The Patient Protection and Affordable Care Act
Implications for Geriatric Nurses and Patients

The Patient Protection and Affordable Care Act (PPACA), which became law in 2010 and was recently upheld on June 28, 2012, by the Supreme Court, addresses a number of significant changes in health care access and services in the United States (National Federation on Independent Business Et Al. v. Sebelius Et Al., 2012; U.S. Department of Health and Human Services [USDHHS], 2012a). As the nation faces full implementation of the PPACA by 2014, it is imperative that nurses who care for older adults have a firm understanding of the implications of this legislation on our practice and research.

To a great extent, no one—policy makers, health care professionals, providers, and consumers—can easily predict what health care services will look like over the next 5 years. Simply, we know this legislation has put levers in place to increase access to care and create opportunities for quality, preventive services, efficiencies, and innovations. However, it will be up to all stakeholders, especially nurses—the largest and most ubiquitous members of the health care workforce—to create the future for care. As geriatric nurses, we are responsible for understanding the changes in this health care law that will have the greatest effect on you and your patients so you can best advocate for them. Therefore, the following outlines the major changes affecting geriatric nurses and patients.

INDIVIDUAL MANDATE AND INCREASED COVERAGE

The most significant aspect of the PPACA and subsequent Supreme Court ruling was the upholding of the individual mandate and expanded coverage of health care services. The individual mandate requires that all individuals obtain a prescribed level of health insurance or have a financial penalty levied on them when they submit their annual federal income tax return (Patient Protection and Affordable Care Act, 2010). Moreover, to address gaps in coverage, Medicaid coverage was expanded so more individuals with disabilities or younger than 65 would meet eligibility requirements, and insurance providers are now...
prohibited from denying coverage or charging higher fees based on health conditions.

As a result, it is predicted that the 49 million people who are currently uninsured will be reduced by half following the 2014 implementation of efforts to establish the individual mandate, provide increases in Medicaid eligibility, and prevent insurers from denying coverage or charging higher fees based on health status (Kaiser Family Foundation, 2011).

For those younger than 65, improvement in access to preventive services and management of chronic disease may lead to better functional and physical health as they enter their senior years. This includes family caregivers of older adults who have struggled with health problems as caregivers.

INNOVATIONS IN CARE DELIVERY AND PAYMENT

The Center for Medicare and Medicaid Innovation (CMMI) was established by the PPACA to develop, implement, and coordinate proposals in innovations that could ultimately be widely adapted. The CMMI’s mission focuses on “better healthcare... better health...lower costs through improvement (Centers for Medicare & Medicaid Services [CMS], 2012a, para. 3). Models of care that address care coordination, transitions in care, and hold providers accountable include Accountable Care Organizations (ACOs) and Programs for All-Inclusive Care of the Elderly (PACE).

PACE was established throughout the country, prior to the PPACA, to provide coordinated, comprehensive care of nursing home-eligible older adults in their homes and has shown to improve quality while simultaneously decreasing costs (Hirth, Baskins, & Dever-Bumba, 2009). Expansion of PACE programs is currently being evaluated by the new Medicare and Medicaid Coordination Office, also established by the PPACA.

An ACO is a network of health care and hospitals that share responsibility for the care of a beneficiary and must have a minimum of 5,000 patients on its panel (Claffey, Agostini, Collet, Reisman, & Krakauer, 2012). Originating in state Medicaid programs, Pioneer ACO Models (32 in all) are now being tested for 850,000 older adults and are projected to save Medicare $1.1 billion over 5 years (CMS, 2012b). As coordinated care models, such as ACOs, take a strong hold in health care delivery in the United States, nurses and advanced practice nurses in home care, care coordination, transitional care, and primary care for older adults are—and will be—needed to take these pioneer models to scale (Kaiser Family Foundation, 2011).

For primary care providers and nurses in community health, there are now better opportunities to address prevention and wellness, as an annual wellness visit to the patient’s primary care provider is fully covered under Medicare Part B. Other preventive services now also covered without a co-pay by Medicare include influenza, pneumococcal pneumonia, and hepatitis B vaccination; tobacco cessation counseling; and preventive screenings, including bone density, cholesterol, Pap smears, diabetes, mammograms, and medical nutrition therapy for those with diabetes or kidney disease. The goal is that fully funding these preventive services will lead to decreases in morbidity, mortality, and costs over time (Sabatino et al., 2012). In 2011, after the change in law went into effect, more than 32.5 million Medicare beneficiaries received at least one preventive benefit free of charge (USDHHS, 2012b).

NURSING EDUCATION

The PPACA also provides geriatric nurses with numerous opportunities to advance their education. The PPACA increases funding and eligibility for a number of programs that pay for or subsidize costs for nurses returning for baccalaureate or graduate education, including the nurse student loan program, nursing workforce diversity program, and nurse faculty loan program. Additionally, the PPACA expands the public health workforce, which repays loans for nurse practitioners upon graduation with a 2-year service commitment (Wakefield, 2010).
MEDICARE PART D
Prior to the PPACA, when older adults reached a certain pre-determined level of spending on prescription drugs under Medicare Part D, they had to pay all costs over that amount related to prescription drugs until they spent a certain amount out of pocket. This out-of-pocket cost in the middle was known as a “donut hole.” This caused many older adults to not take their medication or ration their medications, potentially leading to increases in hospitalizations and costs (Gu, Zeng, Patel, & Tripoli, 2010). The PPACA has already decreased costs when older adults reach the “donut hole” in Medicare Part D both through requiring discounts from drug manufacturers and shrinking the donut hole (Kaiser Family Foundation, 2012).

NURSING HOME TRANSPARENCY
To address transparency and quality of care in nursing homes, the PPACA will require that nursing homes disclose the identities of owners and operators, which increases accountability when fines or lawsuits are filed for malpractice or substandard care. It will also require reporting and collection of staffing data, including staff hours of care provided, turnover, and wage and benefit information. This will assist geriatric patients and family members as they assess the quality of care of nursing homes they may be placed in. Geriatric nurses will be called on to help these patients and family members assess this information. Finally, the PPACA now requires additional elder abuse training be provided to workers who care for patients with dementia (CMS, 2012b; Sabatino et al., 2012; USDHHS, 2012b; Wakefield 2010).

CONCLUSION
This act is the largest reform in health policy in the United States in more than 40 years and thus controversy regarding its implementation and potential for effectiveness will continue. Nurses have the opportunity to engage in the policy implementation of the PPACA through fellowships such as the Health and Aging Policy Fellowship, sponsored by Atlantic Philanthropies, and the Robert Wood Johnson Policy Fellowship. These are critical positions for professionals to work with federal and state administration and legislative branches of government and directly impact policy design and regulatory action. Geriatric nurses will be in the forefront of the potential these changes will have on improving the quality of care older adults receive.

REFERENCES

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