ACA on Life Support: The Affordable Care Act, Medicaid Expansion, and Reckoning with *Sebelius* During the COVID-19 Pandemic

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ABSTRACT:

In an effort to address the cost of healthcare and the number of uninsured people in the United States, Congress passed the Patient Protection and Affordable Care Act, commonly called the "Affordable Care Act," "ACA," or "Obamacare," in 2010. Signed into law by President Barack Obama, the Act required states to expand Medicaid coverage to various segments of the population not previously covered by the program, or states may lose all of their federal Medicaid funding. Additionally, a provision known as the "individual mandate" required those uninsured by the government or their employer to either pay a small penalty to the Internal Revenue Service or purchase private insurance. In 2012, a group of 26 states and other parties sued Health and Human Services Secretary, Kathleen Sebelius, and related parties regarding the constitutionality of the statute. In a 5-4 decision, the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius*, 567 U.S. 519 (2012), found the individual mandate constitutional under Congress's power to tax but found the Medicaid expansion provision to be unconstitutionally coercive under Congress's spending power. This note will seek to further contextualize Justice Ginsburg's dissent, which argued the Medicaid expansion provision should not have been struck down by the majority, as the states are merely expecting Medicaid funds from Congress, but they are not at all entitled to them if they do not meet the criteria set by Congress, in the present moment. This note will explore the COVID-19 pandemic and the role that the states and the federal government ought to play in ensuring the general welfare of the nation is protected, primarily by either expanding Medicaid or otherwise ensuring free healthcare in response to the greatest economic and health crisis in over a century. To achieve this, the note will revisit the ACA and the Supreme Court's spending clause analysis given the changing dimensions of the healthcare debate, with employer-sponsored insurance enrollment declining (along with overall employment) and government insurance and subsidies for COVID-19 testing dominating the market, and analyze, through a policy-oriented lens, whether states ought to take the lead in closing the so-called "coverage gap," or whether Congress should have the power to expand insurance in a cooperative federalism model, especially in a deadly pandemic emergency which was not at all contemplated by the Court in *Sebelius*.

I. INTRODUCTION

One area which has dominated political and legal conversations throughout this young century has been healthcare, particularly the role of the government in ensuring its availability

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and administration.[2] These debates, which have dictated the trajectories of American presidential primaries since 2008, could best be characterized, on the Democratic side as a fractured battle between moderate-friendly policies such as those proposed by Barack Obama in 2008,[3] and Joe Biden in 2020,[4] and more ambitious, progressive-friendly policies such as those proposed by Bernie Sanders and Elizabeth Warren in 2020.[5] On the Republican side, however, the healthcare debate has been less nuanced other than opposing said Democratic proposals as they have gained traction.[6]

Nonetheless, the most successful of these proposals, eventually codified as the Patient Protection and Affordable Care Act ("Affordable Care Act," "ACA," or "Obamacare") signed by President Barack Obama in 2010, has combatted an incredible amount of legal challenges over the last decade, particularly for its "individual mandate" and "Medicaid expansion" provisions.[7] One of the most significant legal challenges (at time of this writing) has been the U.S. Supreme Court's 2012 decision in *National Federation of Independent Business v. Sebelius*.[8] In a 5-4 decision, the Court found the individual mandate constitutional under Congress's taxing power, but found the Medicaid expansion provision to be unconstitutionally coercive under Congress's spending power.[9]

The Court failed, however, to consider the policy implications of such a decision in a pandemic, such as the one which not only continues to ravage American politics and law, but also has left hundreds of thousands of Americans dead and even more with some kind of unforeseeable economic hardship.[10] The novel coronavirus ("COVID-19") pandemic has changed the dimensions of the healthcare debate, and the long term repercussions of this shift are, as of yet, impossible to completely quantify as the virus continues to grow in both economic and human casualties as of December 2021.[11] In short, *Sebelius* effectively changed the number

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[2] *See generally* Kaiser Family Foundation, *Timeline: History of Health Reform in the U.S.* (2011) https://www.kff.org/wp-content/uploads/2011/03/5-02-13-history-of-health-reform.pdf [hereinafter Kaiser Family Foundation].

[3] *See* Kevin Sack, Shan Carter, Jonathan Ellis, Farhana Hossain & Alan McLean, *Election 2008 - On the Issues: Health Care*, N.Y. TIMES (May 23, 2012), https://www.nytimes.com/elections/2008/president/issues/health.html.

[4] *See* Abby Goodnough & Trip Gabriel, *'Medicare for All' vs. 'Public Option': The 2020 Field Is Split, Our Survey Shows*, N.Y. TIMES, (June 23, 2019), https://www.nytimes.com/2019/06/23/us/politics/2020-democrats-medicare-for-all-public-option.html.

[5] *See id.*

[6] *See generally* "Providing More Healthcare Choices & Lower Costs," HOUSE GOP (last visited Dec. 13, 2021) https://www.gop.gov/providing-more-healthcare-choices-lower-costs/. As of December 2021, the official national GOP website has removed its "Health Care" page explaining this policy, so readers are referred to the House Republicans' website in lieu of this change.

[7] *See generally* Patient Protection and Affordable Care Act, 111 Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.); *see also* National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).

[8] *See generally* Sebelius, 567 U.S. 519 (2012).

[9] *Id.* at 588-89.

[10] *But see* Jesse Cross-Call & Matt Broaddus, *States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession*, Center for Budget and Policy Priorities (July 15, 2020), https://www.cbpp.org/sites/default/files/atoms/files/7-15-20health.pdf.

[11] *See, e.g.*, Julie Bosman, Amy Harmon & Albert Sun, *As U.S. Nears 800,000 Virus Deaths, 1 of Every 100 Older Americans Has Perished*, N.Y. TIMES (Dec. 13, 2021), https://www.nytimes.com/2021/12/13/us/covid-deaths-

of Americans who could qualify for Medicaid insurance, where the Supreme Court agreed with states which believed they were being unfairly "coerced" into protecting the health and welfare of their citizens.[12] Conversely, COVID-19 changed the number of Americans who have *needed* access to quality, low-cost healthcare, especially those in vulnerable populations who would be covered under the ACA if their state opted-in to Medicaid expansion.[13] Thus, this paper will revisit the *Sebelius* decision on Medicaid expansion, illustrate how the spending clause analysis should be considered in light of the COVID-19 pandemic, and outline the legal and policy solutions states and the federal government can implement to address the disparity between the Medicaid coverage gap which emerged after *Sebelius* and the new necessity for Medicaid expansion which emerged as a result of the pandemic.

It ought to be noted that while *Sebelius* is a constitutional law case, this note primarily contends with the policy considerations the Court failed to consider and properly weigh. It is difficult to completely divorce the constitutional analysis from the policy one, so this note will detail both through a careful, intersectional approach. This note does not operate under the delusion that the Supreme Court will be so easily persuaded to overturn its own ruling after a decade of vague and unclear public health consequences (for the citizens whose rights it aims to protect), especially given the Court's current makeup. However, introducing the Court's flawed spending clause analysis in *Sebelius* will hopefully serve as a linchpin to look at a) how Americans have been affected by the limits on Medicaid expansion (particularly in "non-expansion states"), and b) how state and federal actors can remedy this nationwide accessibility issue with the knowledge that this is not just poor policy, but an arguably deadly one (see: a once-in-a-century pandemic where poor and historically disadvantaged Americans do not have access to healthcare simply due to the state they call "home") shielded by this country's occasional veneration of poor legal analysis. In short, this note discusses the Court's constitutional debates surrounding Medicaid expansion at some length, but does so with the understanding that furthering good policy in harmony with the Court's ruling, rather than attempting (and likely failing) to overturn arguably the "bad law" which is *Sebelius*'s holding on Medicaid expansion, seems to be the most efficacious way to deal with the access to healthcare issues exacerbated by the recent COVID-19 pandemic in a timely manner.

First, this paper will outline a brief background on healthcare in the United States to properly contextualize the ACA and its individual mandate and Medicaid expansion provisions. Then, this paper will revisit *Sebelius*, the majority opinion's analysis and the partial dissent by Justice Ruth Bader Ginsburg on the issue of Medicaid expansion. This will precede an overview of the COVID-19 pandemic, particularly the health and economic crises it has created and how it has changed the American health insurance landscape in an alarmingly short amount of time. With this in mind, the paper will then turn to recommendations on how to best account for COVID-19 in the legal and policy debates over Medicaid expansion, and highlight areas for future research which may be considered as more data on the effects of the pandemic is reported.

II. BACKGROUND

elderly-americans.html; Patricia Cohen, *Omicron Could Knock a Fragile Economic Recovery Off Track*, N.Y. Times (Dec. 2, 2021), https://www.nytimes.com/2021/12/02/business/economy/omicron-economy.html.

[12] *See generally* 567 U.S. at 541-42, 587-88.

[13] *See* Cross-Call & Broaddus, *supra* note 10, at 1-4.

a. Health Insurance in the United States

While considered one of the most hotly contested issues in political and legal spaces today, healthcare, as it is currently known, was not likely contemplated by the Founding Fathers at the inception of the United States Constitution.[14] As a result, as modern medicine became a booming market which remedied a great number of diseases and ailments which plagued the first century or so of the republic, it also created the need for a new kind of market: health insurance.[15]

20th century American politics constantly shifted as to whether healthcare ought to be privatized or provided by the government.[16] President Theodore Roosevelt advocated for health insurance as part of his Progressive Party's political platform in 1912.[17] Over a quarter-century later, President Franklin Roosevelt included healthcare as a right in his 1944 State of the Union address.[18] Lastly, over twenty-years later, FDR's successor, then-former President Harry Truman became the first beneficiary of a new government healthcare program, Medicare, signed into law by President Lyndon Johnson in 1965.[19] A sister program, Medicaid, providing government healthcare for indigent folks, was also codified that same day.[20] However, while important gains were made through these various political moments, mounting legal challenges and political pressure continued to make health insurance exclusionary rather than revolutionary.[21]

By the time then-U.S. Senator Barack Obama was competing for the Democratic presidential nomination against then-U.S. Senator Hillary Clinton (who had led an ill-fated push for national healthcare reform while her husband was president),[22] the healthcare debate exemplified deep policy divides both across the political spectrum and within the parties themselves.[23] Obama promised to, inter alia, ensure no one was denied insurance based on age or pre-existing conditions, require employers to either pay for their workers' insurance or pay a tax to the government to subsidize those costs, and expand Medicaid eligibility to cover more people in need.[24] During his second year in office, Obama made good on those promises, and after lengthy intra-party negotiations, the ACA was finally signed into law in 2010 (albeit, without a single Republican vote).[25]

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[14] *See generally Talk of the Nation: Founding Fathers Faced Health Care Revolt, Too*, N.P.R. (Oct. 6, 2009), https://www.npr.org/templates/story/story.php?storyId=113543985.
[15] *See* Kaiser Family Foundation, *supra* note 2, at 2-5.
[16] *See id.* at 2-15.
[17] *Id.* at 2.
[18] *Id.* at 5.
[19] *Id.* at 9.
[20] *Id.*
[21] *See generally id.*
[22] *See* Susan Cornwell, *From 'Hillarycare' debacle in 1990s, Clinton emerged more cautious*, REUTERS (June 6, 2016), https://www.reuters.com/article/us-usa-election-hillarycare/from-hillarycare-debacle-in-1990s-clinton-emerged-more-cautious-idUSKCN0YS0WZ.
[23] Kaiser Family Foundation, *supra* note 2, at 18.
[24] *See* Kevin Sack et al., *Election 2008 – On the Issues: Health Care*, N.Y. TIMES, May 23, 2012.
[25] *See generally* Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of 42 U.S.C.); *Obama Signs Historic Health Care Legislation*, NPR (March 23, 2010), https://www.npr.org/templates/story/story.php?storyId=125058400.

b. The Affordable Care Act and Medicaid Expansion

When the Patient Protection and Affordable Care Act was signed by President Obama in 2010, the statute sought to remedy a healthcare coverage deficit through both 1) requiring uninsured Americans to either buy insurance or pay a penalty to offset costs for providers and 2) expanding the cooperative (meaning a program relying on collaboration between federal and state governments) federal health insurance program, "Medicaid."[26] These provisions are commonly referred to as the "individual mandate" and "Medicaid expansion", respectively.[27] As this note does not concern the individual mandate generally, in *Sebelius* nor in the COVID-19 pandemic, it will not be expanded on at great length here.

Building off of Obama's desire to insure as many Americans as possible through, inter alia, expanding Medicaid eligibility to cover a larger number of Americans, the ACA contains a provision to do just that.[28] The Act a) requires states to expand Medicaid coverage to those living 133 percent below the federal poverty level, b) increases federal funding to cover costs of expansion (as explored below, the federal government covers almost all (90 percent) of the costs of expansion), and finally— and most controversially— c) provides that if states do not comply with these new requirements, they may not just lose this new Medicaid funding, but *all* of it.[29] This was accomplished by both amending Medicaid's existing governing statute, first introduced in 1965, and creating new requirements to meet the needs of those the program seeks to provide coverage for.[30]

III. *SEBELIUS* AND MEDICAID EXPANSION

Sebelius is a dense and complicated opinion, and for good reason. Lawyers for plaintiffs, including 26 states, sued then-Secretary of Health and Human Services, Kathleen Sebelius (and others), as the coalition of states and business leaders sought to have the ACA be struck down as unconstitutional.[31] As necessary, the Government sought to defend its actions using various arguments on congressional enumerated powers, which Chief Justice John Roberts dealt with in kind.[32] The 5-4 ruling held the individual mandate to be constitutional under Congress's power to tax, whereas the court found the new Medicaid expansion requirement to be too coercive against states who depended on federal funding for their existing Medicaid programs, and thus unconstitutional under Congress's spending power.[33]

It is also important to note that, while the individual mandate analysis is essential to understanding the implications of *Sebelius* as a whole, for the purposes of this note, the analysis will focus strictly on the majority and Ginsburg's partial dissent's analysis of Medicaid

[26] *Sebelius*, 567 U.S. at 530.
[27] *Id*. at 530, 539.
[28] *See* Kevin Sack et al., *Election 2008 - On the Issues: Health Care*, N.Y. TIMES (May 23, 2012), https://www.nytimes.com/elections/2008/president/issues/health.html.
[29] *Sebelius*, 567 U.S. at 542 (citing 42 U.S.C. § 1396c).
[30] *See id*.; *see also* Nicole Huberfeld, *Federalizing Medicaid*, 14 U. PA. J. CONST. L. 431, 434 (2011).
[31] *Sebelius*, 567 U.S. at 540.
[32] *See generally id.* at 546-48.
[33] *See generally id.* at 588-89.

expansion under the spending clause. The intention of this note is not to relitigate *Sebelius*, but rather to use it as a vantage point to view legal and policy avenues for Medicaid expansion in the age of COVID-19.

a. Procedural History

While questions on the ACA had been heard by several federal district and circuit courts by the time it reached the Supreme Court's docket, this particular suit was brought by 26 states, several individuals, and the National Federation of Independent Business ("NFIB").[34] The Supreme Court granted certiorari on the Court of Appeals for Eleventh Circuit's decision on both the individual mandate and Medicaid expansion provisions.[35]

The plaintiffs (NFIB and others) argued the individual mandate exceeded Congress's Article I powers.[36] The U.S. District Court for the Northern District of Florida agreed, and ruled the provision could not be severed from the remainder of the Act, so the ACA was struck down in its entirety.[37] On appeal, the Eleventh Circuit held the individual mandate exceeded Congress's enumerated powers, but it could be severed from the remainder of the Act, which was a much needed victory for the defendants (including then-Secretary Sebelius, among others).[38]

The plaintiffs also argued that the Medicaid expansion provision exceeded Congress's enumerated powers in the constitution.[39] The Eleventh Circuit disagreed and found the Medicaid expansion provision to be a valid exercise of Congress's spending power.[40] Moreover, the Eleventh Circuit's decision rejected the plaintiffs' argument that the revocation of federal Medicaid funds to non-compliant states violated the Tenth Amendment.[41]

These two questions decided by the Eleventh Circuit, whether the individual mandate and Medicaid expansion provisions exceeded Congress's enumerated powers, respectively, were the ones the Supreme Court sought to answer in its opinion.[42] Other legal arguments, including whether the individual mandate could be severed from the ACA, and whether the Anti-Injunction Act barred the Court from hearing the question on the individual mandate, takes up some space in Chief Justice Roberts's majority opinion.[43] However, because they are not at issue in this note, they will not be summarized as the two aforementioned main legal challenges will be.[44]

b. Majority Opinion

Writing for the majority, Chief Justice Roberts first addressed the question of the

[34] *Id.* at 540.
[35] *Id.* at 540-42.
[36] *Id.* at 540.
[37] *Id.*
[38] *See id.* at 540-41.
[39] *Id.* at 542.
[40] *Id.* (citing U.S. CONST., art. I., § 8, cl. 1).
[41] *Id.*
[42] *Id.*
[43] *Id.* at 542-43.
[44] *See id.*

constitutionality of the individual mandate.[45] First, the Court ruled the individual mandate was not a valid exercise of Congress's power to "regulate Commerce" in Article I, as the individual mandate was interpreted as compelling participation in commerce rather than regulating it.[46] Similarly, the Court ruled the individual mandate was not authorized by the Necessary and Proper Clause in relation to its integral nature to the ACA, as it would improperly expand Congress's reach over an area typically outside of its scope (i.e., here, the healthcare marketplace).[47] Finally, the Court ruled the individual mandate, though called a "penalty" in the legislation, was a valid exercise of Congress's power to tax.[48] In short, the Court applied a substantive and functional analysis to find that the penalty, paid to the IRS in the same manner as tax-related penalties, could be construed as a tax for the purposes of meeting constitutional muster.[49]

In deciding the Medicaid expansion question, Chief Justice Roberts, joined in the majority by "liberal" jurists Justice Stephen Breyer and Justice Elena Kagan, focused on Congress's power to spend and contemplated whether or not the conditional funding aspect of the Medicaid expansion provision was a proper use of this power.[50] To combat the states' argument that Congress exceeded the scope of its enumerated power in seeking to deny all federal Medicaid funds to states which refused to expand the program, the Government argued the ACA's provision was analogous to the federal government's actions in *South Dakota v. Dole*, where Congress's withholding of federal highway funds unless states lowered their drinking age was deemed a valid exercise under the Spending Clause.[51] To consider whether Congress's actions crossed the line from "pressure …into compulsion,"[52] Roberts writes:

> "[T]he financial 'inducement' Congress has chosen is much more than 'relatively mild encouragement'--it is a gun to the head. Section 1396c of the Medicaid Act provides that if a State's Medicaid plan does not comply with the Act's requirements, the Secretary of Health and Human Services may declare that 'further payments will not be made to the State.' 42 U.S.C. §1396c. A State that opts out of the Affordable Care Act's expansion in health care coverage thus stands to lose not merely 'a relatively small percentage' of its existing Medicaid funding, but all of it."[53]

The Court held Medicaid expansion violated the Constitution's spending clause, on the grounds that states simply could not have seen such an expansion coming, as the expansion marked a shift in the very nature of the statute, not simply amending its existing structure.[54] To surmise, the Court unceremoniously undermined the ACA's goal to expand Medicaid to those

[45] *Id*. at 546-58.
[46] *Id*.
[47] *Id.* at 558-61.
[48] *Id*. at 561-74.
[49] *See id.*
[50] *See id.* at 575.
[51] *Id.* at 580 (citing South Dakota v. Dole, 483 U.S. 203, 208 (1987)).
[52] *Sebelius*, 567 U.S. at 580 (quoting *Dole*, 483 U.S. at 211).
[53] *Id*. at 581 (quoting 42 U.S.C. § 1396(c)).
[54] *Id.* at 582-83.

who needed it on the grounds that it was too much of a surprise for the states to implement, and too big an amount of money for them to lose as a result of their non-compliance.[55]

However, despite the Court's rejection of the Medicaid expansion provision, the Court held the proper remedy was to allow the remainder of Congress's law to stand, on the condition that the Health and Human Services Secretary not induce Medicaid expansion from states by withholding federal funds from them.[56] Chief Justice Roberts and the majority ruled the rest of the ACA was to be "fully operative as law," while writing the Court knew well that many states would now not expand Medicaid, hindering the intended benefits of the statute.[57]

c. Partial Dissent by Ginsburg

Justice Ginsburg, while concurring with the decision to uphold the individual mandate, disagreed with the majority's reasoning in regard to Medicaid expansion on the basis of precedent, namely, *Dole*.[58] To begin, Ginsburg writes,

> "The question posed […] is essentially this: To cover a notably larger population, must Congress take the repeal/reenact route, or may it achieve the same result by amending existing law? The answer should be that Congress may expand by amendment the classes of needy persons entitled to Medicaid benefits. A ritualistic requirement that Congress repeal and reenact spending legislation in order to enlarge the population served by a federally funded program would advance no constitutional principle and would scarcely serve the interests of federalism. To the contrary, such a requirement would rigidify Congress' efforts to empower States by partnering with them in the implementation of federal programs."[59]

To revisit Chief Justice Robert's earlier analogy, here, Ginsburg illustrates that the plaintiffs (including 26 states) and their legal challenges, supposedly advocating for cooperative federalism (by seeking to operate without the "coercion" of the federal government), are committing the legal equivalent to remove the proverbial gun to their heads and shooting themselves in the foot.[60] Medicaid is a shining example of federalist principles and state-federal cooperation, serving the needs of the States' citizens, through a characteristically collaborative model. Congress, Ginsburg argues, reserved the right to amend provisions of the program as the needs of its intended recipients (the People) began to change.[61]

Further, Ginsburg characterizes Roberts and the majority's finding (carefully highlighting— for the first time in the nation's history— that Medicaid expansion violates the

[55] *See id.* at 584.
[56] *See id.* at 587-88.
[57] *Id.*
[58] *See id.* at 632 (Ginsburg, J., dissenting).
[59] *Id.* at 624 (Ginsburg, J., dissenting).
[60] *See generally id.* at 624-25; *id.* at 581.
[61] *Id.* at 625.

Spending Clause) by stating it rests upon a) characterizing Medicaid expansion as a new grant program rather than an amendment to an existing one, b) the expansion was unforeseeable when states signed onto the program, and c) that the funds at risk are too great that it would be impossible for States not to participate in Medicaid expansion.[62]

Addressing these parts in kind, Ginsburg clearly outlines that Medicaid expansion is not a new program, but an amendment to an old one.[63] Further, the amendment was clearly foreseeable as the original Medicaid statute gives Congress the authority to change the terms of agreement for funding states' programs.[64] Any given Congress is not bound by the terms set by its predecessors, just as its successors are not bound by the requirements the current Congress agrees upon.[65]

Finally, Ginsburg outlines that the joint dissenters (Justices Antonin Scalia, Anthony Kennedy, Clarence Thomas, and Samuel Alito) and the majority seem to be confused on the responsibilities of federal and state actors in relation to federal government spending.[66] Rather than limit the spending power of Congress because of the States' reliance on these funds, Ginsburg correctly points out that it is Congress which is charged with spending money to promote the general welfare; it is simply not the States' money to spend.[67] To this point, Ginsburg wrote, "When the 110th Congress reached a conclusion about Medicaid funds that differed from its predecessors' view, it abridged no State's right to "existing," or "pre-existing," funds. […] For, in fact, there are no such funds. There is only money States anticipate receiving from future Congresses."[68]

Ginsburg's conclusion that Medicaid expansion did not exceed the bounds of the Spending Clause creates a textualist contrast to the finding by the majority that, even though states were explicitly forewarned that Medicaid funds were conditioned on states meeting requirements set by Congress, this future loss of funds from non-compliance (or non-cooperation) violated not only the Spending Clause, but the principles of *cooperative* federalism.[69] Perhaps this could have all been avoided if Congress created a single-payer, completely federal apparatus for a program like Medicaid.[70] Surely states would not have to worry about their funds being revoked, or worry about expanding a health insurance program which would actually meet the needs of the residents they are charged to serve, if Congress decided to replace Medicaid with an *actually* new, federalized program, as states argued they did with the ACA.[71] Ginsburg's eerily timely dissent captures that some states would rather enable the Supreme Court to obstruct the will of Congress and stifle the availability of widespread, life-saving medical treatment to vulnerable communities by complaining they simply had no idea federal funds earmarked for a program established by Congress was not bound to requirements

[62] *See id.*
[63] *Id.* at 625-26.
[64] *Id.*
[65] *Id.* at 626.
[66] *See id.* at 644.
[67] *See id.*
[68] *Id*. at 644.
[69] *See id.*
[70] *See id.* at 595-96.
[71] *See generally id.*

set by Congress, than support, in any meaningful way, healthcare solutions which would help the overall general welfare of their citizens.[72] As explored below, this line of thinking eventually led to disastrous consequences during the COVID-19 pandemic.

IV. COVID-19 AND MEDICAID EXPANSION[73]

The following section will cover the role greater Medicaid expansion under the ACA could have played in mitigating the effects of the COVID-19 pandemic. The COVID-19 pandemic has had both health and economic consequences for Americans nationwide.[74] These areas will be explored here.

a. COVID-19's Health Crisis

i. Inconsistent Testing Practices

One way to operationalize the effects of the COVID-19 pandemic is complete testing data. The COVID Tracking Project, created by *The Atlantic*, sought to provide complete data sets in the absence of comprehensive federal reporting (namely by the Center for Disease Control ("CDC")), and broke down these sets based on "testing data" (to track the virus's spread and whether enough testing is being conducted), "hospitalizations and outcomes data" (to track how the virus is affecting different communities, especially compared to the testing being done), and "race and ethnicity data" (to track which communities are most vulnerable to the virus on the basis of race).[75] This compares to other institutions, such as Johns Hopkins University, which focused primarily on positivity and death rates, rather than testing totals.[76]

Tracing the testing done during the COVID-19 pandemic beginning on March 13, 2020, the day then-U.S. President Donald J. Trump declared a national emergency,[77] to September 13, 2020, six months after that date, the numbers alone are staggering. By March 13, 2020, 37,447 people had been tested for the virus, while 3,748 of those people had tested positive, nationwide.[78] Conversely, by September 13, 2020, 94,749,217 tests for COVID-19 had been administered, and 6,461,066 people had tested positive, nationwide.[79] Based on this snapshot of the first six months of the COVID-19 pandemic in the United States, two questions arise: a) was

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[72] *See generally id.*

[73] Before exploring the implications of *Sebelius* on Medicaid expansion in the context of COVID-19, it is important to note the national COVID-19 pandemic has remained ongoing for over 18 months at time of this writing. As such, the health and economic data provided below will likely be incomplete and only offer a limited glimpse into the legal ramifications during this pandemic. The author recommends future research as state and federal data permits.

[74] *See generally* Cross-Call & Broaddus, *supra* note 10.

[75] *See How We Source Our Data and Why It Matters*, The COVID Tracking Project (CC BY 4.0), THE ATLANTIC (2021), https://covidtracking.com/analysis-updates/how-we-source-our-data. At time of initial writing, this data was sourced being collected daily, but at the COVID Tracking Project is no longer collecting data. Please refer to the hyperlinked website in the source for archived data.

[76] *See id.*

[77] Proclamation No. 9994, 85 Fed. Reg. 15337 (Mar. 13, 2020). https://www.govinfo.gov/content/pkg/DCPD-202000156/html/DCPD-202000156.htm.

[78] *Totals for the US*, The COVID Tracking Project (CC BY 4.0), THE ATLANTIC (2020), https://covidtracking.com/data/national(last updated Mar. 7, 2021).

[79] *Id.*

the amount of testing enough, and if not, b) could Medicaid expansion under the ACA have cushioned the impact of these devastating statistics?

ii. Overwhelming Hospitalizations

Now turning to the data on "hospitalizations and outcomes", by March 13, 2020, where there had been 3,748 total COVID-19 cases in the United States, no hospitalization data was available according the COVID Tracking Project. Despite the lack of hospitalization numbers, there were only 56 confirmed deaths reported by states at the time.[80] Conversely, by September 13, 2020, when there had been 6,461,066 total COVID-19 cases in the United States, six months into the pandemic, there had been 29,804 people then-hospitalized, and 186,163 confirmed deaths by that date.[81] This data is relevant not in isolation, but to discern whether Congress's intended Medicaid expansion in the ACA could have made a meaningful difference in how state and federal coordination tried to mitigate the pandemic, and whether the *Sebelius* decision reverberated beyond its intended, strictly legal effect.[82]

iii. Health Benefits of Medicaid Expansion[83]

In examining the data collected by the COVID Tracking Project, this note will now look to the benefits of Medicaid expansion (as seen in states which have already complied with the ACA's original eligibility requirements), and how those benefits have affected the climate of the pandemic. In July 2020, the Center on Budget and Policy Priorities ("CBPP"), a "nonpartisan research and policy institute" based in Washington, D.C.,[84] released a report titled "States That Have Expanded Medicaid Are Better Positioned to Address COVID-19 and Recession"[85], which can help contextualize the data provided by *The Atlantic*'s project.

First, on the two questions arising from U.S. testing practices in the first six months of this pandemic,[86] the CBPP report begins by expressing that the amount of people tested in the U.S. was directly affected by the amount of people covered by Medicaid (an estimated 12 million people as a result of ACA expansion).[87] The authors write,

> "Expansion states entered the crisis with much lower uninsured rates than non-expansion states, due in large part to expansion. That's important for public health because people who are

[80] *Id.*
[81] *See id.*
[82] *See generally id.*
[83] *See generally* Madeline Guth, Rachel Garfield & Robin Rudowitz, The Effects of Medicaid Expansion under the ACA: Studies from *January* 2014 to January 2020, KFF (Mar. 17, 2020), https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/.
[84] *About the Center*, CENTER ON BUDGET AND POLICY PRIORITIES (2021), https://www.cbpp.org/about/mission-history.
[85] *See generally* Cross-Call & Broaddus, *supra* note 10.
[86] It ought to be noted that the CBPP's report was released on July 15, 2020, and some of the data expressed above in the six-month window from March 13 to September 13 of 2020 was not contemplated in this report. That said, CBPP's analysis of Medicaid expansion and how it prepared states to handle the first, harsh months of the pandemic is crucial for understanding the legal proposal of this note.
[87] *See* Cross-Call & Broaddus, *supra* note 10, at 10.

> uninsured may forgo testing or treatment for COVID-19 due to concerns that they cannot afford it, endangering their health while slowing detection of the virus' spread."[88]

The contention that uninsured folks, particularly those eligible for Medicaid under the ACA's proposed eligibility requirements, had a real effect in the nature of this pandemic is borne out in the data. Medicaid covers some vulnerable populations, including older Americans, folks with disabilities, folks living below the federal poverty line, and those with underlying conditions.[89] For low-income workers, many of them now (finally) branded "essential workers" by policymakers, the uninsured rate in non-expansion states is 30 percent, double the amount of states with Medicaid expansion under the ACA.[90] If, per se, *Sebelius* did not let non-expansion states freeload from increased federal funding and, rather, allowed Congress to continue to allocate funds only to states which complied with its expansion requirements (as Congress, the national legislature, ought to be able to legislate), and all states opted-in to Medicaid expansion as a result of that incentive, an estimated, additional 4,006,000 Americans would now have coverage under Medicaid.[91] Of that number, 508,000 would be people with disabilities, 650,000 would be those working on the "frontlines"— home health aides, grocery store workers, hospital workers and others— and an exceedingly high 1,118,000 would be parents, denied Medicaid coverage Congress earmarked for them, again, because the states were *surprised* by something they knew Congress could do.[92] COVID-19 was certainly a surprise, but the data demonstrating the disparity of folks vulnerable to the virus because of their state's inaction and shallow "coercion" arguments before the Court in *Sebelius* is not at all surprising.

This data illustrates that even if the testing were "enough", it still likely would not have mattered for millions of people who needed it to begin with. According to the U.S. Department of Health and Human Services (the same department states sued in *Sebelius*), "COVID-19 tests are available at no cost nationwide at health centers and select pharmacies. The Families First Coronavirus Response Act ensures that COVID-19 testing is free to anyone in the U.S., including the uninsured."[93] This is very positive, however, millions of Americans, uninsured due to their state's well-documented unwillingness to expand Medicaid to more communities who need it, cannot be expected to know they, in this instance, *can* get a COVID-19 test without needing to pay.[94] Thus, it would be ludicrous to deny that Medicaid expansion under the ACA could have cushioned the devasting blow COVID-19 had on Americans' households, their families and their communities, precisely because expansion states have seen an increase in patients seeking medical care, not avoiding lifesaving prescriptions due to fear of costs, and earlier diagnoses and treatments of illnesses such as cancer.[95]

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[88] *Id*.
[89] *See id*. App. 1, at 14.
[90] *Id*. at 1.
[91] *See generally Sebelius*, 567 U.S. 519; *see also* Cross-Call & Broaddus, App. 1.
[92] *See* Cross-Call & Broaddus, App. 1.
[93] *Community-Based Testing Sites for COVID-19*, U.S. DEP'T OF HEALTH & HUM. SERVICES (2021), https://www.hhs.gov/coronavirus/community-based-testing-sites/index.html.
[94] *See* Cross-Call & Broaddus, at 1-3.
[95] *See id.* at 1-4.

The data is relatively intuitive: if you allow people to have healthcare, they will use it.[96] If insured people get sick, they are more likely to seek medical attention.[97] If those people seek medical attention, they are more likely to live healthier and happier lives.[98] COVID-19 is not exacerbating an unforeseeable problem, but rather produces critical policy questions which illustrate the true necessity of Medicaid expansion.

b. COVID-19's Economic Crisis

i. Unemployment and Insurance

According to the KFF (formerly referred to as the "Kaiser Family Foundation"), a non-profit organization focusing on health policy,[99] over 31 million people had filed for unemployment insurance between March 1st and May 2nd, 2020 in the U.S.[100] This does not necessarily operationalize job losses during the pandemic, but can provide some insight into the financial situations created by COVID-19 and its associated shutdowns.[101] Oftentimes, with the loss of jobs comes the loss of employer-based insurance, and Medicaid is meant to help deliver services to folks who may be economically disadvantaged and not otherwise covered.[102] The KFF report states,

> "Some people who lose their jobs and health coverage—especially those who live in states that expanded Medicaid under the ACA—may become newly eligible for Medicaid if their income falls below state eligibility limits (138% of poverty in states that expanded under the ACA). […] In states that have not expanded Medicaid under the ACA, eligibility is generally limited to parents with very low incomes (typically below 50% of poverty and in some states quite a bit less); thus many adults may fall into the "coverage gap" that exists for those with incomes above Medicaid limits but below poverty (which is the minimum eligibility threshold for marketplace subsidies under the ACA)."[103]

Thus, by May 2020, when the American economy was in an unprecedented downturn, the strokes of the Chief Justice's pen eight years prior were being felt around the country where a) people were losing their jobs, b) those people were losing their work-based insurance, c) some of those people likely fell ill to COVID-19 and d) as illustrated above, folks who were uninsured likely did not seek treatment.[104]

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[96] *See generally id.*
[97] *See generally id.*
[98] *See generally id.*
[99] *About Us*, KFF (2020), https://www.kff.org/about-us/.
[100] Rachel Garfield, Gary Claxton, Anthony Damico & Larry Levitt, *Eligibility for ACA Health Coverage Following Job Loss*, KFF (May 13, 2020), https://www.kff.org/coronavirus-covid-19/issue-brief/eligibility-for-aca-health-coverage-following-job-loss/.
[101] *See generally id.*
[102] *See id.*
[103] *Id.*
[104] *See id.*; *see also* Cross-Call & Broaddus, *supra* note 10, at 1-3.

ii. Increased Burden of Healthcare Costs

The circuitous nature of the intersecting health and economic consequences begs the question: why do folks who do not have health insurance not seek medical treatment? The short answer is there is a tremendous cost to low-income folks, particularly those in vulnerable populations, who do not have access to health insurance but still require care.[105]

For example, in January 2020, it was reported that more than two million people (poor uninsured adults) who would be eligible for Medicaid under the ACA were unable to receive Medicaid because they lived in non-expansion states.[106] This "coverage gap"— where folks would receive Medicaid but for them living in a non-expansion state— was likely mitigated by the fact that people were working (at least somewhat), and there was not a global pandemic necessitating that they seek medical care urgently.[107] Considering over 31 million people filed for unemployment insurance in the first two months of the pandemic, it is likely that at least *some* of those people fell in this "coverage gap" in non-expansion states.[108] This coverage gap is an economic emergency born out of a health crisis.[109]

The solution is expanding eligibility for Medicaid, closing the coverage gap in the wake of the COVID-19 pandemic. This is not a thought exercise, but one illustrated in the CBPP report, which writes,

> "Even those near-poor adults who qualify for marketplace coverage are more likely to remain uninsured than if their states expanded Medicaid, since marketplace premiums, even with financial assistance, are high relative to their monthly incomes. […] Enhanced unemployment insurance benefits enacted as part of federal COVID-19 response legislation are temporarily lifting many unemployed workers in non-expansion states out of the coverage gap and into the income range where they can qualify for subsidized marketplace coverage. But these enhanced benefits are scheduled to end at the end of July, many low-wage workers do not receive unemployment insurance, and many will find marketplace premiums unaffordable (even with subsidies)."[110]

State marketplace alternatives for poor uninsured folks who are in the "coverage gap" are not the proper solution for non-compliant states to implement, because those individuals cannot typically afford those plans.[111] In fact, the data shows that it took a *global pandemic* to finally

[105] *See generally* Cross-Call & Broaddus, *supra* note 10.
[106] Rachel Garfield, Kendal Orgera & Anthony Damico, *The Coverage Gap: Uninsured Poor Adults in States that Do Not Expand Medicaid* (Jan. 21, 2021), https://www.kff.org/medicaid/issue-brief/the-coverage-gap-uninsured-poor-adults-in-states-that-do-not-expand-medicaid/.
[107] *See generally id.*
[108] *See generally* Cross-Call & Broaddus, *supra* note 10.
[109] *See generally id.*
[110] *Id.* at 7.
[111] *See generally id.*

temporarily allow folks to *perhaps* qualify for *subsidized* marketplace plans, because the marketplace plans they ordinarily would qualify for were too expensive.[112] These emphasized qualifiers are too many to be comfortable with the possibility that millions of poor Americans will have lived through this pandemic without health insurance.[113] To marry the policy considerations with the constitutional law doctrine explored above, just because the Court in *Sebelius* said states can get away with not providing life-saving medical coverage through a program which is already largely being funded by federal taxpayer dollars anyway, does not mean they should.[114]

iii. Economic Benefits of Medicaid Expansion

The economic benefits of Medicaid expansion are plentiful, all stemming from the fact that folks will spend less on healthcare than they otherwise would.[115] This creates greater financial stability, which is why expansion states are considered more likely to weather the fiscal storms brought on by COVID-19.[116] There are a few reasons for this. First, because more than 90 percent of Medicaid funds come from the federal government (as of 2020), even in expansion states, this would mitigate state budget stresses, and even encourage net savings.[117] With this in mind, the CBPP report writes,

> "[…] increased Medicaid coverage comes at little upfront cost to states, even if more people need coverage because of the recession. Moreover, many states have seen offsetting savings from expansion, for example due to reduced uncompensated care costs for public hospitals, reduced costs for safety net health programs (especially behavioral health), and increased revenue from taxes on providers and managed care plans. Since the recession will increase uninsured rates, uncompensated care costs, and costs for safety net health programs, expansion's offsetting savings will grow along with its gross costs. And the billions of dollars in additional federal funds that will flow to expansion states will provide valuable fiscal stimulus that will help preserve jobs."[118]

This alone would neutralize the argument in *Sebelius* that states would be burdened by expanding Medicaid— especially if they were only footing ten percent of the bill ten years into the program (even though *Sebelius* was more concerned about states losing 100 percent of their Medicaid funds rather than the percentage of what they would have to pay after expanding the program).[119] Turning more explicitly to policy considerations, the economic case is clear: if states want to save money, they need to expand Medicaid as Congress intended under the

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[112] *See generally id*.
[113] *See generally id*.
[114] *See generally id*.; *Sebelius*, 567 U.S. at 587-88.
[115] *See* Cross-Call & Broaddus, *supra* note 10, at 1-3.
[116] *See id*.
[117] *See id*. at 11-13.
[118] *Id*. at 2.
[119] *See id*. at 11-13.

ACA.[120] Finally, on an individual level, Medicaid expansion is known to create more financial stability for low-income folks, particularly in helping them build and access credit, significantly reducing the amount of evictions, and as such, facilitating a financial norm where poor families do not to choose between paying the rent or paying for insulin for their diabetes or medication for their heart disease.[121] Medicaid expansion goes beyond the bounds of the COVID-19 pandemic— it's a smart solution which will save states' money and save American lives.[122]

V. RECOMMENDATIONS

a. Medicaid Expansion under the ACA should now be reconsidered given the COVID-19 national emergency.

In March 2020, then-incumbent President Trump declared the COVID-19 pandemic a national emergency.[123] As illustrated by the data compiled by the CBPP, the communities most vulnerable to the virus are not being given Medicaid coverage by their states, which are receiving funds from Congress for that purpose, could also be construed as a national emergency.[124] But unlike the former crisis, which is plagued by conversations on the best practices to combat the virus's spread,[125] the Medicaid coverage crisis can be remedied through a series of legal and policy solutions.

States ought not to be entitled Medicaid funds without fulfilling the criteria set forth by Congress. As Justice Ginsburg noted, it is not their funds to begin with, it is the American people's tax dollars given to Congress to carry out programs in the national interest as Congress deems fit.[126] The argument that states are responsible for funding Medicaid should be quickly disregarded by courts, when only about 10 percent of those funds come from the states as of 2020.[127] Again, the goal here is not to relitigate *Sebelius*, but to illustrate that making Medicaid expansion an "option" is not a legal question of choice, but a question of equal access to a national healthcare program not based on the state one calls "home".

COVID-19 does not respect state lines,[128] and as such each citizen deserves access to a robust Medicaid program. Illness, be it COVID-19, influenza, HIV/AIDS, or cancer, does not care whether you live in New York (a state with Medicaid expansion)[129] or Florida (a non-

[120] *See id*.
[121] *Id*. at 3-4.
[122] *See id*.
[123] Proclamation No. 9994, 85 Fed. Reg. 15,337 (March 18, 2020). Mr. Trump's successor, President Joe Biden, extended the national emergency for one year, effective February 24, 2021. *E.g.*, Continuation of the National Emergency Concerning the Coronavirus Disease 2019 (COVID–19) Pandemic, 86 Fed. Reg. 11,599 (Feb. 26, 2021).
[124] *See* Cross-Call & Broaddus, *supra* note 10, at 7.
[125] *See* Mark Leibovich, *Treacherous Times for Dr. Fauci in the Sacred Cow Business*, N.Y. TIMES (Oct. 19, 2020), https://www.nytimes.com/2020/07/17/us/fauci-trump.html.
[126] *See Sebelius*, 567 U.S. at 624-46 (Ginsburg, J., dissenting).
[127] *See* Cross-Call & Broaddus, *supra* note 10, at 11-13.
[128] *See The COVID Tracking Project*, THE ATLANTIC (2020), https://covidtracking.com/data/charts.
[129] *Status of State Medicaid Expansion Decisions: Interactive Map*, KAISER FAMILY FOUNDATION (March 26, 2021), https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/.

expansion state)[130]— anyone can get sick. While wearing face masks, performing testing, practicing social distancing, and questioning the veracity of the virus itself have all become political talking points,[131] it is still impossible to fathom how the Supreme Court, the United States Congress, or state and national politicians at large would protect a legal standard which prescribes that it is okay to be too poor to live in America, especially in a pandemic, simply based on the state you live in. In the hope lawmakers and policy advocates begin to conceptualize the crater that *Sebelius* and optional Medicaid expansion have left in the U.S. healthcare apparatus,[132] here are a few solutions.

i. State Action

The easiest way to remedy the issues created by the *Sebelius* ruling is through state action. *Sebelius* gave states the option to expand Medicaid in line with the ACA's eligibility requirements, and more than two-thirds of states have done just that.[133] At time of this writing, the only states which have not expanded Medicaid are Alabama, Florida, Georgia, Kansas, Mississippi, North Carolina, South Carolina, South Dakota, Tennessee, Texas, Wisconsin and Wyoming.[134] Missouri and Oklahoma have recently adopted Medicaid expansion, but neither state is required to implement it until July 1, 2021.[135] The spread of COVID-19 has created virus "hot spots" across the U.S., so the assertion that Medicaid expansion would immunize the states which have yet to adopt it from the effects of this pandemic is unfortunately moot.[136]

There are several benefits to this approach, and few drawbacks. First, the twelve non-expansion states finally adopting Medicaid expansion now would do so at little cost to them.[137] Aside from the federal government covering most of the expansion budget (over 90 percent in 2020 and onwards), the CBPP explains both state budget savings and, at times, *revenues* have increased for expansion states.[138] This is a result of Medicaid covering what was previously largely uncompensated hospital care for poor folks, inpatient healthcare costs for eligible inmates, and behavioral treatment programs for eligible folks, leaving less expenses to be paid by

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[130] *Id.*
[131] *See generally* Leibovich, *supra* note 125.
[132] *See generally* Cross-Call & Broaddus, *supra* note 10, at 7.
[133] *See Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 129. There is an argument to be made that this means *Sebelius* was actually a victory for Medicaid expansion, because states continue to expand Medicaid without the threat of losing all of their federal funds for the program. That argument would be persuasive except that it still creates a hierarchy where some eligible citizens are receiving the healthcare they need, and some are not, and yet states face no consequences for not expanding the program in the way Congress crafted it in the ACA. After *Sebelius*, there is little reason not to expand Medicaid, particularly because the federal government covers upwards of 90 percent of the cost of expansion anyway. The politics of some sentiment like "we, the state, were not coerced and instead took money earmarked to expand a program which opened up healthcare options for people in need" do not seem overly controversial or risky. At this point, non-expansion states just seem as if they have not thought this whole "our state can have a healthier and more equitable populous on the federal government's dime" thing through. *See generally* Ricardo Alonso-Zaldivar, *Obama's Medicaid expansion keeps gaining ground under Trump*, ASSOCIATED PRESS (August 6, 2020). https://apnews.com/article/virus-outbreak-ap-top-news-ok-state-wire-michael-brown-health-a535f2211b7d536813119362d5de3578.
[134] *Status of State Medicaid Expansion Decisions: Interactive Map*, *supra* note 129.
[135] *Id.*
[136] *See The COVID Tracking Project*, *supra* note 128.
[137] *See* Cross-Call & Broaddus, supra note 10, at 11-13.
[138] *Id.* (emphasis added).

the states.[139] Data also shows that while Medicaid expenses increase for expansion states, those costs are largely covered by the federal government, meaning their net savings increase, too—debunking the myth that increased enrollment in Medicaid would bankrupt states.[140]

Second, states with expansion have not only enjoyed economic benefits, but their citizens are healthier and happier as a result.[141] Studies show that those living in Medicaid expansion states were a) more likely to be covered, b) as a result, more likely to go to a doctor, and c) more likely to be screened and treated for life-threatening illnesses, including those underlying conditions which make folks more susceptible to severe cases of COVID-19.[142] This illustrates the states' expanding Medicaid is not only a solution to COVID-19, but broader disparities in healthcare coverage in general.

Finally, larger amounts of uninsured, unemployed folks will no longer fall into the "coverage gap" and be eligible for Medicaid insurance, ensuring they are covered especially in areas where their local marketplace solutions are financially untenable for them to enroll in.[143] This would also be true for essential workers who do not qualify for employer-sponsored insurance, as 650,000 of them would be covered if all states expanded Medicaid.[144] Expansion in accordance with the ACA will not kneecap states' economic successes, but act as a crutch as they struggle through this pandemic and the decades of economic and social recovery which will follow.[145]

The most significant drawback to this proposal is that lawmakers in non-expansion states, historically adversarial to the both the ACA and Medicaid expansion, could lose their political capital, particularly with voters who have traditionally shared their sentiments (though, this is beginning to change as the ACA has grown more popular).[146] The process of expanding healthcare could continue to be undermined by disinformation campaigns, amplifying the aforementioned myths about the burden of costs of expanding Medicaid being brought on the states.[147] Medicaid expansion would be a victory for cooperative federalism (with states working hand-in-hand with their federal partners to deliver necessary healthcare to citizens), and an antidote to *Sebelius*'s unique analysis of the spending clause (at the expense of millions of Americans' well-being and their healthcare coverage), but such a victory would neutralize the political bi-polarity which has defined the COVID-19 pandemic.[148] States ought to expand Medicaid as the ACA calls for, if for no other reason than to save more lives from the virus, but given the fact that state governments continue to defy federal healthcare guidance, it is hard to

[139] *Id.*
[140] *See id.*
[141] *See id.* at 3-5.
[142] *See id.*
[143] *See id.* at 7.
[144] *See id.* at App. 1.
[145] *See generally id.*
[146] *See* Michael Ollove, *The Politics of Medicaid Expansion Have Changed*, PEW (Nov. 13, 2019), https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/11/13/the-politics-of-medicaid-expansion-have-changed.
[147] *But see* Julie Rovner, *Why Do So Many People Hate Obamacare So Much?*, NPR (Dec. 13, 2017), https://www.npr.org/sections/health-shots/2017/12/13/570479181/why-do-so-many-people-hate-obamacare-so-much.
[148] *See generally id.; see* Leibovich, *supra* note 125.

prescribe state-based solutions to this uniquely legal and healthcare problem which depends on accepting science as facts.[149]

ii. Federal Government Action

In *Sebelius*, Justice Ginsburg cleverly hints that if Medicaid expansion did not meet constitutional muster due to the "coercive" nature of the conditional funding, perhaps an all-federal alternative, like a single-payer healthcare system, would.[150] Here, Ginsburg's hypothetical of a sweeping federal healthcare reform program without state involvement would avoid the issues of a) "withholding" Medicaid funds under the ACA and b) some states' clear, gross incompetence in dealing with administering healthcare as illustrated by this pandemic.[151] This option, however satisfying to champions of plans like "Medicare for All" as proposed by Senator Bernie Sanders or even a public option plan as most recently proposed by former mayor and current Secretary of Transportation Pete Buttigieg it may be,[152] would likely be dead on arrival. This is almost guaranteed given both the continued legal challenges facing the ACA,[153] and the fact that passing future COVID-19 stimulus packages which would lift millions out of sudden economic hardship remains a political talking point,[154] rather than a response to any kind of legal or societal necessity.[155]

For these reasons, the easiest legal suggestion is simply for the federal government (in this case, the legislative and executive branches) to try Medicaid expansion again. Re-implementing conditional funding under a statute like the ACA (perhaps a modification of that law or a new one) would open the floodgates of relitigating *Sebelius*,[156] except the nature of facts of that case have changed as a result of the COVID-19 pandemic, which could dictate a different outcome in court. Perhaps limiting the revocation of Medicaid funds to non-expansion states from *all* funds to only *some* funds could persuade judges that there is no coercion of states at play. Whether federal courts, including the Supreme Court, would be sympathetic to the fact that millions of Americans have been left uninsured as they continue to fall ill to the virus as a result of the judiciary's infinite wisdom (but clear lack of foresight) in 2012 remains to be seen.

But, in short, while states may not act due to political reasons, Congress should once again attempt to pass and incentivize nationwide Medicaid expansion, providing funding on the condition states expand in line with the terms set forth by the ACA or a newer, better version of that law. Again, perhaps Congress could consider an approach other than cutting *all* Medicaid funds for non-compliant states, which would help prevent the remaining non-expansion states from crying "coercion!" when faced with the reality that they, too, may have to give more of their citizens access to healthcare. This would likely be met with a court challenge, but the facts

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[149] *See generally id.*
[150] *Sebelius*, 576 U.S. 595-96.
[151] *See generally id.*
[152] *See* Goodnough & Gabriel, *supra* note 4.
[153] *But cf.* Adam Liptak, *Key Justices Signal Support for Affordable Care Act*, N.Y. TIMES (Nov. 10, 2020), https://www.nytimes.com/2020/11/10/us/supreme-court-obamacare-aca.html.
[154] This sentiment remains true regardless of whether any stimulus plans have been or will be passed in response to the COVID-19 pandemic.
[155] *See generally* Leibovich, *supra* note 125.
[156] *See Sebelius*, 576 U.S. at 586-89.

of COVID illuminate the disparities set forth by the Supreme Court in *Sebelius*, providing room for a future legal remedy.[157]

b. Future Research

As this note has been written, the national judicial and political climates of the United States have dramatically shifted in a way which could decide the future of laws like the ACA. The passing of Justice Ginsburg, a champion of Medicaid expansion whose dissent in *Sebelius* inspired this paper, during an unprecedented global pandemic,[158] and the confirmation of Justice Amy Coney Barrett, a protégé of Justice Scalia, a judicial opponent of Medicaid expansion in *Sebelius*, illustrates the uncertainty of the Court's future decisions on the ACA or other (existing or future) federal healthcare statutes.[159] Additionally, the recent election and inauguration of Democrat Joe Biden, a strong proponent of the ACA who became President of the United States on January 20, 2021, may change the nature of the legal challenges facing the law, as it may be augmented by further legislation, executive orders, or support from *amici curiae* in court.[160] As such, this is an area ripe for legal research, examining more long-term repercussions of *Sebelius*'s limited reasoning on Medicaid expansion beyond the initial outbreak of COVID-19.

Additionally, it ought to be noted that most data sets cited in the health and economic sections detailing the COVID-19 pandemic highlight racial and ethnic disparities.[161] This intersectional facet of this crisis is desperately in need of future social-legal research, particularly when looking at states which have decided to not expand Medicaid and contextualizing the Movement for Black Lives gaining nationwide attention.[162] This area was simply too important to simply be facially explored in this paper, and ought to constitute a robust series of scholarship in the coming years.

VI. CONCLUSION

The court in *Sebelius* could not have possibly known the effects COVID-19 would have had on American health and economics. That said, while the option of Medicaid expansion was created by the Court to protect states' rights, it has proven to have infringed on more than Americans' rights: it has potentially led to the end of several thousand American lives. With this in mind, given the unprecedented nature of this crisis and its toll on the nation's general welfare, either all states need to opt-in to Medicaid, or the federal government needs to create a

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[157] *See generally* Cross-Call & Broaddus, *supra* note 10.
[158] *See* Nina Totenberg, *Justice Ruth Bader Ginsburg, Champion Of Gender Equality, Dies At 87*, NPR (Sept. 18, 2020), https://www.npr.org/2020/09/18/100306972/justice-ruth-bader-ginsburg-champion-of-gender-equality-dies-at-87.
[159] *See* Nicholas Fandos, *Senate Confirms Barrett, Delivering for Trump and Reshaping the Court*, N.Y. TIMES (Oct. 26, 2020), https://www.nytimes.com/2020/10/26/us/politics/senate-confirms-barrett.html.
[160] *See generally* Paige Winfield Cunningham, *The Health 202: Obamacare may be safer than ever. But Biden will struggle to expand it.*, WASH. POST. (Nov. 11, 2020), https://www.washingtonpost.com/politics/2020/11/11/health-202-obamacare-may-be-safer-than-ever-biden-will-struggle-expand-it/.
[161] *See How We Source Our Data and Why It Matters*, *supra* note 75; Cross-Call & Broaddus, *supra* note 10 at 8-11.
[162] *See generally* Larry Buchanan, Quoctrung Bui & Jugal K. Patel, Black Lives Matter May Be the Largest Movement in U.S. History, N.Y. TIMES (July 3, 2020), https://www.nytimes.com/interactive/2020/07/03/us/george-floyd-protests-crowd-size.html.

nationalized healthcare plan which will not befall the same fate as the ACA under *Sebelius*. The jurisprudential gutting of the Affordable Care Act has cost the U.S. countless lives. It is time for this egregious oversight to be swiftly remedied, for the remainder of this pandemic and beyond.