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Promoting Prevention Under the Affordable Care Act

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Keywords

Affordable Care Act, public health, prevention, reform, incentives, capacity

Abstract

The Affordable Care Act (ACA) of 2010 placed a substantial emphasis on public health and prevention. Subsequent research on its effects reveals some notable successes and some missteps and offers important lessons for future legislators. The ACA's Prevention and Public Health Fund, intended to give public health budgetary flexibility, provided crucial funding for public health services during the Great Recession but proved highly vulnerable to subsequent budget cuts. Several programs that aimed to increase strategic thinking and planning around public health at the state level have proven to be more enduring, suggesting that the convening authority of the federal government can be a powerful tool for progress, especially when buttressed by some funding. Most important, by expanding insurance and mandating a minimum level of coverage, the ACA both increased access to clinical preventive services and freed up local public health budgets to engage in population health activities.

INTRODUCTION

Most research on the Affordable Care Act of 2010 (ACA) has focused on its objectives of reducing the nation's uninsurance rate and improving access to medical care. The law has been quite successful in accomplishing these objectives: By the third quarter of 2016, the percentage of Americans lacking health coverage was at the lowest level ever recorded, and measures of access to care had improved substantially (1, 5, 59, 62). Less-often discussed has been the ACA's impact on public health and prevention. This article addresses the ACA's public health goals and provisions and what has been learned, to date, about the successes and challenges of implementing these provisions.

In the period during which the ACA was debated and drafted, public health experts called for the focus of health care reform to extend beyond increasing health insurance coverage to encompass population health. They sought added funding and policy attention to reflect the importance of population health (8, 13, 20, 24, 68). Public health advocates saw health reform as an opportunity to address the social determinants of health well beyond medical care, including, for example, objectives such as reducing food insecurity in childhood and improving access to fruits and vegetables in schools (8, 61). There were calls for more community-based prevention and for the creation of a community health worker corps (8, 13, 24). Advocates hoped for enhanced regulatory tools to reduce smoking, encourage exercise, and improve nutrition and for efforts to increase the proportion of health spending going to population health (8). Some proponents also wanted structural changes, such as a reorganization of public health departments throughout the United States, to focus on the environment and chronic disease, and many called for increased funding for population-level chronic disease prevention (8, 20). The public health community also pushed for the law to bolster enrollment outreach for existing insurance programs that had prevention components, such as Medicaid and the Children's Health Insurance Program (CHIP) (61). Whatever specific effort was promoted, the broad goal of the public health community was clear: a law that would focus on eliminating health disparities and improving health across communities (57).

The final bill, signed into law by President Barack Obama on March 23, 2010, contained many of the provisions the public health community had sought. Several of the major sections of the law included a prevention or public health component; Title IV, Prevention of Chronic Diseases and Improving Public Health, focuses most on the issues advocated by the public health community (see **Table 1** for a full list of public health initiatives). The ACA addressed public health goals in three ways: It expanded public health capacity by establishing new programs and structures that focused on public health objectives and enhanced funding for existing programs; it increased access to clinical preventive services; and it provided new incentives for prevention and wellness programs in the private sector.

EXPANDING PUBLIC HEALTH CAPACITY

The law created both the National Prevention, Health Promotion, and Public Health Council and the \$15 billion Prevention and Public Health Fund; together, these represented the first time that a comprehensive public health strategy, with dedicated funding, was articulated in federal law (26, 52). The Council and the Fund are the most prominent of several portions of the law that were designed to increase public health capacity. The logic of their creation stems from a historical artifact. The Centers for Disease Control and Prevention (CDC) was "created to serve the states," and for most of its history, it has provided grants and technical assistance to the states for their programs (19). Consistent with that mission, the CDC's budget has been delineated by Congress down to the \$250,000 level, a degree of scrutiny unique among federal agencies. This highly fragmented budget meant that the CDC had often been largely unable to create national, flexible, and timely public health programs. The Fund was designed to fix this principal problem.

Table 1 Preventive initiatives in the Affordable Care Act

Section	Section name	Summary	Research
Public health capacity			
Section 4001 (70)	National Prevention, Health Promotion and Public Health Council	Creates a council, composed of representatives from 17 agencies, responsible for bringing public health into all sectors of public policy	Released National Prevention Strategy in 2011 (52); has successfully pushed public health goals into other agencies, including HUD public housing smoking ban (11)
Section 4002	Prevention and Public Health Fund	Creates a \$15 billion fund for national investments in public health	Largely failed; significantly cut and Congress ultimately designated all the funds rather than leaving their distribution to the CDC's discretion (42)
Section 4003	Clinical and Community Preventive Services Task Force	Creates the Community Preventive Services Task Force, a community prevention counterpart to the USPSTF. Reauthorizes USPSTF	
Section 4004	Education and Outreach Campaign Regarding Preventive Benefits	Allocates up to \$500 million in funding for a variety of programs to educate Americans about preventive care	Medicaid expansion states saw increase in use of certain preventive services; ambiguous results in other populations (53)
Section 4102	Oral Health Activities	Creates several oral health care programs, including an education initiative, and makes a school-based dental sealant program mandatory	
Section 4201	Community Transformation Grants	Provides grant funding for evidence-based community prevention programs	
Section 4202(a)	Community Wellness Pilot	Provides grant funding to health departments for community-based prevention programs targeting individuals aged 55–64	
Section 4204	Immunization	Provides explicit authority for the Secretary to negotiate vaccine prices; creates a grant program to states to improve immunization rates	
Section 4206	Demonstration Project Concerning Individualized Wellness Plan	Initiated a pilot of individual wellness plans at community health centers	
Section 4301	Research on Optimizing Delivery of Public Health Services	Requires the Secretary, through the CDC, to fund research on effective public health interventions and implementations	
Section 4304	Epidemiology and Laboratory Capacity Grants	Provides grants to state, local, and tribal health departments to increase capacity to respond to infectious disease outbreaks	\$90–240 million appropriated annually from FY2011 to FY2016; funds distributed to all 50 state health departments, 8 territories, and 6 largest municipal health departments (12)
Section 5601	Health Center Appropriations	Allocated \$33.9 billion, in increasing amounts per year, from FY2010 to FY2015, for health centers	

(Continued)

Table 1 (Continued)

Section	Section name	Summary	Research
Section 10503	Community Health Center Fund	Allocates \$9.5 billion for health center operations and patient services and \$1.5 billion for health center construction and renovation	Has served an additional 1.5 million patients owing to ACA funding and was able to continue serving 2.2 million patients who had been served through a now-expired temporary increase in federal funding; 700 grants awarded for capital improvements
Section 5207	Funding for National Health Service Corps	Permanently authorizes and funds the National Health Service Corps	
Section 4101	School-Based Health Centers	Authorizes grant funding for school-based health centers	
Section 5208	Nurse-Managed Health Clinics	Establishes grants for nurse-managed health clinics	
Section 10334	Offices of Minority Health	Elevates and expands offices of minority health throughout the HHS and its agencies	
Section 10407	Better Diabetes Care	Requires publication of a National Diabetes Report Card and requires the Secretary to promote vital statistics reporting	
Section 10411	Congenital Heart Disease Programs	Authorization to create a national congenital heart disease surveillance system and to expand CHD research with a focus on minority and medically underserved populations	
Sections 5201, 5202, 5203, 5204, 5310, and 10501(n)	Student Loans	Increased the maximum loan amounts and decreased the fees associated with federal student loans for physicians, nurses, members of the National Health Service Corps, and the public health workforce	
Sections 3509 and 3511	Offices on Women's Health	Creates an Office of Women's Health within the Office of the Secretary and additional offices within the AHRQ, HRSA, FDA, and CDC	
Preventive services			
Section 1001	Regarding Coverage of Preventive Services	Includes requirements for coverage with no cost sharing of clinical preventive services in private insurance	71 million have access to free preventive services (6); current research inconclusive whether this increased utilization (29)
Section 4103	Medicare Annual Visit and Personalized Prevention Plan	Provides coverage for annual comprehensive health risk assessment and prevention plan	Small increase among fee-for-service patients (15)

(Continued)

Table 1 (Continued)

Section	Section name	Summary	Research
Section 4104	Removal of Cost-Sharing for Medicare Preventive Services	Requires coverage of USPSTF-recommended services with no cost sharing	Current research inconclusive on whether this initiative increased utilization (32)
Section 10501(i)(3)	Preventive Services Furnished at FQHCs	Stipulates that FQHCs can receive reimbursement for preventive services provided to Medicare beneficiaries	
Section 4106	Medicaid Preventive Services for Adults	Increased Federal Medical Assistance Percentage by 1% for states that eliminated cost sharing for USPSTF and AHIP recommendations	Increased uptake of several screenings among the Medicaid expansion population (64)
Section 4107	Medicaid Tobacco Cessation Services for Pregnant Women	Requires states to cover tobacco cessation drugs and counseling for pregnant Medicaid beneficiaries	
Section 4108	Incentives for Chronic Disease Prevention Under Medicaid	Provides up to \$100 million in grants to states that provide incentives to Medicaid beneficiaries to adopt and maintain healthy behaviors	Some positive preliminary results but impact is largely unknown. Many states had enrollment challenges (54)
Section 10412	Public Access Defibrillation Programs	Offers grants for publicly accessible defibrillators	
Section 10413	Young Women's Breast Health Awareness	Mandates the creation of a national breast cancer awareness campaign targeted at young women	
Section 10501(g)	National Diabetes Prevention Program	Creates a national diabetes prevention program	Found to create weight loss significant enough to reduce the risk of diabetes (17)
Section 4205	Chain Restaurant Menus and Vending Machines	Requires nutritional labeling for chain restaurants and vending machines	Compliance date extended to May 7, 2018, for restaurant menus; compliance date July 26, 2018, for vending machines (66)
Section 4306	CHIPRA Childhood Obesity Demonstration Project	Funding for a demonstration project to reduce childhood obesity. Originally authorized in Children's Health Insurance Program Reauthorization Act of 2009	Impact unknown. Articles describing program baseline and evaluation methods available
Section 2951	Early Childhood Home Visitations Programs	Creates grants and mandates HHS technical assistance for early-childhood home visitation programs	Impact unknown, though previous research has shown these programs to be effective (56)
Wellness initiatives			
Section 1201	Regarding Prohibiting Discrimination Based on Health Status	Raises the maximum reward for wellness incentives to 30% of premium costs	
Section 4303	CDC Grants for Employer-Based Wellness Programs	Required CDC to provide technical and evaluation assistance to workplace wellness programs	
Section 2705(m)(1)	Report (Prohibiting Discrimination Against Individual Participants and Beneficiaries Based on Health Status)	Requires the HHS Secretary to report on the effectiveness and impact of workplace wellness programs	Uptake of wellness programs is limited but the interventions can have meaningful results on weight control, smoking cessation, and exercise frequency (43)

(Continued)

Table 1 (Continued)

Section	Section name	Summary	Research
Section 10408	Workplace Wellness Program Grants	Up to \$200 million in grants to small businesses to create workplace wellness programs	
Section 4202(b)	Medicare Wellness Evaluation	Requires the Secretary to develop a plan to promote healthy lifestyles and chronic disease self-management among Medicare beneficiaries	

Abbreviations: AHIP, America's Health Insurance Plans; AHRQ, Agency for Healthcare Research and Quality; CDC, Centers for Disease Control and Prevention; CHD, coronary heart disease; FDA, Food and Drug Administration; FQHC, Federally Qualified Health Center; FY, fiscal year; HHS, Health and Human Services; HRSA, Health Resources and Services Administration; HUD, Housing and Urban Development; USPSTF, US Preventive Services Task Force.

Funding from the Prevention Fund allowed the CDC to pursue some specific, targeted national initiatives that were quite successful, particularly the Tips from Former Smokers campaign and the National Diabetes Prevention Program. The initial ad-buy for the Tips from Former Smokers campaign led to a 12% increase in quit attempts and is expected to lead to 100,000 smokers remaining abstinent long term (44). Similarly, the National Diabetes Prevention Program was found to induce weight loss significant enough to reduce the risk of diabetes (17). Unfortunately, the substantial size of the Fund, combined with the reluctance of many in Congress to give broad authority to the CDC, led to limits on its effectiveness. The Fund was cut by \$5 billion in 2012, and as of fiscal year 2016, the entirety of Fund spending was dictated by Congress to the CDC, undoing the intention of the effort to allow the CDC to direct its use. The Fund was further cut by the passage of the 21st Century Cures Act, which took \$3.5 billion from the Fund to pay for medical research at the National Institutes of Health (34).

The Council, which is chaired by the Surgeon General and has Cabinet-level representatives from 17 agencies, has had more success. In particular, the release of the National Prevention Strategy in 2011 served as a useful articulation of the nation's public health priorities. The four pillars (eliminating health disparities, creating healthy communities, providing preventive services in clinical settings and in the community, and helping consumers make health decisions) comprise many areas for which the public health community had advocated when the law was written. The seven priority areas include many of the most important public health issues, such as reducing substance use and increasing healthy eating, as well as some newer areas such as injury- and violence-free living and mental and emotional well-being (52). The Council has successfully encouraged agencies and departments outside of the Department of Health and Human Services (HHS) to consider public health when creating policies, exemplified by the nationwide ban on smoking in public housing announced in 2016 by the Department of Housing and Urban Development (HUD), a Council member (48). This ban is the result of a collaboration between HUD and the CDC, which is an outgrowth of the Council (11).

Other aspects of the law also succeeded in expanding public health capacity. The law allocated funding specifically to improve public health laboratory capacity, which was distributed to all 50 state health departments, 8 US territories, and the 6 largest municipal health departments (12). The National Health Service Corps (NHSC) was reauthorized, along with increased funding for public health fellowships and other health practitioners (37, 70). The law strengthened community health centers by providing \$9.5 billion for operations and patient services and \$1.5 billion for construction and renovation, in addition to funding for school-based health centers and

nurse-managed health clinics (37, 70). The expansion of the NHSC contributed to the training of an additional 6,000 clinicians, who have provided primary care for more than 10 million people (35). New funding for federally qualified health centers allowed 1.5 million new patients to be served and 2.2 million existing patients to continue being served for whom temporary funding had expired (35). The impact of the NHSC's expansion has been easier to identify than the effects of other efforts in the law that were intended to encourage clinicians to practice primary care in underserved areas. Although the law increased funding for various loan repayment programs targeted at these providers, the effect of these provisions on the availability of services is not yet clear.

Within the HHS, the Prevention Fund and National Prevention Strategy worked primarily with existing public health-focused agencies, such as the CDC and the Health Resources and Services Administration (HRSA). It is critical, however, that the prevention focus of the ACA stretched beyond these agencies into the Center for Medicare and Medicaid Services (CMS), which has a much larger budget and political presence. The creation of the Center for Medicare and Medicaid Innovation (CMMI) within CMS opened up new opportunities for prevention funding.

One important CMMI initiative created an avenue for states to receive millions of dollars to transform their health care systems and improve population health using the resources of the health care system. To date, the State Innovation Model (SIM) program, run by CMMI, has funded efforts in 34 states, 3 territories, and Washington, DC, to improve population health and the delivery of health care, while decreasing costs (53). States received funding to create and implement a state health improvement plan, which is required to include a statewide population health plan that targets the preventable drivers of poor health in that state and a plan to integrate public health, community-based, and behavioral health services (54). Almost 30 states have received funding for model design, and 15 states, including some that initially received model design funding, have received grants to test their models.

The final evaluations for the initial six states that received funding for model testing have not yet been released, but there are some encouraging signs so far. Most of the funded states had plans for new health care workforce models, including team-based care and nontraditional health care workers. Most created accountable care organizations that had plans for care linkages to public health, community organizations, and social services (54). Maine, Minnesota, and Oregon all used part of their SIM funding to create Accountable Communities for Health, which focus on population prevention and integrate medical and nonmedical services to create greater health equity and increase population health (27).

The year two annual report on the initial SIM states showed some positive results, including that half of the states were halfway to meeting the goal of providing 80% of health care through value-based delivery models (63). However, it is clear that states faced several challenges in implementing their plans. Many states struggled to integrate public health into their SIM initiatives, although stakeholders acknowledged that by requiring population health, CMS had fostered increased engagement across sectors and agencies. In addition, many of the funded states lack comprehensive data systems that would allow state agencies to fully monitor the impacts of new programs and changes, a clear evaluation challenge (63). Despite the implementation challenges, most states are moving forward with the program. As more data are collected over the coming years and decades, the effectiveness of the different state programs can be fully ascertained.

INCREASING CLINICAL COVERAGE

In addition to its impact on public health capacity, the ACA expanded access to preventive care by requiring that all insurers provide preventive services without cost sharing and by expanding access to coverage that included these preventive services.

The law's requirement that preventive care be covered at no cost to the patient has provided 71 million people with free access to vaccines, cancer screenings, and primary care, among other services (61). The impact on health outcomes, however, is not clear yet. Results from studies on whether the use of covered preventive services has increased since the law's passage are mixed. The extension of preventive benefits without cost sharing to those with private insurance in 2011 led to increases in the incidence of flu vaccinations, and blood pressure and cholesterol checks increased; however, cervical, colorectal, and breast cancer screening rates did not change (29). Similarly, provisions eliminating cost sharing for preventive services from Medicare had mixed effects on the use of these services (15, 28). Prior to the ACA, many Medicare beneficiaries already had access to no-cost preventive services through their supplemental insurance plans, which may explain why the change had limited effects in this population.

By contrast, studies of those who gained coverage (including coverage of preventive care) through the expansion did show improvements in the use of these services. Studies find increases in preventive visits, diabetes screening, glucose testing, and HIV screening among the newly insured Medicaid population. Additionally, a decrease in emergency department use and in smoking rates was seen in this population, along with a 5% increase in the percentage of individuals reporting excellent health (60, 64). A review of several studies that looked specifically at the impact of the ACA on cancer screenings found that the use of screenings and the early detection of disease increased among new Medicaid enrollees and among other vulnerable populations, including Medicare enrollees who did not previously have free coverage (55). One study, which focused on the ACA's expansion of employer-sponsored coverage to young adult dependents under age 26, found that the coverage expansion increased by 3–5% the number of young adults who were receiving several preventive services but that the rate of flu vaccination did not change (38). The ACA's coverage of an Annual Wellness Visit (AWV) in Medicare, a new benefit, led to a significant increase in use, from 7.5% in 2011 to 15.6% in 2014 (23). At a large provider in California, use increased from 1.4% before the ACA to 27.5% after, showing the significant regional variation in adoption (15). Ganguli et al. find that “adoption was concentrated in ACOs and among certain PCPs and regions of the country, suggesting that the decision to perform an AWV was primarily driven by practice factors” (23, p. 2234).

The inclusion of contraception as a women's preventive service has substantially altered payments for these services. The proportion of claims with no cost sharing for intrauterine devices (IUDs) increased 50% after the provision went into effect. A similar increase was seen for users of the pill, injectable contraception, and the ring (49, 65).

To date, however, the inclusion of birth control as a preventive service available without cost sharing has not led to substantial increases in the use of more-costly birth control measures, particularly IUDs. IUD use did increase in 2013, after the provision went into effect, but the increases were in line with previous increases in IUD use (49). The lack of use of IUDs and contraceptive implants may be due in part to a lack of awareness of ACA coverage provisions: One nationally representative survey found that 65% of women did not know if the ACA would affect their contraceptive coverage, and a second study of Pennsylvania women found that only 11% were aware of the IUD coverage (14, 27). Lack of use may also be due in part to insurance noncompliance, as the Kaiser Family Foundation has identified several insurance companies whose plans did not include contraceptive implants, included only one kind of IUD, and/or included medical management techniques that could limit coverage (63). As insurance companies come into full compliance with the law and women learn about this benefit, the proportion of women using IUDs and other long-acting reversible contraceptives may increase. Even without an increase in IUD use, the ACA has helped women by improving the affordability of contraception.

INCENTIVIZING PERFORMANCE AND WELLNESS

The final prong of the ACA's public health initiatives consisted of various incentives to states, providers, patients, and employers to improve health. To create healthier workplaces, the law lifted the ceiling on workplace wellness incentives from 20% of health care costs to 30%. It allowed employers to increase premiums up to 50% for participation in smoking cessation programs (41). Additionally, grant funds were made available for small businesses to create workplace wellness programs, and the CDC was tasked with providing technical assistance for evaluations of employer-based wellness programs. The Act also mandated the evaluation of existing federal health and wellness initiatives, resulting in a report to Congress released in 2013 (37).

The Medicaid Incentives for Prevention of Chronic Diseases (MIPCD) is one of the largest incentive-based programs in the law. Ten states were awarded demonstrations to test the use of targeted incentives for prevention (54). As more results come in, states will be able to learn from each other and refine their programs to create more effective incentives. If these programs succeed, they could be a powerful tool to improve public health.

Even without incentive programs targeted to specific behaviors, the Medicaid expansion improved public health. In states that expanded Medicaid, prescriptions for smoking cessation medication increased 36% compared with nonexpansion states (40). Medicaid payments for these medications increased 28% (40). This finding strongly suggests that expanding coverage, even without additional interventions, leads to increased quit attempts, a clear public health success.

By funding delivery system reform, the law encouraged providers to think beyond just ordering another test. In particular, the law encouraged the creation of accountable care organizations (ACOs), which many saw as an opportunity to address the "triple aim" (9). ACOs have a financial stake in the health of their patients, which ideally would encourage more preventive care, better follow-up after a hospitalization, and other actions to reduce health care utilization. The potential of ACOs to improve population health has yet to be realized, however. None of the current quality measures for Medicare ACOs are tied to community health indicators (9). Additionally, most public health analysts consider socioeconomic factors to have a much greater impact on health than medical care, so it is not clear how much improvement in population health could be expected from the clinical care offered by ACOs (10). As ACOs develop and grow, however, there may be greater opportunities for the integration of ACOs and public health (16). The Henry Ford Health System, a Michigan ACO, explicitly includes community health as one of its pillars. Several ACOs surveyed by Frazee et al. reported that they addressed the transportation, housing, and/or food insecurity needs of their patients (21). Some paid for the patient's transportation, while others partnered with public health or housing agencies to improve patients' housing and worked with food banks to improve the quality of their patients' diets (21).

The impact of the workplace wellness programs is somewhat unclear, in part because private employers do not face the reporting requirements that Medicaid and Medicare do. These programs could increase public health through the use of outcomes-based incentives, which reward individuals only when there is a demonstrated improvement in their health (typically shown through a screening or test result). Vu et al. reviewed several studies of employee wellness programs implemented by hospitals and found that some programs were successful at reducing health risks and had a 2:1 or 3:1 return on investment among high-risk employees (67). Because fewer than 50% of hospitals collected outcomes data, it is difficult to determine the overall effectiveness of these programs. The final HHS report on workplace wellness programs found that programs had a positive result on several markers, but it also urged caution on interpreting this outcome because most evaluations were not rigorously conducted (43). Without both more and more precise

studies, the impact of workplace wellness programs, and the ACA's role in encouraging them, is difficult to determine.

The law also included provisions to directly change individual behavior. It requires fast-food restaurants to label their menus and created a 10% excise tax on tanning. The effective date for the rule establishing the menu labeling regulations has been repeatedly pushed back and is currently set for May 7, 2018. The tanning tax was quickly implemented, but only minimal research exists on its impact. One study found that 26% of salons reported a decline in use after implementation of the tax, but the study's investigators could not determine if the decline was due to the tax or to the poor economic climate at the time (31). The tanning industry, however, reports that the tax led to the closure of approximately half of all tanning salons in the United States, which would represent a remarkable public health success (4). The industry's analysis, however, does not isolate the effect of the tax, so this result may be confounded by changing consumer preferences and a poor economic climate.

LESSONS LEARNED

Seven years after the passage of the ACA, and 3–5 years after its largest components were implemented, its impact on prevention is only beginning to become known. Many evaluations have yet to be released, and many programs have only been operating for a few years. However, early results, summarized above, provide evidence on specific provisions. Moreover, the accumulation of evidence across programs provides some lessons for future actions that might be considered by the public health community.

Historically, the federal government served as the funder and technical adviser to state and local governments for public health purposes (39). At the time of the ACA's passage, this role was critical. As the impact of the recession on state finances became more intense during 2009–2010, 31 states cut health care services and 29 cut services to the elderly and disabled (25). The Prevention and Public Health Fund served as a crucial stopgap in maintaining public health services throughout the country, halting the erosion of public health services in some states while enabling other states to maintain the status quo. Approximately half of all public health expenditures come from state funding, and another 20% come from local governments (39). Without the Fund, cuts to public health around the country would have been far more drastic.

The Fund, however, was also created to free up the CDC to address a national public health agenda, instead of simply supporting fragmented programs. This effort was not as successful; while there is a clear constituency for disease- and location-specific programs, there is a much more limited political constituency urging the funding of a national public health agenda.

Other aspects of the ACA successfully increased local and state public health capacity. The funding of the SIMs encouraged states to think strategically about their public health plans and to bring diverse stakeholders to the table. The requirement to include public health in the strategic plans ensured that states discussed issues that were previously ignored. Several states, for example, reported struggling with how to define population health and identify measurable public health outcomes (54). Each of the participating states have now made determinations in these areas, so their public health priorities will be clear going forward and results will be measurable.

The SIM funding also encouraged several states to bring together health and government leaders who had not previously interacted frequently. In Arkansas, for example, the plan included input from providers, private insurers, Medicaid leadership, long-term care services, behavioral health providers, programs for developmentally disabled individuals, self-insured employers, and representatives of several government agencies (54). In Maine, similar groups of stakeholders were brought together. When interviewed about their experiences, many stated that the greatest

accomplishment of SIM was the ability to “bring these different groups together as one” (54, p. 134). Although the long-term impact of SIM is not yet known, the conversations and plans are likely to have a lasting impact on public health in the states. Most of the states, however, struggled to create and implement SIM and other programs because they lacked the experience and technical capabilities necessary for success. To ease implementation, future programs should utilize CDC expertise to a greater extent and build up local capabilities.

By expanding insurance and mandating a minimum level of coverage, the ACA has the potential to free up local public health departments. Prior to the ACA’s passage, public health departments offered a variety of clinical services, including childhood immunizations and sexually transmitted disease (STD) screening and treatment. With these and other preventive services now covered under the ACA, some in public health were hopeful that departmental capacity could be redirected toward more traditional public health functions, including community-based prevention and disease surveillance (18). Others thought that departments could continue providing these services and create the capacity to bill private insurers (18). Some early results suggest success on both counts. In Tennessee, one local health department put in place a process to bill insurance companies for the vaccination of insured patients (36). A different health department in Tennessee chose instead to direct insured patients to other providers, presumably allowing the department to increase services in another area (36). A survey of patients at a health clinic suggests that billing capabilities will be critical for health departments, as a significant percent of patients (42%) were insured at the time of their visit but chose the health clinic owing to confidentiality and convenience (46).

Expansions of coverage allow health departments that continue to provide services to bill insurance, which may ultimately increase their capacity by allowing for the redirection of funds that would have previously been used on these services. A survey of health departments in five states found that most had begun billing insurance in the aftermath of the ACA (45). However, health departments often lost money on billing. Health department leaders were also concerned that their funding would be cut if clients went elsewhere for services because policy makers may not consider traditional public health services essential (45).

The preventive services coverage mandate has been viewed as generally successful; research shows that it increased rates of screenings among vulnerable populations. However, implementing requirements to cover preventive services has also generated some controversy. In particular, the preventive services provisions altered the longstanding advisory role of the US Preventive Services Task Force (USPSTF). Under the ACA, the determinations of the USPSTF more directly alter coverage decisions for public and private plans, though these determinations are mediated by the Department of Health and Human Services’ formal rulemaking process. As Johns & Bayer write, the USPSTF was not created to consider costs or to serve as a regulatory body and has no expertise in how to incorporate policy considerations into its decision-making processes (33). These pressures could be seen even before the enactment of the ACA, when the Task Force’s grading of mammograms at a C led to an amendment to the law to overrule the Task Force and guarantee mammography coverage (33). The scientific role of determining the benefits of a proposed service is very different from the policy role of deciding if that service should be covered and, if so, how generously. It is not clear whether the USPSTF is the body that should be making both of these decisions.

Debate also continues about what, exactly, constitutes prevention. The ACA focused primarily on secondary prevention, by expanding access to insurance and covering screenings at no cost. New funding for primary prevention came in the form of the Prevention and Public Health Fund, but as discussed, the Fund served primarily to stop cuts rather than expand funding.

Many of the services now available without cost sharing are screening services. Many types of screening—cancer screenings, for example—are intended for early detection of cancer, not as a form of prevention. The value of widespread screening is in some dispute (69). The corollary of increased screening is the need for treatment in screened patients; it is the treatment, after all, that prevents the sequelae of the conditions diagnosed. Newly screened patients, who have no symptoms, will be faced with biopsies, chemotherapy, radiation, and surgery because doctors struggle to distinguish between a cancer that will cause problems and a cancer that will not (69). These follow-on services are not part of the preventive services requirement. To the extent that the specificity of screening tests is low, reducing cost sharing for screening may lead to increased out-of-pocket expenses for these follow-on screenings and diagnostic tests.

A separate concern has been raised for certain areas of the preventive services coverage that allow for the use of tiering to limit coverage. Many insurance companies have continued to use formulary tiers for the contraceptive coverage mandate, covering most or all generics and some brand-name drugs at no cost to the consumer while requiring copays for other types. Under the ACA, insurance companies are required to cover each method of birth control but do not need to cover all options within a category (for example, insurance companies must cover a form of the contraceptive pill at no cost but do not need to cover all brands). Initially, some insurance companies failed to comply with the requirement to cover all methods; many women were unable to access free contraceptive rings (47). However, following guidance from HHS in May 2015, the National Women’s Law Center reports that these issues have largely dissipated (47). Although some women may be frustrated at a lack of coverage for brand-name pills, insurance companies requiring the use of generics is widespread across prescription categories and leads to lower costs. However, plans must communicate clearly with their beneficiaries; women have reported birth control costs jumping from free of charge one month to \$30 or \$50 the next month because of formulary changes that were not communicated to them (47).

The use of tiering for breast pumps presents another challenge to women. Breastfeeding is an important preventive health measure that can reduce the incidence of chronic disease in both mothers and children. In 2007, the American Public Health Association released a policy statement, titled “A Call to Action on Breastfeeding,” which stated that “universal requirements do not exist for third-party payers to cover lactation support and services or breast pumps, which would allow working mothers to continue to breastfeed according to medical recommendations” (3). The ACA mandated coverage of breast pumps, removing this barrier for many women. However, the bill did not require electric pumps to be covered. Manual pumps take longer, can lead to hand cramping, and are generally intended only for occasional use (7). Electric pumps are much faster and are the choice for women who work full time and want to continue nursing (7). The data are not clear about how many women have needed to pay for electric pumps that their insurance did not cover, but news articles and Internet forums suggest that this has been a problem for at least some women (50; see also <https://redd.it/3k3z1r>). Future research should explore the extent to which tiering for both birth control and breast pumps makes it more difficult for women to access these services and increases their out-of-pocket expenses.

The ACA’s wellness incentives allow employers to reward employees with a discount of up to 30% of their insurance premium for undertaking wellness activities. A substantial literature in behavioral economics suggests that financial incentives are successful at inducing behavioral change; this literature provides much of the foundation for the inclusion of these incentives in the law. The magnitude of the financial incentives permitted, however, is much larger than the effect on health care costs likely generated by the chronic conditions targeted (30). These potentially large incentives may, in effect, constitute a penalty on those with certain poor health conditions. Overweight people and those with high blood pressure or cholesterol, among others, can potentially

be charged hundreds or thousands of dollars more in premiums than their healthier coworkers, which raises clear equity concerns, particularly because low-income workers are more likely to have the conditions targeted by these programs (30, 41). There is, therefore, concern that these wellness programs may be regressively redistributive (30).

A further risk is that these incentives will lead people to forego coverage rather than to change behavior. Under the ACA's insurance expansions, which generally do not permit risk rating for health conditions, states could increase rates for tobacco users by up to 50%. In states with these penalties, studies found that smoking cessation did not increase, but rates of coverage enrollment among smokers were lower than they otherwise would have been (22). It is possible that workplace wellness programs could have the same effect, forcing workers who smoke or who have high blood pressure or blood sugar to forego insurance rather than pay premium surcharges they cannot afford. At least one wellness consulting firm has implied that this result is desirable, owing to the savings to the employer (58). To date, very few firms actually use financial incentives of the magnitude permitted under the ACA, so the likelihood of this effect is not high. A Kaiser Family Foundation survey of employers finds that only 11% of employers offered wellness incentives in 2015 (51). These incentives were generally cash, gift cards, or other merchandise and not substantial insurance discounts (51).

Finally, it is not clear that what wellness programs encourage is actually wellness. More than one-third of large-firm wellness programs include only health risk assessments and biometric screening (51). These do not necessarily provide useful advice and sometimes use inaccurate metrics (2). They may also overtest: Most companies with wellness programs do biometric screening once per year, testing their employees' cholesterol, blood pressure, and glucose (2). But the USPSTF recommends cholesterol tests only once every five years for otherwise healthy adults and recommends glucose screenings only for people over age 40 who are overweight and obese (2). Screening these employees more often than recommended may actually raise costs, and generate false positives, rather than providing health benefits. Some wellness programs, particularly those that focus on smoking cessation or obesity reduction in very high-risk populations, have been effective; even here, however, equity considerations suggest caution in the use of high-powered incentive programs.

Some employers have more extensive programs that require improvement to be shown for the employee to avoid paying an increased premium. These programs raise further equity concerns. Lifestyle change is very difficult; for example, most diets do not result in lasting weight loss. In addition, these changes will be more achievable for the high-income employee with a gym in their building and ready access to fruits and vegetables than for the low-income employee who goes from one job straight to a shift at the next job and has minimal access to exercise equipment or healthy food (58). Therefore, wellness programs may actually increase, rather than reduce, health disparities (30).

CONCLUSION

The ACA differed from most prior US health care reform legislation in putting prevention squarely into the coverage and cost containment mix. The Act bolstered financing for building public health and prevention capacity, improved access to preventive services, and encouraged private employers and insurers to incorporate prevention and wellness into workplaces and coverage policies. Not everything that was tried was as successful as proponents had hoped, but a great deal of progress was made.

The ACA experience also offers important lessons for future efforts to integrate prevention into health care reform. In terms of increasing capacity, the ACA experience showed that the bully

pulpit and convening authority of the federal government can be powerful tools for progress, especially when buttressed by some funding. The Prevention and Public Health Fund and the CMMI jump-started conversations at the local and state levels, bringing together health care providers, insurers, community groups, and public officials and encouraging initiatives that had been languishing. However, even though access to less-restricted money through the Prevention and Public Health Fund provided critical flexibility to the CDC, it was a perennially tempting target for cost cutters in Congress. Future efforts to enhance CDC flexibility need to couple funding with a well-specified mission for which CDC leadership can be held clearly accountable by outside stakeholders and members of Congress.

Although advocates for prevention quite naturally focus on preventive services, the ACA experience has shown that access to broad-based coverage, rather than to targeted screenings, is the key to connecting people to preventive care. Reducing cost sharing for preventive services benefited many people by reducing their out-of-pocket exposures. Gains in the use of preventive services, however, were concentrated among those who newly gained access to insurance coverage. This result is hardly surprising: People are unlikely to seek out screening for diseases that they do not think they can afford to treat. Coverage expansions also improved access to prevention and public health indirectly, by increasing funding to local health departments that provided safety net medical care and by reducing the care provision burden on these departments. While some believe that prevention can be a substitute for insurance expansion, the ACA experience suggests that it is better seen as a complement; more coverage leads to more prevention.

The attractiveness of prevention encouraged Congress to loosen restrictions on wellness incentives and to increase incentives for prevention among providers. Here, the ACA experience may offer a cautionary tale. Prevention is often cost-effective—that is, it achieves an incremental gain in health outcomes at an acceptable cost—but it is rarely cost saving. Outsized promises of savings from prevention have the potential to lead to excessively strong wellness incentives in employer plans or in provider reimbursement arrangements. Given the high correlation between social determinants of health and unhealthy behaviors, these high-powered incentives may generate inequities and further increase disparities. Strong incentives for performance on preventive measures may lead to efforts to select those employees or patients who are best able to perform on these measures. Prevention advocates should recognize the risks of overpromising potential savings.

The ACA has generated substantial benefits for Americans, greatly expanding insurance coverage, spurring delivery system reforms, and protecting the financial security of American families. It has also generated great progress in the prevention of ill-health among Americans through increases in capacity, coverage, and incentives. As Congress works to improve or alter the law, public health advocates should focus on ensuring that funding for coverage and for public health capacity remains in place.

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LITERATURE CITED

1. Altman D. 2016. The Affordable Care Act's little-noticed success: cutting the uninsured rate. Oct. 12, Kaiser Family Found., Menlo Park, CA. <https://www.kff.org/uninsured/perspective/the-affordable-care-acts-little-noticed-success-cutting-the-uninsured-rate/>
2. Anderson LV. 2016. Workplace wellness programs are a sham. *Slate* Sept. 1. http://www.slate.com/articles/health_and_science/the_ladder/2016/09/workplace_wellness_programs_are_a_sham.html
3. APHA (Am. Public Health Assoc.). 2007. *A call to action on breastfeeding: a fundamental public health issue*. Policy 200714, Nov. 6, APHA, Washington, DC. <https://www.apha.org/policies-and-advocacy/public-health-policy-statements/policy-database/2014/07/29/13/23/a-call-to-action-on-breastfeeding-a-fundamental-public-health-issue>
4. ASA (Am. Suntanning Assoc.). 2017. *Consequences of the 10% 'tan tax.'* <http://americansuntanning.org/wp-content/uploads/2017/02/2017-Tan-Tax-1-Pager-1.pdf>
5. Avery K, Finegold K, Whitman A. 2016. *Affordable Care Act has led to historic, widespread increase in health insurance coverage*. Issue Brief, Sept. 29, Assist. Sec. Plan. Eval., Washington, DC. <https://aspe.hhs.gov/system/files/pdf/207946/ACAHistoricIncreaseCoverage.pdf>
6. Avery K, Finegold K, Xiao X. 2016. *Impact of the Affordable Care Act coverage expansion on rural and urban populations*. Issue Brief, June 10, Assist. Sec. Plan. Eval., Washington, DC. <https://aspe.hhs.gov/system/files/pdf/204986/ACARuralbrief.pdf>
7. BabyCenter. 2016. *How to buy a breast pump*. Updated April, BabyCenter, San Francisco. https://www.babycenter.com/0_how-to-buy-a-breast-pump_429.bc
8. Bassett MT. 2009. Bold steps for the health of Americans: yes we can. *Am. J. Public Health* 99:587
9. Calman NS, Hauser D, Chokshi D. 2012. "Lost to follow-up": the public health goals of accountable care. *Arch. Intern. Med.* 172:584–86
10. Casalino LP, Erb N, Joshi MS, Shortell SM. 2015. Accountable care organizations and population health organizations. *J. Health Polit. Policy Law* 40:821–37
11. CDC (Cent. Dis. Control Prev.). 2014. *Almost \$500 million could be saved annually by making subsidized housing smoke-free*. Sept. 9, CDC, Atlanta. <https://www.cdc.gov/media/releases/2014/p1002-smoke-free-housing.html>
12. CDC (Cent. Dis. Control Prev.). 2017. *Epidemiology and Laboratory Capacity for Infectious Diseases (ELC) cooperative agreement*. Updated Aug. 2, CDC, Atlanta. <https://www.cdc.gov/nceizd/dpei/epidemiology-laboratory-capacity.html>
13. Chernichovsky D, Leibowitz AA. 2010. Integrating public health and personal care in a reformed US health care system. *Am. J. Public Health* 100:205–11
14. Chuang CH, Mitchell JL, Velott DL, Legro RS, Lehman EB, et al. 2015. Women's awareness of their contraceptive benefits under the Patient Protection and Affordable Care Act. *Am. J. Public Health* 105:S713–15
15. Chung S, Lesser LI, Lauderdale DS, Johns NE, Palaniappan LP, Luft HS. 2015. Medicare annual preventive care visits: Use increased among fee-for-service patients, but many do not participate. *Health Aff.* 34:11–20
16. Costich JF, Scutchfield FD, Ingram RC. 2014. Population health, public health, and accountable care: emerging roles and relationships. *Am. J. Public Health* 105:846–50
17. DiBenedetto JC, Blum NM, O'Brian CA, Kolb LE, Lipman RD. 2016. Achievement of weight loss and other requirements of the Diabetes Prevention and Recognition Program. *Diabetes Educ.* 42:678–85
18. Erwin PC, Brownson RC. 2017. Macro trends and the future of public health practice. *Annu. Rev. Public Health* 38:393–412
19. Etheridge EW. 1992. *Sentinel for Health: A History of the Centers for Disease Control*. Berkeley/Los Angeles: Univ. Calif. Press
20. Farley TA. 2009. Reforming health care or reforming health. *Am. J. Public Health* 99:588–90
21. Frazee T, Lewis VA, Rodriguez HP, Fisher ES. 2016. Housing, transportation, and food: how ACOs seek to improve population health by addressing nonmedical needs of patients. *Health Aff.* 35:2109–15
22. Freidman AS, Schpero WL, Busch SH. 2016. Evidence suggests that the ACA's tobacco surcharges reduced insurance take-up and did not increase smoking cessation. *Health Aff.* 35:1176–83

23. Ganguli I, Souza J, McWilliams JM, Mehrotra A. 2017. Trends in use of the US Medicare annual wellness visit, 2011–2014. *JAMA* 317:2233–35
24. Goodman A. 2009. President Obama’s health plan and community-based prevention. *Am. J. Public Health* 99:1736–38
25. Gordon T. 2012. *State and local budgets and the Great Recession*. Dec. 31, Brookings Inst., Washington, DC. <https://www.brookings.edu/articles/state-and-local-budgets-and-the-great-recession/>
26. Haberkorn J. 2012. Health Policy Briefs: The prevention and public health fund. *Health Aff.* Feb. 23. http://healthaffairs.org/healthpolicybriefs/brief_pdfs/healthpolicybrief_63.pdf
27. Hall KS, Fendrick AM, Zochowski M, Dalton VK. 2014. Women’s health and the Affordable Care Act: high hopes versus harsh realities? *Am. J. Public Health* 104:e10–13
28. Hamman MK, Kapinos KA. 2015. Affordable Care Act provision lowered out-of-pocket cost and increased colonoscopy rates among men in Medicare. *Health Aff.* 34:2069–76
29. Han X, Yabroff KR, Guy GP Jr., Zheng Z, Jemal A. 2015. Has recommended preventive service use increased after elimination of cost-sharing as part of the Affordable Care Act in the United States? *Prev. Med.* 78:85–91
30. Horwitz JR, Kelly BD, DiNardo JE. 2013. Wellness incentives in the workplace: cost savings through cost shifting to unhealthy workers. *Health Aff.* 32:468–76
31. Jain N, Rademaker A, Robinson JK. 2012. Implementation of the federal excise tax on indoor tanning services in Illinois. *JAMA Dermatol.* 148:122–24
32. Jensen GA, Salloum RG, Hu J, Ferdows NB, Tarraf W. 2015. A slow start: use of preventive services among seniors following the Affordable Care Act’s enhancement of Medicare benefits in the U.S. *Prev. Med.* 76:37–42
33. Johns DM, Bayer R. 2016. The paradox of authority—transformation of the USPSTF under the Affordable Care Act. *N. Engl. J. Med.* 375:1710–12
34. Johnson SR. 2016. Passage of Cures Act comes at expense of preventive health funding. *Modern Healthcare* Dec. 7. <http://www.modernhealthcare.com/article/20161207/NEWS/161209925>
35. Kaiser Family Found. 2013. *The Affordable Care Act three years post-enactment*. Issue Brief, March 26. Kaiser Family Found., Menlo Park. <https://kaiserfamilyfoundation.files.wordpress.com/2013/04/84291.pdf>
36. Knight MA, Kershenbaum AD, Buchanan M, Ridley J, Erwin PC. 2014. The effects of the changes in Section 317 rules for administration of federally purchased vaccines. *Am. J. Public Health* 104:e42
37. Koh HK, Sebelius KG. 2010. Promoting prevention through the Affordable Care Act. *N. Engl. J. Med.* 363:1296–99
38. Lau JS, Adams SH, Park MJ, Bsocardin WJ, Irwin CE Jr. 2014. Improvement in preventive care of young adults after the Affordable Care Act: The Affordable Care Act is helping. *JAMA Pediatr.* 168:1101–6
39. Lister SA. 2005. *An Overview of the U.S. Public Health System in the Context of Emergency Preparedness*. CRS Rep. Congr. Washington, DC: Congr. Res. Serv., Libr. Congr. <https://fas.org/sgp/crs/homsec/RL31719.pdf>
40. Maclean JC, Pesko MF, Hill SC. 2017. *The effect of insurance expansions on smoking cessation medication use: evidence from recent Medicaid expansions*. NBER Work. Pap. 23450
41. Madison K, Schmidt H, Volpp KG. 2013. Smoking, obesity, health insurance, and health incentives in the Affordable Care Act. *JAMA* 310:143–44
42. Mann C. 2013. *Letter to State Medicaid Directors on Affordable Care Act Section 4106 (Preventive Services)*. Feb. 1, Cent. Medicaid CHIP Serv., Dep. Health Hum. Serv., Baltimore, MD. <https://www.medicaid.gov/federal-policy-guidance/downloads/smd-13-002.pdf>
43. Mattke S, Liu H, Caloyeras JP, Huang CY, Van Busum KR, et al. 2013. *Workplace Wellness Programs Study: Final Report*. Arlington, VA: Rand Corp. https://aspe.hhs.gov/system/files/pdf/76661/rpt_wellness.pdf
44. McAfee T, Davis KC, Alexander RI Jr., Pechacek TF, Bunnell R. 2013. Effect of the first federally funded US antismoking national media campaign. *Lancet* 382:2003–11
45. Meit M. 2015. *The impacts of the Affordable Care Act on state and local health departments*. Presented at Keeneland Conf., Sept. 22, Lexington, KY. http://www.aohc.net/aws/AOHC/asset_manager/get_file/136228?ver=57

46. Mettenbrink C, Al-Tayyib A, Eggert J, Thrun M. 2015. Assessing the changing landscape of sexual health clinical service after the implementation of the Affordable Care Act. *Sex. Transm. Dis.* 42:725–30
47. Natl. Women's Law Cent. 2016. *The Affordable Care Act birth control benefit: progress on implementation and continuing challenges*. Rep., July 29, Natl. Women's Law Cent., Washington, DC. <https://nwlc.org/wp-content/uploads/2016/07/The-ACAs-BC-Benefit-Report-1.pdf>
48. Navarro M. 2016. U.S. will ban smoking in public housing nationwide. *New York Times* Nov. 30. <https://www.nytimes.com/2016/11/30/nyregion/us-will-ban-smoking-in-public-housing-nationwide.html>
49. Pace LE, Dusetzina SB, Keating NL. 2016. Early impact of the Affordable Care Act on uptake of long-acting reversible contraceptive methods. *Med. Care* 54:811–17
50. Pearson C. 2013. Breast pumps now covered by insurance, but does it help? *Huffington Post* Jan. 23. https://www.huffingtonpost.com/2013/01/08/breast-pumps-insurance-free_n_2432777.html
51. Pollitz K, Rae M. 2016. *Workplace wellness programs characteristics and requirements*. Issue Brief, May, Kaiser Family Found., Menlo Park, CA. <http://files.kff.org/attachment/Issue-Brief-Workplace-Wellness-Programs-Characteristics-and-Requirements>
52. Rigby E. 2011. How the National Prevention Council can overcome key challenges and improve Americans' health. *Health Aff.* 30:2149–56
53. Rojas Smith L, Amico P, Goode S, Hoerger T, Jacobs S, Renaud J. 2016. *Evaluation of the Health Care Innovation Awards: Community Resource Planning, Prevention, and Monitoring. Second Annual Report*. Research Triangle Park, NC: RTI Int. <https://downloads.cms.gov/files/cmmi/hcia-communityrppm-secondannualrpt.pdf>
54. RTI Int. 2016. *State Innovation Models (SIM) Initiative Evaluation: Model Test Year Two Annual Report*. Baltimore, MD: Cent. Medicare Medicaid Serv. <https://downloads.cms.gov/files/cmmi/sim-round1-secondannualrpt.pdf>
55. Sabik LM, Adunlin G. 2017. The ACA and cancer screening and diagnosis. *Cancer J.* 23:151–62
56. Sama-Miller E, Akers L, Mraz-Esposito A, Zukiewicz M, Avellar S, et al. 2017. *Home Visiting Evidence of Effectiveness Review: Executive Summary*. OPRE Rep. 2017–29. Washington, DC: Adm. Child. Fam., US Dep. Health Human Serv. https://www.acf.hhs.gov/sites/default/files/opre/homvee_executive_summary_03162017_508.pdf
57. Satcher D, Higginbotham EJ. 2008. The public health approach to eliminating disparities in health. *Am. J. Public Health* 98:S8–11
58. Schmidt H, Voight K, Wikler D. 2010. Carrots, sticks, and health care reform—problems with wellness incentives. *N. Engl. J. Med.* 362:e3
59. Shartzter A, Long SK, Anderson N. 2015. Access to care and affordability have improved following Affordable Care Act implementation; problems remain. *Health Aff.* 35:161–68
60. Simon K, Soni A, Cawley J. 2016. *The impact of health insurance on preventive care and health behaviors: evidence from the 2014 ACA Medicaid expansions*. NBER Work. Pap. 22265
61. Skopec L, Sommers BD. 2013. *Seventy-one million additional Americans are receiving preventive services coverage without cost-sharing under the Affordable Care Act*. Issue Brief, March 18, Assist. Secr. Plan. Eval., Washington, DC. https://aspe.hhs.gov/system/files/pdf/76626/fb_prevention.pdf
62. Skopec L, Waidmann TA, Sung J, Dean O. 2016. *Access to health care improved during early ACA marketplace implementation*. Brief, Jan., AARP Public Policy Inst., Washington, DC. <http://www.aarp.org/content/dam/aarp/ppi/2015/access-to-health-care-improved-during-early-aca-%20marketplace-implementation.PDF>
63. Sobel L, Salganicoff A, Kurani N, Wiens J. 2015. *Coverage of Contraceptive Services: A Review of Health Insurance Plans in Five States*. Menlo Park, CA: Henry J. Kaiser Family Found. <http://files.kff.org/attachment/report-coverage-of-contraceptive-services-a-review-of-health-insurance-plans-in-five-states>
64. Sommers BD, Blendon RJ, Orav EJ, Epstein AM. 2016. Changes in utilization and health among low-income adults after Medicaid expansion or expanded private insurance. *JAMA Intern. Med.* 176:1501–9
65. Sonfield A, Tapales A, Jones RK, Finer LB. 2015. Impact of the federal contraceptive coverage guarantee on out-of-pocket payments for contraceptives: 2014 update. *Contraception* 91:44–48

66. US FDA (Food Drug Adm.). 2017. *Menu labeling requirements*. Updated Sept. 29, US FDA, Silver Spring, MD. <https://www.fda.gov/Food/GuidanceRegulation/GuidanceDocumentsRegulatoryInformation/LabelingNutrition/ucm515020.htm>
67. Vu M, White A, Kelley VP, Hopper JK, Liu C. 2016. Hospital and health plan partnerships: the Affordable Care Act's impact on promoting health and wellness. *Am. Health Drug Benefits* 9:269–78
68. Wallace J, Sommers BD. 2015. Effect of dependent coverage expansion of the Affordable Care Act on health and access to care for young adults. *JAMA Pediatr.* 169:495–96
69. Welch HG. 2015. *Less Medicine, More Health: 7 Assumptions That Drive Too Much Medical Care*. Boston: Beacon
70. Williams ED, Redhead CS. 2010. *Public Health, Workforce, Quality, and Related Provisions in the Patient Protection and Affordable Care Act (PPACA)*. CRS Rep. Congr. Washington, DC: Congr. Res. Serv., Libr. Congr. <https://www.aamc.org/download/130996/data/ph.pdf.pdf>