The Legality of Executive Action After *King v. Burwell*

*By Josh Blackman**

Note from the Editor:

This article discusses the legality of possible executive actions if the Supreme Court rules in favor of the plaintiffs in the pending *King v. Burwell* case before the U.S. Supreme Court. As always, The Federalist Society takes no position on particular legal or public policy initiatives. Any expressions of opinion are those of the author. The Federalist Society seeks to foster further discussion and debate about the issues involved. To this end, we offer links below to other perspectives on the subject, and we invite responses from our audience. To join the debate, please e-mail us at info@fed-soc.org.

Related Links:

- Nicholas Bagley & David K. Jones, *No Good Options: Picking up the Pieces After King v. Burwell*, 125 Yale L.J. Forum 13, 19 (2015): http://www.yalelawjournal.org/forum/no-good-options-picking-up-the-pieces-after-king-v-burwell
- Nicholas Bagley, David K. Jones & Timothy Stoltzfus Jost, *Predicting the Fallout from* King v. Burwell—*Exchages and the ACA*, 372 New Engl. J. Med. 101 (2015): http://www.nejm.org/doi/full/10.1056/NEJMp1414191
- Trish Riley et al., Nat'l Acad. For State Health Pol'y, *King v. Burwell*: State Options, Mar. 17, 2015: http://www.nashp.org.php5-2.dfw1-1.websitetestlink.com/wp-content /uploads/2015/03/King_v._Burwell_Brief_FINAL.pdf
- Rachana Pradhan & Brett Norman, *No Easy Fix if Supreme Court Halts Obamacare cash*, Politico (Mar. 2, 2015): http://www.politico.com/story/2015/03/supreme-court-obamacare-white-house-115631.html

Introduction

Section 36B of the Affordable Care Act (ACA) authorizes subsidies in the form of refundable tax credits for health insurance purchased through a state-established exchange. The "credit" "shall be allowed" based on the number of months "the taxpayer . . . is covered by a qualified health plan . . . enrolled in through an Exchange established by the State under § 1311."[1] After recognizing that this statute on its face limited subsidies to exchange established by states—meaning no subsidies would be paid in states relying on the federal exchanges—the Treasury Department issued a rule, providing that subsidies would be available in *all* states "regardless of whether the Exchange is established and operated by a State . . . or by HHS."[2] The Supreme Court is currently considering the legality of this rule in the case of *King v. Burwell*. A decision is expected by the end of June.

Only sixteen states, plus the District of Columbia, elected to establish a state-based exchange. (Three of these states operate what is known as a "federally-supported exchange," which is treated as a state-based exchange). The other thirty-four states declined to establish an exchange. In response, the Department of Health & Human Services (HHS) established a "federally-facilitated exchange," allowing consumers in each of the thirty-four states to purchase health insurance. At issue in *King v. Burwell* is whether the federal government can continue to pay subsidies to consumers on the federally-facilitated exchange.

This article will assess the legality of executive actions that the Administration may take after *King v. Burwell* to continue paying subsidies in these thirty-four states. I will not discuss the merits of the case, predict how the Court should construe the statute or IRS rule, or propose congressional modifications to the ACA.[3] Rather, this analysis is premised on potential administrative fixes HHS could employ following an adverse ruling in *King v. Burwell.*

There are two possible approaches HHS could take that would continue the payment of subsidies in some or all of the thirty-four states using the federally-facilitated exchange. First, HHS could unilaterally deem several of these states as having *tacitly* established an exchange, *without* the state's subsequent cooperation. Specifically, HHS could construe the fact that fourteen states perform certain functions that overlap with the ACA—what is known as "plan management"—as evidence that they in fact intended to establish an exchange. This *post-hoc* recognition of an establishment would drastically alter the terms on which states accepted certain responsibilities. Each of the fourteen states at issue notified HHS that it was *only* performing certain limited functions, and expressly declined to establish a state-based exchange. Retroactively and unilaterally declaring that these states in fact established a state exchange would distort political accountability, and disregard the considered judgments of the sovereign states, in violation of the principles of federalism. If HHS issued this interim rule without notice and comment, litigation would likely immediately follow by the *King* plaintiffs and the states. These suits, however, would face an uphill battle to stop the unlawful payment of subsidies. The administration could also attempt to limit the judgment in *King v. Burwell* to the four named plaintiffs, but that effort to evade the Court's judgment would be met with further litigation.

Second, HHS can streamline the process to fast-track the process for states seeking to establish an exchange. The threshold inquiry is whether a state has the appropriate authority to establish an exchange. The ACA requires that before a state can elect to establish an exchange, the state shall "adopt and have in

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effect . . . a state law or regulation that the Secretary determines implements the standards within the State."[4] Eighteen of the thirty-four states enacted the "Healthcare Freedom Act," which would require an act of the legislature, or even a constitutional amendment, in order to allow the creation of an exchange. In the remaining exchanges, it is feasible that a governor's executive order would satisfy the Secretary of HHS that the state has established an exchange. Even with this speculative authority, it is unlikely that the state would be able to complete all of the necessary steps to establish an exchange in 2015. However, a state could possibly deem the federally-facilitated exchange *as* state-established. This approach would be inconsistent with the text and history of the ACA, and would likely be challenged by further litigation.

A ruling against the federal government in *King v. Burwell*, even if stayed until the end of the tax year, would leave the Administration and the states with very limited options of how to respond quickly. Resorting to dubious administrative fixes to continue the payment of subsidies would invite an immediate court challenge. The path to amend the ACA must go through Congress.

I. HHS Lacks the Authority to Deem Unwilling States as Having Established Exchanges

HHS could determine that the fourteen states that declined to establish an exchange, but continued to perform certain regulatory activities that overlap with the ACA, have in effect established an exchange. As a result, consumers in these states could continue to receive subsidies. This approach would be inconsistent with the ACA, and disregard the choices the sovereign states made not to establish an exchange. If HHS issued such regulations—likely without notice and comment—it would amount to an end-run around an adverse ruling in *King v. Burwell*, and open the door to future litigation.

A. HHS "Administrative Fix"

The statutory framework concerning the establishment of the exchange is fairly open-ended, but not devoid of any direction. The ACA grants the Secretary of HHS the authority to "issue regulations setting standards for meeting the requirements" for "the establishment and operation of Exchanges."[5] A state's "elect[ion]" to establish an exchange will occur "at such time and in such manner as the Secretary may prescribe."[6] Specifically, the Secretary determines if the state's exchange meets "Federal standards established" or if "a State law or regulation . . . implements the standards within the State."[7] At an absolute minimum, a state would have two different responsibilities: "elect" to establish an exchange, and then in fact "establish" such an exchange that meets the Secretary's standards.

In 2012, HHS released a document known as the "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges," that offered a guide for states to "document[] how its Exchange meets, or will meet, all legal and operational requirements."[8] Under the Blueprint, the Governor of a state must submit two documents to HHS that meet the two minimum criteria: a declaration letter and exchange application.[9] The declaration letter, sent to HHS, will indicate the "type of Exchange Model [the state] intends to pursue."[10] The exchange application must "document a State's completion, or progress towards completion, of all Exchange requirements."[11]

Professors Nicholas Bagley and David K. Jones suggest in the *Yale Law Journal Forum* that "[g]iven these broad statutory delegations, HHS could revise its regulations and the Blueprint to provide that some states should be understood as having established an exchange, even if they never formally elected to do so."[12] In other words, HHS would look to past actions as tacit evidence that the state in fact established an exchange, even in states that *did not* submit the declaration and application. Bagley and Jones query whether "the regular performance of essential and substantial exchange functions, over time, [could] constitute the establishment of an exchange."[13]

Citing several dictionaries which offer definitions of "establish," the authors conclude that an "act of creation need not be intentional or formal" and "over time through a regular course of conduct, so too might states establish exchanges."[14] Based on this functionalist approach, they contend that "[s]o long as the state's ongoing activities are, by themselves, sufficient to constitute the establishment of an exchange, the federal government's heavy involvement in exchange operations should be irrelevant."[15] According to this theory, HHS could waive the "Blueprint" requirements, and deem some or all of these fourteen states to have established an exchange through past cooperation with the federal government—even if the Governor never explicitly declared an intent to establish an exchange. Call it *establishment by estoppel*.

While HHS Secretary Sylvia Burwell testified before Congress that "we don't have an administrative action that we believe can undo the damage,"[16] Bagley and Jones's proposal is worth taking seriously as a possible model for HHS's response in the event of a reversal. We must remember how *King v. Burwell* arose. Although today, the federal government has developed sophisticated and nuanced arguments about how the entire ACA, when read in context, in fact provides subsidies for federally-facilitated exchanges, and "established by the states" is a term of art, *none* of these arguments were made when the initial IRS rule was issued.[17] Rather, as documented in a House Oversight Committee Report, in justifying the IRS Rule, the Treasury Department issued a single paragraph of *ipse dixit*, simply stating that federal and state exchanges should be treated in the exact same manner.[18] All of the legal justifications came *long* after the rule was issued, during the course of litigation. The government officials who promulgated the specious reasoning behind the IRS Rule will be the same lawyers who are planning a response to an adverse ruling in *King v. Burwell*.

An "administrative fix" that treats states that perform plan management functions as having established an exchange would amount to an unlawful end-run around an adverse ruling in *King v. Burwell* for three reasons. First, HHS cannot alter the terms on which states agreed to perform plan management. The fix would amount to a bait and switch. Second, sanctioning the Secretary's aggrandizement of such wide-ranging discretion of how to recognize an established exchange would disregard Congress's intent. Third, had a state known that the continued performance of plan management would be treated as establishing an exchange, it may have chosen otherwise. Such a regula-

tion, absent subsequent actions by the state, unlawfully distorts political accountability. An effort to adopt this administration fix would be susceptible to legal challenge.

B. "Administrative Fix" Would Amount to a Bait and Switch

Of the thirty-four states that did not establish a state-based exchange, fourteen perform certain "plan management" functions that overlap with the ACA. Seven of these states have a "state-partnership exchange" (AR, DE, IL, IA, MI, NH, and WV), and another seven have a "federally-facilitated exchange" that offers plan management (KS, ME, MT, NE, OH, SD, and VA).[19] Allowing HHS to alter the status of what constitutes a state-established exchange would amount to a bait and switch for the states. Professors Bagley and Jones concede that "[b]ecause the states were not on notice that operation of the exchange might be taken to count as establishment, treating that continued operation as establishment would arguably show disrespect to the states' considered choices."[20] As the Supreme Court recognized in *Pennhurst State Sch. & Hosp. v. Halderman*, "if Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously."[21] A regulatory agency cannot move the goal posts on a whim—especially as a means to evade a Supreme Court decision invalidating its prior malfeasance.

1. State-Partnership Exchanges

Seven states currently operate what is known as a *State-Partnership Exchange*: Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, West Virginia. In these states, HHS performs *all* of the Marketplace functions, with the exception of plan management and in-person consumer assistance.[22] Plan management allows a state to "conduct all analyses and reviews necessary to support" the purchase of qualified health plans (QHP).[23] It also "include[s] recommending health plans for certification to the federally-facilitated exchange and conducting health plan oversight and monitoring."[24] These are functions long performed under state law that would overlap with HHS's duties under the ACA. In-person consumer assistance allows states to provide customer service to consumers concerning "filing an application, obtaining an eligibility determination, reporting a change in status, comparing coverage options, and selecting and enrolling in a QHP."[25] Other than these two functions, the federal government maintains *all* aspects of the exchanges. Consumers in these states will apply for and enroll in coverage on HealthCare.gov, and will likely never even realize their state has any role in the process.

It would be perverse for HHS to determine that these seven states in fact elected to establish an exchange. In late 2012 through early 2013, the Governors of each of these states sent a declaration to HHS indicating an intent to proceed *only* with a state-partnership exchange.[26] Typical of the seven declarations was Arkansas Governor Mike Beebe, who wrote that "the State of Arkansas wishes to retain as much control and autonomy as possible with regard to the operation of our health insurance exchange, rather than concede that control to Washington, D.C."[27] Arkansas sought "approval to pursue full Plan Management and Consumer Assistance functions" alone.[28] Secretary Kathleen Sebelius granted "conditional approval" on January 3, 2013 so long as Arkansas "demonstrate[s] the ability to perform all required Exchange activities" declared in the Blueprint submission, and comply with other regulations.[29]

Several of the letters stressed that the state was only electing a state-partnership exchange, and nothing else. Arkansas explained that this partnership status "will place Arkansas in a good position to make the transition to a State-Based exchange in the future *should legislative authority be obtained to do so*."[30] West Virginia Governor Earl Ray Tomblin wrote that "West Virginia retains the ability to modify the stated intent to proceed in a State Partnership Exchange until appropriate State analysis of forthcoming federal rules and guidance occurs."[31] The letter added that "West Virginia will continue to evaluate all available options concerning the Health Benefit Exchange so as to ensure that the most fiscally prudent and consumer-conscious approach is adopted in West Virginia."[32] Iowa Governor Terry E. Branstand, seeking to minimize the "Federal government's intrusion into the regulation of insurance," declared that the Hawkeye State "will continue to regulate insurance plans in Iowa."[33] (Iowa did not indicate that it would perform consumer assistance functions).

Illinois Governor Pat Quinn wrote that the state "sees this partnership as a bridge to running our own state-based Exchange," and will work with the "Illinois General Assembly to pass legislation with governance and financing language that will allow us to operate a state-based Exchange beginning in 2015."[34] (Illinois ultimately did not elect to operate its own exchange in 2015). Michigan Governor Rick Snyder noted that there was "potential for changes to Michigan's framework as more complete information is issued by the federal government."[35] New Hampshire Governor Margaret Wood Hassan explained the "New Hampshire legislature's . . . goals for the Exchange," stressing that the "partnership exchange is essential to preserving" the state's "traditional regulatory authority over insurance carriers."[36] Delaware Governor Jack A. Markell wrote that his state will "retain responsibility for both Plan Management and Consumer Assistance."[37]

Each of these seven states made clear that they were only electing for a state-partnership exchange, and nothing more. In no sense did these seven states understand that they were establishing a state-based exchange. HHS makes clear in the Blueprint that a state-based exchange is different from a state-partnership exchange.[38] Any decision by HHS to read these letters otherwise would disregard the reasoned decision-making of the sovereign states.

2. Federally-Facilitated Exchange with States Performing Plan Management

Thirty-four states (including the fourteen discussed in the previous section) expressly refused to establish an exchange or partner with HHS in any way. As a result, HHS established HealthCare.gov as a fallback federally-facilitated exchange for each state. (Subsidies being paid out on these federally-facilitated exchanges are at issue in *King v. Burwell*). On February 20, 2013, the Centers for Medicare and Medicaid Services, through an FAQ, announced that states that declined to establish an exchange, or officially partner with the federal government can still "conduct other specified plan management activities as a

part of its established regulatory role and in connection with market reform standards without submitting a Blueprint."[39] To participate, an "interested State should submit to HHS a letter as soon as possible from its Governor or Commissioner of Insurance attesting that the State will perform all the plan management activities."[40] In response, state insurance commissioners in seven of the thirty-four states notified HHS that they would continue to perform certain plan management functions, without complying with the "Blueprint" requirements: Kansas, Maine, Montana, Nebraska, Ohio, South Dakota, and Virginia. Each letter, signed by an insurance commissioner and not a Governor, made clear that the state was not electing to establish an exchange, or even partner with HHS, but simply wanted to continue its pre-existing regulatory regime for insurance plans.

South Dakota, "accept[ed]" the offer "to conduct plan management functions . . . *without* taking part in what HHS has termed the 'State Partnership Insurance Exchange Model.'"[41] Kansas's Insurance Commissioner notified HHS that though the Governor and Legislature did not "support[] the development of a state-based exchange, the Kansas Insurance Department (KID) had hoped that Kansas might be able to enter into a partnership with the federal government to perform both the plan management and consumer assistance functions required for the FFE."[42] The Commissioner wanted to "maintain [KID's] statutory and operational authority over those aspects of an exchange that are traditionally performed by state insurance regulators," which "[u]nder Kansas law KID [was] obligated" to do.[43]

Nebraska notified HHS that "while we are not entering into a formal 'partnership plan' with the federal government, we agree to perform plan management functions," which "will fall in line with our routine duties as the primary regulator of the business of insurance."[44] However, "consumer complaints about the plans or policies will remain with" HHS.[45] Montana "decided not to submit the blueprint for plan management," but asked HHS "to accept the regulatory function" to allow Montana to "conduct all plan management activities."[46] Montana did not propose to offer any consumer assistance functions. Ohio "elected not to run a state-based exchange" but "reiterated our intentions to conduct plan management activities . . . . at the state level . . . as Ohio has done for decades."[47] Maine notified HHS that the state would perform certain plan management functions.[48] Virginia Governor Robert F. McDonnell also agreed that the Commonwealth would perform plan management.[49]

The argument that these seven states elected to establish an exchange is equally, if not more strained than the seven states that opted into the state-partnership exchanges. First, state insurance commissioners (some independently elected), rather than the Governors and Legislatures made this decision. Second, almost every letter stressed that the state was *not* entering into a state-based exchange or an official partnership with the federal government. They wanted to rely on the federally-facilitated exchange. Third, and most importantly, the states were seeking to continue implementing their pre-existing regulatory regimes, which in many cases were mandated under state law. This would avoid duplication of work, and prevent HHS from intruding onto the state's traditional role in regulating insurance markets. Under this arrangement, no new responsibilities were being undertaken, and the federal government would not interfere with those efforts.

After an adverse ruling in *King v. Burwell*, HHS could argue that under an administrative fix, practically speaking, nothing changes. The states would still perform the same plan management functions, and the federal government would still perform all other tasks. In other words, all that changes is the label of the program. This argument fails because the payment of the subsidies would still trigger the individual and employer mandates, as the exchanges would now be considered "state-based," and fall within the rubric of Section 36B. In no sense can HHS deem these states to have elected to establish an exchange—that would be contrary to their clearly-expressed intents, and disregard the well-reasoned decisions of the sovereign states.

C. Administrative Fix Would Continue to Disregard Distinction Between State and Federal Exchanges

If the Supreme Court rules against the federal government in *King v. Burwell*, the Justices will recognize that through the ACA, Congress demarcated a difference between federal and state exchanges. State-established exchanges were favored, as consumers would receive subsidies. Federal exchanges were disfavored, as consumers would not receive subsidies. While Congress decided that an exchange is established "at such time and in such manner as the Secretary may prescribe,"[50] it legislated against the background principles that states would have to take certain new steps—potentially with federal funding Congress allocated—to create its own exchange. This was an important decision, and could not be brushed aside by executive fiat. Under the ACA, a state-established exchange "shall be a governmental agency or nonprofit entity that is established by a State."[51] For HHS to "deem" the "governmental agency" that specifically declined to have established an exchange, to have in fact established an exchange, would show a disregard Congress's intent, the state's intent, and principles of federalism.

Further, the ACA requires that before a state establishes an exchange, it must "adopt and have in effect . . . a State law or regulation that the Secretary determines implements the standards within the State."[52] In these fourteen states, no "law or regulation" was enacted in response to the ACA. It is true that the state had previously engaged in these functions, but the state did not opt to take these steps to comply with the law. The ACA's focus on election should not be understood to be satisfied by pre-existing state functions.

D. Post-Hoc Establishment of Exchange Distorts Political Accountability

The administrative fix would also distort political accountability. Specifically, issuing a regulation that recognizes that a state established an exchange two years after a state expressly declined to do so nullifies the tough choices politicians had to make concerning the ACA. Had a state legislator elected to participate in an exchange in 2012 or 2013, the voters of the state could have reacted accordingly. But now the elected branches of the states will have unknowingly assumed the political liability for federal policy choices. The state government will now be

perceived as responsible for the controversial law. Businesses and individuals in the state that were previously exempt from the unpopular employer and individual mandate would now be subject to expensive penalties. With the administrative fix, as the Supreme Court held in *New York v. United States*, "it may be state officials who will bear the brunt of public disapproval, while the federal officials who devised the regulatory program may remain insulated from the electoral ramifications of their decision."[53]

By blurring political accountability, the sovereignty of the states and their considered judgment are harmed. The federal government interferes with the relationship between the state and its people, and negates the ability of the electorate to hold officers accountable. This action amounts to a concrete and cognizable injury to the state's sovereignty.[54] Professors Bagley and Jones recognize that "[r]espect for federalism principles may also cut against a capacious understanding of 'establish.'"[55] Even if the meaning of "establish" is ambiguous, *Chevron* deference would not support such an expansive reading of the Secretary's discretion, as it would nullify the prerogatives of the states to decline to participate, and distort the decisions of the states to only perform plan management.[56]

E. Litigating The Administrative Fix

If HHS issues an administrative fix that retroactively deems any state that facilitates plan management as having established an exchange, litigation would almost certainly follow. Such a regulation would likely be issued before notice-and-comment rulemaking, so it can go into effect immediately and minimize any disruption in the payment of subsidies.[57] Therefore, litigation would be the only viable option to halt the change *after* it has already gone into effect.

Two parties may bring suit. First, the plaintiffs in *King v. Burwell* could allege that the "fix" amounts to an end-run around the Court's decision in their favor. Conceivably, they could even petition the Supreme Court for a rehearing if the federal government flouts an adverse ruling, so long as the petition is filed "within 25 days after entry of the judgment or decision."[58] If the judgment is issued right away, HHS could conceivably stall until after that period is over to eliminate a petition for rehearing. If the Supreme Court stays the judgment until the end of the tax year—as Justice Alito suggested during oral argument—the clock for rehearing may not start ticking until *after* the regulation is issued. If the Supreme Court does not grant rehearing, the plaintiffs would have to seek redress from the District Court for the Eastern District of Virginia.

Second, the states with federally-facilitated exchanges could also bring suit, basing standing on the penalties applied to the states as employers, as advanced in *Pruitt v. Burwell*.[59] Further, one of the fourteen states that conduct plan management could bring suit based on the "political accountability" theory of standing or based on the imminent harm of financial responsibility for a state exchange's operating expenses.[60]

In any event, litigation would be very high stakes for both the government and the challengers. For the federal government, the Supreme Court would have just held that the Treasury paid out billions of dollars of subsidies by distorting the plain meaning of a statute. The administrative fix would likely be viewed by the courts as another end-run around an uncooperative Congress. The stakes are equally high for the challengers. When *King v. Burwell* was first filed, the subsidies had not yet been paid. Today, millions of people have come to rely on these subsidies, and may be unable to afford health insurance if the subsidies are eliminated. The Supreme Court's decision would have put those subsidies on hold, but the "fix" kept the funds pouring. An injunction at this stage would halt the subsidies, restoring the status quo following a ruling in *King*, that was temporarily obviated by the administrative fix. Further, the states may not wish to litigate this issue further, as consumers in their states will lose subsidies. Indeed, many states that were involved in the constitutional challenge to the individual mandate in 2012 have not taken a position in *King v. Burwell*.[61] The political calculus makes this decision very difficult. Professors Bagley and Jones accurately state the situation: "the political conversation in the deemed states would shift: the question would be not whether to establish a state-based exchange, but whether to dismantle it."[62]

F. Limiting King v. Burwell *to Four Plaintiffs*

Another possible, even more radical option, would be for the Administration to limit the scope of *King v. Burwell* to the four named plaintiffs. University of Chicago Law Professor William Baude suggested this strategy in a controversial *New York Times* editorial.[63] "If the administration loses in King," Baude wrote, "it can announce that it is complying with the Supreme Court's judgment—but only with respect to the four plaintiffs who brought the suit." As off-the-wall as this idea sounds, the Justice Department has already suggested this ploy.

The week before oral arguments in *Halbig v. Burwell*—which raises the same issues as *King*—the Justice Department submitted a letter to the D.C. Circuit Court of Appeals, taking the position that the government was constitutionally prohibited from denying subsidies to millions of Americans.[64] In short, the government argued that people who were not parties to the suit had a due-process right to be heard before their subsidies were extinguished—as if Obamacare were some sort of constitutionally protected property interest! The challengers represented by Michael Carvin—also counsel of record in *King*—shot back, incredulous that the government had an "apparent intention to lawlessly flout this Court's binding order."[65] In August, the D.C. Circuit ruled for the plaintiffs, and sent the case back to the lower court with instructions to "vacate the IRS Rule" in its entirety—not merely with respect to the named plaintiffs.[66]

If DOJ attempted to limit the ruling in *King v. Burwell* to the named plaintiffs, the district court on remand would have to order that the Court's judgment extends beyond the named plaintiffs. While DOJ's stratagem would certainly be reversed by the courts, it would still buy time for the administrative fix to take hold.

II. HHS Has Some Authority to Streamline Establishment of State Exchanges

In order to maintain the payment of subsidies after *King v. Burwell*, states may attempt to establish exchanges before the end of 2015. Under the current regime, it is impossible for a state to establish an exchange this quickly. However, HHS may

alter the guidelines in the Blueprint to expedite the process. As a report for the National Academy of State Health Policy observed, "It is possible that HHS might revisit, allow for phased compliance, or otherwise adapt these requirements in light of *King* to allow for state exigencies."[67] Because the states are attempting to work with HHS, the federal government would have more leeway to streamline the establishment of exchanges. Though at bottom, the state still must take specific actions to *actually* establish an exchange, rather than just deeming the federal exchange as a state-based exchange.

A. State Authority to Establish Exchange

As a threshold matter, the ACA does not specifically define how a state establishes an exchange. The ACA requires that before a state can elect to establish an exchange, the state shall "adopt and have in effect . . . a state law or regulation that the Secretary determines implements the standards within the State."[68] This is easier said than done. Even assuming that state legislatures can overcome political opposition to the ACA, the majority of the thirty-four states with federally-facilitated exchanges have part-time legislatures that will be out of session by the summer of 2015.[69] Further, calling a special session is quite difficult and expensive in these states.[70]

However, Governors also have their pens and phones. In the Blueprint, HHS has deemed acceptable not only a "current law and/or regulation" but a "general authority (e.g., Executive Order) that the State has determined provides the necessary legal authority to establish an exchange."[71] In other words, even an executive order by the Governor, if he or she determines it is sufficient, will satisfy the Secretary's determination that the State has the authority to proceed. Such an executive order could allow a Governor to bypass the state legislature. At least three states—Kentucky, New York, and Rhode Island—have already established exchanges through executive order.[72] It is conceivable that Governors, in the face of opposition from their legislatures, could issue executive orders to elect to establish an exchange.

An executive order is not an option in eighteen of the thirty-four states that enacted variants of the *Healthcare Freedom Act*, which prohibits state officials from taking any actions that helps to enforce the ACA's penalties: AL, AZ, GA, ID, IN, KS, LA, MO, MT, ND, NH, OK, OH, TN, UT, VA, and WY.[73] Opting to establish an exchange would have the effect of triggering the employer and individual mandates, and would run afoul of the Healthcare Freedom Act.[74] For these states, a statutory, or even constitutional amendment, may be necessary before *any* subsidies can be paid out.

If a state is able to obtain legislation supporting the establishment of an exchange, the state would still face the formidable task of actually establishing a functional exchange. Under the Blueprint, there are fourteen distinct functions a state would need to perform before its exchange could be certified by HHS. It would be virtually impossible for a state to start building one in July 2015 with no assistance or federal funding, and expect to be ready before the end of the year.[75] Indeed, states that began the process in 2011 with significant federal funding were largely unable to meet the demand when the ACA went live in 2013—and that was with hundreds of millions of dollar in federal funding.

B. State Deeming a Federally-Facilitated Exchange is State-Based

I previously discussed the possibility that HHS may deem a federally-facilitated exchange to be stated based if the state performs certain responsibilities, such as plan management functions. The mirror-image of this proposal is that the states could recognize the federally-facilitated exchange operated by HHS to be their own state based-exchange. Once the state makes this determination, the Secretary of HHS could rubberstamp the proposal, allowing for the subsidies to continue. In other words, states with federally-facilitated exchanges would continue to rely on HealthCare.gov, but allow the Secretary to deem it a state-based exchange. With this plan, the subsidies would continue.

A report from the National Academy for State Health Policy suggests, "[t]his model offers some advantages in that it would allow for a simple, low-burden, low-cost way for the state to sustain the coverage model and subsidies now in effect under the" federally-facilitated exchange. The New Hampshire House introduced a bill that would do just this, and "establish[] the federally-facilitated health exchange as the health exchange."[76]

There are serious, but not insurmountable legal obstacles for this path. First, it would be anomalous for a state—that does absolutely *nothing* to manage an exchange—to simply deem that the federal government was in fact a state-exchange. As Professors Bagley and Jones point out, the ACA distinguishes between a state choosing to "elect[]" to create an exchange, and actually "establish[ing]" the exchange.[77] Such a reading would merge these two distinct statutory requirements, as electing to have an exchange would be no different than actually having one. There must be an actual *establishment*.

Second, this approach would (likely) conflict with the text of the statute. Section 1311(d)(1) of the ACA provides that a state exchange shall be a "governmental agency or nonprofit entity that is established by a State."[78] The most logical reading of this provision is that the phrase "established by a State" modifies both preceding clauses—"governmental agency" and "nonprofit entity." In other words, the governmental agency must be state-based. HHS is most certainly not state-based. But, as Professors Bagley and Jones observe, HHS could conclude that "established by a State" only modifies the "nonprofit entity." A court could defer to a regulatory action finding that the governmental agency—HHS—need not be state-established.[79] To reiterate a point made earlier, we must not lose sight of the fact that this entire case arose because the IRS decided to rewrite a statute that yielded results it did not like. This construction is far more linguistically plausible, and could warrant *Chevron* deference.

Third, under the ACA, all state-based exchanges are required to be "self-sustaining" by January 1, 2015.[80] As a result, states would be required to fund their operations through "user fees, state appropriations, or through redirecting existing revenue sources."[81] If HHS continued to fund the exchange in its entirety, with no state appropriations—as it must under this proposal—that would render these provisions of the ACA a nullity. States that submit blueprints that do not list all of the necessary appropriated sources of funding should be summarily denied. Finally, if a state submits a blueprint indicating that it *intends* to establish an exchange, but has not yet en-

acted the appropriate legislation, it would be inappropriate to deem that state to have established an exchange. An inchoate pledge to build an exchange—especially when not based on concrete legislation and authority—is not an establishment. Simply stated, HHS should not rubberstamp blueprints from states based on dubious legal authority, with an insufficient appropriation of funds, that is to be completed on an entirely unrealistic schedule.

C. "Supported State-Based Exchange" For States That Perform Plan Management

For the fourteen states that perform plan management functions, HHS may allow them to be certified as a "Supported State-Based Exchange." As implemented in Oregon, Nevada, and New Mexico, these states operate certain exchange functions, using the federal IT platform of HealthCare.gov. The National Academy for State Health Policy suggests that this model "is a flexible model that may be attractive to states that have the capacity to perform some functions of an SBE but where the cost and time associated with IT development is the most significant barrier to establishing a SBE." As it stands now, however, the states would have to perform far more functions than merely plan management. Nothing prevents the Secretary from modifying these regulations at her discretion, and decreasing the number of responsibilities a state must perform. However, the states will still have to perform sufficient responsibilities for it to be an actual state exchange, rather than a state shell with a federal core.

Conclusion

If the Supreme Court invalidates the IRS Rule in *King v. Burwell*, all levels of the federal and state governments will be faced with difficult decisions. However, all changes must be made in accordance with the law, and the rule of law. HHS cannot adopt an "administrative fix" to deem states that declined to establish an exchange as having established exchanges. Similarly, the Secretary does not have the authority to accept petitions to establish exchanges unless the state takes specific actions in pursuance of that objective. HHS cannot wave its wand and determine that any state performing minimal functionalities had established an exchange. This legerdemain would violate the letter, and spirit of the law. Any effort by the federal government to disregard the text and history of the ACA—which deliberately sought to put the states in control of whether to establish an exchange—will be met with future litigation.

If the ACA is to succeed, it will be based on a partnership between the states and federal governments, complying with the law Congress drafted. Executive action to bypass the separation of powers will negate the reasoned decisions of the states, and distort political accountability in violation of the principles of federalism.

Endnotes

1 26 U.S.C. § 36B(c)(2)(A)(i) (emphasis added).

2 26 C.F.R. § 1.36B-2; 45 C.F.R. § 155.20.

3 For a discussion of the merits, *see* Brief for Cato Institute & Prof. Josh Blackman as Amici Curiae Supporting Petitioners, King v. Burwell (No. 14-114), *available at* https://www.scribd.com/doc/251279503/King-v-Burwell-Brief-for-the-Cato-Institute-and-Prof-Josh-Blackman-as-Amici-Curiae-Supporting-the-Petitioners.

4 42 U.S.C. 18041(b)(2).

5 42 U.S.C. § 18041(a)(1).

6 *Id.* at § 18041(b).

7 *Id.* § 18041(b)(1-2).

8 Ctrs. for Medicare & Medicaid Servs., Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges, (2012) [hereinafter Blueprint], https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie-blueprint-11162012.pdf.

9 *Id.* at 4.

10 *Id.* at 6.

11 *Id*. at 10.

12 Nicholas Bagley & David K. Jones, *No Good Options: Picking up the Pieces After King v. Burwell*, 125 Yale L.J. Forum 13, 19 (2015).

13 Bagley, *supra* note 12, at 19.

14 Bagley, *supra* note 12, at 19.

15 Bagley, *supra* note 12, at 20.

16 Rachana Pradhan & Brett Norman, *No Easy Fix if Supreme Court Halts Obamacare cash*, Politico, Mar. 2, 2015, http://www.politico.com/story/2015/03/supreme-court-obamacare-white-house-115631.html.

17 Ilya Shapiro & Josh Blackman, *A Litmus Test for ObamaCare and the Rule of Law*, Wall St. J., Feb. 26, 2015, http://www.wsj.com/articles/ilya-shapiro-and-josh-blackman-a-litmus-test-for-obamacare-and-the-rule-of-law-1424997418.

18 Committee on Oversight and Government Reform, Committee on Ways and Means, Administration Conducted Inadequate Review of Key Issues Prior to Expanding Health Law's Taxes and Subsidies, Joint Staff Report, U.S. House of Representatives (Feb. 5, 2014), http://oversight.house.gov/wp-content/uploads/2014/02/IRS-Rule-OGR-WM-Staff-Report-Final1.pdf.

19 The remaining states with a federally-facilitated exchange are Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Utah, Virginia, Wisconsin, and Wyoming.

20 Bagley, *supra* note 12, at 20.

21 451 U.S. 1, 17 (1981).

22 Blueprint, *supra* note 8, at 3.

23 *Id.*

24 Sarah Dash, Christine Monahan & Kevin W. Lucia, Health Policy Brief: Health Insurance Exchanges and State Decisions, Health Aff., July 18, 2013, http://healthaffairs.org /healthpolicybriefs/brief_pdfs/healthpolicybrief_96.pdf.

25 *Id.*

26 *State Health Insurance Marketplaces*, The Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/state-marketplaces.html.

27 Letter from Gov. Mike Beebe to Sec. Kathleen Sebelius (Dec. 12, 2013), http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ar-exchange-letter.pdf.

28 *Id.*

29 Letter from Sec. Kathleen Sebelius to Gov. Mike Beebe (Jan. 3, 2013), http://www.cms.gov/CCIIO/Resources/Files/Downloads/ar-blueprint-exchange-letter-01-03-2013.pdf.

30 Beebe, *supra* note 27.

31 Letter from Gov. Earl Tomblin to Sec. Kathleen Sebelius (Feb. 15, 2013), http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/wv-marketplace-letter.pdf.

32 *Id.*

33 Letter from Gov. Terry Branstad to Sec. Kathleen Sebelius (Dec. 14, 2012). http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ia-exchange-letter.pdf.

34 Letter from Gov. Pat Quinn to Sec. Kathleen Sebelius (Oct. 16, 2012), http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/il-exchange-letter.pdf.

35 Letter from Gov. Rick Snyder to Sec. Kathleen Sebelius (Jan. 22, 2013), http://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/mi-marketplace-letter.pdf.

36 Letter from Gov. Margaret Hassan to Sec. Kathleen Sebelius (Feb. 13, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/nh-marketplace-letter.pdf.

37 Letter from Gov. Jack Markell to Sec. Kathleen Sebelius (Nov. 14, 2012), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/de-exchange-letter.pdf.

38 Blueprint, *supra* note 8, at 2-3.

39 *State Evaluation of Plan Management Activities of Health Plans and Insurers,* Department of Health and Human Services (Feb. 20, 2013), https://www.cms.gov/CCIIO/Resources/Files/Downloads/plan-management-faq-2-20-2013.pdf.

40 *Id.*

41 Letter from SD Director of the Division of Insurance Merle Scheiber to Gary Cohen (March 11, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/sd-exchange-letter-03-11-2013.pdf (emphasis in original).

42 Letter from Sandy Praeger, the Kansas Commissioner of Insurance to Gary Cohen (Feb. 15, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ks-exchange-letter-2-15-2013.pdf.

43 *Id.*

44 Letter from Nebraska Director of the Department of Insurance Bruce R. Ramge to Gary Cohen (Feb. 20, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/ne-exchange-letter-2-20-2013.pdf.

45 *Id.*

46 Letter from Commissioner of Securities & Insurance Moncia J. Lindeen to Gary Cohen (Feb. 26, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/mt-exchange-letter-2-26-2013.pdf.

47 Letter from Director of the Department of Insurance Mary Taylor to Gary Cohen (Feb. 14, 2013), http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=4EevXzKUgxE%3D&tabid=150.

48 Letter from Superintendent of Insurance Eric Cioppa to Gary Cohen (Mar. 18, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/me-exchange-letter-03-18-2013.pdf.

49 Letter from Gov. Robert McDonnell to Gary Cohen (Feb. 14, 2013), https://www.cms.gov/CCIIO/Resources/Technical-Implementation-Letters/Downloads/va-exchange-letter-02-14-2013.pdf.

50 42 U.S.C. § 18041(b).

51 42 U.S.C s. 18031(d)(1).

52 42 U.S.C. s. 18041(b)(2).

53 505 U.S. 144, 169 (1992).

54 Gregory v. Ashcroft, 501 U.S. 452, 460 (1991) ("Through the structure of its government, and the character of those who exercise government authority, a State defines itself as a sovereign.").

55 Bagley, *supra* note 12, at 20.

56 Chevron U.S.A. Inc. v. NRDC, Inc., 467 U.S. 837 (1984).

57 5 U.S.C. s. 533(b)(B) (noting that an agency can issue a rule without notice and comment "when the agency for good cause finds . . . that notice and public procedure thereon are . . . contrary to the public interest").

58 Supreme Court Rule 44.

59 *Oklahoma ex rel Pruitt v. Burwell*, 51 F.Supp.3d. 1080, 1084-87 (E.D. Oklahoma 2014) ("Oklahoma has not established its own Exchange, and therefore state employees would not be eligible for subsidies if not for the IRS Rule. Accordingly, the State of Oklahoma would, if not for the IRS Rule, face no risk of incurring penalties under the employer mandate.").

60 West Virginia, which is one of the 14 states that perform plan management functions, articulated this theory of standing in its challenge to the delay and modification of the individual mandate. *See* Josh Blackman, *West Virginia Files Motion for Summary Judgment in Obamacare Administrative Fix Suit*, Josh Blackman's Blog (Sep. 17, 2014), http://joshblackman.com/blog/2014/09/17/west-virginia-files-motion-for-summary-judgment-in-obamacare-administrative-fix-suit/.

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62 Bagley, *supra* note 12, at 21.

63 Will Baude, *Could Obama Bypass the Supreme Court*, N.Y. Times, Mar. 17, 2015, http://www.nytimes.com/2015/03/17/opinion/could-obama-bypass-the-supreme-court.html. For a response to Baude's argument, see Josh Blackman, *The President Cannot Bypass the Courts*, National Review, Mar. 19, 2015, http://www.nationalreview.com/article/415635/president-cannot-bypass-courts-josh-blackman.

64 Halbig v. Sebelius, No. 14-5018 (D.C. Circuit), Notice of Supplemental Authority from Department of Justices (Mar. 12, 2014), http://www.cato.org/sites/cato.org/files/documents/govt_28j_on_class_actions.pdf.

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66 Halbig v. Burwell, 758 F.3d 390, 412 (D.C. Cir. 2014) reh'g en banc granted, judgment vacated, No. 14-5018, 2014 WL 4627181 (D.C. Cir. Sept. 4, 2014).

67 Trish Riley et al., Nat'l Acad. for State Health Pol'y, *King v. Burwell*: State Options, Mar. 17, 2015, http://www.nashp.org.php5-2.dfw1-1.websitetestlink.com/wp-content /uploads/2015/03/King_v._Burwell_Brief_FINAL.pdf.

68 42 U.S.C. 18041(b)(2).

69 Nicholas Bagley, David K. Jones & Timothy Stoltzfus Jost, *Predicting the Fallout from King v. Burwell—Exchanges and the ACA*, 372 New Engl. J. Med. 101, 102 (2015).

70 *Special Sessions*, Nat'l Conf. St. Legislatures, http://www.ncsl.org/research/about-state-legislatures/special-sessions472.aspx.

71 Blueprint, *supra* note 8, at 19.

72 David K. Jones, Katharine W. V. Bradley & Jonathan Oberlander, *Pascal's Wager: Health Insurance Exchanges, Obamacare, and the Republican Dilemma*, 39 J. Health Pol. Pol'y & L. 97, 98 (2014).

73 *ALEC's Health Care Freedom Initiative*, American Legislative Exchange Council, http://www.alec.org/initiatives/health-care-freedom-initiative/.

74 See Michael F. Cannon, *Goldwater Attorney: ObamaCare-Compliant Exchange Would Violate Idaho's Health Care Freedom Act*, Cato At Liberty (Jan. 30, 2013), http://www.cato.org/blog/goldwater-attorney-obamacare-compliant-exchange-would-violate-idahos-health-care-freedom-act.

75 42 U.S.C. s 18031(a)(4)(B) (no "grant [for establishing an exchange] shall be awarded under this subsection after January 1, 2015.").

76 New Hampshire House Bill 548, introduced March 11, 2015.

77 Bagley, *supra* note 12, at 27.

78 42 U.S.C. 18031(d)(1).

79 Bagley, *supra* note 12, at 27.

80 Sarah J. Dash et al., State Marketplace Approaches to Financing and Sustainability, The Commonwealth Fund Blog, (Nov. 6, 2014), http://

www.commonwealthfund.org/publications/blog/2014/nov/state-marketplace-approaches-to-financing-and-sustainability.

81 *Id.*