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Article

UNDERSTANDING STATE RESISTANCE TO THE PATIENT PROTECTION AND AFFORDABLE CARE ACT: IS IT REALLY JUST POLITICS AS USUAL?

Amy Lischko [a1] Beth Waldman [d1]

I. Introduction

On March 23, 2010, President Obama signed into law Public Law 111-148, known as the Patient Protection and Affordable Care Act ("PPACA"). [1] The enactment and implementation of PPACA is the latest chapter in a long debate over the appropriate balance of state and federal government in setting domestic policy. [2] The ability to achieve a workable federal-state relationship will again be tested under PPACA over the next several years as implementation of provisions of the law occurs. [3]

***28** Significant formal resistance by states through legal and legislative challenges to federal laws has been relatively rare in American history, [4] and, therefore, predicting how resistance to PPACA will affect its long-term implementation is difficult. The No Child Left Behind Act ("NCLB") of 2001, [5] provides a recent example of the conflicts that can develop between the federal government and the states during implementation of a federal law. [6]

Over a decade old, NCLB initially enjoyed bipartisan support. [7] However, the law experienced significant resistance from states throughout its implementation, as it required changes to states' educational systems regarding accountability for student performance, school choice, and teacher certification. [8] The newly imposed responsibilities were not tacitly implemented by the states. [9] Instead, states undertook numerous actions, including the proposal and enactment of state legislation rejecting NCLB, [10] a state lawsuit against the U.S. Department of Education, [11] and state ***29** applications for waivers from some of the law's provisions. [12] Today, NCLB has opponents on both sides of the political spectrum: Democrats angry over the identification of too many schools as failing, and Republicans arguing the law gives too much power to the federal government. [13]

Not unlike NCLB, PPACA asks states to implement federal requirements in an important area of domestic policy. [14] PPACA gives states extensive implementation responsibilities, including requiring their citizens to obtain health insurance if it is affordable, [15] requiring their larger employers to cover their employees or face penalties, [16] expanding Medicaid eligibility to all legal residents under age sixty-five with income up to 133 percent of the federal poverty level ("FPL"), [17] establishing American ***30** Health Benefit Exchanges ("Exchanges") and Small Business Health Options Program ("SHOP Exchange"), [18] and significantly dictating state regulation of insurance. [19]

However, PPACA differs from NCLB in several meaningful ways. Unlike NCLB, PPACA was passed with a slim-margin, on a strictly partisan basis,[20] and drew significant state resistance within hours of enactment, when the attorney general of Virginia filed suit in federal court claiming that PPACA was unconstitutional.[21] In addition, PPACA is, without question, more far-reaching than NCLB. It requires significant transformation not only of programs funded with a combination of state and ***31** federal dollars, such as Medicaid and Disproportionate Share Hospitals ("DSH"),[22] but also transforms states' private insurance markets and places responsibilities on private employers and individuals.[23] Unsurprisingly, resistance to implementing PPACA has, to date, come primarily from the Republican Party.[24]

Understanding that PPACA's ultimate success rests with states' efforts, or lack thereof, to implement it, the federal government has provided states some flexibility in implementation through promulgating regulations and guidance.[25] The U.S. Department of Health and Human Services' ("HHS") recent guidance on essential health benefits and conditional approval of all states' Exchange plans offer examples of this flexibility.[26] The Supreme Court's decision to make the Medicaid expansion ***32** optional for states may also help to mitigate some of the state-level resistance to PPACA.[27]

This paper reviews some of the underlying factors, beyond politics, that may contribute to state resistance to PPACA today and, more importantly, in the future. In addition, this paper discusses why the federal government should continue to implement the law in a flexible manner to allow states to move towards greater coverage and sustainability without causing significant disruption to insurance markets, providers, and consumers.

II. Major Components of the Law

Much has been written about PPACA and states' ongoing challenges to its provisions.[28] Early resistance included arguments that PPACA's "regulation of the states violates their independent sovereignty" and the "minimum coverage requirement exceeds Congress's enumerated powers."[29] Since the Supreme Court's ruling in June 2012 upholding most of the law, implementation at the state level has continued in earnest.[30] The major components of PPACA where resistance may occur as ***33** implementation progresses can be categorized into the following core areas: (1) Insurance Regulation; (2) Medicaid Expansion; and (3) Mandates and Exchanges. Assessment of each state's economic condition relative to its "readiness" to implement PPACA is also considered.

A. Insurance Regulation

Perhaps some of the most far-reaching aspects of the law can be found in the law's requirements regarding how states must modify regulation of small group and individual insurance markets. PPACA requires states to prohibit coverage exclusions for preexisting conditions, as well as annual and lifetime limits on costs incurred by an individual under a health insurance policy.[31] Further, health plans may not rescind health coverage for any reason other than fraud.[32] These changes, among others, result in the guaranteed availability of coverage.[33] In addition, PPACA prohibits cost sharing for preventive services and eliminates any rate variation by health status, industry sector, and gender.[34] Limited variation in rates is allowed for age (within a ratio of 3:1) and for tobacco use (within a ratio of 1.5:1).[35] Finally, dependents are allowed to remain on their parents' health insurance policies until age 26, and states must provide greater oversight over insurance rate increases and institute strict medical loss ratio ("MLR") standards of 80 percent in the individual market and 85 percent in the small group market.[36]

***34 B. Medicaid Expansion**

As passed, PPACA mandates that states expand their Medicaid programs to people with incomes up to 133 percent of the FPL by tying that expansion to the ability of a state to receive federal matching funds toward the state's entire Medicaid program.[37] The expansion of Medicaid eligibility is now essentially optional based on the Supreme Court's decision.[38] PPACA also mandates a standard formula, known as modified adjusted gross income ("MAGI"), for determining whether certain groups of individuals, including pregnant women, children, parents, and childless adults, meet financial income requirements.[39] This new standard may make it either easier or harder for an individual to receive coverage from his or her state Medicaid program, including both those populations that are newly or currently eligible for benefits.[40] Under MAGI, states must follow a relatively complex formula to determine an individual's eligibility that is based on income but does not require an asset test.[41] States are also charged with reducing the ***35** burden on applicants to verify eligibility information by first using available electronic federal and/or state sources.[42]

PPACA also requires expansion to smaller populations, including coverage of individuals formerly in foster care up to age 26, and optional expansions for family planning services.[43] With the creation of the Essential Health Benefits for plans offered through the Exchanges, the Centers for Medicare and Medicaid Services ("CMS") has tied the benchmark benefit to be provided to Medicaid expansion beneficiaries to services defined by the Essential Health Benefits.[44] This benefit includes services that are currently optional under the Medicaid program, such as prescription drugs.[45] While all states provide prescription drug coverage in their Medicaid programs today,[46] the inclusion of it as a mandatory benefit through the Exchange may impact the level of prescription drug coverage states must provide, as well as limit their ability to reduce prescription drug coverage to manage a difficult budget.

Because PPACA assumed a mandatory expansion of Medicaid, as well as that the national uninsured rate would decrease, the law includes a significant reduction in ***36** payments to both Medicaid and Medicare DSH,[47] which may dramatically impact the financial stability of safety net hospitals that are dependent on DSH funding to remain solvent.[48] Specifically, Medicaid DSH payments are reduced over a seven-year schedule beginning in 2014, requiring a total reduction in payments of $18.1 billion.[49] From 2014 through 2019, the reduction amounts generally increase, "represent[ing] approximately a 50% reduction over baseline projections."[50]

PPACA and the Health Care and Education Reconciliation Act of 2010 make several other changes to the Medicaid program that are not the focus of this discussion, including temporary increases in primary care provider rates[51] and opportunities for enhanced federal funding over a limited time period for development of care management programs focused on health homes.[52] Further, PPACA creates the Federal Coordinated Health Care Office aimed at improved coordination across the Medicare and Medicaid programs, including the availability of demonstration planning funds and demonstrations.[53]

C. Mandates and Exchanges

A centerpiece of PPACA is the individual and employer mandates - requiring that individuals purchase insurance meeting minimum benefit requirements and that employers offer insurance for their employees at an affordable cost, or face monetary penalties.[54] As contemplated in PPACA, the Exchanges provide a user-friendly ***37** mechanism to assist individuals and

small businesses to meet the law's mandates by providing increased and clear options for the purchase of affordable health insurance.[55]

In preparation for the Exchange launch on January 1, 2014, states were required to make a determination about whether or not they would establish a state-based Exchange, work with the federal government in a partnership Exchange, or not establish an Exchange at all.[56] The Exchange will need to perform a broad range of tasks including providing standardized information on all available health insurance products to be offered through the Exchange,[57] coordinating eligibility determinations for advanceable premium tax credits and cost-sharing subsidies available to individuals with incomes below 400 percent of the FPL and Medicaid,[58] developing risk adjustment mechanisms,[59] overseeing health plan practices with respect to benefit design, marketing, network adequacy, quality, and affordability.[60] States operating their own state-based Exchanges or partnership Exchanges are expected to assist the federal government in determining whether an employer is offering coverage that meets certain affordability and coverage standards, and whether individuals are purchasing and maintaining coverage.[61]

III. Political Representation

As reported in the press, early opposition to PPACA had been along partisan lines.[62] Therefore, one would expect that states with Democratic governors and/or ***38** legislatures who tend to favor the law to have moved forward with enthusiastic implementation plans embracing all aspects of the law, while states with Republican governors and/or legislatures who have generally opposed the law to have lagged behind or refused to participate in important implementation milestones. However, because the law is so complex and far-reaching, such a simple partisan dichotomy does not fully explain state resistance and implementation strategy. There are parts of the law that likely appeal to Republicans and parts which may not resonate with Democrats. Moreover there are financial and other incentives inherent in PPACA that make it difficult to predict behavior strictly along political lines.

Table 1 presents the political party representation in each state's governor's office and majority party in the legislative branches. It also presents several variables that are indicative of early resistance or uncertainty regarding implementation of PPACA. Rows with bolded font in the first two columns of Table 1 represent states where Republicans dominate both the governor's office and legislature. Many of these states opposed the law prior to the general election in the fall of 2012 and also announced their opposition to two major implementation components: the now optional Medicaid expansion, and the establishment of a state-based Exchange. A decision to take advantage of the federal Exchange or to agree to a federal-state partnership Exchange does not in and of itself represent opposition to the law or to this particular feature of the law. Nevertheless, it does suggest that a state is not prepared to accept full responsibility for implementation of the law and may indicate that there may be implementation barriers for that particular state moving forward.

It seems clearest in the Republican states fully denoted in bold that politics are driving resistance and implementation decisions. In most of these states there also has been some state-level action following the Supreme Court's Ruling to uphold the law, including banning implementation of various components of the law or promoting the Interstate Health Compact Law, in direct opposition to PPACA.[63] Conversely, the states with italicized font in the first two columns of Table 1 represent states with a majority of Democrats, both in the governor's office and representation in the legislature. Many of these states have supported the law since its inception and have announced that they will expand Medicaid and establish their own state-based Exchange.

***39** Surprisingly, this clearly “political” factor only accounts for 18 states.[64] The other 32 states may be somewhat more nuanced in their response to PPACA and its implementation. It is interesting to note that a number of states regarded as Republican-dominated have announced their desire to implement the Medicaid expansion (Arizona, Florida, North Dakota, and

Ohio) or are still deciding (Kansas, South Dakota, and Utah).[65] In addition, several Republican states (denoted in bold) also have decided to establish their own Exchange (Idaho and Utah).[66] Similarly, there are a number of predominantly Democratic states (denoted in italics) that are still considering whether to expand their Medicaid program to everyone under 133 percent of the FPL (Kentucky and West Virginia) or that have declined to establish a state-based Exchange (Delaware, Illinois, New Hampshire, and West Virginia).[67]

***40 Table 1: Party Representation (2013) and Resistance to PPACA, by State (Data contained in this chart and related analysis is as of April 16, 2013)**

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***41 *42** Although politics will likely continue to factor into each state's overall perspective and enthusiasm for implementation of PPACA, it seems evident that other variables may also play an important role. One federalism scholar's framework for explaining state resistance to a federal law includes the following components: (1) "key constituencies at the state level oppose it;" (2) the law "eliminates state government discretion above and beyond what a typical federal regulation does;" and (3) the law "requires states to bear its costs" - commonly referred to as "unfunded mandates."[74] If this thesis is correct, one might expect states where key constituents such as insurers, employers, and residents who experience their health insurance marketplace and employer cultures as very different from that envisioned by PPACA, to be more likely to oppose the law. As well, states that experience higher implementation costs or whose fiscal condition is such that even minor increases will cause significant budgetary concerns, will likely display greater implementation resistance.

IV. Methodology

Characteristics of states' insurance markets, Medicaid programs, employer culture, and economic condition are culled from websites such as the National Conference of State Legislatures ("NCSL") and the Henry J. Kaiser Family Foundation's State Health Facts.[75] States are considered to have a high level of resistance to the law, or a 3 on a scale of 0-3, if a state has announced it joined the litigation against PPACA last spring, enacted laws or constitutional amendments against PPACA, and will not expand Medicaid and not establish a state-based Exchange. States that have agreed to expand Medicaid, to establish a state-based Exchange, that supported PPACA in the Supreme Court Case, and that have no pending legislation opposing the law, receive a resistance designation of "None" or 0. States that do not fall into either extreme category are designated as either a "Medium" or 2 (two or three out of four factors point to some opposition) or "Mild" or 1 (one out of four factors point to some opposition) level of resistance.

Because the dependent variable, resistance, is ordinal, Spearman's rank correlation coefficients are calculated to estimate the relationship between the dependent variable (resistance) to each independent variable.[76] The coefficients are rounded to the ***43** nearest hundredth decimal place and interpreted as follows: coefficients between .50 and 1.0 are considered strongly correlated, between .30 and .50 moderately correlated and between .10 and .30 weakly correlated.

V. Results

A. Insurance Regulation

As discussed, PPACA dramatically changes the insurance marketplace by requiring certain rating requirements in the individual and small group marketplace including rate bands, guaranteed issue, and the health status underwriting prohibition.[77] States that are closer to these requirements due to previous state regulation would be expected to show less resistance than states that are farther away. Data from the Henry J. Kaiser Family Foundation's State Health Facts[78] were used to compute summary scores for each state's current level of insurance market regulation. Columns 1 and 2 of Table 2 provide these scores for each state's individual (Column 1), and small group (Column 2) markets using a scale of 1 (furthest away from PPACA requirements) to 4 (closest to PPACA requirements).

Most states that have more highly regulated individual markets (scores of 3 or 4) have shown no resistance to implementing PPACA, with Maine as the exception.[79] Likewise, a number of states with the least regulated individual markets (score of 1), such as California, Connecticut, and Maryland, also have shown no resistance to the law thus far.[80] The law also requires states to regulate the MLR in their small and large group markets, and further requires that insurers provide rebates to policyholders if the MLR falls below the required level.[81] In 2012, rebates were provided to consumers where insurance companies collected premiums that exceeded health care costs.[82] The average rebates to consumers in 2012 may be used as an indicator of insurance company resistance to PPACA, as these rebates would have been considered profit or surplus had the law not been enacted.

***44 Table 2: Insurance Factors by State**

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***45** Formal testing with Spearman Rank correlation coefficients for the insurance variables found weak to moderate correlations with level of state resistance. States that implemented more market reforms in their small group market showed less resistance to the law than states that were farther away from the market reforms proposed by PPACA (r = -0.4). A weak negative correlation also was found with the level of reform in a state's individual market (r = -0.24). Almost no correlation was found between state resistance and the amount of MLR rebates (r = -0.1)

B. Medicaid

Resistance corresponding to unfunded mandates may be an important dimension of a state's resistance to a federal law.[87] The Supreme Court's decision essentially made the Medicaid Expansion optional for states, meaning it can no longer be viewed as an unfunded mandate.[88]

***46** While the Medicaid expansion will be fully federally funded between January 1, 2014 and January 1, 2017 for most states, beginning in 2017 states will need to begin funding a portion of the cost of the expansion (5% in 2017 moving gradually to 10% by 2020).[89] While it is relatively a small percentage of the total cost of providing the expanded Medicaid coverage, the addition of any new Medicaid costs is very difficult for states where Medicaid is already viewed as a budget buster and for states that have difficulty funding their current Medicaid programs within available state revenues.[90] Unlike the federal government, nearly all states must balance their budget on an annual basis,[91] making the impact of new Medicaid spending an

issue for states on an annual basis. Additionally, some states fear that over time the federal government may reduce the amount of funding it provides for the expanded population, or otherwise change the federal funding mechanism utilized to determine funding for the Medicaid population as ***47** a whole.[92]

In states where past expansion of the Medicaid program has been more extensive, and where outreach and enrollment efforts have already been strong, state finances are more likely to be improved, or additional state costs are minimal under PPACA.[93] A number of states are prepared to implement the expansion based on their current Medicaid eligibility levels and the initial three years of 100% federal funding.[94]

One issue facing all states is what is known as the "woodwork effect."[95] ***48** Specifically, as more people become eligible for Medicaid in a state, the state experiences expanded enrollment both based on the newly added population, and the "eligible but unenrolled" population.[96] This can occur because individuals apply when another family member is eligible.[97] Increased awareness of the program based on outreach and marketing for those newly eligible for benefits, also causes more people to apply.[98] The impact of the woodwork effect may be greater because of the individual mandate as individuals eligible for Medicaid may believe that they will be subject to a penalty if they fail to enroll.[99] Importantly, states will receive their regular matching rate from the federal government for individuals who are currently eligible but not enrolled, placing a burden on state budgets.[100] In addition, PPACA requires significant administrative resources from states as the expanded eligibility requires significant systems and process ***49** changes in all states,[101] and requires significant overlap and coordination with the state Exchange or the federally-run Exchange for states that do not administer their own Exchange.[102]

States that may not support PPACA overall or the Medicaid expansion, may feel financial pressure from their safety net hospitals and low-income residents to expand coverage.[103] Because the law includes reductions to DSH funding as implementation progresses, states that choose to forgo the Medicaid expansion may find it increasingly difficult to find revenue to cover care that their uninsured use.[104] Moreover, employers that employ many low-income people who would have been eligible for Medicaid under PPACA will need to cover or pay a fine for these individuals.[105] Moving forward, these factors could play a larger role than politics, particularly in states with significant budget deficits.

Table 3 presents projections for the percent change in Medicaid enrollment, should a state expand their Medicaid program to PPACA levels, and the new state spending necessary for the expansion both in dollars and percent increase, and current estimates of the percent enrolled among currently eligible to assess the impact of the ***50** woodwork effect. The strongest correlations with resistance for these Medicaid factors were found for the percent increase in state spending from baseline (r = 0.37) and the percent change in Medicaid enrollment (r = 0.35). Weaker correlations were found for the overall increase in dollars required for the expansion (r = 0.15) and current Medicaid enrollment among those eligible (our measure for the woodwork effect) (r = - 0.23).

Table 3: Projected Increases in Medicaid Enrollment and Estimated State Spending[106]

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***52 C. Mandates and Exchanges**

Only Massachusetts and Hawaii had implemented any sort of mandate for insurance coverage prior to PPACA. [109] In addition, with the exception of Massachusetts and Utah, no state had implemented a state-wide Exchange prior to the passage of PPACA. [110] Therefore, there are no readily available data that can be used to assess states' relative position on these indicators. This section will assess variables that are related to these features of PPACA. For example, states' employer environments regarding the offering and affordability of health insurance will be assessed as a proxy for employer resistance. States where employers have high offer rates of insurance coverage and provide a more generous share of the premium may be more supportive of PPACA and its mandate for large employers to cover employees. States with expensive insurance coverage may positively view Exchanges as a way to lower costs by making insurance choices more transparent. However, states with expensive insurance coverage may resist PPACA because of its large employer mandate and the costs associated with the provision of insurance. The percent of a state's population without insurance is also assessed. It is possible that the higher the coverage rate, the lower the resistance of a state's population to an individual mandate may be. Massachusetts, for example, had a high rate of insurance coverage before it passed its reform and experienced generally high support for its mandate. [111]

There does not appear to be much of a relationship between the employer environment and resistance to PPACA. As shown in Table 4 below, several states with low employer offer rates are also states that have thus far shown little resistance to PPACA. States with some of the highest offer rates also tend to support PPACA with the exception of New Hampshire and Utah. [112] The Spearman Rank correlation ***53** coefficient shows only a weak negative correlation between employer offer rates and level of resistance (r = -0.19). States with higher employer contributions also are less likely to show resistance to the law but the relationship is weak (r = -0.27). A weak correlation exists between average per capita health care costs and resistance to the law (r = -0.18). Finally, a weak correlation also was found between the percent uninsured in a state and level of resistance, possibly reflecting some greater resistance to the individual mandate in states with lower insurance coverage (r = 0.24).

Table 4: Employer Subsidized Insurance, by State

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***55 D. Economic Factors**

PPACA requires extensive efforts at the state level regarding implementation. Although the federal government will fund many of these activities, states are required to request funds, and doing so requires state resources. Moreover, it is not only state funds that are affected by PPACA, but various stakeholders will also need to build the capacity to respond to new data requests and programmatic changes at the state and federal level in order to comply with the law.

At least 31 states are projecting shortfalls totaling $55 billion for fiscal year 2013, which began July 1, 2012. [118] For the economic factors assessed in Table 5, there is a strong negative correlation (r = -0.53) between a state's median income and resistance to PPACA. Interestingly, there is only a weak correlation (r = -0.16) between state budget shortfalls and resistance to PPACA. As expected, there is a strong negative correlation (r = -0.53) between the amount of federal funding a state has received thus far and resistance to the law.

***56 Table 5: Economic Factors, by State**

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***58 VI. Discussion and Conclusion**

This paper fills a gap in the health policy literature by analyzing factors contributing to formal state resistance to PPACA. It provides guidance to federal policymakers about the potential causes of state resistance to PPACA. To reduce state resistance as implementation continues, we propose that the federal government continue to take a flexible approach, providing states with a variety of options that meet the spirit of PPACA.

While much of the observed opposition to PPACA thus far can be directly tied to partisan politics, [123] it is also true that, in most instances, states opposing PPACA are states that need to undergo the most dramatic changes to their private insurance markets and eligibility levels for public assistance as part of PPACA implementation. [124] They are also among the states with the largest rates of poverty and budget shortfalls. [125] Nevertheless, as many have argued, states that are the farthest away from the goals of PPACA are also those that could benefit most from the additional outlay of cash from the federal government. [126]

This descriptive analysis does not attempt to model the factors that are most responsible for a state's resistance to the law. Rather, this article discusses general correlations between various state-level factors and resistance. Table 2 clearly depicts the differences that exist among states' insurance market regulations. These features are moderately correlated with the resistance expressed thus far. It is also possible that because many of these rating features have yet to be implemented, additional resistance will occur in states farthest away from compliance as implementation occurs. [127]

***59** How different a state's Medicaid program is from that required by PPACA also may contribute to a state's resistance. Significant research exists examining the striking differences across states in eligibility, enrollment, and benefit level in state Medicaid programs. [128] The percent potential increase in Medicaid enrollment and the percent increase in spending on Medicaid are some of the more highly correlated factors assessed in this analysis. [129] Resistance may be higher in states where a large number of people may be newly eligible for Medicaid per PPACA. Even though the expansion is now optional, funds for the safety net will not be available to the same extent moving forward. Even in states that support PPACA, significant new funding required for the Medicaid expansion can greatly impact funds that are available to support other non-health services, including funding for cities and towns, infrastructure such as roads and highways, and public education.

The individual insurance mandate and the implementation of Exchanges are hallmarks of the PPACA legislation. [130] Not surprisingly, implementation of a state-run Exchange is closely tied to a state's leading political party. [131] As shown in Table 1, only two states with Republican governors and legislatures have agreed to run their own Exchanges. [132] In the six states with a Republican governor but split or democratic ***60** legislature, only one (New Mexico) has agreed to run an Exchange and one (Iowa) has agreed to run an Exchange in partnership with the federal government. [133] In states with Democratic governors, regardless of the legislative majority, only two states have opted out of running an Exchange (Missouri and Montana). [134]

It is not surprising that states vary significantly on factors related to PPACA implementation as observed in Tables 2 through 5. To date, states have had considerable freedom to regulate their insurance markets and to a smaller extent, to manage their Medicaid and safety net programs as they have seen fit.[135] PPACA changes this "federalist" approach.[136] Allowing greater flexibility through regulations and guidance and the possibility of the waiver of certain provisions will ease the transition for states whose insurance market structures and safety net systems are very different from the law's vision. Waivers from various provisions of PPACA are allowed beginning in 2017.[137] As CMS develops criteria for waivers, broader waiver criteria may allow more states that are resistant to provisions of PPACA to participate in aspects of the law, while using state authority for aspects that prove to be most difficult to transition in the next three years.

Moreover, such an approach may also encourage greater experimentation leading to the identification of best practices. A flexible approach also can save the federal government significant revenue and may, in the end, achieve better outcomes, particularly in states where opposition is strongest. If the experience with NCLB teaches us anything, it is that implementation is often much more difficult than the passage of a law.[138] Although NCLB enjoyed bipartisan support upon passage, it has been much more challenging to strike an appropriate balance between federal and state authority during implementation.

Footnotes

a1 Associate Professor of Public Health and Community Medicine, Tufts University School of Medicine; BS, MSPH, University of Massachusetts, Amherst; DSc, Health Services Research, Boston University. Prof. Lischko may be contacted at amy.lischko@tufts.edu.

d1 Senior Consultant, Bailit Health Purchasing; MPH, Harvard School of Public Health; JD Boston College Law School. Ms. Waldman may be contacted at bwaldman@bailit-health.com.

1 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029.

2 See generally Wendy K. Mariner et al., Reframing Federalism--The Affordable Care Act (and Broccoli) in the Supreme Court, 367 New Eng. J. Med. 1154 (2012), available at http://www.nejm.org/doi/pdf/10.1056/NEJMhle1208437 (highlighting varying views from the Supreme Court decision to uphold PPACA with regards to federal government authority over states); see also Elizabeth Weeks Leonard, The Rhetoric Hits the Road: State Challenges to the Affordable Care Act Implementation, 46 U. Rich. L. Rev. 781, 782-83 (2012) (noting state objections to PPACA and "struggle[s] to define [this] overarching model of federalism").

3 See Leonard, supra note 2, at 786-821 (analyzing failure, success, and strategies of five "fronts of state resistance" to PPACA). Leonard asserts that the five "fronts of state resistance" vis-à-vis PPACA are the Medicaid Expansion, High-Risk Insurance Pools, Exchanges, Federal Insurance Market Regulations, and the Individual Mandate. Id.

4 Bryan Shelly, Rebels and Their Causes: State Resistance to No Child Left Behind, 38 Publius 444, 444 (2008); see also Charlton C. Copeland, Beyond Separation in Federalism Enforcement: Medicaid Expansion, Coercion, and the Norm of Engagement, 15 U. Pa. J. Const. L. 91, 139-53 (2012) (focusing on state and federal interplay concerning enactment and implementation of the No Child Left Behind Act of 2001 and the REAL ID Act of 2005).

5 No Child Left Behind Act of 2001, Pub. L. No. 107-110, 115 Stat. 1425 (2002), available at http://www.gpo.gov/fdsys/pkg/PLAW-107publ110/pdf/PLAW-107publ110.pdf.

6 See generally Shelly, supra note 4.

7 Tom Loveless, Brookings Inst., The Peculiar Politics of No Child Left Behind 1 (2006), available at http://www.brookings.edu/~/ media/research/files/papers/2006/8/k12education%20l*o*veless/08k12education_ loveless.pdf (noting "a left-right coalition formed that successfully steered the [NCLB] through Congress"); Brian M. Stecher & Georges Vernez with Paul Steinberg, RAND Corp.,

Reauthorizing No Child Left Behind: Facts and Recommendations 2 (2010), available at http:// www.rand.org/content/dam/rand/pubs/monographs/2010/RAND_MG977.pdf; U.S. Dep't of Educ., A Guide to Education and No Child Left Behind 13 (2004), available at http://www2.ed.gov/nclb/overview/intro/guide/guide.pdf ("President Bush signed [[NCLB] into law with overwhelming bipartisan support ... [with] Senators Ted Kennedy (D-MA) and Judd Gregg (R-NH) and Congressmen George Miller (D-CA) and John Boehner (R-OH) [as] its chief sponsors in the Senate and the House.").

8 See Shelly, supra note 4, at 444.

9 Id.

10 Id. at 444, 446 (noting 38 states considered legislation criticizing NCLB and five states passed such legislation); Loveless, supra note 7, at 30-34 (listing state activities in response to NCLB). States viewing NCLB as inflexible considered legislation that would exempt them from NCLB in the absence of additional federal funding, and Hawaii, New Hampshire, Utah, and Vermont considered legislation to decline all related federal funds. Gina Austin, Note, Leaving Federalism Behind: How the No Child Left Behind Act Usurps States' Rights, 27 T. Jefferson L. Rev. 337, 364-65 (2005).

11 Connecticut v. Duncan, 612 F.3d 107 (2d Cir. 2010); Shelly, supra note 4, at 444 (noting Connecticut sued the U.S. Department of Education). The National Education Association ("NEA"), a teachers' union, along with local school districts in Michigan, Texas, and Vermont also brought a lawsuit against the U.S. Department of Education, "seeking a declaratory judgment that [the school districts] need not comply with [NCLB's] requirements where doing so would result in increased costs of compliance not covered by federal funds." Sch. Dist. of City of Pontiac v. Sec'y of U.S. Dep't. of Educ. 584 F.3d 253 (6th Cir. 2009); see also Regina R. Umpstead & Elizabeth Kirby, Reauthorization Revisited: Framing The Recommendations for the Elementary and Secondary Education Act's Reauthorization in Light of No Child Left Behind's Implementation Challenges, 276 Ed. Law Rep. 1, 17-18 (2012) (discussing both lawsuits).

12 Elementary & Secondary Education: ESEA Flexibility, U.S. Dep't of Educ. (Mar. 12, 2013), http://www2.ed.gov/policy/elsec/guid/esea-flexibility/index.html (noting 34 states and the District of Columbia have been granted flexibility in compliance with the Elementary and Secondary Education Act as amended by NCLB); Elementary & Secondary Education: Waivers Granted Under No Child Left Behind, U.S. Dep't of Educ. (Oct. 26 2012), http:// www2.ed.gov/nclb/freedom/local/flexibility/waiverletters/index.html (detailing waivers granted pursuant to § 9401 of the Elementary and Secondary Education Act as amended by NCLB); see also Elementary & Secondary Education: Flexibility and Waivers, U.S. Dep't of Educ. (Oct. 12, 2012), http:// www2.ed.gov/nclb/freedom/local/flexibility/index.html#waivers (detailing opportunities for flexibility and waivers).

13 See Patricia Gándara & Gabriel Baca, NCLB and California's English Language Learners: The Perfect Storm, 7 Language Pol'y 201, 206 (2008), available at http://www.usc.edu/dept/education/CMMR/FullText/GandaraNCLB_ ELLs.pdf.

14 See State Health Insurance Mandates and the PPACA Essential Benefits Provisions, Nat'l Conf. of State Leg., http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx (last updated Feb. 20, 2013).

15 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1501(b), 124 Stat. 119, 244 amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1002, 124 Stat. 1029, 1032 (to be codified as amended at 26 U.S.C. § 5000A).

16 Patient Protection and Affordable Care Act of 2010 § 1513(a), amended by Health Care and Education Reconciliation Act of 2010 § 1003 (to be codified as amended at 26 U.S.C. § 4980H).

17 Patient Protection and Affordable Care Act of 2010 § 2001(a) (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)). Technically, the eligibility is expanded to such individuals with income up to 138% of the federal poverty level because of a 5% income disregard. Health Care and Education Reconciliation Act of 2010 § 1004(e) (to be codified at 42 U.S.C. § 1396a(e)(14)(I)).

18 Patient Protection and Affordable Care Act of 2010 § 1311 (to be codified at 42 U.S.C. § 18031).

19 Id. §§ 1001, 1201, 1252; Patient Protection and Affordable Care Act of 2010 § 1251, amended by Health Care and Education Reconciliation Act of 2010 § 2301.

20 In the Senate, every Democrat voted in favor of PPACA, while every Republican voted against it, except for one Republican Senator who did not participate in the vote. U.S. Senate Roll Call Votes 111th Congress-1st Session, U.S. Senate, http://www.senate.gov/legislative/LIS/roll_call_ lists/roll_call_vote_cfm.cfm?congress=111&session=1&vote=00396 (last visited Apr. 21, 2013). In the House, 219 Democrats voted in favor of PPACA, while 34 Democrats and 178 Republicans voted against PPACA. Final Vote Results for Roll Call 165, Office of the Clerk, U.S. House of Rep., http:// clerk.house.gov/evs/2010/roll165.xml (last visited Apr. 30, 2013).

21 See Virginia ex rel. Cuccinelli v. Sebelius, 702 F. Supp. 2d 598, 601 (E.D. Va. 2010), rev'd, 656 F.3d 253 (4th Cir. 2011). The Commonwealth of Virginia asserted that PPACA is beyond the scope of Congressional power under the Commerce Clause, Necessary and Proper Clause, and taxation powers. Id. The Secretary of the Department of Health and Human Services, Kathleen Sebelius, filed a Motion to Dismiss, asserting the Attorney General of Virginia lacked standing and the issues at hand were not ripe because the individual mandate is not effective until 2014. Id. The District Court ultimately denied the Motion to Dismiss, reasoning the issue of whether Congress possesses the power to regulate and tax a person's choice "not to participate in interstate commerce" had not been "squarely addressed" by any court. Id. at 615. The District Court held that the mandate exceeded Congressional power under the Commerce Clause and that, as to taxation, the tax was in fact a penalty rendering the provision unconstitutional. Virginia ex rel. Cuccinelli v. Sebelius, 728 F. Supp. 2d 768, 782, 787-88 (E.D. Va. 2010), vacated, 656 F.3d 253 (4th Cir. 2011). On appeal, the Fourth Circuit reversed the case, holding that Virginia lacked standing. Virginia ex rel. Cuccinelli v. Sebelius, 656 F.3d 253, 266 (4th Cir. 2011). Specifically, the court noted Virginia had failed to show it had "suffered an injury in fact" because the mandate "does not directly burden Virginia." Id. at 268. Virginia's petition for a writ of certiorari was denied. Virginia ex rel. Cuccinelli v. Sebelius, 133 S. Ct. 59, 60 (2012). Currently, 20 state legislatures have taken action to challenge or opt out of PPACA provisions. Richard Cauchi, State Legislation and Actions Challenging Certain Health Reforms, Nat'l Conf. of State Leg., http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-ppaca.aspx (last updated Mar. 2013).

22 See, e.g., Patient Protection and Affordable Care Act of 2010 §§ 2001-2007, 2201, 2551. State transformations to Medicaid required by PPACA include extending "eligibility to non-elderly individuals with incomes at or below 133 percent of [the federal poverty level]." U.S. Gov't Accountability Office, GAO-12-821, Medicaid Expansion: States' Implementation of the Patient Protection and Affordable Care Act 6 (2012). PPACA ultimately "cuts payments to [DSH] ... [and] [i]nstead, ... calls on the Secretary of Health and Human Services to devise a fairer approach to allocating Medicaid DSH funds among states." Mark A. Hall, Getting to Universal Coverage with Better Safety-Net Programs for the Uninsured, 36 J. Health Pol. Pol'y & L. 521, 524 (2011).

23 Patient Protection and Affordable Care Act of 2010 §§ 1201-1415, 1501-1515.

24 That is, Republican opposition to PPACA implementation is unsurprising in light of the party's substantial opposition to the law's enactment and its stated preference that the law be repealed. See, e.g., Letter from Bob McDonnell, Republican Governor's Ass'n Chairman and Gov. of Va., to Barack Obama, U.S. President (July 10, 2012), available at http:// rgppc.com/medicaid-and-exchange-letter-2/; see also supra note 20 and infra Table 1.

25 Regulations & Guidance, HealthCare.gov, http:// www.healthcare.gov/law/resources/regulations/ (last visited Apr. 30, 2013) (providing links to the "[r]egulations and guidance ... used to implement ... provisions that address both private and public health insurance"); see also Bernadette Fernandez & Annie L. Mach, Cong. Research Serv., R42663, Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA) 8, 14 (2013) (noting States have flexibility in Exchange implementation under PPACA).

26 Patient Protection and Affordable Care Act - Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, 78 Fed. Reg. 12,834 (Feb. 25, 2013) (to be codified at 45 C.F.R. pts. 147, 155, 156), available at http://www.gpo.gov/fdsys/pkg/FR-2013-02-25/pdf/2013-04084.pdf; Essential Health Benefits Standards: Ensuring Quality, Affordable Coverage, Ctr. for Consumer Info. & Ins. Oversight, http:// cciio.cms.gov/resources/factsheets/ehb-2-20-2013.html (last visited Apr. 30, 2013); State Health Insurance Marketplaces, Ctr. for Consumer Info. & Ins. Oversight, http://cciio.cms.gov/resources/factsheets/state-marketplaces.html (last visited Apr. 30, 2013). HHS has recently shown willingness to allow federal Medicaid Expansion funds to be used to purchase coverage through qualified health plans on an Exchange, giving oral approval to Arkansas to use that method to provide coverage to the newly-eligible Medicaid population under PPACA. Sara Rosenbaum, Using Medicaid Funds to Buy Qualified Health Plan Coverage for Medicaid Beneficiaries, HealthReformGPS, http:// www.healthreformgps.org/wp-content/uploads/SR-Arkansas-

premium-support-pdf.pdf (last visited Apr. 21, 2013). It is unclear, however, whether this increased flexibility will provide enough incentive to encourage other states to participate. Id. at 3-4.

27 See Nat'l Fed'n of Indep. Businesses v. Sebelius, 132 S. Ct. 2566, 2607-08 (2012). Technically, the Supreme Court invalidated the enforcement provision as applied to the Medicaid Expansion - essentially, rendering compliance optional. Id.

28 E.g., Hinda Chaikind et al., Cong. Research Serv., R41664, PPACA: A Brief Overview of the Law, Implementation, and Legal Challenges 5-6 (2011) (highlighting constitutional and states' rights issues); Janet L. Dolgina & Katherine R. Dieterich, Social and Legal Debate About the Affordable Care Act, 80 UMKC L. Rev. 45, 58-69 (2011) (reviewing legal challenges to PPACA); Elizabeth J. Bondurant & Steven D. Henry, Constitutional Challenges to the Patient Protection and Affordable Care Act, 78 Def. Couns. J. 249, 250-52 (2011) (discussing cases challenging PPACA); Christopher B. Serak, Note, State Challenges to the Patient Protection and Affordable Care Act: The Case for a New Federalist Jurisprudence, 9 Ind. Health L. Rev. 311, 322-334 (2012) (providing overview of multiple state challenges to PPACA).

29 Bradley W. Joondeph, Federalism and Health Care Reform: Understanding the States' Challenges to the Patient Protection and Affordable Care Act, 41 Publius 447, 447 (2011).

30 E.g., Henry J. Kaiser Family Found., Establishing Health Insurance Exchanges: An Overview of State Efforts (2013) available at, http:// www.kff.org/healthreform/upload/8213-02.pdf; Henry J. Kaiser Family Found., Navigator and In-Person Assistance Programs: A Snapshot of State Programs (2013), available at http://www.kff.org/healthreform/upload/8437.pdf; see also Timing Matters: States Waiting for a Supreme Court Decision to Plan an Exchange, Henry J. Kaiser Family Found. (May 25, 2012), http:// www.kff.org/healthreform/quicktake_SCOTUS_exchanges.cfm (providing state-by-state overview of PPACA implementation efforts prior to Supreme Court decision).

31 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1201(2)(a), 124 Stat. 119, 154-55 (to be codified at 42 U.S.C. § 300gg-3); id. § 1001(5), 124 Stat. at 131 (to be codified at 42 U.S.C. § 300gg-11).

32 Patient Protection and Affordable Care Act of 2010 § 1001(5), 124 Stat. at 131 (to be codified at 42 U.S.C. § 300gg-12).

33 See supra notes 31-32 and accompanying text; see also Patient Protection and Affordable Care Act of 2010 § 1201(4), 124 Stat. at 156 (to be codified at 42 U.S.C. §§ 300gg-1, -2, -4) (guaranteeing availability and renewability of coverage, as well as prohibiting certain health status-related discrimination in coverage eligibility rules).

34 Patient Protection and Affordable Care Act of 2010 § 1001(5), 124 Stat. at 131 (to be codified at 42 U.S.C. § 300gg-13); see id. § 1201(4), 124 Stat. at 155-56 (to be codified at 42 U.S.C. § 300gg). A state's large group market is subject to the rate variation restrictions only "[i]f [the] State permits health insurance issuers that offer coverage in the large group market in the State to offer such coverage through the State Exchange. Patient Protection and Affordable Care Act of 2010 § 1201(4), 124 Stat. at 155-56 (to be codified at 42 U.S.C. § 300gg(a)(5)).

35 Id. § 1201(4), 124 Stat. at 155 (to be codified at 42 U.S.C. 300gg(a)(1)(iii)-(iv)).

36 Id. §§ 1001(5), 1003, 124 Stat. at 132, 136-37, 139 (to be codified at 42 U.S.C. §§ 300gg-15, -18, -94); see also infra notes 81-82 and accompanying text (detailing MLRs further).

37 Patient Protection and Affordable Care Act of 2010 § 2001(a)(1)(C), 124 Stat. at 271 (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)); 42 U.S.C. § 1396c (enforcing compliance with § 1396a through withholding of funds); see also supra note 17.

38 See Nat'l Fed'n of Indep. Businesses v. Sebelius, 132 S. Ct. 2566, 2607-08 (2012). Again, technically, the Supreme Court invalidated the enforcement provision as applied to the Medicaid Expansion - thereby, rendering compliance optional. See id. CMS has indicated that states engaging in only a partial Medicaid Expansion will not be eligible to receive 100% federal matching funds, at least from 2014 through 2016. Ctrs. for Medicare & Medicaid, U.S. Dep't of Health & Human Servs., Frequently Asked Questions on Exchanges, Market Reforms, and Medicaid 12 (2012), available at http:// cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf.

39 Patient Protection and Affordable Care Act of 2010 § 2002(a), 124 Stat. 279-82 (to be codified at 42 U.S.C. § 1396a(e)(14)); Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1004, 124 Stat. 1029, 1034. The MAGI calculation does not apply to eligibility requirements for certain individuals who may be eligible for Medicaid prior to any PPACA amendments, including those age 65 or older and those with certain disabilities. See Patient Protection and Affordable Care Act of 2010 § 2002(a), 124 Stat. at 280 (to be codified at 42 U.S.C. § 1396a(e)(14)(D)).

40 See generally Kaiser Comm'n on Medicaid & the Uninsured, Henry J. Kaiser Family Found., Medicaid Eligibility and Enrollment for People with Disabilities Under the Affordable Care Act: The Impact of CMS's March 23, 2012 Final Regulations (2012), available at http:// www.kff.org/medicaid/upload/8390.pdf; see also John A. Graves, Better Methods Will Be Needed To Project Incomes To Estimate Eligibility for Subsidies in Health Insurance Exchanges, 31 Health Aff. 1613, 1614 (2012); Leighton Ku, Ready, Set, Plan, Implement: Executing the Expansion of Medicaid, 29 Health Aff. 1173, 1175 (2010).

41 Patient Protection and Affordable Care Act of 2010 § 2002(a), 124 Stat. at 280 (to be codified at 42 U.S.C. § 1396a(e)(14)(C)); see also Medicaid Program - Eligiblity [sic] Changes Under the Affordable Care Act of 2010, 77 Fed. Reg. 17,144 (Mar. 23, 2012) (to be codified at 42 C.F.R. pts. 431, 435, and 457), available at http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/2012-6560.pdf (providing final rule for MAGI calculations).

42 Patient Protection and Affordable Care Act of 2010 § 1413(c), 124 Stat. at 234-35 (to be codified at 42 U.S.C. § 18083(c)); see also id. § 1413(b), 124 Stat. at 233 (to be codified at 42 U.S.C. § 18083(b)) (requiring states to develop streamlined application process).

43 Patient Protection and Affordable Care Act of 2010 §§ 2004(a)(3), 10201(a), 124 Stat. at 283, 917-18 (to be codified at 42 U.S.C. § 1396a(a)(10)(A)(i)(IX)) (extending Medicaid coverage, effective Jan. 1, 2014, to individuals under age 26 who age out of foster care); id. § 2303, 124 Stat. at 293-96 (amending 42 U.S.C. § 1396a) (permitting states, effective Mar. 23, 2010, to include family planning services in Medicaid program).

44 See Patient Protection and Affordable Care Act of 2010 § 2001(a)(2)(A), (c), 124 Stat. at 271-72 (to be codified at 42 U.S.C. § 1396a(k)(1)); id. § 2001(a)(5)(E), (c), 124 Stat. at 275, 276-77 (to be codified at 42 U.S.C. § 1396u-7(b)(5)) (requiring benchmark plan or its equivalent to include essential health benefits); see also id. § 1302(b), 124 Stat. at 163-64 (to be codified at 42 U.S.C. 18022(b)) (listing essential health benefits).

45 Patient Protection and Affordable Care Act of 2010 § 1302(b), 124 Stat. at 163-64 (to be codified at 42 U.S.C. 18022(b)) (listing essential health benefits); Prescription Drugs: Medicaid Prescription Drug Programs, Medicaid.gov, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Prescription-Drugs/Prescription-Drugs.html (last visited Apr. 21, 2013) (noting "pharmacy coverage is an optional benefit under federal Medicaid law"); see also 42 U.S.C. § 1396a (detailing mandatory benefits for Medicaid programs).

46 Prescription Drugs: Medicaid Prescription Drug Programs, supra note 45. "Although pharmacy coverage is an optional benefit under federal Medicaid law, all States currently provide coverage for outpatient prescription drugs to all categorically eligible individuals and most other enrollees within their Medicaid programs." Id.

47 Patient Protection and Affordable Care Act of 2010 §§ 2551(a)(4), 3133(2), 124 Stat. at 313-14, 432-33 (to be codified at 42 U.S.C. §§ 1396r-4(f)(7), 1395ww(r)).

48 Nat'l Ass'n of Public Hospitals & Health Sys., Medicaid DSH Funds: Essential Support for the Nation's Health Care Safety Net 1 (2012), available at http://www.naph.org/Main-Menu-Category/Publications/Medicaid-DSH-Facts-Policy-Brief.aspx?FT=.pdf; Nat'l Ass'n of Urban Hospitals, The Potential Impact of the Affordable Care Act on Urban Safety-Net Hospitals 2-3 (2012), available at http://www.nauh.org/component/option,com_rubberdoc/format,raw/id,115/view, doc/.

49 Health Care Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1203(a)(2), 124 Stat. 1029, 1054 (to be codified at 42 U.S.C. § 1396r-4(f)(7)).

50 Id.; see also Corey Davis, Q&A: Disproportionate Share Hospital Payments and the Medicaid Expansion 4 (2012), available at http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_ final.pdf.

51 Health Care Education Reconciliation Act of 2010 § 1202, 124 Stat. at 1052-53.

52 Patient Protection and Affordable Care Act of 2010 § 2703, 124 Stat. at 319 (to be codified at 42 U.S.C. § 1396w-4).

53 Id. § 2602, 124 Stat. at 315 (to be codified at 42 U.S.C. § 1315b).

54 Id. §§ 1501(b), 1513, 124 Stat. at 244-49, 253, amended by Health Care and Education Reconciliation Act of 2010 §§ 1002, 1003 (to be codified as amended at 26 U.S.C. §§ 5000A, 4980H).

55 Patient Protection and Affordable Care Act of 2010 §§ 1311-1312, 124 Stat. at 173-84 (to be codified at 42 U.S.C. §§ 18031-18032).

56 See id. § 1311(b)(1), 124 Stat. at 173 (to be codified at 42 U.S.C. § 18031(b)(1)). If a state elects not to administer an Exchange, the federal government will administer the Exchange on the state's behalf. Id. § 1321(c) (to be codified at 42 U.S.C. § 18041).

57 Id. § 1311(d)(4)(c), 124 Stat. at 176 (to be codified at 42 U.S.C. § 18031(d)(4)(C)). It is the duty of the Exchange to "maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans." Id.

58 See id. §§ 1311(d)(4)(F)-(G), 1402, 124 Stat. at 177, 220-24 (to be codified at 42 U.S.C. §§ 18031(d)(4)(F)-(G), 18071) (establishing reduced cost-sharing eligibility requirements).

59 Id. §§ 1321(a)(1)(C), 1343, 124 Stat. 186, 212-13 (to be codified at 42 U.S.C. §§ 18041(a)(1)(C), 18063).

60 Initial Guidance to States on Exchanges, U.S. Dep't of Health & Human Servs., http://cciio.cms.gov/resources/files/guidance_to_states_on_ exchanges.html (last visited Apr. 21, 2013).

61 See Fernandez & Mach, supra note 25, at 8, 11-14 (2013).

62 Neal Devins, Party Polarization and Judicial Review: Lessons From the Affordable Care Act, 106 Nw. U. L. Rev. 1821, 1829-30; Abby Goodnough & Robert Pear, Governors Fall Away in G.O.P. Opposition to More Medicaid, N.Y. Times, Feb. 22, 2013, at A1; see also Cauchi, supra note 21.

63 Cauchi, supra note 21. For example, as of November 9, 2012, Georgia, Indiana, Missouri, Oklahoma, South Carolina, Texas, and Utah had enacted laws toward the establishment of Interstate Health Compacts. Id.

64 See infra Table 1.

65 See infra Table 1.

66 See infra Table 1.

67 See infra Table 1.

68 Governors Roster 2013: Governors' Political Affiliations & Terms of Office, Nat'l Governors Ass'n, http:// www.nga.org/files/live/sites/NGA/files/pdf/GOVLIST.PDF (last visited Apr. 21, 2013).

69 Party Composition of State Legislatures, Nat'l Conf. of State Leg., http://www.ncsl.org/legislatures-elections/elections/statevote-charts.aspx (last visited Apr. 30, 2013). This column looks to the party composition of the House and Senate for each State Legislature and indicates the majority party. The notation of "Split" signifies that the majority party in the House and Senate is different for that State. Please note that for Virginia, the majority party in the House is Republican; however, for the Senate there is an equal split. Id.

70 Henry J. Kaiser Family Found., The Health Reform Law's Medicaid Expansion: A Guide to the Supreme Court Arguments 3 (2012), available at http://www.kff.org/healthreform/upload/8288.pdf (providing state-by-state analysis). Figure 2 of this source provides a map of the United States highlighting four positions states have taken with respect to Florida v. U.S. Department Health & Human

Services, specifically: 1) states challenging PPACA; 2) states both challenging and supporting PPACA; 3) states supporting PPACA; and 4) states not taking a position as to the litigation. Id.

71 State Activity Around Expanding Medicaid Under the Affordable Care Act, as of April 16, 2013, StateHealthFacts.org, http:// www.statehealthfacts.org/comparereport.jsp?rep=158&cat=17 (last visited Apr. 30, 2013).

72 State Decisions for Creating Health Insurance Exchanges, as of April 1, 2013, StateHealthFacts.org, http:// www.statehealthfacts.org/ comparemaptable.jsp?ind=962&cat=17 (last visited Apr. 30, 2013).

73 Cauchi, supra note 21. The website enumerates which states have: 1) filed constitutional amendments or enacted state laws banning the individual and/or employer mandate; 2) enacted prohibitions to implementing PPACA Exchanges without legislation; 3) enacted laws to create "Interstate Health Compacts"; and 4) addressed 2012 Ballot questions opposing health care reform. Id. Each state scoring a zero in this column did none of the above. Id.

74 Shelly, supra note 4, at 448 (citing Dale Krane, The Middle Tier in American Federalism: State Government Policy Activism During the Bush Presidency, 37 Publius 454 (2007)).

75 See generally, Nat'l Conf. of State Leg., http://www.ncsl.org/ (last visited Apr. 30, 2013); StateHealthFacts.org, Henry J. Kaiser Family Found., http://www.statehealthfacts.org/ (last visited Apr. 30, 2013).

76 See John McDonald, Handbook of Biological Statistics: Spearman Rank Correlation, Univ. of Del., http://udel.edu/~mcdonald/ statspearman.html (last visited Apr. 21, 2013).

77 See supra, note 19.

78 StateHealthFacts.org, supra note 75.

79 See infra Table 2.

80 See infra Table 2.

81 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1001, 124 Stat. 119, 137 (to be codified at 42 U.S.C. § 300gg-18)); 45 C.F.R. § 158.210 (2012); see also supra note 36 and accompanying text.

82 The 80/20 Rule: Providing Value and Rebates to Millions of Consumers, HealthCare.gov (June 21, 2012), http:// www.healthcare.gov/ news/reports/mlr-rebates06212012a.html (providing state-by-state rebate statistics).

83 See supra Part V.A. for discussion of calculation used; see also StateHealthFacts.org, supra note 75.

84 See supra Part V.A. for discussion of calculation used; see also StateHealthFacts.org, supra note 75.

85 The 80/20 Rule: Providing Value and Rebates to Millions of Consumers, supra note 82 (Appendix I: Total Rebates in All Markets for Consumers and Families, by State).

86 See supra Part IV for discussion of methodology.

87 Shelly, supra note 4, at 448 (citing Krane, supra note 74).

88 See supra note 38 and accompanying text (discussing Supreme Court decision).

89 Patient Protection and Affordable Care Act of 2010 §§ 2001(a)(3), 10201(c), amended by Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1201, 124 Stat. 1029, 1051-52.; see also id. § 10201 (amending provisions in Title II of PPACA). States that had already expanded coverage to non-pregnant, childless adults under 133% FPL are treated differently in their federal medical assistance percentage ("FMAP"). See Patient Protection and Affordable Care Act of 2010 § 2001(a)(3).

90 Robert Pear & Michael Cooper, Reluctance in Some States over Medicaid Expansion, N.Y. Times, June 30, 2012, at A1. In response to projected increased costs due to the Medicaid Expansion, governors from states including Kansas, Nebraska, and South Carolina are predicting "difficulty affording even the comparatively small share of costs that states would eventually have to pay." Id. "Many states that have difficulty paying for their current Medicaid programs are carefully weighing the costs and benefits of changes that could, for some of them, increase enrollment by one-quarter to one-third." Robert Pear, Administration Advises States to Expand Medicaid or Risk Losing Federal Money, N.Y. Times, Oct. 2, 2012, at A20. For background on state Medicaid expenditures prior to PPACA's enactment, see Daniel C. Vock, Medicaid: Biggest Insurer Is a Budget Buster, Stateline (Aug. 3, 2006), http:// www.pewstates.org/projects/stateline/headlines/medicaid-biggest-insurer-is-a-budget-buster-85899387495.

91 Nat'l Conf. of State Leg., NCSL Fiscal Brief: State Balanced Budget Provisions 2 (2010), available at http:// www.ncsl.org/documents/fiscal/StateBalancedBudgetProvisions2010.pdf.
The National Conference of State Legislatures (NCSL) has traditionally reported that 49 states must balance their budgets, with Vermont being the exception. Other authorities add Wyoming and North Dakota as exceptions, and some authorities in Alaska contend that it does not have an explicit requirement for a balanced budget. Two points can be made with certainty, however: Most states have formal balanced budget requirements with some degree of stringency, and state political cultures reinforce the requirements. Id.

92 See, e.g., Fernanda Santos, Medicaid Expansion Is Delicate Maneuver for Arizona's Republican Governor, N.Y. Times, Jan. 20, 2013, at A20 (noting Arizona Governor's plan to implement "circuit breaker," freezing childless adult Medicaid coverage if federal matching drops below 80%). For an overview of the Medicaid funding process, see Kaiser Comm'n on Medicaid & the Uninsured, Henry J. Kaiser Family Found., Medicaid Financing: An Overview of the Federal Medicaid Matching Rate (FMAP) (2012), available at http:// www.kff.org/medicaid/upload/8352.pdf. The federal government provides matching funds for state Medicaid programs, with the matching rate varying from state to state. Id. at 2. Regardless of the state's per capita income, the federal matching rate cannot be below 50%. Id. at 1. There is no maximum rate, but Mississippi currently receives the highest federal matching rate at 74%. Id. at 1, 6.

93 See, e.g., Katie Kerwin McCrimmon, Medicaid Expansion a 'No-Brainer': Hike in GDP and New Jobs by 2015, Health Pol'y Solutions (Feb. 14, 2013), http://www.healthpolicysolutions.org/2013/02/14/medicaid-expansion-a-no-brainer-hike-in-gdp-and-new-jobs-by-2015/ ("Expanding Medicaid to an estimated 275,000 additional people will cost Colorado less than the price of not adding them."); Laurel Lucia et al., Medi-Cal Expansion Under the Affordable Care Act: Significant Increase in Coverage with Minimal Cost to the State 4-5 (2013), available at http://laborcenter.berkeley.edu/healthcare/medi-cal_ expansion13.pdf (discussing how California will benefit from Medicaid expansion and noting federal funding will cover 85% of new spending).

94 See supra Table 1; Harvard Law School Ctr. for Health Law & Policy Innovation, Expanding Medicaid Under the Affordable Care Act: Where Do States Stand Today? 4 (2012), available at http:// www.law.harvard.edu/academics/clinical/lsc/documents/CHLPI%20advocate%C20tool%C20state%C20stances%C20*o*n%M#edicaid2.pdf (illustrating states' stances on Medicaid expansion shortly after 2012 Supreme Court ruling).

95 See, e.g., Elizabeth Weeks Leonard, Affordable Care Act Litigation: The Standing Paradox, 38 Am. J. L. & Med. 410, 421 (2012) (describing increased state burden as more individuals apply and qualify for Medicaid); Benjamin D. Sommers & Arnold M. Epstein, Why States Are So Miffed About Medicaid - Economics, Politics, and the "Woodwork Effect," 365 New Eng. J. Med. 100, 100 (2011) (noting state anticipation that uninsured individuals will suddenly sign up for Medicaid), available at http:// www.nejm.org/doi/pdf/10.1056/NEJMp1104948. The reason that the "woodwork effect" is such a "wrinkle" for states and their budgets is because, while starting in 2014 all newly enrolled Medicaid recipients will be fully covered by federal funding, currently states will only receive "the traditional federal contribution rate" of 50-75% for any new, already eligible enrollees. Id. at 100. The fiscal concerns are exaggerated by corresponding demands, such as improved administrative protocols and provider coverage for new enrollees. Id. at 101. See also Julie Rovner, Will Medicaid Bring The Uninsured Out of the Woodwork?, NPR (July 11, 2012, 3:21 AM), http:// www.npr.org/blogs/health/2012/07/11/156568678/will-medicaid-bring-the-uninsured-out-of-the-woodwork (theorizing that millions of non-enrolled, Medicaid-eligible individuals will come out of the woodwork in 2014); Avik Roy, Why States Have a Huge Fiscal Incentive To Opt Out of Obamacare's Medicaid Expansion, Forbes (July 13, 2012, 11:40 AM), http:// www.forbes.com/sites/aroy/2012/07/13/why-states-have-a-huge-fiscal-incentive-to-opt-out-of-obamacares-medicaid-expansion/ (classifying Medicaid's "woodwork effect" as a "hidden time bomb"). But see Sommers & Epstein, supra, at 101-02 (arguing that despite states' warranted concerns,

"dismantling Medicaid would make the problem dramatically worse"); Josh Barro, States Will Not Turn Down Obamacare's Medicaid Expansion, Bloomberg (July 24, 2012, 3:19 PM), http://www.bloomberg.com/news/2012-07-24/states-will-not-turn-down-obamacare-s-medicaid-expansion-really-.html (arguing that costs of "woodwork" problem are not as large as they may appear).

96 See, e.g., Sommers & Epstein, supra note 95, at 100 (outlining Medicaid Expansion and explaining "woodwork effect").

97 See id. (citing lack of information as one of several reasons for lack of enrollment of eligible individuals).

98 See id. at 100-01 (explaining factors that contribute to "woodwork effect"). "States anticipate that many [Medicaid-eligible but] uninsured individuals will come out of the woodwork and sign up for Medicaid under [PPACA], thanks to heavy media coverage, streamlined enrollment procedures required by the law, and the individual mandate to obtain insurance." Id.

99 Id. at 100-01; Michelle Greenhalgh, Am. Acad. of Family Physicians, The Affordable Care Act: Medicaid Expansion & Healthcare Exchanges 9 (2012), available at http://www.aafp.org/online/etc/medialib/aafp_ org/documents/policy/state/statehealthpolicy/expansion100212.Par.0001.File.dat/TheAffordableCareActMedicaidExpansionand (noting current uninsured who are Medicaid-eligible will need to find insurance or pay penalty under PPACA).

100 Henry J. Kaiser Family Found., Financing New Medicaid Coverage Under Health Reform: The Role of the Federal Government and States 3 (2010), available at http://www.kff.org/healthreform/upload/8072.pdf (explaining how state matching rates for currently eligible Medicaid population will be affected by PPACA Medicaid Expansion).

101 Sommers & Epstein, supra note 95, at 101. The Medicaid Expansion will "require revamped administrative procedures" and related "concerns pose administrative challenges that already-pressed state governments could do without." Id. The Congressional Budget Office estimates that the Medicaid expansion will nationally cost states $20 billion, not including administrative costs. Randall R. Bovbjerg et al., Kaiser Comm'n on Medicaid & the Uninsured, Henry J. Kaiser Family Found., State Budgets Under Health Care Reform: The Extent and Causes of Variations in Estimated Impacts 4 (2011), available at http://www.kff.org/healthreform/upload/8149.pdf. States project the administrative cost of the Medicaid expansion to account for approximately 3.75% to 8% of benefit spending. Id. at v (Table 3).

102 Id. at vi (noting coordination of Medicaid with state exchanges will create new administrative costs for states).

103 See Jennifer Lubell, Safety-Net Hospitals Warn of ACA's Uncompensated Care Crunch, Am. Med. News (Nov. 12, 2012), http:// www.amednews.com/article/20121112/government/311129953/6/ (discussing how a state's failure to expand Medicaid will financially strain its safety net hospitals).

104 See Nat'l Ass'n of Urban Hospitals, supra note 48, at 2; Manoj Jain & William H. Frist, Benefits, Risks of Medicaid Expansion, Memphis Commercial Appeal, Dec. 9, 2012, Business Section, at 1 ("[PPACA] has put Tennessee in a pickle: choose to expand and provide Medicaid to an additional 180,000 previously uninsured people, or lose $1 billion of new federal funding over six years ....").

105 See Kaiser Comm'n on Medicaid & the Uninsured, Henry J. Kaiser Family Found., The Uninsured: A Primer: Key Facts About Americans Without Health Insurance 22 (2012), available at http:// www.kff.org/uninsured/upload/7451-08.pdf.

106 See John Holahan & Irene Headen, Kaiser Comm'n on Medicaid & the Uninsured, Henry J. Kaiser Family Found., Medicaid Coverage and Spending on Health Reform: National and State-by-State Results for Adults at or Below 133% FPL 10 (2010), available at http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf. The data compiled in the columns titled "Change in Enrollment % Based on Expansion," "New State Spending (in millions)," and "% Increase in Baseline" is found in "Table 1: Standard Participation Scenario," on page 10 of this source. Id.

107 Genevieve M. Kenney et al., Medicaid/CHIP Participation Among Children and Parents: Timely Analysis of Immediate Health Policy Issues 5 (2012), available at http://www.urban.org/UploadedPDF/412719-Medicaid-CHIP-Participation-Among-Children-and-Parents.pdf (providing 2010 Children's Medicaid/Chip Participation by State). The data compiled for this column is found in "Table 3: Children's Medicaid/CHIP Participation, by State, 2008 and 2010," on page 5 of this source. Id.

108 See supra Table 2.

109 Massachusetts implemented an individual mandate and an employer fine in the Commonwealth's 2006 health care reform law. Henry J. Kaiser Family Found., Massachusetts Health Care Reform: Six Years Later 3 (2012), available at http:// www.kff.org/healthreform/upload/8311.pdf. Hawaii implemented an employer mandate in 1974. Healthcare Ass'n of Hawaii, Affordable Care Act Implementation in Hawaii: Fact Sheet, (2012), available at http:// www.hah.org/site/DocServer/ Affordable_Care_Act_Implementation_in_Hawaii.pdf? docID=1508.

110 Sharon Silow-Carroll et al., States in Action Archive Health Insurance Exchanges: State Roles in Selecting Health Plans and Avoiding Adverse Selection, Commonwealth Fund, http:// www.commonwealthfund.org/Newsletters/States-in-Action/2011/Mar/February-March-2011/Feature/Feature.aspx (last visited Apr. 30, 2013).

111 See Support for Massachusetts Landmark Health Reform Law Rises in 2011, Harvard School of Public Health, Harvard.Edu (June 5, 2011), http:// www.hsph.harvard.edu/news/press-releases/massachusetts-health-reform-poll-2011/.

112 See infra Table 4.

113 State Health Access Data Assistance Ctr., Robert Wood Johnson Found., State-Level Trends in Employer-Sponsored Health Insurance: A State-by-State Analysis, 15 (2013), available at http:// www.rwjf.org/content/dam/farm/reports/reports/2013/ rwjf405434. The data provided in this column is found in "Table 1: Trend in Employer-Sponsored Insurance (ESI) Coverage, Non-Elderly," on page 15 of this source. Id.

114 Family Premium per Enrolled Employee for Employer-Based Health Insurance, 2011, StateHealthFacts.org, Henry J. Kaiser Family Found., http:// statehealthfacts.org/comparetable.jsp?ind=1075&cat=17 (last visited Apr. 30, 2013)

115 Health Care Expenditures per Capita by State of Residence, 2009, StateHealthFacts.org, Henry J. Kaiser Family Found., http:// www.statehealthfacts.org/comparemaptable.jsp?ind=596&cat=5 (last visited Apr. 30, 2013).

116 Health Insurance Coverage of Nonelderly 0-64, States (2010-2011), U.S. (2011), StateHealthFacts.org, Henry J. Kaiser Family Found., http:// www.statehealthfacts.org/comparetable.jsp?ind=126&cat=3 (last visited Apr. 30, 2013).

117 See supra Table 2.

118 Phil Oliff et al., Ctr. on Budget & Pol'y Priorities, States Continue To Feel Recession's Impact 1 (2012), available at http:// www.cbpp.org/files/2-8-08sfp.pdf.

119 Median Annual Household Income, 2009-2011, StateHealthFacts.org, Henry J. Kaiser Family Found., http:// www.statehealthfacts.org/comparemaptable.jsp?ind=15&cat=1 (last visited Apr. 30, 2013).

120 State Budget Shortfalls, SFY2010, StateHealthFacts.org, Henry J. Kaiser Family Found., http://www.statehealthfacts.org/ comparemapreport.jsp? rep=49&cat=1 (last visited Apr. 30, 2013).

121 ACA Federal Funds Tracker, Health Reform Source, Henry J. Kaiser Family Found., http://healthreform.kff.org/federal-funds-tracker.aspx (last visited Apr. 21, 2013). The data compiled in this column is found in the table entitled "Total Funding (in dollars) December 3, 2012." Id.

122 See supra Table 2.

123 See supra Part III and Table 1.

124 See supra Table 2.

125 See State Budget Shortfalls, SFY2010, StateHealthFacts.org, Henry J. Kaiser Family Found., supra note 120; Distribution of Total Population by Federal Poverty Level, States (2010-2011), U.S. (2011), StateHealthFacts.org, Henry J. Kaiser Family Found., http:// www.statehealthfacts.org/comparebar.jsp? ind=9&cat=1 (last visited Apr. 30, 2013).

126 See Mapping the Effects of the ACA's Health Insurance Coverage Expansions, Health Source Reform, Henry J. Kaiser Family Found., http:// healthreform.kff.org/coverage-expansion-map.aspx (last visited Apr. 21, 2013); see also supra Table 1.

127 For example, Massachusetts recently requested additional flexibility in allowing certain rating factors to remain in their merged individual and small group market. Robert Weisman, Businesses Don't Like Insurance Decision, Boston Globe, Apr. 9, 2013, at B1. HHS, however, will require the Commonwealth to conform to the rating standards in PPACA but did allow for additional transition time. Id.

128 E.g., Kaiser Comm'n on Key Facts, Henry J. Kaiser Family Found., Where Are States Today? Medicaid and CHIP Eligibility Levels for Children and Non-Disabled Adults (2013), available at http:// www.kff.org/medicaid/upload/7993-03.pdf; Cynthia Bansak & Steven Raphael, The Effects of State Policy Design Features on Take-up and Crowd-out Rates for the State Children's Health Insurance Program, 26 J. Pol'y Analysis & Mgmt. 149, 150 (2007); Teresa A. Coughlin et al., Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States, 24 Health Aff. 1073 (2005); Medicaid Benefits: Online Database, Henry J. Kaiser Family Found., http:// medicaidbenefits.kff.org/state_main.jsp (last visited May 2, 2013); Medicaid Enrollment by State, Medicaid.gov, http://www.medicaid.gov/medicaid-chip-program-information/by-state/by-state.html (last visited May 2, 2013); State Medicaid Fact Sheets, StateHealthFacts.org, http:// www.statehealthfacts.org/medicaid.jsp (last visited May 2, 2013);

129 See supra Part V.C. and Table 3.

130 Douglas A. Bass, Annotation, Validity of the Minimum Essential Medical Insurance Coverage, or "Individual Mandate," Provision of § 1501 of the Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119, 60 A.L.R. Fed. 2d 1 (2011) (noting individual mandate is "crucial component" of PPACA); Ctr. on Budget & Pol'y Priorities, Status of State Health Insurance Exchange Implementation (2013) (describing exchanges as "key coverage elements" of PPACA).

131 See supra Table 1.

132 See supra Table 1; see also Richard J. Fidei & Erin T. Siska, Top Ten Insurance Regulatory Issues and Trends of 2012, 2013 Emerging Issues 6880 (2013) ("Many Republican states are opting out and many Democratic ones are opting in."); State Decisions for Creating Health Insurance Exchanges and Expanding Medicaid, as of March 5, 2013, StateHealthFacts.org, http:// statehealthfacts.org/comparetable.jsp?ind=1075&cat=17 [hereinafter State Decisions for Exchanges].

133 See supra Table 1; see also State Decisions for Exchanges, supra note 132.

134 See supra Table 1; see also State Decisions for Exchanges, supra note 132.

135 See Timothy Stolzfus Jost, The Regulation of Private Health Insurance 9, 26-27, 36 (2009), available at http://www.nasi.org/usr_doc/The_ Regulation_of_Private_Health_Insurance.pdf.

136 See Mariner et al., supra note 2, at 1155-57 (explaining PPACA changes upheld by the Supreme Court).

137 Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, § 1332, 124 Stat. 119, 203-206 (to be codified at 42 U.S.C. § 18052); Waivers for State Innovation: Basis & Purpose, 31 C.F.R. § 33.100 (2012).

138 See Loveless, supra note 7, at 1, 9-11.

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