

ISSUE BRIEF

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Prevention Provisions in the Affordable Care Act

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Executive Summary

In 2010 Congress enacted the Affordable Care Act, a historic and vigorously debated law designed to dramatically overhaul the health system. Included in the Affordable Care Act are comprehensive prevention provisions consistent with those called for by the American Public Health Association (APHA) in its health reform agenda and supported by other leading experts in population health and prevention.¹² The Affordable Care Act, if it is adequately funded, effectively implemented, and creatively leveraged through public and private-sector partnerships, will mark the turning point in the fundamental nature of our health system, initiating the transformation of our health system from one that treats sickness to one that promotes health and wellness. This issue brief begins (Section III) by summarizing the state of public health in the United States, including some measures of the growth of preventable diseases. Section IV describes the major provisions of the Affordable Care Act that address prevention through: (1) investing in public health; (2) educating the public; (3) expanding insurance coverage and requiring that health insurance include recommended preventive benefits; and (4) building capacity for better prevention in the future through demonstrations, research and evaluation.





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Section V identifies key implementation issues. Federal, state and local policy makers charged with implementing the Affordable Care Act face challenging issues in the near future such as: (1) deciding how to allocate new prevention funds and protect existing funds; (2) allocating grants (federal) and applying for grants (state and local) so that prevention efforts are coordinated efficiently; (3) learning the best ways to ensure the accessibility of available information about the benefits of prevention to both the general population and hard-to-reach populations; and (4) learning how best to communicate with consumers and patients so that they act on that information to prevent disease and disability and improve health.

Successful implementation of the prevention provisions of the Affordable Care Act will require the devoted efforts of staff at all levels of government, of all members of the healthcare and public health professional workforce, and of health plans and insurance companies. It also will demand the engagement of citizens, who will need to be more educated about choices in the health system. Section VI includes recommendations for policymakers to: (1) leverage health reform funding and other existing funding to expand total funds for prevention and maximize progress; (2) conduct research about how to communicate prevention messages most effectively to traditionally underserved populations; and (3) improve public health by making comparative effectiveness research on prevention a priority and by expanding successful prevention pilot projects.

This issue brief does not cover workforce issues such as the expansion of primary care and community health centers. These important areas will be addressed in a separate forthcoming issue brief.

I. Introduction and Overview

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Senator Harkin, a long-time leader on preventive health care, captures in his quote the hope that the landmark health reform legislation enacted in 2010 will make fundamental changes in our system so that it prevents disease and promotes wellness. The Affordable Care Act, signed into law on March 23, 2010⁴, included comprehensive initiatives that elevate the nation's commitment to preventing disease and promoting wellness. Its provisions cut across a range of needs that have been articulated by experts.⁵ These include the establishment of a large Prevention and Public Health Fund, creation of a National Prevention, Health Promotion and Public Health Council to coordinate federal prevention initiatives, development of new grant programs to fund state and local initiatives at the community level, a new requirement that health insurance policies cover recommended preventive services, and development and implementation of a goal-driven strategy for prevention that will include a timeline for measurable actions. The law also requires that changes to insurance coverage and policy must be guided by scientific evidence, and calls for evaluations and reports that provide an opportunity to learn from experience and make improvements over time.

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access to care for all residents. APHA also has supported the creation of a dedicated funding stream for prevention, wellness and public health.⁶ APHA's *2009 Agenda for Health Reform* describes the population-based services needed to help communities and individuals be healthy.⁴ A number of organizations and coalitions that promote improved public health have taken similar positions.⁷

The Affordable Care Act addresses many of these recommendations from the public health community and represents a bold step for the nation in creating a system that promotes wellness.

This issue brief addresses the provisions in health reform that directly relate to prevention. It does not deal with the many indirect ways that health reform promotes health and prevents disease, most notably by reducing the ranks of the uninsured who have faced financial and access barriers to both acute and preventive care. Nor does it cover workforce issues, such as those related to the expansion of primary care, the public health workforce, medical homes, and community health centers, all of which will play a crucial role in supporting the transformation of our health care culture to one that embraces prevention.

At this time, there is ambiguity in the law about the extent to which funds are authorized and/or appropriated, creating uncertainty about the precise amounts of funding that will actually be available. The law often uses language such as "there are authorized to be appropriated such sums as may be necessary to carry out this section" (Section 4004), and "out of any funds in the Treasury not otherwise appropriated, there are appropriated \$1,000,000 for fiscal year 2010 to carry out this subsection" (Section 4203). Many sections do not include any language about funding, creating uncertainty about future funding. The Congressional Budget Office has published a table of authorizations subject to appropriation in order to clarify which provisions have specific dollar amounts authorized (by year) and which provisions do not yet have a specified budget.⁸ The success of the Affordable Care Act's prevention and public health initiatives will depend not only on whether



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the authorized funds are appropriated, but also on the ability to achieve changes across many non-health care aspects of our society through healthy environments, education, a more nutritious food supply, and modification of individual behaviors.

After a brief overview of the problem of inadequate focus on prevention in the past, this issue brief describes the major prevention provisions in health reform and identifies some of the key policy and implementation issues that lie ahead. For an implementation timeline of the public health, prevention and wellness provisions in the Affordable Care Act, see Appendix 1.

II. The Problem

Rising rates of preventable disease and death, as well as international comparisons of health outcome measures, reveal that Americans are not as healthy as they could be, and that they are becoming increasingly unhealthy over time. The relatively unhealthy population stems from many factors, including but not limited to the health system. Lack of access to a high-quality education, nutritious food, adequate exercise, and a healthy and safe environment are key factors driving the diminishing health of the

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nation. In the absence of other changes, even a complete transformation of the health system is not sufficient to significantly alter the growing problems of heart disease, obesity and cancers that affect our nation's health.

Preventable disease and death: Preventable disease and death impose a large burden in the United States. In 2009, an alarming 26.6 percent of the U.S. population was obese,⁹ 8.2 percent of the adult U.S. population had diabetes,¹⁰ and 27.8 percent of the adult population had high blood pressure.¹¹ Lifestyle behaviors and choices, such as tobacco use, poor diet, physical inactivity, and alcohol consumption are primary determinants of disease and death in the United States, yet these have historically received little attention from our health system with respect to preventing them in the first place. This lack of attention has resulted in an estimated 60 percent of deaths in America being attributed to "social or behavioral circumstances."¹² In many cases, the unhealthy

choices that lead to poor health outcomes are not in fact lifestyle "choices," but rather the consequences of economic and geographic factors that restrict or prevent access to healthy food and safe environments in which to exercise.

Research has shown that coronary artery disease can be reversed with lifestyle changes including diet, stress reduction, psychosocial support and exercise.¹³ Recent growth in the self-reported obesity rate, a 1.1 percentage point increase (2.4 million additional people) between 2007 and 2009, is another indicator of the growth of preventable disease and the need for an aggressive public health focus.¹⁴ The World Cancer Research Fund and American Institute for Cancer Research found that cancers are principally caused by environmental factors, the most important of which are tobacco, diet, physical activity and exposures in the workplace. Two-thirds of all cancers can be eliminated through changes to diet, physical activity and tobacco use.¹⁵ It is widely recognized that as a country we need to take steps to prevent obesity, and that problems with "the availability of healthy and affordable food options, eating patterns, levels of physical activity, quality of the built environment, social and cultural attitudes around body weight, and reduced access to primary care" all contribute to the prevalence of obesity.¹⁶

International comparisons of health:

The United States lags far behind other countries in key health measures, yet we manage to spend far more per capita each year on health care than other countries, \$7,680 per person, for a national total of \$2.3 trillion in 2008.¹⁷ Male life expectancy (at birth) in the United States in 2006 was 75, compared with 79 in Australia, 77 in Austria, and 79 in Japan.¹⁸ "Healthy life expectancy," a measure of the number of years a newborn can be expected to live a productive and healthy life, is 70 years in the United



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States, less favorable than 30 other countries such as the United Kingdom, Spain, and Japan, which has the highest life expectancy of 76.¹⁹ Infant mortality in the United States was seven per 1,000 live births in 2009, with 36 countries (out of 193 rated) having lower infant mortality rates.²⁰ A Commonwealth Fund international comparison of health systems placed the United States as worst in an analysis that considered measures such as quality, access, efficiency, equity and cost.²¹

Health System Failures: Primary Care Shortages. A central challenge to the health system is the short supply of primary care providers and public health professionals, and their maldistribution across the nation. Seventy percent of health leaders surveyed by the Commonwealth Fund said that addressing the shortage of trained health care workers was an essential, urgent part of health reform.²² The Institute of Medicine has documented how demands for the health-care workforce will grow because of the aging of the Baby Boomers.²³ The current shortage of primary care providers, especially in rural areas, *before* Baby Boomers turn 65 and before the enactment of the Affordable Care Act, undoubtedly means that shortages will intensify over the coming years as Boomers need more health services, and implementation of the law removes financial barriers to seeking health care. Additionally, the recession, the high unemployment rate, and continued financial pressures has led to a long-lasting crisis affecting state budgets, and resulted in severe cuts in the workforce that provides basic health, public health and other services at the state and local levels.

Health System Failures: Financial Incentives. Another factor contributing to the declining population health is the health care financing system, which is largely fee-for-service. The U.S. health system is riddled with financial incentives to provide medical care to treat disease (e.g., coronary bypass and bariatric surgery) rather than offer primary care and guidance to address health through basic lifestyle changes before the disease process begins.

Focus on Children as a Proxy. The health of the nation's children best exemplifies our lack of attention to prevention. The following measures indicate how poorly our nation

is doing with respect to raising healthy children.

- Only 70 percent of pregnant women have access to adequate prenatal care.²⁴
- Seventy-eight percent of children between the age of 19 months and 35 months received complete immunizations in 2009 (a 42 percent increase in 10 years).²⁵
- In 2007–2008, 19 percent of children six to 17 years old were obese.²⁶
- Nine percent of children have asthma, with 400,000 of these having mild to severe asthma.²⁷
- In 2008, 25 percent of 12th graders reported having five or more alcoholic beverages in a row in the last two weeks.²⁸
- An estimated 17 percent of children have “some type of developmental disorder,” and 21 percent have a “diagnosable mental or addictive disorder”;²⁹
- About 1.2 million children drop out of high school every year, with only 70 percent of freshmen ultimately graduating from high school.³⁰
- The Surgeon General reported a suicide incidence of 9.5 per 100,000 for 15- to 19- year-olds in 1996.³¹

There is increasing awareness that early environmental factors before birth and in early childhood influence health over the long term. These disturbing measures of the health status of children are troubling harbingers of health status of the population of the future.

Making the Case for Prevention: Another way to consider the value of prevention is to examine the “return on investment” for prevention dollars. A report by Trust for America’s Health estimated that investments in community-based programs in initiatives that encourage physical activity, good nutrition and tobacco cessation can yield very favorable returns on investment, returning an overall \$5.60 in health cost savings for every \$1 spent.³²

Health outcomes reflect the physical, social, and demographic environments and communities in which people live, work, play, learn, pray and seek healthcare. Each plays a critical role in determining the health



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of a population. *Healthy People*³³ creates a roadmap for achieving population health goals through interventions in a variety of non-health and health arenas. Achieving the goal of reducing childhood obesity, for example, will require changes outside the health system, such as removing junk food from schools and taxing sodas. The Commission to Build a Healthier America, convened by the Robert Wood Johnson Foundation, recently concluded that achieving the goal of a healthy nation will require broad changes “in every aspect of society and daily life.” The Commission recommendations focused on improving early childhood health and development, encouraging good nutrition and promoting healthy communities.³⁴ APHA’s work to improve the health of the nation supports changes in the workplace, in schools and in the environment, in addition to changes in the health system. For example, APHA has outlined five general goals and 27 specific goals across non-health and health sectors to reduce childhood obesity. The Prevention Institute has documented the impact of community violence on healthy eating and activity.³⁵

Each of these efforts supports the intent of addressing poor health outcomes by reaching beyond the traditional “health care system” of doctors, nurses and hospitals; instead, they involve coaching (from parents and educators) about a range of things including nutrition, exercise, activities; and systemic changes to our environments.

III. Preventive Health Provisions in the Affordable Care Act

The Affordable Care Act addresses poor health outcomes in a number of ways, such as improving access to care, making care and coverage more affordable, encouraging preventive care, and increasing the supply of primary care providers. Congress recognized the need to address population health comprehensively, both within the health system and through initiatives that extend to other sectors, such as the school system.

The Affordable Care Act includes a broad range of initiatives designed to promote

wellness and prevent disease. The prevention provisions in the Affordable Care Act require large implementation roles for federal, state and local governments and the private sector. While phased in over time, implementation timelines are tight. Many involve multiple divisions within the U.S. Department of Health and Human Services. Stakeholders in the health care system—patients, consumers, doctors, nurses, insurance companies, hospitals, employers, and government employees at the federal, state and local levels—will all face major changes in how they interact with the health system. For example, the Affordable Care Act provides grants to state and local health departments to educate targeted populations, build the public health infrastructure, prevent chronic disease, and foster healthy and safe communities through policy, systems, and environmental changes. A second category of initiatives—public education campaigns—are designed to promote healthy behaviors (e.g., good nutrition, adequate exercise) and discourage unhealthy behaviors (e.g., tobacco use). A third category tests new approaches to improving health, evaluates the effectiveness of these approaches, and expands successful efforts over time to promote healthy behavior and healthy outcomes. Finally, a fourth category of initiatives involves insurance coverage requirements that are designed to assure that various populations (e.g., Medicare beneficiaries, people with private insurance coverage) do not face financial barriers to accessing evidence-based preventive care such as cancer screenings.

In this issue brief the provisions of the Affordable Care Act are grouped into four categories:

- investing in public health through grant programs, contracts, support and infrastructure that will develop a national prevention, health promotion and public health strategy, and coordinate federal programs;
- educating the public through educational campaigns aimed at improving health;
- learning from experience through research and demonstrations; and
- requiring that evidence-based preventive health care services be covered in both



The Affordable Care Act addresses this fragmentation and lack of coordination through two initiatives: (1) the National Prevention, Health Promotion and Public Health Council, which will coordinate and execute a comprehensive strategy; and (2) the Prevention and Public Health Fund, which will invest in prevention and public health programs to improve health and restrain health costs.

public and private health coverage, without cost-sharing.

A. INVESTMENTS IN PUBLIC HEALTH

The United States dedicates a mere 3 percent of its healthcare budget to disease prevention and public health.³⁶ These funds are administered across multiple federal, state and local agencies, with no loci of coordination and review.

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National Prevention, Health Promotion and Public Health Council³⁸ (Section 4001, 10401): The law creates a new Council, within HHS, to coordinate and lead the federal government's efforts on prevention, wellness and health promotion, and establishes a locus of control, multi-sector coordination, and accountability for advancing a national prevention agenda. The Council is to be chaired by the U.S. Surgeon General and will consist of Secretaries of appropriate federal departments (e.g., Health and Human Services, Agriculture, Education, Homeland Security, Transportation, Labor), the Chairman of the Federal Trade Commission, the Director of the Domestic Policy Council, several other senior administration appointees, and other members as determined appropriate.³⁸ The Council is charged with making policy recommendations to the President and Congress to advance public health goals. It is to consider and propose "evidence-based models, policies, and innovative approaches for the promotion of transformative models of prevention, integrative health, and public health on individual and community levels across the United States."

A key function of the Chairperson (in consultation with the Council) is to "develop and make public a national prevention, health promotion, public health strategy,"



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within one year of enactment. The strategy must articulate specific goals and objectives for improving the health status of Americans through federal health promotion and prevention programs. It is to include "specific and measurable actions and timelines" to implement the strategy. An annual report to the President and relevant committees of Congress will provide a forum for the Council to describe activities on prevention, health promotion and public health, report on progress in meeting the goals of *Healthy People 2020*, and report on the status of federal coordination of programs. The first report was issued on July 1, 2010. (See Section V.)

Prevention and Public Health Fund (Sections 4002, 10401): While the National Prevention, Health Promotion and Public Health Council provides a mechanism to coordinate federal programs, the new Prevention and Public Health Fund provides the resources to fund prevention and public health initiatives. The Fund is intended "to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs." The law provides \$500 million for the Fund in FY2010, and annual

Table 1: Grant Programs to Promote Prevention⁴¹

School-based Health Centers (Section 4101)
<p>The Secretary of HHS will establish a grant program “to support the operation of school-based Health Centers”</p> <ul style="list-style-type: none"> ■ grants for schools, preference to those with large number of children eligible for Medicaid ■ funds to support facilities and equipment, not to support personnel or pay for health services ■ Secretary is to develop evaluation plan and monitor quality performance of grants ■ appropriates \$50 million per year for FY2010 to FY2013
Incentives for Prevention of Chronic Disease in Medicaid (Section 4108)
<p>The Secretary of the Department of Health and Human Services (HHS) will award grants to states to carry out comprehensive, evidence-based, accessible programs to lower health risks of Medicaid beneficiaries</p> <ul style="list-style-type: none"> ■ funds can be used, for example, for programs to cease use of tobacco products, control or reduce weight, lower cholesterol, lower blood pressure, avoid onset of diabetes ■ requires various reports from states receiving grants, independent evaluation of initiatives, reports from Secretary to Congress ■ appropriates \$100,000,000 for the five-year period beginning January 1, 2011
Community Transformation Grants (Section 4201)*
<p>The Secretary of HHS, through the Director of the Centers for Disease Control and Prevention (CDC), to award grants “for the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence-base of effective prevention programming”</p> <ul style="list-style-type: none"> ■ competitive grants to state and local governmental agencies, community-based organizations, non-profit organizations, and Indian tribes for implementation, evaluation and dissemination of evidence-based community preventive health care activities ■ grant recipients to provide detailed plan for the policy, environmental, programmatic and (as appropriate) infrastructure changes needed to promote healthy living and reduce disparities ■ activities could include: creating healthier school environments, creating infrastructure to support active living, access to nutritious food, and tobacco cessation ■ grant recipients are to evaluate impact by measuring the changes in prevalence of chronic disease risk factors of community members participating in preventive health activities ■ grantees will meet at least annually to discuss challenges, best practices, and lessons learned ■ does not specify an amount to be appropriated (authorizes “sums as may be necessary”)
Health Aging, Living Well (Section 4202)^{42*}
<p>Secretary of HHS (through the Director of the CDC) will award grants to states, local health departments and Indian tribes:</p> <ul style="list-style-type: none"> ■ to carry out 5-year pilot programs to provide public health community interventions, screenings, and where necessary clinical referrals for individuals who are between 55 and 64; ■ interventions include efforts to improve nutrition, increase physical activity, reduce tobacco use and substance abuse, improve mental health, and promote healthy lifestyle ■ grant applicants to design a strategy to improve the health of individuals between ages 55 and 64 through community-based public health interventions; ■ does not specific an amount to be appropriated (authorizes “sums as may be necessary”)
Epidemiology and Laboratory Capacity Grant Program (Section 4304)*
<p>The Secretary of HHS (through the CDC Director) to establish a grant program to provide:</p> <ul style="list-style-type: none"> ■ grants to state health departments, local health departments, tribal jurisdictions, and academic centers ■ funding for assisting public health agencies in improving surveillance for, and response to, infectious diseases and other important public health conditions ■ authorizes \$190,000,000 for each year between FY2010 and FY2013
Maternal, Infant and Early Childhood Home Visiting Programs (Section 2951)
<p>The Secretary of HHS will award grants to states, Indian tribes, and (in certain circumstances) non-profit organizations:</p> <ul style="list-style-type: none"> ■ to fund early childhood home visitation programs; ■ each grantee is to measure benchmarks including maternal and newborn health, prevention of child injuries, improvement in school readiness, reduction in crime or domestic violence; ■ Appropriates \$100 million in FY2010, increasing steadily until FY2014 when appropriations are \$400,000.

*Funds have not been appropriated for these grant programs, and they will not be implemented in the absence of future appropriations.

authorizations increase, with total authorizations of \$15 billion for FY2010 to FY2019. The Fund is administered by the Secretary of the Department of Health and Human Services (HHS).

Table 1 summarizes the five major prevention programs to be funded by the health reform law, to be administered by the Secretary of the HHS. The programs include:

- support for the operation and expansion of school-based health centers;
- state programs to help lower health risks of Medicaid beneficiaries;
- state, local, and other organization projects to fund implementation, evaluation and dissemination of preventive health activities through enhancing infrastructure and capacity (community transformation grants);
- state, local and Indian tribe pilot programs to provide public health community interventions for individuals between ages 55 and 64 (e.g., increasing physical activity of 64-year-olds);
- grants to state, local and tribal health departments and academic centers to increase surveillance and response to emerging public health issues, including infectious disease (epidemiology and laboratory capacity grant program); and
- grants to state and tribal organizations, and under certain circumstances non-profit organizations, to provide early childhood home visitation programs, with a requirement that at least 75% of the funding be used for programs using evidence-based models.

Each of these grant programs provides an opportunity to address health disparities that result in disproportionate adverse health conditions for specific groups in the United States.³⁹

The health reform law also provides support at a more modest funding level for important but smaller-scale preventive

programs. It provides for technical assistance, through the Director of the Centers for Disease Control and Prevention, for employer-based wellness programs (Section 4303). For example, it provides tools for measuring participation in workplace wellness programs, methods for increasing participation, and assistance for determining the impact on participants' health status.⁴¹ The Act authorizes \$500 million to fund the public education campaigns of the Secretary (described below in the next section). It authorizes the Secretary of HHS to negotiate contracts with manufacturers for vaccines, and supports a demonstration program to improve immunization coverage and grants to states to increase rates for recommended immunizations for children, adolescents and adults (Section 4204).

B. PUBLIC EDUCATION CAMPAIGNS

As described above (Section II), the prevalence of largely preventable diseases such as heart disease, cancer and diabetes has increased in the United States. Congress recognized the potential to improve population health by addressing these preventable diseases through broad-based public education campaigns, and included them as a cornerstone of reform. The Act establishes a well-funded "education and outreach campaign" on preventive services that will be included in health coverage for most people. The public education campaigns aim to dramatically alter behaviors that result in 60 percent of deaths attributed to "social or behavioral circumstances" as described in the Problem section above.⁴³

The Secretary of HHS is charged with planning and implementing a national public-private partnership that will focus on educating the nation's diverse population about disease prevention and health promotion. The campaign will provide information about the importance of using evidence-



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based preventive services “to promote wellness, reduce health disparities and mitigate chronic disease.”⁴⁴ The campaign may use TV, radio, a Web site, and other venues to address lifestyle choice related to appropriate and adequate nutrition, exercise, tobacco cessation and obesity reduction. The five leading disease killers in the United States (heart disease, cancer, stroke, respiratory disease and Alzheimer’s disease in 2007) will also be targeted in a public education campaign, and will include an educational Web site that includes information for health care providers and for consumers.

A second public education campaign is to be carried out by a non-traditional source of health information: restaurants that are part of a chain with 20 or more locations. Restaurants will be required to include the nutrient content and the number of calories in food selections on their menus, and must make additional nutritional information available upon request. In addition, vending machine operators who own more than 20 machines are required to post signs disclosing the number of calories in each item sold.

The third education initiative establishes a five-year, national public educational campaign on oral health care and the prevention of oral disease. This campaign will target

activities to children, pregnant women, the elderly, individuals with disabilities, and ethnic and racial minority populations. It will convey oral health prevention messages, including education about the importance of community water fluoridation and dental sealants to encourage broader provision and use of routine dental services. This campaign is authorized, and will be implemented only if funds are appropriated. Section 1302 of the Affordable Care Act specifies that oral health services are to be included in the basic benefits for children (but not adults).

C. COVERING RECOMMENDED PREVENTIVE SERVICES AS A HEALTH BENEFIT

There are several reasons that preventive services have not been included in health insurance policies until recently. The relative predictability of the cost of recommended preventive services makes them different (from an insurance perspective) from low-probability illnesses and injuries that health insurance was initially designed to cover. Health insurance was originally designed to be more “catastrophic” rather than “first-dollar coverage”. Insurers would argue that including preventive benefits simply increased premiums to cover the expected cost of the benefits. Additionally, health plans and employers have little incentive to cover preventive services that are more likely to have an impact on a member’s or employee’s long-term health and well-being, because the employee might have left the employer by the time the preventive services pay off.

However, increased employer and consumer demand for coverage of services which prevent disease and disability over the long term, in conjunction with the evidence of value and effectiveness, led to the change in insurance coverage in recent years. The scientific understanding of which preventive services are appropriate at different stages of life increased, with the help of the U.S. Preventive Services Task Force. Insurers have responded to employers’ and consumers’ demand for coverage of preventive services in otherwise high deductible health insurance policies: 92 percent of high deductible plans offered by employers included preventive care without any deductible in 2009.⁴⁵



A PHA recommended first-dollar coverage for evidence-based clinical preventive services in its Agenda for Health Reform.⁴⁷ And in fact, the new health reform law requires that health benefits include selected preventive services with no cost-sharing both for individual and group plans and for Medicare.

At the same time, there is growing awareness that cost-sharing (e.g., co-payments, deductibles) presents a financial barrier that deters people from getting the screenings and preventive services that are recommended for them. The continuing recession has resulted in cutting back on routine care such as preventive services, most likely because of the large out-of-pocket costs involved.⁴⁶ While most employer plans include preventive care without cost-sharing, individual policies (under competitive pressure to keep premiums low) are unlikely to do so in the absence of a legal requirement.

Recognizing the importance of eliminating financial barriers to receiving evidence-based preventive services, APHA recommended first-dollar coverage for evidence-based clinical preventive services in its Agenda for Health Reform.⁴⁷ And in fact, the new health reform law requires that health benefits include selected preventive services with no cost-sharing both for individual and group plans and for Medicare. These new benefits will be required by late 2010 (six months after enactment) for indi-

viduals with new private coverage, and by January 1, 2011, for Medicare beneficiaries. States are encouraged to extend preventive health services in their Medicaid programs, paid for in large part by increased federal payments for Medicaid.

The U.S. Preventive Services Task Force, an independent panel of experts in primary care and prevention, is based at the Agency for Healthcare Research and Quality. Its recommendations provide the basis for preventive services coverage. Specific recommendations vary by age and other factors, and the U.S. Preventive Services Task Force recommends that clinicians discuss the recommended preventive services with patients as appropriate. Examples of the services recommended for adult women include screening for breast cancer, cervical cancer, colorectal cancer, depression, high blood pressure and obesity.⁴⁸

Private plans: For private plans, coverage will be required in new plans for all evidence-based preventive services that are rated “A” or “B” by the U.S. Preventive Services Task Force (Section 1001). Cost-

Table 2: Preventive Care and Public Health Research Projects⁵³

Individualized Wellness Plans (Sec. 4206)
<p>Goal: Test impact of providing at-risk populations an individualized wellness plan designed to reduce risk of preventable conditions. Wellness plans would include plans for nutritional counseling, physical activity, alcohol and tobacco cessation counseling, stress management.</p> <p>Target population: At-risk individuals who use community health centers.</p> <p>Implementation: Secretary of HHS to identify 10 community health centers to conduct evaluation.</p>
Delivery of Public Health Services (Sec. 4301)
<p>Goal: Evaluate (and report to Congress) the effectiveness of evidence-based practices relating to prevention and community-based public health interventions, and identify effective strategies for state and local systems to organize, finance and deliver public health services.</p> <p>Target population: Communities and populations that would benefit from prevention priorities identified by the National Prevention Strategy and <i>Health People 2020</i>.</p> <p>Implementation: The Secretary of HHS, working with the CDC, Community Preventive Services Task Force, and various private and public partners, will analyze and report annually to Congress.</p>
Evaluation of Community-based Prevention and Wellness Programs (Sec. 4202)
<p>Goal: Evaluate the ability of community health interventions to improve the health of people nearing Medicare eligibility and the effectiveness of community-based prevention and wellness programs for Medicare beneficiaries.</p> <p>Target Population: People nearing Medicare eligibility (55 to 64 years old) and Medicare beneficiaries.</p> <p>Implementation: The Secretary of HHS, working with the CDC and the Administration on Aging, will provide grants for the pilot study of people nearing Medicare eligibility. The Secretary of HHS will evaluate the programs for Medicare beneficiaries.</p>



Shortages in the primary care health workforce, especially in underserved areas, will grow more intense as the number of insured adults grows. This will require early and aggressive attention so that the expanded access to care does not result in long waiting lines at doctors' offices and clinics.

sharing (i.e., deductibles and co-payments) is explicitly prohibited. Similarly, immunizations that are recommended by the Advisory Committee on Immunization Practices and “evidence-informed preventive care and screenings” for infants, children and adolescents, and breast cancer screening mammography are covered (Section 1001).

Medicare: Cost-sharing will be eliminated for Medicare beneficiaries for preventive services (including colorectal cancer screening) that are rated “A” or “B” by the Task Force.⁴⁹ Medicare beneficiaries will be covered for an annual wellness visit. Before the visit, beneficiaries will receive support to help them complete a health risk assessment. Each beneficiary will be provided with a personalized prevention plan that includes a health risk assessment, the establishment or update of an individual medical and family history, personalized health advice, and, when appropriate, referral to health education or preventive counseling services. Even if recommended, health education services are generally not covered by Medicare, with the exception of medical nutrition therapy for people with diabetes or kidney disease, and diabetes education for those with diabetes; outpatient mental health counseling will continue to be covered with a 45 percent coinsurance rate in 2010–2014.⁵⁰

Medicaid: The health reform law encourages, but does not require, states to expand preventive coverage for Medicaid beneficiaries. It adds preventive services rated “A” or “B” by the U.S. Preventive Services Task Force and vaccines recommended by the Advisory Committee on Immunization Practices to the list of services that state Medicaid programs *can* cover, and encourages states to do so by increasing the federal financial contribution (federal medical assistance percentage, or FMAP) by 1 percent for any states that cover these services without any cost-sharing (Section 4106). Pregnant women covered by Medicaid will have coverage for counseling and prescription drugs for cessation of tobacco use (Section 4107).

D. DEMONSTRATION PROGRAMS AND RESEARCH PROJECTS

The health reform law uses evidence of effectiveness to make decisions and fund

educational programs. New programs will be evaluated and adjusted based on effectiveness evidence. The law includes a number of research and demonstration programs designed to improve capacity to promote prevention and public health in the future. There are three major prevention-oriented research projects in the health reform law: (1) a demonstration project for individualized wellness plans developed for individuals at risk of preventable conditions; (2) a comparative analysis of effectiveness and cost of public health interventions; and (3) an analysis of community-based prevention and wellness programs for the population nearing Medicare eligibility and for Medicare beneficiaries. These three programs are summarized in Table 2.

In addition, the health reform law has a number of provisions aimed at improving the understanding of prevention-related activities, in concert with the needs of various population groups. Other evaluation-oriented provisions of the law include:

1. a requirement that all federal surveys collect data on race, ethnicity, sex, primary language and disability status (Section 4302);
2. the convening of a conference, through the Institute of Medicine, that explores many facets of pain management, including how specific races, genders and ages are affected, and reports to Congress (Section 4305);
3. appropriation of funds for a previously authorized Childhood Obesity Demonstration project⁵² (Section 4306);
4. development of methodologies for estimating the budget impact of prevention and wellness programs (since benefits often accrue beyond a 10-year budget window) by the Congressional Budget Office (Section 4401);
5. an analysis of the impact of health and wellness initiatives on the health status (e.g., absenteeism, productivity) of the federal workforce (Section 4402);
6. review of the scientific evidence of effectiveness, appropriateness, and cost-effectiveness of clinical preventive services by the U.S. Preventive Services Task Force, and publication of the findings in the

Guide to Clinical Preventive Services (Section 4003);⁵²³ and

7. review of the effectiveness, appropriateness and cost-effectiveness of community preventive interventions (including health impact assessments and population health modeling) and publication of recommendations in the *Guide to Preventive Services* by the independent Community Preventive Services Task Force (Section 4003)

IV. Some Key Issues

Transforming our nation's health system to one that promotes health and wellness in the first place is an iterative process, one that requires routine assessment, evaluation and adjustments over time. The scope of problems addressed by the legislation is ambitious and broad, and cuts across many sectors of the economy and across disciplines/sectors. The ambiguity about authorizations and appropriations ensures that there will be scrutiny by Congress with input from many stakeholders, and that there will be uncertainty on the part of implementing agencies about precise funding streams. Early implementation efforts are occurring at a time of fiscal crisis in virtually all states, making it especially difficult for state and local governments to continue to provide existing services at the same time that they ramp up comprehensive health reform implementation activities. Shortages in the primary care health workforce, especially in underserved areas, will grow more intense as the number of insured adults grows. This will require early and aggressive attention so that the expanded access to care does not result in long waiting lines at doctors' offices and clinics.

There are a number of factors that will influence the ultimate impact of the preventive provisions. First and foremost is the state of the economy and pace of the recovery. This directly influences the ability of state and local governments to fund a depleted public health workforce. Without a significant improvement, state and local governments will be able to do little more than hold steady, perhaps even facing further erosion of their public health infrastructure and programs. A second key factor is the need for prevention and public health advocates to

coordinate their efforts in order to maximize their influence in bringing about change.

More significantly, success in altering the course of the public's health and its growing prevalence of obesity requires substantial lifestyle changes by individuals, communities, businesses and governments. This is a long and arduous road, and while the United States has made advances in many areas, we will need comprehensive policies to support environmental change.

The following section summarizes some of the implementation challenges facing the federal, state and local governments as they implement the Affordable Care Act.

Deployment of the Prevention and Public Health Fund:

Never before has the government invested such a large amount of money—\$15 billion over the next 10 years—in prevention through a single funding stream. The harsh reality is, however, that the amount of money authorized is not as large as the need. Tough choices lay ahead to ensure that the investment successfully “[transforms] our health system into one that truly promotes health, not just disease treatment.”⁵⁴ It will have a greater chance of success if the funding represents a new investment rather than supplants existing prevention and public health funding.⁵⁵

One implementation issue that arose early, with the Administration's announcement of how to deploy the \$500 million appropriated for Fiscal Year 2010, is whether funds targeted for prevention and public health could be diverted to fund other priorities. On June 18, 2010, the Department of Health and Human Services announced that it would spend \$250 million (half of the appropriated funding for the year) on a one-time investment in the primary care workforce. The other \$250 million was spent on community and clinical prevention (\$126 million), the public health infrastructure (\$70 million), research and tracking (\$31 million) and public health training (\$23 million).⁵⁶ APHA was part of a group of 90 organizations that urged the Administration to allocate the entire \$500 million, not just \$250 million, to public health issues, not the primary care workforce.⁵⁷ The allocation process for the Prevention and Public Health Funds is expected to receive increased scrutiny by



Definition of Health Disparities⁷⁰

“...the difference in the incidence, prevalence, mortality and burden of disease and other adverse health conditions that exist among specific groups in the United States.”

congressional appropriations committees in future years.⁵⁸

Assuming future Fund allocations are entirely devoted to prevention and public health workforce training, there will still be difficult decisions about how to allocate the funds among different public health initiatives (e.g., tobacco cessation, nutrition, physical activity), the public health infrastructure, research and tracking, and public health workforce training. Transparent reporting of funding allocations, evaluation and strategic planning is required by both the National Health Prevention, Health Promotion and Public Health Council and the Secretary of the Department of Health and Human Services. Ideally, the investment will be leveraged through careful coordination with state, local and private resources and reflect the best evidence on efficacy to have maximum impact.⁵⁹

An amendment (to the Small Business Jobs and Credit Act) by Senator Mike Johanns in late summer of 2010 was the first official congressional threat to the Prevention and Public Health Fund. This amendment would have repealed a provision of the Affordable Care Act designed to raise new revenue by decreasing non-compliance with tax laws. It would have been funded by eliminating the Prevention and Public Health Fund from fiscal year 2010 to fiscal year 2017. APHA and other organizations opposed the amendment and it was defeated.⁶⁰ Increased pressure to reduce the federal deficit during the 112th Congress is likely to result in legislative proposals to cut the Fund. Preserving the Fund as created by the Affordable Care Act will require vigilance and coordinated strategic efforts by public health and prevention advocates. It will be important to remind lawmakers of the economic case for prevention, with an estimated \$5.60 of health cost savings for every \$1 spent on certain prevention initiatives.⁶¹

Role of the National Prevention, Health Promotion, and Public Health Council. The White House released an Executive Order on June 10, 2010, officially establishing the National Prevention, Health Promotion, and Public Health Council.⁶² On July 1, 2010, the Surgeon General released the Council's first annual status report.⁶³ The Council

is charged with coordinating and leading the work on the federal level with respect to prevention, wellness, health promotion, public health system, and integrative health care. In addition, it is to develop a broad-ranging "national prevention, health promotion, public and integrative health-care strategy," and make recommendations to the President and Congress regarding tobacco use, sedentary behavior and poor nutrition. The Council is well-positioned to build on the work of Healthy People 2010 and Healthy People 2020, and has the authority to coordinate the work of various federal agencies in a way that is more transparent and accountable to the public, the Administration and Congress. The first annual report acknowledges the importance of leading and coordinating federal efforts on prevention. That role will continue into the future even after the strategy is completed and released to the public early in 2011.

The Council's first status report notes the significance of its taking "a community health approach to prevention and wellness" and of the requirement that its recommendations be grounded in science-based prevention recommendations and guidelines.⁶⁴ The Council's report reflects an understanding of the need for actions, interventions and policies that go beyond the health system to address problems in schools, transportation and education. The report expands on how it will determine whether interventions are effective, listing five major strategies for public health interventions. They are:⁶⁵

- **Policy:** supporting policies that promote prevention, create healthy environments, and foster healthy behaviors (e.g., removing barriers to safe and convenient walking and bicycling).
- **Systems change:** establishing policies that support healthy behaviors (e.g., establish patient registries, appointment and medication reminder systems, and incentives to help monitor and control high blood pressure and high cholesterol).
- **Environment:** creating social and physical environments that support healthy lives and choices (e.g., improve access to fresh fruits and vegetables in at-risk urban and underserved communities).



National Prevention, Health Promotion, and Public Health Council is to develop a broad-ranging "national prevention, health promotion, public and integrative health-care strategy," and make recommendations to the President and Congress regarding tobacco use, sedentary behavior and poor nutrition.

■ **Communications and media:** Supporting healthy choices and raising health awareness, especially among those who experience health disparities, through interactive, social and mass media (e.g., inform consumers about options for accessing and preparing healthy and affordable foods).

■ **Program and Service Delivery:** Designing prevention programs and services to contribute to wellness (e.g., provide safe and affordable opportunities for physical activity in schools).

Implementation Issues at Various Government Entities: As noted above, the National Prevention, Health Promotion and Public Health Council will coordinate federal prevention and public health initiatives. The Secretary of HHS, and agencies such as CDC, HRSA, and AHRQ are responsible for specific initiatives of varying scope and complexity, including hundreds of reports, and strategic decisions on a myriad of issues such as what criteria to use in awarding grants to state and local governments for various programs.⁶⁶ Each entity will face a set of implementation challenges in balancing research, grant-making, public education and congressional reporting deadlines. For example, the timing of the funding will impact implementation. Furthermore, specific awards will receive media scrutiny and pushback from stakeholders who may disagree. These pressures make it crucial that the leaders of the implementation effort, both in the Office of the Secretary and at each implementing agency, build highly skilled staff to lead the implementation efforts, including staff with proven project management skills and expertise in the communication of findings, recommendations and programs to the public in an accessible and transparent manner.

Efficient Use of State and Local Resources: Implementation of the health reform law is beginning at a time of strains and restrictions on the budgets of state and local governments. According to the National Association of County and City Health Officials, the recession has forced state and local governments



Public Health Council's intervention is creating social and physical environments that support healthy lives and choices (e.g., improve access to fresh fruits and vegetables in at-risk urban and underserved communities).

to reduce their overall workforces by 15 percent, cutting 23,000 staff, many of whom protect health and provide safety. It would take tens of billions of dollars to replace the lost staff, and the money provided in the Affordable Care Act will not be sufficient to restore the services that these employees provided.⁶⁷ So while state and local governments will mobilize to respond to the many new grant opportunities, they will do so in the context of a depleted health and public health workforce. This will make it difficult to create and sustain efficiencies around the new prevention and public health opportunities. It will be especially difficult for implementation efforts to reach their full potential at the state and local levels during the prolonged weak economy.

The states have major implementation responsibilities, including administering expanded Medicaid programs, revising state high-risk pool programs, establishing and regulating health insurance exchanges, and regulating and policing the health insurance marketplace. In addition, they are eligible to apply for grants, for example, to help them monitor premium increases, participate in personal respon-

The Council is well-positioned to build on the work of Healthy People 2010 and Healthy People 2020, and has the authority to coordinate the work of various federal agencies in a way that is more transparent and accountable to the public, the Administration and Congress.

sibility education programs, and establish insurance exchanges.

States already have established the State Consortium on Health Care Reform, consisting of the National Governors Association, the National Association of Insurance Commissioners, the National Association of State Medicaid Directors, and the National Academy for State Health Policy. Individual states have set up organizational structures. For example, California has established the Health Care Reform Task Force, and Colorado has appointed a Director of Health Reform Implementation and an Interagency Health Reform Implementing Board.⁶⁸

Additionally, 13 states have jointly filed a lawsuit contending that the individual mandate provision violates the Constitution. The outcome of this lawsuit, and its impact on implementation actions of these states, threatens to delay or even derail the ability of the Affordable Care Act to meet its potential.⁶⁹

Lessons learned from the American Recovery and Reinvestment Act of 2009 (ARRA). The implementation experience with the ARRA offers some lessons for consideration as the Affordable Care Act is implemented. Dr. Paul Jarris, Executive Director of the Association of State and Territorial Health Officials (ASTHO), contends that the ARRA prevention funds, which were distributed as two-year grants, were disseminated to high-capacity proven entities with “ready-to-go” programs. They were allocated, in large part, to big, sophisticated organizations, with the hope that positive results could be demonstrated more clearly. But to reach underserved and rural populations, the prevention funds would need to be distributed in a way that disseminates benefits more broadly, even though this may divert some funds to building infrastructure and may produce a more diffuse (and less measurable) impact. In the long-term, making an investment to communities where there is the greatest need but the weakest

infrastructure is likely to have a large impact on the improvement of public health.

Using Investment in Prevention to Address Health Disparities: The Agency for Healthcare Research and Quality has issued reports for the past seven years that measure and document the extent to which disparities exist in our health system. The reports document the level of quality (e.g., safety, timeliness) and access to care (e.g., barriers to care) for various racial, ethnic, income groups, as well as priority populations such as children and older adults. This year’s report found that significant disparities continue to pervade our health care system.⁷¹

The Affordable Care Act has several provisions that address health disparities as a priority in awarding various grants (e.g., community transformation grants) (Section 4201), developing research priorities (Section 6301), gathering accurate data (Section 4302), and evaluating community preventive services (Section 4003). In addition, the Prevention Education Campaign must address health disparities. The challenge of reaching individuals and groups that have traditionally been least well served by our health care system is large, and it is important that attention be paid during implementation to developing effective strategies that reach underserved populations with the information they need.

Preventive Care Benefits: The requirement that private group and individual health plans include preventive care benefits (recommended by the U.S. Preventive Services Task Force) without cost-sharing could face some implementation challenges. First, large employers that do not currently cover preventive services (a small percentage of health plans)⁷² could argue that the requirement to cover preventive services will increase premiums. Some might argue that the requirements to cover preventive services will increase total health care costs, notwithstanding research that estimates an average return of over \$5 for each dollar invested in

prevention.⁷³ While premiums could increase for the small percentage of plans that do not already include preventive care benefits, the increase in premium will offset out-of-pocket costs to cover such benefits, all of which are to be covered because they are recommended based on scientific evidence.

Another implementation issue concerning the preventive benefits in private and public health plans is the potential controversy that could arise over certain recommendations offered by the U.S. Preventive Services Task Force and the Task Force on Community Preventive Services. The controversy over the recommendations on mammography provided lessons about wording recommendations carefully to reflect the nuances of the evidence, and about the need for discussing an individual's personal circumstances with health care providers.⁷⁴

A third implementation issue is timing: When will health plans incorporate the new preventive benefits? The grandfather provision (and Administration rule) affects the timing. Grandfather status refers to the ability of a plan to continue to be offered “as is” to current enrollees so that people can truly “keep the plan” they are in.⁷⁵ In general, new private policies issued after Sept. 23, 2010, must include the new preventive benefits.

Employer Wellness Plans: Before the enactment of the health reform law, 58 percent of companies that offered health benefits covered at least one wellness program—such as gym membership discounts, weight-loss programs or nutrition classes—with larger firms more likely than smaller firms to do so. Few firms provided financial incentives for employers to participate in these programs. The most common forms of incentive, used by 10 percent of firms, were gift cards, travel, merchandise or cash. Only 1 percent of firms offered a lower deductible for participating in these programs, while 4 percent offered a discount on the employer share of premium.⁷⁶

The Health Insurance Portability and Accountability Act (HIPAA), enacted in 1996, established requirements for employer wellness programs that guard against employer health plans using minimum health standards (e.g., blood pressure levels or tobacco ces-

sation) to discriminate against people who have existing health conditions.⁷⁷

The provisions in the health reform law that encourage and support employer wellness plans have the potential to raise concerns that some employees may be penalized because they do not meet certain health status standards. The health reform law (section 4303) provides support to employers that offer wellness programs. For example, technical assistance will be provided to help employers increase participation and evaluate the impact. In addition, the law provides grants to employers with fewer than 100 employees to establish wellness programs.⁷⁸ While the law prohibits the use of assessments to require workplace wellness programs, some questions could arise when another provision is implemented. Section 2705 of Title I, which prohibits discrimination against individuals based on health status (i.e., higher premiums or denial of coverage), allows employers to provide financial rewards to employees who meet certain health standards. The financial incentive can be as high as 30 percent of the total employee premium initially, and can increase to 50 percent eventually, if the Secretary of the Department of Health and



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Expanding access to high-quality, high-value care—and matching that care to a workforce with the requisite skills to provide it—is a long-term endeavor. Reaching that goal will require us to consider new team practice approaches to increase the accountability of health organizations, medical homes and other models of care, integration of electronic health records and interactive systems, and review of medical licensing restrictions, among many other things.⁸³

Human Services allows this increase. Today the potential reward for employees is limited to 20 percent.⁷⁹ There are a number of restrictions that provide an opportunity for an employee to improve his or her performance on a health measure, but the bottom line is that some employees might feel that they are financially penalized for a poor blood pressure or cholesterol test result which they may consider to be more genetic than controllable through good nutrition, exercise and modified lifestyle habits.

The Affordable Care Act (Section 4303) requires employers to build capacity to evaluate the affect of these programs, and the Director of the Centers for Disease Control and Prevention to assess, analyze and monitor the impact of the programs, and report findings and recommendations to Congress. Earlier research about disease management programs, which share many elements of employer wellness programs, should provide lessons for employers and the CDC to help shape evaluation of these programs.⁸⁰

Healthcare and Public Health Workforce:

Millions of people will be newly covered under health reform by expanded benefits that include preventive care. This will place increased demands on primary care providers who focus on prevention. Massachusetts experienced shortages in primary care doctors after implementation of its health reform law.⁸¹ Title V of the Affordable Care Act calls for a Healthcare Workforce Commission that will issue reports with recommendations every year, beginning April 1, 2011. Even before health reform was enacted, the Association of American Medical Colleges projected that there would be a shortage of 46,000 primary care doctors in 2025.⁸²

The workforce issues that must be addressed go beyond the pipeline issue of training more primary care providers. Expanding access to high-quality, high-value care—and matching that care to a workforce with the requisite skills to provide it—is a long-term endeavor. Reaching that goal will require us to consider new team practice approaches to increase the accountability of health organizations, medical homes and other models of care, integration of electronic health records and interactive systems, and review of medi-

cal licensing restrictions, among many other things.⁸³

Patient-Centered Outcomes Research Institute (Institute): The Affordable Care Act establishes a new Institute that will establish and carry out a clinical outcomes research agenda to help patients, providers and policymakers make better informed decisions to advance health care quality. While the law refers to preventing illness as one of the areas for research, much depends on the extent to which the Institute makes prevention-focused research a priority. Close coordination with the U.S. Preventive Services Task Force and the Task Force on Community Preventive Services will be critical.

V. Conclusion and Recommendations

The health reform law includes language and funding that significantly expand the country's commitment to promoting health and preventing disease. The Affordable Care Act:

- establishes a high-level Council, with substantial funding for programs to improve population health, to coordinate federal programs and develop and implement a national strategy;
- seeks to reduce the large number of preventable deaths and illness by improving the environment and policies which in turn will increase positive health behavior; for example, by educating the public about nutrition, exercise, and tobacco cessation;
- builds evidence-based preventive services into private and public health coverage, without cost-sharing; and
- conducts pilot projects and research in communities nationwide that will increase our ability to further improve preventive and public health services and population health in the future.

The implementation challenges ahead are substantial, and legal and political challenges to the law create additional uncertainty. Coordination and cooperation across all levels of government and the private health industry will be needed to achieve the law's potential. The following recommendations, many drawn from the work of experts in the prevention arena, are offered to help guide the work of policymakers at the federal, state and local levels who are implementing reform:

- Policymakers should take steps to ensure that Prevention and Public Health Fund dollars provide a net incremental investment rather than displace existing spending,⁸⁴ and find creative ways to alleviate the severe budget pressure at state and local government agencies.
- New efforts should build on the theme emphasized throughout the health reform law that bases policy on good science. Communicate with target populations, healthcare providers, public health professionals and individuals, with evidence-based information that can improve health.
- Programs to improve population health should be designed with sensitivity to patient preferences, culture, needs and well-being, and with the goal of addressing the health disparities which severely limit the quality of care and health of millions of people;
- The Patient-Centered Outcomes Research Institute and other entities establishing research priorities should make research about effectiveness of techniques to prevent disease and disability a high priority, enabling new research that substantially improves population health.
- Notwithstanding the health reform law's focus on "clinical effectiveness" and not "cost-effectiveness," policymakers should explore how reimbursement policy (for Medicare, Medicaid, the Department of Veterans Affairs, the Federal Employees Health Benefits Program, and the private marketplace) can further encourage promotion of health and prevention of disease.
- Pilot projects (such as individual wellness plans for at-risk populations and interventions targeted at the pre-Medicare population) should be evaluated, and those that prove successful should be expanded nationwide.

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The Affordable Care Act seeks to reduce the large number of preventable deaths and illness by improving the environment and policies which in turn will increase positive health behavior; for example, by educating the public about nutrition, exercise, and tobacco cessation.

and Caroline Fichtenberg, staff member of the Senate HELP Committee.

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Appendix 2

Terms Used in Preventive Health and in the Issue Brief

Agency for Healthcare Quality and Research (AHRQ)—The agency within the U.S. Department of Health and Human Services that is charged with improving the quality, safety, efficiency, and effectiveness of health care for all Americans.

Centers for Disease Control and Prevention (CDC)—This is an agency within HHS responsible for increasing access to health care services to the uninsured and others who are medically vulnerable.

Department of Health and Human Services (HHS)—This is the federal department that is responsible for federal programs that involve the health and human services of Americans. It is the focal point for the nearly all health reform implementation. Key agencies are housed within HHS – the Agency for Health care Research and Quality, the Center for Disease Control and Prevention, the Health Resources Administration.

Health Resources and Services Administration (HRSA)—The Health Resources and Services Administration (HRSA), an agency of the U.S. Department of Health and Human Services, is the primary Federal agency for improving access to health care services for people who are uninsured, isolated or medically vulnerable.

Affordable Care Act—Congress enacted two laws in 2010 that reform the health care system in many ways. The Patient Protection and Affordable Care Act (P.L. 111-148) is the law that includes the provisions described in this issue brief. The Health Care and Education Reconciliation Act of 2010 (P.L. 111-152) included provisions primarily related to funding and payment issues. The “Affordable Care Act” encompasses both laws.

Healthy People—A project by federal agencies, working with State and Territorial health departments and hundreds of consortium members, to establish a framework for disease prevention and health promotion. The overarching goals are to increase quality and years of healthy life and to reduce health disparities. Healthy People 2010 had a comprehensive list objectives for disease prevention and health promotion, covering 28 focus areas (e.g., diabetes).⁸⁵

Task Force on Community Preventive Services—This independent task force, newly authorized by the health reform law and housed at the CDC, consists of experts in prevention and public health experts. It is charged with overseeing the analyses of public health interventions. It makes recommendations for interventions that advance population health. Its recommendations are available for free online; they are published in the *Guide to Community Preventive Services*.⁸⁶

U.S Preventive Services Task Force—An independent panel of experts in prevention and primary care. First established in 1984, it is now housed at the Agency for Healthcare Research and Quality. Its recommendations for preventive care are available for free online to everyone and are published in the *Guide to Clinical Preventive Services*.⁸⁷

Appendix 1:

APHA's Health Reform Implementation Timeline—Beyond coverage: Public health, prevention and wellness provisions

	2010
Prevention and Wellness	<ul style="list-style-type: none"> • Prevention and Public Health Investment Fund: Provides expanded and sustained national investment increasing from \$500 million in FY2010 to \$2 billion in FY2015 and year thereafter. • National Health Promotion and Prevention Strategy: Directs an interagency council, chaired by the U.S. Surgeon General, to develop a national prevention and health promotion strategy. • Healthy Aging, Living Well Program: Creates a pilot program to help control chronic disease and reduce Medicare costs of the pre-Medicare-eligible population. • Pregnancy Assistance Fund: Awards competitive grants to states to assist pregnant and parenting teens and women, and victims of domestic violence and sexual assault. \$100 million each year for FY2010-2019. • Commission on Key National Indicators: Establishes "Commission on Key National Indicators" to develop and oversee a "Key National Indicators" system. Authorizes but does not appropriate \$10 million for FY2010 ; \$7.5 million from FY2011-2018. • Community Transformation Grants: Grants to implement, evaluate and disseminate proven evidence-based community preventive health activities. • Increased Funding for Immunizations: State grants to increase recommended immunizations in high-risk populations. Allows states to purchase adult vaccines directly from manufacturers at HHS-negotiated price. Reauthorizes section 317 program; Authorizes but does not appropriate \$1 million for FY2010. • Maternal, Infant and Early Child Home Visitation Programs: Funding to states, tribes and territories to develop and implement one or more evidence-based Maternal, Infant and Early Childhood Visitation model(s). Authorizes \$1.5 billion in total funding FY2010-2015. • Personal Responsibility Education Grants: Funding to states to educate adolescents on abstinence and contraception for prevention of teenage pregnancy and sexually transmitted infections, including HIV/AIDS. Authorizes but does not appropriate \$75 million/year FY2010-2014.
Public Health	<ul style="list-style-type: none"> • Federally Qualified Health Center (FQHC): Authorizes but does not appropriate funding for FQHCs that increases from \$2.98 billion in FY2010 to \$8.33 billion in FY2015. • Address Access to Care Issues: Authorizes but does not appropriate \$100 million to be available through September 30, 2011 to fund infrastructure projects to expand access to care. • School-Based Health Clinics: Creates a grant program for the operation and development of school-based health clinics. Authorizes \$50 million each year for FY2010-2014 and equipment expenditures. • Nurse-Managed Health Clinics: Grant program, administered by HRSA, to support nurse-managed health clinics. Authorizes but does not appropriate \$50 million for FY2010-2014. • Surveillance and Lab Capacity: Establishes a CDC grant program to improve surveillance for and responses to infectious diseases and other conditions of public health importance. Authorizes but does not appropriate \$190 million each year for FY2010-2013.
Public Health Workforce	<ul style="list-style-type: none"> • National Health Care Workforce Commission: Creates a commission charged with disseminating information on current and projected health care workforce supply and demand, education and training capacity, retention programs, and fiscal sustainability. • National Health Service Corps: Increases and extends funding authorization for the scholarship and loan repayment program for FY2010-2015. • Public Health Professional Training: Training program for mid-career public health professionals. Authorizes but does not appropriate \$30 million for FY2010. • Healthcare Workforce Development: Grant program to support state and regional partnerships to complete comprehensive workforce planning and development. Authorizes but does not appropriate \$8 million in FY2010 for planning grants (entities must match at least 15% of funding) and \$150 million for FY2010 for implementation grants (entities must match 25% of funding). • National Emergency Corps: Establishes Ready Reserve Corps within the Commissioned Corps for service in times of national emergency. Authorizes but does not appropriate \$100 million each year for FY2010-2014. • Allied Health Professional Loan Repayment: Loan repayment to allied health professionals employed at public health agencies or in settings providing health care to patients in underserved areas. Authorizes but does not appropriate \$30 million for FY2010. • Pediatric Loan Repayment: Loan repayment program for pediatric subspecialists who are or will be working in underserved areas. Authorizes but does not appropriate \$30 million year for FY2010-2014. • Primary Care Training: Authorizes but does not appropriate \$125 million for FY2010 for primary care training grants. Authorizes but does not appropriate \$750,000 for each year from FY2011-2014 for integrating academic units of primary care.
Insurance	<ul style="list-style-type: none"> • Elimination of Cost-Sharing for Preventive Care in Private plans: Eliminates co-payments, co-insurance, and deductibles for preventive care for plans purchased after September 23, 2010; provides 100% coverage for preventive services.
Medicaid	<ul style="list-style-type: none"> • Coverage for Family Planning Services: Creates a state option to provide Medicaid coverage for family planning services to certain low-income individuals. • Coverage for Tobacco Cessation Programs: Requires states to provide Medicaid coverage for tobacco cessation services for pregnant women and eliminates cost sharing for tobacco cessation services.
Medicare	

	2011	2012	2013
<p>and each fiscal</p> <p>promotion strategy.</p> <p>Authorizes \$25</p> <p>it does not</p> <p>om</p> <p>nt, and Early</p> <p>nsmitted</p>	<ul style="list-style-type: none"> National Improvement Strategy: Develops a national quality improvement strategy that includes priorities to improve the delivery of health care services, patient health outcomes, and population health. Nutrition Labeling Requirements: Requires nutrition labeling on standard menu items at chain restaurants and on food sold from vending machines. Education and Outreach Campaign on Preventive Benefits: Requires HHS to convene a national public/private partnership to conduct a national prevention and health promotion outreach and education campaign; funding not to exceed \$500 million. 	<ul style="list-style-type: none"> Oral Health Campaign: Establishes 5-year national public education campaign on oral healthcare prevention. Demonstration grants to demonstrate the effectiveness of research-based dental caries disease management activities. 	
<p>ccess to care.</p> <p>13 for facilities</p> <p>2010.</p> <p>mportance.</p>	<ul style="list-style-type: none"> Expansion of National Health Service Corps: Establishes Community Health Center Fund to increase investment in National Health Service Corps. Authorizes a total of \$1.5 billion in funding increasing from \$290 million in FY2011 to \$310 million in FY2015. Increasing Community Health Center Funding: Authorizes additional funding for community health centers, increasing from \$1 billion in FY2011 to \$3.6 billion in FY2015. Provides an additional \$1.5 billion for renovation and construction. 		
<p>demand,</p> <p>es but does not</p> <p>match at least</p> <p>ropriate \$50 million</p> <p>nts in</p> <p>0 million each</p> <p>ch year FY2010-</p>	<ul style="list-style-type: none"> Payments for Teaching Residency Positions: Requires HHS to redistribute certain unfilled residency positions for training of primary care physicians. Public Health Workforce Loan Repayment: Creates a Public Health Workforce Loan Repayment Program, authorizing but not appropriating \$195 million for FY2010 and such sums as may be necessary for FY2011-2015. Participants eligible to receive up to \$35,000 for loan repayment for each year of service. 		
<p>ptember 23,</p>			
<p>for these</p>	<ul style="list-style-type: none"> Behavior Modification Incentives: State grants for behavior modification incentive programs to lower chronic disease risk factors among Medicaid beneficiaries. Authorizes \$100 million in FY2011-2015. 		<ul style="list-style-type: none"> Primary Care Payment Increase: Increases Medicaid payments for primary care services provided by primary care doctors for FY2013-2014 with 100% federal funding. Elimination of Cost-Sharing for Preventive Care in Medicaid: Eliminates co-payments, co-insurance and deductibles for preventive care; provides 100% coverage for preventive services. Increases FMAP allocation to states for these services by 1%.
	<ul style="list-style-type: none"> Elimination of Cost-Sharing for Preventive Care in Medicare: Eliminates co-payments, co-insurance and deductibles for preventive care; provides 100% coverage for preventive services. Prevention Plans and Behavior Modification: Medicare coverage of an annual wellness visit and personalized prevention plan, which include a comprehensive health risk assessment. Provides incentives to complete behavior modification programs. Health Profession Shortage Area (HPSAs) Bonuses: Provides primary care practitioners and general surgeons practicing in HPSAs, with a 10% Medicare payment bonus for five years. 		

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