Setting the Stage

With the recent passage of PL 111-148, the Patient Protection and Affordable Care Act (PPACA), America is entering a new era of expanded coverage for health care. In a much debated and often contentious political environment, Congress has seen fit to cobble together a large number of health policy interventions designed to address a wide range of perceived “ills” of our health care system. The dominate concern of the legislation is subsidizing health insurance cost and securing uninterruptable access to coverage, but sandwiched into this overwhelmingly large piece of legislation (906 pages) are a large number of health system interventions that touch virtually every facet of health care delivery.

Through a very persistent and well-led effort, our own health promotion advocates were successful in securing inclusion of several key provisions that address wellness and health promotion. However, it also did not hurt to have two key supportive political figures (Senators Tom Harkin and Max Baucus) in prominent legislative roles with the health care reform legislation.

This historic legislation is very likely to have a number of profound effects on our health care system and our society. Several of these probable effects are likely to modify the field and practice of wellness and health promotion, some for the better and some potentially for the worse. Because of the need to better understand and hopefully compensate for some of these anticipated effects, we are going to provide a two-part approach to the law. Part I is an in-depth overview of the new law. Part II will deal with its likely effects on major stakeholders, while suggesting some ways in which the full potential of the current wellness and health promotion provisions can be realized. Specifically, we will be addressing the following 3 topics in this edition of The Art of Health Promotion: What are the main provisions of the law? What are the key wellness and health promotion provisions? Where does the word wellness show up in the new law?

What Are the Main Provisions of the Law?

The original legislative package for health care reform numbered more than 2300 pages and presented the casual reader with the overwhelming impression that there had to have been a conscientious effort to collect every previously proposed and failed piece of health legislation from the last decade and recast them into a “mega” bill that had a presumed high probability of passage. The resulting engrossed act (HR 3590) runs to a mind-numbing 906 pages, and the authenticated version provided by the Government Printing Office is what will be used for this analysis. This significant piece of health care reform legislation was followed quickly by a set of largely housekeeping revisions encompassed in HR 4872, which became the Health Care and Education Reconciliation Act of 2010 (PL 111-152) (HCERA), a document that runs 55 pages in length.
With federal legislation, each section of a bill or law is usually considered to be a discrete activity or legislative intervention, and examining the number of sections in each main title of a law is often useful for understanding the extent of change or complexity and priorities in a legislative initiative. A listing of the main titles, the number of sections within each title, and the percentage that represents of the total sections in the law are given in Table 1.

The areas of health care improvements in quality and efficiency, including expanding access to accomplish those goals, surface as the major focus of the legislation (Titles I, III, and X). The reconciliation bill (HR 4872) contains a number of amendments (as does the PPACA in Title X). Table 2 gives a similar overview look at PL 111-152 (HCERA), which includes a number of "cleanup" amendments and a few additional legislative initiatives.

The two pieces of legislation together contain 512 sections and run to 961 pages. It will presumably take several years for the governmental agencies involved to even begin to plan and implement a full legislative initiative of this complexity. Because of its size and complexity, Congress included a phased approach to its major provisions. In addition, if the already emerging call for repeal of the law gains political traction, it will likely create further uncertainty in the promulgation of regulations and implementation of its provisions.

The PPACA contains a number of significant changes in the way our health care system works and how health care is provided and financed. Table 3 gives the most significant of these changes and identifies the timing of implementation if the legislation takes a clear position.

These 10 major titles in PL 111-148 contain an enormous number of changes to federal programs, administrative practices, policies, and laws. The PPACA almost defies simple analysis because of its complexity and sheer number of legislative provisions.

What Are the Key Wellness and Health Promotion Provisions?

For wellness and health promotion issues, Title IV (Prevention of Chronic Disease and Improving Public Health) contains the most relevant provisions in its 27 sections. To better understand this key title, the major sections are summarized in Table 4, and a look at each section’s primary significance to the wellness and health promotion field is offered.

Where Does the Word Wellness Show Up in the New Law?

The word wellness appears 86 times in the PPACA in 31 sections of the law. Table 5 gives an analysis of every time the word

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**Table 1**

Summary of Major Sections of PL 111-148 Patient Protection and Affordable Care Act (PPACA)

<table>
<thead>
<tr>
<th>Title</th>
<th>Name of Title</th>
<th>No. of Sections</th>
<th>Percentage of Total No. of Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Quality, Affordable Health Care for All Americans</td>
<td>76</td>
<td>16.7</td>
</tr>
<tr>
<td>II</td>
<td>Role of Public Programs</td>
<td>42</td>
<td>9.2</td>
</tr>
<tr>
<td>III</td>
<td>Improving the Quality and Efficiency of Health Care</td>
<td>97</td>
<td>21.2</td>
</tr>
<tr>
<td>IV</td>
<td>Prevention of Chronic Disease and Improving Public Health</td>
<td>27</td>
<td>5.9</td>
</tr>
<tr>
<td>V</td>
<td>Health Care Workforce</td>
<td>50</td>
<td>10.9</td>
</tr>
<tr>
<td>VI</td>
<td>Transparency and Program Integrity</td>
<td>49</td>
<td>10.7</td>
</tr>
<tr>
<td>VII</td>
<td>Improving Access to Innovative Medical Therapies</td>
<td>6</td>
<td>1.3</td>
</tr>
<tr>
<td>VIII</td>
<td>CLASS Act (Community Living Assistance Services and Support)</td>
<td>2</td>
<td>0.4</td>
</tr>
<tr>
<td>IX</td>
<td>Revenue Provisions</td>
<td>20</td>
<td>4.4</td>
</tr>
<tr>
<td>X</td>
<td>Strengthening Quality, Affordable Health Care for All Americans</td>
<td>88</td>
<td>19.3</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td><strong>457</strong></td>
<td><strong>100</strong></td>
</tr>
</tbody>
</table>

**Table 2**

Summary of Major Sections of PL 111-152 Health Care and Education Reconciliation Act of 2010 (HCERA)

<table>
<thead>
<tr>
<th>Title</th>
<th>Name of Title</th>
<th>No. of Sections</th>
<th>Percentage of Total No. of Sections</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Coverage, Medicare, Medicaid, and Revenues</td>
<td>35</td>
<td>63.6</td>
</tr>
<tr>
<td>II</td>
<td>Education and Health</td>
<td>20</td>
<td>36.4</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td></td>
<td><strong>55</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

* The Education provisions primarily include student loan program reform.
Table 3
Summary of Major Titles and Key Sections of PL 111-148 Patient Protection and Affordable Care Act (PPACA)*

<table>
<thead>
<tr>
<th>Statutory Reference</th>
<th>Brief Description</th>
<th>Timing of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Title I—Sections 2711–2719 (Subtitle A)</td>
<td>QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS. A large number of coverage improvements that apply to all group and individual health plans. These include prohibition of lifetime or annual plan limits, prohibitions of rescissions, required inclusion of preventive medical benefit coverage, extension of dependent coverage up to the age of 26 y, establishment of standardized definitions and coverage options (bronze, silver, gold, and platinum levels), and a variety of requirements regarding the availability of consumer information and appeal mechanisms.</td>
<td>These provisions shall become effective for plan years beginning on or after the date that is 6 mo after the date of enactment of this Act (March 23, 2010), except that the amendments made by Sections 1002 and 1003 shall become effective for fiscal years beginning with fiscal year 2010</td>
</tr>
<tr>
<td>Title I—Sections 1002–1105m (Subtitle B)</td>
<td>Immediate actions to preserve and expand health insurance coverage, including establishment of a temporary high-risk pool at the federal level, establishment of a temporary reinsurance program for employees aged ≥55 y, establishment of an Internet portal with information on affordable health insurance options in each state, and provision of requirements for electronic data transfer.</td>
<td>These provisions shall be effective on the date of enactment of the Law</td>
</tr>
<tr>
<td>Title I—Sections 1201–1253 (Subtitle C)</td>
<td>Several health insurance market reforms, including prohibition of preexisting condition exclusions, discrimination based on health status, requirement of fair premiums, requirement of guaranteed availability of coverage, guaranteed renewability of coverage, definition of comprehensive health insurance coverage, prohibition of excessive waiting periods, preservation of right to existing coverage, equal application of rating reforms.</td>
<td>This Subtitle (and the amendments made by this Subtitle) shall become effective for plan years beginning on or after January 1, 2014</td>
</tr>
<tr>
<td>Title I—Sections 1301–1343 (Subtitle D)</td>
<td>Available coverage options for all Americans includes establishment of “Qualified Health Plans,” “Essential Health Benefit Requirements,” “American Health Benefit Exchanges,” state flexibility relating to exchanges and alternatives, reinsurance, and risk adjustment procedures.</td>
<td>Not clear</td>
</tr>
<tr>
<td>Title I—Sections 1401–1421 (Subtitle E)</td>
<td>Affordable coverage choices for all Americans include use of tax credits for premium assistance or limits on health plan cost sharing, eligibility determination, and small business tax credits.</td>
<td>Not clear</td>
</tr>
<tr>
<td>Title I—Sections 1501–1563 (Subtitle F)</td>
<td>Shared responsibility for health care, including individual mandate for health insurance coverage, reporting of status, employer responsibilities, and miscellaneous provisions.</td>
<td>Not clear</td>
</tr>
<tr>
<td>Title II—Section 2001–2915 (Subtitles A–L)</td>
<td>ROLE OF PUBLIC PROGRAMS. A variety of provisions that deal with improved access to Medicaid, CHIP, long-term care, prescription drug coverage, reimbursement policies, quality-of-care issues, advisory commissions, Indian and Alaska Native health services, and maternal and child health services.</td>
<td>Not clear</td>
</tr>
<tr>
<td>Title III—Sections 3001–3602 (Subtitles A–G)</td>
<td>IMPROVING THE QUALITY AND EFFICIENCY OF HEALTH CARE. Improving the quality and efficiency of health care through a large number of provisions, including linking of payment to quality outcomes under Medicare, development of a national strategy for quality improvement, new patient care models, Medicare modifications, rural care modifications, improvement of payment accuracy, prescription drug improvements, Medicare sustainability, health care quality improvements, and prohibition of benefit reductions in Medicare.</td>
<td>Not clear</td>
</tr>
<tr>
<td>Title I—Sections 4001–4402</td>
<td>PREVENTION OF CHRONIC DISEASE AND IMPROVING PUBLIC HEALTH. Prevention of chronic disease and improving public health (see Table 4 for the details of this Title).</td>
<td>See Table 4</td>
</tr>
<tr>
<td>Title V—Sections 5001–5605</td>
<td>HEALTH CARE WORKFORCE. A variety of provisions that affect the training and deployment of health professionals.</td>
<td>Variable</td>
</tr>
<tr>
<td>Title VI—Sections 6001–6801</td>
<td>TRANSPARENCY AND PROGRAM INTEGRITY. A variety of provisions, including physician ownership of health facilities, nursing homes, disclosure of information, complaint details, enforcement, staff training, patient-centered outcomes research, program integrity provisions, elder justice, and medical malpractice.</td>
<td>Variable</td>
</tr>
<tr>
<td>Title VII—Sections 7001–7103</td>
<td>IMPROVING ACCESS TO INNOVATIVE MEDICAL THERAPIES. Several provisions, including biologics price competition and innovation and more affordable medicines for children and underserved communities.</td>
<td>Not clear</td>
</tr>
<tr>
<td>Title VIII—Sections 8001–8002</td>
<td>CLASS ACT. Authorizes a new Title to the Public Health Service Act that establishes a national voluntary insurance program for purchasing community living assistance services and support.</td>
<td>October 1, 2012</td>
</tr>
<tr>
<td>Title IX—Sections 9001–9023</td>
<td>REVENUE PROVISIONS. Authorizes a number of revenue sources to support the funding of the changes included in the Law. These include 20 different changes to tax policy, penalty provisions, and new fees for specific entities.</td>
<td>Not clear</td>
</tr>
<tr>
<td>Title X—Sections 1002–1003</td>
<td>STRENGTHENING QUALITY, AFFORDABLE HEALTH CARE FOR ALL AMERICANS. Authorizes a large number of changes and implements amendments to Titles I, II, III, IV, V, VI, VII, and IX of the PPACA.</td>
<td>Variable</td>
</tr>
</tbody>
</table>

* CHIP indicates Children’s Health Insurance Program; PPACA, Patient Protection and Affordable Care Act.

wellness is used and a brief explanation of the main features of each occurrence.

The new health care reform law (PPACA) contains a large number of references to wellness. Table 5 lists each section in which the word appears, the page number of the law, the number of times the word wellness appears in that section (in parentheses), the title of the section, a brief description of the section, and the proposed timing of implementation if available. The sections are listed in their order of occurrence in the law.

Conclusion

This edition of The Art of Health Promotion provides an in-depth overview of the wellness and health promotion provisions of the new health care reform legislation. Its sheer size and complexity almost defy meaningful analysis. In the next edition of the Art of Health Promotion, we will examine how stakeholder interests will likely be affected and what are the ways of potentially maximizing the effectiveness of the wellness and health promotion provisions of the new law.
proving Public Health) of PL 111-148*

of the policies and programs. It also requires the
ty building.

they relate to changes in the health status of
s, and other resources in evaluating such employers'
establishes a "Community Preventive Services
actors contributed to such conclusions.

ng, adds personalized prevention plan service
rked (including absenteeism of employees,
ng, provides a formal recognition and inclusion of preventive services for adults and especially immunizations in the federal cost sharing with states under the Medicaid program. Supports prevention among adults on Medicaid. Also important for the

Subtitle D—Support for Prevention and Public Health Innovation: Research on

Subtitle E—Miscellaneous Provisions: Sense of the Senate Concerning CBP Scoring

Effectiveness of Federal Health and Wellness Initiatives

requires the use of this "annual wellness visit" by beneficiaries and therefore is not likely to reach the majority of Medicare beneficiaries. It does provide the infrastructure for a future requirement. Still a very significant development for the field.

helps make prevention a legitimate goal of Medicare and removes cost sharing, adds personalized prevention plan service and eliminates major barriers. Helps set the stage for a shift to prevention within Medicare.

Provides authority for the Secretary to add or remove preventive services from Medicaid. Its significance is that it gives more latitude for the Secretary to follow the advice of the Preventive Services Task Force in administering the Medicare program.

Subtitle C—Creating Healthier Communities

Improving Access to Preventive Services for Eligible Adults in Medicaid

Subtitle B—Increasing Access to Clinical Preventive Services: School-Based


Prevention and Public Health Fund

Clinical and Community Preventive Services

Education and Outreach Campaign Regarding Preventive Benefits

Subtitle E—Miscellaneous Provisions


Establishes a high-level federal group to focus on prevention, along with an advisory group. The Law also requires the development of a national prevention and health promotion strategy. Potentially very significant to the field.

4002 Prevention and Public Health Fund

Creates a new funding source for prevention and health promotion. $500 Million is authorized in 2010. Increases to $2 billion for 2015 and beyond. Very significant development for the field.

4003 Clinical and Community Preventive Services

Establishes, redirects, and coordinates a "Preventive Services Task Force" and provides a revised set of functions for the
group. Formalizes the U.S. Preventive Services Task Force activity. Also establishes a "Community Preventive Services Task Force" and requires coordination. Both will be administered by the CDC. "Housekeeping" but important for long-term prevention policy.

4004 Education and Outreach Campaign Regarding Preventive Benefits

Provides for the first nationwide implementation of a public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the lifespan. It also proposes special initiatives through all health care providers that work for federal programs, as well as the establishment of a national Web site. Helps give legitimacy and visibility to prevention and health promotion.

4101 Subtitle B—Increasing Access to Clinical Preventive Services: School-Based

Establishes a new matching grant program for school-based health centers. No funding amount is identified in the Law. Unclear significance.

4102 Oral Healthcare Prevention Activities

Establishes a 5-year national education campaign on oral health and authorizes the launch of a research-based dental caries disease management demonstration, along with revision of oral health infrastructure, surveillance activities, and addition of oral health to national health survey activity. Helps bring parity to dental and oral health issues.

4103 Medicare Coverage of Annual Wellness Visit Providing a Personalized Prevention Plan in Medicare

Authorizes the addition of a formal wellness assessment process as a covered service for Medicare. However, it does not require the use of this "annual wellness visit" by beneficiaries and therefore is not likely to reach the majority of Medicare beneficiaries. It does provide the infrastructure for a future requirement. Still a very significant development for the field.

4104 Removal of Barriers to Preventive Services in Medicare

Provides authority for the Secretary to add or remove preventive services from Medicare. Its significance is that it gives more latitude for the Secretary to follow the advice of the Preventive Services Task Force in administering the Medicare program.

4106 Improving Access to Preventive Services for Eligible Adults in Medicaid

Provides a formal recognition and inclusion of preventive services for adults and especially immunizations in the federal cost sharing with states under the Medicaid program. Supports prevention among adults on Medicaid. Also important for the

4107 Coverage of Comprehensive Tobacco Cessation Services for Pregnant Women in Medicaid

Provides an expansion of smoking cessation options for pregnant women under Medicaid and removes cost sharing provisions. Good for updating the intervention options under Medicaid.

4108 Incentives for Prevention of Chronic Diseases in Medicaid

Authorizes grants to states to provide incentives for reducing risks and prevention of chronic diseases. Provides $100 million for 2011. An important change for Medicaid.

4201 Subtitle C—Creating Healthier Communities: Community Transformation Grants

Authorizes a new grant program to help communities adopt evidence-based community prevention activities. Also requires the development of a "community transformation plan." However, no funding amounts are identified in the Law. Still a very significant development for the field.

4202 Healthy Aging, Living Well: Evaluation of Community-Based Prevention and Wellness Programs for Medicare Beneficiaries

Authorizes a new grant program to support up to 5-year pilot community wellness programs with a focus on those who are aged 55–64 y and a parallel effort for those who are Medicare beneficiaries. Provides for formal evaluation process. A significant development for the wellness field.

4203 Removing Barriers and Improving Access to Wellness for Individuals with Disabilities

Adds a new section to the Rehabilitation Act of 1973 that requires the establishment of standards for accessible medical diagnostic equipment. Largely housekeeping-type change.

4204 Immunizations

Provides for a focus on immunizations for adults and tightens up the federal role in vaccine development and use. Largely housekeeping-type change.

4205 Nutrition Labeling of Standard Menu Items at Chain Restaurants

Requires nutrition labeling on menus for all restaurant chains with >20 outlets and for vending machines. Another important pro-prevention intervention with national reach.

4206 Demonstration Project Concerning Individualized Wellness Plan

Authorizes the funding of demonstration projects for at-risk populations served by community health centers. Important, but no funding level is identified in the Law.

4207 Reasonable Break Time for Nursing Mothers

Amends the Fair Labor Standards Act of 1938 to require employers with >50 employees to provide adequate break time for nursing mothers to express their milk, a separate place for such activity (other than a bathroom). DuH!

4301 Subtitle D—Support for Prevention and Public Health Innovation: Research on Optimizing the Delivery of Public Health Services

Authorizes research on the effectiveness of public health services. However, no funding level is identified in the Law.

4302 Understanding Health Disparities: Data Collection and Analysis

Amends the Public Health Service Act to add provisions for the collection of information from other major federal sources that will help define and examine health disparities. Aligns data collection with the purpose of eliminating health disparities.

4303 CDC and Employer-Based Wellness Programs

Adds a new section to the Public Health Service Act on "Employer-Based Wellness Programs." The Director of CDC will…provide employers…with technical assistance, consultation, tools, and other resources in evaluating such employers’ employer-based wellness programs. Significant formalization of Congressional intent for CDC to move into worksite wellness. It also includes a requirement for a national study of worksite policies and programs. It also requires the Secretary to prioritize evaluation of CDC funding activity, and it prohibits the promulgation of any federal requirements for worksite wellness. Shows Congressional reluctance to require wellness programs in employer settings.

4304 Epidemiology—Laboratory Capacity Grants

Establishes a new grant program to build capacity for epidemiological surveillance within the public health system. Includes an authorization for $190 million for each year between 2010 and 2013. Capacity building.

4305 Advancing Research and Treatment for Pain Care, Management

Authorizes an Institute of Medicine conference on pain and authorizes a new research grant program on pain and a new planned expansion of training program on pain care. Capacity building.

4306 Funding for Childhood Obesity Demonstration Project


4401 Subtitle E—Miscellaneous Provisions: Sense of the Senate Concerning CBP Scoring

Recognizes the need for better scoring methodologies for wellness and prevention programs. Confirms what the field has known for decades, but glad they are acknowledging it.

4402 Effectiveness of Federal Health and Wellness Initiatives

Requires the Secretary of DHHS to conduct an evaluation of such programs as they relate to changes in the health status of the American public and specifically on the health status of the federal workforce (including absences of employees, productivity of employees, rate of workplace injury, and medical costs incurred by employees, and health conditions such as workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program) and to deliver to Congress a report concerning such evaluation, which shall include conclusions concerning the reasons that such existing programs have proven successful or not successful and what factors contributed to such conclusions. Congress wants to make sure worksite wellness and prevention really works.

* CBO indicates Congressional Budget Office; CDC, Centers for Disease Control and Prevention; and DHHS, Department of Health and Human Services.

Table 4
Summary of Major Sections of Title IV (Prevention of Chronic Disease and Improving Public Health) of PL 111-148*
## Table 5
Summary of Each Time the Word Wellness Appears in the New Health Care Reform Law*

<table>
<thead>
<tr>
<th>Section</th>
<th>Page Number (No. of Times)</th>
<th>Title</th>
<th>Brief Explanation</th>
<th>Timing of Implementation</th>
</tr>
</thead>
<tbody>
<tr>
<td>2717</td>
<td>17 (1)</td>
<td>ENSURING THE QUALITY OF CARE</td>
<td>Includes wellness and health promotion activities in reporting on quality of care</td>
<td>Within 2 y of enactment (March 23, 2012)</td>
</tr>
<tr>
<td>2717</td>
<td>18 (6)</td>
<td>ENSURING THE QUALITY OF CARE</td>
<td>Defines wellness in (b)</td>
<td>Within 2 years of enactment (March 23, 2012)</td>
</tr>
<tr>
<td>2705</td>
<td>38–41 (19)</td>
<td>PROHIBITING DISCRIMINATION AGAINST INDIVIDUAL PARTICIPANTS AND BENEFICIARIES BASED ON HEALTH STATUS</td>
<td>Defines employer wellness program and provides identical wording on the use of wellness incentives attached to health plans from the December 13, 2006, Final Rules for the HIPAA Non-Discrimination provisions. Also establishes a maximum incentive value of 30% of premium. Secretaries of Labor, Treasury, and Health and Human Services may increase the amount to 50% of premium if they deem it appropriate.</td>
<td>At time of enactment (March 23, 2010); also allows all programs in existence prior to this legislation that are consistent with applicable regulations to continue unchanged.</td>
</tr>
<tr>
<td>2705</td>
<td>41–42 (2)</td>
<td>WELLNESS PROGRAM DEMONSTRATION PROJECT</td>
<td>Establishes a 10-state demonstration project among health insurers using the rules concerning wellness incentives and health plans under part (j) of this Section. Can be expanded to more states by July 1, 2017.</td>
<td>Must be in place by July 1, 2014</td>
</tr>
<tr>
<td>2705</td>
<td>42 (3)</td>
<td>REPORT</td>
<td>The Secretary of Health and Human Services will in consultation with the Secretaries of Labor and Treasury issue a report on: (A) the effectiveness of wellness programs, as defined in subsection (j) in promoting health and preventing disease; (B) the impact of such wellness programs on the access to care and affordability of coverage for participants and nonparticipants of such programs; (C) the impact of premium-based and cost sharing incentives on participant behavior and the role of such programs in changing behavior; and (D) the effectiveness of different types of rewards.</td>
<td>Within 3 y of enactment (March 23, 2013)</td>
</tr>
<tr>
<td>1302</td>
<td>46 (1)</td>
<td>ESSENTIAL HEALTH BENEFITS REQUIREMENTS</td>
<td>Includes “preventive and wellness services and chronic disease management” services in the definition of essential health benefits requirements. This provision will require that all qualified health plans must include a prevention, wellness, and chronic disease management component.</td>
<td>Not clear</td>
</tr>
<tr>
<td>1311</td>
<td>62 (1)</td>
<td>AFFORDABLE CHOICES OF HEALTH BENEFIT PLANS</td>
<td>Authorizes the rewarding of quality care with market-based incentives that can include “the implementation of wellness and health promotion activities.”</td>
<td>January 1, 2015 (?)</td>
</tr>
<tr>
<td>1401</td>
<td>97 (1)</td>
<td>REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN</td>
<td>Provides for states that are participating in the 10-state demonstration program and allows them to exclude the cost of the incentive from the “adjusted monthly premium.”</td>
<td>Not clear</td>
</tr>
<tr>
<td>3202</td>
<td>337 (1)</td>
<td>BENEFIT PROTECTION AND SIMPLIFICATION. (Medicare Advantage Plans)</td>
<td>Authorizes the use of rebates to cover uncovered wellness and prevention services.</td>
<td>Plan years after 2012</td>
</tr>
<tr>
<td>3306</td>
<td>353 (1)</td>
<td>FUNDING OUTREACH AND ASSISTANCE FOR LOW-INCOME PROGRAMS (Medicare)</td>
<td>Authorizes the provision of financial support for the National Center for Benefits and Outreach Enrollment to “support the conduct of outreach activities aimed at preventing disease and promoting wellness.”</td>
<td>January 1, 2012</td>
</tr>
<tr>
<td>3403</td>
<td>373 (1)</td>
<td>IMAB</td>
<td>Authorizes the inclusion of wellness and prevention in cost saving proposal developed by the IMAB.</td>
<td>January 15, 2014 (Date of first-allowed proposal submission)</td>
</tr>
<tr>
<td>4001</td>
<td>421 (1)</td>
<td>NPHPPHC</td>
<td>Authorizes a national council composed of all major federal agencies that are related to the health of the U.S. population. This section also authorizes the formation of the “Advisory Group on Prevention, Health Promotion, and Integrative and Public Health” to provide technical advice to the NPHPPHC.</td>
<td>July 1, 2010</td>
</tr>
<tr>
<td>4001</td>
<td>422 (1)</td>
<td>NATIONAL PREVENTION AND HEALTH PROMOTION STRATEGY</td>
<td>The Council will “develop and make public a national prevention, health promotion and public health strategy, and shall review and revise such strategy periodically.”</td>
<td>1 y From enactment of the Law (March 23, 2011)</td>
</tr>
<tr>
<td>4002</td>
<td>423 (1)</td>
<td>PREVENTION AND PUBLIC HEALTH FUND</td>
<td>Authorizes the formation of a fund to carry out initiatives authorized by the Council ($500 million in 2010, moving up to $2 billion in 2015 and beyond).</td>
<td>December 31, 2010 (?)</td>
</tr>
<tr>
<td>4004</td>
<td>426 (1)</td>
<td>EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS</td>
<td>The Secretary of Health and Human Services “shall provide for the planning and implementation of a national public-private partnership for a prevention and health promotion outreach and education campaign to raise public awareness of health improvement across the lifespan.”</td>
<td>1 y From the date of enactment (March 23, 2011)</td>
</tr>
<tr>
<td>4103</td>
<td>435 (3)</td>
<td>MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN</td>
<td>Adds an “annual wellness visit” to Medicare-covered services, including the development of a personalized prevention plan using an HRA, biometrics, screening recommendations, care plan, provision of personalized health advice, and other elements.</td>
<td>January 1, 2011</td>
</tr>
<tr>
<td>4201</td>
<td>447 (3)</td>
<td>COMMUNITY TRANSFORMATION GRANTS</td>
<td>Authorizes a community grant program that addresses a wide range of wellness and prevention issues.</td>
<td>December 31, 2010</td>
</tr>
<tr>
<td>4202</td>
<td>449 (7)</td>
<td>HEALTHY AGING, LIVING WELL: EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES</td>
<td>Authorizes up to 5-year pilot programs for those who are aged 55-64 y.</td>
<td>December 31, 2010</td>
</tr>
<tr>
<td>4203</td>
<td>452 (1)</td>
<td>REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES</td>
<td>Establishes standards for the accessibility of medical diagnostic equipment.</td>
<td>2 y After enactment (March 23, 2012)</td>
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<tr>
<td>Section</td>
<td>Page Number</td>
<td>Title</td>
<td>Brief Explanation</td>
<td>Timing of Implementation</td>
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<td>4206</td>
<td>459 (7)</td>
<td>DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN</td>
<td>&quot;The Secretary shall establish a pilot program to test the impact of providing at-risk populations who utilize community health centers funded under this section an individualized wellness plan that is designed to reduce risk factors for preventable conditions as identified by a comprehensive risk-factor assessment.&quot;</td>
<td>Not clear</td>
</tr>
<tr>
<td>4303</td>
<td>464 (1)</td>
<td>CDC AND EMPLOYER-BASED WELLNESS PROGRAMS</td>
<td>&quot;Establishes a new section of the Public Health Service Act that addresses employer Wellness programs.&quot;</td>
<td>Not clear</td>
</tr>
<tr>
<td>399Mt</td>
<td>465 (4)</td>
<td>TECHNICAL ASSISTANCE FOR EMPLOYER-BASED WELLNESS PROGRAMS</td>
<td>&quot;The Director of CDC will: (1) provide employers (including small, medium, and large employers, as determined by the Director) with technical assistance, consultation, tools, and other resources in evaluating such employers’ employer-based wellness programs, including— (A) measuring the participation and methods to increase participation of employees in such programs; (B) developing standardized measures that assess policy, environmental and systems changes necessary to have a positive health impact on employees’ health behaviors, health outcomes, and health care expenditures; and (C) evaluating such programs as they relate to changes in the health status of employees, the absenteeism of employees, the productivity of employees, the rate of workplace injury, and the medical costs incurred by employees; and (2) build evaluation capacity among workplace staff by training employers on how to evaluate employer-based wellness programs by ensuring evaluation resources, technical assistance, and consultation are available to workplace staff as needed through such mechanisms as web portals, call centers, or other means.&quot;</td>
<td>Not clear</td>
</tr>
<tr>
<td>399Mt</td>
<td>465 (1)</td>
<td>NATIONAL WORKSITE HEALTH POLICIES AND PROGRAMS STUDY</td>
<td>&quot;The Secretary shall conduct a national worksite health policies and programs survey to assess employer-based health policies and programs.&quot;</td>
<td>2 y After enactment (March 23, 2012)</td>
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<tr>
<td>399Mt</td>
<td>465 (1)</td>
<td>PRIORITIZATION OF EVALUATION BY SECRETARY</td>
<td>&quot;The Secretary shall evaluate, in accordance with this part, all programs funded through the Centers for Disease Control and Prevention before conducting such an evaluation of privately funded programs unless an entity with a privately funded wellness program requests such an evaluation.&quot;</td>
<td>Not clear</td>
</tr>
<tr>
<td>399Mt</td>
<td>465 (1)</td>
<td>PROHIBITION OF FEDERAL WORKPLACE WELLNESS REQUIREMENTS</td>
<td>&quot;Notwithstanding any other provision of this part, any recommendations, data, or assessments carried out under this part shall not be used to mandate requirements for workplace wellness programs.&quot;</td>
<td>Not clear</td>
</tr>
<tr>
<td>4401</td>
<td>469 (1)</td>
<td>SENSE OF THE SENATE CONCERNING CBO SCORING</td>
<td>&quot;It is the sense of the Senate that Congress should work with the Congressional Budget Office to develop better methodologies for scoring progress to be made in prevention and wellness programs.&quot;</td>
<td>Not clear</td>
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<td>4402</td>
<td>470 (2)</td>
<td>EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES</td>
<td>The Secretary of Health and Human Services shall conduct an evaluation of such programs as they relate to changes in health status of the American public and specifically on the health status of the federal workforce (including absenteeism of employees, productivity of employees, rate of workplace injury, and medical costs incurred by employees) and health conditions (including workplace fitness, healthy food and beverages, and incentives in the Federal Employee Health Benefits Program).</td>
<td>Not clear</td>
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<td>5208</td>
<td>495 (2)</td>
<td>NURSE-MANAGED HEALTH CLINICS (grants)</td>
<td>&quot;The term nurse-managed health clinic means a nurse-practice arrangement, managed by advanced practice nurses that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health care or social services agency.&quot;</td>
<td>December 31, 2010</td>
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<td>2716</td>
<td>767 (2)</td>
<td>PROHIBITION ON DISCRIMINATION IN FAVOR OF HIGHLY COMPENSATED INDIVIDUALS</td>
<td>&quot;Stipulates that wellness programs should not require the disclosure or collection of information about lawful firearms nor should such information lead to any penalty or disqualification for a wellness incentive reward.&quot;</td>
<td>December 31, 2010 (7)</td>
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<td>10408</td>
<td>859 (7)</td>
<td>GRANTS FOR SMALL BUSINESSES TO PROVIDE COMPREHENSIVE WORKPLACE WELLNESS PROGRAMS</td>
<td>&quot;Authorizes a grant program for employers with &lt; 100 employees to implement a new comprehensive wellness program for their employees. $200 Million is appropriated for fiscal years 2011–2015.&quot;</td>
<td>October 1, 2010</td>
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<tr>
<td>399Nt</td>
<td>873 (2)</td>
<td>YOUNG WOMEN’S BREAST HEALTH AWARENESS AND SUPPORT OF YOUNG WOMEN DIAGNOSED WITH BREAST CANCER</td>
<td>&quot;Authorizes a national education campaign for health care professionals that includes a number of wellness and prevention issues.&quot;</td>
<td>2 mo After enactment (May 23, 2010)</td>
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* CDC indicates Centers for Disease Control and Prevention; DHHS, Department of Health and Human Services; Health Insurance and Portability and Accountability Act of 1996; HRA, Health Risk Assessment; IMAB, Independent Medicare Advisory Board; and PPHPPHC, National Prevention, Health Promotion and Public Health Council.
† Indicates the number of times the word wellness appears in this Section.
‡ This type of labeling indicates a placeholder function for when the section is included in another statute.
Selected Abstracts

Analyzing National Health Reform Strategies With a Dynamic Simulation Model.

Milstein B, Homer J, Hirsch G.

Proposals to improve the US health system are commonly supported by models that have only a few variables and overlook certain processes that may delay, dilute, or defeat intervention effects. We use an evidence-based dynamic simulation model with a broad national scope to analyze 5 policy proposals. Our results suggest that expanding insurance coverage and improving health care quality would likely improve health status but would also raise costs and worsen health inequality, whereas a strategy that also strengthens primary care capacity and emphasizes health protection would improve health status, reduce inequities, and lower costs. A software interface allows diverse stakeholders to interact with the model through a policy simulation game called HealthBound.


The Certitudes and Uncertainties of Health Care Reform.

Doherty RB.

The Patient Protection and Affordable Care Act (PPACA) of 2010 was signed into law by President Obama on March 23. This legislation has elicited much debate among policy experts and the public alike. No one knows exactly how this new complex law will play out, and objective evaluation of its effects is important. The American College of Physicians hopes that the legislation will advance key priorities on coverage, workforce, and payment and delivery system reform. The goal of the PPACA is to help provide affordable health insurance coverage to most Americans, improve access to primary care, and lower costs. This article discusses what the chances are that it will accomplish these objectives. It also explains many of the key provisions in the legislation and how they will affect both physicians and patients. Despite considerable uncertainty about the effects of this act, when compared with the status quo, it is an extraordinary achievement that will continue to evolve through its implementation.


Health Care Reform in Massachusetts: Implementation of Coverage Expansions and a Health Insurance Mandate.

Doonan MT, Tull KR.

CONTEXT: Much can be learned from Massachusetts’s experience implementing health insurance coverage expansions and an individual health insurance mandate. While achieving political consensus on reform is difficult, implementation can be equally or even more challenging. METHODS: The data in this article are based on a case study of Massachusetts, including interviews with key stakeholders, state government, and Commonwealth Health Insurance Connector Authority officials during the first three years of the program and a detailed analysis of primary and secondary documents. FINDINGS: Coverage expansion and an individual mandate led Massachusetts to define affordability standards, establish a minimum level of insurance coverage, adopt insurance market reforms, and institute incentives and penalties to encourage coverage. Implementation entailed trade-offs between the comprehensiveness of benefits and premium costs, the subsidy levels and affordability, and among the level of mandate penalties, public support, and coverage gains. CONCLUSIONS: National lessons from the Massachusetts experience come not only from the specific decisions made but also from the process of decision making, the need to keep stakeholders engaged, the relationship of decisions to existing programs and regulations, and the interactions among program components.

Milbank Q. 2010;88:54-80.

How Health Reform Legislation Will Affect Medicare Beneficiaries.

Guterman S, Davis K, Streuikis K.

Despite criticism that health reform legislation will result in cuts to Medicare, the bills passed by the House of Representatives and the Senate, as well as President Obama’s proposal, contain provisions that would strengthen the program by reducing costs for prescription drugs, expanding coverage for preventive care, providing more help for low-income beneficiaries, and supporting accessible, coordinated, and comprehensive care that effectively responds to patients’ needs. The legislation also would help to extend the program’s fiscal solvency—for nine years, under the Senate bill. This issue brief examines the provisions in the pending legislation and how each one would work to improve benefits, extend the fiscal solvency of the Medicare Hospital Insurance Trust Fund, reduce pressure on the federal budget, and contribute to moving the health care system toward better access to care, improved quality, and greater efficiency.


Health Care Reform and Federalism.

Greer SL, Jacobson PD.

Health policy debates are replete with discussions of federalism, most often when advocates of reform put their hopes in states. But health policy literature is remarkably silent on the question of allocation of authority, rarely asking which levels of government ought to lead. We draw on the larger literatures about federalism, found mostly in political science and law, to develop a set of criteria for allocating health policy authority between states and the federal government. They are social justice, procedural democracy, compatibility with value pluralism, institutional capability, and economic sustainability. Of them, only procedural democracy and compatibility with value pluralism point to state leadership. In examining these criteria, we conclude that American policy debates often get federalism backward, putting the burden of health care coverage policy on states that cannot enact or sustain it, while increasing the federal role in issues where the arguments for state leadership are compelling. We suggest that the federal government should lead present and future financing of health care coverage, since it would require major changes in American intergovernmental relations to make innovative state health care financing sustainable outside a strong federal framework.


Employers, Workers, and the Future of Employment-Based Health Benefits.

Blakely S.

EBRI’S BIANNUAL POLICY FORUM: This Issue Brief summarizes presentations at EBRI’s 65th biannual policy forum, held in
Final Report of the National Health and Hospitals Reform Commission: Will We Get the Health Care Governance Reform We Need?

Stoeblinger J U.

The National Health and Hospitals Reform Commission (NHHRC) has recommended that Australia develop a "single health system," governed by the federal government. While achieving this includes a "Healthy Australia Accord" to agree on the reform framework; the progressive takeover of funding of public hospitals by the federal government; and the possible implementation of a consumer-choice health funding model, called "Medicare Select." These proposals face significant implementation issues, and the final solution needs to deal with both financial and political sustainability. If the federal and state governments cannot agree on a reform plan, the Prime Minister may need to go to the electorate for a mandate, which may be shaped by other economic issues such as tax reform and intergenerational challenges.


The Organization for Economic Cooperation and Development and Health Care Reform in the United States.

McCauley DR.

Among OECD nations, the United States is an outlier in having the highest per capita health care costs in a system that unnecessarily exposes many individuals to financial hardship, physical suffering, and even death. President Obama and Congress are currently involved in a process to reform the flawed health care system. The OECD has contributed to that process by releasing a paper, "Health Care Reform in the United States," which describes some of the problems that must be addressed, but then provides proposals that support the private insurance industry, the source of much of the waste and inequities in health care, the authors of the OECD paper have failed in their responsibility to inform on policies rather than politics.


Frohstcin P, Helman R.

PUBLIC SUPPORT FOR HEALTH REFORM: Findings from the 2009 Health Confidence Survey—the 12th annual HCS—indicate that Americans have already formed strong opinions regarding various aspects of health reform, even before details have been released regarding various key factors. These include health insurance market reform, the availability of a public plan option, mandates on employers and individuals, subsidized coverage for the low-income population, changes to the tax treatment of job-based health benefits, and regulatory oversight of health care. These opinions may change as details surface, especially as they concern financing options. In the absence of such details, the 2009 HCS finds generally strong support for the concepts of health reform options that are currently on the table. U.S. HEALTH SYSTEM GETS POOR MARKS, BUT SO DOES A MAJOR OVERHAUL: A majority rate the nation’s health care system as fair (30 percent) or poor (29 percent). Only a small minority rate it excellent (6 percent) or very good (10 percent). While 14 percent of Americans think the health care system needs a major overhaul, 51 percent agree with the statement “there are some good things about our health care system, but major changes are needed.” NATIONAL HEALTH PLAN ELEMENTS RATED HIGHLY: Between 68 percent and 88 percent of Americans either strongly or somewhat support health reform ideas such as national health plans, a public plan option, guaranteed issue, expansion of Medicare and Medicaid, and employer and individual mandates. MIXED REACTION TO HEALTH BENEFITS TAX CAP: Reaction to capping the current tax exclusion of employment-based health benefits is mixed. Nearly one-half of Americans (47 percent) would switch to a lower-cost plan if the tax exclusion were capped, 38 percent would stay on their current plan and pay the additional taxes, and 9 percent don’t know. CONTINUED FAITH IN EMPLOYMENT-BASED BENEFITS.
FITs, BUT DOUBTS ONAFFORDABILITY: Individuals with employment-based health benefits are confident that employers will continue to offer such benefits. They are much less confident that they would be able to afford coverage on their own, even if employers gave them the money they currently spend on health benefits. However, very few employers stop offering coverage. A surprising number of respondents report that they are likely to purchase it on their own. RISING HEALTH COSTS HURTING FAMILY FINANCES: Those experiencing health cost increases tend to say these increases have negatively affected their household finances. In particular, they indicate that increased health care costs have resulted in a decrease in contributions to a retirement plan (32 percent) and other savings (53 percent) and in difficulty paying for basic necessities (29 percent) and other bills (37 percent). COSTS ALSO AFFECTING HEALTH CARE USE. Many consumers report that they are changing the way they use the health care system in response to rising health care costs. Roughly 80 percent of those with higher out-of-pocket expenses say these increased costs have led them to try to take better care of themselves and choose generic drugs more often. One-quarter also say they did not fill or skipped doses of their prescribed medications in response to increased costs.


Addressing Health Care Market Reform Through an Insurance Exchange: Essential Policy Components, the Public Plan Option, and Other Issues to Consider.

Fronstin P, Ross MN.

HEALTH INSURANCE EXCHANGE: This Issue Brief examines issues related to managed competition and the use of a health insurance exchange for the purpose of addressing cost, quality, and access to health care services. It discusses issues that must be addressed when designing an exchange in order to reform the health insurance market and also examines state efforts at health reform that use an exchange. RISK VS. PRICE COMPETITION: The basic component of managed competition is the creation of an organized marketplace that brings together health insurers and consumers (either as individuals or through their employers). The sponsor of the exchange would set "rules of engagement" for participating insurers and offer consumers a menu of choices among different plans. Ultimately, the goal of a health insurance exchange is to shift the market from competition based on risk to competition based on price and quality. ADVERSE SELECTION AND AFFORDABILITY: Among the issues that need to be addressed if an exchange that uses managed competition has a realistic chance of reducing costs, improving quality, and expanding coverage: Everyone needs to be in the risk pool, with individuals required to purchase insurance or face significant financial consequences; effective risk adjustment is essential to eliminate risk selection as an insurance business model—forcing competition on costs and quality; the insurance benefit must be specific and clear—without standards governing cost sharing, covered services, and network coverage there is no way to assess whether a requirement to purchase or issue coverage has been met; and subsidies would be necessary for low-income individuals to purchase insurance. THE PUBLIC PLAN OPTION: The public plan option is shaping up to be one of the most contentious issues in the health reform debate. Proponents also believe a public plan is necessary to drive private insurers toward true competition. Opponents view it as a step toward government-run health care and are wary of cost shifting from the public plan to private insurers. FUTURE OF EMPLOYMENT-BASED COVERAGE: The availability of a health insurance exchange may have implications for the future of the employment-based health benefits system and raises major questions for workers. Will employers provide a fixed contribution for the purchase of insurance through an exchange? Would that be large enough to purchase coverage? Would it be flat or vary by such factors as worker health status, age, and/or marital status or the presence of children? Would it be taxed? For both employers and workers, the implications are enormous.


Plotted WG III.

This article discusses the need for health care reform. The American Medical Association has devised a plan that would allow all Americans to obtain health care coverage. This article discusses that plan and advocates for physicians and patients to demand meaningful health care reform from lawmakers.


US Health Care: Single-Payer or Market Reform.

Himmelstein DU, Woolhandler S.

The authors advocate a fundamental change in health care financing—national health insurance (NHI). NHI would reorient the way we pay for care, bringing the hundreds of billions now squandered on malignant bureaucracy back to the bedside. NHI could restore the physician-patient relationship, offer patients a free choice of physicians and hospitals, and free physicians from the hassles of insurance paperwork.


Reducing Racial, Ethnic, and Socioeconomic Disparities in Health Care: Opportunities in National Health Reform.

Lillie-Blanton M, Maleque S, Miller W.

Policy often focuses on reducing health care disparities through interventions at the patient and provider level. While unquestionably important, system-wide reforms to reduce insurance, improve geographic availability of services, increase workforce diversity, and promote clinical best practices are essential for progress in reducing disparities.


Health Care Reform and Social Movements in the United States.

Hoffman B.

Because of the importance of grassroots social movements, or “change from below,” in the history of US reform, the relationship between social movements and demands for universal health care is a critical one. National health reform campaigns in the 20th century were initiated and run by elites more concerned with defending against attacks from interest groups than with popular mobilization, and grassroots reformers in the labor, civil rights, feminist, and AIDS activist movements have concentrated more on immediate and incremental changes than on transforming the health care system itself. However, grassroots health care demands have also contained the seeds of a wider critique of the American health care system, leading some movements to adopt calls for universal coverage.

Closing Thoughts

Larry S. Chapman, MPH

This is truly a historic time. Through one of the most partisan political battles of our time, we now have a new health care reform law. This law is so complex and multifaceted that few serious commentators have the stomach to begin dissecting its detailed provisions. I believe that the law’s complexity has also led to a period of silence after its passage. It almost represents a Gordian knot that defies discussion. Where does one start to get a handle on its contents? It also probably represents the equivalent of several health policy wonks’ entire lifework. The span of disparate issues that are addressed in the law is also historic, including everything from adequate break time at work for nursing mothers to express their breast milk to a new national insurance program to support community assistance services (CLASS Act).

Even a casual student of the new law would have a hard time refuting the appearance of a piece of legislation that is composed of every recent unsuccessful health care legislative proposal.

However, this truly omnibus piece of health care legislation will need to be unpacked slowly over the next year. As an ex-federal regulator, I can only marvel at the challenge of implementing such an incongruous collection of legislative initiatives. This “everything but the kitchen sink” legislative approach strains both the executive branch’s ability to implement or manage it and the legislative branch’s ability to monitor or apply accountability. If our remaining private health insurance industry can function under all the new rules, it will surprise me.

It is almost as if the legislators guiding the bill’s development decided to throw every conceivable policy change affecting health insurance into the legislative package in the hope that at least some of it would work. If its sheer complexity and unmanageable nature blunt its ultimate effectiveness, then I can also foresee these same legislator’s coming back in a few years having given the pluralistic approach their best effort and now advocating the expansion of the federal government’s role and the adoption of a single-payer solution. Makes you wonder if this might be a setup….

Larry S. Chapman, MPH, is president and CEO of the Chapman Institute and editor of The Art of Health Promotion.
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