Application For Medicaid And Affordable Health Coverage

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Affordable Care Act For Dummies - Lisa Yagoda 2014-05-20
An essential and easy-to-understand guide to the Affordable Care Act The Affordable Care Act For Dummies is your survival guide to understanding the changes in our health care system and how they benefit you. Written in down-to-earth language, this handy resource outlines new protections under the Affordable Care Act, and walks you through what you—as an individual or an employer—need to do to select the best health insurance plan for your needs. With this book, you get answers to your top questions about how the law applies to you. The folks that bring you the For Dummies line of useful, educational books have teamed up with AARP to give you a hands-on guide that offers insight into how to make the right decisions about health care and improve your quality of life. It is filled with examples, ideas, and information as well as useful takeaways to help you take full advantage of the reforms. Uncover the 10 essential benefits of the Affordable Health Care Act Receive guidance on what will improve if you already have insurance coverage If you don't have coverage, determine which insurance program is right for you and your family and whether you're eligible for financial assistance Find out what changes businesses large and small can anticipate Learn how to avoid scammers who are taking advantage of consumers' confusion Use this complete guide to get the facts about the Affordable Care Act, clear up any misconceptions you may have about the law, and prepare for the health care choices ahead.

Medicaid and Health Insurance Exchanges - Scott Ahearn 2013
The Patient Protection and Affordable Care Act (ACA) expands health insurance coverage primarily through two mechanisms: by expanding the existing Medicaid program and by establishing new health insurance exchanges where certain individuals and businesses can purchase private health insurance. Under ACA, Medicaid and exchanges are envisioned to work in tandem, with the potential to provide a continuous source of subsidised coverage for lower-income individuals and families, beginning in 2014. This book provides an analysis of some of the key similarities and differences between Medicaid and insurance plan structure in plans offered through exchanges. Because Medicaid services vary by population covered and by state, and exchange plans can also vary by state, this book provides insight into the complexities and issues when comparing beneficiary benefits and costs to individuals for Medicaid and the exchanges. The inherent variations in Medicaid and the uncertainty about exactly how the exchanges will operate are just two of the factors that complicate this comparison.

Impacts of the Affordable Care Act's Medicaid Expansion on Insurance Coverage and Access to Care - 2016
This issue brief provides a literature review of the effects of Medicaid expansion, with a focus on the impacts of the ACA's Medicaid expansion in 2014 and 2015. Specifically, the brief focuses

on the effects of expansion on health coverage and access, affordability and quality of care. The first section of this issue brief examines the evidence to date on the impact of Medicaid expansion on health coverage. The second section explores the beneficiary impacts of Medicaid expansion, by examining access to care and utilization. The third section examines research to date on affordability and quality including enrollee financial well-being, satisfaction and experience. This literature review adds to prior ASPE research on the economic impacts of Medicaid expansion including the impact on the cost of uncompensated care.

Tax-Related Provisions in the Affordable Care Act - William Medeiros 2013

The Subcommittee on Oversight of the Committee on Ways and Means has reviewed the implementation of the tax and tax-related revenue provisions of the Patient Protection and Affordable Care Act (ACA). The Affordable Care Act has made broad-based changes to the law with respect to health insurance coverage in the individual and group markets and the law with respect to group health plans as well as laws that apply to Medicare and Medicaid. The ACA also includes a significant number of changes to the Code, including the addition of new Code sections and the amendment of previously existing Code sections. The ACA also includes off-Code revenue provisions that impose certain industry fees. This book provides a summary of health insurance changes made by the ACA and a description of the present law rules with respect to ACA revenue provisions and their implementation.

An Employee's Guide to Health Benefits Under COBRA - 2010

Patient Protection and Affordable Care Act - United States Government Accountability Office 2017-09-26

PPACA provides for the establishment of health-insurance marketplaces where consumers can, among other things, select private health-insurance plans or apply for Medicaid. The act requires verification of applicant information to determine enrollment or subsidy eligibility. In addition, PPACA provided for the expansion of the Medicaid program. GAO was asked to examine enrollment and verification controls for the marketplaces. This report, which follows earlier testimony, provides final results of GAO testing and describes (1) undercover attempts to obtain health-plan coverage from the federal Marketplace and selected state marketplaces for 2015, and (2) undercover attempts to obtain Medicaid coverage through the federal Marketplace and the selected state marketplaces. GAO submitted, or attempted to submit, 18 fictitious applications by telephone and online. Ten applications tested controls related to obtaining subsidized coverage available through the federal Marketplace in New Jersey and North Dakota, and through state marketplaces in California and Kentucky. GAO chose these states based partly on range of population and whether the state had expanded Medicaid eligibility under PPACA. The other 8 applications tested controls for determining Medicaid eligibility. The results, while illustrative, cannot be generalized. GAO discussed results

The Economics of Medicaid - Jason J. Fichtner 2014-03-24

Medicaid, originally considered an afterthought to Medicare, is today the largest health insurance provider in the United States. Under the Affordable Care Act, the Congressional Budget Office projects Medicaid enrollment to increase nearly 30 percent by 2024 and federal spending on the program to double over the next decade. For the states, Medicaid is already the largest single budget item, and its rapid growth threatens to further crowd out other spending priorities. In this collection of essays published by the Mercatus Center at George Mason University, nine experts discuss the escalating costs and consequences of a program that provides second-class health care at first-class costs. The authors begin with an explanation of Medicaid’s complex state-federal funding structure. Next, they examine how the system’s conflicting incentives discourage both cost savings and efficient care. The final chapters address the pros and cons of the most mainstream Medicaid reform proposals and offer alternative solutions. This book offers a timely assessment of how Medicaid works, its most problematic components, and how—or if—its current structure can be adequately reformed to

provide quality care for those in need at sustainable costs. Contributors include: Joseph Antos, American Enterprise Institute Charles Blahous, Mercatus Center at George Mason University Darcy Nikol Bryan, MD, practicing physician James C. Capretta, Ethics and Public Policy Center Robert F. Graboyes, Mercatus Center at George Mason University June O'Neill, Baruch College, CUNY Nina Owcharenko, Heritage Foundation Thomas Miller, American Enterprise Institute

Medicare and Medicaid at 50 - Alan B. Cohen 2015-06-01

For fifty years, Medicare and Medicaid have stood at the center of a contentious debate surrounding American government, citizenship, and health care entitlement. In Medicare and Medicaid at 50, leading scholars in politics, government, economics, health policy, and history offer a comprehensive assessment of the evolution of these programs and their impact on society -- from their origins in the Great Society era to the current battles over the Affordable Care Act ("Obamacare"). These highly accessible essays examine Medicare and Medicaid from their origins as programs for the elderly and poor to their later role as a safety net for the middle class. Along the way, they have served as touchstones for heated debates about economics, social welfare, and the role of government. Medicare and Medicaid at 50 addresses key questions for understanding the past and future of health policy in America, including: · What were the origins for these initiatives, and how were they transformed over time? · What marks have Medicare and Medicaid left on society? · In what ways have these programs produced innovation, even in eras of retrenchment? · How did Medicaid, once regarded as a poor person's program, expand its benefits and coverage over the decades to become the platform for the ACA's future expansion? The volume's contributors go on to examine the powerful role of courts in these transformations, along with the shifting roles of Congress, public opinion, and state governors in the programs' ongoing evolution. From Lyndon Johnson to Barack Obama on the left, and from Ronald Reagan to George W. Bush on the right, American political leaders have tied their political fortunes to the fate of America's entitlement programs; Medicare and Medicaid at 50 helps explain why, and how those ongoing debates are likely to shape the future of the Affordable Care Act.

Health Insurance and Managed Care - Peter R. Kongstvedt 2015-03-27

Health Insurance and Managed Care: What They Are and How They Work (formerly titled Managed Care: What It Is and How It Works) is a concise introduction to the foundations of the American managed health care system. Written in clear and accessible language, this handy guide offers an historical overview of managed care and then walks the reader through the organizational structures, concepts, and practices of the managed care industry. The Fourth Edition is a thorough update that addresses the impact of the Affordable Care Act throughout the industry including: - New underwriting requirements - New marketing and sales channels - Limitations on sales, governance, and administrative (SG&A) costs and profits - New provider organizations such as Patient Centered Medical Homes (PCHMs) and Accountable Care Organizations (ACO's) - New payment mechanisms such as shared savings with ACOs, and severity-adjusted diagnosis related groups - Changes to Medicare Advantage - Medicaid expansion and reliance on Medicaid managed care

The Affordable Care Act and Medicaid Expansion - Brian Dermot Coyne 2016

The Arkansas premium assistance model, commonly known as the Private Option, is one of six alternative Medicaid waiver designs that have been approved in states to expand coverage for low-income adults. The waiver places adults age 19-64 and under 138% of poverty in the newly established health insurance exchange and uses Medicaid funding to purchase the premium payment for health plan coverage. The program began in January 2014. This qualitative descriptive study examined the key operational and program features of the Private Option in order to provide a formative evaluation of how well it is working at this early stage. The study also examined if this model, or similar models, might offer a promising path for the 19 states that have chosen not expand coverage for populations newly eligible for Medicaid under the Affordable

Care Act. The results of the study suggest that it is a potentially promising model. Arkansas saw the largest drop in the uninsured rate in the country in the first 18 months since the program began. It has also expanded its provider networks, added new health plans to the marketplace, and the program is generating overall net state savings. Politics, policy, and state costs are factors that drive the current debate in states that have not expanded. Framing coverage as a uniquely designed state approach and not Medicaid expansion are key conditions for moving forward. Language emphasizing a private sector approach and personal responsibility are critical factors as well. There are challenges, however, between Medicaid rules and exchange rules, particularly around the issue of cost-sharing. There is a significant cliff between the two programs in terms of personal financial obligations that will likely need to be remedied in the years ahead. Studies show that as many as 50% of those under 200% of poverty are likely to transition between eligibility for these two programs in any given year, and these cost-sharing differences apply despite an integrated program. The Affordable Care Act is part of an ongoing process that has transformed Medicaid from a social welfare program to an income-based program to provide health insurance coverage to low-income populations. The integration of these two programs, Medicaid and the health insurance exchanges, through premium assistance, reflects these transformative changes and are part of the continuing evolution of our nation's health care system.

Medicaid Eligibility Quality Control: The review process - United States. Social and Rehabilitation Service 1975

Health-Care Utilization as a Proxy in Disability Determination - National Academies of Sciences, Engineering, and Medicine 2018-04-02
The Social Security Administration (SSA) administers two programs that provide benefits based on disability: the Social Security Disability Insurance (SSDI) program and the Supplemental Security Income (SSI) program. This report analyzes health care utilizations as they relate to impairment severity and SSA's definition of disability. Health Care Utilization as a Proxy in Disability Determination identifies types of utilizations that might be good proxies for "listing-level" severity; that is, what represents an impairment, or combination of impairments, that are severe enough to prevent a person from doing any gainful activity, regardless of age, education, or work experience.

Patient Protection and Affordable Care Act Preliminary Results of Undercover Testing of the Federal Marketplace and Selected State Marketplaces for Coverage Year 2015 - U.s. Government Accountability Office 2017-06-02
PPACA provides for the establishment of health-insurance marketplaces where consumers can, among other things, select private health-insurance plans or apply for Medicaid. The Congressional Budget Office estimates the cost of subsidies and related spending under PPACA at $60 billion for fiscal year 2016. PPACA requires verification of applicant information to determine enrollment or subsidy eligibility. In addition, PPACA provided for the expansion of the Medicaid program. GAO was asked to examine application and enrollment controls for the marketplaces and Medicaid. This testimony provides preliminary results of undercover testing of the federal and selected state marketplaces during the 2015 open-enrollment period, for both private health-care plans and Medicaid. GAO submitted, or attempted to submit, 18 fictitious applications by telephone and online, 10 of which tested controls related to obtaining subsidized health-plan coverage available through the federal Marketplace in New Jersey and North Dakota, and through state marketplaces in California and Kentucky. GAO chose these four states based partly on a range of population sizes and whether the state had expanded Medicaid eligibility under terms of the act. The other 8 applications, among the 18 GAO made, tested marketplace and state controls under the marketplace system for determining Medicaid eligibility in these four states. The undercover results, while illustrative, cannot be generalized to the full population of enrollees. GAO discussed the results of its testing with CMS and state officials to obtain their perspectives.

America's Affordable Health Choices Act of 2009, October 14, 2009, 111-1 House Report 111-299, Part 3 - 2009

Investigating State Incentives and Decision-Making During Section 1115 Waiver Application - Kathryn Brooks Vaughn 2022
The social determinants of health are relatively well-documented, considering that the academic and research concept of studying the non-clinical causes of health disparities is little more than twenty years old. The World Health Organization recognizes ten different social elements that are likely to influence health outcomes in both positive and negative ways: income and social protection, education, unemployment and job insecurity, food insecurity, housing, basic amenities and the environment, early childhood development, social inclusion and non-discrimination, structural conflict, and access to affordable services of decent quality. The United States healthcare system is one of few among the developing nations that centers health policy decisions upon favoring employer sponsored insurance, or ESI. Such a practice has deep roots in American history and policy. What is concerning about this focus, however, is that less than fifty percent of Americans actually access their primary insurance coverage through employer-sponsored plans. Lower-income families and workers are traditionally less likely to be covered by employer plans, meaning that those who qualify are all but forced to seek coverage through state and federal insurance programs, like Medicaid. As prices and overall spending continues to increase at concerning rates, the reliance upon insurance as a mechanism to facilitate affordability is nearly cemented. Overall health outcomes among the uninsured (or underinsured) tend to be worse than those who have insurance, as we know that in many cases, the uninsured end up delaying or avoiding care due to cost.States that consistently rank as having the worst health outcomes , tend to coincide with data that indicates that they also spend less on care per capita. There are a multitude of reasons why this could be - some research points to burdens in accessing public health care provisions (both insurance and clinical care), others point to high rates of uninsurance due to cost, while others examine the relationship between cultural and dietary habits and health maintenance. Many of these concentrations in poor health outcomes tend to reside in states that also have poor outcomes in education, poverty, and other social metrics that tend to be predictors of health outcomes. For these reasons, this paper will explore the access to affordable and quality services in the United States, specifically in the realm of Medicaid and state efforts to alter its accessibility and quality. Section 1115 Medicaid waivers have long been utilized by states to change health care policy in ways that the federal government does not. From expanding eligibility criteria, to imposing work requirements, it is often implied that state leaders use this tool for political posturing rather than program improvement. However, almost every state has applied for a waiver at some point in time, making irrelevant the argument that one party rather pulls this lever more than another. This paper seeks to quantify some of the assumptions about why states use this tool to alter Medicaid and its structure: by incorporating state demographic factors, I will examine the varying incentives that states have to apply for Medicaid demonstration waivers. I will investigate this question by using data from a combination of sources including for poverty and income levels, employment, state gross domestic product, Medicaid enrollment, state legislative leanings, and more. Due to the multi-faceted nature of these waivers, my research will examine waivers in all states, along with separate analyses for states that are re-applying for existing waivers, and further stratification for addressing the individual likelihoods of applying for "progressive" waivers (that seek to expand Medicaid access and enrollment) versus "regressive" waivers (or waivers that seek to restrict Medicaid access and enrollment). This research will provide valuable context for further discussion around political incentives, and whether state efforts to better manage (or better afford) Medicaid programs are really of merit.

The Uninsured and Affordable Health Care Coverage - United States. Congress. House. Committee on Energy and Commerce. Subcommittee on Health 2002

Health Care Reform and American Politics - Lawrence R. Jacobs 2016
The Patient Protection and Affordable Care Act signed by President Obama in March 2010 is a

landmark in U.S. social legislation, and the Supreme Court's recent decision upholding the Act has ensured that it will remain the law of the land. The new law extends health insurance to nearly all Americans, fulfilling a century-long quest and bringing the United States to parity with other industrial nations. Affordable Care aims to control rapidly rising health care costs and promises to make the United States more equal, reversing four decades of rising disparities between the very rich and everyone else. Millions of people of modest means will gain new benefits and protections from insurance company abuses - and the tab will be paid by privileged corporations and the very rich. How did such a bold reform effort pass in a polity wracked by partisan divisions and intense lobbying by special interests? What does Affordable Care mean - and what comes next? In this updated edition of Health Care Reform and American Politics: What Everyone Needs to Know(R), Lawrence R. Jacobs and Theda Skocpol - two of the nation's leading experts on politics and health care policy - provide a concise and accessible overview. They explain the political battles of 2009 and 2010, highlighting White House strategies, the deals Democrats cut with interest groups, and the impact of agitation by Tea Partiers and progressives. Jacobs and Skocpol spell out what the new law can do for everyday Americans, what it will cost, and who will pay. In a new section, they also analyze the impact the Supreme Court ruling that upheld the law. Above all, they explain what comes next, as critical yet often behind-the-scenes battles rage over implementing reform nationally and in the fifty states. Affordable Care still faces challenges at the state level despite the Court ruling. But, like Social Security and Medicare, it could also gain strength and popularity as the majority of Americans learn what it can do for them.
Health Benefits Coverage Under Federal Law--. - 2010

The Affordable Care Act - Tamara Thompson 2014-12-02
The Patient Protection and Affordable Care Act (ACA) was designed to increase health insurance quality and affordability, lower the uninsured rate by expanding insurance coverage, and reduce the costs of healthcare overall. Along with sweeping change came sweeping criticisms and issues. This book explores the pros and cons of the Affordable Care Act, and explains who benefits from the ACA. Readers will learn how the economy is affected by the ACA, and the impact of the ACA rollout.
Health Care Coverage for Children - United States. Congress. Senate. Committee on Finance 1990

Health Insurance and Managed Care - Peter R. Kongstvedt 2019-02-14
Health Insurance and Managed Care: What They Are and How They Work is a concise introduction to the workings of health insurance and managed care within the American health care system. Written in clear and accessible language, this text offers an historical overview of managed care before walking the reader through the organizational structures, concepts, and practices of the health insurance and managed care industry. The Fifth Edition is a thorough update that addresses the current status of The Patient Protection and Affordable Care Act (ACA), including political pressures that have been partially successful in implementing changes. This new edition also explores the changes in provider payment models and medical management methodologies that can affect managed care plans and health insurer.
Healthcare Changes and the Affordable Care Act - James S. Powers 2014-10-20
Healthcare Changes Reach Main Street: A Call to Action for Physicians provides guidance, examples, and information on processes and time lines for physicians based on the implementation of The Affordable Care Act (ACA) that was established in 2010. This volume focuses on how geriatricians and other healthcare professionals can be engaged in responding to the roll-out of the ACA in their communities, and through this engagement assume leadership roles in local hospitals, healthcare organizations, and medical societies to advance quality improvement and new models of care for older adults. In-depth chapters provide an update on quality improvement efforts at the state level, as well as changes in Medicaid financing and the significant impact this will have for older adults, particularly dual-

eligibles. Many elements of the ACA are yet to be rolled out and many healthcare decisions are yet to be made. Healthcare Changes Reach Main Street: A Call to Action for Physicians will guide healthcare decision makers and help them to play a leadership role in advancing quality care for older adults in our changing healthcare environment.

Landmark - Staff of the Washington Post 2010-04-27

The Washington Post's must-read guide to the health care overhaul What now? Despite the rancorous, divisive, year-long debate in Washington, many Americans still don't understand what the historic overhaul of the health care system will—or won't—mean. In Landmark, the national reporting staff of The Washington Post pierces through the confusion, examining the new law's likely impact on us all: our families, doctors, hospitals, health care providers, insurers, and other parts of a health care system that has grown to occupy one-sixth of the U.S. economy. Landmark's behind-the-scenes narrative reveals how just how close the law came to defeat, as well as the compromises and deals that President Obama and his Democratic majority in Congress made in achieving what has eluded their predecessors for the past seventy-five years: A legislative package that expands and transforms American health care coverage. Landmark is an invaluable resource for anyone eager to understand the changes coming our way.

Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-expansion States - Charles Courtemanche 2016

The Affordable Care Act (ACA) aimed to achieve nearly universal health insurance coverage in the United States through a combination of insurance market reforms, mandates, subsidies, health insurance exchanges, and Medicaid expansions, most of which took effect in 2014. This paper estimates the causal effects of the ACA on health insurance coverage using data from the American Community Survey. We utilize difference-in-difference-in-differences models that exploit cross-sectional variation in the intensity of treatment arising from state participation in the Medicaid expansion and local area pre-ACA uninsured rates. This strategy allows us to identify the effects of the ACA in both Medicaid expansion and non-expansion states. Our preferred specification suggests that, at the average pre-treatment uninsured rate, the full ACA increased the proportion of residents with insurance by 5.9 percentage points compared to 3.0 percentage points in states that did not expand Medicaid. Private insurance expansions from the ACA were due to increases in both employer-provided and non-group coverage. The coverage gains from the full ACA were largest for those with incomes below the Medicaid eligibility threshold, non-whites, young adults, and unmarried individuals. We find some evidence that the Medicaid expansion partially crowded out private coverage among low-income individuals.

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). - 1986

Care Without Coverage - Institute of Medicine 2002-06-20

Many Americans believe that people who lack health insurance somehow get the care they really need. Care Without Coverage examines the real consequences for adults who lack health insurance. The study presents findings in the areas of prevention and screening, cancer, chronic illness, hospital-based care, and general health status. The committee looked at the consequences of being uninsured for people suffering from cancer, diabetes, HIV infection and AIDS, heart and kidney disease, mental illness, traumatic injuries, and heart attacks. It focused on the roughly 30 million-one in seven-working-age Americans without health insurance. This group does not include the population over 65 that is covered by Medicare or the nearly 10 million children who are uninsured in this country. The main findings of the report are that working-age Americans without health insurance are more likely to receive too little medical care and receive it too late; be sicker and die sooner; and receive poorer care when they are in the hospital, even for acute situations like a motor vehicle crash.

Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and App (Us Centers for Medicare and Medicaid Services

Regulation) (Cms) (2018 Edition) - The Law The Law Library 2018-06-16
Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and App (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and App (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule implements provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act. This final rule finalizes new Medicaid eligibility provisions; finalizes changes related to electronic Medicaid and the Children's Health Insurance Program (CHIP) eligibility notices and delegation of appeals; modernizes and streamlines existing Medicaid eligibility rules; revises CHIP rules relating to the substitution of coverage to improve the coordination of CHIP coverage with other coverage; and amends requirements for benchmark and benchmark-equivalent benefit packages consistent with sections 1937 of the Social Security Act (which we refer to as "alternative benefit plans") to ensure that these benefit packages include essential health benefits and meet certain other minimum standards. This rule also implements specific provisions including those related to authorized representatives, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges. This rule also updates and simplifies the complex Medicaid premium and cost sharing requirements, to promote the most effective use of services, and to assist states in identifying cost sharing flexibilities. It includes transition policies for 2014 as applicable. This book contains: - The complete text of the Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and App (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section
The Medicare Handbook -

Medicaid and Children's Health Insurance Programs - Fair Hearing and Appeal Processes for Medicaid (Us Centers for Medicare and Medicaid Services Regulation) (Cms) (2018 Edition) - The Law The Law Library 2018-06-16
Medicaid and Children's Health Insurance Programs - Fair Hearing and Appeal Processes for Medicaid (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Medicaid and Children's Health Insurance Programs - Fair Hearing and Appeal Processes for Medicaid (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule implements provisions of the Affordable Care Act that expand access to health coverage through improvements in Medicaid and coordination between Medicaid, CHIP, and Exchanges. This rule finalizes most of the remaining provisions from the "Medicaid, Children's Health Insurance Programs, and Exchanges: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes for Medicaid and Exchange Eligibility Appeals and Other Provisions Related to Eligibility and Enrollment for Exchanges, Medicaid and CHIP, and Medicaid Premiums and Cost Sharing; Proposed Rule" that we published in the January 22, 2013, Federal Register. This final rule continues our efforts to assist states in implementing Medicaid and CHIP eligibility, appeals, and enrollment changes required by the Affordable Care Act. This book contains: - The complete text of the Medicaid and Children's Health Insurance Programs - Fair Hearing and Appeal Processes for Medicaid (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section
Key Facts on Health Coverage for Low-Income Immigrants Today and Under the Affordable Care Act - 2013
Beginning in 2014, the Affordable Care Act (ACA) will expand Medicaid and create new health insurance exchange marketplaces with

advance tax credits to help purchase exchange coverage. These expansions will significantly increase coverage options for citizens and lawfully present immigrants. Further, as immigration reform proposals emerge, it will be important to consider to what extent aspiring citizens will have access to affordable health coverage. This brief provides an overview of health coverage for immigrants today, their coverage options under the ACA, and key issues to consider looking forward.

Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing (Us Department of Health and Human Services Regulation) (Hhs) (2018 Edition) - The Law The Law Library 2018-11-09

Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing (US Department of Health and Human Services Regulation) (HHS) (2018 Edition) The Law Library presents the complete text of the Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing (US Department of Health and Human Services Regulation) (HHS) (2018 Edition). Updated as of May 29, 2018 This final rule implements provisions of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act. This final rule finalizes new Medicaid eligibility provisions; finalizes changes related to electronic Medicaid and the Children's Health Insurance Program (CHIP) eligibility notices and delegation of appeals; modernizes and streamlines existing Medicaid eligibility rules; revises CHIP rules relating to the substitution of coverage to improve the coordination of CHIP coverage with other coverage; and amends requirements for benchmark and benchmark-equivalent benefit packages consistent with sections 1937 of the Social Security Act (which we refer to as "alternative benefit plans") to ensure that these benefit packages include essential health benefits and meet certain other minimum standards. This rule also implements specific provisions including those related to authorized representatives, notices, and verification of eligibility for qualifying coverage in an eligible employer-sponsored plan for Affordable Insurance Exchanges. This rule also updates and simplifies the complex Medicaid premium and cost sharing requirements, to promote the most effective use of services, and to assist states in identifying cost sharing flexibilities. It includes transition policies for 2014 as applicable. This book contains: - The complete text of the Medicaid and Children's Health Insurance Programs - Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing (US Department of Health and Human Services Regulation) (HHS) (2018 Edition) - A table of contents with the page number of each section

Data Needs for the State Children's Health Insurance Program - National Research Council 2002-07-26

The State Children's Health Insurance Program (SCHIP) was established by Congress to provide health insurance to uninsured children whose family income was too high for Medicaid coverage but too low to allow the family to obtain private health insurance coverage. The enabling legislation for SCHIP, included in the Balanced Budget Act of 1997, made available to states (and the District of Columbia) almost $40 billion over a 10-year period for this program. Like Medicaid, SCHIP is a joint federal-state program, with funding from both sources, but it is implemented by the states. Thus, there are SCHIP programs in all of the states and the District of Columbia. The National Research Council, through the Committee on National Statistics, was asked to explore some of the ways in which data analysis could be used to promote achievement of the SCHIP goal of expanding health insurance coverage for uninsured children from low-income families. To inform its work, the panel for this project held a workshop to bring together state SCHIP officials and researchers to share findings and methods that would inform the design, implementation, and evaluation of SCHIP at the state and national levels. In keeping with this charge, this report is limited to discussions at the workshop. It does not attempt to provide a summary of all the state programs nor a comprehensive review of the literature. Data Needs for the State Children's Health Insurance Program concludes

that data are insufficient in the individual states to provide a clear picture of the impact of SCHIP on the number of children who are eligible for the program, the rate at which eligible children are enrolled in the program, and the rate at which they are retained in the program once enrolled. This situation is due, in part, to the fact that sample sizes in national surveys are too small to provide detailed data for individual states. In addition, the great amount of movement of children among health insurance categories-Medicaid, SCHIP, private insurance, or no insurance at all-makes it difficult for states to count the number of children in specific categories at a particular point in time. The panel specifies a number of practices that could be implemented to improve the overall functioning of SCHIP and the ability of policy makers to evaluate the program. Foremost among these are: (1) developing more uniform ways of estimating eligibility and health insurance coverage among the states; (2) sharing among the states effective methods for outreach; (3) taking qualitative information into account, in addition to quantitative information, in assessing variation among states in enrollment and disenrollment; and (4) implementing longitudinal studies to track the movement of children among the various insurance statuses.

Health Care Coverage and Financing in the United States - Timothy F. Harris 2011

Is the guarantee of health care services a luxury or a right? Health Care Coverage and Financing in the United States discusses this timely and controversial topic, and was written in response to the recent, increased interest in health insurance or the lack thereof in the United States. It discusses the history of health insurance over the ages and subsequent development in the U.S. The different types of health insurance are explained, and the terminology commonly used in health insurance is defined and discussed. In addition, the Commercial health insurance that many employees and individuals see in the U.S. is addressed along with the Medicaid and Medicare programs. Finally, the politically-charged topic of Health Reform legislation, its impact on individuals, employers, and insurers is discussed, and the uninsured population that it intends to cover is examined.

ObamaCare - Lori-Ann Rickard 2014-09-20

Healthcare expert Lori-Ann Rickard reveals the easy and practical answers that only an insider knows. Spin Your Healthcare Your Way through ObamaCare with her guide. Easy Healthcare: ObamaCare gives you the secrets no outsider would guess such as: • What ObamaCare means for you if you already have insurance • What ObamaCare means for small businesses • What healthcare changes are already in place • What ObamaCare means for seniors • What Medicaid expansion is and how it impacts you • What a healthcare exchange is and how to use one This guide reveals how ObamaCare impacts you and your family. Lori-Ann Rickard gives you The Bottom Line. With over 30 years of experience in the healthcare industry, HealthSpin founder Lori-Ann Rickard puts you in charge so you can Spin Your Healthcare Your Way!

Medicaid and CHIP - Carolyn L. Yocom 2011-05

The 2010 Patient Protection and Affordable Care Act expands health insurance to millions of individuals, including many parents. New insurance options for parents raise a question about whether providing health insurance to parents benefits their children. The Children¿s Health Insurance Program Reauthorization Act of 2009 required this assessment of: (1) the extent to which a parent¿s health insurance status is associated with a child¿s health insurance status, use of services, and parental satisfaction with their child¿s care; and (2) how selected states¿ parent coverage under Medicaid and CHIP may change given upcoming expansions. Charts and tables. This is a print on demand edition of an important, hard-to-find publication.

Obamacare: Complete Law, Latest Statistics & Republican's Counterproposal - White House 2017-03-20

This e-book contains the complete text of The Patient Protection and Affordable Care Act which is formatted for your eReader with a functional and detailed table of contents. The edition also includes the latest data on health coverage and health care expenses, as well as the Republicans' counter arguments and their proposed bill. Patient Protection and Affordable Care Act or Obamacare, is a United States

federal statute which, at the same time, represents the complete reform of the American health care system conducted by the former president Barack Obama. The main goal of this act was to drive better health outcomes, lower costs, and improve accessibility to health services. The whole system was designed to increase health insurance quality and affordability, lower the uninsured rate by expanding insurance coverage and reduce the costs of healthcare. In March 2017 the Republican Party, which opposed Obamacare, released its plan to replace it.

Health Insurance and Labor Supply - Daeho Kim 2016

This paper examines how health insurance affects labor supply by exploiting a quasi-experimental change in health insurance provision under the Affordable Care Act (ACA) early Medicaid expansion in Connecticut implemented in 2010. Applying an instrumental variables approach to a difference-in-differences-in-differences strategy, I find remarkable labor supply impacts of the ACA early Medicaid expansion in Connecticut. I show evidence that Connecticut's Medicaid expansion increased Medicaid coverage for low-income childless adults by 5.9 percentage points, and as a result reduced the employment rate by 3.8 to 4.5 percentage points among those low-income childless adults.

Essential Health Benefits - Institute of Medicine 2012-02-17

In 2010, an estimated 50 million people were uninsured in the United States. A portion of the uninsured reflects unemployment rates; however, this rate is primarily a reflection of the fact that when most health plans meet an individual's needs, most times, those health plans are not affordable. Research shows that people without health insurance are more likely to experience financial burdens associated with the utilization of health care services. But even among the insured, underinsurance has emerged as a barrier to care. The Patient Protection and Affordable Care Act (ACA) has made the most comprehensive changes to the provision of health insurance since the development of Medicare and Medicaid by requiring all Americans to have health insurance by 2016. An estimated 30 million individuals who would otherwise be uninsured are expected to obtain insurance through the private health insurance market or state expansion of Medicaid programs. The success of the ACA depends on the design of the essential health benefits (EHB) package and its affordability. Essential Health Benefits recommends a process for defining, monitoring, and updating the EHB package. The book is of value to Assistant Secretary for Planning and Evaluation (ASPE) and other U.S. Department of Health and Human Services agencies, state insurance agencies, Congress, state governors, health care providers, and consumer advocates.

Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended - Richard S. Foster 2010-09

This memorandum summarizes the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary¿s estimates of the financial and coverage effects through FY 2019 of selected provisions of the ¿Patient Protection and Affordable Care Act¿ (PPACA) (P.L. 111-149) as enacted on March 23, 2010, and amended by the ¿Health Care and Education Reconciliation Act of 2010¿ (P.L. 111-152) as enacted on March 30, 2010. Included are the estimated net Federal expenditures in support of expanded health insurance coverage, the associated numbers of people by insured status, the changes in Medicare and Medicaid expenditures and revenues, and the overall impact on total national health expenditures. Charts and tables.

Workbook for Health Insurance Today - E-Book - Janet I. Beik 2017-09-07

Corresponding to the chapters in Health Insurance Today, 6th Edition, this workbook lets you practice the skills you will need to succeed as a health insurance professional. Practical assignments reinforce the information in the text, and learning activities and exercises challenge you to apply your knowledge to real-world situations. This new edition incorporates the latest information surrounding ICD-10, the Patient Protection and Affordable Care Act, and other timely federal influencers. Additionally, application exercises, critical thinking activities, and case studies allow you to apply critical thinking skills to solve a problem or answer a question. Performance objectives include hands-on, application-based learning activities with

practice in areas such as completing claim forms, posting payments to a patient's ledger, filling out "Release to Return to Work" forms, and filling out Medicare appeals. Critical thinking activities strengthen your ability to apply health insurance concepts to a variety of challenging situations. Includes Stop and Think exercises which allow you to apply critical thinking skills to problem solving. Defining Chapter Terms activities help you review and understand key terms in each chapter. Chapter assessments test your knowledge of text content with multiple choice, true/false, short answer, fill-in-the-blank, and matching questions. Problem solving/collaborative (group) activities emphasize the importance of teamwork in the health care field. Case studies ask you to solve a real-world problem related to health insurance, such as completing a CMS-1500 claim form or explaining how HIPAA could affect someone recently out of work. Application exercises ask you to apply your knowledge and skills to real-world situations. In-class projects and discussion topics enhance your understanding of specific content from the text. Internet Exploration exercises in each chapter help you learn how to perform research online. NEW! Up-to-date information on all topics including key coverage of Medicare, Electronic Health Records, and Version 5010. NEW! Expanded ICD-10 coverage and removal of all ICD-9 content other than as reference material ensures you stay up-to-date on these significant healthcare system changes.