



## Expanding Health Coverage and Access

### AHA View

Universal health care coverage is key to achieving the AHA's vision of healthy communities where all individuals reach their highest potential for health. To achieve this goal, the AHA has long advocated for the expansion of coverage through private and public-sector means. In addition, AHA continues its efforts to work with a broad spectrum of stakeholders, as well as the state hospital associations and member hospitals, to provide resources and tools to help connect patients and their families with affordable coverage and access to quality care.

### Background

Five years after the enactment of the Affordable Care Act (ACA), the Department of Health and Human Services (HHS) reports that 16.4 million uninsured people have gained health insurance coverage. Coverage gains came through the Health Insurance Marketplaces, Medicaid and the Children's Health Insurance Program (CHIP), and through policies allowing children to stay on their parents' plan until age 26. According to HHS, the uninsured rate dropped from 20.3 percent to 13.2 percent between October 2013 (the start of the first open enrollment period) and March 2015 (the end of the second open enrollment period). This represents a gain in health coverage for 14.1 million individuals during that time. While the recent numbers point to continued improvements in health insurance coverage, several threats – legal and legislative – remain to achieving universal coverage.

### Key Priorities

The AHA will continue to work on several fronts to protect and expand health care coverage and access to health care services, including:

- Maintaining health insurance subsidies for low-income individuals;
- Expanding Medicaid coverage for low-income adults;
- Maintaining CHIP funding for low-income children;
- Supporting supplemental hospital payment programs such as Medicaid Disproportionate Share Hospital (DSH) payments for hospitals that serve low-income and uninsured patients;
- Ensuring access to providers and services through adequate provider network standards; and
- Maintaining access to Medicare Advantage (MA) plans for enrollees.

### Maintaining Subsidies for Low-income Individuals

The ACA currently provides financial help to low-income individuals purchasing health care coverage through the state or federal Health Insurance Marketplaces in the form of premium tax credits, commonly known as subsidies, and cost-sharing assistance. The ACA's subsidies have made it possible for more than 9 million men, women and children to obtain health care coverage with financial help. But their continued availability is in jeopardy in states that have not set up their own marketplaces. The U.S. Supreme Court in late June will rule on a case (*King v. Burwell*) challenging the permissibility of those subsidies for individuals purchasing insurance through the federally-facilitated Marketplace, known as Healthcare.gov. The AHA filed a friend-of-the-court brief supporting the

government's interpretation of the ACA's subsidies, emphasizing that the loss of those subsidies would be a disaster for millions of lower- and middle-income Americans. The brief was filed in collaboration with the Federation of American Hospitals, Association of American Medical Colleges and America's Essential Hospitals. In addition, the AHA is working with state hospital associations in the impacted states to develop tools and resources to ensure that coverage is protected in the wake of the *King v. Burwell* decision should the Court rule in favor of the plaintiffs.

### **Expanding Medicaid Coverage for Low-income Adults**

By 2022, Medicaid is expected to add 13 million enrollees as a result of the ACA's coverage expansions. This is 4 million fewer than originally projected by the Congressional Budget Office (CBO) due to the U.S. Supreme Court's 2012 ruling that resulted in states having the choice to expand or not expand their Medicaid programs. To date, 28 states and the District of Columbia are expanding their programs. According to an October 2014 report from The Urban Institute, states not expanding Medicaid may miss out on more than \$420 billion in federal funding between 2014 and 2022. The AHA believes it is important for all states to expand Medicaid to deliver on the ACA's promise of coverage. Expanding Medicaid coverage is good for the health of communities because the program helps millions of low-income adults, children and their families receive health care, serving as a backstop for those who have lost employment-based health care coverage and providing access to health care services to those who cannot afford private insurance. In addition, expanding Medicaid is good for employers because people who do not have ready access to health care put off care leading to higher absenteeism, while a healthy and productive workforce is good for economic development.

### **Maintaining CHIP Funding for Low-income Children**

The ACA envisioned that CHIP would no longer be necessary because of Medicaid improvements and expansion and the subsidized family coverage in the Health Insurance Marketplaces. CHIP eligibility standards were extended by the ACA through 2019 to transition CHIP beneficiaries to either Medicaid or subsidized coverage through the Marketplaces. The ACA, however, did not extend CHIP funding, and it was set to expire at the end of fiscal year (FY) 2015. However, the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015, H.R. 2., extended CHIP funding for two additional years, through Sept. 30, 2017.

### **Supporting the Medicaid DSH program for Hospitals that Serve Low-income and Uninsured Patients**

The Medicaid DSH program helps hospitals serving low-income and uninsured populations shoulder the financial burden of providing uncompensated care to these populations. The ACA cuts to the Medicaid DSH program were intended to coincide with increases in health care coverage. However, the 2012 Supreme Court decision on the ACA's Medicaid expansion has changed that trajectory resulting in fewer covered individuals. According to recent CBO projections, the ACA will expand coverage to 25 million – rather than the originally projected 32 million – individuals. In 2013, hospitals provided \$46 billion in uncompensated care, underscoring the importance of supplemental programs like Medicaid DSH.

The AHA has been successful in delaying for three years the start of Medicaid DSH cuts. Most recently, the MACRA eliminated the Medicaid DSH cuts in FY 2017 and lowered the Medicaid DSH cuts in FYs 2018 through 2020.

**Ensuring Access to Providers and Services through Adequate Provider Network Standards**

The issue of health plan provider network adequacy and health plans' use of narrow or tiered provider networks has been raised in several different contexts: the new federal and state Health Insurance Marketplaces, the National Association of Insurance Commissioners, the MA program and non-grandfathered health plans. The AHA is actively advocating for adequate provider network standards in all of these contexts. The AHA strongly believes that patients and providers, the primary parties involved in care delivery, are best served when: 1) there is sufficient choice of providers; 2) care is easily accessible; and 3) patients and providers are certain of when care is being provided in or out of network and clearly understand their financial obligations under either scenario. Patients and their families should be protected, to the extent possible, from the financial burdens of unexpected balance billing. It is important to ensure that health plan enrollees have access to a selection of high-quality providers in or near their communities, while not inhibiting care coordination and the growth of integrated care systems, which by their nature, offer smaller networks of providers.

**Maintaining Access to MA Plans for Enrollees and Providers**

America's hospitals have been moving aggressively toward payment systems that reward value over volume, incentivize the integration of payment and care delivery, and place an emphasis on quality and access. To this end, many hospitals and health systems either now have a Medicare Advantage Organization (MAO), are planning to add an MAO or are looking to share risk with an MAO because MA serves a critically important population, values care integration and rewards quality and access. These hospital-based plans bolster the affordable plan choices available to Medicare beneficiaries across the country, enable beneficiaries to access high-quality providers who share common records and can coordinate their care, and offer value-added benefits and services beyond what basic Medicare covers.

A sustainable MA program is in the best interest of the 30 percent of beneficiaries who choose such plans. Medicare beneficiaries should have a selection of high-quality plans that include affordable premiums and cost sharing, and access to the value-added benefits on which MA beneficiaries have come to rely.