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CONGRESS HAS ALREADY RULED IN *CALIFORNIA v. TEXAS*

JOHN ALOYSIUS COGAN JR.*

Abstract: In *California v. Texas*, opponents of the Affordable Care Act (ACA) have asked the Supreme Court to invalidate the statute. Relying on a 2017 legislative change to the ACA’s individual mandate, the challengers argue that the mandate is unconstitutional. They then assert that the mandate is inseverable from the rest of the ACA, thus the entire statute must fall. Earlier this year, however, Congress said otherwise. Last March, Congress passed the Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act. The two statutes amend and expand provisions of the ACA, thereby overriding *Texas v. United States*, the district court decision that underlies *California v. Texas*. In short, Congress has already ruled, via an override, on the severability question at issue in *California v. Texas*. The ACA stands, even with an unconstitutional individual mandate.

INTRODUCTION

In the midst of the COVID-19 pandemic, when access to health insurance is a financial and medical necessity for nearly every American, *California v. Texas* raises a critical question: is the Affordable Care Act¹ (ACA) still good law?² The parties challenging the ACA have asked the Supreme Court to invalidate the entire statute. Their argument has two parts. First, they claim a 2017 statute, the Tax Cuts and Jobs Act³ (TCJA), rendered the ACA’s individual mandate—the requirement that most Americans buy standardized health insurance policies or pay a penalty⁴—unconstitutional.⁵ They quickly pivot to their second, more consequential claim: the individual mandate cannot be severed from the rest of the ACA.⁶ Thus, the entire ACA must be struck down.

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¹ Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified as amended in scattered sections of the U.S.C.).

² *Texas v. United States*, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020).

³ Tax Cuts and Jobs Act (TCJA), Pub. L. No. 115-97, 131 Stat. 2054 (2017) (codified as amended in scattered sections of 26 U.S.C.).

⁴ 26 U.S.C. § 5000A(a) (providing that certain individuals “shall . . . ensure” they are “covered under minimum essential coverage”).

⁵ Opening Brief for the Petitioners at 2, *California v. Texas*, 140 S. Ct. 1262 (No. 19-840).

⁶ *Id.*

Despite their many differences, the parties in *California v. Texas* agree on one thing—the severability analysis, which is the central issue in the case, turns on congressional intent.⁷ The two sides, however, offer contradictory evidence of that intent. The challengers point to the text of the ACA from 2010 and argue that Congress intended the mandate to be inseverable from the rest of the statute.⁸ The defenders contend that Congress’s intent to preserve the ACA was manifest in 2017 when the TCJA affected only one part of the ACA but left the rest of the statute standing.⁹ In this Essay, I argue that the parties’ focus on congressional intent from 2010 and 2017 is misplaced. The Court should instead look at what Congress did in 2020.

In March of 2020, Congress passed the Families First Coronavirus Response Act (FFCRA)¹⁰ and the Coronavirus Aid, Relief, and Economic Security Act (CARES) Act.¹¹ Twenty separate provisions of the FFCRA and the CARES Act incorporate, apply, or extend parts of the ACA.¹² Critically, Congress passed these statutes knowing the individual mandate had already been ruled unconstitutional by two federal courts.¹³ As a result, the FFCRA and the CARES Act have a direct and consequential effect on *California v. Texas*. The FFCRA and the CARES Act not only offer up-to-the-minute evidence of Congress’s intent regarding the viability of the ACA, they do something much more substantial. The two statutes override the severability ruling in *Texas v. United States*, the district court decision that underlies *California v. Texas*.¹⁴

To restate this point in the plainest possible terms, Congress has already ruled—through an override—on the severability question at issue in *California v. Texas*. When it passed the FFCRA and the CARES Act, Congress made clear, *as a matter of law*, that the ACA stands, even without the individual mandate.

This Essay proceeds in three parts. Part I provides necessary background on *Texas v. United States*.¹⁵ Part II briefly describes congressional overrides.¹⁶

⁷ See *Alaska Airlines, Inc. v. Brock*, 480 U.S. 678, 685 (1987) (“The more relevant inquiry in evaluating severability is whether the statute will function in a *manner* consistent with the intent of Congress.”).

⁸ Brief for Respondent/Cross-Petitioner States at I, 7, 14, *California v. Texas*, 140 S. Ct. 1262 (No. 19-840).

⁹ Opening Brief for the Petitioners, *supra* note 5, at 36–39.

¹⁰ Families First Coronavirus Response Act (FFCRA), Pub. L. No. 116-127, 134 Stat. 178 (2020).

¹¹ Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, 134 Stat. 281 (2020).

¹² See *infra* Appendix A (listing seven provisions of the FFCRA that incorporate, apply, or extend parts of the ACA); Appendix B (listing thirteen provisions of the CARES Act that incorporate, apply, or extend parts of the ACA).

¹³ See *infra* notes 28–38 and accompanying text.

¹⁴ See *Texas v. United States*, 340 F. Supp. 3d 579, 619 (N.D. Tex. 2018), *aff’d in part, vacated in part*, 945 F.3d 355 (5th Cir. 2019), *cert. granted sub nom.* *California v. Texas*, 140 S. Ct. 1262 (2020).

¹⁵ See *infra* notes 18–40 and accompanying text.

Part III explains how Congress overrode the severability ruling in *Texas v. United States*.¹⁷

I. TEXAS V. UNITED STATES

The origins of *Texas v. United States* date back to *National Federation of Independent Business (NFIB) v. Sebelius*, when the Supreme Court first considered the constitutionality of the individual mandate.¹⁸ Although the Court ruled that Congress lacked authority to impose the mandate under the Constitution’s Commerce and Necessary and Proper Clauses,¹⁹ the Court nevertheless upheld the individual mandate.²⁰ Writing for the split majority, Chief Justice John Roberts reasoned that the individual mandate’s penalty could be viewed as an exercise of Congress’s taxing power because it “looks like a tax in many respects”²¹ and would provide “some revenue” for the government.²²

Nearly five years later, in December of 2017, Congress revisited the mandate penalty. After failing to repeal the ACA at least seventy times,²³ Congress enacted the TCJA, which reduced the mandate penalty to \$0, but left the mandate—and the rest of the ACA—in place.²⁴ After the TCJA was passed, President Trump claimed in the State of the Union address that “the individual mandate is now gone.”²⁵ Shortly thereafter, more than a dozen Republican-led states and several individuals filed suit in federal district court challenging the ACA.²⁶

The plaintiffs in *Texas v. United States* offered a two-step argument to strike down the ACA. First, they claimed the ACA’s individual mandate is unconstitutional. Once the TCJA reduced the mandate penalty to \$0, the penalty no longer “looks like a tax” because it generates no revenue. Thus, *NFIB*’s

¹⁶ See *infra* notes 41–51 and accompanying text.

¹⁷ See *infra* notes 52–91 and accompanying text.

¹⁸ *Nat’l Fed’n of Indep. Bus. (NFIB) v. Sebelius*, 567 U.S. 519, 530 (2012).

¹⁹ *Id.* at 561.

²⁰ *Id.* at 588.

²¹ *Id.* at 563.

²² *Id.* at 564.

²³ See Chris Riotto, *GOP Aims to Kill Obamacare Yet Again After Failing 70 Times*, NEWSWEEK (July 29, 2017), <https://www.newsweek.com/gop-health-care-bill-repeal-and-replace-70-failed-attempts-643832> [<https://perma.cc/QAK9-L5MT>] (noting at least seventy attempts by Republicans to repeal or undermine the ACA between 2010 and 2017).

²⁴ TCJA, Pub. L. No. 115-97, § 11081(b), 131 Stat. 2054, 2092 (2017) (codified at 26 U.S.C. § 5000A(c)(3)).

²⁵ See Dan Mangan, *Trump Touts Repeal of Key Part in ‘Disastrous Obamacare’—the Individual Mandate*, CNBC (Jan. 30, 2018), <https://www.cnbc.com/2018/01/30/trump-touts-repeal-of-obamacare-individual-mandate.html> [<https://perma.cc/NJ7G-8DCQ>].

²⁶ See Katie Keith, *DOJ, Republican AGs Ask Supreme Court to Strike Down ACA*, HEALTH AFFAIRS BLOG (June 26, 2020), <https://www.healthaffairs.org/doi/10.1377/hblog20200626.180922/full/> [<https://perma.cc/X48U-GZEP>].

holding—that the mandate is authorized by Congress’s taxing power—no longer applies.²⁷

The plaintiffs’ second, more consequential claim was that the mandate cannot be severed from the rest of the ACA. Their argument is based largely on a provision of the ACA they call the “inseverability clause.”²⁸ To be clear, the ACA contains no express inseverability clause. The plaintiffs, however, argued that 42 U.S.C. § 18091(2)(I) functions as an inseverability clause because it states that the mandate is “essential” to the functioning of the ACA.²⁹ The U.S. Department of Justice (DOJ) agreed that the mandate was unconstitutional,³⁰ but argued that the individual mandate was not severable from two other provisions of the ACA, the guaranteed-issue and community-rating requirements.³¹ Instead, DOJ argued the three provisions were severable from the rest of the ACA.³²

The district court sided with the plaintiffs. After ruling the mandate unconstitutional, the court determined that the mandate was inseverable from the ACA.³³ The text of § 18091, the court concluded, was “the best evidence of congressional intent.”³⁴ The court continued, “Virtually every subsection of 42 U.S.C. § 18091 is teeming with Congress’s intent that the Individual Mandate be inseverable—because it is *essential*—from the entire ACA—because it must work *together* with the other provisions.”³⁵ The court went on, “In sum, the Individual Mandate ‘is so interwoven with [the ACA’s] regulations that they cannot be separated. None of them can stand.’”³⁶

²⁷ Brief of Plaintiffs in Support of Application for Preliminary Injunction at 23–26, *Texas v. United States*, 340 F. Supp. 3d 579 (N.D. Tex. 2018) (No. 4:18-cv-00167-O).

²⁸ *Id.* at 33.

²⁹ *Id.* at 30–35; see 42 U.S.C. § 18091(2)(I). The plaintiffs in *Texas v. United States* were not the first to refer to § 18091(2)(I) as an inseverability clause. In *NFIB*, the Solicitor General argued that the mandate was inseverable from the guaranteed-issue and community-rating provisions and proposed that § 18091(2)(I) “effectively serves as an inseverability clause.” Brief for Respondents (Severability) at 26, *NFIB v. Sebelius*, 567 U.S. 519 (2012) (Nos. 11-393, 11-400); Reply Brief for the Respondents (Severability) at 10, *NFIB*, 567 U.S. 519 (Nos. 11-393, 11-400).

³⁰ Federal Defendants’ Memorandum in Response to Plaintiffs’ Application for Preliminary Injunction at 9, *Texas v. United States*, 340 F. Supp. 3d 579 (No. 4:18-cv-00167-O) [hereinafter Federal Defendants’ Memorandum] (“The United States agrees with Plaintiffs that the ACA’s individual mandate, as amended by the TCJA, is unconstitutional.”).

³¹ *Id.* at 13–15. The guaranteed-issue requirement prohibits insurers from denying coverage based on an applicant’s health status and requires insurers to offer insurance to any eligible individual or group applying for coverage. 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4(a). The community-rating requirement bars insurers from using health status and most other factors to vary their rates. Insurers can only use family size, geographic area, age, and tobacco use. *Id.* §§ 300gg(a)(1), 300gg-4(b). These are part of the ACA’s protections for people with preexisting medical conditions.

³² Federal Defendants’ Memorandum, *supra* note 30, at 16–19.

³³ *Texas v. United States*, 340 F. Supp. 3d at 610.

³⁴ *Id.* at 609–10 (quoting *Marx v. Gen. Revenue Corp.*, 568 U.S. 371, 392 n.4 (2013)).

³⁵ *Id.* at 610.

³⁶ *Id.* at 615 (quoting *Hill v. Wallace*, 259 U.S. 44, 70 (1922)).

The United States Court of Appeals for the Fifth Circuit agreed the mandate was unconstitutional but remanded the matter for further analysis of the severability question.³⁷ The case did not go back to the district court. Instead, it went to the Supreme Court.³⁸

As a practical matter, there is no mandate; it has been a toothless requirement since Congress eliminated its penalty in 2017. And, as it turns out, recent coverage data suggests the ACA operates just fine without the mandate.³⁹ In *Texas v. United States*, however, the mandate did serve an important purpose—it was the launchpad for the challengers’ inseverability argument. Last March, however, Congress passed the FFCRA and the CARES Act, which shredded the challengers’ argument by overriding the severability ruling in *Texas v. United States*.⁴⁰

II. CONGRESSIONAL OVERRIDES

A congressional override is “the legislative equivalent of a judicial overruling.”⁴¹ As a constitutional matter, Congress enjoys supremacy over statutory matters. Section 1 of Article I of the Constitution vests Congress with “All legislative Powers.”⁴² As Chief Justice Roberts has recognized, Congress—not the judiciary—has the final say on how a statute should be interpreted and applied.⁴³ Thus, when a court says that a statute means X, Congress has the power to say, “No, it does not.”⁴⁴ To be clear, an override is not a reversal of a particular court decision. Instead, an override is a superseding instruction to the judiciary about how a statute should be applied.

Congressional overrides of judicial decisions may seem unusual, perhaps unique. Not so. Congress has enacted legislation to override, reverse, or modi-

³⁷ *Texas v. United States*, 945 F.3d 355, 393 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020). During the appeal, DOJ changed its position and argued that the entire ACA was inseverable from the mandate. *Id.* at 374.

³⁸ See *California v. Texas*, No. 19-840 (S. Ct. argued Nov. 10, 2020).

³⁹ See Sarah Kliff, *Republicans Killed the Obamacare Mandate. New Data Shows It Didn’t Really Matter.*, N.Y. TIMES, <https://www.nytimes.com/2020/09/18/upshot/obamacare-mandate-republicans.html> [<https://perma.cc/5PJZ-P6S9>] (Sept. 21, 2020).

⁴⁰ See *supra* notes 10–11 and accompanying text.

⁴¹ Brian J. Broughman & Deborah A. Widiss, *After the Override: An Empirical Analysis of Shadow Precedent*, 46 J. LEGAL STUD. 51, 52 (2017).

⁴² U.S. CONST. art. I, § 1 (“All legislative Powers herein granted shall be vested in a Congress of the United States . . .”).

⁴³ *Confirmation Hearing on the Nomination of John G. Roberts, Jr. to Be Chief Justice of the United States: Before the S. Comm. on the Judiciary*, 109th Cong. 231 (2005). C.J. Roberts noted during his confirmation hearing, “The final say on a statute is with Congress, and if they don’t like the Supreme Court’s interpretation of it, they can change it . . .” *Id.*

⁴⁴ See Deborah A. Widiss, *Shadow Precedents and the Separation of Powers: Statutory Interpretation of Congressional Overrides*, 84 NOTRE DAME L. REV. 511, 513 (2009) (citing *Johnson v. Transp. Agency*, 480 U.S. 616, 630 n.7 (1987) (quoting GUIDO CALABRESI, A COMMON LAW FOR THE AGE OF STATUTES 31–32 (1982))).

fy hundreds of judicial interpretations of statutes and regulations since the late 1960s.⁴⁵ It is not uncommon, as in *Texas v. United States*, for Congress to override lower court decisions.⁴⁶

Unfortunately, two things complicate the application of the FFCRA and the CARES Act override in *California v. Texas*. The first is timing. Congress passed the FFCRA and the CARES Act after the Supreme Court granted certiorari in *California v. Texas* but before the first briefs were due.⁴⁷ The parties were left with little time to analyze how the FFCRA and the CARES Act might affect the severability question. Thus, it is not surprising that the parties did not brief the issue.

The second complication is the visibility—or perhaps *the invisibility*—of overrides. Empirical studies note that overrides are hard to identify.⁴⁸ Sometimes Congress explicitly identifies a statute as an override.⁴⁹ Often, though, there is no express language in a statute or its committee reports (if any exist) that identifies a statute as an override. Thus, many overrides are implicit.⁵⁰ Congress says nothing about the override even as it issues one. This is the case with the FFCRA and the CARES Act override. Congress provided no affirmative, ex ante statement that the FFCRA and the CARES Act override the severability ruling in *Texas v. United States*.⁵¹ Thus, detailed statutory analysis is

⁴⁵ See William N. Eskridge, Jr., *Overriding Supreme Court Statutory Interpretation Decisions*, 101 YALE L.J. 331, 338 tbl.1 (1991) (noting that between 1967 and 1990, Congress passed 187 override statutes, overriding 344 federal court statutory interpretations).

⁴⁶ See *id.* at 338 (“Congress frequently overrides or modifies statutory decisions by lower federal courts as well as those by the Supreme Court.”).

⁴⁷ The opening briefs in *California v. Texas* were due on May 6, 2020. See Docket Entry, *California v. Texas*, No. 19-840 (S. Ct. Apr. 2, 2020), <https://www.supremecourt.gov/docket/docketfiles/html/public/19-840.html> [<https://perma.cc/W9CU-62FJ>]. The FFCRA became law on March 18, 2020. Pub. L. No. 116-127, 134 Stat. 178 (2020). The CARES Act became law on March 27, 2020. Pub. L. No. 116-136, 134 Stat. 281 (2020).

⁴⁸ See, e.g., Deborah A. Widiss, *Identifying Congressional Overrides Should Not Be This Hard*, 92 TEX. L. REV. SEE ALSO 145, 147 (2014), <http://texaslawreview.org/wp-content/uploads/2015/08/Widiss-92-SeeAlso1.pdf> [<https://perma.cc/Z7CF-KRBE>] (noting that researchers “agree that it is very difficult to identify overrides”).

⁴⁹ See, e.g., Eskridge, *supra* note 45, at 418–19 (identifying overrides by searching for references to Supreme Court statutory interpretation decisions in Congressional committee reports); Richard L. Hasen, *End of the Dialogue? Political Polarization, the Supreme Court, and Congress*, 86 S. CAL. L. REV. 205, 217, 259–60 (2013) (applying the same method of identifying overrides).

⁵⁰ See Matthew R. Christiansen & William N. Eskridge, Jr., *Congressional Overrides of Supreme Court Statutory Interpretation Decisions, 1967–2011*, 92 TEX. L. REV. 1317, 1328–29 (2014) (identifying overrides using an expanded method that included Westlaw data and other sources).

⁵¹ Implicit overrides are just as much the law as explicit overrides. Moreover, even if an override is “unconscious,” that is, the override statute was not “consciously” aimed at superseding a court decision, it is still law and must be followed. See Matthew R. Christiansen, William N. Eskridge Jr. & Sam N. Thypin-Bermeo, *The Conscious Congress: How Not to Define Overrides*, 93 TEX. L. REV. SEE ALSO 289, 297 (2015), <https://texaslawreview.org/wp-content/uploads/2019/04/93-Tex.-L.-Rev.-See-Also-289.pdf> [<https://perma.cc/4WLA-K43J>] (“[W]hen it comes to congressional overrides . . .

necessary to show how the FFCRA and the CARES Act override and supersede the severability ruling in *Texas v. United States*. Part III of this Essay provides that detailed statutory analysis.

III. CONGRESS OVERRODE THE SEVERABILITY RULING IN *TEXAS V. UNITED STATES*

Following the outbreak of the COVID-19 pandemic in the United States, Congress passed three relief statutes in March of 2020.⁵² Two of those statutes, the FFCRA and the CARES Act, provide coverage for COVID-19 testing and preventive care (i.e., vaccinations) to millions of Americans.⁵³ Congress relied on existing public and private health insurance systems and funding mechanisms to expand this coverage and the ACA was a key mechanism to provide this expanded coverage.⁵⁴ Section A of this Part describes how the FFCRA and the CARES Act incorporated, applied, and expanded provisions of the ACA in response to the COVID-19 pandemic. Next, Section B shows how the FFCRA and the CARES Act overrode the severability holding in *Texas v. United States*. Congress knew the mandate had been ruled unconstitutional in *Texas v. United States* and that the ruling had been upheld on appeal. Nevertheless, Congress passed the FFCRA and the CARES Act, thereby overriding *Texas v. United States*.

A. The Override Provisions

Congress's use of the ACA to expand coverage in response to the COVID-19 pandemic was no mistake or oversight; it was quite deliberate. The FFCRA and the CARES Act cite the ACA by name or citation more than a half-dozen times.⁵⁵ The two statutes use ACA-defined terms, such as "minimum essential coverage"⁵⁶ and "grandfathered" health plan.⁵⁷ The FFCRA even incorporates the ACA's individual and group health insurance market reforms provisions, which include the guaranteed-issue and community-rating

[agencies, courts, and private actors] must obey the override, unless it is a scrivener's error or an unconstitutional directive.").

⁵² The first COVID-19 response law was the Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020. Pub. L. No. 116-123, 134 Stat. 146 (2020).

⁵³ See generally CARES Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); FFCRA, Pub. L. No. 116-127, 134 Stat. 178 (2020) (expanding COVID-19 coverage through Medicare, Medicare Advantage, Medicaid, the State Children's Health Insurance Program, TRICARE, the Veterans Administration, the Federal Employees Health Benefits Program, the Indian Health Service, and private health insurance).

⁵⁴ See *infra* notes 60–85 and accompanying text.

⁵⁵ CARES Act §§ 3211(a), 3803(a)(1), 3812(a), 3812(b), 3831(a), 3831(b); FFCRA § 6001(a).

⁵⁶ CARES Act § 3716.

⁵⁷ FFCRA § 6001(a).

requirements.⁵⁸ But the FFCRA and the CARES Act connect to the ACA even more deeply. Twenty separate provisions of the two statutes incorporate, apply, and extend parts of the ACA to provide health benefits through a variety of public programs and insurance markets, including individual and group private health insurance, Medicaid, Medicare, the Indian Health Service, and through federal health centers.⁵⁹

1. Private Health Insurance

The FFCRA expands ACA private health insurance coverage by requiring all private health insurers and group health plans offering ACA insurance to cover COVID-19 testing, the costs of test administration, and related items and services, without cost sharing (no deductibles, coinsurance, or copays) through the duration of the emergency.⁶⁰ This requirement applies *only* to ACA health insurance.⁶¹ The CARES Act establishes a method for determining the amount ACA health insurers and group plans must pay health care providers for COVID-19 testing required by the FFCRA.⁶²

Moreover, because these coverage benefits are tied to the ACA, and because ACA benefits and protections are integrated, these ACA benefits automatically trigger all of the ACA's patient protections, including the protections for preexisting conditions.⁶³ No one who tests positive for COVID-19 under these coverage provisions can be denied coverage or charged a higher premium in ACA health plans.⁶⁴

The CARES Act also expands ACA private health insurance coverage by requiring all private health insurers and group health plans offering ACA insurance to cover the cost of COVID-19 vaccination and other potential COVID-19 preventive services.⁶⁵ Like the testing requirement of the FFCRA, this applies only to ACA health insurance.⁶⁶

⁵⁸ FFCRA § 6001(b) states that provisions of section 6001(a) “shall be applied . . . to group health plans and health insurance issuers offering group or individual health insurance coverage as if included in the provisions of part A of title XXVII of the Public Health Service Act.” The ACA amended Part A of title XXVII of the Public Health Service Act to include the guaranteed-issue and community-rating requirements. See 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4; see also *supra* note 31 and accompanying text.

⁵⁹ See *infra* Appendices A–B (listing provisions of the FFCRA and the CARES Act that incorporate, apply, and extend the ACA).

⁶⁰ FFCRA § 6001(a) (as amended by CARES Act § 3201).

⁶¹ Individuals with a non-ACA health insurance are considered “uninsured” for the purposes of the FFCRA and may be eligible for coverage under other provisions of the FFCRA. *Id.* § 6004 (defining uninsured).

⁶² CARES Act § 3202.

⁶³ See *supra* note 31 and accompanying text.

⁶⁴ See 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3, 300gg-4.

⁶⁵ CARES Act § 3203.

⁶⁶ *Id.*

2. Medicaid

The FFCRA increases Medicaid benefits, including benefits for individuals with ACA-expanded Medicaid coverage. These benefits include COVID-19 testing, the costs of test administration, and related items and services, without cost sharing, during the public health emergency.⁶⁷

The FFCRA also creates a new Medicaid coverage category for the uninsured. States have the option to extend Medicaid eligibility to uninsured individuals for purposes of COVID-19 diagnostic testing and testing-related services during the emergency period.⁶⁸ The FFCRA incorporates the definition of ACA insurance coverage into its definition of an “uninsured individual.” For the purposes of the FFCRA, an individual not enrolled in ACA individual or group coverage or enrolled in a federal health plan is considered “uninsured.”⁶⁹ Thus, anyone with non-ACA private health insurance is deemed “uninsured” and eligible for this new category of Medicaid coverage. In other words, Congress recognized only one kind of health insurance under the FFCRA—ACA health insurance.⁷⁰

The FFCRA also provides increased Medicaid funding to all states and territories, but under the condition that states and territories cannot remove Medicaid enrollees from coverage, including enrollees in ACA-expanded Medicaid, during the public health crisis.⁷¹

3. Medicare

Among the various Medicare-related provisions in the FFCRA and the CARES Act, the CARES Act amends the Medicare hospital inpatient payment formula, which was extensively reworked by the ACA. Medicare increased hospital payments for patients diagnosed with COVID-19.⁷²

4. Indian Health Service

The FFCRA also includes,⁷³ and provides payment for,⁷⁴ COVID-19 testing and items and services associated with such testing, without any cost-sharing requirements through the Indian Health Service (IHS). The IHS pro-

⁶⁷ FFCRA § 6004(a)(1)–(2) (as amended by CARES Act § 3717).

⁶⁸ *Id.* § 6004(a)(3)(A)–(C).

⁶⁹ *Id.* § 6004(a)(3)(C).

⁷⁰ In addition to using Medicaid as a vehicle to provide COVID-19 testing to uninsured individuals, Title V of the FFCRA provides funding to the National Disaster Medical System that can be used to reimburse health care providers for costs related to COVID-19 testing for uninsured individuals. *See id.* Div. A, tit. V.

⁷¹ *Id.* § 6008 (as amended by CARES Act § 3716).

⁷² CARES Act § 3710(a) (increasing diagnosis-related group payment by twenty percent).

⁷³ FFCRA § 6007.

⁷⁴ *Id.* Div. A, tit. IV.

vides health care to American Indians and Alaska Natives directly or through programs or facilities operated by Indian tribes or tribal organizations. The IHS also provides services to urban Indians through grants to or contracts with Urban Indian Organizations (UIOs). The testing provisions of the FFCRA apply to any Indian, as defined by the Indian Health Care Improvement Act (IHCA), receiving services through the IHS, including through UIOs, during the emergency period.⁷⁵ Thus, the FFCRA incorporates and applies a provision of the ACA that permanently reauthorized the IHCA⁷⁶ and gave IHS authority to grant funding to UIOs.⁷⁷

5. Federal Health Centers

The federal Health Center Program, which was permanently authorized by the ACA, provides funding to federal health centers that provide medical care to low-income individuals.⁷⁸ The CARES Act supplements ACA funding of the Health Center program by appropriating \$1.32 billion for federal health centers for the detection of the COVID-19 virus, or prevention, diagnosis, and treatment of COVID-19 illnesses.⁷⁹ In addition, the CARES Act adds more than \$2 billion to the Community Health Center Fund (CHCF).⁸⁰ The CHCF was established by the ACA and funds community health centers, a type of federal health center that serves individuals in the general population who have limited access to health care.⁸¹

6. Other ACA Provisions

The CARES Act also amends several non-health coverage sections of the ACA, including provisions related to the Public Health Service's Ready Reserve Corps,⁸² health savings and flexible spending account spending,⁸³ Medicaid spousal impoverishment protections,⁸⁴ and funding assistance for low-income health programs.⁸⁵

⁷⁵ *Id.* § 6007.

⁷⁶ ACA, Pub. L. No. 111-148, § 10221(a), 124 Stat. 119, 935 (2010) (codified at 25 U.S.C. §§ 1601–1680v).

⁷⁷ *See* 25 U.S.C. §§ 1603(29), 1652.

⁷⁸ ACA § 5601(a) (codified as amended at 42 U.S.C. § 254b).

⁷⁹ CARES Act § 3211.

⁸⁰ *Id.* § 3831.

⁸¹ *See* ELAYNE J. HEISLER, CONG. RSCH. SERV., R43937, FEDERAL HEALTH CENTERS: AN OVERVIEW 13 (2017), <https://fas.org/sgp/crs/misc/R43937.pdf> [<https://perma.cc/RGM8-MHFF>].

⁸² CARES Act § 3214.

⁸³ *Id.* § 3702.

⁸⁴ *Id.* § 3812.

⁸⁵ *Id.* § 3803.

B. Congress Knew the Mandate Was Unconstitutional

Typically, there is a presumption that Congress is “aware of relevant judicial precedent” when it enacts a new statute.⁸⁶ If we were to assume, consistent with this presumption, that Congress was aware of all relevant caselaw when it applied and extended the ACA via the FFCRA and the CARES Act, we would assume the following. First, Congress was aware that *NFIB v. Sebelius* upheld the mandate penalty as an exercise of Congress’s taxing power. Thus, when Congress reduced the mandate penalty to \$0, it was aware that mandate’s constitutional support evaporated. Second, we would also assume that Congress was aware that two federal courts had already ruled the mandate unconstitutional prior to March 2020, when it passed the FFCRA and the CARES Act. Given these assumptions, the FFCRA and the CARES Act must be seen as an implicit override of the severability ruling in *Texas v. United States*. Congress knew the mandate was unconstitutional. Nevertheless, it applied and extended the ACA via the FFCRA and the CARES Act.

There is, however, no need to rely on presumptions to draw this conclusion. Congress had actual knowledge of the unconstitutionality of the mandate when it passed the FFCRA and the CARES Act. The Attorney General notified Congress in June of 2018 that DOJ viewed the individual mandate as unconstitutional and would not defend it in court.⁸⁷ Moreover, Congress documented its knowledge of the district court’s ruling in *Texas v. United States*. Just weeks after the court issued its decision, the United States House of Representatives voted by resolution to intervene in the case.⁸⁸ The House then intervened and joined the appeal of the *Texas v. United States* decision.⁸⁹ Following the Fifth Circuit’s decision that ruled the mandate unconstitutional, the House then joined *California v. Texas* as a respondent supporting the state petitioners.⁹⁰ All of this happened *before* Congress applied and extended the ACA by passing the FFCRA and the CARES Act.⁹¹

⁸⁶ *Merck & Co. v. Reynolds*, 559 U.S. 633, 648 (2010).

⁸⁷ Letter from Jefferson B. Sessions, Att’y Gen., to Paul Ryan, Speaker, House of Representatives (June 7, 2018), <https://www.justice.gov/file/1069806/download> [<https://perma.cc/H43U-FAFC>]. The Attorney General is required to notify Congress when DOJ will not defend the constitutionality of a federal statute in court. 28 U.S.C. § 530D(a)(1)(B)(ii).

⁸⁸ H.R. Res. 6, 116th Cong. § 103(n) (2019), <https://www.congress.gov/116/bills/hres6/BILLS-116hres6eh.pdf> [<https://perma.cc/A8LJ-WUNX>].

⁸⁹ *Texas v. United States*, 945 F.3d 355, 373–74 (5th Cir. 2019), *cert. granted sub nom. California v. Texas*, 140 S. Ct. 1262 (2020).

⁹⁰ See Blanket Consent Filed by Respondent, U.S. House of Representatives, *California v. Texas*, No. 19-840 (S. Ct. Jan. 10, 2020), https://www.supremecourt.gov/DocketPDF/19/19-840/128206/20200110133802899_19-840%20-%20cert%20blanket%20consent.pdf [<https://perma.cc/4HHG-NYNR>] (noting that the U.S. House of Representatives is a respondent supporting the petitioner and consents to the filing of all amicus briefs).

⁹¹ The House of Representatives’ defense of the mandate before the Court of Appeals and the Supreme Court does not affect this analysis. Although the House may disagree with the district and

CONCLUSION

In March of 2020, Congress reshuffled the ACA deck of cards and dealt the Supreme Court a new hand—a hand the Court must play. When it passed the FFCRA and the CARES Act, Congress confirmed that the ACA stands, despite the loss of the individual mandate. Congress made this clear by incorporating, applying, and extending the ACA in twenty separate provisions of the FFCRA and the CARES Act. Rather than tussling over a “nebulous inquir[y] into hypothetical congressional intent”⁹² from 2010 or 2017, the Court should apply Congress’s override of the severability ruling in *Texas v. United States*. The FFCRA and the CARES Act provide the Court with a direct, superseding instruction on the issue of severability: the ACA stands despite an unconstitutional mandate.

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circuit court decisions, that disagreement does not alter the fact that Congress passed the FFCRA and the CARES Act with knowledge that the mandate had twice been ruled unconstitutional and could again be ruled unconstitutional by the Supreme Court.

⁹² *Seila Law LLC v. Consumer Fin. Prot. Bureau*, 140 S. Ct. 2183, 2220 (2020) (Thomas, J., concurring in part and dissenting in part) (quoting *United States v. Booker*, 543 U.S. 220, 320 n.7 (2005) (Thomas, J., dissenting in part)).

APPENDIX A

FFCRA INCORPORATIONS, APPLICATIONS, AND EXTENSIONS OF THE ACA

FFCRA Section	Explanation	Section(s) of the ACA Implicated
Div. A, tit. IV Second Corona- virus Preparedness and Response Sup- plemental Appro- priations Act, 2020. 134 Stat. 181	Appropriates \$64 million to the IHS until September 30, 2022 to provide COVID-19 items and services, as described in FFCRA § 6007, to Indians, as defined in the IH CIA, receiving health services through the IHS, including through UIOs.	ACA § 10221(a), which permanently reauthorized and updated the IH CIA (codified at 25 U.S.C. §§ 1601–1680v). As part of its ACA updates, the IH CIA authorizes IHS to grant funding to UIOs. <i>See</i> 25 U.S.C. §§ 1603(29), 1652.
Div. A, tit. V Second Corona- virus Preparedness and Response Sup- plemental Appro- priations Act, 2020. 134 Stat. 182	Appropriates \$1 billion to pay claims of health care providers for COVID-19 testing as described in FFCRA § 6001(a), provided to “uninsured individuals” during the emergency period. An “uninsured individual” is an individual not enrolled in (1) a federal health care program or (2) a group health plan or individual and group health insurance coverage as defined in § 2791 of the Public Health Service Act (PHSA) (codified at 42 U.S.C. § 300gg-91). The ACA patient protection and market reforms apply to group health plans and individual and group health insurance coverage as defined in PHSA § 2791. Thus, individuals without ACA-compliant private health insurance would be	ACA § 1001, which amended the PHSA to include individual and group health insurance reforms for individual and group health insurance coverage and group health plans defined in PHSA § 2791. ACA § 1551, which applies the definitions in PHSA § 2791 to the ACA.

	deemed “uninsured” even if that person has some other form of coverage.	
§ 6001(a), (b), (d) Coverage of Testing for COVID-19. 134 Stat. 201–02	Expands benefits offered by ACA group health plans and health insurers offering ACA group or individual health insurance coverage (including ACA grandfathered health plans) to include COVID-19 testing and related items and services without cost sharing during the emergency period. The section incorporated the definitions of “group health plan,” “health insurance issue,” “group health insurance coverage,” and “individual health insurance coverage” in PHSA § 2791, the Employee Retirement Income Security Act of 1974, and § 9832 of the Internal Revenue Code of 1986. These definitions define ACA plans and coverage.	<p>ACA § 1001, which amended the PHSA to include individual and group health insurance reforms for individual and group health insurance coverage and group health plans defined in PHSA § 2791.</p> <p>ACA § 1251(e), which defines grandfathered health plans).</p> <p>ACA § 1551, which applies definitions in PHSA § 2791 to the ACA.</p> <p>FFCRA § 6001(b) requires § 6001(a) to be applied as if included in part A of title XXVII of the PHSA, which includes the ACA’s individual and group market reforms, including, but not limited to, the ACA’s community rating and guaranteed issue requirements (codified at 42 U.S.C. §§ 300gg-1, 300gg-3, 300gg-4).</p> <p>ACA § 1201, which amended the PHSA to include health insurance market reforms for individual and group health insurance and group health plan coverage defined in PHSA § 2791.</p>

<p>§ 6004(a)(1), (2) Coverage at No Cost Sharing of COVID-19 Testing Under Medicaid and CHIP. 134 Stat. 204-05</p>	<p>Expands Medicaid benefits to include coverage for COVID-19 testing and related items and services without cost sharing during the emergency period. These expanded benefits apply to Medicaid coverage expanded under ACA. <i>See</i> 42 U.S.C. § 1396d(a)(xiv).</p>	<p>ACA § 2001, which expands Medicaid coverage to low-income individuals. <i>See</i> 42 U.S.C. § 1396a(a)(10)(A)(i)(VII).</p>
<p>§ 6004(a)(3)(A)–(C) Coverage at No Cost Sharing of COVID-19 Testing Under Medicaid and CHIP. 134 Stat. 205–06</p>	<p>Gives states the option to extend Medicaid eligibility to “uninsured individuals” for purposes of providing COVID-19 testing and related items and services during the emergency period. An “uninsured individual” for the purpose of this section is a person not eligible for ACA’s Medicaid expansion (in expansion states) and not enrolled in a federal health care program, a federal employee plan, or a group health plan or individual and group health insurance coverage as defined in § 2791 of the PHSA. Like FFCRA Div. A, tit. V, the § 6004 definition of “uninsured” incorporates the definition of ACA group plans and individual and group health insurance coverage. It also incorporates the definition of ACA Medicaid expansion coverage. Individuals without ACA-compliant private health insurance would be deemed “uninsured” even if that</p>	<p>ACA § 1001, which amended the PHSA to include individual and group health insurance reforms for individual and group health insurance coverage and group health plans defined in PHSA § 2791.</p> <p>ACA § 1551, which applies definitions in PHSA § 2791 to the ACA.</p> <p>ACA § 2001, which expands Medicaid coverage to low-income individuals.</p>

	person has some other form of coverage and would therefore be eligible for this extended Medicaid coverage.	
§ 6007 Coverage of Testing for COVID-19 at No Cost Sharing for Indians Receiving Purchased/Referred Care. 134 Stat. 208	Expands coverage for Indians, as defined in IHCIA § 4, receiving health services through the IHS, including through a UIO, to include COVID-19 testing and related items and services or the administration of such products during the emergency period.	ACA § 10221(a), which permanently reauthorized and updated the IHCIA (codified at 25 U.S.C. §§ 1601–1680v). As part of its ACA updates, the IH-CIA authorizes IHS to grant funding to UIOs. <i>See</i> 25 U.S.C. §§ 1603(29), 1652.
§ 6008 Temporary Increase of Medicaid FMAP. 134 Stat. 208–09	Provides states with temporary increase in federal Medicaid funding during the emergency period. States accepting this funding many not impose new Medicaid eligibility restrictions or take away Medicaid coverage during the public health emergency. The bar on eligibility restrictions and Medicaid terminations applies ACA-expanded Medicaid coverage.	ACA § 2001, which expands Medicaid coverage to low-income individuals.

APPENDIX B

CARES ACT INCORPORATIONS, APPLICATIONS, AND EXTENSIONS OF THE ACA

CARES Act Section	Explanation	Section(s) of ACA Implicated
<p>§ 3201 Coverage of Diagnostic Testing For COVID-19. 134 Stat. 366–67</p>	<p>Amends the definition of a COVID-19 diagnostic test enacted in FFCRA § 6001(a) to include a broader range of covered diagnostic items and services. FFCRA § 6001(a) expands benefits offered by ACA group health plans and health insurers offering ACA group or individual health insurance coverage (including ACA grandfathered health plans) to include COVID-19 testing and related items and services without cost sharing during the emergency period.</p>	<p>Sections of the ACA implicated by FFCRA § 6001(a), including: ACA § 1001, which amended the PHSA to include individual and group health insurance reforms for individual and group health insurance coverage and group health plans defined in PHSA § 2791.</p> <p>ACA § 1251(e), which defines grandfathered health plans.</p> <p>ACA § 1551, which applies definitions in PHSA § 2791 to the ACA.</p> <p>FFCRA § 6001(b) requires § 6001(a) to be applied as if included in part A of title XXVII of the PHSA, which includes the ACA’s individual and group market reforms, including, but not limited to, the ACA’s community-rating and guaranteed-issue requirements (codified at 42 U.S.C. §§ 300gg, 300gg-1, 300gg-3,</p>

		<p>300gg-4).</p> <p>ACA § 1201, which amended the PHSAs to include health insurance market reforms for individual and group health insurance and group health plan coverage defined in PHSAs § 2791.</p>
<p>§ 3202 Pricing of Diagnostic Testing. 134 Stat. 367</p>	<p>Requires ACA group health plans and health insurers offering ACA group or individual health insurance coverage (including ACA grandfathered health plans) that are providing coverage of COVID-19 diagnostic testing and related items and services pursuant to FFCRA § 6001(a) to reimburse health care providers at either the negotiated rate or, if the plan or issuer does not have a negotiated rate with the provider, the listed cash price for that service.</p>	<p>Sections of the ACA implicated by FFCRA § 6001(a), including ACA § 1001, which amended the PHSAs to include individual and group health insurance reforms for individual and group health insurance coverage and group health plans defined in PHSAs § 2791.</p> <p>ACA § 1251(e), which defines grandfathered health plans. ACA § 1551, which applies definitions in PHSAs § 2791 to the ACA.</p>
<p>§ 3203 Rapid Coverage of Preventive Services and Vaccines for Coronavirus. 134 Stat. 367–68</p>	<p>Expands benefits offered by ACA group health plans and health insurers offering ACA group or individual health insurance coverage by requiring group health plans and health insurance issuers offering group or individual health insurance to cover, without cost-sharing, any qualifying coronavirus preventive ser-</p>	<p>ACA § 1001, which amends the PHSAs to include individual and group health insurance reforms for individual and group health insurance coverage and group health plans defined in PHSAs § 2791.</p> <p>ACA § 1001, which amends the PHSAs to</p>

	<p>vice, pursuant to section PHSA § 2713(a) (codified at 42 U.S.C. 300gg-13(a)). The terms “group health plan,” “health insurance issuer,” “group health insurance coverage,” and “individual health insurance coverage” have the meanings given in PHSA § 2791.</p>	<p>require group health plans and providers of individual and group health insurance to cover recommended preventive services and screenings and immunizations without cost sharing.</p> <p>ACA § 1551, which applies definitions in PHSA § 2791 to the ACA.</p>
<p>§ 3211 Supplemental Awards for Health Centers. 134 Stat. 368</p>	<p>Supplements ACA funding of the Health Center Program by appropriating \$1.32 billion to federal health centers for the detection of the COVID-19 virus, or prevention, diagnosis, and treatment of COVID-19.</p>	<p>ACA § 5601(a), which permanently authorized the federal Health Center Program.</p>
<p>§ 3214 United States Public Health Service Modernization. 134 Stat. 372-73</p>	<p>Amends § 203 of the PHSA to allow the Ready Reserve Corps to be activated during a public health emergency.</p>	<p>ACA § 5210, which amends § 203 of the PHSA (codified at 42 U.S.C. § 204), to establish a Ready Reserve Corps to have additional Commissioned Corps personnel available on short notice, similar to the uniformed services’ reserve program.</p>
<p>§ 3702 Inclusion of Certain Over-the-Counter Medical Products as Qualified Medical Expenses. 134 Stat. 416</p>	<p>Amends Internal Revenue Code § 233(d)(2) to allow patients to use funds in Health Savings Accounts (HSAs) and Flexible Spending Accounts (FSAs) for the purchase of menstrual care products and over-the-counter medical products</p>	<p>ACA § 9003, which previously permitted the use of funds from HSAs and FSAs only to pay for prescribed medicines or drugs.</p>

	without a prescription from a physician. <i>See</i> 26 U.S.C. § 223(d)(2).	
§ 3710 Medicare Hospital Inpatient Prospective Payment System Add-On Payment for COVID-19 Patients During Emergency Period. 134 Stat. 422	Amends the Medicare inpatient payment formula to increase payments by increasing the weighting factor that applies to the diagnosis-related group (DRG) for patients diagnosed with COVID-19 by twenty percent.	Medicare's inpatient hospital payment statute was extensively amended by the ACA, including provisions related to adjustments to Medicare DRG payments, including ACA §§ 3001, 3025.
§ 3716 Clarification Regarding Uninsured Individuals. 134 Stat. 425	Clarifies that "uninsured" individuals under FFCRA § 6004, which allows states to expand Medicaid coverage to "uninsured" individuals, includes individuals in a state that did not expand Medicaid under the ACA and individuals who are enrolled in a government program, but whose benefits under such a program do not meet the ACA definition of "minimum essential coverage."	ACA § 1501(b), which sets out the definition of "minimum essential coverage" (codified at 26 U.S.C. § 5000A(f)). ACA § 2001, which expands Medicaid coverage to low-income individuals.
§ 3803 Extension of Funding Outreach and Assistance for Low-Income Programs. 134 Stat. 428-29	Amends the Medicare Improvements for Patients and Providers Act of 2008 § 119(a)(1)(B), as amended by ACA § 3306, to extend funding for outreach and assistance for low-income programs. <i>See</i> Pub. L. No. 110-275, § 119(a)(1)(B), 122 Stat. 2492, 2508 (2008) (codified as amended at 42 U.S.C. § 1395b-3).	ACA § 3306, which amends the Medicare Improvements for Patients and Providers Act of 2008 § 119(a)(1)(B).
§ 3812 Extension of Spousal	Amends ACA § 2404 to extend the Medicaid spousal	ACA § 2404, which provided Medicaid spousal

<p>Impoverishment Pro- tections. 134 Stat. 429</p>	<p>impoverishment protections program through November 30, 2020. Spousal impoverishment protections prevent married couples from becoming poverty-stricken in order for one of the spouses to qualify for long-term care under Medicaid.</p>	<p>impoverishment protec- tions for a limited time period.</p>
<p>§ 3813 Delay of DSH Reduc- tions. 134 Stat. 429–30</p>	<p>Amends Social Security Act § 1923(f)(7)(A) (codified at 42 U.S.C. 1396r–4(f)(7)(A)) to delay scheduled reduc- tions in Medicaid dispropor- tionate share hospital (DSH) payments through Novem- ber 30, 2020.</p>	<p>ACA § 2551, which amends Social Security Act § 1923(f) to insert subsection (7), which reduces DSH payments (codified at 42 U.S.C. 1396r–4(f)(7)).</p>
<p>§ 3831 Extension for Com- munity Health Cen- ters, the National Health Service Corps, and Teaching Health Centers That Operate GME Programs. 134 Stat. 433–34</p>	<p>Amends ACA § 10503(b)(1)(F) to extend funding for the Community Health Center Fund (CHCF).</p>	<p>ACA § 10503(b)(1)(F), which created and ap- propriated funds to the CHCF (codified at 42 U.S.C. § 254b- 2(b)(1)(F)).</p>
<p>Div. B, tit. VII Department of Health and Human Services Indian Health Service Indian Health Ser- vices. 134 Stat. 550–51</p>	<p>Appropriates \$1.032 billion, available until September 30, 2021, to “prevent, pre- pare for, and respond to coronavirus” for “Indian Health Services” provided that not less than \$450 mil- lion shall be distributed through IHS programs and to tribes and tribal organiza- tions under the Indian Self- Determination and Educa- tion Assistance Act and through contracts or grants with UIOs under the IHCA.</p>	<p>ACA § 10221(a), which permanently reauthorized and updated the IHCA (codified at 25 U.S.C. §§ 1601–1680v). As part of its ACA updates, the IHCA authorizes IHS to grant funding to UIOs. <i>See</i> 25 U.S.C. §§ 1603(29), 1652.</p>