**CHRONIC DISEASE AND HEALTHCARE COSTS: IMPLICATIONS OF THE AFFORDABLE CARE ACT AND SUBSEQUENT SUPREME COURT DECISIONS**

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**ABSTRACT**

American public health has enjoyed successes in infectious disease prevention, healthcare access expansion, workplace safety, and other areas. Yet due to chronic disease, an area of public health significance, Americans face worsening health outcomes and exorbitant healthcare costs. The federal government included provisions in the Patient Protection and Affordable Care Act (PPACA) in order to improve these issues, including population based prevention, clinical prevention, and healthcare payment and organizational reforms. Each of these may have a long term impact upon chronic diseases and their associated costs by focusing on prevention and chronic disease management. Recent Supreme Court decisions, however, have had an effect on these laws. First, the Court’s Medicaid expansion decision in *National Federation of Independent Business v. Sebelius* limited the proliferation of clinical-based preventive based services. Second, the *Burwell v. Hobby Lobby Stores, Inc.* decision likely opened employer and insurer mandated preventive services to legal attack. While the PPACA did not cure the chronic disease and cost issues that the United States faces, it contains essential steps in the nation’s incremental health policy process.

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1. Introduction

Research suggesting that U.S. children risk living shorter lives on average than their parents for the first time in two centuries places into stark focus the importance of health reform.[[1]](#footnote-1) In previous eras, infectious diseases often proved themselves prominent hazards to the public’s health.[[2]](#footnote-2) The mother of all pandemics, the 1918 Spanish Flu, took the lives of up to 100 million individuals,[[3]](#footnote-3) and the Black Death of the 14th Century claimed as much as 60 percent of Europe’s population.[[4]](#footnote-4) Tuberculosis, pneumonia, and various fevers have taken untold additional numbers of lives. These and similar catastrophes were central drivers of health reform for centuries.

Thanks to powerful public health measures, infectious disease deaths have plummeted to historic lows.[[5]](#footnote-5) Public health engineering and environmental health initiatives, such as sanitation infrastructure, constituted public health’s main historical thrust.[[6]](#footnote-6) With the advent of modern medicine, antibiotics and vaccines later entered the stage and made further progress in the fight against infectious disease. These reforms have effectively eradicated smallpox from our world, and other diseases such as polio are drastically curtailed save in some lingering locations. Apart from emerging and reemerging agents including drug resistant tuberculosis, pandemic influenza, and the risk wrought by antimicrobial resistance, the nation is at small risk from many pathogens of the old world.[[7]](#footnote-7)

Despite our advances against infectious disease, U.S. longevity is threatened by an established and growing chronic disease crisis.[[8]](#footnote-8) Chronic disease, not infectious disease, constitutes the primary challenge facing 21st Century public health. The incidence rates of diabetes, cardiovascular disease, and other chronic diseases are frightening as our health system has achieved little success in curtailing them. Due to an advancing industrial and urban society, combined with the shift from infectious disease, these chronic diseases are responsible for 70 percent of all deaths in our nation.[[9]](#footnote-9) If current trends continue, 33 percent of all U.S. citizens will develop diabetes in their lifetimes. Nearly 40 percent of Americans now have two or more prominent risk factors for heart disease and stroke.[[10]](#footnote-10) Obesity, a tell-tale risk factor for chronic diseases including heart disease, diabetes, and stroke, afflicts over one-third of all U.S. adults[[11]](#footnote-11) and approximately 20 percent of children aged 6 to 19.[[12]](#footnote-12) It is difficult to understate the danger brought on by chronic disease: these startling figures reveal the status, and more frighteningly, the direction of U.S. health absent reforms that drive incidence rates lower.

While spending more than $7,000 per individual and nearly 20 percent of our gross domestic product on healthcare expenditures, it is reasonable to expect that U.S. healthcare should significantly improve these ills.[[13]](#footnote-13) Surely, with these remarkably high costs, and 75% of all healthcare spending devoted to individuals with chronic conditions,[[14]](#footnote-14) our healthcare system should at least provide similar longevity results to other industrialized nations. Yet due largely to chronic disease, average life expectancy in the United States embarrassingly trails many other nations that spend half as much or less on healthcare. In fact, among the Organisation for Economic Co-Operation and Development member nations, our nation ranks behind twenty-six other industrialized nations in longevity.[[15]](#footnote-15)

Other cost and outcome problems afflicting the U.S. population have driven reform legislation since the beginning of the last century. Nearly 100 years ago, Theodore Roosevelt nationalistically advocated for universal coverage, stating that “no country can be strong if its people are sick and poor.”[[16]](#footnote-16) Later, the federal government brought about Medicare, health maintenance organization support, and other corrective measures. More recently, the landmark Patient Protection and Affordable Care Act (PPACA) focused primarily on correcting access issues by expanding coverage to millions of uninsured Americans.[[17]](#footnote-17)

Certainly, improved access is a positive step for the nation’s health issues, yet our health and financial woes will not find substantive relief through greater access to tertiary medicine.[[18]](#footnote-18) Chronic diseases are driven by factors far outside the reach of the doctor’s office and hospital.[[19]](#footnote-19) Therefore, absent a fundamental shift of medicine’s tertiary focus towards public health, reformers must look within and beyond the PPACA’s public health preventive advancements for meaningful corrections to these problems.

In Part II, this paper describes the nation’s healthcare access developments, cost problems, and expenditures related to chronic disease. In Part III, it details the PPACA’s preventive provisions, including public health funding, improved access to preventive services, and healthcare organizational and reimbursement improvements that incentivize the prevention and mitigation of chronic disease. With these provisions, the PPACA took important yet limited steps towards chronic disease mitigation. Finally, this paper describes the implications of recent Supreme Court decisions on preventive services. The Court’s decisions in *National Federation of Independent Businesses v. Sebelius* has had a substantial impact on preventive services under Medicaid, and *Burwell v. Hobby Lobby Stores, Inc.* may open employer based preventive services requirements to litigation pursuant to the Religious Freedom Restoration Act.

# Access to and cost issues of the U.S. Medical System

## access: The Tortured expansion of insurance

With the nation’s industrial advancement, policymakers have long sought to bring contemporary medicine to the far reaches and rural areas of the nation. While the metropolises of the East Coast offered ever advancing health centers, Americans elsewhere have not historically had access to comparable hospitals. Although Congress sought to remedy this issue with a proliferation of hospitals through passage of the Hill-Burton program, millions of Americans still faced significant access barriers because they lacked health insurance.[[20]](#footnote-20) Accordingly, the federal government took significant yet politically difficult steps to insure older and indigent Americans through Medicare and Medicaid during the 1960s.[[21]](#footnote-21)

These programs are part of a longer narrative of coverage expansion efforts. Social coverage gained notoriety but ultimately failed in California and New York during the 1910s.[[22]](#footnote-22) Yet similar coverage expansions were well underway in other industrialized nations such as Britain and Germany. Indeed, many proponents of expanded coverage such as Theodore Roosevelt took a nationalistic view of coverage expansion.[[23]](#footnote-23) Despite Europe’s movement and momentum at home, social coverage here failed to stick.

 After the complacency of the post-WWI years, social coverage again gained attention in President Roosevelt’s New Deal and President Truman’s agenda, but did not become law due to a number of political and industry factors.[[24]](#footnote-24) Insurance expansions continued to earn national consideration after Medicare and Medicaid became law, but significant reform did not pass until the PPACA. While the PPACA expands Medicaid and provides insurance subsidies for other individuals, what persists today is a fractured, patchwork system of coverage including Medicare, Medicaid, COBRA, CHIP, Veterans healthcare, employer based coverage, and personal insurance. Nonetheless, federal action has largely remedied the strongest barrier to tertiary medical services.

## costs

National healthcare costs, driven by a focus on tertiary cures, are increasingly problematic. In 2010, U.S. healthcare expenditures reached $2.6 trillion and made up 17.6% of national GDP.[[25]](#footnote-25) Comparatively, the United States spends less than a quarter of that amount on public education.[[26]](#footnote-26) While healthcare cost inflation has decelerated recently, likely due to the Great Recession, the Congressional Budget Office projects that costs will soon resume their upward march. More specifically, healthcare cost inflation will average 5.8 percent and outpace the growth of the national economy by 1.1 percent through 2020.[[27]](#footnote-27) By then, healthcare spending is expected to reach $4.6 billion and make up nearly 20 percent of U.S. GDP.[[28]](#footnote-28)

Following a decades-long upward trend, the government’s share will comprise 50 percent of all healthcare spending as more individuals will use Medicare, Medicaid, and insurance exchange subsidies.[[29]](#footnote-29) Specifically, Medicare spending will continue to rise well above the rate of national inflation in the absence of physician cost reforms instituted by the Medicare Sustainable Growth Rate (SGR) formula.[[30]](#footnote-30) Overall, the CBO projects that Medicare growth will average 6.3 percent between 2013 and 2020.[[31]](#footnote-31) Medicaid will likely follow similar growth patterns, partly driven by ACA coverage expansions, as the program will soon cover 75.6 million individuals.[[32]](#footnote-32) The program’s costs are projected to grow 7.5 percent per year and account for 20 percent of national health expenditures by 2020.[[33]](#footnote-33)

Catalytic healthcare spending is not limited to the public sector.[[34]](#footnote-34) Although Medicare and Medicaid have troubling growth rates, private insurance spending will follow a similar course.[[35]](#footnote-35) More specifically, private insurance spending will increase above inflation as well, as premiums are expected to increase an average of 5.6 percent per year between 2015 and 2020.[[36]](#footnote-36) CBO data demonstrates that cost inflation is not simply an entitlement issue; rather, cost problems are systemic across all American healthcare.

Importantly, these data also detail shrinking employer based coverage as many businesses struggle under healthcare costs.[[37]](#footnote-37) While employer based insurance was the primary bulwark of American coverage following the Second World War, the persistent private cost increases have exacted immense pressure on employers. While the burden upon employers eased when managed care capitation methods drastically slowed cost inflation, systemic issues have reversed this trend.

In addition to near term cost growth, the CBO provides longer term projections which show drastic increases in health expenditures. By 2037, total U.S. health expenditures may comprise 25 percent of GDP.[[38]](#footnote-38) The sustainability of our healthcare system, and indeed our entire federal budget, teeters on these bloated costs. Nearly one out of every five U.S. dollars is already devoted to healthcare, and federal data suggests that this figure may well increase to one of four. Somehow the nation may have to squeeze defense, infrastructure, education, research and development, social security, housing, transportation, and other vital expenditures into a shrinking share of resources. The burden of healthcare costs, which already cause access problems and significant employer stress, will become an ever weightier anvil tied to our national economy.

## chronic disease burdens and costs

As the U.S. searches for ways to improve the nation’s health status and control healthcare expenditures, policymakers must understand the nature and impact of chronic disease and its relationship to the tertiary focus of U.S. medicine. Chronic diseases are the nation’s leading cause of death and disability.[[39]](#footnote-39) Cardiovascular disease, smoking induced lung cancer, diabetes, stroke, and others account for 70 percent of all deaths.[[40]](#footnote-40) By 2020, researchers expect that approximately half of all Americans (157 million) will suffer from one chronic disease, and nearly a quarter (81 million) will suffer from multiple conditions despite significant access reforms.[[41]](#footnote-41) Diabetes, along with its costly and chronic complications, is expected to eventually afflict 33 percent of all individuals born in the year 2000 following years of growing incidence.[[42]](#footnote-42) Tobacco use, known for decades as a morbid activity, exposes smokers and nonsmokers to significant risks. Compared to non-smokers, smokers are up to four times more likely to develop coronary heart disease, have a four-fold higher risk of from stroke, and are up to twenty-five times more likely to contract lung cancer.[[43]](#footnote-43) These chronic conditions, caused by poor diet, lack of exercise, and a variety of social and environmental factors are putting generations at risk for significantly shorter lifespans.

Chronic conditions walk hand in hand with healthcare costs, and the high growth of these conditions marks a costlier future. The CDC claims that they drive at least 75 percent of all health care costs.[[44]](#footnote-44) Researchers have determined that of the top 5 percent healthcare spending patients, 90 percent have at least one chronic condition.[[45]](#footnote-45) Hypertension, high cholesterol, diabetes, and heart disease are pervasively common in the top spenders compared to the remainder of the population, particularly among non-elderly individuals.[[46]](#footnote-46)

Research also provides insight into the total direct and indirect costs of chronic conditions. For instance, five particularly prevalent chronic conditions, including heart conditions, cancer, COPD, diabetes, and hypertension, comprised 30 percent of all U.S. healthcare expenditures in 2010.[[47]](#footnote-47) Other researchers claim that chronic conditions cost the national economy approximately $1.3 trillion dollars in direct and indirect costs, and that such costs could rise significantly by 2050.[[48]](#footnote-48)

# chronic disease, a tertiary medical system, and ppaca reforms

A significant reason why the U.S. healthcare system hasn’t achieved strong results lies in its methods, and continuing to rely on expanded access through Medicare, Medicaid, and the PPACA will not solve the nation’s chronic disease ills. Of course, healthcare providers do treat chronic diseases. A physician, for example, may prescribe pharmaceuticals to lower blood pressure and cholesterol, and a surgeon may remove blood clots brought on by obesity. Yet our medical system, despite robust funding, has not effectively curbed chronic disease.

While essential in many injury situations, the U.S. system focuses predominately on individual and tertiary aspects of health to the detriment of prevention and public health.[[49]](#footnote-49) Medicine’s focus does not reach far beyond the hospital or office to the complex and multiple determinates of chronic disease. For instance, individual decisions to use tobacco, lead a sedentary lifestyle, and follow a harmful diet do not find cures in drugs or surgeries. Further, our fee-for-service system does not reimburse a physician for educating patients about the dangers of these behaviors.[[50]](#footnote-50) Too often, our system only acts when chronic disease patients arrive in emergency departments showing signs costly, complicated, and dangerous conditions.

In addition to medicine’s limited reach over individual decisions, it fails to correct deficiencies in the built environment that factor into chronic disease incidence.[[51]](#footnote-51) Unhealthy, inexpensive, and ultimately dangerous food options line urban streets, low density urban centers encourage individuals to use automobiles for short distance travel, and dangerous neighborhoods often preclude exercise. Remedying these problems takes place outside physician offices and emergency departments, where insurance access has little to no effect. Because of its focus on improving the built environment and conditions in which people live, public health is better poised than healthcare access reform to correct these deficiencies.

The nature of chronic disease and how individuals pay for medical services further reduce tertiary medicine’s potential to reduce our ills. Unlike many acute injuries, chronic diseases manifest after years of exposure to risk factors. Cardiovascular disease, for example, may only harm an individual after years of risk factors such as unhealthy eating and a lack of exercise accumulate. The financial harms of chronic disease follow a similar paradigm. Only after years of poor decision making combined with social and environmental risk factors do individuals face the financial costs of chronic disease, and even then individuals may face limited repercussions through cost sharing for medical services.

The PPACA contains a variety of reforms that have the potential to reduce chronic disease incidence. These include public health directives and grants, evidence based clinical prevention, and system organization reforms. Although the nation took a significant step forward in preventive based policy with passage of the PPACA, the Supreme Court’s decision in *National Federation of Independent Business v. Sebelius*[[52]](#footnote-52) significantly affected access to clinical preventive efforts amongst many of the sickest and costliest patients. While the Court’s closely watched decision regarding the constitutionality of the “individual mandate” did not implicate these services, its decision to strike Congress’ expansion of Medicaid did. The impact of judicial decisions did not end with the *Sebelius* case, however. Although *Burwell v. Hobby Lobby Stores, Inc.*[[53]](#footnote-53) focused on employer based objections to contraceptives, the decision may open other preventive measures in the PPACA to similar litigation.

## public health task forces, funding, and evidence-based preventive measures

The newly created Prevention and Public Health Fund (Prevention Fund) provides $15 billion over 10 years[[54]](#footnote-54) to stimulate wellness, prevention, and other public health initiatives that improve health and restrain the rate of growth in healthcare costs.[[55]](#footnote-55) These include prevention research, health screenings, health education, and immunization programs.[[56]](#footnote-56) HHS has recently funded programs in Alzheimer’s disease prevention education and outreach, chronic disease self-management, and diabetes and heart disease prevention.[[57]](#footnote-57) Scholars, however, argue that the Prevention Fund is poorly funded, especially in comparing it to the impact of preventable diseases and tertiary spending applied to them.[[58]](#footnote-58) In addition, the PPACA does not mandatorily appropriate funding, instead only loosely authorizing “monies in the Treasury not otherwise appropriated.”[[59]](#footnote-59) This language leaves the fund at risk to future budgetary setbacks.

By Executive Order through the PPACA, the National Prevention, Health Promotion, and Public Health Council (Council) must develop a national prevention, health promotion, public health, and integrative healthcare strategy. [[60]](#footnote-60) Notably, the strategy must focus on reducing the incidence of preventable illness and disability.[[61]](#footnote-61) The Council shall also provide coordination among federal entities with respect to prevention, wellness, health promotion, the public health system, and integrative care.[[62]](#footnote-62) As the nation’s healthcare and public health systems are considerably separated, this measure reflects federal efforts to integrate the systems in order to drive efficiency and efficacy. However, the PPACA fails to discuss implementation of the Council’s recommendations, rather tasking it with providing recommendations to the President and Congress.[[63]](#footnote-63)

The Centers for Disease Control and Prevention (CDC) must carry out an additional public health measure. The CDC must create a Preventive Services Task Force (Task Force) which shall review empirical evidence pertaining to the effectiveness, appropriateness, and cost effectiveness of community preventive interventions.[[64]](#footnote-64) These reviews must be used to develop recommendations for a broad range of entities delivering population based services.[[65]](#footnote-65) The PPACA requires that in completing this objective, the Task Force must coordinate with the U.S. Preventive Services Task Force and the Advisory Committee on Immunization Practices.[[66]](#footnote-66)

In order to better educate the public on health improvement, the Department of Health and Human Services (HHS) is required by the PPACA to plan and implement a national public-private partnership for prevention and health promotion education.[[67]](#footnote-67) This partnership must disseminate information on the importance of utilizing preventive services, encourage behaviors that reduce the risk of chronic diseases, and disseminate other information to the public that may reduce the burden of chronic disease.[[68]](#footnote-68) In addition, HHS must build a personalized prevention plan tool accessible through the Internet.[[69]](#footnote-69) This website shall contain tools used to determine individual disease risk relating to leading diseases afflicting the U.S. population and methods for prevention.[[70]](#footnote-70)

## healthcare organizational and payment reforms

Within the PPACA, Congress created the Center for Medicare and Medicaid Innovation (CMMI) to help contain healthcare spending.[[71]](#footnote-71) CMMI is directed to evaluate payment and delivery models that reduce the Centers for Medicare and Medicaid Services’ (CMS) expenditures while upholding or improving healthcare quality.[[72]](#footnote-72) In carrying out its duties, CMMI is directed to consult with representatives of relevant agencies and clinical and analytical experts in healthcare.

Per the PPACA, CMMI is advised, but not required, to explore numerous priorities.[[73]](#footnote-73) These include, but are not limited to: primary care payment and practice reforms such as medical homes;[[74]](#footnote-74) transitioning away from fee-for-service reimbursement models towards population and performance models;[[75]](#footnote-75) risk based and salary based payments for groups of providers;[[76]](#footnote-76) coordination and comprehensive care improvements;[[77]](#footnote-77) and improvements to chronic disease management.[[78]](#footnote-78)

CMMI is particularly influential because its cost containing and quality promoting models can be implemented by HHS without congressional approval.[[79]](#footnote-79) More specifically, the Secretary of HHS through rulemaking may expand the duration and scope of a model if the model is expected to reduce spending while maintaining or improving quality.[[80]](#footnote-80)

Another critical PPACA reform for prevention is the accountable care organization (ACO).[[81]](#footnote-81) The statute requires the Secretary of HHS to establish a shared savings program that encourages groups of providers to integrate in order to manage and coordinate care for individuals covered by Medicare.[[82]](#footnote-82) These ACOs are eligible to keep savings generated as a result of their organizational reforms provided performance standards are met.[[83]](#footnote-83) A variety of professionals and entities are eligible to form an ACO: these include group and individual practices, partnerships or joint ventures between practitioners and hospitals, hospitals employing ACO practitioners, and other groups determined by the Secretary of HHS.[[84]](#footnote-84)

An ACO is required take financial accountability for the quality, cost, and overall care of its Medicare beneficiaries[[85]](#footnote-85) for a period of not less than 3 years.[[86]](#footnote-86) To incentivize providers and suppliers to meet performance goals, an ACO is required to create a formal legal structure that will distribute shared savings to them. [[87]](#footnote-87) Additionally, ACOs must promote evidence based medicine, patient engagement, and care coordination among their patients and providers.[[88]](#footnote-88)

Other commentators have described how these payment reforms, such as ACOs, entice providers to collaborate in order to improve disease prevention.[[89]](#footnote-89) Additionally, these models are important for the prevention of chronic diseases due to their potential to shift reimbursement models from fee-for-service towards other, preventive friendly constructs. Fee-for-service, which has long dominated U.S. healthcare, incentivizes providers to increase their volume of services to the detriment of prevention and public health.[[90]](#footnote-90) For instance, under such a model, physicians are incentivized to see numerous patients, but not to spend extra appointment time counseling those patients on preventive behaviors that reduce the risk for chronic disease.[[91]](#footnote-91) In effect, fee-for-service does not incentivize providers to maintain or improve their patients’ health, but rather to provide voluminous tertiary medical services.

Risk-based payment models, on the other hand, place the financial risk of a covered patient’s health outcome into hands of the provider, whether or not that outcome is accompanied with costly chronic diseases. For instance, in capitated models, a physician is provided a set payment for each patient within his or her patient pool for the entire cost of the patient’s healthcare.[[92]](#footnote-92) If the physician minimizes or prevents chronic diseases, then he or she will ultimately save money by avoiding costly tertiary measures such as medications, imaging scans, and specialist consultations. In effect, in contrast to fee-for-service arrangements, risk based payment models incentivize providers to prevent chronic diseases or minimize their impact in their patient pools.

## clinical preventive services in private insurance and medicare

In addition to the broad initiatives detailed above, the PPACA enlarged coverage for clinical preventive services for a large portion of the nation.[[93]](#footnote-93) Non-grandfathered private insurance plans are now required to provide coverage for services recommended by the U.S. Preventive Services Task Force (USPSTF) with no deductibles, co-insurance, or other cost sharing requirements.[[94]](#footnote-94) Current chronic disease focused services include measures for diabetes, tobacco use, blood pressure, heart disease, obesity, and alcohol abuse.[[95]](#footnote-95) Immunizations recommended by the Advisory Committee on Immunization Practices of the CDC are also covered by the statute.[[96]](#footnote-96)

In effect, all individuals with private insurance are better encouraged to use preventive services, since all costs for these services will find their way into insurance premiums rather than upfront fees. Previously, these services would have been subjected to medical necessity rules, and cost sharing requirements would have discouraged their use. Typically, cost sharing under consumer driven healthcare is meant to reduce utilization of unnecessary services and products in order to reduce costs.[[97]](#footnote-97) Indeed, consumer driven healthcare is important to reducing expenditures through consumer choice and competition. Preventive services, however, are highly cost effective compared to most tertiary measures. While causing up-front costs, they can drastically reduce the need for downstream, costly procedures and medications.

Notably, the list of services is dynamic as all services currently given an “A” or “B” rating by the USPSTF are covered by the provision.[[98]](#footnote-98) The USPSTF is an independent collection of experts that reviews empirical evidence of such services and provides an “A” grade when evidence suggests a high certainty that the net benefit of the service is substantial, and a “B” grade when the net benefit is moderate.[[99]](#footnote-99) Therefore, with additional research, other promising services may be added while less beneficial services removed without the need for legislative intervention.

While private insurers cover a substantial proportion of the nation’s population, many other individuals would have missed out on preventive coverage if the benefits had not been expanded. Therefore, Title IV of the PPACA extends similar benefits to Medicare enrollees.[[100]](#footnote-100) Specifically, these individuals may receive all clinical preventive services recommended by the USPSTF.[[101]](#footnote-101) Other provisions of the PPACA provide Medicare patients with annual wellness visits with no required co-pay.[[102]](#footnote-102)

# preventive services after the national federation OF independent businesses v. sebelius and burwell v. hobby lobby stores, inc. decisions

## preventive services after national federation of independent businesses v. sebelius

As passed, the PPACA likely would have expanded Medicaid in all fifty states. The authors of the PPACA assumed that due to this expansion, largely financed through federal funds, numerous additional individuals in all states would have access to preventive services through an essential health benefits package.[[103]](#footnote-103) The U.S. Supreme Court’s opinion in *National Federation of Independent Businesses v. Sebelius*, however, drastically changed the dynamics of Medicaid expansion and slowed preventive services expansion.[[104]](#footnote-104)

In *Sebelius*, the petitioning states argued that Congress exceeded its Spending Clause Powers in expanding Medicaid[[105]](#footnote-105) by crossing “the line distinguishing encouragement from coercion.”[[106]](#footnote-106) The authors of the PPACA stipulated that if a state decided not to expand its Medicaid program pursuant to the statute, it would in effect would lose its existing Medicaid funds.[[107]](#footnote-107) In previous cases, the Court has allowed Congress to use the Spending Clause to both provide grants to states and to condition them on requirements prescribed by Congress[[108]](#footnote-108) in order to influence state policy decisions.[[109]](#footnote-109) A federal statute, for instance, may provide health infrastructure funds to states provided that the states use the funds to improve rural hospitals.

However, despite this broad allowance on spending conditions, the Court has limited Congress’ behavior in other instances. In *Pennhurst State School & Hospital v. Halderman*, the Court reasoned that the legitimate use of the Spending Clause rests on a state’s voluntary and knowing acceptance of the conditions placed on funding.[[110]](#footnote-110) In more extreme cases, when Congress in effect commandeers or coerces a State for federal purposes, as in *Printz v. United States*, where federal legislation required states to perform federally mandated background checks, the Court has again reversed Congress.[[111]](#footnote-111) In these cases, the Court described a line between permissible conditions placed on funding and involuntary requirements (and in some cases commandeering) heaped upon the states.

In deciding the constitutional merit of the Medicaid expansion, the Court inquired whether Congress’ monetary requirements were “so coercive as to pass the point at which ‘pressure turns into compulsion.’”[[112]](#footnote-112) In other words, the degree to which Congress restrained the states’ decisions whether to expand Medicaid was paramount. In doing so, the Court heavily relied upon *South Dakota v. Dole*.[[113]](#footnote-113) In *Dole*, South Dakota challenged a federal law that withheld 5% of a state’s federal highway funds unless the state raised its drinking age.[[114]](#footnote-114) The Court reasoned that this provision was a “relatively mild encouragement”[[115]](#footnote-115) to encourage a state to reform its alcohol policy. In fact, the funding at stake comprised less than one half of one percent of South Dakota’s budget.[[116]](#footnote-116) As a result, the Court did not find Congress’ conduct impermissibly compulsive – the decision to raise the drinking age remained the prerogative of the states.[[117]](#footnote-117)

In contrast with *Dole*, The Court found that Congress’ structuring of Medicaid funding in the PPACA unconstitutionally coerced the states into adopting the expansion requirements prescribed by the statute.[[118]](#footnote-118) In comparing *Dole* with the PPACA, the Court did not find “relatively mild encouragement.” Rather, it saw a far more draconian arrangement that impermissibly constrained the states’ options whether or not to accept new Medicaid requirements. The Court compared an effective loss of less than one percent of a state’s budget in *Dole* with a loss of ten percent or more if a State did not expand its Medicaid program pursuant to the PPACA. The Court stated that “[t]he threatened loss of over 10 percent of a State’s overall budget… is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.”[[119]](#footnote-119)

The *Sebelius* decision acted as a significant strike to providing substantive reform to one of the nation’s largest healthcare programs, as the PPACA would have provided coverage and preventive services to all individuals who earn up to 133% of the federal poverty level.[[120]](#footnote-120) Supported by the Supreme Court’s ruling, 23 states have not chosen to expand Medicaid and provide additional preventive services.[[121]](#footnote-121) Because Medicaid recipients are generally at the highest risk for chronic, expensive, yet preventable diseases, the nation is failing to fulfill an opportunity to provide preventive services that will improve population health and reduce the burden on future taxpayer funds. Although all states do provide some preventive services through their Medicaid programs, the nation needs a more comprehensive approach to combat its chronic disease problem.

In her dissent, Justice Ginsburg wrote at length that uninsured individuals, such as those who would have found coverage through the Medicaid expansion, significantly affect our healthcare spending. Individuals with no insurance or underinsurance use healthcare services, often in an emergency room when significant yet preventable health issues arise. These costs do not simply disappear; instead, they are compensated for by insurance premiums and government programs. As Justice Ginsburg stated, “the uninsured “free ride” on those who pay for health insurance.”[[122]](#footnote-122) No matter the scenario, whether an individual is covered by Medicaid or uninsured, taxpayers, employers, and those paying premiums will often foot his or her chronic disease bill.

Given the nature of healthcare reimbursement, it is highly inefficient that many individuals earning up to 133% of the federal poverty level in non-expansion states will not have access to clinical preventive services. Although the PPACA does include primary prevention efforts, commentators remark that the statute is heavily geared towards these clinical services, which are secondary and tertiary in nature.[[123]](#footnote-123) The Prevention Fund, for example, authorizes just $15 billion over ten years, while current national health expenditures eclipse this amount 180 fold over just one year, or 1,800 fold over the full ten years. Failing to provide cost effective clinical prevention to all individuals reduces much of the PPACA’s potential and will only increase the nation’s long term health expenditures and the financial burden on those who pay for healthcare.

## preventive services after national federation of independent businesses v. sebelius

The implications of judicial action on the PPACA and other preventive efforts did not end with the *Sebelius* decision. In another important case, *Burwell v. Hobby Lobby* *Stores, Inc*.,[[124]](#footnote-124) the Supreme Court decided a contentious issue regarding contraceptive requirements placed upon employers. As part of the effort to provide preventive services such as those recommended by the USPSTF, the PPACA requires group health plans and insurance issuers offering group or individual health insurance coverage to provide additional preventive services upon the guidelines of the Health Resources and Services Administration (HRSA).[[125]](#footnote-125) When HRSA guidelines included certain contraceptives, Hobby Lobby Stores and Conestoga Wood Specialties Corporation challenged this provision based upon asserted religious beliefs against contraceptive use.[[126]](#footnote-126)

Writing for a 5-4 majority, Justice Alito, joined by Chief Justice Roberts and Justices Scalia, Kennedy, and Thomas provided clarity on the how the Religious Freedom Restoration Act (RFRA) applies to for profit corporations.[[127]](#footnote-127) Congress, the majority reasoned, included corporations within the RFRA’s conception of personhood,[[128]](#footnote-128) thus abrogating the 6th Circuit’s holding in *Autocam Corp. v. Sebelius*.[[129]](#footnote-129) Reasoning that corporations are a form of human organization, and that rights such as those provided by the RFRA are purposed for the protection of people, the majority decided that the RFRA’s protections apply to for-profit corporations such as Hobby Lobby.[[130]](#footnote-130)

Congress passed the RFRA in response to the Court’s decisions in *Employment Div., Dept. of Human Resources of Ore. v. Smith*[[131]](#footnote-131)and *City of Boerne v. Flores*,[[132]](#footnote-132) each of which substantially lessened the level of judicial review on laws that curtailed religious practice in a generally applicable manner. Within the RFRA, Congress specified that laws may not substantially burden a person’s exercise of religion even if the burden results from a rule of general applicability.[[133]](#footnote-133) Pursuant to the law, the Court explained that strict scrutiny should apply.[[134]](#footnote-134) Specifically, Justice Alito wrote that under the RFRA “a Government action that imposes a substantial burden on religious exercise must serve a compelling government interest.”[[135]](#footnote-135) In order to pass scrutiny, “it must also constitute the least restrictive means of serving that interest.”[[136]](#footnote-136) The Court found a substantial burden, as it stated that Hobby Lobby may have had to expend $475 million per year in order to comply with the requirement.[[137]](#footnote-137) Granting for the sake of argument that providing contraceptives is a compelling governmental interest, the majority found that the PPACA’s requirement failed the second arm of strict scrutiny.[[138]](#footnote-138) Justice Alito wrote that there are less restrictive ways for the government to achieve the goal of providing cost-free access to contraceptives than placing requirements upon employers.[[139]](#footnote-139)

The Court’s ruling places at risk the remainder of the PPACA’s preventive health requirements of employers to religious based challenges under the RFRA. Specifically, the PPACA’s requirement that such entities provide preventive measures under HRSA guidelines is startlingly similar to the requirement regarding USPSTF recommended preventive services. In her dissent, Justice Ginsburg asserted that the majority’s ruling opens the lower courts to a confusing obstacle course of religious based challenges to a variety of laws, including those focused on prevention.[[140]](#footnote-140) Specifically, she asked whether the Court’s ruling would extend to “employers with religiously grounded objections to blood transfusions (Jehovah’s Witnesses); antidepressants (Scientologists); medications derived from pigs, including anesthesia, intravenous fluids, and pills coated with gelatin (certain Muslims, Jews, and Hindus); and vaccinations (Christian Scientists, among others).”[[141]](#footnote-141) Using this broader reasoning, requirements such as the USPSTF recommended preventive services detailed earlier would fall under scrutiny.

Justice Alito and the majority attempted to narrow the applicability of the ruling. As with all cases, the Court resolved the dispute before it, and the majority took pains to make this clear.[[142]](#footnote-142) In its opening sentence, the opinion limits the question before the court to “closely held corporations.”[[143]](#footnote-143) In addition, in responding to Justice Ginsburg’s dissent, Justice Alito took up an equal employment opportunity hypothetical to illustrate the holding’s limitations pursuant to the RFRA.[[144]](#footnote-144) The majority reasoned that the government “has a compelling interest in providing equal employment opportunity to participate in the workforce without regard to race, and prohibitions on racial discrimination are precisely tailored to achieve that critical goal.”[[145]](#footnote-145) Under Justice Alito’s reasoning, these statutes would survive an RFRA challenge.

Indeed, Justice Alito’s hypothetical is simpler to solve than many others as ensuring equal employment opportunities is a recognized compelling interest.[[146]](#footnote-146) Providing preventive services and resources may not rise to a compelling interest like that of providing contraception, especially considering that few interests do so. Parallel with the majority’s reasoning, even if providing preventive services is a compelling interest, there are numerous ways for the government to provide them absent a mandate placed on employer based insurance plans. The application of strict scrutiny permits few means of fulfilling a compelling interest, because less restrictive alternatives are typically available. Nearly automatically, preventive provisions of the PPACA would quickly fall under RFRA claims as Justice Ginsburg postulates.

# Conclusions

For all of our healthcare system’s complexities, the PPACA contains reforms that may have a meaningful impact on chronic disease incidence over a number of years. Public health funding, prevention focused task forces, stronger public health education, and the expansion of clinical preventive services are all meaningful measures that aim to reduce the burden of chronic disease for millions of Americans. Additionally, new ACOs and payment models created by the CMMI may better refine managed care and financially incentivize disease mitigation and prevention. Taken together, these reforms may have catalytic effects on healthcare costs over the long term.

Nevertheless, some commentators rightly point out that many of these reforms pale in comparison to established U.S. tertiary healthcare norms.[[147]](#footnote-147) As noted, many products of the PPACA’s provisions will find themselves simple recommendations, without any binding authority. Public health funding has fallen catastrophically across many states, and the new Prevention Fund is a drop in the bucket compared to tertiary health expenditures. Furthermore, the PPACA does nothing to correct the problems in the built environment that substantially contribute to chronic disease incidence.[[148]](#footnote-148) To complicate matters, the Supreme Court’s decision in *Sebelius* struck a significant blow to preventive services access, and the result of the *Hobby Lobby* decision may open the PPACA’s preventive reforms to further challenges.

Yet despite these weaknesses, it is unrealistic to expect the PPACA to remedy all of the drivers of chronic disease or make an immediate impact. The U.S. policymaking process is nearly without fail incremental, and if history is any guide, health reform will continue to materialize as it has in the U.S. for over a century.[[149]](#footnote-149) Because the PPACA’s reforms are indirect and catalytic in nature, only data with time will show how they affect our problematic health disposition.

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108. College Savings Bank v. Florida Prepaid Postsecondary Ed. Expense Bd., 527 U.S. 666, 686 (1999). [↑](#footnote-ref-108)
109. New York v. United States, 505 U.S. 144, 166 (1992). [↑](#footnote-ref-109)
110. Pennhurst State Sch. & Hosp. v. Halderman, 451 U.S. 1, 17 (1981). [↑](#footnote-ref-110)
111. Printz v. United States, 521 U.S. 898, 924 (1997). [↑](#footnote-ref-111)
112. Steward Machine Co. v. Davis, 301 U.S. 548, 590 (1937). [↑](#footnote-ref-112)
113. South Dakota v. Dole, 483 U.S. 203 (1987). [↑](#footnote-ref-113)
114. *Id.* [↑](#footnote-ref-114)
115. *Id.* at 211 [↑](#footnote-ref-115)
116. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2604 (2012). [↑](#footnote-ref-116)
117. *Id.* [↑](#footnote-ref-117)
118. *Id.* [↑](#footnote-ref-118)
119. *Id.* at 2605. [↑](#footnote-ref-119)
120. The Henry J. Kaiser Family Foundation, Summary of the Affordable Care Act (2013), http://kff.org/health-reform/fact-sheet/summary-of-the-affordable-care-act/ [↑](#footnote-ref-120)
121. The Henry J. Kaiser Family Foundation, Status of State Action on the Medicaid Expansion Decision (2014), http://kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/ [↑](#footnote-ref-121)
122. Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2611 (2012). [↑](#footnote-ref-122)
123. Hardcastle, *supra* note 18, at 324 [↑](#footnote-ref-123)
124. Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751 (2013). [↑](#footnote-ref-124)
125. 42 U.S.C. §300gg-13(a)(4) [↑](#footnote-ref-125)
126. Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2751 (2013). [↑](#footnote-ref-126)
127. *Id.* at 2775. [↑](#footnote-ref-127)
128. *Id.* at 2768. [↑](#footnote-ref-128)
129. Autocam Corp. v. Sebelius, 730 F.3d 618 (2013). [↑](#footnote-ref-129)
130. Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2767 (2013). [↑](#footnote-ref-130)
131. Employment Div., Dept. of Human Resources of Ore. v. Smith, 494 U.S. 872 (1990). [↑](#footnote-ref-131)
132. City of Boerne v. Flores, 521 U.S. 507 (1997). [↑](#footnote-ref-132)
133. 42 U.S.C. §§2000bb-1(a) [↑](#footnote-ref-133)
134. Burwell v. Hobby Lobby Stores, Inc., 134 S. Ct. 2751, 2767 (2013). [↑](#footnote-ref-134)
135. *Id.* at 2759 [↑](#footnote-ref-135)
136. *Id.* [↑](#footnote-ref-136)
137. *Id.* at 2775-76 [↑](#footnote-ref-137)
138. *Id.* at 2781-82 [↑](#footnote-ref-138)
139. *Id.* [↑](#footnote-ref-139)
140. *Id.* at 2805 [↑](#footnote-ref-140)
141. *Id.* [↑](#footnote-ref-141)
142. *Id.* at 2783 [↑](#footnote-ref-142)
143. *Id.* at 2759 [↑](#footnote-ref-143)
144. *Id.* at 2783 [↑](#footnote-ref-144)
145. *Id.* [↑](#footnote-ref-145)
146. *Id.* [↑](#footnote-ref-146)
147. Hardcastle, *supra* note 18, at 324 [↑](#footnote-ref-147)
148. *Id.*  [↑](#footnote-ref-148)
149. James, *supra* note 16, at 251. [↑](#footnote-ref-149)