
Rhetorical Federalism: The Role of State Resistance in Health Care Decision-Making

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Introduction

The Patient Protection and Affordable Care Act (ACA)¹ represents the most significant reform of the United States health care system in decades. ACA also substantially amplifies the federal role in health care regulation. Among other provisions, ACA expands government health care programs, imposes detailed federal standards for commercial health insurance policies, creates national requirements on employers and individuals, and enlists state administrative capacity to implement various federal reforms. In response, a persistent voice in the protracted, contentious debate surrounding ACA was, and continues to be, resistance from states. The rhetoric of federalism — states' rights, reserved powers, state sovereignty, limited government, and local diversity — resonates deeply even around provisions of ACA that do not specifically implicate state interests. For example, the loudest and most persistent state objections target the new mandate that individuals maintain health insurance, a requirement imposed by ACA and enforced through federal tax penalties.

While it is easy to dismiss state resistance to ACA as nothing more than Tea Party politics, my counter view suggests several possible values deriving from the anti-health reform movement.² “Rhetorical federalism” refers to the highly public and vocal invocation of states-rights arguments to frame objections to comprehensive, sea-changing federal policies. The theory finds normative value in state-based resistance to sweeping federal initiatives although not all strategies employed are condoned. The point is not to argue the

merits of particular provisions of ACA or any of the related state lawsuits, amendments, and resolutions related to the passage of the Act. Rather, this article considers the potential benefits to health care policy-making and federal-state relations stemming from the apparently distracting and obstructive health reform nullification movement.

Health Reform Nullification Movement

During and after Congressional deliberation over ACA, at least 40 states considered state constitutional amendments or legislative resolutions purporting to nullify the federal laws.³ Several states enacted resolutions establishing that citizens of their respective states would not be required to comply with the individual insurance mandate. Other resolutions focus on state responsibilities, prohibiting state regulators and law enforcement officials from implementing ACA or punishing individuals, employers, or providers who refuse to comply with federal mandates. Additional proposals preserve states' right to opt out of federal laws or object to the fiscal impact of ACA, in particular through Medicaid expansion. Forty-two states have also entertained general, states rights “reinvigoration” amendments or resolutions, affirming their constitutionally reserved powers under the 10th Amendment.⁴

Within hours of President Obama's signing ACA into law, more than a dozen states' Attorney Generals filed federal lawsuits challenging the constitutionality of the law on states' rights grounds.⁵ The lawsuit filed by Virginia's Attorney General relies on Virginia's recently enacted statute providing that no resident “shall be required to obtain or maintain a policy of individual insurance coverage.”⁶ A second suit, filed by Florida and joined by 19 states, challenges the individ-

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ual mandate as well as Medicaid expansion and other ACA requirements as encroachments on 10th Amendment reserved powers, among other arguments. Both the Virginia and Florida cases have survived the federal government's initial motions to dismiss.⁷ A Virginia judge recently ruled in favor of the Commonwealth's constitutional challenge to ACA's individual mandate.⁸

States also convey objection by refusing to assist the federal government in implementing several provisions of ACA that specifically call for state cooperation. Georgia's Insurance Commissioner and gubernatorial candidate took the lead in informing United States Secretary of Health and Human Services, Kathleen Sebelius, that he would not comply with her request to create a state high-risk insurance pool pursuant to ACA.⁹ Subsequently, at least 19 more states, with both Republican and Democratic governors, similarly declined federal grants to establish high-risk pools, leaving the job to the federal government.¹⁰

Health Care Federalism

Most commentators view these sort of health reform nullification efforts are nothing more than political theater, mid-term election-year gamesmanship, and Tea Party antics. The states' lawsuits are generally considered meritless.¹¹ Moreover, resolutions providing that federal law will not apply within particular states' borders are almost certainly null and void as a matter of the federal Constitution's Supremacy Clause.¹² Yet state nullification efforts are not unprecedented in the nation's history:¹³ states and localities expressed similar opposition concerning the USA PATRIOT Act, passed after the September 11, 2001, terrorist attacks.¹⁴

State-centered dissent, such as refusing to implement new federal legislation, challenging the constitutionality of federal laws, resisting federal mandates, ignoring federal precedent, and even threatening to secede from the Union, would seem to hinder productive functioning within the federal system. Historically, however, scholars and political actors recognize the value of state-level dissent within a federal system.¹⁵ Dissent contributes to the marketplace of ideas, engages electoral minorities, and facilitates self-expression. The Framers envisioned friction, clashes, and "jarring" as part of the constitutional design.¹⁶ Many of the same values underlying the federal structure of government — providing an accessible forum for political participation, allowing state experimentation, diffusing power, and recognizing more robust individual rights — further support the value of state dissent.

Health care falls squarely in the realm of shared federal and state powers, creating a ripe environment for friction. Most federal health care legislation, including large government health care programs like Medicare and Medicaid, are enacted under federal spending or interstate commerce powers.¹⁷ At the same time, states retain vast reserved powers and broad discretion to carry out state policy objectives. Health, welfare, and safety fall squarely within states' traditional reserved powers.¹⁸ States have exercised their authority in various ways, including licensing of health care professionals and facilities, licensing and regulation of health insurance companies, common law standards of care and other civil liability theories, and establishment of public health departments and agencies dedicated to protecting the health and welfare of residents.

Until ACA, the federal government largely refrained from substantively regulating commercial health insurance,¹⁹ going so far as to exempt insurance from federal antitrust scrutiny.²⁰ Conversely, states have actively regulated health insurers and plans, including laws imposing coverage mandates, premium-rating rules, guaranteed issue and renewability, restrictions on rescission, "any willing provider" laws, marketing restrictions, grievance and appeals rights, and various other insurance market reforms. The number and specificity of the new ACA rules targeting the same issues represent a significant reallocation of authority from states to the federal government.

Rhetorical Federalism in Health Care Decision-Making

The invocation of federalism arguments in the health care debate offers several possible benefits. Rhetorical federalism brings transparency to the challenges of implementing a complex, multi-faceted package of reforms. Often, the general public, aside from motivated special interest groups, may be unaware and, therefore, not particularly involved with, the administrative rulemaking process and other implementation details behind federal legislation. Persistent state challenges reveal those mechanisms at work. As ACA's requirements gradually roll out overtime, states as regulatory partners will be attuned to the law's impact. Each new call for state cooperation will likely result in another round of state resistance.

Ongoing state dissent can increase public understanding of, or at least appreciation for, the challenges that lie ahead. The public will be regularly reminded of ACA's price tag and asked to consider the government's increasing role in health care delivery. Increased attention to the particulars of ACA implementation also can address accountability problems otherwise associated with cooperative federalism arrangements, like

Medicaid. Highly vocal, public statements regarding states' refusals of federal requests for cooperation may clarify lines of accountability, even if states ultimately fall in line.

Rhetorical federalism may also help educate the electorate on particular features of the comprehensive Act by distilling it down to discrete issues. Post-enactment polling revealed that citizens' understanding of ACA increased in the months that followed its passage.²¹ Polls also demonstrate that public support for discrete components of ACA is stronger than for the legislation as a whole.²² One interpretation of these data is that the law is simply too long and complex to be well understood. But when the law is parsed into separate provisions, respondents' understanding of and appreciation for the law improves.²³ States' incremental, perhaps strategically timed, objections to particular provisions of ACA may have the salutary effect of distilling the issues and improving public understanding.

States' active role in the health reform debate also gives voice to minority views that may not be heard in national debates. Our system of representative government envisions that individual constituents will share their concerns and objections with locally-elected senators and representatives, who then carry those views into the federal forum.²⁴ When Congress and the White House are controlled by the same party, however, dissenting views may not be heard outside of state-level politics. Moreover, state officials, including, state legislators, attorneys general, and insurance commissioners, are more politically connected and may have stronger voices in the national dialogue than individual voters.

Even if Washington political power is more evenly divided, state governments allow alternative forums for citizen participation in the political process. State legislatures may be more accessible and responsive to constituents' concerns than Congress. Local representatives also may embrace and express particular values of their communities, especially on social policy matters, even if local and regional views are not shared by the entire nation. The diversity of approaches creates a political marketplace, allowing citizenry a choice rather than a one-size-fits-all approach to policymaking.

Another value of rhetorical federalism is codifying dissent. With many of ACA's key provisions not taking effect for several years and midterm elections bringing a shift in congressional power, specific provisions of the Act are vulnerable through repeal.²⁵ State nullification laws, even if legally unenforceable as a matter of federal supremacy, serve to codify dissent and avoid resurrection of failed proposals (e.g., universal health

care, a federal public option) that tend to bog down health reform debates.

There also may be value in repackaging the health reform debate in that politically neutral, structural language, thereby depoliticizing hot issues and overcoming voter fatigue. Objections based on 10th Amendment or state autonomy grounds suggest no partisan preference or view on the underlying substantive policies. By framing objections to ACA as concern for the allocation of power within the federal system, dissenters may more effectively capture and re-engage the public's attention. Congressional and public debates over ACA were long, bitter, and highly charged. Federalism slogans provide seemingly neutral grounds for objecting to contentious political issues, such as health care rights and the role of government in health care decision-making. In addition, ACA opponents may gain credibility by rising above the fray, objecting on seemingly principled, even patriotic, grounds.

Finally, rhetorical federalism highlights the increased government involvement in health care delivery, renewing deliberation about the appropriate role of states in federal policymaking and government in individuals' lives. Federalism slogans enliven the ongoing debate over deep ideological and constitutional issues regarding personal autonomy, government responsibility, and health care rights. Even when opponents adopt inconsistent positions, the health reform nullification movement, for all its distractions, persistently impresses those issues on the electorate. The movement demands that the public consider repeatedly our deeply held views on rights and responsibility, the role of government, and state identity.

Conclusion

Any assessment of the impact of the ongoing nullification movement is necessarily predictive in the early stages of ACA implementation. With that caveat in mind, this article offers a novel, affirmative view of the seemingly distracting and destructive trend of state resistance to federal health reform. Federalism values are not easily defined and are the subject of widely varying opinions. Likewise, sweeping health reform legislation like ACA relies on an array of approaches and strategies, each of which invites different reactions. The debate over health reform juxtaposes political issues of individual rights and the role of government in health care. The national conversation has the perhaps unexpected effect of placing the ancillary issue of allocation of power between the central government and the sovereign states squarely before the electorate.

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