ACCESS TO HEALTH COVERAGE

POSITION

ANA is committed to comprehensive health care reform that will ensure universal access to health care (preferably through a single-payer system). ANA also continues to support progressive, incremental steps to cover the millions of Americans who lack health care coverage and to oppose efforts to exempt new insurance pools such as association health plans (AHPs) from state insurance laws and regulations. In 2010, the ANA reaffirmed its longstanding position that health care is a basic human right for all people, and all individuals living in the US (documented or not) should have access to health care.

BACKGROUND

The U.S. system of private, employer-based health insurance has served a crucial role in expanding the availability of health care coverage and ensuring a stable financial base for the health care system. However, this system has never reached all Americans, nor was it designed to provide coverage for all. The Medicare and Medicaid programs were enacted in 1965 to fill two of the most gaping holes in the system by providing coverage for those over 65 (and later, the permanently disabled) and for a large segment of the poor.

ANA has supported efforts to increase access to quality health care, even when they are limited to a specific population and not intended to be comprehensive in scope. Since 1994, a number of notable efforts have been made to increase health care access for specific target populations, including the Health Insurance Portability and Accountability Act (HIPAA) and the State Children's Health Insurance Program (S-CHIP), in 2009 renamed CHIP. On March 23, 2010 President Barack Obama signed House of Representatives bill HR 3590, Affordable Care Act (ACA), into law, Public Law No: 111-148. The enactment of this historic legislation is an affirmation that Americans recognize the need for affordable, quality health care reform.

ANA supported the Affordable Care Act and welcomes a dialogue to improve and strengthen its provisions. The following ANA criteria to improve access for the American population were met under ACA:

Availability (geographic; times; alternative sites; disabled; elderly)-No insurance discrimination based on employee's wages; and no discrimination by insurers based on health status, medical condition or history, claims experience, genetic information, disability, evidence of insurability, or other factors HHS deems (effective 2014)

Acceptable (respect autonomy & culture; patient-centered)-Establishes new programs to support school-based health centers and nurse-managed health centers (effective 2010)

Affordable (treatment and follow-up care; based on ability to pay) -Premium and cost-sharing subsidies for individuals, through the Health Exchanges, sliding scale dependent on income 100-400% FPL. -Expands Medicaid to all people under age 65, up to 133%FPL.

All citizens and residents -US citizens and legal residents. Undocumented immigrants are not included, except as they are exempt from the individual mandate to obtain coverage.

RATIONALE

The number of uninsured Americans remains unacceptably high, at nearly 43 million people, or 15 percent of the U.S. population. Too many Americans are simply not reached by employer-based insurance, private plans, or existing public programs. They include those who work for employers that do not provide health benefits, part-time or seasonal workers in positions that do not offer benefits, the self-employed, families who do not qualify for Medicaid, and people for whom coverage is available but who cannot afford to pay the premiums.

The uninsured experience poorer health and die sooner as compared to individuals who are covered by health insurance. The Institute of Medicine reports that lack of insurance at the community level is associated with financial instability for health care providers and institutions, reduced hospital services and capacity, and significant cuts in public health programs, all of which impact access to certain types of care for all residents, even those who have coverage.