

Executive Summary

2010 National Health Care Reform: An Initial Overview of Opportunities for Nurses and Nursing in Washington State

By Louise Kaplan, PhD, ARNP, FNP-BC, FAANP

INTRODUCTION

When President Obama signed the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, the United States (U.S.) became the last industrialized nation in the world to provide all citizens with access to health care. The PPACA is the first major health care reform since Medicare and Medicaid were created in 1965. While some components of the PPACA went into effect in 2010, many of the major changes will be phased in over a period

of four or more years. Although highly controversial, the law affirms the long held positions of the Washington State Nurses Association and the American Nurses Association that health care is a right. The new law affords opportunities for individuals struggling to obtain or afford health insurance. It also affords nurses with increased opportunities in education and practice.

BACKGROUND OF THE PROBLEM

Total health care spending in the U.S. in 2008 was \$2.3 trillion and accounted for 16.2% of the Gross Domestic Product. This equates to an average annual health care expenditure of \$7681 per person, more than any nation in the world. Despite this amount of spending, in 2009, more than 46 million (15.4%) people in the U.S. lacked health insurance. Just over 58 million (19.4%) people had been uninsured for part of the year and almost 33 million (10.9%) had been uninsured more than one year. The result of a Commonwealth Fund study that compared health care in seven

nations ranked the U.S. last overall in health outcomes which included quality of care, access, efficiency, equity, long healthy productive lives and health expenditures.

Some of the problems in the U.S. health care system result from an inadequate supply of well-educated nurses who are appropriately utilized and distributed. Overuse of acute care and technology driven services diverts resources from primary and preventive care, a cornerstone of nursing.

ANA'S PRINCIPLES FOR HEALTH CARE REFORM

In 1989, the ANA House of Delegates passed a resolution committing to the principles that health care is a human right and that people should have access to affordable, high quality health care. These principles have been the ongoing basis of ANA's Agenda for Health Care Reform which is founded on four critical elements: access to health care, the quality of health care, the cost of health care, and the health care workforce.

Summary of the PPACA

The PPACA and its associated legislation, the Health Care and Education Reconciliation Act of 2010, require most U.S. citizens and legal residents to have health insurance. The PPACA will be implemented over a period of years with the most substantial

changes in expanded coverage beginning in 2014. Health care coverage will be extended to an estimated 32 million people through a variety of mechanisms including expansion of public programs, creation of state health insurance exchanges, and changes to private insurance. Several benefit packages will provide a range of coverage options and funding mechanisms that include employer-sponsored insurance, premium assistance on a sliding scale basis, and increased use of Medicaid funds to cover people with income up to 133% of the Federal Poverty Level (FPL).

A variety of tax changes will provide some revenue to offset the cost of expanded health coverage options. Changes to reimbursement, administrative simplification and the reduction of fraud

and abuse are other important elements of cost containment. Consumer cost is controlled through provisions such as eventual elimination of the Medicare prescription drug benefit's "doughnut hole" and elimination of a lifetime dollar limit on coverage. Some new requirements for private insurance already assure access to insurance and continuity of coverage. For example parents may continue to cover children up to age 26 and insurers are prohibited from rescinding coverage because of pre-existing or new health conditions.

OPPORTUNITIES FOR NURSES

The PPACA has the potential to promote the contributions of nurses and nursing to health care in an unprecedented manner. These include increased financial supports for education and innovative programs, incentives for participating as providers, and an opportunity to better document the quality of care provided by nurses. There are opportunities for educators and students through increased funding for workforce diversity grants, scholarships, loan repayment programs and programs designed to retain nurses. Advanced practice nursing education has been strengthened with additional funding for educational programs and demonstration projects for education and post-education training. Academic institutions that want to develop a nurse managed health center can apply for grant support.

The looming shortage of primary and specialty care providers will increase demand for all advanced practice registered nurses (APRNs) including nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists. The requirement for mental health parity will increase demand for an already limited supply of psychiatric mental health nurse practitioners. Nurse managed health centers require one APRN to be in an executive management position. Medicare reimbursement for CNMs will increase from 65 to 100% of the physician fee schedule and there will be a 10% bonus for primary care providers including APRNs.

Incremental implementation of mechanisms to provide insurance coverage will increase demand for health care services almost immediately and may increase the need to employ more hospital and community nurses. Several programs in the PPACA will enhance opportunities for nurses who provide population based care and care coordination. Diffusion of comparative effectiveness research funded by PCORI will enhance the ability of staff nurses to provide evidence-based care and improve the quality of care. Many nurses are engaged in clinical research and they will have an opportunity to apply for PCORI funding to conduct CER.

There are many aspects of the PPACA that initiate changes to the way health care quality is improved, prevention of disease and wellness care are promoted, and investments are made in the workforce. Significant investment is made in creating a larger, more diverse health care workforce through increased funding of scholarships and loans and funding to increase the capacity of nursing education for basic and advanced education. Nurse managed centers, school health centers and community health centers which all offer health care services to vulnerable and underserved populations receive additional supports.

School based health clinics will expand capacity for primary care services to school-aged children. School nurses can collaborate with these clinics; however, there is no federal funding for additional school nurses. The Public Health Workforce Loan Repayment Program will contribute to the development of the public health workforce, including public health nurses (PHNs). Funding for public health programs through the Prevention and Public Health Fund will also be available to promote the efforts of PHNs.

As new reimbursement strategies are developed, nurse administrators need to be prepared to contribute to the discussion and validate the contributions nurses make to care. Part of this process requires nurse administrators to advocate that the cost of nursing care be itemized in hospital billing rather than be bundled into a room fee.

WHAT IS HAPPENING IN WASHINGTON STATE?

State Government

State government is actively involved in taking advantage of the provisions of the PPACA that can expand and strengthen health care services to Washington residents. The Washington State Legislature created the Joint Select Committee on Health Reform Implementation to determine what legislation may be needed to comply with and maximize the benefit from the PPACA. Governor Christine Gregoire established a Health Care Cabinet to assure ongoing coordination of the federal health care reforms. The Insurance Commissioner created the Health Reform Realization Committee in 2009 to develop recommendations to implement federal health care reform. Many state agencies and the Legislature will be involved in implementation of specific provisions of the PPACA.

Washington Center for Nursing

The Washington Center for Nursing (WCN), in collaboration with the Council of Nurse Educators of Washington State, developed the Master Plan for Nursing Education. The plan is designed to ensure a nurse workforce that has the appropriate education to provide care for the state's residents. This document can be used to guide workforce development efforts and to capitalize on education grant opportunities included in the PPACA.

Washington State Nurses Association

WSNA is actively involved in the implementation of the PPACA to assure that nurses provide input and participate in a meaningful way. This policy brief is an example of WSNA's commitment to inform nurses about the PPACA. WSNA consistently nominates nurses to be members of health care committees. Staff monitor the work of legislative committees and participate in coalitions such as the Healthy Washington Coalition and the Governor's Health Disparities Workforce Development Committee.

CONCLUSION

The extended period of time over which the PPACA will be implemented leaves many unanswered questions. Will there be concerted efforts made to change the substance of the law or erode the significance of its provisions? Will access be improved to the extent predicted and will costs be contained or expand further? The results of the 2010 and 2012 elections will have a strong influence on the implementation of the PPACA.

Nurses, alongside consumers, have much to gain from the PPACA, despite many unanswered questions. WSNA, ANA and other nursing organizations will participate in the implementation of the law and advocate for changes that correct the fundamental flaws of our current health care system. It is both our right and our responsibility to be part of this historic process of health care reform.

WEB BASED RESOURCES

American Association of Colleges of Nursing

<http://www.aacn.nche.edu/Government/pdf/HCRreview.pdf>

American Nurses Association Health System Reform

<http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform.aspx>

Key Provisions Related to Nursing

<http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Key-Provisions-Related-to-Nurses.aspx>

The Commonwealth Fund Health Reform Resources

<http://www.commonwealthfund.org/Health-Reform.aspx>

Kaiser Family Foundation Health Reform

<http://healthreform.kff.org/>

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INTRODUCTION

When President Obama signed the Patient Protection and Affordable Care Act (PPACA) on March 23, 2010, the United States (U.S.) became the last industrialized nation in the world to provide all citizens with access to health care. Passage of the law occurred nearly a century after President Theodore Roosevelt first proposed comprehensive health care reform in 1912. The PPACA is the first major health care reform since Medicare and Medicaid were created in 1965. While some components of the PPACA went into effect in 2010, many of the major changes will be phased in over a period of four or more years. This incremental approach to implementing the new law presents many challenges to millions of people who are uninsured or lack access to care. The pressing need for the PPACA is also underscored by the failure to achieve better health outcomes.

Passage of the PPACA came more than a year after the inauguration of President Obama and was highly controversial. Many compromises were necessary to pass the legislation and controversy continues. There is wide agreement that the law will significantly expand health insurance coverage and reform health care in many other ways but there is concern that costs will also expand rather than be contained (Gruber, 2010).

Twenty state attorneys general, governors, and organizations have filed lawsuits arguing that the PPACA is unconstitutional (Richman 2010). These plaintiffs interpret the law as a mandate

for individuals to have coverage although in actuality there is no language about a mandate but rather a tax penalty for failing to obtain health insurance (Rosenbaum, 2010). On the other hand, the legislation will solve many problems for millions of people including those who are uninsured, intermittently insured, or under insured; small businesses and their employees; and people with pre-existing conditions (Davis, 2010). It also affords opportunities, including many for nurses. The law, for example, includes grants to establish School Based Health Centers and Nurse Managed Health Centers, increases funding for nursing education, and identifies nurse practitioners as providers who can participate in a demonstration project to deliver home based primary care to high need populations (Graham, 2010).

Nurses who understand the provisions of the PPACA will be better prepared to advocate on behalf of individuals, families and communities who experience the burdens of our broken health care system. This policy brief provides an overview of the problems that contributed to the passage of the PPACA. The American Nurses Association's (ANA) Health System Reform Agenda is described and the PPACA is summarized. The provisions of the law are analyzed using the ANA reform agenda as a framework. Opportunities for nurses to improve the health care system and improve it are identified.

BACKGROUND OF THE PROBLEM

How much do we spend on health care?

Total health care spending in 2008 was \$2.3 trillion and accounted for 16.2% of the Gross Domestic Product. This equates to an average annual health care expenditure of \$7681 per person, also referred to as the per capita cost. Although the rate of growth in health care spending slowed, this represents a rise in overall spending of 4.4% from the previous year. Hospital costs grew 4.5% and accounted for \$718.4 billion of the total costs (Center for Medicare and Medicaid Services, 2010). The United States (U.S.) spends more on health care than any other country in the world,

and nearly twice as much as Norway, the country with the second highest per capita cost of \$4,763 in 2007. The U.S. also spends about two-and-a-half times more per capita than the average spent by other countries in the Organisation for Economic Co-Operation and Development (Pearson, 2009).

Who are the uninsured?

In 2009, more than 46 million (15.4%) people in the U.S. lacked health insurance. Just over 58 million (19.4%) people had been uninsured for part of the year and almost 33 million (10.9%) had

been uninsured more than one year. The uninsured included just over 6 million children under age 18 and 40 million people ages 18 to 64. Most adults age 65 and older are insured through Medicare, some have private insurance and less than 2% are uninsured (Cohen, Martinez & Ward, 2010; U.S. Census Bureau 2008).

Some people are surprised to know that most uninsured people are young and employed. In 2008, 30% of young adults ages 19-29 were uninsured while 17% of adults ages 30-64 were uninsured. Factors that contribute to this disparity are the loss of parental coverage for many teens at age 19, employment in entry-level or low wage jobs that do not provide health insurance, or the inability to afford insurance. More than half (56%) of these uninsured young adults do not have a usual source of care (Schwartz & Schwartz, 2010).

Although a holistic view of health includes oral health, little attention is given to the number of people in the US without dental insurance or who have inadequate access to dental care. A decade ago, over 100 million people, 23 million children and 85 million adults, were estimated to have no dental insurance (Surgeon General's Report, 2000). Among the 172 million people under age 65 who have private health insurance, approximately 45 million have no dental insurance (Bloom & Cohen, 2010). Having dental coverage does not guarantee access to care. As with health insurance plans, many dental plans have limited benefits, and co-pays and deductibles may make care unaffordable.

Poor children experience a higher burden of dental disease than other children and are twice as likely to have untreated caries. Over 29 million children had dental coverage through Medicaid in 2007 yet access was difficult. Low reimbursement rates discourage dentists from accepting Medicaid clients. Travel to the few participating dentists is often difficult for low income families (Geshan, Snyder, & Paradise, 2008).

Does health care spending improve health outcomes?

Does spending more money on health care than any other country in the world make a difference? A Commonwealth Fund (2010) report, *Mirror Mirror on the Wall*, compared health care in seven nations – Australia, Canada, Germany, the Netherlands, New Zealand, the United Kingdom and the United States. The U.S. ranked last overall in health outcomes which included quality of care, access, efficiency, equity, long healthy productive lives and health expenditures. The U.S. also ranked last on each of the outcomes of safe care, cost-related problems, efficiency, equity, long healthy productive lives, and health expenditures.

One measure of an effective health care system is life expectancy. On this measure the U.S. also ranks behind many other countries that spend less on health care. Comparing 224 countries in 2010, Monaco has the world's longest life expectancy at birth, 89.8 years. Japan ranks fifth with a life expectancy of 82.2 years. In 2007, the last year for which data is available, Japan's health care expendi-

tures accounted for 8.1% of its gross domestic product compared to the 16% spent by the U.S. Ranked number 49, life expectancy at birth in the U.S. is 78.2 years. In contrast, Cuba spends only a little more than \$300 per capita on health care yet ranks 54th with a life expectancy of 77.6 years (Central Intelligence Agency, 2010; Keim, B. 2010; Organisation for Economic Co-Operation and Development, 2009).

How are nurses affected by the problems with the health care system?

Periodic shortages of registered nurses underscore the vulnerability of the health care system. Some of the problems in the U.S. health care system result from an inadequate supply of well-educated nurses who are appropriately utilized and distributed. In one study, high patient-to-nurse ratios increased 30 day mortality rates and failure-to-rescue rates among surgical patients. The nurses also were more likely to experience burnout and job dissatisfaction (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002). In another study, a 10% increase in the proportion of hospital registered nurses holding a bachelor's degree was associated with a 5% decrease in patients dying within 30 days of admission and a 5% decrease in the odds of failure to rescue (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). Research also indicates that nurses reporting higher workloads were more likely to report more frequent medical errors and patient falls on their units (Sochalski, 2004).

Nurses often work with people who have no health insurance and may not seek care when a health problem first develops. As a result, more intensive care may be required, draining limited resources. Overuse of acute care and technology driven services diverts resources from primary and preventive care, a cornerstone of nursing.

Long aware of problems with the U.S. health care system, nurses have been on the forefront of health care reform. The Washington State Nurses Association House of Delegates passed a resolution (Appendix 1) in 1983 on access to health care for the poor in which it resolved that the association: "emphatically reaffirm its position to the Legislature that quality care is a right for all persons, not a privilege for the few..." (Washington State Nurses Association, 1983). In 1991 the American Nurses Association (ANA) published *Nursing's Agenda for Health Care Reform* which was endorsed by over 60 nursing and health organizations. The agenda was revised in 2005 and again in 2008. The current agenda contains fundamental principles and a framework for understanding and evaluating provisions of the PPACA and how they will affect the health care system and nurses. The agenda can be accessed at <http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Agenda/ANAsHealthSystemReformAgenda.aspx>.

Overview of ANA's Principles for Health Care Reform

In 1989, the ANA House of Delegates passed a resolution (Appendix 2) committing to the principles that health care is a human right and that people should have access to affordable, high quality health care (American Nurses Association, 1989). In 2010, the ANA House of Delegates passed a resolution on healthcare for undocumented immigrants in which it again affirmed that “the ANA believes healthcare is a basic human right” (ANA 2010). These principles have been the ongoing basis of ANA’s Agenda for Health Care Reform which is founded on four critical elements: access to health care, the quality of health care, the cost of health care, and the health care workforce.

Access involves affordability, availability, and accessibility. The element of quality addresses six aims identified by the Institute of Medicine’s 2001 report, *Crossing the Quality Chasm: A New Health System for the 21st Century*. These aims are: safe, effective, patient-centered, timely, efficient, and equitable health care. ANA supports a single-payer system to finance health care costs and a shift from tertiary care as a priority to a focus on primary care. Health care reform can create a new paradigm in which registered nurses and nursing services are seen as a way to save money through the prevention of health problems and the prevention of complications from existing problems.

Additionally, the registered nurse workforce needs to increase not just in number but in diversity. Recruitment into the profession should reflect the communities that comprise the U.S. population. Retention of nurses is another way to increase supply and hinges on improving the work environment. Increasing the capacity of nursing education requires more faculty and more resources to support students. The workforce needs to be better distributed to meet the needs of underserved areas and should be better utilized. Barriers need to be eliminated to provide nurses with practice acts and laws that allow them practice to the full extent of their abilities. This is one of the four key messages of the October 2010 Institute of Medicine Report, *The Future of Nursing: Leading Change, Advancing Health*.

Results of two Washington State surveys identify nurse workforce needs specific to the state. A study of the demographic, education, and practice characteristics of Registered Nurses (RNs) revealed that only 64% of nurses licensed in Washington actually practiced in the state and fewer than 10% were non-white. Only 57% of the respondents received some or all of their nursing education in Washington State indicating a reliance on in-migration to meet the state’s nurse workforce needs (Skillman, Andrilla, Tieman & Doescher, 2008). A 2008 study of the demographic, education, and practice characteristics of Advanced Registered Nurse Practitioners (ARNPs) in Washington State found that as with RNs, less than 10% of the ARNPs in Washington are non-white. Over one-third (37%) were over age 55 which indicates the possibility of a large number of ARNPs retiring in the next decade. With

70% of ARNPs reporting that their entire career as an ARNP has been in Washington, educating Washington residents as ARNPs in the state may continue this trend and result in a more stable workforce (Skillman, Andrilla, Kaplan & Brown, 2009).

Summary of the PPACA

The PPACA and its associated legislation, the Health Care and Education Reconciliation Act of 2010, require most U.S. citizens and legal residents to have health insurance. Health care coverage will be extended to an estimated 32 million people through a variety of mechanisms including expansion of public programs, creation of health state insurance exchanges, and changes to private insurance. Several benefit packages will provide a range of coverage options and funding mechanisms that include employer-sponsored insurance, premium assistance on a sliding scale basis, and increased use of Medicaid funds to cover people with income up to 133% of the Federal Poverty Level (FPL) (Davis, 2010; Kaiser Family Foundation, 2010).

A variety of tax changes will provide some revenue to offset the cost of expanded health coverage options. Changes to reimbursement, administrative simplification and the reduction of fraud and abuse are other important elements of cost containment. Consumer cost is controlled through provisions such as eventual elimination of the Medicare prescription drug benefit’s “doughnut hole” and elimination of a lifetime dollar limit on coverage. Some new requirements for private insurance already assure access to insurance and continuity of coverage. For example parents may continue to cover children up to age 26 and insurers are prohibited from rescinding coverage because of preexisting or new health conditions (Davis, 2010; Kaiser Family Foundation, 2010).

There are many aspects of the PPACA that initiate changes to the way health care quality is improved, prevention of disease and wellness care are promoted, and investments are made in the workforce. For example, the Patient-Centered Outcomes Research Institute will promote comparative effectiveness research. A national quality improvement strategy to improve the delivery of health care services and population health will be developed and a federal council will coordinate prevention, wellness, and public health activities. There are incentives to use health information technology, grants for wellness programs, and support for patient centered health care homes (Davis, 2010; Kaiser Family Foundation, 2010).

Significant investment is made in the health care workforce through increased funding of scholarships and loans and funding to increase the capacity of nursing education for basic and advanced education. The workforce provisions also include support for recruitment and training of more diverse providers and emphasis on cultural competence. For the first time, recipients of National Health Service Corps (NHSC) scholarships or loan repayment programs awards allow for half of the service to be time

spent teaching. (The NHSC has already initiated a pilot program for half time service in its loan repayment program.) Expansion of the NHSC, nurse managed centers, school health centers and community health centers which all offer health care services to vulnerable and underserved populations receive additional supports (Kaiser Family Foundation, 2010).

The PPACA will be implemented over a period of years with the most substantial changes in expanded coverage beginning in 2014. A few of the provisions that began in 2010 include insurers no longer being able to deny coverage to children with pre-existing conditions, the establishment of a temporary subsidized high-risk pool for people who have been uninsured for at least six months, and increased funding for community health centers. A timeline for the implementation of health care reform from the Kaiser Family Foundation can be accessed at <http://www.kff.org/healthreform/8060.cfm>.

Understanding the PPACA Using ANA's Health System Reform Agenda

Passage of the PPACA required the marshalling of major political and legislative resources. Implementation of the law demands concerted efforts both to take advantage of the opportunities and to assure that there is no erosion or rescinding of the law. Nurses who understand the provisions of the reforms can be active participants and influence the implementation at the local and state level. Many health care organizations have summarized the key elements of the legislation. ANA and other nursing groups, such as the American Association of Colleges of Nursing, have specifically reviewed the relevance of the reforms to nursing. The four critical elements that serve as the basis of ANA's Health System Reform Agenda – access, quality, cost and workforce – can be used as a framework to analyze the PPACA.

This analysis synthesizes several excellent summaries of the PPACA. These include documents from the American Nurses Association, the American Association of Colleges of Nursing, the Kaiser Family Foundation, and The Commonwealth Fund. A link to these documents appears at the end this policy brief.

ACCESS

Is health care a human right?

As noted above, the ANA House of Delegates passed a resolution in 1989 affirming health care as a human right and reaffirmed this in 2010. Despite the expansion of health care coverage to millions of Americans, the law fails to declare health care as a human right. PPACA specifically excludes undocumented residents and exempts them from the requirement to have health coverage and the penalty for non-coverage.

Is there a public option?

President Obama's initial proposal for health care reform included a public, government-offered insurance plan to compete with private plans. Referred to as the "public option," this provision was intended to be available to people who lacked employer-provided health insurance and employees of small businesses. The public option was dropped just a month before the legislation passed as a way to garner support which faltered. State run Health Insurance Exchanges (HIE) were substituted for the public option.

The HIE will offer individuals insurance through the American Health Benefit Exchanges. Small businesses with up to 100 employees will be able to purchase insurance through the Small Business Options Program Exchanges. The HIE will be administered by a governmental agency or non-profit organization. Health plans must qualify to participate in the HIE by meeting certain requirements such as having an adequate provider network and contracts with essential community providers, be accredited with

respect to performance on quality measures, and use a standard enrollment form and standard language to present plan information.

Will health care be affordable?

There are many provisions of the law that should make insurance affordable. Eligibility for Medicaid will be extended to people with incomes up to 133% of the federal poverty level (FPL) from the current 100%. People with incomes from 133% to 400% of the FPL who purchase coverage through the health exchanges to pay for premiums will receive premium credits. These will be based on a sliding scale and limit the cost of premiums to a range of 3-4% for people with incomes from 133-150% FPL to 9.5% for people with income 300-400% FPL. There will also be cost-sharing subsidies to recue cost sharing amounts and annual cost-sharing limits. There will be four standard plans that offer essential benefits and a catastrophic plan for people up to age 30 or who are exempt from the mandate to purchase coverage. These options, each with different costs, allow the selection of a health plan that is affordable.

The lowest premiums will be for the minimum benefit package, the 'bronze plan', covering 60% of benefit costs. The 'silver plan' covers 70% of the benefit cost of the plan and the 'gold' plan covers 80% of the cost. The highest premiums will be for a 'platinum plan' that pays 90% of the costs of benefits. There will also be limits on out of pocket costs. Premium costs will be monitored and the amount of administrative costs that are a component of

premiums will be limited. Increases in premiums will need to be justified in advance by companies that want to become certified health plans through the exchanges.

Insurance coverage encourages people to seek primary health care when they first become ill rather than use an emergency department (ED). Primary care is less expensive for the individual and the overall system than an ED visit. Another example of provisions to make health care affordable is that Medicare beneficiaries who have Part D prescription drug coverage received a \$250 rebate in 2010 if they reached the coverage gap, known as the 'doughnut hole'. The individual responsibility for the coverage gap will reduce from 100% to 25% by 2020.

Will health care be available?

The response to this question involves both the availability of coverage and the availability of providers. Individuals and small businesses will be able to purchase insurance through state-based government or non-profit administered HIE programs, the American Health Benefit Exchanges and Small Business Health Options Program Exchanges. Eventually states will have the option to offer these plans to businesses of any size. Employers with more than 50 employees are required to offer insurance or pay a fee to cover the cost of employee insurance. As people change jobs, insurance coverage will be portable rather than being lost as now occurs because most health insurance is linked to a job.

As of September 2010, parents are able to cover their children up to age 26 or until they find a job with health benefits even if the children are no longer dependents. Health plans can no longer deny children coverage because of pre-existing conditions; this extends to adults in 2014. As noted above, some health plans avoided this provision of the law by ending the sale of plans for children. Insurance companies may no longer rescind new health plans once it is issued which they have done when people became ill after joining the plan. There are other provisions that bar discrimination based on factors such as genetics, claims experience and gender.

The essential benefits package must include hospital services, professional services, preventive services with no cost sharing, and vaccines and maternity care. Mental health and substance abuse coverage on par with physical health coverage will also be available. The services must provide well child care, oral health, vision and hearing services for people under age 21. Oral health coverage is not a core service for adults over age 21 (Silberman, Liao, & Ricketts, 2010).

An estimated 32 million more people will have health insurance and many will need primary and specialty care. The current shortage of primary care providers will be exacerbated. The law has several provisions to make health care more available. As an incentive to increase the number of primary care providers, Medi-

care will give a 10% bonus to primary care providers, including nurse practitioners, beginning in 2011. Medicare reimbursement to certified nurse midwives (CNMs) will increase from 65% of the physician rate to 100% in January 2011. This is important as Medicare serves approximately 7 million disabled people under age 65, some of whom will require pregnancy care services. Full reimbursement is an incentive for CNMs to provide care to this group.

There is increased funding for the education of health professionals including registered nurses and advanced practice registered nurses. An appropriation of \$50 million in fiscal year (FY) 2010 was authorized to support nurse managed health centers. School based clinics received \$50 million for FYs 2010 through 2013. There was also increased funding for community health centers and the National Health Service Corps (NHSC). The NHSC will be better able to recruit health professionals into the program and place them into underserved areas.

Will health care be acceptable?

Cultural acceptability is addressed by allowing exemption from the individual insurance mandate for American Indians or people with religious objections. Training of a more diverse workforce that reflects the population is supported and resources are available to provide cultural competence training.

Quality of Care

A national quality improvement strategy to be delivered to Congress by January 1, 2011 is being developed in consultation with the National Quality Forum. The strategy will set priorities to improve the delivery of health care services, health outcomes, and population health. Data will be collected and analyzed to monitor trends in health disparities. In order to improve quality there are incentives such as enhanced Medicare reimbursement when quality benchmarks are met or exceeded.

Will health care be safe?

A Center for Quality Improvement and Patient Safety will be created to conduct research to improve the quality of care and reduce medical errors. Health plans must meet quality improvement requirements including strategies to prevent hospital readmissions. Grants for demonstration projects will create and evaluate alternatives to medical malpractice lawsuits and reduce adverse events and errors. A requirement to develop provider level outcome measures could involve use of the National Database of Nursing Quality™ Indicators. Nurse-sensitive outcome measures are used to demonstrate the value of nursing in assuring quality patient care (Montalvo, 2007).

Will health care be effective?

A non-profit Patient-Centered Outcomes Research Institute (PCORI) was created in September 2010 to establish research priorities and fund comparative effectiveness research (CER). CER compares the outcomes, effectiveness, risks and benefits of two or more treatments, services, drugs, biologicals, or medical devices (Silberman, Liao, & Ricketts, 2010). Results of the research will be disseminated to promote the use of treatments that are effective and change the way care is delivered. Debra Barksdale, PhD, RN, an associate professor at the University of North Carolina at Chapel Hill was appointed to the PCORI Board of Governors.

The Preventive Services Task Force and Community Preventive Services Task Force will review existing and emerging evidence regarding effectiveness and cost effectiveness of clinical preventive services. Bernadette Melnyk, PhD, RN, CPNP/PMHP, FNAP, FAAN, Dean of the Arizona State University College of Nursing and Health Innovation, and Adelita Gonzales Cantu, PhD, RN, an assistant professor at the University of Texas Health Science Center are members of this task force.

Will health care be patient centered?

There are many provisions that promote self care and patient control. These include new consumer protections and increased choices for selecting a health plan. One consumer protection is the requirement for standardized language to be used by insurers when providing information on health plans. The federal government has already implemented a web site to help consumers access information about the health care reform legislation. The web site address is <http://www.healthcare.gov/>.

Some high-need Medicare patients will be able to have primary care at home through the Independence at Home demonstration project. Providers will share in savings if they meet certain benchmarks including reduced hospitalizations, improved health care outcomes and patient satisfaction. Other patient centered provisions include community based care transition programs and home visits for new mothers.

The Department of Health and Human Services will develop a program to establish patient centered 'medical homes' for primary care practices to develop community based interdisciplinary teams to provide integrated, coordinated and evidence based care. State Medicaid programs will have the option to establish 'health homes' for patients with chronic conditions to access comprehensive coordinated care and disease management services.

Will health care be timely?

Workforce development provisions are designed to assure a sufficient number of providers to allow access to care when it is needed. Insurance coverage encourages prompt use of primary care. One factor in assessing the quality of care is whether it is received by a patient in a timely manner. This will require ongoing monitoring and measurement.

Will health care be efficient?

Efficiencies in the system can be obtained in a variety of ways. Private insurers will be limited to how much of their costs can be for administration which encourages administrative simplification. Simplification will also be obtained through a requirement for private insurance to adopt standards for financial and administrative transactions and adoption of a single set of rules for verifying eligibility and processing of claims. The American Recovery and Reinvestment Act of 2009 included support for increased use of electronic health records and information systems. The PPACA has additional incentives to establish these systems to assure the correct information is available when needed thereby eliminating duplicate testing, unnecessary appointments and inappropriate care.

More efficient reimbursement strategies and service delivery models will be developed through a new Center for Medicare and Medicaid Innovation and other changes to the way services are reimbursed. Care delivery will be more efficient as health care homes are implemented and incentives for improved outcomes are implemented.

Will health care be equitable?

Equity means that distributions are considered fair although there may be equalities and inequalities involved (Stone 1988). Expansion of Medicaid coverage and financial assistance for lower income individuals and families to purchase insurance are examples of how the PPACA addresses equity. Analysis of access and treatment data according to race, ethnicity, sex, primary language, disability, and rural/frontier location to identify disparities is another measure of equity.

COST OF CARE

Will the PPACA reduce overall health care costs?

The PPACA includes both cost containment strategies and mechanisms to raise revenue. Cost containment strategies include: a reduction in certain Medicare payments; a Medicare advisory board to make recommendations to reduce the annual per capita growth in spending; prohibition of payment to states for Medicaid services related to hospital acquired conditions; and promotion of administrative simplification. The Congressional Budget Office estimated that revenue measures in the PPACA will exceed costs for a reduction in the federal deficit of \$118 billion over the 10 year period of 2010-2019 (Elmendorf, 2010).

A variety of tax changes will raise revenue. For example, the Medicare Part A (hospital insurance) tax rate on wages will increase on January 1, 2013 from 1.45% to 2.35% on earnings over \$200,000 for an individual and \$250,000 for a married couple that files jointly. There will be new fees on the pharmaceutical manufacturing sector and the health insurance sector as well as an excise tax of 2.3% on taxable medical devices. Effective July 1, 2010 indoor tanning services are taxed 10%. The threshold for the itemized deduction for unreimbursed medical expenses will increase from 7.5% to 10% of adjusted gross income beginning in 2013.

Individuals without qualifying health coverage will pay the greater of \$695 per year up to a maximum of three times that amount or 2.5% of household income beginning in 2014. Employers with 50 or more employees who do not offer health coverage will also be assessed fines.

Medicare will establish accountable care organizations (ACOs) to share in cost savings the ACOs achieve for Medicare. An organization must meet certain quality benchmarks to become an ACO. The ACO must assume and coordinate care for the Medicare patients, have an adequate primary care provider network, promote evidence-based care, and report on quality and costs.

Health care costs can also be reduced by promoting health and preventing disease. The PPACA establishes a National Prevention, Health Promotion and Public Health Council to develop a strategy to improve the nation's health. The Prevention and Public Health Fund will be created and used to support wellness, prevention, and public health activities. There will also be an Education and Outreach Campaign to promote preventive benefits and immunization programs. In an effort to help people make healthier food choices and decrease the prevalence of overweight and obesity, restaurant chains and food vending machines will be required to have nutritional food labeling.

What will this cost employers?

Employers with 50 or more employees must offer them coverage or pay a penalty of \$2,000 per full-time employee excluding the first 30 from the assessment. PPACA does not require these employers to pay for any portion of the premiums for the employee or dependents (Silberman, Liao, & Ricketts, 2010). Employers with more than 200 employees are required to automatically enroll new workers into health plans. Small business owners with fewer than 50 employees are exempt from this provision. Employers with 25 or fewer employees and average annual wages of no more than \$50,000 that purchase insurance for employees will be eligible for tax credits beginning in 2010.

What will this cost individuals?

Costs to the individual will vary depending in large part on income. People below 133% of the FPL will be covered by Medicaid and pay nothing. Premiums for people between 133% and 400% of the FPL will be subsidized on a sliding scale to pay for premiums. Costs to people who are covered by employers will be different than costs for people who purchase a plan through the health exchanges. Each of the four plans previously described will cover between 60% and 90% of costs with differing out-of-pocket limits for people between 100% and 400% of the FPL. Total health care costs to the individual will be minimized by the prohibition of lifetime limits on coverage that began in September 2010. Annual limits on coverage will be eliminated for individual and group plans beginning January 1, 2014.

HEALTHCARE WORKFORCE

Supply Solutions

A National Health Workforce Commission has been created to serve as a resource to Congress and make recommendations about the supply and distribution of the workforce and related factors. States can compete for grants to design strategies to develop the health care workforce. Workforce diversity grants will assist disadvantaged students who want to become nurses and diploma and associate degree nurses who want to obtain a baccalaureate degree. Peter Buerhaus, PhD, RN professor of nursing and director of the Center for Interdisciplinary Health Workforce Studies, Institute for Medicine and Public Health at Vanderbilt University was appointed to chair the commission. Mary Mincer Hansen, PhD, RN, director for the master's in public health program, College of Health Services, Des Moines University was also appointed to the commission.

Education solutions

Enhanced loan repayment and scholarship programs target basic nursing students, nurses planning to become faculty, advanced practice registered nurse, professionals entering public health, and professionals who commit to working in pediatrics acute care and mental health. There are grants specifically for nurse retention and to promote nurses to work as a direct care provider in a long-term or chronic care setting and to work in the field of geriatrics. These grants, part of a \$159 million package, were announced in August 2010 by Health and Human Services Secretary Kathleen Sibelius.

For the first time the National Health Service Corps scholarships and loan repayment programs allow for up to 50% of time spent teaching to be counted as part of a full time service obligation. A \$50 million graduate nurse education demonstration project for advanced practice registered nurses will be established through Medicare. There will also be a demonstration project grant to provide family nurse practitioners with a one year post-graduate full time paid training program.

Distribution solutions

Workforce development requires both an adequate supply of health care professionals and their distribution in areas of need. The National Health Service Corps (NHSC) scholarship and loan repayment programs places health professionals in Health Professional Shortage Areas. The PPACA increased funding for the NHSC and eliminated a cap on the number of commissioned officers.

Nurse Managed Health Clinics (NMHCs) are supported to provide primary care to underserved or vulnerable populations. The clinics must be managed by advanced practice registered nurses and be affiliated with a school, college, university or department of nursing, federally qualified health center, or independent non-profit health or social service agency. NMHCs receive \$50 million

in fiscal year 2010 and additional funding in subsequent years. Community health centers will receive \$11 billion over a five year period that began in 2010.

Utilization solutions

There are several aspects of the PPACA that enhance utilization of nurses. There will be grant support to develop evidence-based nurse home visitation programs for maternal, infant and early childhood services. Nurses may be part of teams that implement 'medical' homes. The Medicare Independence at Home Demonstration program stipulates that nurse practitioners can both participate in and lead a home care team. Medicare and Medicaid will require a face-to-face encounter with a patient before a physician can certify eligibility for home health services or durable medical equipment. Nurse practitioners, clinical nurse specialists and certified nurse midwives may conduct this encounter. This does not, however, authorize the advanced registered nurse practitioners (APRNs) to actually certify the patient for home health services or to order the durable medical equipment.

Primary care APRNs will be eligible for a 10% bonus from Medicare over a five year period beginning January 1, 2011. With the exception of CNMs who will be reimbursed at 100% of the physician fee schedule, APRNs will continue to be reimbursed by Medicare at only 85% of the physician fee schedule. The physician fee schedule is already considered low and many physicians no longer accept new Medicare clients. The further reduced reimbursement of 85% for APRNs is a disincentive to accept Medicare patients. Medicaid law, however, was not amended to recognize all APRNs as primary case managers in managed care plans or to be eligible for fee-for-service payments.

Opportunities for Nurses

The PPACA has the potential to promote the contributions of nurses and nursing to health care in an unprecedented manner. These include increased financial supports for education and innovative programs, incentives for participating as providers, and an opportunity to better document the quality of care provided by nurses. The following section summarizes the opportunities for nurses previously described.

Educators and Students

Potential and current nursing students will benefit from increased funding for workforce diversity grants, scholarships, loan repayment programs and programs designed to retain nurses.

Current educational loan amounts under the Nurse Student loan program have increased from \$2,500 to \$3,300 and from \$4,000 to \$5,200 for the last two academic years. The total loan level increased from \$13,000 to \$17,000. Loan repayment for nurses and scholarships for students are now offered if they agree to serve

as nurse faculty for two years at an accredited school of nursing. Workforce diversity grants will provide funds for stipends to diploma or associate degree nurses to enter degree completion programs, scholarships or stipends to students in accelerated degree programs, and for pre-entry preparation, advanced education and retention activities.

Advanced practice nursing education has been strengthened with additional funding for geriatric traineeships. There will be the development of the graduate nurse education demonstration project to five hospitals to expand APRN education for a total of \$200 million over four fiscal years. In addition, a one year training demonstration project for new graduate family nurse practitioners (FNPs) will provide grants to pay the FNPs a full time salary and benefits. Advanced education nursing grants are no longer limited to a 10% cap on doctoral student education. Academic institutions that want to develop a nurse managed health center can apply for grant support.

Advanced Practice Registered Nurses (APRNs)

The looming shortage of primary and specialty care providers will increase demand for all APRNs including nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists. The requirement for mental health parity will increase demand for an already limited supply of psychiatric mental health nurse practitioners. Nurse managed health centers require one APRN to be in an executive management position

Several scholarship and loan repayment programs target nurses who want to become APRNs as noted above. Funding for nurse managed health centers, community health clinics, school based clinics and the Medicare Independence at Home Demonstration program afford APRNs more opportunities for employment. APRNs will benefit financially from some provisions such as Medicare reimbursement for CNMs at 100% of the physician fee schedule and the 10% bonus for primary care providers.

Hospital and Community Based Staff Nurses

Incremental implementation of mechanisms to provide insurance coverage will increase demand for health care services almost immediately and may increase the need to employ more nurses. Both the coverage for people who are in a high risk pool and for people up to age 26 who can be covered on their parents insurance plans began within six months of the PPACA becoming law.

Some academic institutions that partner with a long term care facility can apply for grants to train nurses as direct care workers for long term or chronic care. There is also whistleblower protection for employees of skilled facilities who raise concerns about the quality of care.

Several programs in the PPACA will enhance opportunities for nurses who provide population based care and care coordination. There is grant funding for states to apply for to offer evidence based nurse home visitation programs for maternal, infant, and early childhood care. The Independence at Home Demonstration program will use home based primary care teams to reduce costs and improve quality of care. These teams, and the ACOs, may use nurses for care coordination.

Nurses should look for opportunities to use their skills innovatively as health care reforms are implemented. The IOM Future of Nursing report highlights nurses in the Geisinger Health System who initially provided care coordination and advice through a call center. The nurses added in-person visits with the patients in primary care sites to build more effective relationships and use a predictive model to identify patients at risk for hospitalization. The successful program is used in both Geisinger's Medicare and commercial health plans.

The IOM report also profiles nurses who work for Kaiser Permanente in San Diego who have improved the efficiency and effectiveness of discharge processes. Discharge nurses are authorized to make all decisions regarding discharge and are in control until home health, hospice or palliative care nurses take over. Within 3 months involvement of home health nurses within 24 hours increased from 44 to 77 percent.

Diffusion of comparative effectiveness research funded by PCORI will enhance the ability of staff nurses to provide evidence-based care and improve the quality of care. Many nurses are engaged in clinical research and they will have an opportunity to apply for PCORI funding to conduct CER.

As noted above, there is a requirement to develop provider level outcome measures. Should the National Database of Nursing Quality™ Indicators (NDNQI) be selected for use, there will be additional opportunities to use this data to conduct research regarding the contributions nurses make to quality care. Use of the NDNQI would also contribute to recognizing nursing's impact on outcomes of care.

School Nurses

School based health clinics will expand capacity for primary care services to school-aged children. The clinics will be required to provide a range of services including primary care for acute and chronic problems, referral to specialists and dentists, assessments for mental health and substance abuse, crisis intervention and counseling (Silberman, Liao, & Ricketts, 2010). School nurses can collaborate with these clinics; however, there is no funding for additional school nurses. That funding comes from local and state budgets. The Education and Outreach Campaign will include immunization programs that can enhance the efforts of school nurses.

Public Health

The Public Health Workforce Loan Repayment Program will contribute to the development of the public health workforce, including public health nurses (PHNs). PHNs need to be active participants in the development of the national strategy to improve the nation's health. Funding for public health programs through the Prevention and Public Health Fund will also be available to promote the efforts of PHNs. Another opportunity for PHNs is participation in a regular and reserve corps that will respond to national emergencies.

Nurse administrators

Efforts to create administrative simplification and increase use of electronic health records can tap into the talents of nurse administrators. As new reimbursement strategies are developed, nurse administrators need to be prepared to contribute to the discussion and validate the contributions nurses make to care. Part of this process requires nurse administrators to advocate that the cost of nursing care be itemized in hospital billing rather than be bundled into a room fee. Nurse administrators should assure representation from nursing on internal and external boards and committees, and in the multidisciplinary teams created to implement provisions of the PPACA.

What Additional Legislation is Needed?

Many members of the House of Representatives believe additional legislation is needed to complete health care reforms. On July 22, 2010, Representative Lynn Woolsey, D-California, introduced the Public Option Act, H.R. 5808, to create a Medicare – like public insurance plan that can compete with the private plans that will be part of the PPACA. Representative Jim McDermott, D-Washington, is one of 128 co-sponsors. A Congressional Budget Office (CBO) analysis indicates a public option could reduce the federal deficit by \$53 billion between 2014 and 2019. The CBO analysis estimates that about 13 million of the 38 million people who are uninsured would purchase a public option insurance plan rather than a private plan (Song, 2010)

APRNs need a variety of types of legislation nationwide to remove practice barriers. In most states APRNs need legislation that authorizes fully autonomous practice and complete prescriptive authority. APRNs also need legislation to require health plans to reimburse them at the same rate as physicians for the same services. This is an incentive for APRNs to provide more primary care. This is particularly true for Medicare which currently reimburses APRNs at only 85% of the physician fee scale. Medicare law also needs to be changed to allow APRNs to function within their full scope of practice. Examples of these changes are to allow APRNs to certify Medicare patients for home health care and admit Medicare patients to skilled nursing facilities and hospice. Medicaid law needs to be amended to mandate states to allow all APRNs to be providers. Currently only family and pediatric NPs and CNMs are mandated as providers.

WHAT IS HAPPENING IN WASHINGTON STATE?

State Government

State government is actively involved in taking advantage of the provisions of the PPACA that can expand and strengthen health care services to Washington residents. The Washington State Legislature created the Joint Select Committee on Health Reform Implementation to determine what legislation may be needed to comply with and maximize the benefit from the PPACA. For example, there is legislation that will be needed to establish the insurance exchanges. Legislation may also be needed to take advantage of grant opportunities such as workforce development programs or increasing community health centers.

Governor Christine Gregoire established a Health Care Cabinet to assure ongoing-coordination of the federal health care reforms. The permanent members of the Cabinet are the administrator of the Health Care Authority, Secretary of the Department of Health, Secretary of the Department of Social and Health Services, Director of the Executive Policy Office and the Director of the Office of Financial Management. Other members of state agencies will participate on an as-needed basis. The Cabinet will provide leadership and accountability for implementation of state and federal health care reform, make recommendations to the Governor on the implementation of state health initiatives and national health reforms, interact with key stakeholder organizations and groups, share information and coordinate with the Legislative Joint Select Committee on Health Care Reform, and share information and coordinate with the Office of the Insurance Commissioner (Office of the Governor, 2010).

The Office of the Insurance Commissioner worked with the Washington State Health Insurance Pool to run the temporary federally funded Pre-Existing Condition Insurance Plan. This plan will provide temporary health insurance to people who have been uninsured for at least six months and have a pre-existing condition. The law stipulates which pre-existing conditions qualify a person for the coverage. The list can be accessed at <http://www.insurance.wa.gov/consumers/health/preconditionplanwa/eligibility.shtml>.

The Insurance Commissioner created the Health Reform Realization Committee in 2009 to develop recommendations to implement federal health care reform. The committee also makes recommendations to strengthen Washington's infrastructure and to innovate as needed to improve aspects of the health care system not addressed by the PPACA. The committee coordinates with the Legislature and Office of the Governor (Office of the Insurance Commissioner, 2010).

Many state agencies and the Legislature will be involved in implementation of specific provisions of the PPACA. For example, the Department of Health administers many of the scholarship and loan repayment programs. The Department of Social and Health

Services administers the state's Medicaid program and will be required to implement expanded coverage to people with incomes up to 133% of the FPL. The Medicaid program will also need to determine if participation on demonstration projects such as changes to reimbursement and health homes for people with chronic conditions.

Washington Center for Nursing

Implementation of the PPACA provides nurses with an opportunity to advocate for policies that improve access to care, improve the delivery system and maximize the contributions of nurses to health care. The Washington Center for Nursing (WCN) in collaboration with the Council of Nurse Educators of Washington State developed the Master Plan for Nursing Education. The plan is designed to ensure a nurse workforce that has the appropriate education to provide care for the state's residents. This document can be used to guide workforce development efforts and to capitalize on education grant opportunities included in the PPACA. The WCN in 2010 held a series of meetings to solicit input about the role of the nurse of the future. The ideas gleaned from participants can be used to facilitate nurses' involvement in the implementation of the PPACA.

Washington State Nurses Association

WSNA is actively involved in the implementation of the PPACA to assure that nurses provide input and participate in a meaningful way. This policy brief is an example of WSNA's commitment to inform nurses about the PPACA. WSNA consistently nominates nurses to be members of health care committees. For example, former WSNA President and current ANA second vice-president Kim Armstrong is a member of the Insurance Commissioner's Health Reform Realization Committee. Staff monitor the work of legislative committees such as the Joint Select Committee on Health Care Reform Implementation, participate in coalitions such as the Healthy Washington Coalition, the Primary Care Coalition, and the Governor's Health Disparities Workforce Development Committee.

As the PPACA is implemented over the next several years, WSNA will work tirelessly to increase and advance the nursing workforce, improve the quality of health care delivery, support increased access to care, support public health, and promote prevention of disease and a focus on wellness. This is part of WSNA's consistent efforts to guarantee that every person has access to quality care in a timely manner delivered by the most appropriate provider at an affordable cost.

CONCLUSION

The extended period of time over which the PPACA will be implemented leaves many unanswered questions. Will there be concerted efforts made to change the substance of the law or erode the significance of its provisions? Will access be improved to the extent predicted and will costs be contained or expand further?

Interestingly, one of the first provisions of the PPACA has not been used as widely as expected. People with certain health conditions who were unable to obtain insurance for six months became eligible in July 2010 for a temporary 'high risk' pool. While many thousands of people were expected to apply, only 3,600 applied and only about 1,200 were approved within the first six weeks (Galewitz, 2010).

In contrast, the 2006 requirement for individuals to obtain insurance coverage has reduced the number of uninsured to a nationwide low in Massachusetts. Compared to the estimated 15%-18% uninsured nationwide, a 2009 survey in Massachusetts revealed the overall rate of people who were uninsured at 2.7% with children having a rate of only 1.9% and almost all people age 65 and older were insured. Despite an increase in unemployment from 5.1% to 8.6% in the prior year, the rate of uninsured among working age adults had not increased (Long and Phadera, 2010).

The results of the 2010 and 2012 elections will have a strong influence on the implementation of the PPACA. Election of representatives supportive of PPACA can secure its future. Election of its opponents will make PPACA vulnerable to being undermined or repealed. Many of the provisions are authorized but not yet funded. The legal challenges to the requirement to obtain insurance or pay a penalty will also have a major impact on the fate of the law.

Nurses, alongside consumers, have much to gain from the PPACA, despite many unanswered questions. WSNA, ANA and other nursing organizations will participate in the implementation of the law and advocate for changes that correct the fundamental flaws of our current health care system. It is both our right and our responsibility to be part of this historic process of health care reform.

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WEB BASED RESOURCES

American Association of Colleges of Nursing

<http://www.aacn.nche.edu/Government/pdf/HCRreview.pdf>

American Nurses Association Health System Reform

<http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform.aspx>

Key Provisions Related to Nursing

<http://www.nursingworld.org/MainMenuCategories/HealthcareandPolicyIssues/HealthSystemReform/Key-Provisions-Related-to-Nurses.aspx>

The Commonwealth Fund Health Reform Resources

<http://www.commonwealthfund.org/Health-Reform.aspx>

Kaiser Family Foundation Health Reform

<http://healthreform.kff.org/>