The passage of the Affordable Care Act had a great impact on the landscape of public health programming and clinical preventive care in North Carolina. Large funding measures have supported community-based prevention efforts and led to policy, systems, and environmental changes to support a healthier population.

Introduction

The Affordable Care Act (ACA), signed into law on March 23, 2010, by President Barack Obama, altered the landscape of health insurance access, clinical preventive services, and funding for public health in the United States. While the health insurance mandate of the ACA was among the more well-known provisions, the law also required coverage of clinical preventive services and provided funding for numerous public health initiatives. This article focuses on select provisions of the ACA including the National Prevention Strategy, the Prevention and Public Health Fund, coverage of clinical preventive services, and maternal and child health provisions.

National Prevention Strategy

The ACA created the National Prevention, Health Promotion and Public Health Council to coordinate federal prevention efforts and increase funding for state and local public health. The Council included heads of departments, agencies, and offices across the federal government tasked with the creation of a National Prevention Strategy to guide the national health agenda. The Prevention Strategy called for partnerships among all levels of government, business and private sector partners, and community- and faith-based organizations to improve health through prevention. Priorities of the National Prevention Strategy included tobacco-free living, preventing drug and excessive alcohol use, active living, healthy eating, injury- and violence-free living, reproductive and sexual health, and mental and emotional well-being [1]. In addition, the Strategy included a focus on community and environmental health, aimed at eliminating health disparities and empowering individuals to make healthier choices.

The ACA and Coverage of Clinical Preventive Services

The Affordable Care Act also expanded the coverage of clinical preventive services. Before 2010, it was estimated that 100,000 additional lives could be saved each year with increased uptake of a few clinical preventive services [2]. Provisions within the ACA sought to increase the number of Americans with access to preventive services and save lives by requiring health plans to cover these services with no out-of-pocket costs for individuals [3]. The ACA stressed coverage for clinical preventive care including evidence-based screening and counseling, routine immunizations, and preventive services for women and children.

Several organizations were designated to provide expertise on recommended preventive services, including the United States Preventive Services Task Force (USPSTF), the Advisory Committee on Immunization Practices (ACIP), and the Health Resources and Services Administration (HRSA). The USPSTF serves as a task force designed to make evidence-based recommendations on screenings, counseling services, and preventive medications. ACIP is designated as the main body of public health experts in charge of establishing recommendations and plans regarding vaccines. The HRSA serves as the main body that focuses on improving health care access to those who are geographically isolated or economically or medically vulnerable.

These bodies recommended routine preventive services such as breast cancer screening, tobacco cessation, and type 2 diabetes screening, which were required under the ACA to be covered by health plans with no out-of-pocket costs for individuals. These changes resulted in increased uptake of some clinical services, including the influenza vaccine and blood pressure and cholesterol checks [4]. For those who gained insurance coverage due to the ACA, there
was a decrease in emergency visits, decrease in smoking, increased early detection of disease, and an increase in self-reported excellent health [4].

Prevention and Public Health Fund

The Prevention and Public Health Fund (PPHF) was a financing measure in the ACA for state and local governments and served many important purposes in the rollout and implementation of ACA provisions. The fund was intended to provide for expanded and sustained national investment in prevention and public health programs to improve health and help restrain the rate of growth in private and public health care costs. In 2010, the ACA authorized the spending of $15 billion over a 10-year period—the most that the federal government had ever allocated to prevention in a single stream of funding [5].

However, the fund was used to support federal priorities that were, at best, loosely tied to public health or prevention. For example, of the $500 million invested in FY 2010, half of it went to the primary care workforce not directly tied to prevention or public health [5]. In 2017, additional cuts were made to PPHF funding. The Tax Cuts and Jobs Act, which was enacted in late 2017, cut $750 million from the PPHF, and later in 2018 Congress passed a cut of $1.3 billion to the PPHF over 10 years [6]. At the time of the cuts, various health leaders expressed concern, indicative of the overall cloudiness of the future of the PPHF [6].

The North Carolina Division of Public Health (DPH) received PPHF funding to implement the Communities Putting Prevention to Work (CPPW) program in 2010 and the Community Transformation Grant (CTG) in 2011. Both initiatives aimed to increase policies, systems, and environments supporting healthy living. CPPW focused on increasing opportunities for healthy eating and active living, while CTG expanded that work to include tobacco-free living and increased access to clinical preventive services. The DPH Chronic Disease and Injury Section was responsible for oversight and coordination of the grants, and community efforts were led by local health departments and key partners.

CPPW-funded programs were implemented in diverse areas of the state: Ashe, Watauga, Alleghany, and Pitt counties. The funding addressed 23 separate objectives across multiple settings, such as work sites, health care organizations, and schools. The project resulted in more than 135 environmental changes and 65 policy and systems changes over two years (internal data). Accomplishments included incorporating health considerations in comprehensive county-wide plans and making child care centers healthier.

CTG funding was awarded to 10 local health departments to lead regional collaboratives. Accomplishments included county-wide and region-wide changes, such as adopting smoke-free policies, and organizational changes, such as increasing the availability of healthy food options in corner stores and increasing acceptance of SNAP-EBT at farmers markets.

CPPW and CTG both leveraged skills of local health departments in convening diverse partners to address community issues and expanded collaborations to include new partners, such as transportation planners and retail owners. Both funding streams created sustainable changes that reached low-income and minority populations in both urban and rural settings, where there are greater health disparities.

Preventive Health and Health Services Block Grant (PHHSBG) funds through the PPHF continue to be critical for maintaining a core public health infrastructure in North Carolina. The state’s PHHSBG activities are guided by the objectives of the federal Healthy People initiative. The majority of PHHSBG funding is allocated to local health departments/districts through the Healthy Communities program. Ninety-eight out of 100 North Carolina counties promote community-specific policy and environmental changes supporting increased healthy eating, physical activity, prevention of tobacco use, chronic disease prevention and management, and injury/violence prevention. Incorporation of health equity principles is required as part of the planning, implementation, and evaluation of these strategies. Healthy Communities activities reported from 2018 to 2019 [7] reflect numerous accomplishments, some of which include:

Increasing Access to Healthy Foods for Low-Income Populations

This effort took place through small food retailers and food pantries improving food offerings and building capacity of farmers markets and mobile markets to create new markets and accept SNAP-EBT. This resulted in 23 small food retail stores improving food and beverage options and 52 community venues increasing access to fresh produce [7].

Partnering With Local Planners to Adopt Jurisdiction-wide Transportation and Infrastructure Plans

These plans also included other supportive activities such as conducting walkability assessments and strategically placing wayfinding signage. This resulted in four jurisdiction-wide plans incorporating active transportation goals and 39 supportive activities [7].

Increasing Tobacco/Smoke-free Policies

Thirty-seven new tobacco-free living policies were implemented in multi-unit housing complexes, local government buildings, grounds, indoor public places, and colleges and universities [7].

Addressing Injury/Violence-Prevention Strategies

These strategies focused on suicide prevention, syringe exchange programs, and awareness campaigns around the risks, signs, and symptoms of opioid overdose, and how to...
access and administer naloxone. Outcomes included implementation of 35 suicide prevention trainings, 14 syringe exchange programs, and 169 opioid awareness campaigns [7].

North Carolina also uses PHHSBG funding to address HIV/AIDS, oral health, rape prevention, and to support critical public health infrastructure.

**Maternal and Child Health Prevention Efforts**

The ACA also included many provisions that specifically impacted the health of women, infants, children, and children with special health care needs. Not only did the ACA expand coverage, including clinical preventive services for women and children, but it also included provisions and upstream investments in prevention and public health.

One such investment was the creation of the Maternal, Infant, and Early Childhood Home Visiting (MIECHV) program, which was authorized by the ACA and amended Title V of the Social Security Act. Initially funded at $1.5 billion for five years in escalating amounts, the program enabled states to implement or expand evidence-based home visiting programs to improve outcomes of women and children, especially in at-risk communities. The main goals of MIECHV were to improve maternal and infant health; prevent child injuries and abuse/neglect; improve school readiness and achievement; reduce crime and interpersonal violence; improve family economic self-sufficiency; and improve coordination of maternal/early childhood systems and supports [8]. The creation of MIECHV also highlighted the importance of evidence-based initiatives, which included the establishment of the Home Visiting Evidence of Effectiveness (HomVEE) project to conduct a systematic review of home visiting programs [9].

The NC DPH manages the MIECHV program as a larger public-private partnership to enhance evidence-based home visiting programs in North Carolina. The MIECHV funding allows for enhanced infrastructure and implementation of evidence-based home visiting in North Carolina as one source of funding, in addition to Title V Maternal and Child Health Block Grant funding, state appropriations, and private philanthropy funding. Over the years, investments by several public and private funders have enabled various community organizations to implement home visiting, including but not limited to local health departments, local Smart Start partnerships, universities, and other community-based organizations. To maximize effectiveness and efficiency and to strengthen early childhood systems, North Carolina partners and funders have since focused on planning to enhance a more comprehensive, statewide system for home visiting and parenting education that is coordinated, family-centered, and equitable.

Given the established benefits of breastfeeding for maternal and child health [10, 11], the ACA pushed forward policy that promoted breastfeeding in the workplace and access to breastfeeding supplies, counseling, and support with baseline regulations. Under the ACA, new insurance policies (not grandfathered plans) provide coverage for certain preventive services, including comprehensive prenatal and postnatal lactation support, counseling, and equipment rental for breastfeeding with no cost sharing by the insured. However, access to breastfeeding consultation and supplies may vary, as while there are requirements under the ACA for coverage, insurance policies have some flexibility and room for interpretation [11]. By amending Section 7 of the Fair Labor Standards Act (FLSA), the ACA also requires employers to provide reasonable break time and an appropriate place (that is not a bathroom) to express milk. While there are some noted limitations and gaps that do not address disparities, and while employers are not required to compensate nursing mothers during time spent breastfeeding [12], the ACA was a start to the increased support needed for mothers returning to work [13].

The ACA also authorized the Personal Responsibility Education Program (PREP), which is focused on preventing teen pregnancy and sexually transmitted infections by providing young people with essential education, supporting academic achievement, encouraging parent-teen communication, promoting responsible citizenship, and building self-confidence. North Carolina PREP funding, managed by NC DPH, is used to support the North Carolina School Health Training Center, which provides teacher training, curricular materials, and ongoing technical support for the Making Proud Choices! evidence-based curriculum in 25 school systems. PREP funding is also being used for implementation of evidence-based curricula in selected communities to provide teen outreach.

**Conclusion**

This report highlights the ongoing legacy of the ACA and its impact on clinical preventive services and public health efforts in the United States. In North Carolina, the ACA and associated funding enabled the implementation of community-based prevention programs throughout the state, as well as improved coverage of preventive health services for the population. Ongoing investment will be required at the local, state, and federal levels in order to continue the important work of prevention and support a healthier population. NCMJ

William Brody intern, Department of Health and Human Services, Raleigh, North Carolina.
Karen Stanley RDN, LDN healthy communities program manager, Chronic Disease & Injury Section, North Carolina Division of Public Health, Raleigh, North Carolina.
Sharon Nelson, MPH program initiatives manager, American Heart Association, Dallas, Texas.
Susan M. Kansagra, MD, MBA section chief, Chronic Disease and Injury, North Carolina Division of Public Health, Raleigh, North Carolina.
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