

The Supreme Court Decision Matters for Registered Nurses, their Families, and their Patients

The Supreme Court's finding that most of the provisions of the Affordable Care Act (ACA) are constitutional provides increased certainty as healthcare professionals and organizations continue their work to the healthcare system and improve patient care. Politics being what it is, battles over the healthcare law will continue. ANA recognizes that we need to continue our tenacity and vigilance in supporting the significant movement begun with passage of the ACA. Regardless of ongoing political battles, the marketplace is forging ahead to reduce healthcare costs and improve quality of care. There is still much to be worked out, as transformation is a continual process of innovation, evaluation, modification, and more innovation. Registered nurses are uniquely positioned to continue to provide vocal and knowledgeable guidance to this effort.

So what did the Supreme Court say and how does its decision affect patients and registered nurses?
More people will have access to affordable care. And the law's structural and financial incentives remain in place for innovation in quality and delivery of care, primary care expansion and care coordination, as well as nursing workforce education and funding.

First, more people have access to affordable healthcare. Two overarching provisions of the ACA are designed to help all families and children afford basic primary and acute healthcare services, as well as management for chronic conditions. This strong step toward recognizing the importance of affordable, effective, basic care for everyone endorses nurses' professional ethical obligation to help shape social policy to advocate for patients and their families.

The first provision is the requirement that everyone purchase insurance or pay a penalty (the "shared responsibility" or "mandate" provision), starting in 2014. This requirement was upheld by the Court, but not necessarily on the legal grounds expected. The Court was not persuaded by the Administration's primary argument that congressional authority under the Commerce Clause permits the law to penalize the non-purchase of insurance. However, the Court upheld the mandate based on the government's alternate argument that the penalty imposed for not buying insurance is a *tax*, which the Congress does have authority to impose.

Chief Justice Roberts wrote that: "The payment is not so high that there is no real choice but to buy health insurance; the payment is not limited to willful violations, as penalties for unlawful acts often are; and the payment is collected solely through the IRS through the normal means of taxation." So the mandate doesn't say that not buying insurance is unlawful. It says you can either buy it or pay a tax. You either pay your own way by purchasing insurance – with or without government assistance provided for in the law – or you pay a tax to help defray the taxpayers' burden of paying for your care when you need it in the future. The "cost-shifting" or, in plain terms, the "freeloader" problem in healthcare is at least partially redressed by this approach.

The shared responsibility among a larger pool of insurance beneficiaries is accompanied by consumer protections against insurance companies' more egregious abuses. Already under the law, they cannot deny children needed care based on pre-existing conditions; this provision will be expanded to everyone in 2014. Your insurer can no longer cease covering you or your family member's medical expenses based on having reached an annual or lifetime cap arbitrarily set by actuaries. Your children can stay on your plan until age 26. Preventive care and screenings are largely available without a co-pay. Adults who have been denied insurance because of expensive preexisting conditions now have access to high-risk insurance pools (which themselves will be phased out when the complete prohibition on pre-existing conditions for everyone goes into effect in 2014).

The second major provision extends healthcare through an expansion of Medicaid eligibility to everyone who is at or below 133% of the federal poverty level. This was upheld in part by the Court and struck down in part. The law's Medicaid expansion was written so that states would lose their existing Medicaid federal matching grants if they declined to comply with the federal requirement to expand Medicaid to all individuals at or below 133% poverty level. In exchange for compliance, the federal government would provide 100% of the extra funds a state would need to cover this larger population; this federal subsidy would gradually reduce to 90% by 2017. The Court said that the federal government could offer the money in exchange for a state expanding its Medicaid rolls under federal parameters, but that a state is not required to accept the offer. It removed the stick, but kept the carrot; it basically creates an "opt-in" provision for the states.

Some commentators believe that most states would accept the carrot because, after all, their citizens are paying taxes and the federal offer is exceedingly generous. Yet there are leaders in some states who, at least for now, propose to refuse the money on political principle. People in those states who would have been eligible for the expanded Medicaid program might then have to either get individual federal subsidies to buy insurance, or apply for a "hardship waiver" to avoid having to buy insurance at all – both provided for in other parts of the law.

Second, registered nurses have greater opportunities to lead and contribute to a healthcare delivery that increasingly can focus on wellness and prevention, rather than simply "sick care." The healthcare system has added momentum and incentives to move toward value-based purchasing and more efficient care models, rather than maintain the current fee-for-service reimbursement that pays for volume of services rather than value.

In upholding most of the ACA, the Supreme Court automatically preserved numerous provisions vigorously pursued by the nursing community. These include incentives for quality innovations to improve patient care and satisfaction; and delivery systems that require greater coordination of care, an area in which nurses lead and strengthen inter-professional team-based care. The ACA improves access to primary care (including improved reimbursement for NPs, CNMs and CNSs) and wellness and prevention services, as well as increases funding for nurse-led health centers and federally qualified health centers (in which RNs typically provide the majority of care).

One of the ACA's important gateways for registered nurses to spotlight and replicate their success stories is through the Center for Medicare and Medicaid Innovation (CMMI), created by the ACA and sustained by the Supreme Court's decision. CMMI promotes health care

transformation by pursuing research and providing grants to develop new ways to pay for and deliver care in ways that both improve the quality of care while lowering costs. It “identifies, develops, supports, and evaluates innovative models of payment and care service delivery for Medicare, Medicaid and CHIP beneficiaries.” CMMI has already provided the first two sets of a series of grants to registered nurses and other healthcare professionals and organizations, with more funding available over time.

The ACA increases funding for nursing education and workforce development, nurses’ hard-won provisions also preserved by the Supreme Court’s ruling upholding the ACA. These additional funds not only provide new opportunities for registered nurses seeking to advance their career, they also represent increased awareness that nurses matter and are an essential resource in the healthcare workforce that should be fully developed and utilized. The law authorizes spending that includes advanced nursing education grants, workforce diversity grants, and grants for nurse education, quality and retention. It also authorizes grants to support development of specific nursing specialties; these include advance practice registered nurses (APRNs) who are pursuing a doctorate or other advanced degree in geriatrics, long-term care, or chronic care management. Loan repayment programs are now in place for nurses pursuing the specialty of pediatric mental and behavioral health. The Nursing Student Loan Program updates student loan amounts, and the Loan Repayment and Scholarship Program is expanded to provide loan repayments for students who serve at least two years as a faculty member of an accredited school of nursing.

The Affordable Care Act is not perfect. It does represent an enormous step forward in advocating for registered nurses, their families and their patients. It is clear progress for our profession. Nursing can continue to shape higher quality, more effective health care, influencing the changes we want to see for our patients and our profession.

We invite you to view ANA’s extensive coverage and advocacy regarding the Affordable Care Act and its effects on registered nurses and their patients, updated continually at:
www.nursingworld.org/healthcarereform.