COMMENTARY

Remaking the American Health Care System: A Positive Reflection on the Affordable Care Act with emphasis on Mental Health Care

Babatunde Ogundipe, MD, MPH
Farzana Alam, MD
Lalitha Gazula, MD, MPH
Yetunde Olagbemiro, MD, MPH
Kenneth Osiezagha, MD
Rahn K. Bailey, MD, DFAPA
William D. Richie, MD, DFAPA

Abstract: Health care reform under the Patient Protection and Affordable Care Act (PPACA, ACA) of 2010 may be the most significant health care-related legislation enacted since the establishment of Medicare and Medicaid several decades ago. Over two years ago the U.S. Supreme Court upheld the constitutionality of the individual mandate of the Patient Protection and Affordable Care Act. This legislation has emerged as a significant and ambitious undertaking for all levels of the U.S. government. With the need to accommodate the estimated 30 million people projected over time to become newly insured it is increasingly important to understand the necessity of reform, how the legislation has been interpreted and implemented to fit the goals of the federal, state, and local governments, and what the potential benefits and consequences of changing the system are, in particular, as it relates to mental health care.

Key words: Health care, health reform, Affordable Care Act, health insurance, state-based health insurance marketplaces, mental health care.

Under the Obama Administration health care reform has become a reality through two separate pieces of legislation designed to improve the structure of health care delivery and the quality of health care. These include: (1) The Patient Protection and Affordable Care Act of 2010 (PPACA, or ACA), and (2) The Health Care and Education Reconciliation Act of 2010 (HCERA). Focused on cost containment and improved access, these two legislative acts define changes made within the health care system and have the potential to affect other important facets of United States (U.S.) society both politically and economically.

The authors are affiliated with Meharry Medical College. Please address correspondence to William D. Richie, MD, DFAPA; Meharry Medical College, 1005, Dr. D.B. Todd Jr. Blvd., Nashville, TN 37208; wrichie@mmc.edu; (615) 327-6823.

© Meharry Medical College

The Patient Protection and Affordable Care Act was designed to extend insurance coverage through an expansion of Medicaid, as well as through state-run marketplaces (exchanges) for health insurance supplemented by tax relief for middle-income participants who qualify for assistance.[1] The Patient Protection and Affordable Care Act has provided federal funding to enable states to expand the availability of Medicaid to people who previously did not qualify (either because they had too high an income or were single, non-disabled adults). Those individuals under 133% of the federal poverty level are now eligible for Medicaid in states that have chosen to expand. Many states, however, have not yet accepted this offer from the federal government resulting in gaps where the poorest of the uninsured are remaining uninsured while those who have somewhat higher incomes have been able to purchase insurance on the federal health insurance exchange.[2] In an effort to increase participation of healthy people in both Medicaid and the newly created exchanges a critical piece of the mechanism, known as the *individual mandate*, requires citizens to carry health insurance. In effect, this means that citizens who are uninsured must either sign up for Medicaid or if they earn too much to qualify for it, must purchase health insurance for themselves. Failing to purchase their own insurance would result in a tax penalty. Provisions also exist for the enforcement of penalties on employers with 50 or more full-time (or full-time equivalent) workers who do not provide health insurance coverage for their employees. Originally set to begin in 2014, the employer mandate has been delayed until 2015/2016.[1]

The health insurance marketplaces established through the Patient Protection and Affordable Care Act were set up so that small businesses and individuals could compare plans and purchase private insurance coverage that covers all the "essential health benefits," including services in: ambulatory care, emergency room, mental health, substance use disorders (counseling and psychotherapy), laboratory studies, rehabilitation, maternity/newborn care, prescription drugs, preventive medicine/wellness, pediatrics, and hospitalization.[3,4] More details are available at the federal government's website for the program, https://www.health care.gov/what-does-marketplace-health-insurance-cover.

When a few of the specific policies set forth through the PPACA were disputed, the U.S. Supreme Court investigated the claims and on June 28, 2012, ultimately upheld the constitutionality of much of the ACA including the individual mandate for eligible individuals and the Medicaid expansion. The court, however, did not agree for any individual state to be penalized for not implementing an expansion of its Medicaid program. Most significantly, the decision of the U.S. Supreme Court confirmed that many policy changes coming to the U.S. Health Care System were inevitable and would, as part of the timeline included in the ACA, take effect by late 2013 through 2015.[4] In view of all of this it is increasingly important to understand the ACA especially due to the numerous daily changes being made by the federal and state governments for the implementation of its programs. This article aims to provide a brief overview of what the problems have been within the U.S. health care system; highlight the need for health care reform by describing the consequences of being underinsured or uninsured in the United States; discuss the overall goals of the ACA; examine the potential beneficial effects of the ACA on health care in the United States, and in particular the impact that the ACA should have on mental health care.

Problems with the U.S. Health Care System

There were numerous problems faced by the health care system in the United States prior to the ACA. Rising costs of health care coupled with lack of access to health insurance affected many Americans.[5] The uninsured rate for children under the poverty line was 13.8%, while the overall rate was (9.4%). Nine million children were without insurance.[6] According to the U.S. Census Bureau report, titled *Income, Poverty, and Health Insurance Coverage in the United States: 2011*, there were 48.6 million people, 15.7% of the U.S. population, who were uninsured in 2011.[5] Additionally, the lack of health insurance has been found to result in more than 44,000 deaths each year.[7] In 2006 Massachusetts passed comprehensive health care reform with the goal of near universal coverage. Its law resembles the Affordable Care Act in expanding Medicaid, offering subsidized private insurance, and creating an individual mandate. A recent study published in the *Annals of Internal Medicine* found that health reform in Massachusetts was associated with significant reductions in all-cause mortality and deaths from causes amenable to health care.[8]

Prior to 2014, many individuals had trouble finding providers that would accept their insurance or were declined service because providers were no longer accepting new patients. Working class families worried about becoming ill or getting injured because they could not afford health insurance or basic health care. Others were turned away by insurance companies because of a pre-existing medical condition or illness. Additionally, many who were previously insured lost their health insurance when they changed jobs or were laid off from work.[9]

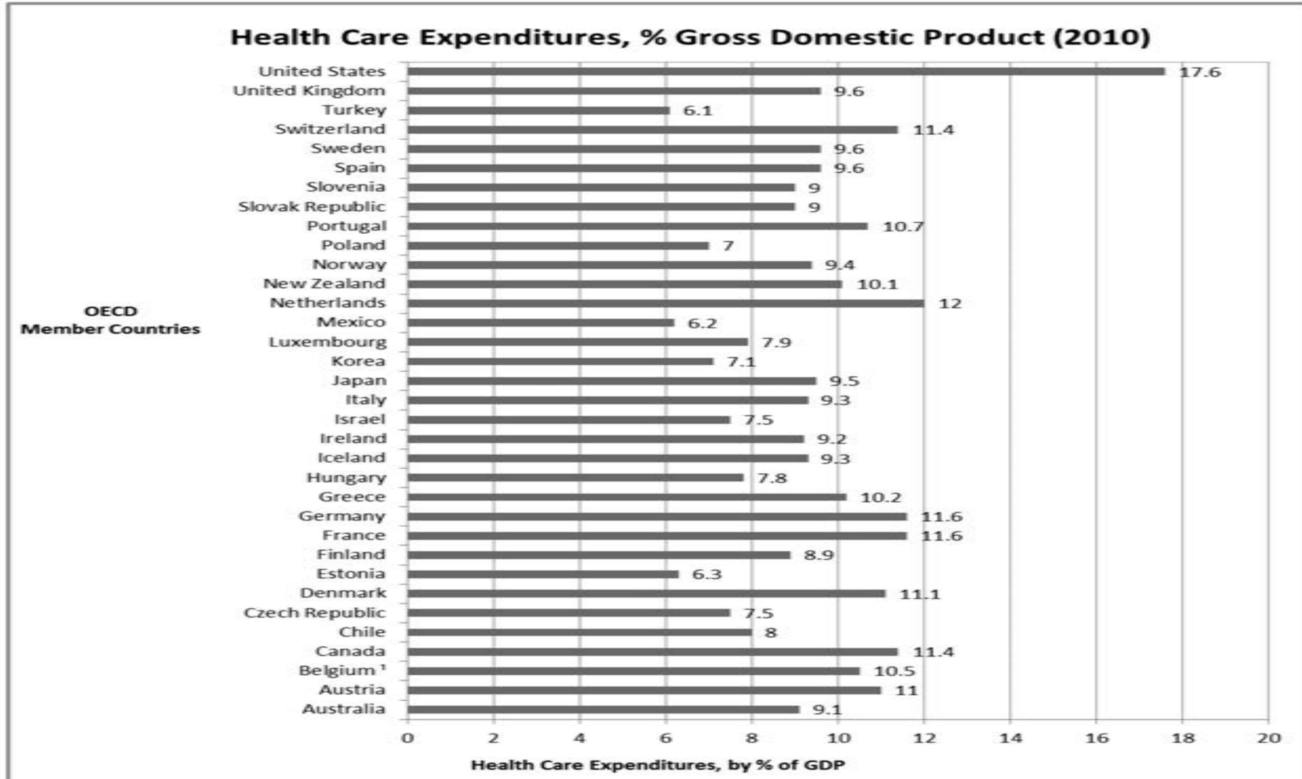
The mixed public-private health care system in the U.S. is the most expensive in the world, with *per capita* costs higher than those of any other nation. Data from the Organization for Economic Co-operation and Development (OECD) of the 34 member countries show that in 2010, the U.S. spent 17.6% of its gross domestic product (GDP) on health care while other member countries spent far less. (See Table 1.) The U.S. was followed by the Netherlands, which spent 12% of its GDP, and Germany and France, both of which spent 11.6% of their GDP on health care. More details are available at http://www.oecd.org/els/health-systems/health-data.htm. Within the United States, data from the Centers for Disease Control and Prevention (CDC) indicate that health care spending *per capita* (in dollars) climbed sharply from $147 in 1960 to $6,868 in 2005 and $8,402 in 2010.[10]

Consequences of Being Uninsured

The increasing costs of the U.S. health care system highlight many problems springing from the old model of health care, most importantly the effects it had on the uninsured. The Biennial Health Insurance Study (BHS) from the Commonwealth Fund found that 75 million people were carrying medical debt and 80 million were unable to afford care in 2012.[11] It can be inferred that when individuals have no health insurance they miss wellness or preventive visits and avoid physician visits until they are unavoidable. Without the use of various cost-effective preventive health maintenance services such

Table 1.

HEALTH CARE EXPENDITURES AS % GDP OF 34 COUNTRIES



Source: OECD Health Statistics 2013—Frequently Requested Data http://www.oecd.org/els/health-systems/oecdhealthdata2013-frequently requesteddata.htm

as routine physical examinations and laboratory tests, individuals tend to be subjected to more invasive and expensive procedures and therapies and to make more frequent visits to the emergency department. Consequently, there are worse health outcomes for patients accompanied by greater financial burden and extended financial liabilities, which are often passed on to the hospital, the community, and the government to cover gaps in payment for services.[7]

Goals of the Affordable Care Act

The purpose of health care reform is to increase access to health care while reducing or eliminating many of the consequences of not having health insurance. The Affordable Care Act ultimately seeks to provide health care coverage to more than 30 million Americans. It is to do this through provisions and plans for programs to improve the access to health insurance as well as to the quality of care. Two prominent goals of the ACA are to give American consumers more options for their health care and to prevent insurance companies from continuing potentially detrimental and unfair practices, such as denying coverage for pre-existing conditions. It is expected that these changes will not only provide more affordable options for health insurance but also greater coverage.[12]

As we suggested earlier, an important feature of the ACA is granting tax credits to both individuals and families (legal resident aliens and eligible citizens) to help make insurance affordable. Specifically, through the ACA refundable tax credits became available for Americans with incomes between 100% and 400% of the federal poverty line (FPL) (400% being approximately $88,000 for a family of four). These credits are to be calculated on a sliding scale, beginning at 2% of household income for those at 100% of the FPL and phasing out at (9.8%) of household income for those at 300–400% of the FPL. Tax credits are also being provided for employees choosing the insurance plan offered by their employers. If the insurance plan premium offered by a company

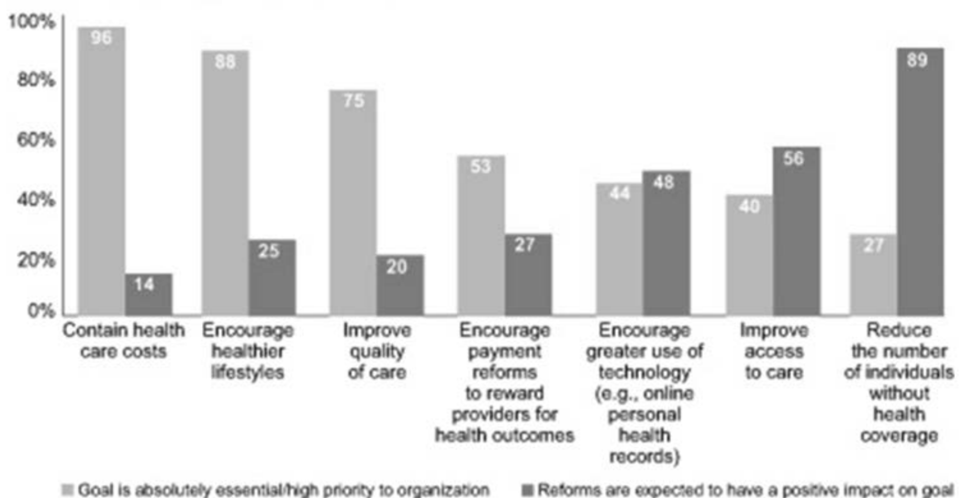


Figure 1. Importance and impact of health reform goals.
Source: Towers Watson © 2010

exceeds 9.8% of a worker's family income, or the employer contributes to less than 60% of the premium, the employee is eligible to enroll in an exchange and receive tax credits in order to help pay part of their insurance premiums. Additionally, the out-of-pocket maximum payments ($5,950 for individuals and $11,900 for families) have been decreased by one third for those with an income between 100–200% of FPL, by one half for those with incomes between 200–300% of FPL, and by two thirds for those with incomes between 300–400% of FPL. Furthermore, a new credit for up to 50% of the total premium cost is applied to assist small business owners that employ fewer than 25 workers.[13]

Health Insurance Exchanges in the ACA

A health insurance marketplace (i.e., an exchange) is a "one-stop shop" that allows individuals and small businesses the opportunity to compare and contrast several affordable health insurance plans that cover the essential health benefits enumerated earlier, and to choose the best one for their needs. The first open enrollment for state's marketplaces ran from October 1st 2013 to March 31st 2014. Open enrollment for 2015 runs from November 15th 2014 to January 15th 2015. States have either implemented a state-run exchange, or let the federal government run the health insurance exchange for them (through the U.S. Department of Health and Human Services). Some states have crafted their systems slightly differently by working with another state or the federal government. More details in this connection are available at http://obamacarefacts.com/state-health-insurance-exchange.php. Each individual state remains the primary regulator of its health insurance marketplace and the key player to enforce the federal laws put in place through the ACA to ensure that consumers are adequately protected.[14] Although states have the primary responsibility of enforcing federal health insurance law, federal regulators reserve the right to enforce proper operation of a marketplace in the event that a state fails to "substantially" enforce it. Furthermore, federal involvement could subject insurers to significant fines for failure to comply with the law.[15]

The Marketplace consists of plans for both individuals and small businesses; each state-run marketplace has created two exchanges: an American Health Benefits exchange for individuals, and a Small Business Health Options (SHOP) exchange for businesses with up to 100 employees. Individuals and small business employers can shop for health insurance from a range of health plans in each exchange. The marketplace is especially crucial for access to affordable and quality health care for those living in rural areas where many are uninsured. Rural areas also tend to have greater numbers of small businesses, as well as inhabitants who purchase health insurance on the individual market. If many of the issues states face as they develop their marketplaces are addressed successfully, then the necessary programs should be accessible for residents of all areas in the U.S. including those in rural areas.[16]

Impact of the ACA: Benefits and Drawbacks

The Congressional Budget Office (2013) estimates that the ACA will result in 37 million uninsured Americans gaining coverage. This foundation of increased insurance

coverage has been built on redesign and expansion of the small group and individual health insurance market (described above in health insurance marketplaces) as well as in an expansion of Medicaid (earlier discussed in our introduction).[17] Besides having the overarching effect of covering more individuals, the ACA has made a provision of $15 billion for a *Prevention and Public Health Fund*. Administered over the next 10 years, the fund is expected to improve health status through emphasis on preventive care.[18] Improved health status of the population should lead to cost savings for both states as well as the federal government.[5]

There are many other changes implemented through the ACA for primary care providers and preventive health services. Such changes will allow for evaluation of the effect of the Affordable Care Act on the field of Preventive Medicine.[19] Those overseeing the field will be able to consider the principal provisions of the ACA, differentiate rates of preventive health services, and examine the coverage of preventive health services under the Act. The new health insurance plans already cover recommended preventive services without cost-sharing, enabling more patients to receive essential health maintenance services.[20] Under the ACA, Americans now have better access to services such as blood pressure monitoring, diabetes and cholesterol screening, cancer screening, routine vaccinations, pre-natal care, and regular wellness visits for infants and children. The elimination of copayments, co-insurance, and deductibles should improve access to quality health care and help prevent or detect serious conditions before they are untreatable.[21]

The stipulation in its law that insurance companies are not to withhold coverage to individuals based on pre-existing conditions, mentioned earlier, is a central accomplishment of the ACA.[22,23] Additionally, the new law ensures health coverage for young adults under the age of 26 who are now able to stay on their parent's private insurance plan.[24] Furthermore, data provided by the White House show that more than 105 million Americans no longer have lifetime limits on their coverage, which means that costs will no longer be shifted to insured patients who accumulate expenses exceeding the dollar limits imposed by their insurance plans. Insurance companies may also not arbitrarily terminate an insured's policy without due cause. For more details on this point, visit http://www.whitehouse.gov/healthreform/health care-overview.

The ACA should improve the quality and efficacy of medical care in the U.S. at the very least for legal U.S. residents (there is currently limited federal coverage for lawfully present immigrants and undocumented immigrants), in particular those enrolled in Medicare and Medicaid (including many homeless people). The new law was written to strengthen the nation's primary care foundation by raising reimbursement rates for providers and introducing innovative delivery models such as patient-centered medical homes. A key provision of the law provides a 10% primary care bonus to clinicians who participate in the Medicare program. Medicaid payment rates to primary care physicians have also been increased to match Medicare levels. Patient-centered medical care homes will improve patient access to a regular source of primary care, provide a stable and ongoing relationship with a personal clinician as well as timely and well-organized health services that emphasize prevention and chronic care management. The Center for Medicare and Medicaid Innovation (CMMI) has been set up to conduct innovative payment and delivery system models that show promise for improving or maintaining

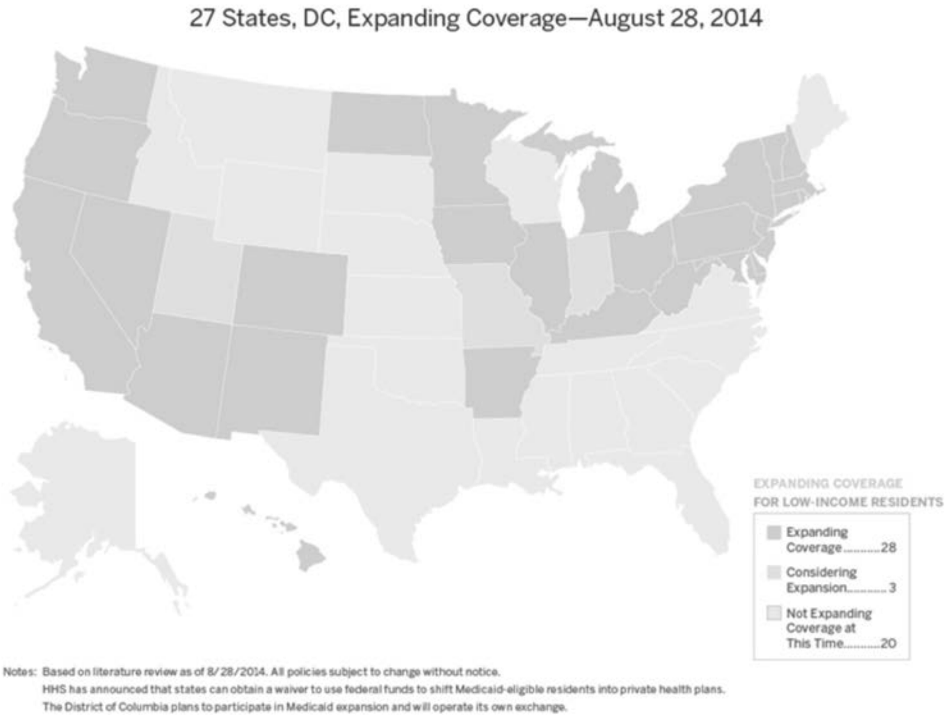


Figure 2. Where the states stand on Medicaid expansion.
Source: ©2014 The Advisory Board Company. All rights reserved.

the quality of care in Medicare, Medicaid, and the Children's Health Insurance Program (CHIP) while slowing the rate of cost growth.[21]

While there has been significant support and hope for the future of health care due to the successes already realized by the ACA, there has also been significant debate, opposition, and disapproval since its passage and implementation. One key issue involves states being allowed to opt out of Medicaid expansion. According to the Health Care Advisory Board, as of May 22, 2014, 27 states (including the District of Columbia) are participating, four states are considering expansion, and 20 states are not participating in Medicaid expansion. More details on this point are available at http://www.advisory.com/daily-briefing/resources/primers/medicaidmap.

As previously noted, Medicaid expansion under the ACA has states receive substantial federal funding to expand Medicaid to all residents with incomes at or below 133% (with an additional 5% income allowance, thus making the standard 138%) of the FPL (an income of about $31,809 for a family of four in 2012), thus expanding Medicaid coverage to individuals who had previously been left out of the program. With health insurance exchanges available to all legal residents and Medicare providing coverage for elderly adults, the addition of all low-income, non-elderly adults to Medicaid by the ACA should give almost the whole population access to affordable health insurance. The June 2012 Supreme Court decision in *National Federation of Independent Business v. Sebelius*, while largely upholding the constitutionality of the ACA, included protection

for states that chose not to expand their Medicaid programs. This provision has resulted in a substantial gap where the ACA as originally signed into law would have ensured much more comprehensive coverage for residents of the states choosing to opt out of Medicaid expansion. States not expanding Medicaid not only deny impoverished citizens the coverage that the federal government is willing to finance, but also leave many who are above the tax-filing threshold subject to the new tax on the uninsured. (There are no tax subsidies provided by the ACA to individuals below 100% of the poverty level given that these people were supposed to be covered by Medicaid.[25]) Another negative effect of states opting out of Medicaid expansion is that disproportionate-share hospitals in these states will feel more financial stress. These hospitals have been receiving payments from the federal government for the high proportion of uninsured persons for whom they provide, but will now see a drop in Medicaid and Medicare Disproportionate Care Hospital funds (due to the assumption by the ACA that the number of uninsured and underinsured would fall in all 50 states and D.C. beginning in 2014).[26] Because a huge proportion of the uninsured are mentally ill, the changes are likely to shut out needed access for this group that would have been otherwise covered had the state opted to expand Medicaid. Acute psychiatric care centers, and residential and outpatient services are also expected to be negatively affected.[27]

Impact on Psychiatric Services

According to the National Alliance of the Mentally Ill (NAMI), in 2011 there were 45.6 million adults with mental health or substance use disorders. Prior to implementation of the ACA, over 11 million (24%) of U.S. adults were affected by mental illness and lacked health coverage. The ACA offers new choices for quality, reliable, low cost private health insurance while opening up coverage to more people living with mental illness through the expansion of Medicaid. For more details, see http://www.nami.org/Content/NavigationMenu/Inform_Yourself/About_Public_Policy/Issue_Spotlights/Health_Care_Reform/ACA-FactSheet1_HealthReformMH.pdf.

The ACA builds on the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) which had been the first step in bringing care for people with mental health and addiction disorders into the mainstream of the U.S. medical care system by requiring parity in behavioral health coverage (benefits for mental health and substance abuse equivalent to all other medical and surgical benefits). Going beyond the federal parity law, the ACA requires that Medicaid plans as well as plans operating through the state-based insurance exchanges cover behavioral health services as one of the 10 required components of the essential benefits package. In combination the two laws mandate coverage of mental health and substance abuse services on a par with medical and surgical care for all those gaining coverage through the exchanges and the Medicaid expansion. Additionally, the ACA's delivery-system reforms seek to address long-standing system fragmentation. There has been a lack of integration of primary care and specialty behavioral health care and poor coordination for patients with coexisting mental health and addiction disorders.[28] Clinical trials of integrated behavioral health and primary care models have demonstrated improvements in physical health as well as mental health. People with mental illness and substance use

disorders have high mortality, poor health outcomes, and face significant barriers to care. They experience high incidence and prevalence of preventable physical health conditions including cardiovascular and respiratory diseases, diabetes, and HIV. Co-occurring disorders are associated with high levels of both emergency department use and unmet treatment needs. Under the ACA there are provisions that may lead to greater integration and in turn bode well for improving coordination and quality of care. Croft organizes these elements into three domains: increasing access, financing and reimbursement changes, and infrastructure enhancements.[27] Access is a critical prerequisite to successful integration of care. The ACA should increase access through expanding Medicaid, extending essential health benefits (including mental health care at parity), and researching and tracking disparities to shape future policy and practice changes for improving access. Patient-centered medical homes, accountable care organizations (ACOs, groups of health care providers that enter in collaborative agreements to share responsibility to improve quality and control costs), increased reimbursement for primary care providers (described above in the section on the impact of the ACA), and co-location of primary care and behavioral health services are all changes in the financing and reimbursement structure that have the potential to move systems toward integration. Finally, several elements of the ACA may enhance infrastructure supporting integrated care. The Community-based Collaborative Care Network Program established under the ACA promises to support a consortium of providers to coordinate and integrate services for low-income uninsured and under-insured populations. Additionally, the Federal Coordinated Health Care Office monitors progress and provides technical assistance to states health plans, and to physicians to develop more integrated programs of care, in particular, helping the mentally ill disabled who are dually eligible for Medicare and Medicaid services to navigate both insurance systems.[27]

Preventive psychiatric services are also an area of focus, and some of the new provisions for services include alcohol misuse screening and counseling for adults; depression screening for adults and adolescents; domestic and interpersonal violence screening and counseling for all women; tobacco use screening for all adults and cessation interventions; alcohol and drug use assessments for adolescents; autism screening for children 18-24 months; behavioral assessments for children of all ages; developmental screening for children under age three years, and surveillance throughout childhood. These new provisions clearly increase access to behavioral health care and should go a long way towards narrowing health care disparities.[9]

Alegria and colleagues conclude that the ACA's policies and provisions to improve patient education and the availability of community clinics, combined with insurance coverage should reduce service disparities across racial/ethnic groups. However, even with expanded insurance coverage, approximately 10% fewer African Americans with need for behavioral health services are likely to receive services compared to non-Latino Whites (Latinos have no measurable disparity). This suggests that it may be necessary to employ targeted services to reduce barriers to different groups, by such measures as the creation of more community health centers in areas predominantly populated by African Americans.[29]

Conclusion

The Affordable Care Act promises to make the health care system better for millions of Americans, most notably by allowing young adults to remain on their parents insurance, ending lifetime limits to insurance coverage, and the ability of insurance companies to deny coverage based on pre-existing conditions. In taking measures to improve access to insurance, strengthen Medicare and Medicaid, reduce health care expenditures, in part, by placing greater emphasis on preventive care, the ACA should positively affect the system of health care delivery in the United States. The provisions for expansion of mental health care on a par with other kinds of care combined with the initiatives for integration of behavioral health and primary care that should improve coordination and quality of care, in turn, should improve both physical health as well as mental health. Disputes continue over many issues, in particular the continued lack of access caused by states opting not to expand the Medicaid program. Weighing both sides, the question remains if the reality of the policies instituted can live up to the great promise of the ACA, and ultimately strengthen the U.S. health care system.

References

1. Blumberg LJ, Holahan J, Buettgens M. Its no contest: the ACA's employer mandate has far less effect on coverage and costs than the individual mandate. Washington, DC: The Urban Institute, 2013. Available at: http://www.urban.org/UploadedPDF/412865-ACA-Employer-Mandate.pdf.
2. Greenhalgh M. The Affordable Care Act: Medicaid expansion & healthcare exchanges. Washington, DC: American Academy of Family Physicians, 2014:1–13. Available at: http://www.aafp.org/dam/AAFP/documents/advocacy/coverage/aca/ES-MedicaidExpansion.pdf.
3. Chockley N, Murphy B, Schoenman J. Understanding the uninsured: tailoring policy solutions for different subpopulations. Washington, DC: National Institute for Health Care Management Research and Educational Foundation (NIHCM), 2008.
4. Garfield RL, Lave JR, Donohue JM. Health reform and the scope of benefits for mental health and substance use disorder services. Psychiatr Serv. 2010 Nov;61(11):1081–6. http://dx.doi.org/10.1176/appi.ps.61.11.1081; PMid:21041345
5. DeNavas-Walt C, Proctor BD, Smith JC. Income, poverty, and health insurance coverage in the United States: 2011. Washington, DC: U. S. Census Bureau, 2012.
6. Baicker K, Congdon WJ, Mullainathan S. Health insurance coverage and take-up: lessons from behavioral economics. Milbank Q. 2012 Mar;90(1):107–34. http://dx.doi.org/10.1111/j.1468-0009.2011.00656.x; PMid:22428694 PMCid:PMC3385021
7. Wilper AP, Woolhandler S, Lasser KE, et al. Health insurance and mortality in US adults. Am J Public Health. 2009 Dec;99(12):2289–95. Epub 2009 Sep 17. http://dx.doi.org/10.2105/AJPH.2008.157685; PMid:19762659 PMCid:PMC2775760
8. Sommers BD, Long SK, Baicker K. Changes in mortality after Massachusetts health care reform: a quasi-experimental study. Ann Intern Med. 2014 May 6;160(9):585–93. http://dx.doi.org/10.7326/M13-2275; PMid:24798521
9. Gauthier A, Cullen A. Reforming health care delivery thorough payment change and transparency: Minnesota's innovation. Washington, DC: National Academy

for State Health Policy, 2010. Available at: http://www.nashp.org/sites/default/files/Health_Care_MN_2010.pdf.
10. National Center for Health Statistics. Health, United States, 2011: with special feature on socioeconomic status and health. Hyattsville, MD: National Center for Health Statistics, 2012. Available at: http://www.cdc.gov/nchs/data/hus/hus11.pdf.
11. The Commonwealth Fund. New health insurance survey: 84 million people were uninsured for a time or underinsured in 2012; nearly decade-long trend of rising uninsured rates among young adults reversed. Washington, DC: The Commonwealth Fund, 2013. Available at: http://www.commonwealthfund.org/~/media/files/news/news-releases/2013/apr/biennial-release-42613-final-rev-2.pdf.
12. McDonough JE. The road ahead for the Affordable Care Act. N Engl J Med. 2012 Jul 19;367(3):199–201. http://dx.doi.org/10.1056/NEJMp1206845; PMid:22747178
13. Garner D, Wakefield M, Tyler TG, et al. Health care access and insurance availability in Nevada. In: Shalin D, ed. The social health of Nevada: leading indicators and quality of life in the silver state. Las Vegas, NV: UNLV Center for Democratic Culture, 2012. Available at: http://cdclv.unlv.edu/healthnv2012/index.html.
14. Keith K, Lucia KW. Implementing the Affordable Care Act: the state of the states. Washington, DC: The Commonwealth Fund, 2014. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Fund%20Report/2014/Jan/1727_Keith_implementing_ACA_state_of_states.pdf.
15. Keith K, Lucia KW, Corlette S. Realizing health reform's potential. Implementing the Affordable Care Act: state action on the 2014 market reforms. Washington, DC: The Commonwealth Fund, 2013. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/1662_Keith_implementing_ACA_state_action_2014_reform_brief_v2.pdf.
16. Bailey JM. Affordable Care Act, what's in it? Health insurance exchanges that work for rural. Lyons, NE: Center for Rural Affairs, 2011. Available at: http://files.cfra.org/pdf/Health-Insurance-Exchanges.pdf.
17. Frank RG, Beronio K, Glied SA. Behavioral health parity and the Affordable Care Act. J Soc Work Disabil Rehabil. 2014;13(1–2):31–43. http://dx.doi.org/10.1080/1536710X.2013.870512; PMid:24483783
18. Preston CM, Alexander M. Prevention in the United States Affordable Care Act. J Prev Med Public Health. 2010 Nov;43(6):455–8. http://dx.doi.org/10.3961/jpmph.2010.43.6.455; PMid:21139405
19. Cogan JA Jr. The Affordable Care Act's preventive services mandate: breaking down the barriers to nationwide access to preventive services. J Law Med Ethics. 2011 Fall;39(3):355–65. PMid:21871033
20. Collins SR, Robertson R, Garber T, et al. Gaps in health insurance: why so many Americans experience breaks in coverage and how the Affordable Care Act will help. Findings from the Commonwealth Fund Health Insurance Tracking Survey of U.S. Adults, 2011. Washington, DC: The Commonwealth Fund, 2012. Available at: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Apr/1594_collins_gaps_in_hlt_ins_tracking_brief_v2.pdf.
21. Davis K, Abrams M, Stremikis K. How the Affordable Care Act will strengthen the nation's primary care foundation. J Gen Intern Med. 2011 Oct;26(10):1201–3. Epub 2011 Apr 27. http://dx.doi.org/10.1007/s11606-011-1720-y; PMid:21523495 PMCid:PMC3181291
22. Newacheck PW, Stoddard JJ, Hughes DC, et al. Health insurance and access to pri-

mary care for children. N Engl J Med. 1998 Feb 19;338(8):513–9. http://dx.doi.org/10.1056/NEJM199802193380806; PMid:9468469

23. Lee MA Jr. Adverse reactions: structure, philosophy, and outcomes of the patient protection and Affordable Care Act. New Haven, CT: Yale Law School, 2010. Available at: http://digitalcommons.law.yale.edu/cgi/viewcontent.cgi?article=1105&context=student_papers.
24. Cantor JC, Monheit AC, DeLia D, et al. Early impact of the Affordable Care Act on health insurance coverage of young adults. Heath Serv Res. 2012 Oct;47(5):1773–90. Epub 2012 Aug 27. http://dx.doi.org/10.1111/j.1475-6773.2012.01458.x; PMid:22924684 PMCid:PMC3513605
25. Miller JE, Lentz C, Maududi N, et al. The waterfall effect: transformative impacts of Medicaid expansion on states. Alexandria, VA: National Association of State Mental Health Program Directors, 2013. Available at: http://www.nasmhpd.org/docs/publications/NASMHPDMedicaidExpansionReportFinal.pdf.
26. Davis C. Q & A: Disproportionate share hospital payments and the Medicaid expansion. Washington, DC: National Health Law Program, 2012. Available at: http://www.apha.org/NR/rdonlyres/328D24F3-9C75-4CC5-9494-7F1532EE828A/0/NHELP_DSH_QA_final.pdf.
27. Croft B, Parish SL. Care integration in the Patient Protection and Affordable Care Act: implications for behavioral health. Adm Policy Ment Health. 2013 Jul;40(4):258–63. http://dx.doi.org/10.1007/s10488-012-0405-0; PMid:22371190 PMCid:PMC3888027
28. Barry CL, Huskamp HA. Moving beyond parity-mental health and addiction care under the ACA. N Engl J Med. 2011 Sep 15;365(11):973–5. Epub 2011 Aug 17. http://dx.doi.org/10.1056/NEJMp1108649; PMid:21848453 PMCid:PMC3359059
29. Alegria M, Lin J, Chen CN, et al. The impact of insurance coverage in diminishing racial and ethnic disparities in behavioral health services. Health Serv Res. 2012 Jun;47(3 Part 2):1322–44. Epub 2012 Mar 30. http://dx.doi.org/10.1111/j.1475-6773.2012.01403.x; PMid:22568675 PMCid:PMC3418830

Reproduced with permission of the copyright owner. Further reproduction prohibited without permission.