵⁸ Johnson’s argument was straightforward: OPM can make contributions toward a health benefits plan “under this chapter,” but the only plans that qualify as “under this chapter” are those with which OPM has contracted to provide coverage to federal employees.¹⁵⁹ Because OPM does not contract directly with exchange plans, they are not health plans “under this chapter.”¹⁶⁰ As such, OPM can no longer contribute to the health insurance of members of Congress and their staffers.¹⁶¹ (In April of last year, the Seventh Circuit upheld the dismissal of the lawsuit for lack of standing.)¹⁶²

The Administration sees matters differently. When finalizing the Hill fix, OPM observed that Congress has actually defined “health benefits plan” for FEHBP purposes.¹⁶³ That statutory definition is broad enough to cover basically any group health plan, OPM contract or not: “a group insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or similar group arrangement provided by a carrier for the purpose of providing, paying for, or reimbursing expenses for health services.”¹⁶⁴ Plans purchased through the small-business exchange in

¹⁵⁶ 42 U.S.C. § 18032(d)(3)(D)(i) (2012). The requirement was the result of an amendment proposed by a Republican senator who hoped it would embarrass the Democrats. “But in a bit of jujitsu of which they were inordinately proud, Democrats instead embraced the amendment and added it to the law.” Ezra Klein, *No, Congress Isn’t Trying to Exempt Itself from Obamacare*, WASH. POST: WONKBLOG (Apr. 25, 2013), <https://www.washingtonpost.com/news/wonk/wp/2013/04/25/no-congress-isnt-trying-to-exempt-itself-from-obamacare/> [<https://perma.cc/5FXC-4G2B>].

¹⁵⁷ 5 C.F.R. § 890.501(h) (2016).

¹⁵⁸ Complaint, *Johnson v. U.S. Office of Pers. Mgmt.*, No. 14-C-0009 (E.D. Wis. July 21, 2014).

¹⁵⁹ *Id.* ¶ 53 (citing 5 U.S.C. § 8906 (2012)).

¹⁶⁰ *Id.* (citing 5 U.S.C. § 8906).

¹⁶¹ *Id.* ¶ 56.

¹⁶² *Johnson v. U.S. Office of Pers. Mgmt.*, 783 F.3d 655, 669 (7th Cir. 2015).

¹⁶³ See Federal Employees Health Benefits Program: Members of Congress and Congressional Staff, 78 Fed. Reg. 60,653, 60,653 (Oct. 2, 2013) (noting that the ACA did not alter the definition of “health benefits plan” for the FEHBP purposes (quoting 5 U.S.C. § 8901(6) (2012))).

¹⁶⁴ 5 U.S.C. § 8901(6) (2012).

Washington, D.C. certainly fit the bill. Such plans, OPM clarified, can therefore qualify as “health benefits plan[s] under this chapter.”¹⁶⁵

The Administration’s argument here is solid. Although Johnson and other critics are right to say that the “health benefits plan under this chapter” language is amenable to a narrower construction, they are wrong to insist that it must be read so narrowly. The statute is ambiguous on the precise question at hand, and OPM is vested with authority to resolve that ambiguity. It is perfectly reasonable for OPM to avoid a construction that would read the ACA to indiscriminately and dramatically cut the compensation of members of Congress and their staffers. After all, the ACA says nothing—not one word—about prohibiting the federal government from continuing to make employer contributions. To the contrary, the Act contemplates that the federal government will still “make available” health insurance to members of Congress and staffers,¹⁶⁶ reinforcing OPM’s conclusion that Congress expected the government to keep contributing to that insurance.¹⁶⁷

H. *The Private Option*

In *National Federation of Independent Business v. Sebelius*, the Supreme Court found the ACA’s Medicaid expansion to be unconstitutionally coercive.¹⁶⁸ As a remedy, the Court prohibited HHS from withdrawing a state’s existing Medicaid funding if the state declined to expand its Medicaid program.¹⁶⁹ Expansion became a take-it-or-leave-it decision, not a decision upon which the future of all Medicaid funding hinged. Because the states could realistically threaten to sit tight—indeed, nineteen states have still not expanded Medicaid¹⁷⁰—they earned new leverage in their negotiations with HHS over the terms on which they would expand.¹⁷¹

For its part, HHS has considerable discretion, under section 1115 of the Medicaid statute, to waive the normal rules governing Medicaid.¹⁷² Although no federal statute or agency regulation requires section 1115 waivers to be

¹⁶⁵ 5 C.F.R. § 890.201(d) (2016) (citing 5 U.S.C. § 8906).

¹⁶⁶ 42 U.S.C. § 18032(d)(3)(D) (2012).

¹⁶⁷ Cf. *Whitman v. Am. Trucking Ass’ns*, 531 U.S. 457, 468 (2001) (noting that Congress “does not alter the fundamental details of a regulatory scheme in vague terms or ancillary provisions”).

¹⁶⁸ 132 S. Ct. 2566, 2605 (2012).

¹⁶⁹ *Id.* at 2608.

¹⁷⁰ *Status of State Action on the Medicaid Expansion Decision*, HENRY J. KAISER FAM. FOUND., <http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/> [<https://perma.cc/P3S6-SXSC>].

¹⁷¹ Samuel R. Bagenstos, *The Anti-Leveraging Principle and the Spending Clause After NFIB*, 101 GEO. L.J. 861, 911-12 (2013).

¹⁷² Public Welfare Amendments of 1962, Pub. L. No. 87-543, § 1115, 76 Stat. 172, 192. This section of the Medicaid statute is codified in 42 U.S.C. § 1315 (2012).

budget neutral,¹⁷³ HHS has a “policy” of declining to approve waivers that will increase federal outlays.¹⁷⁴ Predicting whether a waiver will increase such outlays is not always easy, and HHS varies its scrutiny of state applications—and the assumptions underlying them—depending on its assessment of the merits of the application, the plausibility of the assumptions, and historical experience.

After *NFIB*, several states, led by Arkansas, requested waivers that would channel the Medicaid expansion population into the ACA’s new exchanges.¹⁷⁵ Under the so-called “private option,” federal Medicaid dollars would subsidize the purchase of exchange plans.¹⁷⁶ The hope was to persuade Republican leaders who would not have countenanced a traditional Medicaid expansion to endorse a market-based approach to the program.¹⁷⁷

The challenge was HHS’s cost-neutrality rule. Because exchange plans typically pay hospitals and physicians substantially more for their services than Medicaid pays, they are, on average, about one-and-a-half times as expensive as Medicaid.¹⁷⁸ Channeling beneficiaries onto the exchanges thus presented a serious risk of increasing federal outlays. Sensitive to the risk, HHS adopted a rule providing that the total costs of the private option “must be comparable to the cost of providing direct coverage” through Medicaid.¹⁷⁹

In allowing several states to move ahead with the private option, HHS accepted their representations that the private option would be no more expensive than a conventional Medicaid expansion. Yet those representations were little more than actuarial fictions. When Arkansas submitted its proposal, it did not compare the private option to an expansion of the Medicaid program that it had in place. Instead, it compared the private option to an expanded Medicaid program that paid providers at the same rates as private providers.¹⁸⁰ In other words, Arkansas assumed not only that this hypothetical Medicaid program would cover more people, but that it would also pay more for medical care than Arkansas’s Medicaid program has ever paid. By artificially inflating its payment

¹⁷³ U.S. GOV’T ACCOUNTABILITY OFFICE, GAO-14-689R, MEDICAID DEMONSTRATIONS: HHS’S APPROVAL PROCESS FOR ARKANSAS’S MEDICAID EXPANSION WAIVER RAISES COST CONCERNS 2 n.7 (2014) [hereinafter GAO’S ARKANSAS REPORT].

¹⁷⁴ *Id.* at 2.

¹⁷⁵ JANE B. WISHNER ET AL., URBAN INST., MEDICAID EXPANSION, THE PRIVATE OPTION, AND PERSONAL RESPONSIBILITY REQUIREMENTS: THE USE OF SECTION 1115 WAIVERS TO IMPLEMENT MEDICAID EXPANSION UNDER THE ACA 3-4 (2015).

¹⁷⁶ *Id.*

¹⁷⁷ *Id.* at 17.

¹⁷⁸ CONG. BUDGET OFFICE, ESTIMATES FOR THE INSURANCE COVERAGE PROVISIONS OF THE AFFORDABLE CARE ACT UPDATED FOR THE RECENT SUPREME COURT DECISION 4 (2012), <http://www.cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf> [<https://perma.cc/PY85-JGK8>].

¹⁷⁹ 42 C.F.R. § 435.1015(a)(4) (2013).

¹⁸⁰ GAO’S ARKANSAS REPORT, *supra* note 173, at 7.

rates, GAO later found, Arkansas was able to claim that a traditional Medicaid expansion would cost about 20% more than what it would have cost if the same payment rates were kept in place.¹⁸¹ Only with that 20% of extra padding—amounting to \$778 million over three years, or roughly \$267 per Arkansan—could the state argue that the private option would be cost-neutral.¹⁸²

What was the basis for Arkansas's assumption that Medicaid rates would have to rise to private levels? Arkansas noted that expansion would swell the rolls of Medicaid beneficiaries, which would in turn increase demand for medical services.¹⁸³ At current funding levels, however, Arkansas claimed that not enough physicians and providers would participate in Medicaid to meet that increased demand.¹⁸⁴ Maintaining its current rates would thus violate the Medicaid statute, which requires payment rates to be "sufficient to enlist enough providers so that care and services are available . . . at least to the extent that such care and services are available to the general population."¹⁸⁵

Arkansas submitted no data—and HHS demanded none—to support its assumption about the needed boost to Medicaid payments.¹⁸⁶ But it's an open secret in the health-policy community that the assumption is unrealistic.¹⁸⁷ No other state undertaking a traditional expansion has boosted its payment rates to private levels. Arkansas itself didn't contemplate any such increase when it explored a traditional expansion in 2012.¹⁸⁸ In addition, Arkansas's payment rates began at a substantially higher level than most states—about 20% more than the average rate and more than 50% more than the rate in

¹⁸¹ *Id.* at 8.

¹⁸² *Id.* at 3. The calculation above is based on a population figure of 2,915,918. *Population of Arkansas: Census 2010 and 2000 Interactive Map, Demographics, Statistics, Quick Facts*, CENSUS VIEWER, <http://censusviewer.com/state/AR> [<https://perma.cc/QUM2-4MAK>].

¹⁸³ GAO'S ARKANSAS REPORT, *supra* note 173, at 7.

¹⁸⁴ *Id.*

¹⁸⁵ 42 U.S.C. § 1396a(a)(30)(A) (2012).

¹⁸⁶ GAO'S ARKANSAS REPORT, *supra* note 173, at 7.

¹⁸⁷ See Austin Frakt, *A Privatized, Exchange-Based Medicaid Will Not Be Cheaper Than Public Medicaid*, INCIDENTAL ECONOMIST (Mar. 8, 2013, 7:00 AM), <http://theincidentaleconomist.com/wordpress/a-privatized-exchange-based-medicaid-will-not-be-cheaper-than-public-medicaid/> [<https://perma.cc/5ZA5-EQVC>] (arguing that Arkansas's plan to move the Medicaid expansion population onto the state's ACA exchange will not save the federal government money); Austin Frakt, *The Theoretical Argument for Cost Equivalency of Private Plans and Medicaid*, INCIDENTAL ECONOMIST (Mar. 29, 2013, 7:00 AM), <http://theincidentaleconomist.com/wordpress/the-theoretical-argument-for-cost-equivalency-of-private-plans-and-medicaid/> [<https://perma.cc/N4N5-SR5J>] (criticizing the argument that the cost of covering a Medicaid beneficiary under a private exchange plan will equal that of traditional Medicaid).

¹⁸⁸ ARK. DEP'T OF HUMAN SERVS., ESTIMATED MEDICAID-RELATED IMPACT OF THE ACA WITH EXPANSION (2012), <http://humanservices.arkansas.gov/director/Documents/Updated%20cost%20estimates%20for%20Medicaid%20expansion%20Nov%202012.pdf> [<https://perma.cc/83PA-WW95>].

California.¹⁸⁹ Why then are Arkansas's access concerns substantially more acute than that of other states with much lower payment rates?

HHS's cost-neutrality rule is difficult to square with its credulousness about state assumptions. That's why, in a subsequent review, GAO concluded that the Agency has "waived its cost-effectiveness requirement" in approving the Arkansas waiver application.¹⁹⁰ It's not hard to understand the motivation behind the Agency's willful blindness. For Arkansas, the choice was not between the private option and a traditional Medicaid expansion. The choice was between the private option and no expansion at all. That in turn suggests that HHS's disregard of its own rule may in some respects be salutary. The whole point of section 1115 is to promote state experimentation.¹⁹¹ Given the intrinsic difficulty of forecasting how program changes will affect enrollment, quality, access, and spending, HHS may reasonably think that the right approach is to give states lots of room to run. Sometimes the price of state cooperation is a willingness to look the other way. Perhaps HHS has good reason for treating its cost-effectiveness rule not as a hard-and-fast constraint on plan approval, but instead as a loose guideline that the Agency, for policy reasons, declines to assiduously enforce.

The fight between GAO and HHS thus reflects a tension between the scrupulous application of a black-and-white rule and a desire to encourage experimentation in a realm of political and actuarial uncertainty. That tension is likely to become more salient in the coming years. Starting in 2017, states can ask the federal government to waive nearly all of the ACA's rules within the state pursuant to section 1332 of the Act.¹⁹² In exchange, the state must propose an alternative plan that will cover as many people—and as generously as the ACA already does—without "increas[ing] the Federal deficit."¹⁹³

Experience with the private option supplies a precedent for the benign neglect of these constraints on section 1332 waivers. Instead of insisting on realistic assumptions and careful economic modeling, HHS could emphasize the importance of state innovation and approve state plans that fudge the numbers. Waivers may thus become an instrument for watering down the substantive ACA provisions in states that bridle at their perceived excesses.

¹⁸⁹ See *Medicaid-to-Medicare Fee Index*, HENRY J. KAISER FAM. FOUND., <http://kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/> [<https://perma.cc/5HN5-W5WA>] (providing state-by-state data on Medicaid-provider payment rates from 2014).

¹⁹⁰ GAO'S ARKANSAS REPORT, *supra* note 173, at 3.

¹⁹¹ See 42 U.S.C. § 1315(a) (2012) (providing discretion for Secretary to grant states waivers for Medicaid requirements in cases of "any experimental, pilot, or demonstration project which, in the judgment of the Secretary, is likely assist in promoting the objectives of [the Medicaid statute]").

¹⁹² *Id.* § 18052(a)(1), Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 1332(a)(1), 124 Stat. 119, 203 (2010).

¹⁹³ 42 U.S.C. § 18052(b)(1)(D).

II. AN ASSESSMENT

Collectively, these eight implementation episodes represent the most substantial and legally controversial steps associated with the ACA's implementation. Yet, even in this highly biased sample, the Administration's track record is good. It has usually—albeit not always—colored within the lines. Stepping back, the Administration's record looks even more impressive. Over the course of the past six years, the Administration has made many thousands of legally unimpeachable decisions in connection with the ACA, including instances where it has stuck to the ACA even in the face of intense political pressure.

Three examples stand out. First, take the so-called “family glitch.” Under the ACA, an individual and her family members are ineligible for premium subsidies if the individual's employer offers her affordable coverage—coverage that costs less than 9.5% of household income.¹⁹⁴ What if *individual* coverage is affordable but *family* coverage is not? If the employee declines to take the unaffordable family coverage, will her family members be eligible for premium subsidies on the exchanges? In February 2013, the IRS said no, even though “experts at every point along the political spectrum agree that the . . . interpretation unfairly penalizes families.”¹⁹⁵ The law left the Administration no choice. As the IRS explained, “The language of section 36B . . . specifies that the affordability test for related individuals [i.e., family members] is based on the cost of self-only coverage.”¹⁹⁶ Because of the family glitch, between two and four million people nationwide will lose access to subsidized coverage,¹⁹⁷ including at least 460,000 children.¹⁹⁸

Second, union leaders spent years lobbying the Administration to allow their members greater access to premium subsidies. Under the Taft-Hartley Act, employers can band together and, working with unions, offer health benefits to their employee-members through a jointly administered fund.¹⁹⁹ Many union members receive health coverage through Taft-Hartley plans as a fringe benefit of their employment.²⁰⁰ Since they receive coverage through their jobs, however,

¹⁹⁴ See 26 U.S.C. § 36B(c)(2)(B)(i), (C)(i) (2012) (excluding from eligibility for tax credits those eligible for minimum essential coverage from an employer plan in which the employee's contribution is less than 9.5% of household income).

¹⁹⁵ Tricia Brooks, *Health Policy Brief: The Family Glitch*, HEALTH AFF., Nov. 10, 2014, at 3, http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_129.pdf [<https://perma.cc/PS3P-CXBS>].

¹⁹⁶ Health Insurance Premium Tax Credit, 78 Fed. Reg. 7264, 7265 (Feb. 1, 2013).

¹⁹⁷ Brooks, *supra* note 195, at 2.

¹⁹⁸ U.S. GOV'T ACCOUNTABILITY OFFICE, GAO-12-648, CHILDREN'S HEALTH INSURANCE: OPPORTUNITIES EXIST FOR IMPROVED ACCESS TO AFFORDABLE INSURANCE 14 fig.1 (2012).

¹⁹⁹ *Taft-Hartley Trust Funds*, THE MASS. COAL. OF TAFT-HARTLEY TR. FUNDS, INC., <http://www.macoalthtf.org/new-page/taft-hartley-trust-funds.html> [<https://perma.cc/63JN-HD79>].

²⁰⁰ See *id.* (noting that Taft-Hartley plans are common in the construction, retail, trucking, and warehouse industries).

union members are ineligible to get premium subsidies under the ACA.²⁰¹ Several large, politically powerful unions believed this was discriminatory: why should union members not get subsidies available to other people?²⁰² Citing the delays of the employer mandate as support, they avidly sought a regulatory fix of questionable legality from the Administration.²⁰³ When the Administration declined—in its view, Taft-Hartley plans were clearly employer-sponsored plans and had to be treated as such²⁰⁴—the unions excoriated President Obama for betraying them.²⁰⁵

Third, think back to the risk corridor program, which was meant to provide a backstop for health plans that sustained greater-than-anticipated losses on the exchanges.²⁰⁶ The program was especially important for the ACA's new “cooperative health plans,” which received substantial financial support to

²⁰¹ See *supra* note 194 and accompanying text.

²⁰² See Letter from James. P. Hoffa, Gen. President, Int'l Bhd. of Teamsters et al., to Harry Reid, Majority Leader, U.S. Senate & Nancy Pelosi, Minority Leader, U.S. House of Representatives (July 12, 2014) [hereinafter Hoffa] (explaining that they have been “bringing [their] deep concerns to the Administration, seeking reasonable regulatory interpretations to the statute that would help prevent the destruction of non-profit health plans” like the ones provided by unions), in Tom Gara, *Union Letter: Obamacare Will ‘Destroy the Very Health and Wellbeing’ of Workers*, WALL ST. J.: CORP. INTELLIGENCE (July 12, 2013, 6:08 PM), <http://blogs.wsj.com/corporate-intelligence/2013/07/12/union-letter-obamacare-will-destroy-the-very-health-and-wellbeing-of-workers/> [https://perma.cc/TKV5-YRQS]; Brian Beutler, *What's Behind The Big Union Attack On Obamacare?*, TALKING POINTS MEMO: TPM DC (July 22, 2013, 12:53 PM), <http://talkingpointsmemo.com/dc/what-s-behind-the-big-union-attack-on-obamacare> [https://perma.cc/85CA-7RMQ] (describing the unions' concern that the ACA will lead employers with unionized employees to abandon Taft-Hartley plans and shuffle employees onto the exchanges).

²⁰³ Hoffa, *supra* note 202.

²⁰⁴ See Memorandum from Bernadette Fernandez, Specialist in Health Care Fin., Domestic Soc. Policy Div., Cong. Research Serv. & Jon O. Shimabukuro, Legislative Attorney, Am. Law Div., Cong. Research Serv. to Todd Spangler, House Comm. on Educ. and the Workforce 2 (Mar. 11, 2013), <http://www.healthreformgps.org/wp-content/uploads/CRS-multiemployer-6-25.pdf> [https://perma.cc/327Q-X7AK] (“Because a multiemployer health plan would seem to constitute minimum essential coverage . . . it seems unlikely that an individual who is enrolled in a multiemployer health plan would be eligible for a premium tax credit.”); Dave Jamieson, *Unions To White House On Obamacare, Taft-Hartley Plans: ‘You Made The Problem, You Fix It’*, HUFFINGTON POST: POLITICS (Aug. 21, 2013, 2:26 PM), http://www.huffingtonpost.com/2013/08/21/unions-obamacare-taft-hartley_n_3790548.html [https://perma.cc/2VN5-9M3C] (noting the Administration's view that “Taft-Hartley plans [are] equivalent to other employer-based plans, which aren't eligible for subsidies”).

²⁰⁵ See, e.g., Steven Mufson & Tom Hamburger, *Labor Union Officials Say Obama Betrayed Them in Health-Care Rollout*, WASH. POST (Jan. 31, 2014), www.washingtonpost.com/business/economy/labor-union-officials-say-obama-betrayed-them-in-health-care-rollout/2014/01/31/2cd2a6af-c8789-11e3-833c-33098f9e5267_story.html [https://perma.cc/82QJ-FSN9] (noting unions' complaint that “the Affordable Care Act has subjected union health plans to new taxes and mandates while not allowing them to share in the subsidies”).

²⁰⁶ See *supra* Section I.F.

help them get up and running.²⁰⁷ When Congress refused to fully fund the risk corridor program, the Obama Administration knew that many of the coops could face financial ruin.²⁰⁸ But the Administration adhered to the appropriations restrictions that Congress established—and watched as more than half the coops folded.²⁰⁹

Taken as a whole, then, the record refutes the claim that President Obama has systematically disregarded the ACA's text or displayed contempt for legal constraints. He hasn't. The law still has bite. On occasion, however, the Administration has strayed beyond legal limits. Two episodes raise especially serious legal concerns: the administrative delays²¹⁰ and the decision to finance cost-sharing reductions out of an appropriation governing tax refunds.²¹¹ In both cases, Republican recalcitrance threatened to undermine the President's signal achievement. And in both cases, the President appears to have broken the law.

Just how troubling this should be is open to question. In soccer, a striker who's never offside is not trying hard enough to score. Likewise, in government, a President who never pushes up against legal boundaries—and, in so pushing, occasionally exceeds them—may sacrifice effectiveness and fail to honor the wishes of those who elected him to office. Perhaps, as David Pozen has recently argued, there's even something to be said for presidential self-help—otherwise-unlawful actions that are legitimate countermeasures to Congress's refusal to adhere to conventions that allow the government to function.²¹² Indeed, presidential self-help is here whether we like it or not: it's an inevitable response to the widespread perception of governmental breakdown. If it's inevitable, castigating the Administration for its legal violations seems about as helpful as Lear railing at the storm. Better, in Pozen's view, to put self-help in a legal framework and create rules governing when it is a legitimate and even constructive response to the dysfunction of the political system.²¹³

The price of such self-help, however, is likely to be paid in the further accretion of executive power, in the setting of precedents that make it easier for future Presidents to sidestep legal constraints, and in the tit-for-tat escalation

207 U.S. GOV'T ACCOUNTABILITY OFF., GAO 16-326, PRIVATE HEALTH INSURANCE: FEDERAL OVERSIGHT, PREMIUMS, AND ENROLLMENT FOR CONSUMER OPERATED AND ORIENTED PLANS IN 2015 6-7 (2016).

208 *Id.* at 17.

209 *Id.* at 1-2.

210 *See supra* Section I.B.

211 *See supra* Section I.E.

212 David E. Pozen, *Self-Help and the Separation of Powers*, 124 *YALE L.J.* 2, 7-8 (2014); *see also* N. W. Barber, *Self-Defence for Institutions*, 72 *CAMBRIDGE L.J.* 558, 559 (2013) (discussing institutional self-defense mechanisms that protect institutions from other constitutional bodies).

213 *See Pozen, supra* note 212, at 61 (describing the benefits that would follow from adhering to a set of self-help conventions).

of interbranch conflict. It's not easy to tally those diffuse, systemic costs, but they are serious. Because the sitting President will not bear most of them, and because he is invested in the success of his administration, there's reason to fear he may be too cavalier about invoking his right to self-help. That's why William Marshall calls Pozen's article "one of the most dangerous" ever written:²¹⁴

The last thing American constitutional law needs is another rationale that could be used to justify an expansive exercise of executive branch power, particularly when that exercise is based on little more than a President's own conclusion that Congress has somehow engaged in constitutional wrongdoing when it aggressively seeks to frustrate her agenda.²¹⁵

In other words, Marshall insists on presidential abstinence. If we deny that self-help is legitimate, the President will more often stay within legal bounds. Pozen, in contrast, wants to talk about contraception. Teenagers will have sex; Presidents will break the law. Let's make sure they do it responsibly.

Resolving this debate depends in part on evidence. The argument for self-help depends on the assumption that self-help can be disciplined—that sex can be safer—if we craft a set of legal rules to govern its use. But is that true? For support, Pozen draws a plausible but imperfect analogy to international law, where legal rules have long shaped state-to-state countermeasures,²¹⁶ arguing that past exercises of presidential self-help have loosely respected informal norms that have kept those exercises within tolerable bounds.²¹⁷ What he can't supply is compelling evidence that, in the domestic context, the President will adhere sufficiently often to the limits on his self-help authority so as to make it a legitimate part of the give-and-take between the branches. The reasons that a President breaks the law in the first place may also make him insensitive to legal limits on the exercise of self-help.

Marshall's argument suffers from a similar evidentiary gap. It might be true that endorsing constitutional countermeasures will encourage more presidential lawlessness, but it might not. In an age of perceived congressional dysfunction, the President already has powerful incentives to sidestep the law. Whether there's a discourse legitimating some forms of self-help will probably not make much of a difference. And even if self-help becomes more common, it's possible that it will be more restrained because of conventions governing its use. More sex, but safer sex.

²¹⁴ William P. Marshall, *Warning! Self-Help and the Presidency*, 124 *YALE L.J. F.* 95, 98 (2014), <http://yalelawjournal.org/forum/self-help-and-the-presidency> [<https://perma.cc/J2BJ-9YPX>].

²¹⁵ *Id.*

²¹⁶ Pozen, *supra* note 212, at 52-58.

²¹⁷ *Id.* at 27-48.

The saga of the ACA's implementation offers comfort to both sides. On the self-help side of the ledger, no one questions the intensity of congressional antipathy for the reform law. In the eyes of many, that antipathy has passed well beyond loyal opposition and into the realm of bad faith.²¹⁸ The Republican-controlled House has voted at least fifty-six times to repeal the statute.²¹⁹ Opponents have seized on distortions and lies about the ACA to prevent its adoption and impede its implementation. And Congress has actively worked to hobble the ACA even if doing so will harm people, reckoning that a maimed statute will be more easily uprooted. If self-help is warranted anywhere—and it may not be—it would seem to be warranted here.

On that view, the Administration's legal excesses can be seen as proportionate responses to congressional intransigence. The administrative delays, for example, are only temporary measures to ease implementation of the complex law.²²⁰ They did not purport to permanently change the ACA's basic contours. Similarly, when Congress breached the convention that it will appropriate the funds necessary to discharge its mandatory obligations,²²¹ the Administration fashioned a narrow countermeasure. Indeed, that countermeasure can be seen as a bid to create its own kind of self-help convention: although the President cannot withdraw funds from the Treasury without an appropriation, he will aggressively construe statutes to find such an appropriation where Congress, in a deliberate bid to thwart a duly enacted law, refuses to honor its obligations. That's arguably a salutary development. Congress's bullheaded refusal to pay its debts shouldn't be encouraged.

The argument in favor of self-help also finds support in the political damage that the President has sustained for skirting the law. The storyline of an imperial President—a storyline reinforced by ACA implementation decisions—has become a recurring political theme, even a cliché.²²² Politicians believe—with good reason—that the American public cares about the law and

²¹⁸ See, e.g., Jonathan Cohn, *The Bad Faith of Mandate Critics, Part 2*, NEW REPUBLIC (Feb. 4, 2011), <https://newrepublic.com/article/82828/the-bad-faith-mandate-critics-part-2> [<https://perma.cc/YH5N-FXAN>] (criticizing the ACA's conservative critics for being "mere opportunists").

²¹⁹ Cristina Marcos, *Dems Invoke Groundhog Day for ObamaCare Repeal Vote*, HILL: FLOOR ACTION (Feb. 2, 2015, 12:36 PM), <http://thehill.com/blogs/floor-action/house/231452-dems-invoke-groundhog-day-for-obamacare-repeal-vote> [<https://perma.cc/4QBP-NYRD>].

²²⁰ See, e.g., Timothy Stoltzfus Jost & Simon Lazarus, *Obama's ACA Delays—Breaking the Law or Making It Work?*, 370 NEW ENG. J. MED. 1970 (2014) (articulating the Administration's view that the delays do not constitute a refusal to enforce the law as written but are instead temporary measures to ensure effective implementation).

²²¹ See *supra* note 130 and accompanying text.

²²² See Juan David Romero, *Obama Is a Dictator. And a Tyrant. And a . . .*, NEW REPUBLIC (Nov. 20, 2014), <https://newrepublic.com/article/120347/obama-anything-president-tyrant-dictator-and-king> [<https://perma.cc/QAC3-RL3Y>] (cataloging prominent conservatives labeling Obama a "monarch," "Caesar," "dictator," "emperor," "king," and "autocrat").

will punish a President who flouts it.²²³ Even if a limited right to self-help were to become a recognized, legitimate feature of the separation of powers, the President will likely hesitate before exercising that right, just as he hesitates before exercising his acknowledged right to veto a piece of legislation. Political repercussions thus offer a plausible mechanism for assuring that self-help stays within tolerable bounds.

All this suggests that there's something to be said for constitutional countermeasures. At the same time, it's hard to look at these episodes and not be troubled. Consider the delays.²²⁴ The Administration did not publicly lobby Congress to delay the employer mandate only to have it resist. Rather, the delay was a concession to an influential group that might have otherwise raised a ruckus. Nor is it entirely convincing to treat the “like it, keep it” fix²²⁵ as a response to congressional intransigence. To the contrary, the Administration moved to forestall Congress from acting—and thus prevent it from passing legislation that, in the Administration's view, would have undermined the ACA.²²⁶ The delays thus potentially stand as broad precedent for putting off the effective dates of statutes for reasons of political expedience.

The appropriations dispute raises a different set of concerns. Slow to act and difficult to raise from its torpor, Congress is at a disadvantage when it comes to regulating executive conduct, especially on the international plane.²²⁷ But it is not altogether inactive; in particular, the appropriations power gives Congress substantial leverage over the Executive even in domains—like foreign affairs²²⁸—where Congress has seen its influence decline. Whittling away at the appropriations power thus sets a dangerous example, at least for those who worry about the rising tide of executive authority.

The story of the cost-sharing reductions also suggests that the whittling away will happen quietly—not through a frontal assault on the appropriations power, but through statutory construction. At best, the argument for linking § 1324 to the cost-sharing reductions is strained and unpersuasive.²²⁹ At

²²³ See Julian Davis Mortenson, *Law Matters, Even to the Executive*, 112 MICH. L. REV. 1015, 1017 (2014) (“[I]n the United States, respect for legality is a core component of the collective national culture . . .”).

²²⁴ See *supra* notes 39–40, 45 and accompanying text.

²²⁵ See *supra* notes 41–43, 46 and accompanying text.

²²⁶ See Press Release, Office of the Press Sec'y, The White House, Statement by the President on the Affordable Care Act (Nov. 14, 2013), <https://www.whitehouse.gov/the-press-office/2013/11/14/statement-president-affordable-care-act> [<https://perma.cc/C9A5-H2PY>] (“I will not accept [congressional] proposals that are just another brazen attempt to undermine or repeal the overall law and drag us back into a broken system.”).

²²⁷ Terry M. Moe & William G. Howell, *The Presidential Power of Unilateral Action*, 15 J.L. ECON. & ORG. 132, 161–65 (1999).

²²⁸ Kristina Daugirdas, *Congress Underestimated: The Case of the World Bank*, 107 AM. J. INT'L L. 517, 533 (2013).

²²⁹ See *supra* notes 103–15 and accompanying text.

worst, it's a makeweight that obscures a violation of the Appropriations Clause. That obscuration is arguably the point. Creative interpretation is appealing because condemnation can be met with a lawyerly argument about technical statutory text. So long as the dispute can be kept out of the courts—and the Administration is working overtime to get *House v. Burwell* dismissed on appeal—blowback is likely to be muted.

Indeed, the fact that the Obama Administration believed that it had no choice but to deploy this sort of lawyerly argument underscores just how hard it would be to embed self-help into American constitutional law. Although the President has acknowledged that congressional intransigence has spurred the need for unilateral action,²³⁰ the President has not openly deployed that intransigence as an argument to bolster the legality of contestable moves. He has instead adhered to an apparent convention of defending even his most dubious executive actions in traditional legal terms.

The felt need to adhere to that convention may partly reflect skittishness about judicial review. The courts will not take kindly to an argument that acknowledges the unlawfulness of an administrative action but nonetheless defends it as a proportionate countermeasure. But it also reflects something more profound. Even absent a court threat, the bureaucracy appears to demand a legal justification that won't be a political liability if it comes to light. Otherwise, the Administration would dispense with the convention where the risk of litigation was trivial—say, with the delay of the employer mandate. That demand for a legal justification in turn underscores the depth of the public's commitment to the principle that political leaders must maintain fidelity to law even in the face of serious provocation. The convention preventing a President from acknowledging that a particular action exceeds traditional legal bounds will impede efforts to publicly legitimize a practice of proportional countermeasures.

And eventually, the courts will lose patience with a presidential practice of dressing up lawbreaking in the garb of law. *House v. Burwell* exemplifies the dynamic.²³¹ The district court's conclusion that the House has standing to sue over the appropriations dispute is both unprecedented and difficult to square with existing law.²³² The decision makes sense, however, as a ham-fisted effort to use judicial review to make up for the collapse of durable conventions that might

²³⁰ See Pozen, *supra* note 212, at 43-44 ("The President's entire 'We Can't Wait' campaign can be seen as an advertisement for executive self-help in response to a Congress that, according to Obama, will not 'do its job.'" (footnote omitted) (quoting *We Can't Wait*, THE WHITE HOUSE, <http://www.whitehouse.gov/economy/jobs/we-cant-wait> [<https://perma.cc/GD9S-5K9C>])).

²³¹ See *supra* notes 127-29 and accompanying text.

²³² See Nicholas Bagley, *An Immediate Appeal in House v. Burwell?*, INCIDENTAL ECONOMIST (Sept. 22, 2015, 8:00 AM), <http://theincidentaleconomist.com/wordpress/an-immediate-appeal-in-house-v-burwell/> [<https://perma.cc/3ZE5-RR6N>] (criticizing the decision).

have disciplined executive lawbreaking.²³³ That does not imply that the district court's holding is right. Indeed, cumbersome and unwieldy litigation may impede the formation of new conventions that would better discipline executive lawbreaking. Right or wrong, however, the district court's assertiveness in *House v. Burwell* should come as no surprise.

To be clear, creating a discourse around self-help would generate a more refined sense of what distinguishes legitimate countermeasures from illegitimate usurpation. Perhaps such a discourse would lead to new conventions that could reliably govern self-help. But I will confess to skepticism. After all, the key to enforcing a convention is a public sanction for its violation. In a healthy legal culture, breaches do not go unanswered. Yet the rise of hyperpolarized politics seems to have diminished that public sanction. Nowadays, the President can often count on support—or at least silence—from like-minded attorneys, legal academics, and other expert commentators. During the ACA's rollout, for example, almost no Democratic lawyers spoke out against the Obama Administration's controversial legal moves, just as almost no Republican lawyers spoke in defense of them. Law, I fear, is increasingly seen as simply another move in a partisan game—a raw extension of politics with less persuasive force of its own. If that's the view of law that has enabled Congress to disregard conventions, why won't that same view lead to presidential disregard of similar self-help conventions?

At the end of the day, the story of the ACA's implementation leaves me equally encouraged and unsettled. Law still matters; it's not politics all the way down. At the same time, the Obama Administration's legal violations don't appear to be idiosyncratic expressions of a particular President's governing style, but more-or-less inevitable reactions to polarization and the breakdown of governing conventions. While I am skeptical that self-help conventions will reliably discipline such lawbreaking, I don't have better answers for how to restrain the President. That's why it's hard for me to shake the fear that we are entering an era marked by a relentless chipping away at the rule of law. I do not want to seem alarmist; for now, such chipping is modest. But it may become a durable feature of American governance—if it isn't one already—with consequences I can't begin to anticipate. In contrast to some,²³⁴ I don't view the trend with equanimity. The rule of law is a terrible thing to waste.

²³³ See Adrian Vermeule, *The Third Bound*, 164 U. PA. L. REV. 1949, 1958 (2016) (observing that “law substitutes imperfectly for regulation-by-convention”); cf. Richard H. Pildes, *Institutional Formalism and Realism in Constitutional and Public Law*, 2013 SUP. CT. REV. 1, 2 (observing that courts can “adapt legal doctrine to take account of how [governmental] institutions actually function in, and over, time”).

²³⁴ See generally ERIC A. POSNER & ADRIAN VERMEULE, *THE EXECUTIVE UNBOUND: AFTER THE MADISONIAN REPUBLIC* (2010).

In the meantime, some legal questions have answers. In trying to supply those answers, my hope is to call attention to a record that is neither as dismal as its detractors claim nor as rosy as its supporters believe. The Obama Administration has overwhelmingly kept faith with the rule of law as it implemented the ACA, even as it has occasionally breached legal limits and set unfortunate precedents. Only time will tell whether the Administration has paid too high a price for health reform.