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What Does the Affordable Care Act Mean for Nursing?

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Nurses are ethically bound to engage in efforts of improving health and healthcare delivery and, even more important, nurses recently have been called out as key leaders in the reform of healthcare delivery, including many components of the Patient Protection and Affordable Care Act. The Patient Protection and Affordable Care Act, its history, and what healthcare will look like during and after implementation are addressed in this article. A discussion of the role and value of nurses in healthcare reform accompanies knowledge-building and action-oriented resources available to nurses and clients.

As nurses, we are watching and experiencing healthcare reform as both professionals and citizens. The nursing profession is now placed in a unique position to facilitate development of patient coordination including identification of key points in client care to manage wellness and illness as well as systematic measurement of health outcomes. In this article, we present a review of the Patient Protection and Affordable Care Act (ACA).

When President Obama signed the Patient Protection and Affordable Care Act on March 23, 2010, a collection of laws was created that, as a whole, put in place comprehensive healthcare and health insurance reform. The development of these laws began much earlier with legislation and regulation designed to create a patient's a bill of rights, encourage the use of evidence-based best practices, and increase access to affordable healthcare. The resulting ACA legislation focused on building change into our existing system and is the most significant reform of how we pay for and deliver healthcare since the 1965 adoption of Medicare and Medicaid (Jost, 2014). This legislation represents a complex series of changes.

The major goals of the ACA are to build on our current system by (1) expanding Medicaid, (2) preserving both employer/job-based coverage and Medicare, and (3) promoting state control of insurance markets. The ACA has had early success in implementing these reforms and preserving the structure of care (Jost, 2014). Thirty-four percent of new enrollees are under 34 years of age; during the first enrollment period, more than 8 million people have obtained coverage through the ACA Health Insurance MarketPlace, and even many more private pay nonelderly people are covered with insurance they have personally selected and are personally paying for (Congressional Budget Office, 2014). It is predicted that new and younger people entering the healthcare market will drive the costs of healthcare down. Recent analysis by the Congressional Budget Office now predicts that the costs of implementing the ACA are even lower than previously reported (Stein & Young, 2014). Still, to date, many of the benefits of the ACA remain largely unseen.

The costs of delivering healthcare in our country have become a major concern, with the overall costs of now at 23% of the federal budget and 20% of most household budgets (Centers for Medicare and Medicaid Services, 2014; Hartman, Martin, Benson, & Catlin, 2013). Healthcare costs have risen to a point that 32% of people with insurance have difficulty paying their medicals bills, must pay healthcare over time, or are unable to pay at all (Pollitz & Cox, 2014). The No. 1 cause of personal bankruptcy for middle-class, insured, working U.S. citizens is healthcare costs (Himmelstein, Thorne, Warren, & Woolhandler, 2009). By addressing the cost of healthcare, as well as issues of access to healthcare, better health and financial stability are possible for individuals, businesses, and government.

Historically, U.S. healthcare has been complicated by the inherent competition set up between systems of payers, providers, users, and regulators. Effective healthcare and good and affordable health for any population result from high-quality, affordable, and accessible care (Lamb, 2014). These three points are frequently represented by disparate and disconnected industries, often industries that are competing with each other rather than working together to maintain good health for their clients. The "triple aim" of health reform, and of the ACA, is to (1) improve the patient experience with higher quality care, (2) increase access to care, and (3) control healthcare costs (Institute of

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Medicine, 2011). The ACA has attempted to deal with more than just payment and cost of healthcare by improving the quality of care delivered and access to preventive care and early intervention.

Competition between disconnected organizations is demonstrated in our traditional fee-for-service healthcare system. When more services are provided, more revenue is generated. But more care does not necessarily result in higher quality care or better health outcomes. Services must represent appropriate interventions and expected outcome based on the client's goals of care. While quality is inherently measured and valued in healthcare, it has not often been paid for or incentivized. The economic risks of healthcare costs have traditionally fallen most heavily on third party payers (insurers and the state and federal governments), not the providers.

The ACA and the New Roles for Nurses

The ACA promotes healthcare that is designed within coordinated, orchestrated, and value-based care models. Value-based care incentivizes healthcare providers to keep population groups healthy by focusing on outcomes of care rather than volume of service of care. Value-based care incentivizes healthcare organizations to meet benchmark health outcomes for their clients. This also creates healthcare systems that are focused on wellness, prevention, minimizing repetition, and unnecessary costs. Nurses are key players in this component of healthcare reform. Uniquely situated on the front lines of patient care, as well as within healthcare payer and supplier agencies, nurses have the expertise and obligation to influence practice and policy (Institute of Medicine, 2011). Nurses promote health, navigate chronic illness, and prevent the development of secondary conditions, all of which align with the triple aims of healthcare reform.

As hospitals, insurance providers, and provider groups align to be a part of value-based payment systems, the roles of nurses become integral to promoting these changes. Care managers, care coordinators, and informatics experts—*nurses*—are vital leadership for directing care process changes, quality and evidence-based interventions, and measurement of care outcomes (Lamb, 2014). Nurses have a demonstrated history of leadership in team-based care processes. Nurses have patient-centered care as a core professional standard and competency. Nurses are pivotal to care quality and patient satisfaction, as well as efficacious use of resources to provide patient-centered and evidence-based care.

What Are the Health Insurance MarketPlaces?

Health Insurance MarketPlaces are centralized sources for state-level information on the options and costs for individuals and small businesses when purchasing affordable healthcare coverage. Individuals use the MarketPlace to determine whether they qualify for insurance premium subsidies (subsidies are cost sharing reductions or government-sponsored programs based on income). People living between 130% and 400% of the Federal Poverty Level typically qualify for subsidized policies (Sommers, Graves, Swartz, & Rosenbaum, 2014). States were given the option to develop their own State MarketPlace or to use a state-based but federally developed MarketPlace. In October 2013, the Federal MarketPlace launched with many technical challenges. Yet most stat-developed MarketPlaces were up and functioning with little problems. As of May 2014, more than 8 million new, subsidized enrollees were processed through the MarketPlace and, unexpectedly, more than 12 million private, self-pay clients found affordable healthcare they could purchase (Stein & Young, 2014). People will continue to access the online MarketPlace individually but in-person navigators are also available to help individuals understand their options and the enrollment process. Open enrollment via the MarketPlaces officially closed March 31, 2014. Until the next open enrollment period, the MarketPlace remains open for enrollment for individuals and families experiencing qualifying events such as job loss and changes to family composition.

Sources for Educating Ourselves and Our Clients

As nurses, we are always challenged to teach clients about the healthcare delivery system and the ACA has

Table 1. Definitions

Cost-sharing reduction	A discount given for insurance through the MarketPlace exchanges based on income and health plan type
Deductible	The amount the consumer owes for services before the health plan will begin to pay
Federal poverty level	Levels of personal income used to determine a client's eligibility for Medicaid, Children's Health Insurance Program, and Subsidized Coverage of ACA
Fee-for-service	Paying providers for each service they perform rather than the quality of services provided
Job-based coverage	Insurance coverage offered to employees and often their dependents
MarketPlace	A resource to learn about coverage options, compare plans, and enroll. Some are run by the state and others by the federal government
Navigator	Trained individual or organization to help consumers and small businesses look for healthcare coverage. Services are free to consumers
Qualified health plan	An insurance plan certified to provide the essential benefits and established limits on costs such as deductibles, copay, out-of-pocket
Value-based care	Linking provider payments for services to the quality of care they provide

Table 2. Links for Client Questions

www.healthcare.gov	Need to get ready to enroll? Or, find a local navigator?
	Why should a client be covered?
	What are different types of health insurance?
www.dol.gov	Consumer Information on the Affordable Care Act

significantly increased the need for these efforts. Many clients are confused with their options and the processes for obtaining and accessing health coverage. For example, new users may be surprised that the plans they selected are low cost in monthly premiums and unaware those will typically translate to higher deductibles, even though the deductibles are typically below policies outside of those offered at the MarketPlace (Jost, 2014). Nurses may find themselves overwhelmed by the education and information needs of their clients. Below are three tables: a list of definitions (see Table 1) and lists of resources for client questions (see Table 2) and valuable resources for you as a nurse (see Table 3).

Are There New Services Offered Under the ACA?

There are new requirements for the healthcare benefits offered in any Qualified Health Plan. Enrollment in a Qualified Health Plan is required by the Individual Mandate of the ACA. No longer can policies be offered that do not provide "Essential Benefits" such as preventive care or comprehensive care or maternity benefits, for example (see Table 4). Previous to the ACA individual insurance policies often lacked these basic levels of coverage. Coverage of the essential health benefits, as mandated under the ACA laws and regulations, expanded effective and affordable, quality healthcare coverage for millions of Americans, but some have predicted this may also drive up costs of insurance premiums. This controversy continues to play out in the reform debate, but what is also being discovered is how many people were purchasing ineffective, low-cost/low-benefit policies that actually did not save them money when they needed coverage for essential services.

Interesting components of these essential services are worthy of discussion. For instance, the additional requirement of mental health and behavioral health, including counseling and psychotherapy, has resulted in many primary care organizations developing integrated physical and mental health services for their clients. Those with chronic illness now have access to ongoing therapy services to help them achieve optimal function. New wellness and prevention and behavioral health services are quickly being expanded into the traditional service lines of primary care, medical homes, family practice, and outpatient services.

Key Elements of an Accountability Care Organization

Accountable care organizations (ACOs), a Medicare Pilot Program under the ACA, is a way of organizing care delivery that establishes a system of value-based payment contracts for large populations of the insured. The ACO model allows Medicare, and other payors of healthcare, to contract with providers for services based upon benchmark health outcomes for their clients. Though still a fee-for-service model, the ACO payment structure is based on financial incentives to improve benchmarks. For example, an ACO may negotiate that a majority of their clients will have controlled blood pressure levels. If the ACO attains the agreed-upon benchmark for their population of their clients, the ACO will share in the savings achieved rather than the insurer keeping all those savings. Incentivized, benchmarked, value-based outcomes system is the heart of creating an ACO framework as a method of healthcare reform.

To set and measure benchmarks for quality and cost, we must first reach agreement on accurate measures of quality. This requires available informatics systems capable of tracking and reporting outcomes data in an ACO. This highlights the importance of new health information technology requirements rolled out in the ACA. Many clinical groups and providers did not have

Table 3. Valuable Links for Healthcare Reform Resources

American Nurses Association: "professional organization representing the interests of the nation's 3.1 million registered nurses"	http://www.nursingworld.org/
Centers for Medicare and Medicaid Services: governmental website with client and provider Medicare and Medicaid information	http://www.cms.gov/
Institute of Medicine: "an independent, non-profit organization working outside of government to provide unbiased and authoritative advice ftor decision makers and the public"	http://www.iom.edu/
Kaiser Family Foundation: an independent, non-profit foundation focusing on providing research and knowledge about major healthcare issues	http://kff.org/ http://kff.org/health-reform/faq/health-reform-frequently-asked-questions/
National Council of Nonprofits: a resource and advocate for nonprofit agencies	http://www.councilofnonprofits.org/public-policy/federal-policy-issues/health-care-reform
U.S. Department of Labor: information related to employment-based health plan coverage related to the ACA	http://www.dol.gov/ebsa/healthreform/

Table 4. Essential Health Plans Benefits Must Include

Ambulatory services
Emergency services
Hospitalizations
Maternity and newborn care
Mental health and substance use disorder services including behavioral health treatment
Prescription drugs
Rehabilitation and habilitation services
Laboratory services
Preventative and wellness services

adequate systems for ACO participation; thus, the ACA also offered provider networks funding to upgrade and implement information systems.

An ideal model for healthcare delivery reform addresses four key concepts integral to the sustainability: (1) access, (2) care coordination, (3) healthcare information technology, and (4) payment reform (Patient-Centered Primary Care Collaborative, 2011). Table 5 briefly presents these concepts based on what we know from trends, data, and evidence (Patient-Centered Primary Care Collaborative, 2011).

Nursing and Integrated Care Teams and ACOs

For nurses, being a part of an ACO means being a part of integrated, interdisciplinary teams collecting measurements of health outcomes, being aware of how those outcomes are cared for in their system, and assuring the interventions provided to clients are effective, efficacious, and evidence-based. Important to nursing and healthcare science is that we focus on preventing illness and promoting wellness in our care teams by using evidence-based strategies (Grady, 2014). Integrated teams of care providers will play a major role in applying evidence-based practice to the populations we care for.

Now as new services become available to our clients, such as behavioral and mental health, care teams are challenged to integrate services across disciplines. Coverage of obesity counseling for orthopaedic clients can be paid for under the ACA, coverage for substance abuse, smoking cessation, or other services not previously covered services, are now being provided. This pushes us as nurses to care for our clients in more holistically ways, rather than providing only sick care specialty services as we may have in the past. As the client moves between all types of care services offered, care managers will be monitoring health outcomes and connecting to services. For example, a nurse in an outpatient orthopaedic clinic or a clinician at a behavioral health counseling session could also be monitoring and coordinating efforts to address a client's hypertension.

Integrated clinics specializing in personalized healthcare are showing up in our communities. Integrated care means that nurses may be working in an internal medicine clinic as a care manager, navigating patients through bundled care services and assuring the care bundle developed by their organization are being completed for each client. An integrated, personalized care structure may mean that all the diabetic clients of the clinic's population have a group of ideal outcomes to be accomplished such as controlled A1C levels less than 8%, blood pressure levels less than 140/90 mm Hg, low-density lipoprotein level less than 100, microalbumin check yearly, and eye examination yearly. A variety of clinicians are needed to achieve the goals of this care bundle. To support measuring the outcomes of a bundle, systems need informatics, tracking, assessment, and a team of coordinated care providers. Care managers will be monitoring all of the clients, but they may be supervising medical assistants calling clients for check-ins or scheduling appointments; thus, leaving their time for one-on-one sessions reviewing needed teaching or scheduling a healthcare advocate to make home visits to assess a client's falls risk.

Healthcare providers are becoming connected in new ways. One example may be that the pharmacy would note that a client has not picked up a refill of a medication, and alert the care management team to initiate a call to the client to see what they can do to help the client stay on their medications. Another form of connection would be a care manager alerting a primary care provider when their clients are within the goals of health outcomes and prompt the primary care providers about what could be discussed or revised for the client to improve these goals. Gone are the days when one care provider can be expected to track, remember, and measure all of the outcomes that are now known as basic care for diagnoses or conditions. Teams are needed to provide quality, evidence-based best practices, examine evidence, make system changes, and ultimately interface with the client to bring quality healthcare to their lives.

Table 5. Key Elements of an Affordability Care Organization

Access	Addressing access to primary care providers means to have off-hours or same-day access as improving those decreases emergency department use and improves patient and clinician satisfaction.
Care coordination	Care coordination improves exchanging information between systems and improving accountability of systems to each other and to their clients.
Health information technology	Healthcare information technology offers healthcare providers immense outcomes tracking as well as innovative clinician–provider communication and ultimately improves patient self-management.
Payment reform	Quality is rewarded over quality in a new value-based, shared outcomes setting. Many valuable but unreimbursed services can be provided included such as e-visits and phone visits; RN, pharmacy, health educators, and coaches.

Note. Data from Patient-Center Primary Care Collaborative, 2011. Retrieved from http://www.pcpcc.org/sites/default/files/media/better_best_guide_full_2011.pdf

The examples described previously highlight where nurses are uniquely situated to affect patient outcomes within the work of an ACO. Nurses possess a theoretical base of biophysical, psychosocial, and developmental knowledge. Nurses, in these roles, must expand their skills to effectively support behavior change in clients to achieve quality health outcomes, skills such as motivational interviewing, understanding the stages of change, knowing the challenges of an individual's personal development, and being an expert in interprofessional communication are essential. All are skills that nurses have and can continue to develop.

Conclusion

The ACA of 2010 enacted a large group of laws that brought change to processes, systems, payers, and users of healthcare. This is not the first time that reform of our private, market-based healthcare system has been attempted. Presidents Teddy and Franklin Roosevelt, Harry Truman, John F. Kennedy, Richard Nixon, and Bill Clinton all ventured into lobbying and legislation for reforming healthcare delivery. These leaders, and others, settled for incremental changes to the system and no comprehensive reform occurred; this left us with fractured, disconnected, and competing systems paying and providing healthcare to our nation. This magnitude of collaboration and broad inclusion of stakeholders of the ACA is creating forward thinking health planning and something that will most likely be seen as uniquely American.

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