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Special Article

Prevention in the United States Affordable Care Act

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The Affordable Care Act (ACA) was signed into law on March 23, 2010 and will fundamentally alter health care in the United States for years to come. The US is currently one of the only industrialized countries without universal health insurance. The new law expands existing public insurance for the poor. It also provides financial credits to low income individuals and some small businesses to purchase health insurance. By government estimates, the law will bring insurance to 30 million people. The law also provides for a significant new investment in prevention and wellness. It appropriates an unprecedented $15 billion in a prevention and public health fund, to be disbursed over 10 years, as well as creates a national prevention council to oversee the government's prevention efforts. This paper discusses 3 major prevention provisions in the legislation: 1) the waiving of cost-sharing for clinical preventive services, 2) new funding for community preventive services, and 3) new funding for workplace wellness programs. The paper examines the scientific evidence behind these provisions as well as provides examples of some model programs. Taken together, these provisions represent a significant advancement for prevention in the US health care system, including a shift towards healthier environments. However, in this turbulent economic and political environment, there is a real threat that much of the law, including the prevention provisions, will not receive adequate funding.

Key words: Prevention, Wellness, Affordable Care Act, Health insurance, Clinical preventive services, Community preventive services
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INTRODUCTION

On March 23, 2010, President Obama signed into law legislation that will reshape health care in the United States for years to come. The Affordable Care Act (ACA), as it is known, is the nation's first serious attempt at universal health care. The United States is one of the only countries in the Organization of Economic Cooperative Development (OECD) that does not have universal health coverage for its citizens.

Most countries offer a package of insurance products that are public, private, or a combination of the two-- with or without mandates [1]. Because there are no requirements for health service coverage in the United States, health care is financed in a variety of ways. In 2007, the 1.9 trillion dollars in personal health care expenditures was 45 % public funds and 55% private [2].

The recent recession has taken a heavy toll on Americans' health insurance status. In 2009, individuals receiving public insurance because they met poverty definitions rose to 15.7% of the population-reflecting a higher number of people in poverty than at any time since 1987. The percentage of Americans getting private insurance through their employer (56%) is at its lowest level since 1987 [3]. Most worrisome are the rates of uninsured Americans, which are at an all-time high, rising from 15.4% in 2008 to 16.7% in 2009.

Other significant challenges to the American health care landscape are the many barriers to receiving preventive health services and the significant disparities between utilization of these services by people of color (Hispanic, Black, American Indian and others). Well over 80% of American adults get appropriate screening for hypertension and cervical cancer, while less than 30% of smokers are offered assistance to quit and only 37% of adults receive an annual influenza vaccine. In general, people of color receive clinical preventive services at a lower rate for every recommended service [4].

The ACA is courageous legislation that will go far in providing health insurance to many more Americans and will eliminate a myriad of barriers to preventive services. Official government estimates are that it will newly insure 30 million people, and bring the total percentage of insured up to 96%. It will do this by building on the health system as it is currently organized. Most citizens purchase private health insurance through their employer and they will continue to do so. For those who don't get insurance from their employer, and for employees of some small businesses, the federal government will offer credits to help purchase insurance. The government will also expand its public health insurance to the poor (Medicaid).

To be sure, Americans have access to some of the best diagnostic technologies and cutting edge treatments in

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the world. But that is part of the problem. The US spends twice as much on health care as other developed countries, yet has worse health outcomes. The question is why. In many ways, the United States has a “sick care” system and not a “health care” system. What this means is that very few resources, around 3% of all health spending, are invested in preventing death and disease before they actually happen. Much more money is spent on treating illness as it occurs. For too long, prevention and wellness have been neglected. Now, chronic diseases like heart disease, cancer, and diabetes account for 7 out of 10 deaths and 75% of all health spending. Yet these diseases are largely preventable. Just 4 preventable behaviors, smoking, alcohol misuse, unhealthy eating, and physical inactivity account for 40% of deaths [5]. Under the ACA, prevention will play a much more integral role in American health care. This paper focuses on the ways in which the law will change prevention efforts for the better.

New thinking on prevention is that conditions like obesity are in some ways more a result of unhealthy environments than individual behavior. The United States is a prime example-- the combination of cultural norms, agricultural practices, government policies, big-business interests, and technological advancements make obesity almost a foregone conclusion. As Thomas Frieden, Director of the federal Centers for Disease Control, says, just being an American can lead to obesity [6]. What is important about the way the ACA improves prevention is that it strengthens 3 key environments: the clinic, the community, and the workplace. It does so by improving access to clinical preventive services and by increasing funding for community and workplace wellness activities. To pay for it all, the ACA includes a historic funding stream-- a $15 billion “Prevention and Public Health Fund”, to be administered over 10 years. And, it coordinates these prevention efforts through a new National Prevention, Health Promotion, and Public Health Council, chaired by the Surgeon General, and composed of high level federal officials.

Eliminating Cost Sharing for Clinical Preventive Services

One of the most significant provisions in the legislation eliminates cost-sharing for clinical preventive services–the prevention services furnished in a provider’s office–in all new plans and in Medicare. Though it is well understood that cost-sharing discourages overutilization and helps contain spending, it also discourages utilization of beneficial services. For instance, co-payments decrease the use of services like mammography, pap smears, and blood pressure screenings by as much as 15% [7]. The patients most harmed are low-income minorities because they are more likely to be enrolled in high cost-sharing plans.

The covered services will include all those that have received an “A” or “B” recommendation by the US Preventive Services Task Force (USPSTF). Notable recommendations include aspirin for the prevention of cardiovascular disease, colon cancer screening, smoking cessation counseling, immunization against the flu, and mammography. If these five services were used 90% of the time, it is estimated that more than 100 000 deaths would be prevented in the United States each year [8]. With the exception of breast cancer screening, current estimates are that patients get them only about 50% of the time or less [9]. Medicare recipients will be eligible for a covered annual wellness visit to include a health risk assessment, physical exam, comprehensive medication and provider list, a 5-10 year schedule for preventive screenings, and the USPSTF recommended clinical preventive services.

Unfortunately, the provision to eliminate cost sharing for valued clinical preventive services does not extend to Medicaid. States can, however, receive an increase in their Federal Medical Assistance Percentage (FMAP) if they cover these services on their own. The law also improves access to clinical preventive services for medically underserved children and adolescents through the establishment of school based health centers. In these, students will have access to preventive physicals, acute and chronic disease treatments, and mental health services. Grant preference will be given to those schools that serve a high Medicaid population.

New Funding for Community Preventive Services

Preventive services are more than screening tests delivered in provider offices. Over the last decade, preventive services anchored at the community level have developed, and include programs and policies that promote healthy behaviors. Similar in concept to the USPSTF, the Task Force on Community Preventive Services evaluates and recommends community preventive services. Since its founding in 1996, the Task Force has issued more than 200 recommendations on subjects ranging from alcohol to violence prevention. There are many recommended services, but some of the most effective involve smoking cessation. A Massachusetts program, for example, covering anti-

smoking medication and counseling sessions, has shown a roughly 10% decrease in smokers, or about 30 000 people, in two and a half years. Health reform covers a similar tobacco cessation program for pregnant women in Medicaid, including pharmacotherapy and counseling.

Another widely discussed program is the YMCA in Marshalltown, Iowa, which offers a variety of community preventive services, including a community walking guide, an after-school physical activity program for low-income children, and the construction of a bike and pedestrian friendly river-walk through the middle of town [10]. Other examples of community preventive services include taxes, educational initiatives, disease management programs, and laws, to name just a few.

The new health law would fund community preventive services at levels never before seen by way of federal grants made to states. Under a provision called, “Incentives for Prevention of Chronic Diseases in Medicaid”, states will get $100 million to develop interventions that target tobacco, weight loss, cholesterol, blood pressure, and diabetes. Through “Community Transformation Grants”, there is authorization for states to receive funding for activities that promote healthier school environments, workplace wellness, and active living. And in, “Healthy Aging, Living Well”, there is authorization for states to compete for grant money to develop pilot programs to help people ages 55-64 get community interventions, screenings, and referrals to health care providers before they enter Medicare. Unfortunately, many of these initiatives are authorized but not automatically appropriated. This leaves funding up to Congressional appropriators–making it more unpredictable.

For all their promise, research on the aggregate effectiveness of community preventive services is scant. There is, however, one widely promulgated report by “Trust for America’s Health” which suggested that certain community prevention programs can improve health and lower health care costs [11]. It found that an investment of $1 could yield a return of $5 in 5 years. Its conclusion was based on a review of 84 different programs and suggested that diabetes, heart disease, stroke, kidney disease, and high blood pressure could be reduced by 5% in 2-5 years.

Worksite Wellness Programs

A logical place to target health promotion and wellness interventions is the workplace, and the ACA encourages the development of workplace wellness programs. Specifically, small businesses of less than 100 employees will be eligible for $200 million dollars in newly authorized grant funding for this purpose. The legislation also commissions CDC to study these programs and further elucidate what works.

Employers are increasingly adopting wellness programs because there is strong evidence of their cost-effectiveness. The Citibank Health Management program reported an estimated $4.50 of savings on medical expenses for every dollar invested in the program. In a separate meta-analysis, Baicker et. al found savings of $3.27 on medical costs for every dollar spent [12]. The economic benefits occur because employee health improves–there is strong evidence that wellness programs reduce tobacco use and lower blood pressure, fat intake, and cholesterol levels [13].

Wellness programs take a variety of different forms. Pitney Bowes, a document management company, redesigned their workspace to have fewer walled offices and desktop printers in order to encourage employees to walk more [14]. In the cafeteria, they made access to healthy foods easier by reducing prices and by cutting back on junk food. They also reduced portion sizes.

By far, the most common element of a worksite wellness program is the health risk assessment (HRA). The HRA is a self administered survey of health-related behaviors such as diet, tobacco use, and blood pressure control. Results of the assessment are provided to the participant in a format that signals behaviors that either need modifying or are well managed. Employees are encouraged to use the results of their HRAs to utilize employer sponsored interventions, which include educational materials, counseling, fitness programs, on-site clinics, and financial incentives.

During drafting of the ACA, financial incentives for participation in wellness programs were hotly debated, and some questioned whether they should be included in the legislation at all. Many groups, including members in Congress, had concerns that Americans could be discriminated against if unattainable goals were set (i.e., BMI too low, cholesterol too low, etc.). Despite the controversy, research demonstrates health benefits–a randomized controlled trial for smoking cessation showed that the group receiving financial incentives had a 10% difference in cessation rates 9 or 12 months later compared to control [15]. The law expands these incentives by allowing employers to discount health insurance premiums for all those who satisfy a health standard, by up to 50%.

The evidence for the effectiveness of worksite wellness programs is strong, but they must be delivered correctly. Experts agree that to be successful, programs

should be comprehensive, tailored to the population, marketed in a creative fashion, and be embraced by top management [16].

CONCLUSION

The Affordable Care Act is designed to deliver near-universal health coverage to Americans for the first time in history. Prevention will be a major part of this transformation. New tools at various levels of the environment should actually make it easier to be healthy in America. For all of its social good, universal health coverage and health promotion activities are politically charged areas. The elections of November 2010 have changed the political party power structure in Washington DC and there are rumblings by members of the Republican Party that they want to repeal portions or all of the provisions of the ACA. Only time and the democratic process, will tell whether all Americans are offered the chance to improve and maintain optimum health and change the current "sick care" system into that which can truly be called a "health care" system.

CONFLICT OF INEREST

The authors have no conflicts of interest with the material presented in this paper.

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