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The Patient Protection and Affordable Care Act: opportunities for prevention and public health

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The Patient Protection and Affordable Care Act, which was enacted by the US Congress in 2010, marks the greatest change in US health policy since the 1960s. The law is intended to address fundamental problems within the US health system, including the high and rising cost of care, inadequate access to health insurance and health services for many Americans, and low health-care efficiency and quality. By 2019, the law will bring health coverage—and the health benefits of insurance—to an estimated 25 million more Americans. It has already restrained discriminatory insurance practices, made coverage more affordable, and realised new provisions to curb costs (including tests of new health-care delivery models). The new law establishes the first National Prevention Strategy, adds substantial new funding for prevention and public health programmes, and promotes the use of recommended clinical preventive services and other measures, and thus represents a major opportunity for prevention and public health. The law also provides impetus for greater collaboration between the US health-care and public health systems, which have traditionally operated separately with little interaction. Taken together, the various effects of the Patient Protection and Affordable Care Act can advance the health of the US population.

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Introduction

On March 23, 2010, US President Barack Obama signed the Patient Protection and Affordable Care Act of 2010 (frequently referred to as the Affordable Care Act).[1] The legislation marked the greatest change in health policy in the USA since the 1960s. As Obama said when he signed the bill, the law is intended to enshrine "the core principle that everybody should have some basic security when it comes to their health care".[2] To achieve this aim, the law addresses fundamental problems within the US health system, including the high and rising cost of care, insufficient access to health insurance and health services for many people, low health-care efficiency and quality, and an inadequate emphasis on disease prevention.

The story of the Affordable Care Act is just beginning and its effects will unfold over many years. At the time of publication, more than 4 years after the law was adopted, its main provisions have already become firmly established in US health policy. Even so, the Affordable Care Act remains the subject of controversy and political debate, fuelled partly by difficulties in the implementation of insurance expansion.[3–5] In the midst of these challenges, however, the law's salutary effects on prevention and public health are steadily taking hold. Few articles so far have described the potential effects of the Affordable Care Act on prevention and public health. In this Series paper, we briefly outline the main components of the law and then describe the parts of the law that will affect prevention and public health on a practical level, including a review of how the law is promoting collaboration between the health-care and public health systems in the USA.

Overview of the Affordable Care Act

A constant issue in the US health system has been that a sizeable proportion of the population has not had health insurance. The enactment in 1965 of Medicare and Medicaid, the USA's largest public health insurance programmes (panel 1), began to address this problem on a national scale. Before Medicare, only about 50% of the USA's senior citizens had hospital insurance, but now it covers nearly all people aged 65 years or older for hospital and other services.[8] Similarly, before Medicaid, only a small proportion of people living in poverty had any form of health insurance. By 2012, just before the health insurance expansions of the Affordable Care Act, 68% of non-elderly people (ie, people younger than 65 years) living below the poverty line had health insurance

Key messages

- The Patient Protection and Affordable Care Act, enacted by the US Congress and signed by the US President in 2010, marks the largest change in US health policy since the adoption of Medicare and Medicaid in 1965.
- The central purpose of the law is to bring the security of health insurance to uninsured Americans, but the law also aims to increase the quality of care, restrain the growth of costs, and advance population health.
- By the end of March 2014, the law had brought more than 8 million more people on to the insurance rolls and helped 4·8 million more to obtain Medicaid coverage. As a result of the law, by 2016 the number of people in the USA without health insurance is expected to fall by 25 million.
- To help slow the rate of growth in US health spending while also improving quality, the law promotes innovations to federal health payment systems (eg, greater coordination of care, bundling of payments) and establishes tighter links between payments and the quality of care provided.
- The law places an emphasis on prevention through several measures, including increased access to recommended clinical preventive services, provision of additional funding for prevention programmes, and mandating of a new National Prevention Strategy.
- The law is spurring stronger collaboration between the US public health and health-care systems to help both systems to improve population and community health.

Panel 1: Basics of health insurance in the USA

In many other high-income countries, health insurance is part of a national system operated by the central or provincial governments. In the USA, however, no single system provides insurance for everyone. Individuals and families obtain health insurance from various public and private sources. In 2011, 58% of non-elderly people (ie, people younger than 65 years) had employment-based insurance. Other non-military sources of insurance were Medicare, Medicaid, the State Children's Health Insurance Program, and individually purchased insurance.[6]

Medicare and Medicaid were both enacted in 1965. Medicare is America's universal health insurance programme for people aged 65 years or older or who are permanently disabled. In 2013, about 52 million people (16% of the US population) were Medicare beneficiaries, 83% of whom were aged 65 years or older and 17% of whom were permanently disabled.[7] Medicaid is the nation's main government health insurance programme for people on low incomes. In 2013, about 73 million Americans received coverage through Medicaid,[7] including children, pregnant women, working and jobless parents, and aged and disabled people. The programme is operated individually by each of the US states with financial contributions from the federal government. Eligibility for Medicaid and the benefits provided vary from state to state, although the federal government sets certain minimum services and standards.

coverage.[9] Despite these gains from Medicare, Medicaid, and other public and private sources of coverage, since the 1970s, the proportion of the overall population without health insurance has remained persistently high, from about 12% to 18% (figure 1). A major goal of the Affordable Care Act is to bring the security of health insurance to many of these uninsured people.

People living without health insurance have difficulty accessing needed health services,[10] and when they receive care, the providers often are not compensated, which results in cost shifting to insured and self-pay groups.[11] Acquisition of health insurance has been associated with improvements in health access and some health outcomes.[12–14] The US Congressional Budget Office estimates that the Affordable Care Act will bring 26 million people on to the insurance rolls by 2017.[15] The law achieves this expansion in several ways. For example, the earliest expansion took place when, upon the passage of the law, children were allowed to stay on their parents' health insurance policies until age 26 years, resulting in the acquisition of coverage by 3·1 million young adults by the end of December, 2011.[16]

The law also removes barriers to insurance by making reforms to the business practices of insurance companies. Before the introduction of the Affordable Care Act, individuals with pre-existing disorders often paid higher premiums or were turned away from insurance altogether, and others were subject to yearly or lifetime limits on coverage. The law eliminates these insurance practices and moves premiums closer to a system of community rating (ie, pricing of insurance premiums without regard to claims, health status, or individual characteristics). The law limits the factors that insurance companies can use to rate premiums to four only: individual versus family status, age bands, geographical area, and tobacco use.[17]

The Affordable Care Act promotes a balanced insurance risk pool by requiring that individuals must either have a prescribed minimum level of health coverage (or qualify for an exemption) or make an "individual shared responsibility payment" when their federal income tax return is due. For the 2014 tax year, this payment will be waived for some people whose individual policies were cancelled by their insurance companies and for whom other plans are unaffordable.[18] The law also requires that large employers either offer health coverage to their full-time employees or make a shared responsibility payment. This employer requirement was delayed and is now scheduled to begin in 2015.

The Affordable Care Act makes buying insurance easier for individuals and small businesses by creating new health insurance exchanges (called Health Insurance Marketplaces) in each state. These marketplaces exist in all states, but by early 2014, 36 states had opted for the federal government to manage their marketplace. Consumers can visit Health Insurance Marketplaces online and see all the qualifying insurance plans available for purchase in their state, allowing direct comparisons among different plans by premium, benefits, and quality.[19] They can also establish their eligibility for Medicaid. All insurance plans sold on marketplaces have to provide a package of essential health benefits, although the specific benefits required in the package generally are determined by the states.[20] To make individual coverage easier to afford, the Affordable Care Act creates a refundable tax credit that can be advanced to consumers who generally have incomes between 100% and 400% of the federal poverty level (in 2013, for a family of four, 100% and 400% were $23 550 and $94 200 respectively).[21,22] Of the 7 million people projected to enrol in private health insurance on the marketplaces in 2014, about 6 million were expected to receive tax credits.[23]

Enrolment for the first year of the marketplaces began on Oct 1, 2013, and extended to March 31, 2014, for coverage beginning as early as Jan 1, 2014. Although the marketplaces managed by individual states mostly worked well, the launch of the federally operated marketplace was described by Obama as "rough".[24] Users could not access the website or experienced long delays in response, and concerns arose about whether small enrolment numbers would allow the insurance risk pool to remain balanced.[25] However, after pronounced technological, managerial, and policy fixes, the federal website was substantially improved. In March, 2014, near

the end of the enrolment period, the proportion of young adults who had selected a marketplace plan through the federal and state marketplaces remained "strong" and "consistent with expectations".[26] By April, more than 8 million people had selected plans in the federal and state marketplaces. Another 4·8 million people had qualified for Medicaid, although not all of this enrolment was related to the Affordable Care Act.[27] To add to the difficulties of the rollout, as 2014 approached, millions of people received cancellation notices for their existing coverage from their insurance companies that cited requirements of the Affordable Care Act that would take effect in 2014. In response, the federal government amended several regulatory requirements and deadlines.[28]

Another way the Affordable Care Act makes insurance more accessible is by providing states with the option to expand Medicaid. When enacted, the Affordable Care Act included substantial incentives and penalties to encourage states to expand Medicaid eligibility to a much broader population in all US states (ie, to 138% of the federal poverty level). In response to a legal challenge brought by a group of states and other plaintiffs, in 2012 the US Supreme Court ruled that the imposition of large penalties on states if they decided not to expand Medicaid was unconstitutional.[29] By early May, 2014, 26 states and the District of Columbia had confirmed that they would expand Medicaid. Estimates suggest that non-elderly Medicaid beneficiaries will rise from 33 million in 2013, to 48 million by 2018.[15] Because the pre-expansion Medicaid programme covered mainly children and pregnant women, most of the new enrollees will be adults—particularly childless men.[15,30]

Even after full implementation of the Affordable Care Act, an estimated 30 million non-elderly adults (corresponding to roughly 10% of the non-elderly population) will remain uninsured,[15] including unauthorised immigrants, people who are eligible for, but not enrolled in, Medicaid, people who choose to remain without insurance, and people in states that are not expanding Medicaid who cannot afford to buy insurance because they do not qualify for premium subsidies.[31] Some people will have insurance but will remain underinsured, meaning that they will be obliged to spend more than 10% of their income on out-of-pocket health expenses.[32]

To help to address the needs of the newly insured, the Affordable Care Act has several provisions to increase the number of primary care providers and develop the US health workforce. The act includes an appropriation of US$11 billion for the operation, expansion, and construction of health centres throughout the country; major expansions in the National Health Service Corps (a group of primary care providers assigned to areas with shortages in medical personnel); additional support for health training; and temporarily enhanced payments for Medicaid services provided by primary care physicians.[33,34]

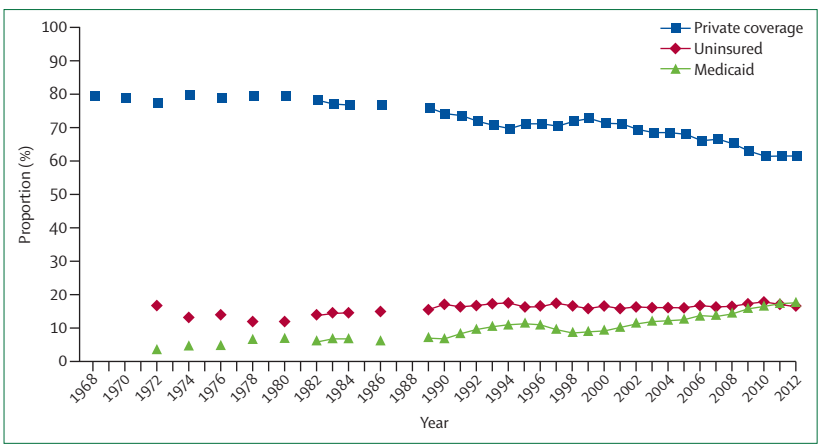

Figure 1: **Insurance trends for people younger than 65 years, 1968–2012**
Adapted from data from the National Health Interview Survey (http://www.cdc.gov/nchs/health_policy/trends_hc_1968_2011.htm). Coverage is at the time of interview, except for 1990–96, when it is within the month before interview. The category private coverage excludes plans that paid for only one type of service, such as accidents or dental care. The Medicaid category includes Medicaid and the State Children's Health Insurance Program (SCHIP). A person was defined as uninsured if he or she did not have any private health insurance, Medicare (1976 or later), Medicaid, SCHIP (1999 or later), state-sponsored (1982–89, 1992 or later), or other government-sponsored health plan (1997 or later) or military plan. A person was also defined as uninsured if he or she had only Indian Health Service coverage or had only a private plan that paid for one type of service, such as accidents or dental care. The percentage of persons younger than 65 years that had Medicare or other public insurance was under 2·5% and 4·0% throughout the time period, respectively.

By 2012, US health-care spending had reached $2·8 trillion, or $8915 per person—about double the 2011 mean spend per person of other countries in the Organisation for Economic Co-operation and Development (OECD). As a proportion of gross domestic product, expenditures have risen from 5·1% in 1960, to 17·2% in 2012, representing a growth rate that is fiscally unsustainable.[35–38] The Affordable Care Act includes provisions to reduce health-care spending in the USA, including, for example, reduced Medicare payment updates for some providers and programmes linked to value (eg, the Hospital Readmissions Reduction Program), the Medicare drug coverage discount programme, and the limits on medical loss ratios established by the act (ie, the minimum proportion of premium revenue that insurance companies have to spend on care and quality improvements). Although these provisions have begun to reduce costs in certain spending categories, such as Medicare, their effect on overall long-term national health spending is unclear.[39–41]

For more on **states expanding Medicaid** see https://stateforum.org

Other provisions of the act make structural changes to federal health payment systems that are expected to generate large savings in time. For example, the act creates a new Center for Medicare & Medicaid Innovation—the Innovation Center—within the US Centers for Medicare & Medicaid Services that is charged with overseeing, creating, and testing new clinical care models and payment approaches to reduce the costs of Medicare and Medicaid while maintaining or improving quality.

For more on the **Innovation Center** see http://innovation.cms.gov/initiatives/index.html

One such model comprises accountable care organisations (ACOs), which are defined as groups of physicians, hospitals, and other health-care providers that

For more on **accountable care organisations** see https://innovation.cms.gov/initiatives/ACO

come together to give highly coordinated care. Through better coordination of care and elimination of duplication of services, ACOs could improve the quality of care and achieve savings, which would then be shared between the ACO and the payer, such as Medicare. Initial results from one model of a Medicare ACO, the Pioneer Model, suggest that, during 2012, costs for its nearly 700 000 beneficiaries rose at a rate less than half that of other Medicare beneficiaries, and it did well on quality measures.[42] ACOs are part of a shift away from government health spending that rewards the volume of care provided towards spending that rewards value provided. The Affordable Care Act also could generate savings over the long term by increasing preventive services, funding research into health-care effectiveness, encouraging the use of improved health information technology, curbing waste and abuse, and other measures.[43]

To address deficiencies in the quality and efficiency of health care in the USA, the Affordable Care Act necessitates the establishment by the federal government of a National Strategy for Quality Improvement in Health Care.[44,45] It sets a three-part aim: to improve overall quality through patient-centred, reliable, accessible, and safe health care; to improve the health of the US population through proven interventions to address behavioural, social and, environmental determinants of health; and to reduce the cost of quality health care for individuals, families, employers, and government. The strategy identifies many individual programmes, such as the Patient-Centered Medical Home model, and priorities that include, for example, the creation of national tracking measures and aspirational targets for health quality.[46]

Provisions of the law also strengthen the link between the cost of care and the quality of care provided. For example, the Hospital Readmission Reduction programme penalises hospitals that have excess risk-adjusted readmission rates. The Centers for Medicare & Medicaid Services, through their Quality Improvement Organisations[47] and Community-Based Care Transitions Program,[48] have invested hundreds of millions of dollars to decrease readmissions to hospital. Another initiative, the Healthcare-Acquired Condition programme, reduces some payments for hospitals in the lowest quartile of performance for the incidence of hospital-acquired illnesses.[49] These programmes have proven successful and may generate $12 billion or more in savings in 10 years.[50,51] Another strategy is the Medicare Hospital Value-based Purchasing Program, which redistributes roughly $1 billion on the basis of hospital performance on quality and cost metrics; high-performing hospitals reap financial benefits.[52]

***Panel 2*: The US National Prevention Strategy strategic directions and priorities**

Strategic directions

Healthy and safe community environments

- Communities, including homes, schools, public spaces, and worksites, can be transformed to support wellbeing and make healthy choices easy and affordable

Clinical and community preventive services

- Ensure that prevention-focused health care and community prevention efforts are available, integrated, and mutually reinforcing

Empowered people

- Support people in making healthy choices

Elimination of health disparities

- Eliminate disparities, improving the quality of life for all Americans

Priorities

- Tobacco-free living
- Prevention of drug misuse and excessive alcohol use
- Healthy eating
- Active living
- Injury-free and violence-free living
- Reproductive and sexual health
- Mental and emotional wellbeing

For more information on the **Million Hearts initiative** see http://millionhearts.hhs.gov

Prevention and public health

Observers have described the US health-care system as a "sick care system"—an allusion to its emphasis on treatment rather than prevention. The low proportion of state and federal government health spending that is devoted to public health activities—only 2·7% in 2012—shows how low a priority it is.[53] The Affordable Care Act aims to better emphasise prevention and public health in the US health system through establishment of national prevention priorities, catalysis of prevention initiatives, reduction of barriers to preventive services, provision of substantial new funding for public health interventions and infrastructure, and fostering of collaboration between public health and health care.[54]

To establish priorities and involve all sectors in health improvement, the Affordable Care Act establishes the National Prevention, Health Promotion and Public Health Council, whose primary task is to create and implement the National Prevention Strategy (NPS). The council comprises leaders from 20 federal departments, agencies, and offices, in recognition of the effect that all sectors have on public health, and is chaired by the US Surgeon General. The NPS identified four strategic directions and seven priorities that will have the greatest effect on US health (panel 2).[55] The act also emphasises prevention through specific programmes, such as the Partnership for Patients, a public–private partnership established with the goals of reducing preventable hospital-acquired disorders and preventing hospital readmissions, and the Million Hearts initiative, which was created to prevent 1 million heart attacks and strokes by 2017.[56] Million Hearts works through clinical delivery and public health systems to increase evidence-based aspirin therapy, control of blood pressure and cholesterol,

and smoking cessation. It also works through community-based prevention efforts to decrease intake of salt and trans fats and decrease tobacco use.

Effective clinical preventive services can reduce premature disease and deaths, but tens of millions of people in the USA are not using these services. For example, less than 50% of patients with diagnosed ischaemic vascular disease were prescribed aspirin or other antiplatelet agents according to a 2012 analysis.[57] Increased uptake of these services could save thousands of lives every year.[58] The Affordable Care Act mandates that new private insurance plans and states with expanded Medicaid programmes provide, without cost-sharing, a set of clinical preventive services that have been recommended by the US Preventive Services Task Force (an independent panel of non-federal experts in prevention and evidence-based medicine) and the Advisory Committee on Immunization Practices (a federal advisory group that issues immunisation recommendations), a group of recommended services for children under Bright Futures (launched by the US federal Government and the American Academy of Pediatrics), and a set of preventive services for women adopted by the federal government and recommended by the Institute of Medicine.[59]

The US federal Government estimated in early 2013 that this new mandated coverage for private plans provided 71 million additional people with access to preventive services without cost sharing.[60] Other provisions of the law promote clinical preventive services in people who receive benefits from traditional Medicaid and Medicare.[61] Contraception is one of the preventive services for women that has to be provided without cost sharing, but two lawsuits challenging that requirement on the grounds of religious freedom reached the Supreme Court in 2013, and are scheduled for decision in 2014.[62–64]

The Affordable Care Act establishes a Prevention and Public Health Fund—the Prevention Fund—to "provide for expanded and sustained national investment in prevention and public health programmes to improve health and help restrain the rate of growth in private and public health sector health care costs".[65] The Prevention Fund supports a broad range of activities, including, for example, programmes to improve the capacity of state and local public health departments to detect and control disease outbreaks by enhancing epidemiological and laboratory capacity, training the workforce, and supporting quality improvement and performance management. The largest portion of the Prevention Fund supports programmes to reduce the leading causes of death, such as grants to local communities to implement proven practices to improve nutrition and physical activity, reduce tobacco use, and control blood pressure and cholesterol.[66] The Prevention Fund also supported TIPS from Former Smokers, the first national anti-tobacco campaign, which caused an estimated 1·64 million additional smokers to make a quit attempt and 220 000 to remain abstinent at follow-up, among other effects.[67]

Public health–health-care collaboration

Some of the Affordable Care Act's effects will result from increasing the impetus for collaboration between the US public health and health-care systems, which for nearly a century have operated with little interaction.[68] The health-care system mostly provides individual care. The public health system focuses on the detection of, and response to, disease threats through epidemiology, disease surveillance, community-wide preventive interventions, and clinical services that are necessary for population health.[69,70] Public health departments also provide direct safety-net individual care services (eg, primary care services) in some places where capacity otherwise does not exist.[71]

For more on the **US Preventive Services Task Force** see https://www.uspreventiveservicestaskforce.org

For more on the **Advisory Committee on Immunization Practices** see http://www.cdc.gov/vaccines/acip/about.html

For more on **Bright Futures** see http://brightfutures.aap.org

The Affordable Care Act fosters collaboration between public health and health care directly through, for example, novel health-care delivery models (eg, ACOs and patient-centred medical homes), which prompt health-care entities to broaden their focus from individual patients to their entire panels of patients or to the whole population. It encourages health-care and public health entities to pursue better ways of organising care, use data to understand the health of patients and communities, and link clinical care to non-traditional resources. Ultimately, this new collaboration could bring more focus to the prevention of disease.

Collaboration between the public health and health-care systems can take various forms—specifically, alignment (the systems focus on the same disease or risk factor—eg, the Million Hearts initiative), coordination (the systems work together, such as when clinical providers refer patients to a community programme), and integration (when structural links exist that implicate financial accountability or organisational arrangements). Collaborations can involve data and measures (data collaboration), delivery of services (delivery collaboration), or drivers of change. Data collaboration includes clinical systems' use of public health data and measures. Standardisation of care and accountability on even one population health measure has the potential to drive pronounced improvement. For example, hospitals and public health departments are working together to use a public health surveillance system, the National Healthcare Safety Network, to track the occurrence of healthcare-associated infections and provide feedback to drive quality improvement. Conversely, public health can use clinical data for surveillance, detection, and response. New York City's Primary Care Information Project can now capture 3 million patient records daily, which can be used to improve the surveillance and management of infectious and chronic diseases.[72]

For more on the **National Healthcare Safety Network** see http://www.cdc.gov/nhsn

Delivery collaboration includes activities that link clinical and community services and improve clinical services or maintain and improve highly effective public health services. Until now, the two systems have often

For more on the **National Diabetes Prevention Program** see http://www.cdc.gov/diabetes/prevention/index.htm

delivered services in an uncoordinated fashion, even when aimed at the same issues and the same patients. Collaboration on service delivery can improve quality and reduce cost. The National Diabetes Prevention Program, for example, uses community health workers to deliver an intervention that improves nutrition and physical activity in people with pre-diabetes, and reduces progression to type 2 diabetes by 58% in these high-risk patients. Another example of delivery integration comes about when public health entities begin to bill insurers for their services. In the face of changes to delivery systems and financial pressures, more public health departments are billing for immunisation and other services covered by insurance—a radical change for a public health system that has traditionally used public dollars to provide services to anyone in need.[73]

Collaboration on drivers of change includes the development and implementation of guidelines, regulations, and incentive systems that allow increased focus on prevention and population health. For example, to sustain non-profit status and exemption from excise taxes, hospitals are required by the Affordable Care Act to do a community health needs assessment and develop an implementation plan to address identified needs.[74] In creating its plan, the hospital has to include "input from people who represent the broad interests of the community served by the hospital facility, including those with special knowledge of, or expertise in, public health". As a result, more hospital systems are working with public health and other community-based organisations to identify their community's health needs and address these needs with community-based interventions.

Contributors

ASR conceived of the paper. All authors participated in its design, drafting, and revision.

Declaration of interests

All authors were employed by the Centers for Disease Control and Prevention (FES, ASR) or the Centers for Medicare & Medicaid Services (CNA, PC) during the writing and initial revision of the manuscript. Both agencies are part of the US Department of Health and Human Services.

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References

1 The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152), together referred to as the Affordable Care Act.
2 Stolberg SG, Pear R. Obama signs health care overhaul bill, with a flourish. http://www.nytimes.com/2010/03/24/health/policy/24health.html?_r=0 (accessed May 26, 2014).
3 Hamel L, Firth J, Brodie M. Kaiser health tracking poll: April 2014. http://kff.org/health-reform/poll-finding/kaiser-health-tracking-poll-april-2014/ (accessed May 26, 2014).
4 Berwick DM. The toxic politics of health care. *JAMA* 2013; **310:** 1921–22.
5 Jost TS. Beyond repeal—a Republican proposal for health care reform. *N Engl J Med* 2014; **370:** 894–96.
6 Fronstin P. Sources of health insurance and characteristics of the uninsured: analysis of the March 2012 current population survey. Employee Benefit Research Institute Issue Brief 2012, No. 376. http://www.ebri.org/pdf/briefspdf/EBRI_IB_09-2012_No376_Sources.pdf (accessed May 25, 2014).
7 Centers for Medicare & Medicaid Services. CMS fast facts. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/CMS-Fast-Facts/index.html (accessed May 25, 2014.
8 De Lew N. Medicare: 35 years of service. *Health Care Financ Rev* 2000; **22:** 75–103.
9 The Henry J Kaiser Family Foundation. The uninsured: a primer—key facts about health insurance on the eve of coverage expansions. http://kff.org/uninsured/report/the-uninsured-a-primer-key-facts-about-health-insurance-on-the-eve-of-coverage-expansions/ (accessed May 26, 2014).
10 Driscoll AK, Bernstein AB. Health and access to care among employed and unemployed adults: United States, 2009–2010. http://www.cdc.gov/nchs/data/databriefs/db83.pdf (accessed April 28, 2013).
11 Hadley J, Holahan J, Coughlin T, Miller D. Covering the uninsured in 2008: current costs, sources of payment, and incremental costs. *Health Aff (Millwood)* 2008; **27:** w399–415.
12 Baicker K, Taubman SL, Allen HL, et al, and the Oregon Health Study Group. The Oregon experiment—effects of Medicaid on clinical outcomes. *N Engl J Med* 2013; **368:** 1713–22.
13 Institute of Medicine. Care without coverage: too little, too late. Washington, DC: National Academy Press, 2002.
14 Levy H, Meltzer D. The impact of health insurance on health. *Annu Rev Public Health* 2008; **29:** 399–409.
15 Congressional Budget Office. CBO's April 2014 estimate of the effects of the Affordable Care Act on health insurance coverage. http://cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables.pdf (accessed June 23, 2014).
16 Office of the Assistant Secretary for Planning and Evaluation. Report shows Affordable Care Act has expanded insurance coverage among young adults of all races and ethnicities. http://aspe.hhs.gov/health/reports/2012/YoungAdultsbyGroup/ib.shtml (accessed May 26, 2014).
17 The Henry J Kaiser Family Foundation. Health insurance market reform: rate restrictions. http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8328.pdf (accessed May 26, 2014).
18 US Department of Health and Human Services. How do I qualify for an exemption from the fee for not having health coverage? https://www.healthcare.gov/exemptions/ (accessed May 26, 2014).
19 US Centers for Medicare & Medicaid Services. http://www.healthcare.gov/marketplace (accessed May 26, 2014).
20 Center for Consumer Information & Insurance Oversight. CMS. Essential health benefits standards: ensuring quality, affordable coverage. http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/ehb-2-20-2013.html (accessed May 26, 2014).
21 Health Insurance Tax Credit. 77 Fed. Reg. 30,377, 30,400 (May 23, 2012) (to be codified at 26 C.F.R. Part 1 and 26 C.F.R. Part 602). Available at: http://www.gpo.gov/fdsys/pkg/FR-2012-05-23/pdf/2012-12421.pdf (accessed May 26, 2014).
22 Federal Register. Annual updated of the HHS poverty guidelines. https://www.federalregister.gov/articles/2013/01/24/2013-01422/annual-update-of-the-hhs-poverty-guidelines (accessed May 26, 2014).
23 The Henry J Kaiser Family Foundation. Issue brief: state-by-state estimates of the number of people eligible for premium tax credits under the Affordable care Act. http://kff.org/health-reform/issue-brief/state-by-state-estimates-of-the-number-of-people-eligible-for-premium-tax-credits-under-the-affordable-care-act/ (accessed May 26, 2014).
24 President Barack Obama. Transcript of news conference on the Affordable Care Act. November 14, 2013. http://www.washingtonpost.com/politics/transcript-president-obamas-nov-14-statement-on-health-care/2013/11/14/6233e352-4d48-11e3-ac54-aa84301ced81_story.html (accessed May 26, 2014).
25 Levitt L, Claxton G, Damico A. The numbers behind "young invincibles" and the Affordable Care Act. http://kff.org/health-reform/perspective/the-numbers-behind-young-invincibles-and-the-affordable-care-act/ (accessed May 26, 2014).

26 US Department of Health and Human Services. Health insurance marketplace: March enrollment report. http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Mar2014/ib_2014mar_enrollment.pdf (accessed May 25, 2014).

27 Office of the Assistant Secretary for Planning and Evaluation. Profiles of Affordable Care Act coverage expansion enrollment for Medicaid/CHIP and the Health Insurance Marketplace, May 1, 2014. http://aspe.hhs.gov/health/reports/2014/MarketPlaceEnrollment/Apr2014/Marketplace_StateSum.cfm (accessed May 25, 2014).

28 Centers for Medicare & Medicaid Services. Questions and answers on options available for consumers with cancelled policies, January 3, 2014. http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/cancellation-consumer-options-faq-01-03-2014.pdf (accessed May 26, 2014).

29 National Federation of Independent Business, et al. v. Kathleen Sebelius, et al. 11-393, 11-398, 11-400 (US Supreme Court, June 28, 2012).

30 Kenney GM, Zuckerman S, Dubay L, et al. Opting in to the Medicaid expansion under the ACA: who are the uninsured adults who could gain health insurance coverage? Timely Analysis of Immediate Health Policy Issues, August 2012. http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf (accessed May 26, 2014).

31 Nardin R, Zallman L, McCormick D, Woolhandler S, Himmelstein D. The uninsured after implementation of the Affordable Care Act: a demographic and geographic analysis. http://healthaffairs.org/blog/2013/06/06/the-uninsured-after-implementation-of-the-affordable-care-act-a-demographic-and-geographic-analysis/ (accessed May 26, 2014).

32 Andrews M. Despite health law's protections, many consumers may be "underinsured". http://www.kaiserhealthnews.org/stories/2013/december/31/michelle-andews-health-law-protections-consumers.aspx (accessed May 26, 2014).

33 Topol EJ. Topol asks Sebelius 5 ACA questions. http://www.medscape.com/viewarticle/806990 (accessed May 26, 2014).

34 Abrams M, Nuzum R, Mika S, Lawlor G. Realizing health reform's potential: how the Affordable Care Act will strengthen primary care and benefit patients, providers, and payers. The Commonwealth Fund (report), January 2011. http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2011/Jan/1466_Abrams_how_ACA_will_strengthen_primary_care_reform_brief_v3.pdf (accessed May 26, 2014).

35 Office for the Assistant Secretary for Planning and Evaluation. Long-term growth of medical expenditures—public and private. http://aspe.hhs.gov/health/MedicalExpenditures/ (accessed May 26, 2014).

36 Martin AB, Hartman M, Whittle L, Catlin A, the National Health Expenditures Accounts Team. Rate of health spending in 2012: rate of health spending growth remained low for the fourth consecutive year. *Health Aff (Millwood)* 2014; **33:** 67–77.

37 National Commission on Fiscal Responsibility and Reform. The moment of truth: report of the National Commission on Fiscal Responsibility and Reform, December 2010. http://www.fiscalcommission.gov/sites/fiscalcommission.gov/files/documents/TheMomentofTruth12_1_2010.pdf (accessed May 26, 2014).

38 Centers for Medicare and Medicaid Services (CMS). National health expenditures 2012 highlights. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/highlights.pdf (accessed May 26, 2014).

39 Ryu AJ, Gibson TB, McKellar MR, Chernew ME. The slowdown in health care spending in 2009–11 reflected factors other than the weak economy and thus may persist. *Health Aff (Millwood)* 2013; **32:** 835–40.

40 Cutler DM, Sahni NR. If slow rate of health care spending growth persists, projections may be off by $770 billion. *Health Aff (Millwood)* 2013; **32:** 841–50.

41 Kronick R, Po R. Growth in Medicare spending per beneficiary continues to hit historic lows. http://aspe.hhs.gov/health/reports/2013/medicarespendinggrowth/ib.pdf (accessed May 26, 2014).

42 Centers for Medicare & Medicaid Services. Pioneer Accountable Care Organizations succeed in improving care, lowering costs. http://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-Releases/2013-Press-Releases-Items/2013-07-16.html (accessed May 26, 2014).

43 The White House. Deficit-reducing health care reform. http://www.whitehouse.gov/economy/reform/deficit-reducing-health-care-reform (accessed May 26, 2014).

44 Lallemand NC. Reducing waste in health care: health policy brief. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=82 (accessed May 26, 2014).

45 US Department of Health and Human Services. 2011 Report to Congress: National Strategy for Quality Improvement in Health Care. http://www.ahrq.gov/workingforquality/nqs/nqs2011annlrpt.htm (accessed May 26, 2014).

46 US Department of Health and Human Services. 2012 Annual Progress Report to Congress: National Strategy for Quality Improvement in Health Care. http://www.ahrq.gov/workingforquality/nqs/nqs2012annlrpt.htm (accessed May 26, 2014).

47 Centers for Medicare & Medicaid Services. Quality improvement organizations. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/QualityImprovementOrgs/index.html?redirect=/qualityimprovementorgs/ (accessed May 26, 2014).

48 Centers for Medicare & Medicaid Services. Community-based Care Transitions Program. http://innovation.cms.gov/initiatives/CCTP/?itemID=CMS1239313 (accessed May 26, 2014).

49 Centers for Medicare & Medicaid Services. Hospital-acquired conditions (present on admission indicator). http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index.html?redirect=/hospitalacqcond (accessed May 26, 2014).

50 Brock J, Mitchell J, Irby K, et al, and the Care Transitions Project Team. Association between quality improvement for care transitions in communities and rehospitalizations among Medicare beneficiaries. *JAMA* 2013; **309:** 381–91.

51 Centers for Medicare & Medicaid Services. Affordable Care Act update: implementing Medicare cost savings. http://www.cms.gov/apps/docs/aca-update-implementing-medicare-costs-savings.pdf (accessed May 26, 2014).

52 Centers for Medicare & Medicaid Services. Hospital value-based purchasing. http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/hospital-value-based-purchasing (accessed May 26, 2014).

53 Centers for Medicare & Medicaid Services. National health expenditures tables, 2012. http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/tables.pdf (accessed May 26, 2014).

54 Koh HK, Sebelius KG. Promoting prevention through the Affordable Care Act. *N Engl J Med* 2010; **363:** 1296–99.

55 National Prevention Council. National prevention strategy: America's plan for better health and wellness. http://www.surgeongeneral.gov/initiatives/prevention/strategy/ (accessed May 26, 2014).

56 Centers for Disease Control and Prevention. CDC grand rounds: the Million Hearts initiative. *MMWR Morb Mort Wkly Rep* 2012; **61:** 1017–21.

57 George MG, Tong X, Sonnenfeld N, Hong Y. Recommended use of aspirin and other antiplatelet medications among adults — National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey, United States, 2005–2008. *MMWR Morb Mort Wkly* 2012; **61** (suppl): 11–18.

58 Frieden TR. Foreword. In: Centers for Disease Control and Prevention. Use of selected clinical preventive services among adults—United States, 2007–2010. *MMWR Morb Mortal Wkly Rep* 2012; **61** (suppl): 1–2.

59 Institute of Medicine. Clinical preventive services for women: closing the gaps. http://iom.edu/Reports/2011/Clinical-Preventive-Services-for-Women-Closing-the-Gaps.aspx (accessed May 26, 2014).

60 Skopec L, Sommers BD. Seventy-one million additional Americans are receiving preventive services coverage without cost-sharing under the Affordable Care Act. http://aspe.hhs.gov/health/reports/2013/PreventiveServices/ib_prevention.cfm (accessed May 26, 2014).

61 Cassidy A. Health policy brief: preventive services without cost sharing. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=37 (accessed May 26, 2014).

62 Kathleen Sebelius, Secretary of Health and Human Services, et al. Petitioners v. Hobby Lobby Stores, Inc., et al. U.S. Supreme Court, certiorari granted, November 26, 2013.

63 Conestoga Wood Specialties Corporation, et al., Petitioners v. Kathleen Sebelius, Secretary of Health and Human Services, et al., U.S. Supreme Court, certiorari granted, November 26, 2013.

64 Denniston L. Court to rule on birth-control mandate, UPDATED. http://www.scotusblog.com/2013/11/court-to-rule-on-birth-control-mandate/ (accessed May 26, 2014).

65 The Patient Protection and Affordable Care Act of 2010, Section 4002. 42 U.S.C. § 300u-11(a).

66 Centers for Disease Control and Prevention. Community transformation grants. http://www.cdc.gov/nccdphp/dch/programs/communitytransformation/ (accessed May 26, 2014).

67 McAfee T, Davis KC, Alexander RL, Pechacek TF, Bunnell R. Effect of the first federally funded US antismoking national media campaign. *Lancet* 2013; **382:** 2003–11.

68 Scutchfield FD, Michener JL, Thacker SB. Are we there yet? Seizing the moment to integrate medicine and public health. *Am J Prev Med* 2012; **42:** S97–102.

69 Institute of Medicine. Primary care and public health: exploring integration to improve population health. Washington DC: National Academies Press, 2012.

70 Beitsch LM, Grigg M, Menachemi N, Brooks RG. Roles of local public health agencies within the state public health system. *J Public Health Manag Pract* 2006; **12:** 232–41.

71 Madamala K, Sellers K, Beitsch LM, Pearsol J, Jarris PE. Structure and functions of state public health agencies in 2007. *Am J Public Health* 2011; **101:** 1179–86.

72 Calman N, Hauser D, Lurio J, Wu WY, Pichardo M. Strengthening public health and primary care collaboration through electronic health records. *Am J Public Health* 2012; **102:** e13–18.

73 Smith D, Kinsley A, Leyvas C, Walker A. California's innovative immunization billing project plan. http://psbweb.co.kern.ca.us/PH_Internet/pdfs/HotTopic/FinalCaliforniaBillingPlan.pdf (accessed May 26, 2014).

74 The Patient Protection and Affordable Care Act of 2010 (P.L. 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152, together referred to as the Affordable Care Act. Section 9007(e).