

HEED NOT THE UMPIRE (JUSTICE GINSBURG CALLED *NFIB*)

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I. INTRODUCTION

To understand the scale of the national problems addressed by the Patient Protection and Affordable Care Act (“the ACA”), think of everyone you know who has blue eyes. Now imagine that every one of those people does not have health insurance. This means that they cannot gain access to the healthcare system except by visiting an emergency room, unless they have large amounts of liquid assets and can pay out of pocket. Some of the blue-eyed people will be healthy, some may have chronic conditions, some may be terminally ill; but, their health status only serves to keep them out of the health insurance market and thus distant from consistent medical care, unless they qualify for federal programs by virtue of their age or their poverty. This was the scale of the problem at the time of the 2008 presidential election: nearly fifty million Americans did not have health insurance because the old mechanisms for obtaining insurance were failing. Just as one in six Americans has blue eyes, likewise one in six Americans had no health insurance, and the inability to obtain access to medical care had become as random as birth traits.¹

The pervasiveness of our healthcare problem seems to have bypassed most justices on the Supreme Court in the landmark case *National Federation of Independent Business v. Sebelius (NFIB)*.² And early commentary predominantly has focused on the constitutionality of the individual mandate, which codified the idea that Americans must have minimum health insurance coverage by January 1, 2014 or pay a tax penalty.³ Further narrowing the conversation, much of the post-decision commentary has also focused on Chief Justice Roberts’s con-

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1 CENTERS FOR DISEASE CONTROL AND PREVENTION, *Health Data Interactive: No Health Insurance, Under Age 65: US 1999–2010 (Source: NHIS)*, <http://205.207.175.93/HDI/TableView/tableView.aspx?ReportId=453> (last visited Dec. 12, 2012) (displaying rates of uninsurance by age group and other demographic data).

2 132 S. Ct. 2566 (2012).

3 26 U.S.C. § 5000A (Supp. IV 2010).

stitutional analysis and its interplay with the joint dissent.⁴ This narrow scrutiny has resulted in missed opportunities: first, a critique of the justices' stilted legislative interpretation and lack of deference to Congress's legislative expertise. And second, an appreciation for Justice Ginsburg's dissenting and concurring opinion, which approached the constitutional questions in *NFIB* with an emphasis on understanding the nature of the healthcare crisis that led to the legislative choices in the ACA. Justice Ginsburg's nuanced approach to the facts in *NFIB* led her to the correct constitutional analysis. This essay will shine a light on these issues with a particular focus on Justice Ginsburg's approach to the case.

II. THE ACA MISUNDERSTOOD

Congress expressed a broad understanding of its enumerated powers in the ACA but did not exercise its Article I authority in a manner inconsistent with existing precedent.⁵ The ACA contained ten titles and many moving parts, but the broad goal of the law was to reform the national markets in healthcare to make all individuals insured and insurable. The two ACA provisions at issue in *NFIB* were the minimum essential coverage provision, which requires Americans to have a health insurance home by 2014 or pay a self-reported tax

⁴ See, e.g., David B. Rivkin Jr., Lee A. Casey & Andrew M. Grossman, *NFIB v. Sebelius and the Triumph of Fig-Leaf Federalism*, 2011–12 CATO SUP. CT. REV. 31, available at <http://www.cato.org/pubs/scr/2012/scr-2012-rivkin.pdf>; ERIKA K. LUNDER & JENNIFER STAMAN, CONG. RESEARCH SERV., R42698, *NFIB v. SEBELIUS: CONSTITUTIONALITY OF THE INDIVIDUAL MANDATE* (2012); John Elwood, *What Did the Court "Hold" About the Commerce Clause and Medicaid?*, THE VOLOKH CONSPIRACY (July 2, 2012, 11:28 AM), <http://www.volokh.com/2012/07/02/what-did-the-court-hold-about-the-commerce-clause-and-medicaid/>; Deborah Pearlstein, *Early Thoughts on the Health Care Case*, BALKINIZATION (June 28, 2012, 5:56 PM), <http://balkin.blogspot.com/2012/06/early-thoughts-on-health-care-case.html>; Steven D. Schwinn, *Chief Justice Roberts's Necessary and Proper Clause*, CONST. L. PROF BLOG (July 2, 2012) <http://lawprofessors.typepad.com/conlaw/2012/07/chief-justice-robertss-necessary-and-proper-clause.html>; Ilya Shapiro, *We Won Everything But the Case*, SCOTUSBLOG (June 29, 2012, 9:38 AM), <http://www.scotusblog.com/2012/06/we-won-everything-but-the-case/>; Ilya Somin, *A Taxing, But Potentially Hopeful Decision*, SCOTUSBLOG (June 28, 2012, 6:13 PM), <http://www.scotusblog.com/2012/06/a-taxing-but-potentially-hopeful-decision/>; Laurence H. Tribe, *Chief Justice Roberts Comes Into His Own and Saves the Court While Preventing a Constitutional Debacle*, SCOTUSBLOG (June 28, 2012, 3:41 PM), <http://www.scotusblog.com/2012/06/chief-justice-roberts-comes-into-his-own-and-saves-the-court-while-preventing-a-constitutional-debacle/>.

⁵ Two symposia provide a snapshot of recent literature on the ACA: *The American Right to Health: Constitutional, Statutory, and Contractual Healthcare Rights in the United States*, 38 AM. J.L. & MED. 243 (2012); *Everything But the Merits: Analyzing the Procedural Aspects of the Health Care Litigation*, 46 U. RICH. L. REV. 691 (2012).

penalty, and the expansion of Medicaid, which facilitates public health insurance for the most impoverished members of our society.⁶

With regard to the minimum coverage provision, popularly dubbed the “individual mandate,” Congress described the law as regulating both healthcare services and health insurance as a “significant part of the national economy.”⁷ Since 1944, Congress has understood that insurance may be regulated as interstate commerce.⁸ But, importantly, Congress was regulating more than insurance in the ACA—it was leveling the insurance playing field to create near universal access to the healthcare system (which is also modified in multifarious ways by the ACA).⁹ Congress was aware of states that had failed at universal coverage when they did not institute an insurance coverage requirement, and legislative findings specifically pointed to the success experienced in Massachusetts in achieving better healthcare through creating an individual mandate to support its goal of universal coverage.¹⁰ Despite the extensive legislative history and the explicit legislative findings within the body of the law, Chief Justice Roberts and the joint dissent rejected Congress’s decisions with regard to the purposes and methods of regulating the healthcare market in *NFIB*.¹¹

⁶ 132 S. Ct. at 2580–82 (majority opinion) (discussing 26 U.S.C. § 5000A (Supp. IV 2010) (the individual mandate) and 42 U.S.C. §§ 1396a(a)(10)(A)(i)(VIII), 1396c, 1396d(y)(1) (2006 & Supp. IV 2010) (provisions of the Medicaid expansion)).

⁷ 42 U.S.C. § 18091 (Supp. IV 2010) (describing the effects of the “[r]equirement to maintain minimum essential coverage” (health insurance) on the “national economy and interstate commerce”).

⁸ See *United States v. Se. Underwriters Ass’n*, 322 U.S. 533 (1944).

⁹ In the United States, health insurance acts as a doorway to medical care. Though the Emergency Medical Treatment and Labor Act (EMTALA) creates a point of rescue in emergency rooms, those without health insurance cannot access medical care with any consistency unless they are wealthy enough to pay for their care out of pocket. See 42 U.S.C. § 1395dd (2006); see generally INSTITUTE OF MEDICINE, COVERAGE MATTERS: INSURANCE AND HEALTH CARE (2001); INSTITUTE OF MEDICINE, INSURING AMERICA’S HEALTH: PRINCIPLES AND RECOMMENDATIONS (2004) (both monographs explaining the connection between insurance and access and the vital role insurance plays in consistent medical care in the United States).

¹⁰ 42 U.S.C. § 18091(2)(D) (Supp. IV 2010) (“In Massachusetts, a similar requirement has strengthened private employer-based coverage . . .”).

¹¹ See Nicole Huberfeld, Elizabeth Weeks Leonard & Kevin Outterson, *Plunging into Endless Difficulties: Medicaid and Coercion in National Federation of Independent Business v. Sebelius*, 93 B.U. L. REV. 1, 56–57, 73–74 (2013) (critiquing the lack of deference to Congress’s legislative expertise); see also Pamela S. Karlan, *Contempt of Court*, BOSTON REVIEW, Nov./Dec. 2012, at 10, available at http://www.bostonreview.net/BR37.6/pamela_s_karlan_supreme_court_contempt_congress.php (discussing the Court’s lack of deference to Congress and the executive branch in a variety of cases).

Chief Justice Roberts's opinion began with an exposition on the virtues of federalism.¹² The Roberts Court's approach to federalism is no longer a mystery; reiterating Justice Kennedy's federalism paean from *Bond v. United States*,¹³ Roberts extolled federalism as a protector of not only the states but also individuals.¹⁴ The Chief Justice's interest in continuing the Rehnquist Court's active enforcement of the Tenth Amendment is now clear, though interestingly, the Tenth Amendment itself made rare appearances in the opinion.¹⁵

While their opinions described the ACA,¹⁶ neither Chief Justice Roberts nor the members of the joint dissent appeared to be concerned with its overarching purposes or Congress's stated goals. The description of the law written by Chief Justice Roberts was brief, which unto itself is not revealing. More importantly, his brevity highlighted an ostensible disinterest in the language and purpose of the law. The Chief Justice gave an impression of holding his nose while diving into the lengthy constitutional analysis that followed.¹⁷ Both

¹² *NFIB*, 132 S. Ct. 2566, 2577–80 (2012) (opinion of Roberts, C.J.). The challenge did involve federalism challenges and principles, and the Medicaid expansion directly affects the federal-state relationship, but by all accounts, the focus of this opinion and its commentary was the individual mandate. The Medicaid expansion is the blockbuster aspect of the opinion, and the federalism exposition is given context by the plurality's ultimate holding that the expansion was unconstitutionally coercive, but Roberts's discussion of federalism was a preamble for the whole opinion and somewhat misplaced in the context of the minimum coverage provision. See, e.g., Abigail R. Moncrieff, *Cost-Benefit Federalism: Reconciling Collective Action Federalism and Libertarian Federalism in the Obamacare Litigation and Beyond*, 38 AM. J.L. & MED. 288 (2012) (critiquing the role of federalism in the *NFIB* litigation).

¹³ 131 S. Ct. 2355, 2364 (2011).

¹⁴ *NFIB*, 132 S. Ct. at 2577–80 (opinion of Roberts, C.J.). Justice Kennedy also expressed his desire to limit spending in *Comstock*: “The limits upon the spending power have not been much discussed, but if the relevant standard is parallel to the Commerce Clause cases, then the limits and the analytic approach in those precedents should be respected.” *United States v. Comstock*, 130 S. Ct. 1949, 1967 (2010) (Kennedy, J., concurring).

¹⁵ See *NFIB*, 132 S. Ct. at 2582 (majority opinion) (discussing the Eleventh Circuit's rejection of the States' Tenth Amendment claim); *id.* at 2643 (joint dissent) (citing the Tenth Amendment as affirming the “structural limits on federal power”); U.S. CONST. amend. X (“The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people.”). Arguably this is because the Court intended to describe Congress as exceeding its enumerated powers, but it also described the dangers to the states, which are protected by the Tenth Amendment. One would expect more direct reference to that amendment in such a discussion.

¹⁶ *NFIB*, 132 S. Ct. at 2580–82 (majority opinion); *id.* at 2644–46, 2657 (joint dissent).

¹⁷ The Chief Justice stated:

We do not consider whether the Act embodies sound policies. That judgment is entrusted to the Nation's elected leaders. We ask only whether Congress has the power under the Constitution to enact the challenged provisions. . . . Members of this Court are vested with the authority to interpret the law; we possess neither the expertise nor the prerogative to make policy judgments. Those decisions are entrusted to our Nation's elected leaders, who can be thrown out of office if the

the Roberts opinion and the joint dissent moved quickly past the facts to expound their constitutional theories.¹⁸

The best example of this disregard for the facts was that the United States argued that it was regulating the healthcare market, for which health insurance facilitates a point of access as well as a method of finance; yet, the Chief Justice and the joint dissent held that the pertinent market being regulated was health insurance, not the broader healthcare market.¹⁹ Perceived through the lens of the doctrine of constitutional avoidance,²⁰ as well as the deferential level of review the Court traditionally applies to exercises of the commerce power,²¹ this redefinition of the market being regulated was notably improper.²² In addition, it displayed a stilted understanding of the

people disagree with them. It is not our job to protect the people from the consequences of their political choices.

See id. at 2577, 2579 (opinion of Roberts, C.J.).

- 18 This dynamic was echoed in the Roberts dissent in the other Medicaid decision during the October 2011 term, *Douglas v. Indep. Living Ctr. of S. Cal., Inc.*, 132 S. Ct. 1204, 1211–15 (2012) (Roberts, C.J., dissenting).
- 19 For just one example of this health insurance market choice, see *NFIB*, 132 S. Ct. at 2591 (opinion of Roberts, C.J.) (disregarding the United States' position that health insurance is part of the healthcare market); see also *id.* at 2644 (joint dissent) (phrasing the problem as one of "health insurance contracts"). Ultimately, this rejection of the United States' articulation of the commercial market being regulated facilitated the conclusion that Congress had the power to tax a choice not to purchase health insurance. Upholding the individual mandate as a tax, Roberts accepted that the exercise of the taxing power required thinking differently about the individual mandate. Instead of requiring purchase, the taxing power allows Congress to "impos[e] a tax on those who do not buy that product." *Id.* at 2593 (opinion of Roberts, C.J.).
- 20 *See, e.g.,* *Gonzales v. Carhart*, 550 U.S. 124, 153–54 (2007) (internal quotation marks omitted) (quoting *Edward J. DeBartolo Corp. v. Florida Gulf Coast Building & Constr. Trades Council*, 485 U.S. 568, 575 (1988) (quoting *Hooper v. California*, 155 U.S. 648, 657 (1895))) (describing the doctrine of constitutional avoidance, the Court wrote: "[T]he elementary rule is that every reasonable construction must be resorted to, in order to save a statute from unconstitutionality.>").
- 21 *See, e.g.,* *Gonzales v. Raich*, 545 U.S. 1, 18–19, 22 (2005). The Court wrote: "In assessing the scope of Congress' authority under the Commerce Clause, we stress that the task before us is a modest one. We need not determine whether respondents' activities, taken in the aggregate, substantially affect interstate commerce in fact, but only whether a 'rational basis' exists for so concluding." *Id.* at 22 (citing *United States v. Lopez*, 514 U.S. 549, 557 (1995); *Hodel v. Virginia Surface Mining & Reclamation Ass'n*, 452 U.S. 264, 276–80 (1981); *Perez v. United States*, 402 U.S. 146, 155–56 (1971); *Katzenbach v. McClung*, 379 U.S. 294, 299–301 (1964); *Heart of Atlanta Motel, Inc. v. United States*, 379 U.S. 241, 252–53 (1964)).
- 22 *See* Lee Epstein & Andrew D. Martin, *Is the Roberts Court Especially Activist? A Study of Invalidating (and Upholding) Federal, State, and Local Laws*, 61 EMORY L.J. 737 (2012) (empirically analyzing a data set that indicates that a justice's ideology strongly correlates with the justice's willingness to overturn a law of the opposite ideology and to uphold a law of the same ideology; one could infer that the Chief Justice's conservative perspective made him more willing to second guess the wisdom of the ACA's substance and structure).

ACA's broadly inclusive approach to health insurance and thus healthcare access.

Likewise, Chief Justice Roberts's plurality opinion and the joint dissent mischaracterized, and misunderstood, the nature of the Medicaid expansion enacted in the ACA. This amendment to the Medicaid Act expands eligibility to citizens under age 65 whose gross income does not exceed 133% of the federal poverty level as of 2014.²³ States initially will be fully funded by the federal government for the cost of covering the expansion population; the federal match will phase down to ninety cents on the Medicaid dollar, a much higher match than states typically receive (50 to 83 cents).²⁴ States' non-compliance with the Medicaid Act can end all or part of their Medicaid funding, but the Secretary of the Department of Health and Human Services (HHS) has never exercised the option of total funding cut-off, because it would harm enrollees.²⁵

As a statutory matter, the eligibility expansion was not radical, as the Medicaid Act has always dictated the major elements of the program that create a federal floor on which states may build. Also, since its inception in 1965, the Medicaid Act has authorized the Secretary of HHS to withdraw all Medicaid funding if a state is noncompliant with the law.²⁶ Further, as part of the effort to achieve universal health insurance coverage, eliminating eligibility variation was highly practical given the resistance to a more unitary reform of the health insurance system. But, the Medicaid expansion was also a philosophical change that federalized the definition of eligibility for Medicaid and rejected the long-standing limitation on assisting only the "deserving poor."²⁷

Both the Roberts plurality and the joint dissent accepted a stilted theory of the Medicaid expansion that the new category of eligibility was not part of the Medicaid Act but instead was part of the ACA. As I and my co-authors have explained, this interpretation of the Medi-

²³ 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII) (Supp. IV 2010).

²⁴ *Id.* § 1396d(y)(1).

²⁵ Justice Kagan provided this answer for General Verrilli when he could not during oral arguments (perplexing, given Justice Kagan's ultimate conclusion that the Medicaid expansion was unconstitutionally coercive). See Nicole Huberfeld, *Uncertainty on ACA Day 3 (Exhaustion Sets In)*, CONCURRING OPINIONS (Mar. 28, 2012, 12:52 AM), <http://www.concurringopinions.com/archives/2012/03/uncertainty-on-aca-day-3-exhaustion-sets-in.html>; see also *NFIB*, 132 S. Ct. 2566, 2606–07 (2012) (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.) (holding that the Medicaid expansion is unconstitutional).

²⁶ 42 U.S.C. § 1396c (2006). In other words, the potential penalty for state noncompliance is neither radical nor new, despite the plurality's contrary view.

²⁷ For more on the threads of states' rights and deserving poor in Medicaid's history, see Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 436–53 (2011).

caid expansion is incorrect.²⁸ It was wrong from a statutory perspective, because the Medicaid Act has always set the floor for Medicaid eligibility. It was wrong from a constitutional perspective, because the premise that Medicaid was divided into two programs led to the faulty conclusion that the expansion was not germane and thus was unconstitutionally coercive.

The United States defended its exercise of the spending power as consistent with the nature of the General Welfare Clause, consistent with the Court's spending power decisions, and consistent with principles of cooperative federalism.²⁹ All of these defenses were correct given the existing jurisprudence; but, a long-standing spending program such as Medicaid magnifies the under-theorization of the *Dole* test for conditions on federal spending.³⁰ The states did not challenge the four-part test established by *Dole*; instead, they asked the Court to enliven the previously unenforced idea of unconstitutionally coercive conditional spending.³¹ The states offered no standard for solidifying the coercion theory beyond the bare assertion of their inability to leave the Medicaid program.³² Seven justices adopted this thin idea, and none of them articulated a rule for coercion beyond stating that it was obvious in this case based on their interpretation of Medicaid.³³

Thus, for the plurality and the joint dissent, it appears that *NFIB* was a vehicle for constitutional change. Not only did Chief Justice Roberts's plurality skate over the realities of healthcare in the United States, it misconstrued the basic structure and nature of the Medicaid program, leading to the biggest doctrinal change in Spending Power jurisprudence since the *Lochner* Era.³⁴ Because the plurality forms the precedent to be followed by lower federal courts, it is important that these errors not be perpetuated; one hopes that Justice Ginsburg's more thorough opinion will inform future decisions.

28 Huberfeld, Leonard & Outterson, *supra* note 11 (detailing the reasons that this legislative interpretation is incorrect).

29 For more on the briefs of the United States in *Douglas* and *Florida v. HHS*, see Nicole Huberfeld, *Post-Reform Medicaid Before the Court: Discordant Advocacy Reflects Conflicting Attitudes*, 21 ANNALS HEALTH L. 513 (2012).

30 See *South Dakota v. Dole*, 483 U.S. 203, 207–08 (1987) (outlining a four-part test for the conditioning of federal spending).

31 See *NFIB*, 132 S. Ct. 2566, 2603 (2012) (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); Huberfeld, *Post-Reform Medicaid Before the Court*, *supra* note 29, at 528.

32 See Huberfeld, *Post-Reform Medicaid Before the Court*, *supra* note 29, at 530.

33 *NFIB*, 132 S. Ct. at 2603–07 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.); *id.* at 2661–68 (joint dissent).

34 See Huberfeld, Leonard & Outterson, *supra* note 11, at 46–76 (critiquing the indeterminate contours of the freshly constructed coercion doctrine in light of the Court's factual missteps in the Medicaid analysis).

III. AN OPPOSING VIEW OF HEALTHCARE REFORM

Justice Ginsburg, writing a dissent in which Justices Breyer, Sotomayor, and Kagan joined, began her opinion not with an explication of federalism but with an explanation of the national scale of the problems being addressed by the ACA.³⁵ Likening it to the passage of the Social Security Act in the 1930s, Justice Ginsburg described the ACA as Congress's effort to reform the entire healthcare market, a market that accounts for nearly 18% of the gross domestic product, a market in which everyone will participate but many cannot predict when.³⁶ Justice Ginsburg described the nationwide problems of uninsurance and escalating costs and noted that the states could not address this problem on their own.³⁷ She observed that Congress very clearly has the power to create a single-payer health insurance mechanism but that it chose to protect the roles of private insurers and states in fashioning the ACA's national market reforms.³⁸

Thus, rather than beginning with a deconstruction of congressional authority, Justice Ginsburg's dissent displayed a thorough understanding of the problems facing American healthcare that drove Congress to find a federal solution to a national problem. Both the discussion of the individual mandate and the discussion of Medicaid began with extensive explanations of the healthcare realities at stake, then applied those basic facts to the provisions of the ACA in question, before providing a constitutional conclusion.³⁹ The extra step of understanding the program facilitated a thicker analysis that should have carried the day.

Like Chief Justice Roberts's plurality opinion, Justice Ginsburg's opinion expressed that the policy embraced by the ACA was Congress's to create, especially in defining the market being regulated;⁴⁰ unlike the plurality opinion, Justice Ginsburg's dissent expressed def-

³⁵ *NFIB*, 132 S. Ct. at 2609–12 (Ginsburg, J., concurring in part and dissenting in part).

³⁶ *Id.* at 2609–10.

³⁷ Here is the flip side of Congress's reliance on the Massachusetts model. Massachusetts submitted a brief describing the influx of out-of-staters who took advantage of the state's universal coverage and encouraging a national solution to the problem of uninsurance and underinsurance. *See id.* at 2612. Cooter and Siegel have described this issue as a problem of collective action that requires federal intervention rather than disparate state efforts. *See* Robert D. Cooter & Neil S. Siegel, *Collective Action Federalism: A General Theory of Article I, Section 8*, 63 STAN. L. REV. 115 (2010).

³⁸ *See NFIB*, 132 S. Ct. at 2609 (Ginsburg, J., concurring in part and dissenting in part).

³⁹ *See, e.g., id.* at 2629 (describing the nature and history of Medicaid as context for understanding the expansion).

⁴⁰ *Id.* at 2619.

erence to Congress's decision-making.⁴¹ This national market for medicine and the impact of health insurance on that market led Justice Ginsburg to conclude, correctly, that "[s]traightforward application" of the "rational basis" review typically afforded national economic policymaking led to an easy conclusion that "Congress had a rational basis for concluding that the uninsured, as a class, substantially affect interstate commerce."⁴² Working within the "novel constraint" (inactivity) on Congress's commerce power fashioned by Roberts and the joint dissent, Justice Ginsburg pointed out that all Americans participate in the healthcare market, thus they are not "inactive" for purposes of the new commerce analysis. She also pointed out that risk pooling requires that everyone participate, regardless of their youth or apparent health.⁴³ The Ginsburg dissent on the individual mandate ended with an important warning against specious slippery slope arguments⁴⁴ and a reiteration that novel line drawing does not stop the law from being an appropriate exercise of congressional authority.⁴⁵

Turning to the Medicaid expansion, Justice Ginsburg recognized the "federalism-based limits on the use of Congress' conditional spending power" but also exposed Chief Justice Roberts's fallacious claim that the ACA created a "new" Medicaid program.⁴⁶ Joined only by Justice Sotomayor, she underlined the key fact that Medicaid is not two programs but one program with one goal, "to enable poor persons to receive basic health care when they need it."⁴⁷ Justice Ginsburg noted that the Medicaid expansion did exactly what Medicaid has always done, "enable States to provide medical assistance" to the poor, and did not amend most of the Medicaid Act.⁴⁸ She rejected the premise that the Medicaid expansion constituted "a shift in kind, not merely degree," when prior statutory expansions did not receive

41 *Id.* at 2614–15 ("Whatever one thinks of the policy decision Congress made, it was Congress' prerogative to make it. Reviewed with appropriate deference, the minimum coverage provision . . . should survive measurement under the Commerce and Necessary and Proper Clauses.")

42 *Id.* at 2617.

43 *Id.* at 2618–20. Justice Ginsburg's emphatic rejoinder to Roberts and the joint dissent that "Virtually everyone, I reiterate, consumes health care at some point in his or her life" seems especially poignant coming from a cancer survivor. *Id.* at 2620.

44 Especially those involving broccoli.

45 *Id.* at 2624–28 (warning against the new line being drawn in Necessary and Proper Clause analysis).

46 *Id.* at 2634.

47 *Id.* at 2630.

48 *Id.* at 2635.

this treatment.⁴⁹ Justice Ginsburg also critiqued the characterization of the expansion as a new program because courts should afford “a large measure of respect” to Congress’s description of its own law.⁵⁰

Justice Ginsburg also observed that Congress has power to repeal the Medicaid Act and replace it with “Medicaid II,” leading her to accuse the plurality and joint dissent of arbitrary line-drawing.⁵¹ This point highlighted the contradictory formalism expressed by the plurality and dissent, that despite a statutory provision dating to the creation of Medicaid that reserves the right to amend or modify the program, Medicaid could not be expanded in the manner chosen by Congress in the ACA because the states were somehow protected from such a modification.⁵²

Justice Ginsburg expressed concern about the Court’s failure to “fix the outermost line” of the “point at which pressure turns into compulsion”⁵³ and warned that the Court failed to answer numerous questions. These questions, including whether courts measure coercion by the amount offered to the states by the federal government, the percentage of the state’s budget affected, what effects on states should figure into the constitutional analysis, and the combined effect of states refusing the spending conditions,⁵⁴ are already inviting new litigation.⁵⁵ Ultimately, Justice Ginsburg suggested that coercion is a political question that courts should not and cannot decide,⁵⁶ yet seven justices agreed in principle that coercion is a judicially administrable concept. Justice Ginsburg’s dissent helped to highlight a major problem with the legislative interpretation adopted by the plurality’s opinion.

Even though only two justices found the Medicaid expansion to be a constitutional exercise of spending power, the ACA was saved by the severability provision in the Medicaid Act (Section 1303), which explicitly prevents the entire Social Security Act (of which Medicaid is

49 *Id.* at 2639. For more factual analysis regarding the inaccuracies of the Roberts plurality on Medicaid, see Huberfeld, Leonard & Outtersen, *supra* note 11.

50 *NFIB*, 132 S. Ct. at 2636 (Ginsburg, J., concurring in part and dissenting in part).

51 *Id.*

52 For more on Chief Justice Roberts’s formalist approach, see Gillian E. Metzger, *To Tax, To Spend, To Regulate*, 126 HARV. L. REV. 83, 95–102 (2012).

53 *NFIB*, 132 S. Ct. at 2639–40 (Ginsburg, J., concurring in part and dissenting in part).

54 *Id.* at 2640–41.

55 *See, e.g.*, Petitioner’s Motion for Injunctive Relief, *Mayhew v. Sebelius*, No. 12-2059 (1st Cir. Sep. 4, 2012) (requesting an order to require the government more expeditiously to approve Maine’s request to amend its Medicaid state plan and make eligibility changes as part of a plan to balance its state budget). *But see* *Mayhew v. Sebelius*, No. 12-2059, 2012 U.S. App. LEXIS 21083 (1st Cir. Sep. 13, 2012) (summarily denying petitioner’s motion for injunctive relief as moot).

56 *NFIB*, 132 S. Ct. at 2640–41 (Ginsburg, J., concurring in part and dissenting in part).

a part) from being invalidated if any provision is found to be unconstitutional.⁵⁷ The plurality's interpretive legerdemain was therein revealed: section 1303, which was enacted in 1935 when the Social Security Act was passed, saved the Medicaid expansion from being struck down, even though the plurality had found the expansion to be a separate program from existing Medicaid for purposes of its constitutional analysis.⁵⁸ In other words, the severability of the Medicaid Act saved a "new program" that was not Medicaid enough for purposes of Congress's exercise of spending authority, but it was Medicaid enough for purposes of limiting the remedy for coercion. This type of severability analysis appears to be novel, and it has thrown other aspects of the Medicaid expansion into some disarray.⁵⁹

Justices Ginsburg and Sotomayor joined the majority in this bizarre legislative maneuver, which was consistent with their analysis of Medicaid being one program and thus the expansion being constitutional.⁶⁰ A majority of five ultimately protected the Medicaid expansion, at least to a degree, by making it an unenforceable mandate that states could choose not to participate in without jeopardizing their existing Medicaid funding.⁶¹ But, the not-Medicaid-but-Medicaid legislative gymnastics highlight the faulty factual findings of the majority in contrast with the internal consistency of Justice Ginsburg's dissent.

IV. CONCLUSION

In short, Justice Ginsburg endeavored to get the facts right, making hers the opinion to read for anyone who wants to understand how the constitutional questions should have been answered in *NFIB* as well as how the healthcare programs at issue actually operate. The recent presidential election confirms that the ACA will not be repealed and will be effectuated. It would be easy to dismiss the variations in legislative interpretation as a reflection of ideology in a complex, contentious, and unusually high-profile case, but the decision seems to invite further litigation. That further litigation offers an opportunity to compound not only the bad legislative interpretation but also the sweeping constitutional analysis in the decision. At least

⁵⁷ 42 U.S.C. § 1303 (2006).

⁵⁸ *NFIB*, 132 S. Ct. at 2607–08 (opinion of Roberts, C.J., joined by Breyer & Kagan, JJ.).

⁵⁹ See Huberfeld, Leonard & Outterson, *supra* note 11, at 76–84 (explaining the open statutory questions that arose due to the severing of the Medicaid expansion and the removal of the Secretary's ability to limit funding to the states for nonparticipation).

⁶⁰ *NFIB*, 132 S. Ct. at 2641–42 (Ginsburg, J., concurring in part and dissenting in part).

⁶¹ The joint dissent would have invalidated the ACA in its entirety, and the opinion rejected this remedy for the agreed-upon unconstitutionality of the Medicaid expansion. *Id.* at 2668 (joint dissent).

two concerns are worth mentioning here: first, *NFIB* reinforces a concern that the Court tends not to do healthcare or any other highly regulated and complex area very well.⁶² The Court had plenty of amicus briefs available to help it discern the meaning of the ACA even if it chose not to accept Congress's findings, yet the opinions created an impression that healthcare was just a vehicle for constitutional projects.

Second, the influx of new Medicaid enrollees will highlight a latent problem in the Medicaid Act itself that was complicated by the ACA and *NFIB*. If all states implement the Medicaid expansion, the ACA will add an estimated twenty-one million enrollees into the Medicaid program by 2022, but the remedies available to them when states fail to deliver the promised benefits of Medicaid are both unstable and in flux.⁶³ Last term, in *Douglas v. Independent Living Center of Southern California*, the Court came close to invalidating Supremacy Clause private rights of action by providers and enrollees who do not receive benefits promised by the Medicaid Act.⁶⁴ Justice Breyer's majority opinion thwarted such a sweeping decision by insisting that HHS exercise primary jurisdiction in the case.⁶⁵ Interestingly, the *Douglas* majority opinion also displayed a concern for Medicaid as a program, not just the constitutional questions in the case.⁶⁶ In contrast, the dissent authored by Chief Justice Roberts jumped straight to the Supremacy Clause question with little regard for the statutory scheme or import of the program at hand, consistent with his ap-

62 See, e.g., Huberfeld, Leonard & Outterson, *supra* note 11, at 9 & n.38 (referring to an instance where a justice admitted at oral argument that he often confused Medicare and Medicaid). The judiciary's deficiencies in making healthcare-related decisions often arise in the end-of-life context. See, e.g., Diane E. Hoffmann, *Mediating Life and Death Decisions*, 36 ARIZ. L. REV. 821 (1994) (advocating for mediation in end-of-life decision-making to remove the process from under-equipped courts); I. Glenn Cohen, *Negotiating Death: ADR and End of Life Decision-making*, 9 HARV. NEGOT. L. REV. 253 (2004) (advocating for alternative dispute resolution to remove end-of-life disputes from courts given the inadequacies displayed in the Schiavo dispute); TIMOTHY STOLTZFUS JOST, *DISSENTLEMENT? THE THREATS FACING OUR PUBLIC HEALTH-CARE PROGRAMS AND A RIGHTS-BASED RESPONSE* 38 (2003) (describing courts' involvement in the formation of healthcare rights as "far from consistent"). My observation is slightly broader, that the Court does not perform healthcare-related analysis particularly well and tends to focus on the constitutional issue rather than the healthcare context in which it sits, and *NFIB* is a microcosm of that problem.

63 See JOHN HOLAHAN ET AL., KAISER COMMISSION ON MEDICAID AND THE UNINSURED, PUB. NO. 8384, *THE COST AND COVERAGE IMPLICATIONS OF THE ACA MEDICAID EXPANSION: NATIONAL AND STATE-BY-STATE ANALYSIS 1* (2012), available at <http://www.kff.org/medicaid/upload/8384.pdf>.

64 132 S. Ct. 1204 (2012).

65 *Id.* at 1210–11.

66 *Id.* at 1208–09.

proach in *NFIB*.⁶⁷ The likelihood that more Medicaid enforcement actions will arise with the influx of new enrollees is bound to test the Court's misconstrual of the Medicaid program in *NFIB*.

It is often said that bad facts make bad law. In this case, the facts themselves were not bad, but certain justices seemed disposed to bypassing the facts. Thus, in *NFIB*, a bad reading of the facts has led to newly shaped constitutional interpretation for three of Congress's major Article I powers (commerce, spending, and necessary and proper),⁶⁸ and this new interpretation has the potential not only to impact new healthcare cases, but also to facilitate additional challenges to congressional authority.

67 *Id.* at 1211–15 (Roberts, C.J., dissenting). *See also* Huberfeld, *Post-Reform Medicaid Before the Court*, *supra* note 29, at 515–27 (describing the *Douglas* litigation); Brietta R. Clark, *Medicaid Access, Rate Setting and Payment Suits: How the Obama Administration Is Undermining Its Own Health Reform Goals*, 55 *HOW. L.J.* 771 (2012) (highlighting Medicaid's remedy problem and the ways in which the Obama Administration has been undermining its own expansion of Medicaid by articulating a desire to eliminate at least some private rights of action against states).

68 Four, if the tax power analysis is deemed "new."

