The Affordable Care Act as it affects Public Health: Opportunities and Challenges

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Abstract

The Patient Protection and Affordable Care Act referred to as ACA offers to public health opportunities and challenges that initiate transformation of the U.S. health system from one that treats sickness to one that promotes health and wellness based on prevention. I examine the current health care system; discuss the ACA agenda, and present funding and implementation of public health and prevention provisions in the ACA impacting public health practice in the near future.
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Introduction

Healthcare reform by definition aims to provide policy changes to modify the existing healthcare system with the goal to increase healthcare protection for greater number of the U.S. population at a lower more affordable cost (ACA, 2012). The Patient Protection and Affordable Care Act (ACA) passed by Congress and signed by President Obama on March 23, 2010 became the historical health reform law. This major health reform bill was upheld by the Supreme Court on June 28, 2012 (Health Care Informatics, 2012) marking a significant milestone of public health’s efforts to promote health and wellness, rather than to focus on disease treatment (APHA, 2012). The ACA initiatives are comprehensive, based on recommendations made by panel of experts including public health practitioners committed to disease prevention and promotion of wellness. The success in the implementation of the ACA’s preventive provisions depends on the full commitment of the government, healthcare providers, public health, health plans, and insurance companies, as well as the community and its citizen’s engagement and education about the new choices available.

Evaluation of the Current Health Care System

Health informatics on preventable disease and death:

Americans lag behind other developed countries in key health measures, spend far more per capita each year on health care, are becoming increasingly unhealthy, lack access to health education, do not consume nutritious foods, have a sedentary lifestyle, and lack access to safe and secure environments (APHA, 2012). According to O’Carroll et al (2003) to many preventive medicines is a contradictory term, after all medicines are used primarily to cure illness, not to prevent them. Altering the chronic diseases problem of obesity, heart disease, and cancer
affecting the whole nation, must start on changing the influence of the curative model of health care through education and promotion of preventive care (APHA, 2012). Determinants of health; poor diet, smoking, excessive alcohol consumption, and physical inactivity as the direct result of poor choices, lifestyle behaviors, economic, and geographic factors have been ignored or given little attention by the health system as preventive causes of coronary artery disease, obesity, and cancer (Shearer, 2010). The statistics are disturbing on the burden of preventable disease and death in the United States. In 2009 an alarming 26.6 percent of the population was obese, 8.2 percent of adults had diabetes, and 27.8 percent of adults had high blood pressure (Minnetonka, 2009). Alternatives use of information technology to help prevent rather than cure disease and gear resources into preventive services include electronic assessment tools, electronic medical records, health information exchange, the comprehensive health risk assessment, and interactive voice response systems (O’Carroll, et al., 2003).

Public health successes and failures:

Numerous are the accomplishments of public health in the 20th century starting with the increase of life expectancy, conquering devastating diseases such eradication of smallpox, control of infectious diseases through mass vaccination campaigns, improved sanitation, access to clean water, food safety, tobacco use reduction, health education, and advances in family planning methods (CDC, 2012). The failures in the health system are evident and will continue to increase mainly due to short supply of primary care providers and public health professionals and the healthcare financial system of fee for service instead of promoting changes in lifestyle. According to Shearer (2010) the following measures indicate how poorly our nation is doing with respect to raising healthy children: only 70 percent of pregnancies receive prenatal care, 85 percent of children receive vaccinations, 19 percent of children are obese, 9 percent of children
have asthma, approximately 17 percent of children have some type of developmental disorder, about 1.2 million children dropout of high school, and a suicide incidence of 9.5 per 100,000 for 15 – 10 years old occurred in 1996. The Institute of Medicine (IOM) (cited in Schneider, M.J., 2006) reported that “the current generation of children and young adults in the United States could become the first generation to experience shorter life spans and fewer healthy years of life than those of their parents”.

**Public health challenges:**

A major challenge in public health is the increasing rates on non-communicable chronic diseases (obesity, diabetes, high blood pressure, heart disease, and cancer) and the prevalence of these conditions despite the success and previous advancements made in life expectancy’s increase of 30 years in the U.S. at the close of the 20th century. Other challenges include decreasing the high overall health care spending, improving early childhood health, decreasing infant mortality, and promoting good nutrition and healthy communities (Robert Wood Johnson Foundation, 2010). Potential public health interventions to meet behavioral factors associated with preventable diseases and possible with the implementation of the ACA Prevention Fund include physical education at schools, workplace policies that support physical activity, projects that make neighborhoods greener and more walkable, nutritious foods available at schools, restaurants, workplace, and communities, clean air, tobacco taxes, tobacco prevention programs at the community and schools, regulation on the number of alcohol retailers in the community, and enhancement of enforcement laws against sale of alcohol to minors, and school and community-based outreach (APHA, 2012). Additional challenges to meet in public health interventions are development of policies that support prevention, system change that support healthy behavior, and creating social and physical environments that support healthy life choices.
Agenda for Health Reform

Population based and community based prevention:
The ACA consist of 10 separate legislative Titles that aims mainly; first, shared responsibility among government, employers and individuals to achieve universal healthcare coverage; second, provide health insurance coverage that is affordable, fair and of high quality; third, reduce spending while improving health care efficiency, value, and accountability; fourth, promote primary and preventive health care; and fifth, invest in public health by expansion of community preventive care (Rosenbaum, 2011). In order to accomplish ACA aims, a broad range of initiatives to promote wellness and prevent disease have been designed and are to be implemented through grants. The provision of a substantial Prevention Health Plan, National Prevention and Health Promotion, and Public Health Council would assist in the coordination of preventive initiatives (APHA, 2012). Local and state health departments are expected to use the qualified funding to build the infrastructure, educate, prevent chronic diseases, and assist to build healthy communities through policy development, and environmental changes. According to Shearer (2010) 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 cost”. Grant programs to promote prevention funded by ACA health reform to be administered by the Department of Health and Human Services fall basically under the following six ACA sections: 1) School based Health Centers operation support, 2) Incentives for Prevention of Chronic Disease in Medicaid, 3) Community Transformation Grants, 4) Healthy Aging, Living Well, 5) Epidemiology and Laboratory Capacity Grant Program, and 6) Maternal, Infant and Early Childhood Home Visiting Programs (ACA, 2012).
Education and Outreach programs:

Public health education campaigns that emphasize the importance of evidence-based preventive services must reach a diverse population to reduce health disparities (APHA, 2012). Multiple communication venues; radio, television, web sites, and innovative information technology tools will be used in the health campaign to address life style choices, good nutrition, obesity reduction, adequate amount of exercise, alcohol consumption, and tobacco cessation. Public health education will target the five disease killers’ heart disease, cancer, stroke, respiratory disease and Alzheimer (CDC, 2011). Nutrition information campaigns led by restaurants disclosure of calories and nutrient content of food and public health educational campaigns on dental, oral, and vision health, as well as pregnancy, disabilities, ethnic and cultural diversity would add to the health prevention messages (APHA, 2012). The U.S. Department of Health and Human Services (2012) offers accessible brochures, posters, fact sheets, and outreach on-line to ethnic populations (African American, Asian Americans, and Latinos), businesses and health care providers, early retirees, families, people living with HIV and other medical conditions, people with disabilities, seniors, veteran, and rural Americans on the benefits of the ACA in both English and Spanish.

Prevention, Wellness Funding and Services:

Two provisions are part of the ACA funding and implementation on prevention and wellness (APHA, 2010). The Prevention and Public Health Fund provides mandatory funding for prevention and public health activities, this provision was to appropriate funds of $500 million in fiscal year (FY) 2010, $750 million FY2011, $1 billion FY 2012, $1.25 billion FY 2013, $1.5 billion FY 2014, $2 billion in FY 2015 and each fiscal year thereafter, but the Congress through
appropriation legislation has already modified the amount for 2012 and the following years (APHA, 2012). The other provision on prevention and wellness is the National Prevention, Public Health and Health Promotion Council/National Prevention Strategy which directs formation of an interagency council, chaired by the U.S. Surgeon General and development of a National Prevention and Health Promotion Strategy (APHA, 2011). Some of the preventive services covered under the ACA free of copayments, co-insurance, or deductible in a new insurance plan or insurance policy beginning on or after September 23, 2010 for adults include: Abdominal Aortic Aneurysm one-time screening of specified ages who have ever smoked, alcohol misuse screenings and counseling, aspirin use at certain age, screening for blood pressure, cholesterol, colorectal cancer, depression, HIV, obesity, sexual transmitted diseases, and Type 2 diabetes, tobacco use and cessation interventions, diet counseling, and immunization vaccines (DHHS, 2012). Covered preventive services for women, including pregnant women include anemia screening, bacteruria, breast cancer mammography and chemoprevention, cervical cancer screening, screening of chlamydia infection, gonorrhea, Hepatitis B, HIV, Human Papilloma Virus, and osteoporosis. Starting August 1, 2012 the new prevention-related health services include breastfeeding, contraception, domestic violence counseling, gestational diabetes, and well-women visit (DHHS, 2012). Covered preventive services for children include alcohol, drug use, and behavioral assessment, autism screening, depression, development screening, fluoride chemoprevention, hearing, blood pressure, congenital hypothyroidism, immunizations, phenylketonuria (PKU), and obesity screening, sexually transmitted disease, tuberculin testing, and vision screening (DHHS, 2012).
**Programs to reduce health disparities:**

Reaching the underserved population (racial, ethnic, and income groups) as well as priorities populations (children and the elderly) with ACA information, health education campaigns, health education, and grant opportunities is addresses by the ACA provisions as a priority in awarding community transformation grants, developing research priorities, gathering accurate data, and evaluating community preventive services (Shearer, 2010).

Empowering individuals and communities to be in charge of their health care under the law, has been ensured with a new “Bill of Rights” which provides stability and flexibility to make health informed choices. The patient’s bill of rights provides coverage to Americans with pre-existing conditions, protects their choice of doctors, keeps young adults covered, ends lifetime limit on coverage, ends pre-existing conditions exclusions for children, ends arbitrary withdrawals of insurance coverage, reviews premium increases, helps get the most of premium dollars with no administration cost, restricts annual dollars limits on coverage, and removes insurance company barriers to emergency services (DHHS). Grant programs to promote prevention which provide an opportunity to address health disparities funded by ACA health reform to be administered by the Department of Health and Human Services fall basically under the following six ACA sections: 1) School based Health Centers operation support, 2) Incentives for Prevention of Chronic Disease in Medicaid, 3) Community Transformation Grants, 4) Healthy Aging, Living Well, 5) Epidemiology and Laboratory Capacity Grant Program, and 6) Maternal, Infant and Early Childhood Home Visiting Programs (APHA, 2011).
**Federal policies:**

The ACA health reform law provides support in the form of grants for employers with less than 100 employees to establish wellness programs. The employer is responsible for evaluating the impact of the wellness program and the Centers for Disease Control and Prevention (CDC) to assess analyze, monitor the impact of the program, and report findings and recommendations to the Congress (Shearer, 2010). According to Rosenbaum (2011) the federal regulation states that “wellness activities need not be limited to the act of participating in wellness programs but can include incentives aimed at actually achieving improved health results”.

When the law is fully implemented in 2014 the affordable insurance exchange will be in effect, individual requirements to begin coverage begins and an estimated 94 percent in California will be ensured, either through their employer, a new exchange market, or expansion to public benefits programs (California Health Care Foundation, 2012).

**CDC’s Public Health Tracking Network:**

The purpose of the Affordable Care Act National Environmental Public Health Tracking Program-Network Implementation from the CDC’s National Center for Environmental Health, Division of Environmental Hazards and Health Effects, Environmental Health Tracking Branch is to establish and maintain a nationwide tracking network to obtain integrated health and environmental data and use it to provide information in support of actions that improve the health of communities (CDC, 2011). The Public Health Tracking Network strengthens public health agencies’ abilities to prevent and control health conditions that may be linked to environmental hazards (APHA, 2012). Approximately $4,920,000 in ACA funding will be awarded to the grantees for network expansion and enhancement. Funding appropriated from the
Prevention and Public Health Fund (PPHF) allows the applicant states to utilize networks available tracking data for health assessments to be used in public health prevention programs (CDC, 2011). Examples of the 2011 successes include identification of pre-term births clusters associated with traffic exposure in California, evaluation of community concerns of unexpected clusters in oral cancer in Massachusetts, and quantification of indoor pollution levels associated with tobacco exposure showing three times the accepted exposure levels identified by the Environmental Protection Agency in Oregon (APHA, 2012).

The Public Health Workforce

Current challenges:

The aims and goals of the ACA are to transform the health care system from one that focuses on treatment into one that focuses on health promotion and prevention. Success in accomplishing the task at hand requires adequate numbers and properly trained workforce. Public health is “the practice of preventing disease and promoting good health by providing the resources and creating environments that help people stay healthy “(APHA, 2012). Therefore, a skilled workforce must match those long range endeavors. A public health professional is defined by the IOM (cited in Schneider, 2006) as “a person educated in public health or related field who is employed to improve health through a population focus”, includes: program administrators, public health epidemiologist, physicians, nurses, pharmacists, educators, veterinarians, laboratory scientist, environmental health specialists, food inspectors, first responders, and sanitarians, a list that keeps on growing (Schneider, 2006).
The public health workforce is currently struggling with decrease in qualified staff, funding, resources, proper training, and distribution of personnel in areas of need and demand. The loss of jobs at both local and state public health departments due to budget cuts have stressed the public health workforce performing more duties with less resources; impacting retention, recruitment, forcing early retirement, and consequently causing reduction in services. The ACA funding encourages health care and public health workforce training, reinstating existing programs and creating new ones, scholarship, fellowships, and residencies (APHA, 2011). Investment in the public health infrastructure by hiring and re-training the existing workforce is also an ACA aim to increase health emergency response capacity. Through the Community Transformation grants provision the demand for community-based programs that supports health promotion will need a trained public health workforce who can respond to the needs at various locations (APHA, 2011). In a study by Kanarek, Stanley, and Bialek (2006) on staff, resources, and community outcomes it was found that public health services such as hazards prevention and response and laboratory analysis substantially influence health outcomes including premature death rate.

**The Affordable Act’s Workforce Provisions:**

The ACA through mandatory appropriations, which do not require congressional actions to be available to public health to spend to enhance the workforce staff numbers and training, can be divided into five sections: 1) *Health Workforce training*; Public Health Workforce Loan Repayment Program creating a new program that provides up to $35,000 in loan payment for public health professionals who work for a minimum of three years at a federal, state, local, or tribal public health agency, Mid-Career Training Grants creates a new program to support scholarships in advanced education for mid-career public health and allied health professionals working in public health agencies, Preventive Medicine and Public Health Training Grants
which expands to support continuing education for current public health workers, besides
training in preventive medicine to physicians and schools of public health, Fellowship Training
in Public Health expanding fellowship programs in epidemiology, laboratory science, and
informatics, and the Public Health Science Track which creates a public health science track at
schools of medicine, dentistry, nursing, public health, pharmacy, dental, behavioral and mental
health to train in team-based service, public health, epidemiology, and emergency preparedness
and response (APHA, 2011). 2) Clinical Health Care Providers Training; expanding Health
Professions, Nursing Education Programs, and creating a new Primary Care Extension Program
to provide support and information in preventive medicine, health promotion, chronic disease
management, and evidence-based therapies. 3) Public Health Infrastructure; provisions for
Elimination of Cap Commission Corps eliminating the previous cap of 2,800 in the U.S. Public
Health Service, establishing a Ready Reserve Corps, expanding the All Hazard Preparedness For
Public Health Emergencies program under the Epidemiology and Laboratory Capacity Grants to
strengthen the epidemiology, laboratory and information technology to manage effective
response to infectious and chronic diseases, Grants to Promote the Community Health
Workforce creating new programs for the CDC to promote healthy behaviors in underserved
communities by training community health workers, and Grants for the construction and
operation of School-Based Health Centers (APHA, 2011). 4) New Public Health Programming;
Maternal, Infant, and Elderly Childhood Home Visiting Program focused in reducing infant and
maternal mortality, increase parental skills, school readiness, and economic self-sufficiency, and
5) Health Care Workforce Analysis creating the National Health Care Workforce Commission,
the National Center for Workforce Analysis, and the State Health Care Workforce Grants which
establishes a new competitive grants program to fund workforce planning, development, and implementation activities (ACA, 2012).

**Public health infrastructure and Funding:**

Provisions to strengthen the U.S. public health infrastructure include Increasing Community Health Center Funding for renovation and construction, Infrastructure to Expand Access to Care for debt service and renovation or construction of health care facilities that provide research, patient tertiary care, or outpatient clinical services, School Base Health Clinics funds for development of clinic facilities and equipment, Nurse-Managed Health Clinics support, and Epidemiology and Laboratory Capacity Grants. The ACA intentions for funding the provisions stated in the Public Health and Prevention Fund which would strengthen the U.S. public health infrastructure have not been implemented. The overall size of the grant and the annual appropriation process by which legislature or administration proposals can reduce, redirect, or eliminate the funding all together have been factors leading to cut in funding. Resources scarcity had prevented full funding also, and major cuts to the fund were applicable on February 2012 when Congress and President Obama signed the Middle Class Tax Relief and job Creation Act which cut $6.2 billion from the Fund over nine years. Instead of providing $16.75 billion from FY 2013 to FY 2021, a 37.3 percent reduction took place reducing the Fund to $10.5 billion (APHA, 2012). In addition, millions of dollars from the Prevention and Public Health Fund went to support clinical primary care force (physician’s residencies and nurse’s education) instead of public health activities and programs. Reduction in funding has also considerably affected programs aimed at training the public health workforce, out of the five programs mentioned previously only two have received funds (APHA, 2011).
Implementation of Public Health and Prevention Provision in the Patient Protection Affordable Care Act

Prevention and Wellness:

The ACA implementation of public health and prevention provision created a Community Preventive Services Task Force to review the scientific evidence related to the effectiveness, appropriateness, and cost-effective of community preventive interventions and recommendations (APHA, 2011) to determine preventive services adequate at different stages of life. According to Holden (2012) when the health care reform becomes effective in 2014, employers will be required to offer employees rewards from 30 percent initially, and up to 50 percent of the cost of coverage for participating in a wellness program and meeting health related standards. Employer’s wellness programs requirements established by the Health Insurance and Accountability Act (HIPPA) enacted in 1996, guard employer health plans to discriminate against prospect employees with existing health conditions (Shearer, 2010). As part of preventive care and public health research projects three examples include: 1) individualized wellness plans; designed to reduce risk of preventable conditions which include nutritional counseling, physical activity and stress management, alcohol use, and tobacco cessation counseling, 2) delivery of public health services; with the goal to evaluate the effectiveness of evidence- bases practices relating to prevention and identify strategies to organize, finance, and deliver public health services; and 3) evaluation of community based prevention and wellness programs for Medicare beneficiaries (Shearer, 2010).
Community and Clinical prevention:

ACA initiative supports prevention activities that work to reduce health care cost and improve the promotion of health and wellness. Non-profit hospitals and health care providers are expected to engage in community health planning and demonstrate the development and implementation of their plans on how their resource investment reflects priority preventive care in the community they serve (Rosenbaum, 2011). The ACA Funding and Implementation of Public Health and Prevention Provisions in Community and Clinical Prevention list of available grants is extensive. Provisions cover creation and expansion of a wide range of services and programs in pregnancy, nutrition labeling requirements, education and outreach campaigns, personal responsibility education, hospital community, Medicaid coverage and incentives for prevention of chronic disease, childhood obesity and immunization.

Insurance:

Affordable Insurance Exchange coverage will be accessible to individuals and small businesses in 2014 through a new competitive private health insurance market to help lower costs. It is expected that transparency to the insurance exchange market will provide American citizens to compare affordable, quality private health insurance options (DHHS, 2012). ACA exchange provisions provide grants to states to plan for the establishment of American Health Benefit Exchange and Small Business Health Option Program Exchanges, as well as it requires health insurers to allow individuals through age 26 to remain on their parent’s plan, creates the National High-Risk Pool for those uninsured because of pre-existing conditions, prohibits employers from limiting eligibility for coverage based on salaries of full-time employees, establishes Reinsurance for Early Retirees to provide employer-based plans reimbursement for 80 percent of the cost of
covering claims up to $90,000 for adults ages 55 to 64. The provisions addresses rebates and discounts for Medicare Enrollees who enter the ‘donut hole” of prescription medicines in 2010 requiring drug manufactures to provide a 50 percent discount for brand- name drugs and biological products purchased from 2011, with discounts increasing to 75 percent by 2020 (ACA, 2011).

**Medicare and Medicaid:**

Medicare beneficiaries will be able to receive free preventive services eliminating cost- sharing on screening tests (mentioned on preventive services page 8 above) and will be covered for a free annual wellness visit after completing a health risk assessment. Personalized health plans, advice, health education, and preventive counseling services are part of the ACA provisions (Shearer, 2010). Seniors on Medicare will be able to receive care from health teams and facilitate coordination of care promoting patient-centered care (DHHS, 2012). Expansion of preventive services provided to Medicaid beneficiaries by states is encouraged but not required by the law. States providing Medicaid services such as immunizations, pregnancy care, counseling and prescription drugs for tobacco use cessation, and other services without beneficiary cost-sharing qualify to receive 1 percent increase in federal financial contribution (ACA, 2012).

**Quality:**

ACA provisions in quality of health care services include first, the development of a National Improvement Strategy reporting directly to Congress that includes priorities to improve the delivery of health care services, population health, and patient health outcomes. Second, provisions on quality are first, Comparative Effectiveness Research that establishes a “Patient
Centered Outcome Research Institute” to assist patient’s clinicians, purchasers, and policy makers in making informed health decisions by advancing the quality and relevance of clinical evidence though research and evidence synthesis, And lastly, the Commission of Key National Indicators to develop and conduct comprehensive oversight of a national health indicators system (ACA, 2012).

Conclusion

The Affordable Care Act presents to public health opportunities and challenges that are transformational providing provision and funding for tremendous advances in public health policy and practice. Implementation of the Act provisions will take collaboration of government, public health agencies, healthcare providers, the private health industry, and citizens. The Act represents a unique opportunity to expand the U.S. public health commitment to promote health and prevent disease, and forces us to evaluate public’s health mission in a nation with universal health care coverage.
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