Setting the Stage

In the last edition of *The Art of Health Promotion*, we provided an overview of the main features of the new health care reform legislation as amended, with a special emphasis on Title IV, which contains the majority of the prevention and health promotion provisions. This piece of legislation represents one of the most significant health initiatives in modern U.S. history. Its implementation will require, conservatively, 3 to 5 years, and will likely continue to be extremely controversial and unabashedly partisan in nature.

Within the 457 separate sections contained in P.L. 111–148, the Patient Protection and Affordable Care Act, prevention, wellness, and health promotion figure prominently. As mentioned in Part I, the sheer size and complexity of this 907-page law has resulted in an unnerving quiet for 4+ months after its formal passage and signature into law by President Obama on March 23, 2010.

In this edition of *The Art of Health Promotion* we will be examining the key provisions of the law, the tentative timetable for implementation, and the major stakeholder groups and how they are likely to be affected, along with some recommendations on how the major prevention, health promotion, and wellness provisions might be implemented for maximum effectiveness. Then we will look more broadly at how the legislation will likely affect the field of health promotion and wellness and the potential for it to help solve the systemic problem of high increases in health cost. The topics to be covered in this edition will include:

- What are the timing-related issues with the new law?
- Who are the major stakeholders affected by the law?
- How are they likely to be affected?
- Recommendations for selected wellness and health promotion provisions
- How will the field of health promotion and wellness be affected by this new law?
- How well is the law likely to work?
- What is missing?
- How should the field respond to this new law?

What Are the Timing-Related Issues With the New Law?

There are several sets of timing issues resident in the law. Presumably all will be affected by the need to promulgate regulations, also called “rule-making,” within the Code of Federal Regulations (CFR). This is usually a fairly time-consuming process and is dependent on federal staffing, interaction with lobbyists and interest groups, the public comment process, and the other process requirements for the various types of regulations (i.e., notice of proposed rule-making, initial or preliminary regulations, emergency regulations, final rules, etc.). Wikipedia is helpful in providing a general understanding of the administrative law portion of the implementation of laws passed by
Congress and signed by the President. Figure 1 provides a general description of the CFR process.

In P.L. 111–148, the Patient Protection and Affordable Care Act, leaves a great deal of the specifics of implementation up to the primary federal agencies involved, generally within the Department of Health & Human Services (DHHS) and specifically within the Centers for Medicare and Medicaid Services and the Centers for Disease Control and Prevention (CDC). This is significant when assessing the potential effects of implementing regulations or rules. Figure 2 contains another excerpt from Wikipedia that helps provide a framework for considering the significance of the rule-making process.

Thus, the issuance of implementing federal regulations for the various provisions of the new law will be of foremost significance for all major stakeholders.

There are several major waves of implementation dates contained in the new law. The most significant for employers are those that involve health plan market reforms. These include:

- Health plan changes (Sections 2711–2719) for plan anniversary dates 6 months from enactment (September 23, 2010)
- Health plan changes (Sections 1201–1563) for plan anniversary dates after January 1, 2014

Both of these sets of dates are also of primary relevance for the health insurance community because of their need to implement these provisions before employers are faced with the need to adjust to these changes. It seems obvious that federal regulatory staff will be addressing the first set of changes immediately, given their initial implementation date of September 23, 2010. These changes are likely to become the first wave of significant public visibility for the implementation of the new law.

When it comes to the various provisions of Title IV, Prevention of Chronic Disease and Improving Public Health, the timing associated with each of the 27 sections is identified in Table 1. These sections will likely be referred to in governmental implementation activities as the “4000” series. These sections are on pages 420 to 470 of the law.

Who Are the Major Stakeholders Affected by the Law?

The Patient Protection and Affordable Care Act (of 2010) contains some 457 distinct changes to the way our health care system works and the various roles allowed for major stakeholders. These changes will become effective from the date of its initial enactment (March 23, 2010) to January 1, 2014. The major stakeholders in our health care system and general economy are identified in Table 2.

Even a quick look at Table 2 should give the reader pause in considering the complexity of health care and the difficulty of understanding the likely direct and indirect effects of the 457 legislative changes contained in this new law. Furthermore, when we consider that our health care system currently consumes approximately 16% of our national gross domestic product, which is estimated to be approximately $2.4 trillion in 2009, it should cause further concern.

How Are They Likely to Be Affected?

The general effects of this piece of legislation will presumably take 3 to 5 years to sort out, but there is at least some preliminary sense of the likely way the various groups will be affected by the progressive implementation of the changes in the law. If we consider the law as a whole and attempt to examine the likely initial effects and the likely response of the various major stakeholders, it may help us understand what the future holds. To help estimate the relative degree of satisfaction or dissatisfaction each major stakeholder group is likely to experience we will use a scale that goes from –5 to +5. At –5 the dissatisfaction is likely to be very great, whereas at the +5 level the satisfaction is likely to be very high. Ranges are provided to give an idea of the estimated impact. Table 3 contains an initial
assessment of the likely effects of the law on the various major stakeholders and their likely initial response to the law. These preliminary projections of the effect and likely response to the Patient Protection and Affordable Care Act by major stakeholder groups can be significantly affected by the directions taken in the rule-making process. Another major variable will be any political action taken to potentially mitigate some of the potential adverse effects of the legislation on selected stakeholder groups.

Recommendations for Selected Wellness and Health Promotion Provisions

When examining the various prevention, health promotion, and wellness provisions of the new health care reform law, some of the changes stand out as opportunities for significant improvement in health risk mitigation, improvements in health status, enhancements in consumer health behavior, and ultimately beneficial economic effects on payers. In Table 4, selected sections and some brief recommendations for implementation are offered. These are just a few of the possible recommendations that might enhance the effectiveness of these selected sections.

How Will the Field of Health Promotion and Wellness Be Affected by This New Law?

In attempting to think through the likely effects of this new law on the field of health promotion and wellness there are a number of possible insights to offer. The new law:

1. **Formalizes Recognition of the Value of Prevention and Wellness.** With more than 30 sections of the new law addressing the issues of prevention, health promotion, and wellness, it’s clear that it is a major statement of the presumed value of these types of health interventions and the importance of their role in helping solve many of our most pressing national health challenges. This is likely to give the field much more visibility and respect.

2. **Codifies Some of the Interventions and Targets of Health Promotion and Wellness.** The legislation defines “annual wellness visit,” “employer wellness program,” “essential health coverage,” “qualified health plan,” and “prevention,” and therefore helps establish basic definitions and components of programs. This is likely to help bring greater consistency to current health promotion and wellness activity across the field. Figure 3 contains the definition of “wellness and prevention program,” for example.

3. **Provides Credibility to Prevention and Wellness.** By formally including prevention and wellness to the extent that it does, the legislation provides a significant degree of credibility to the field and to the quality of the emerging science undergirding the field. Prevention has always historically been overshadowed by treatment concerns and, the improved credibility is likely to lead to improved integration of prevention issues and increases in resourcing for prevention pursuits.

4. **Requires Extensive Evaluation of Effectiveness and Efficiency.** At the same time Congress moved to include a large number of prevention and wellness interventions, it also included several major statements and requirements for

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**Figure 2**

Importance of Administrative Law

“Regulations are treated by the courts as being as legally binding as statutory law, provided the regulations are a reasonable interpretation of the underlying statutes. ……For example, if Congress passed a law that simply stated that there are not to be "excessive" levels of mercury in any significant body of water in the United States (but defined things no further), an entity designated, as part of the law, to enforce it (probably the United States Environmental Protection Agency (EPA)) could define in a scientific way what an excessive level of mercury is, as well as what constitutes a significant body of water. The Agency’s definitions and its plan of enforcement for what Congress intended (along with listed penalties for violation coming from Congress unless Congress specified otherwise) will all go into the CFR.

It is important to understand that the CFR itself is written by lawyers for interpretation by lawyers and judges, and like statutes, must be carefully drafted in highly technical language to have effective broad application, yet limit the availability of loopholes. Unfortunately, the vast majority of employees of the federal government are not lawyers, and it would ask too much to force them to directly read, interpret, and apply the convoluted content of the CFR on a daily basis. Therefore, nearly all federal agencies have in-house counsel draft one or more internal manuals in plain English which set out daily internal operating procedures in very simple language that any layperson can follow. While such manuals do not really have the force of law, they are often the law as far as most employees and customers of such agencies are concerned, unless and until a dissatisfied customer of an agency appeals to a supervisor who does understand the CFR and the U.S.C. (or eventually sues the agency in court)….Oddly, despite the informality of such manuals, the U.S. Supreme Court has occasionally cited them as authority when confronted with situations not precisely addressed by the U.S.C. or the CFR.”
The language of the law is very specific with regard to timing for this section. Congress expects the federal
Council to submit a report by July 1, 2010, and each January 1 thereafter until 2015. By March 23, 2011, a
National Prevention and Health Promotion Strategy is to be developed and released publically. The Secretary
of the Department of Health and Human Services (DHHS) may end up requesting an extension of this
requirement simply given the logistics of what is required in the law.

For federal fiscal year 2010 (October 1, 2009 to September 30, 2010) $500 million was appropriated for the
Fund. The Fund’s purpose is “to provide for expanded and sustained national investment in prevention and
public health programs to improve health and help restrain the rate of growth in private and public sector
health care costs.” Given the very short time frame to allocate half a billion dollars, these funds may be

carried over or handled in an abbreviated manner.

This section formally normalizes the role of the U.S. Preventive Health Services Task Force (now called the U.S.
Preventive Services Task Force) and requires coordination with the Community Preventive Services Task
Force. No clear timing is indicated.

“Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the
Centers for Disease Control and Prevention, shall establish and implement a national science-based media
campaign on health promotion and disease prevention.” The first report from the Secretary of DHHS is
required by January 1, 2011. This activity is intended not to duplicate any current federally sponsored national
media effort.

Appropriates $50 million for fiscal years 2010 through 2014 for physical facility development and construction,
but no service provision or personnel.

Requires within 2 years of enactment (March 23, 2010), or March 23, 2012, that a 5-year national media
campaign on oral healthcare prevention and education be initiated. Also establishes a new grant program in
oral health through the Centers for Disease Control and Prevention (CDC) and adds oral health to major
federal survey efforts such as the National Health and Nutrition Examination Survey.

The Secretary of DHHS is required by March 23, 2011, to “establish publicly available guidelines for health risk
assessments,” and “Not later than 1 year after the date of enactment of this subsection, the Secretary shall
establish standards for interactive telephonic or web-based programs used to furnish health risk assessments
under subparagraph (A)(ii)(I).” This section adds to Medicare covered service definitions a new service called
“Annual Wellness Visit” and defines its basic components. However, on a closer reading, it appears that this
is limited to Medicare beneficiaries during their first 12 months of coverage under Part B. In other words, it
seems to be available only to future Medicare beneficiaries. This section also adds a new concept and service
called a “Personalized Prevention Plan.” This parallels the personal reports that have been traditionally used
in corporate wellness programs but are a little broader in scope.

This provision eliminates policy barriers and user cost sharing for all preventive services consistent with the new
law’s requirements. It is effective as of January 1, 2011.

This provision also gives the Secretary the authority to modify or eliminate preventive services coverage under
Medicare consistent with the U.S. Preventive Services Task Force recommendations. Timing is at the
discretion of the Secretary, but can apply back to January 1, 2010, if deemed appropriate.

This provision matches the Medicare provision (Section 4105) for the Medicaid population. This will normalize
preventive services for the current and future Medicaid population. It is effective as of January 1, 2013.

This provision fixes a regulatory gap that prevented the coverage of nicotine replacement pharmacological
products for pregnant Medicaid beneficiaries. It also eliminates any cost-sharing requirements, in keeping
with the general policy inherent in the law to removal all user cost sharing on all preventive services for all
populations. This Medicaid provision is effective as of October 1, 2010 (the beginning of the new federal fiscal
year).

This section authorizes a grant program for state Medicaid agencies to conduct incentive initiatives for a
minimum of 3 years. The effective date is January 1, 2011, or earlier if the Secretary develops program
criteria. Focus is on tobacco use, weight, cholesterol, blood pressure, prevention of diabetes, and the
comorbidity of depression. $100 million is appropriated for the 5-year expected life span of the grant program.
This section also introduces the concept of Medicaid “beneficiary,” a significant change in federal legal
language.

This section launches a new national grant program available to a broad range of entities for “the
implementation, evaluation, and dissemination of evidence-based community preventive health activities in
order to reduce chronic disease rates, prevent the development of secondary conditions, address health
disparities, and develop a stronger evidence base of effective prevention programming. Proposed purview of
these grants is very broad. However, no specific amount of funds is identified and no timing considerations
are included in the law, which in a practical sense may lead to it being shelved until other priorities with
specific timing requirements are addressed.

Table 1
Approximate Timing of Prevention and Health Promotion Provisions in Title IV

<table>
<thead>
<tr>
<th>Section</th>
<th>Brief Description</th>
<th>Proposed Timing</th>
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<tbody>
<tr>
<td>4001</td>
<td>Subtitle A Modernizing Disease Prevention and Public Health Systems: NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.</td>
<td>The language of the law is very specific with regard to timing for this section. Congress expects the federal Council to submit a report by July 1, 2010, and each January 1 thereafter until 2015. By March 23, 2011, a National Prevention and Health Promotion Strategy is to be developed and released publically. The Secretary of the Department of Health and Human Services (DHHS) may end up requesting an extension of this requirement simply given the logistics of what is required in the law.</td>
</tr>
<tr>
<td>4002</td>
<td>PREVENTION AND PUBLIC HEALTH FUND.</td>
<td>For federal fiscal year 2010 (October 1, 2009 to September 30, 2010) $500 million was appropriated for the Fund. The Fund’s purpose is “to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public sector health care costs.” Given the very short time frame to allocate half a billion dollars, these funds may be carried over or handled in an abbreviated manner.</td>
</tr>
<tr>
<td>4003</td>
<td>CLINICAL AND COMMUNITY PREVENTIVE SERVICES.</td>
<td>This section formally normalizes the role of the U.S. Preventive Health Services Task Force (now called the U.S. Preventive Services Task Force) and requires coordination with the Community Preventive Services Task Force. No clear timing is indicated.</td>
</tr>
<tr>
<td>4004</td>
<td>EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.</td>
<td>“Not later than 1 year after the date of enactment of this Act, the Secretary, acting through the Director of the Centers for Disease Control and Prevention, shall establish and implement a national science-based media campaign on health promotion and disease prevention.” The first report from the Secretary of DHHS is required by January 1, 2011. This activity is intended not to duplicate any current federally sponsored national media effort.</td>
</tr>
<tr>
<td>4101</td>
<td>Subtitle B—Increasing Access to Clinical Preventive Services: SCHOOL-BASED HEALTH CENTERS.</td>
<td>Appropriates $50 million for fiscal years 2010 through 2014 for physical facility development and construction, but no service provision or personnel.</td>
</tr>
<tr>
<td>4102</td>
<td>ORAL HEALTHCARE PREVENTION ACTIVITIES.</td>
<td>Requires within 2 years of enactment (March 23, 2010), or March 23, 2012, that a 5-year national media campaign on oral healthcare prevention and education be initiated. Also establishes a new grant program in oral health through the Centers for Disease Control and Prevention (CDC) and adds oral health to major federal survey efforts such as the National Health and Nutrition Examination Survey.</td>
</tr>
<tr>
<td>4103</td>
<td>MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.</td>
<td>The Secretary of DHHS is required by March 23, 2011, to “establish publicly available guidelines for health risk assessments,” and “Not later than 1 year after the date of enactment of this subsection, the Secretary shall establish standards for interactive telephonic or web-based programs used to furnish health risk assessments under subparagraph (A)(ii)(I).” This section adds to Medicare covered service definitions a new service called “Annual Wellness Visit” and defines its basic components. However, on a closer reading, it appears that this is limited to Medicare beneficiaries during their first 12 months of coverage under Part B. In other words, it seems to be available only to future Medicare beneficiaries. This section also adds a new concept and service called a “Personalized Prevention Plan.” This parallels the personal reports that have been traditionally used in corporate wellness programs but are a little broader in scope.</td>
</tr>
<tr>
<td>4104</td>
<td>REMOVAL OF BARRIERS TO PREVENTIVE SERVICES IN MEDICARE.</td>
<td>This provision eliminates policy barriers and user cost sharing for all preventive services consistent with the new law’s requirements. It is effective as of January 1, 2011.</td>
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<tr>
<td>4105</td>
<td>EVIDENCE-BASED COVERAGE OF PREVENTIVE SERVICES IN MEDICARE.</td>
<td>This provision also gives the Secretary the authority to modify or eliminate preventive services coverage under Medicare consistent with the U.S. Preventive Services Task Force recommendations. Timing is at the discretion of the Secretary, but can apply back to January 1, 2010, if deemed appropriate.</td>
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<tr>
<td>4106</td>
<td>IMPROVING ACCESS TO PREVENTIVE SERVICES FOR ELIGIBLE ADULTS IN MEDICAID.</td>
<td>This provision matches the Medicare provision (Section 4105) for the Medicaid population. This will normalize preventive services for the current and future Medicaid population. It is effective as of January 1, 2013.</td>
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<tr>
<td>4107</td>
<td>COVERAGE OF COMPREHENSIVE TOBACCO CESSATION SERVICES FOR PREGNANT WOMEN IN MEDICAID.</td>
<td>This provision fixes a regulatory gap that prevented the coverage of nicotine replacement pharmacological products for pregnant Medicaid beneficiaries. It also eliminates any cost-sharing requirements, in keeping with the general policy inherent in the law to removal all user cost sharing on all preventive services for all populations. This Medicaid provision is effective as of October 1, 2010 (the beginning of the new federal fiscal year).</td>
</tr>
<tr>
<td>4108</td>
<td>INCENTIVES FOR PREVENTION OF CHRONIC DISEASES IN MEDICAID.</td>
<td>This section authorizes a grant program for state Medicaid agencies to conduct incentive initiatives for a minimum of 3 years. The effective date is January 1, 2011, or earlier if the Secretary develops program criteria. Focus is on tobacco use, weight, cholesterol, blood pressure, prevention of diabetes, and the comorbidity of depression. $100 million is appropriated for the 5-year expected life span of the grant program. This section also introduces the concept of Medicaid “beneficiary,” a significant change in federal legal language.</td>
</tr>
<tr>
<td>4201</td>
<td>Subtitle C—Creating Healthier Communities: COMMUNITY TRANSFORMATION GRANTS.</td>
<td>This section launches a new national grant program available to a broad range of entities for “the implementation, evaluation, and dissemination of evidence-based community preventive health activities in order to reduce chronic disease rates, prevent the development of secondary conditions, address health disparities, and develop a stronger evidence base of effective prevention programming. Proposed purview of these grants is very broad. However, no specific amount of funds is identified and no timing considerations are included in the law, which in a practical sense may lead to it being shelved until other priorities with specific timing requirements are addressed.</td>
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This provision authorizes the establishment of a new prevention-oriented grant program for the pre-Medicare population (ages 55–64) to state or local health department or Indian tribes. No specified appropriation is identified and no timing requirement is identified. However, $50 million is identified for the evaluation of these grants, and a report to Congress is required by September 30, 2013.

This section amends the Federal Rehabilitation Act of 1973 to add a section on “Establishment of Standards for Accessible Medical Diagnostic Equipment,” which appears to be a current oversight. Timing is 24 months after enactment of the “Affordable Health Choices Act” [sic] which shows it was lifted from another companion bill.

This is a technical amendment to the appropriate federal laws to allow direct purchase of vaccines by states and to achieve “progress … toward improving immunization coverage rates among high-risk populations within … State(s)” and to authorize a small study of immunization availability to Medicare beneficiaries. The only timing issue identified is a requirement for a report to Congress by the Secretary within 4 years of the enactment of the “Affordable Health Choices Act” [sic], which shows again that this provision was also lifted from that other draft bill.

This provision amends the Federal Food, Drug, and Cosmetic Act to require nutrition labeling for all chain restaurants with more than 20 outlets and food vending machine providers with more than 20 machines. Regulations are required within 1 year of the date of enactment of this clause (legislation?).

This provision applies to Section 330 (of the Public Health Service [PHS] Act)—funded community health centers. It authorizes up to 10 centers to conduct demonstration projects using Individualized Wellness Plans. No money or timing is identified. This is another item that may be moved to the back of the line.

This provision appears to be effective immediately.

This section establishes a new research-oriented grant program to be administered by CDC, but does not have an amount or any timing requirement.

This section, which amends the PHS Act, contains a number of requirements for federal information sources to collect and analyze health data in ways that would contribute to the reduction of health disparities. These modifications must be made no later than 2 years after enactment (i.e., by March 23, 2012.) No specific amount for appropriations is identified.

Adds a new “Part U” to the PHS Act entitled “Employer-Based Wellness Programs” which requires the Director (of CDC) to “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.” The other major purpose of this section is to “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.” This section also requires a national survey of employer-based wellness programs no later than two years after enactment (i.e., March 23, 2012). Interestingly, Congress explicitly prohibits anything from this part being used to mandate or require workplace wellness programs. No specific money figure is identified.

This amendment to the Public Health Service Act builds the capacity of our surveillance systems for infectious diseases and other conditions of public health importance, $190 million each year for fiscal years 2010 through 2013 is appropriated.

This section calls for a national conference on pain management and a report no later than June 1, 2011, the establishment of a research program within the National Institutes of Health, the establishment of a coordinating committee on pain research and the funding of education and training programs on pain management. No specific appropriations amount is identified in the law.

Amends the Social Security Act to create a new grant program with $25 million each year from 2010 to 2014 to study and affect childhood obesity. No timing other than the assumption of allocation of the identified monies.

Makes explicit statement that Congress is not pleased with the way in which prevention and wellness programs are “scored” (i.e., financially assessed for their budgetary effects) in the legislative process and they want to work with the Congressional Budget Office (CBO) to develop better methodology. No specific timing or monies identified.

Congress clearly wants a credible evaluation of all the federal health and wellness initiatives and tasks the Secretary with conducting a large scale evaluation, including a study of the federal workforce and requires the Secretary to report back to Congress. However, no specific timing or monies are identified.

4202 HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.

4203 REMOVING BARRIERS AND IMPROVING ACCESS TO WELLNESS FOR INDIVIDUALS WITH DISABILITIES.

4204 IMMUNIZATIONS.

4205 NUTRITION LABELING OF STANDARD MENU ITEMS AT CHAIN RESTAURANTS.

4206 DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.

4207 REASONABLE BREAK TIME FOR NURSING MOTHERS.

4301 Subtitle D—Support for Prevention and Public Health Innovation: RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.

4302 UNDERSTANDING HEALTH DISPARITIES: DATA COLLECTION AND ANALYSIS.

4303 CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.

4304 EPIDEMIOLOGY-LABORATORY CAPACITY GRANTS.

4305 ADVANCING RESEARCH AND TREATMENT FOR PAIN CARE MANAGEMENT.

4306 FUNDING FOR CHILDHOOD OBESITY DEMONSTRATION PROJECT.

4401 Subtitle E—Miscellaneous Provisions: SENSE OF THE SENATE CONCERNING CBO SCORING.

4402 EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.

5. **Opens the Door to Wellness for Some Major Subpopulations.** The broad range of preventive interventions proposed for Medicare beneficiaries, Medicaid beneficiaries, Native Americans, and community health center users underscores the position of Congress regarding expansion evaluation and substantiation of the value of these areas. It’s almost as if Congress is saying in the legislation, “We think prevention and wellness works, but make sure we get objective proof of its effectiveness and value.” This is likely to provide the field with an opportunity to demonstrate its value.
of accessibility to preventive and wellness services. This is likely to create more demand pressures for preventive and wellness personnel and programs.

6. **Is Intended to Help Build Prevention Infrastructure.** Several of the key sections (i.e., 4002, 4201, 4301, and 4304) are clearly capacity-building efforts. These efforts are clearly designed to provide a limited number of years of investment in building a prevention infrastructure for the future of the nation. This is likely to also increase the demand for trained and certified personnel and for programs with proven value.

7. **Signals the Economy that Prevention and Wellness Are Growth Industries.** In a largely free-market economy, meta-messages contained in federal legislation are usually not lost on those whose job it is to define business potential and size markets. This legislative statement is likely to create a wave of new entrants to the prevention and wellness fields and to spur growth and investment in current market participants.

8. **Increases the Level of Accountability for Results.** The many formal requirements placed on the Secretary of DHHS and the Director of CDC to conduct rigorous, large-scale evaluations of all preventive interventions should telegraph the message of significantly increased accountability for all of us. The pressure to find more effective techniques and methodology has never been stronger or more focused. The likely effects on the field are to significantly increase the stakes associated with programming and to significantly increase the pressure to produce high-order results.

9. **Provides Some Mechanisms for Societal Level Prevention Impact.** Several of the sections in the law (i.e., 2713 [Public Health Service Act], 1002, 1302, 4001, 4002, 4004, 4103, 4201, and 4205) address societal-level change affecting virtually all populations equally. These preventive interventions for the first time are intentionally directed at society at large, a very significant development. This is likely to provide considerable support for positive attitudes about prevention among the subpopulations that are targeted by individual wellness programs. The lack of this societal-level support for prevention and wellness has historically made it more difficult to achieve behavior change in individual program settings.

### How Well Is the Law Likely to Work?

If I were to project forward 3 years and ask the question, “How well is the health care reform law working?” the answers I would offer are portrayed in Figure 4. This constitutes my personal evaluation or “report card” of how I think the new law is likely to affect seven major dimensions of health system performance. These “grades” are based on many of the comments identified in this publication as well as in Part I.

Perhaps the most problematic part of the new reform law in my opinion is the nonmarket interventions that affect health plans and insurers. These nonmarket interventions essentially remove most of the tools traditionally used by health plans and insurers to guide consumer behavior and manage cost. Table 5 contains a listing of these interventions, a brief description, and their proposed effective dates.

Just a quick glance at the items in Table 5 raises significant questions about how health plans and insurers are going to manage health plans with the significant limitations imposed by the new law. It is true that all health plans and insurers are now on the same playing field, but does the new law provide for enough latitude and tools to manage future claims costs?

### Table 2

**Identification of Major Stakeholder Groups**

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Brief Description</th>
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<tbody>
<tr>
<td>Employees</td>
<td>There are approximately 131 million employees in the U.S. labor force, ranging from large private employers to the self-employed. About 70% receive health benefit coverage from their employer.</td>
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<tr>
<td>Employers</td>
<td>There are approximately 8.4 million employers in the U.S. These range from 1-person businesses to employers with more than a million employees.</td>
</tr>
<tr>
<td>Consumers in Medicare and Medicaid</td>
<td>There are approximately 42 million individuals covered by Medicare and another 27 million covered by Medicaid currently.</td>
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<tr>
<td>Health plans</td>
<td>There are approximately 2100 health plans that run the gamut from Blue Cross and Blue Shield plans to staff-model health maintenance organizations (HMOs).</td>
</tr>
<tr>
<td>Physicians</td>
<td>There are approximately 950,000 physicians in active practice, distributed across more than 60 medical specialties and subspecialties.</td>
</tr>
<tr>
<td>Hospitals</td>
<td>There are approximately 6800 hospitals, including many specialty hospitals.</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>There are approximately 8500 nursing homes.</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>There are approximately 10,500 pharmacies.</td>
</tr>
<tr>
<td>Other health care providers</td>
<td>There are approximately 1.4 million other types of health care practitioners, including dentists, podiatrists, psychologists, physical therapists, chiropractors, etc.</td>
</tr>
<tr>
<td>Benefits brokers</td>
<td>There are approximately 38,000 benefits brokers.</td>
</tr>
<tr>
<td>Consultants</td>
<td>There are approximately 74,000 health care industry consultants.</td>
</tr>
<tr>
<td>Government</td>
<td>There are approximately 96,000 government workers involved in some aspect of health care including military health care workers.</td>
</tr>
<tr>
<td>Educators</td>
<td>There are approximately 16,400 private and public sector educators involved in the health occupations.</td>
</tr>
<tr>
<td>Unions</td>
<td>There are approximately 16 million union workers in the U.S. labor force.</td>
</tr>
<tr>
<td>Nonprofit health organizations</td>
<td>There are approximately 8800 nonprofits in the health care field performing a broad range of functions.</td>
</tr>
<tr>
<td>Stakeholder</td>
<td>Likely Initial Effects</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Employees</td>
<td>Increased choices, individual mandate, initially higher rates of increase in annual premiums, in the long term likely lower annual increases but diminished administrative quality.</td>
</tr>
<tr>
<td>Employers</td>
<td>Increased uncertainty, higher premiums for 2–3 years, then fewer options for cost management, greater spending on consulting, more attention required.</td>
</tr>
<tr>
<td>Consumers in Medicare and Medicaid</td>
<td>Efforts for Medicare management and savings not likely to be politically acceptable; therefore, proposed program reductions not likely occur.</td>
</tr>
<tr>
<td>Health plans</td>
<td>Nonmarket requirements (read, “government mandate”) in the form of required benefits, limitations on annual increases, restrictions on underwriting policies complicated by increased market demand.</td>
</tr>
<tr>
<td>Physicians</td>
<td>The initial situation will look good. More insurance coverage. Better bad debt protection, but likely to receive lower reimbursement over time.</td>
</tr>
<tr>
<td>Hospitals</td>
<td>The initial situation will look good. More insurance coverage. Better bad debt protection, likely to get beat up worse by insurers over time. Required to publish price list annually.</td>
</tr>
<tr>
<td>Nursing homes</td>
<td>The initial situation will look good. Slightly more insurance coverage. However, the cost pressure on Medicaid with its expansion to 18–22 million more people will quickly bring more draconian actions.</td>
</tr>
<tr>
<td>Pharmacies</td>
<td>The initial situation will look good. More insurance coverage. Better bad debt protection, likely to get beat up worse by insurers over time. Pharmacoeconomics as usual will likely be challenged by Congress sometime in the next decade.</td>
</tr>
<tr>
<td>Other health care providers</td>
<td>The initial situation will look good. More insurance coverage. Better bad debt protection, likely to get beat up worse by insurers over time. The potential substitutability of less-expensive providers will be examined and will create some winners.</td>
</tr>
<tr>
<td>Benefits brokers</td>
<td>The initial situation is bad. Brokers lose their commissions under the new purchasing arrangement. They will likely have to come up with another “value-add”—how about consulting on wellness programs?</td>
</tr>
<tr>
<td>Consultants</td>
<td>The high degree of uncertainty and complexity of the legislation is a godsend for the consulting industry.</td>
</tr>
<tr>
<td>Government</td>
<td>The much larger role for government in the health care system creates a boon for government workers. There will need to be a large number of federal and state employees hired to implement these changes.</td>
</tr>
<tr>
<td>Educators</td>
<td>The increase in requirements and the formalization of consensus and policy will provide new content for the educators to convey. It also means that more people will have insurance so more providers will need to be trained.</td>
</tr>
<tr>
<td>Unions</td>
<td>The self-insured nature of most Taft-Hartley trusts and union-run plans will block any pain initially, but if costs continue upward, their plans may come into the “Cadillac plan tax zone” which may cause a great deal of future heartburn.</td>
</tr>
</tbody>
</table>
### Table 3, Continued

<table>
<thead>
<tr>
<th>Stakeholder</th>
<th>Likely Initial Effects</th>
<th>Likely Initial Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nonprofit health organizations</td>
<td>They as a group are not directly addressed in the legislation. Their purchase of health plan coverage for their own staff is likely to be aided, and depending on what function and what sector of health care they work with they will likely feel differently about the legislation.</td>
<td>“This law is good, isn’t it!” If they work with a “winner” they will likely feel good about the law. If they work with “losers” then they will not feel as positive about the law. If they stand to gain new reimbursement from new coverage they will look favorably on the new law. Satisfaction range = −1 to +3</td>
</tr>
</tbody>
</table>

### Table 4

**Selected Recommendations on Prevention, Health Promotion, and Wellness**

<table>
<thead>
<tr>
<th>Section</th>
<th>Brief Description</th>
<th>Brief Recommendations</th>
</tr>
</thead>
<tbody>
<tr>
<td>4001 Subtitle A Modernizing Disease Prevention and Public Health Systems: NATIONAL PREVENTION, HEALTH PROMOTION AND PUBLIC HEALTH COUNCIL.</td>
<td>Make sure that the traditional public health interests focused on vulnerable minorities don’t dominate the focus of the Council and the Advisory Group. Use a community-wide approach to programming rather than population-specific. Use the primary, secondary, and tertiary approach to prevention originally advocated by John Hanlon. Start by building on the “Objectives for the Nation” perspective.* Add consumer health education and medical self-care to the definition of wellness and promotion. Make sure that worksite settings and working populations receive at least a third of all funding. Maintain a community-wide approach to programming rather than population specific.</td>
<td>Make sure that worksite settings and working populations receive at least a third of all funding. Maintain a community-wide approach to programming rather than population specific.</td>
</tr>
<tr>
<td>4002 PREVENTION AND PUBLIC HEALTH FUND.</td>
<td></td>
<td>Make sure that worksite settings and working populations receive at least a third of all funding. Maintain a community-wide approach to programming rather than population specific.</td>
</tr>
<tr>
<td>4003 CLINICAL AND COMMUNITY PREVENTIVE SERVICES.</td>
<td></td>
<td>Make sure that worksite settings and working populations receive at least a third of all funding. Maintain a community-wide approach to programming rather than population specific.</td>
</tr>
<tr>
<td>4004 EDUCATION AND OUTREACH CAMPAIGN REGARDING PREVENTIVE BENEFITS.</td>
<td></td>
<td>Make sure that worksite settings and working populations receive at least a third of all funding. Maintain a community-wide approach to programming rather than population specific.</td>
</tr>
<tr>
<td>4103 Subtitle B—Increasing Access to Clinical Preventive Services: MEDICARE COVERAGE OF ANNUAL WELLNESS VISIT PROVIDING A PERSONALIZED PREVENTION PLAN.</td>
<td></td>
<td>Consider a 3–5-year pilot that requires this annual wellness visit for all Medicare beneficiaries in a region or state and evaluate the utilization and cost outcomes against a matched external control group. Randomize subjects if possible. Consider the same for a pilot group of Medicaid beneficiaries.</td>
</tr>
<tr>
<td>4201 Subtitle C—Creating Healthier Communities: COMMUNITY TRANSFORMATION GRANTS.</td>
<td></td>
<td>Require a portion of each Community Transformation grant to address wellness services for small employers in their community. Include opportunities for commercial wellness vendors to be evaluated against community-based vendors. Include several employer-based demonstration projects.</td>
</tr>
<tr>
<td>4202 HEALTHY AGING, LIVING WELL; EVALUATION OF COMMUNITY-BASED PREVENTION AND WELLNESS PROGRAMS FOR MEDICARE BENEFICIARIES.</td>
<td></td>
<td>Include several employer-based demonstration projects. Provide demonstration for rural, urban and suburban settings. Use randomization in assignment of subjects to intervention and control groups. Require a significant portion of the research to address the prevention needs of working populations.</td>
</tr>
<tr>
<td>4206 DEMONSTRATION PROJECT CONCERNING INDIVIDUALIZED WELLNESS PLAN.</td>
<td></td>
<td>Require a significant portion of the research to address the prevention needs of working populations.</td>
</tr>
<tr>
<td>4301 Subtitle D—Support for Prevention and Public Health Innovation: RESEARCH ON OPTIMIZING THE DELIVERY OF PUBLIC HEALTH SERVICES.</td>
<td></td>
<td>Broader function so that technical assistance on design and implementation of worksite wellness programs is included. Establish a “best practices” process for development of technical aspects of worksite wellness. Utilize some form of advisory group and confirm initial findings from the group by conducting field surveys. Provide national and regional conferences for dissemination of best practices.</td>
</tr>
<tr>
<td>4303 CDC AND EMPLOYER-BASED WELLNESS PROGRAMS.</td>
<td></td>
<td>Examine health plan, sick leave, workers’ compensation, disability management, and presenteeism-related costs when conducting scoring for worksite-based wellness programs.</td>
</tr>
<tr>
<td>4401 Subtitle E—Miscellaneous Provisions: SENSE OF THE SENATE CONCERNING CBO SCORING.</td>
<td></td>
<td>Provide sufficient funding to conduct a valid evaluation.</td>
</tr>
<tr>
<td>4402 EFFECTIVENESS OF FEDERAL HEALTH AND WELLNESS INITIATIVES.</td>
<td></td>
<td>Utilize the new meta-analysis on the economic return of worksite wellness programs to help improve the validity of scoring. Establish a “best practices” process for development of technical aspects of worksite wellness. Utilize some form of advisory group and confirm initial findings from the group by conducting field surveys. Provide national and regional conferences for dissemination of best practices.</td>
</tr>
</tbody>
</table>

* For a discussion of the Objectives for the Nation 2020 visit the following URL: http://www.healthypeople.gov/hp2020/.
What Is Missing?

From my perspective, there are several major things that are missing from the new law. These missing elements underscore and help explain the “report card” grades for the legislation that are presented above in Figure 4. These are:

1. **The Lack of Adequate Consumer Incentives.** Outside of the permissive use of premium reduction incentives addressed in Section 2705, there is virtually no mention of the consumer or patient’s role and responsibilities. The law is heavy on rights and virtually silent on responsibilities. The opportunity to structure choice architecture around health plans to reward effective and efficient consumer or provider decision making is significantly curtailed.

2. **The Lack of Any Change in the Strong Sense of Entitlement Around Health Care.** The rhetoric embodied in the new law contains positive language that reinforces our sense of entitlement, in other words … rights without any responsibilities. Phrases and section titles such as “Immediate Improvements in Health Care for All Americans” feed an unrealistic set of expectations and a high degree of entitlement. How are we ever going to meet these unrealistic expectations?

3. **The Lack of Emphasis on Personal Responsibility.** I searched the entire law for the words “personal responsibility” and found only one mention of the term in a minor section on maternal and child health programs. Not a good portent for a law that is expected to cost more than a trillion federal tax dollars during the next decade.

4. **The Lack of a Feasible Way of Improving Consumer Health Skills.** Very little attention or focus is provided in the law on the education and skill development of health consumers. There is mention in two places about providing information to health consumers, but virtually no mention of a feasible way of enhancing consumer health skills.

5. **The Lack of a New Social Contract Around Personal Health and Health Care Use.** What seems to be missing is the recognition of the need for a new social contract around personal health and health care use. That social contract needs to say to people, “We are providing health benefit coverage for you and your family, but we expect you to take better care of yourself, make healthy lifestyle choices, and learn the skills necessary to use the health care system efficiently and effectively.” Without this kind of societal value, we are not likely to fix the bigger problem of health care costs or find the right balance of accessibility, quality, and cost in our health care system.

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**Figure 3**

Definition of Wellness and Prevention Program

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“SEC. 2717. ENSURING THE QUALITY OF CARE.
“(b) WELLNESS AND PREVENTION PROGRAMS.—For purposes of subsection (a)(1)(D), wellness and health promotion activities may include personalized wellness and prevention services, which are coordinated, maintained or delivered by a health care provider, a wellness and prevention plan manager, or a health, wellness or prevention services organization that conducts health risk assessments or offers ongoing face-to-face, telephonic or web-based intervention efforts for each of the program’s participants, and which may include the following wellness and prevention efforts:

“(1) Smoking cessation.
“(2) Weight management.
“(3) Stress management.
“(4) Physical fitness.
“(5) Nutrition.
“(6) Heart disease prevention.
“(7) Healthy lifestyle support.
“(8) Diabetes prevention

“(1) GENERAL PROVISIONS.—
“(A) GENERAL RULE.—For purposes of subsection (b)(2)(B), a program of health promotion or disease prevention (referred to in this subsection as a ‘wellness program’) shall be a program offered by an employer that is designed to promote health or prevent disease that meets the applicable requirements of this subsection.
```
How Should the Field Respond to This New Law?

Again, from my perspective, I believe that as a field we need to respond to this new law in a constructive manner. I don’t believe that it is likely to be repealed, so I think we have to work within its limitations. To simplify my response to this question I would like to propose that we as a field respond to the law with five “P’s.” These are:

With Perspective: Develop your own perspective on its strengths and weaknesses.

With Preparation: Spend some time to familiarize yourself with its key features.

With Participation: It is the law of the land and we need to participate fully, particularly in the prevention and wellness provisions.

With Potential: The law has a great deal of positive potential; let’s do what can be done to help it improve the health of the greatest number of people.

With Pragmatism: I believe that being a pragmatist is a wise position; you recognize the good and bad and yet do your part to bring about the best outcome.

Conclusion

This two-part series on the new health care reform law is intended to help health promotion professionals understand its implications and potential. It is one of the most complex federal laws ever passed and is likely to dominate our attention for the next decade. Hopefully, the content of the two articles has helped you develop your own perspective and understanding of this landmark piece of health legislation.

Larry S. Chapman, MPH, President and CEO, Chapman Institute, and Editor, The Art of Health Promotion.

References

Analysis & Commentary. How Health Care Reform Must Bend the Cost Curve.

Cutler D.

The true measure of health care reform’s success is whether it drives down medical costs over the long term. The Patient Protection and Affordable Care Act has several features designed to modernize the delivery of services and thus ensure a more efficient, more effective, and less expensive health care system. These features include bundling medical services into larger payment groups, using value-based purchasing, and improving care coordination. These changes could spark a productivity revolution in health care that would make it much more affordable and simultaneously increase the quality of care. The success of these efforts at controlling long-run cost growth will require activism from the government and the private sector.


Holtz-Eakin D, Ramlet MJ.

The federal government faces a daunting fiscal outlook, which makes the budgetary impact of the Patient Protection and Affordable Care Act even more important. The official Congressional Budget Office (CBO) analysis indicates modest deficit reduction over the next ten years and beyond. We examine the underpinnings of the CBO’s projection and conclude that it is built on a shaky foundation of omitted costs, premiums shifted from other entitlements, and politically dubious spending cuts and revenue increases. A more comprehensive and realistic projection suggests that the new reform law will raise the deficit by more than $500 billion during the first ten years and by nearly $1.5 trillion in the following decade.


Analysis & Commentary. The Foundation That Health Reform Lays for Improved Payment, Care Coordination, and Prevention.

Thorpe KE, Ogden LL.

The Patient Protection and Affordable Care Act represents a major opportunity to achieve several key goals at once: improving disease prevention; reforming care delivery; and bending the cost curve of health spending while also realizing greater value for the dollars spent. Reform-based initiatives could produce major gains in a relatively short time. The U.S. Department of Health and Human Services should develop an action plan detailing how the programs that the health reform law sets into motion throughout various agencies can work synergistically. It should also detail how best practices in finance and payment, in the organization and delivery of care, and in prevention can be expanded nationally.


Health Care Reform: Perspectives From Large Employers.

Darling H.

Recently enacted health reform legislation will have mostly positive effects on large employers, as millions more Americans gain access to affordable insurance and, potentially, primary care. But the law will impose new administrative burdens and financing costs on employers, while raising concerns about provisions that could allow their lower-wage employees to obtain coverage through insurance exchanges. Given the need to restrain the rate of growth of health spending, the private sector, especially large employers, must collaborate with the public sector to drive delivery system reform. And every public program and exchange should appoint a chief value officer who reports quarterly on spending, cost drivers, and potential ways to contain costs.

Closing Thoughts

By Larry S. Chapman, MPH

Sorry to be a naysayer on the new health care reform law, but that’s really what I think. Title IV is an excellent catalyst for a new prevention infrastructure, but our prevention efforts will undoubtedly be significantly affected by the way the rest of health care reform plays out. Unfortunately we may sink or swim together.

As an opportunity, this new law provides unparalleled potential for advancing the cause of prevention, health promotion, and wellness. In my 30-year career in health promotion I have not seen a similar situation with as much raw potential for the field. On a positive note, I share much of the optimism expressed by Michael O’Donnell, our esteemed Editor in Chief, in the pages of the American Journal of Health Promotion.

One piece of advice that I hope will resonate with you is for all of us to become more familiar with how our wellness programs relate to health plan activity. Specifically, what tends to limit the effectiveness of our programming efforts that is related to how people perceive and utilize (or don’t utilize) their health plans. Perhaps if we can understand these relationships with greater clarity and accuracy we can compensate for some of the adverse things that may be on the horizon. Also, in the future we may need to be more proactive in pointing out to program sponsors what is realistically achievable given these larger system-related changes in the background. Regardless of the short-term outcomes, it looks to be an exciting time for all of us!

Larry S. Chapman, MPH, is Editor of The Art of Health Promotion.
Definition of Health Promotion

“Health Promotion is the art and science of helping people discover the synergies between their core passions and optimal health, enhancing their motivation to strive for optimal health, and supporting them in changing their lifestyle to move toward a state of optimal health. Optimal health is a dynamic balance of physical, emotional, social, spiritual, and intellectual health. Lifestyle change can be facilitated through a combination of learning experiences that enhance awareness, increase motivation, and build skills and, most important, through the creation of opportunities that open access to environments that make positive health practices the easiest choice.”

(O’Donnell, American Journal of Health Promotion, 2009, 24,1,iv)

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Dean and Avedis Donabedian Distinguished University Professor of Public Health
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