

## Medical Income Guidelines 2014

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Department of Health Care Services. Do You Qualify for Medi-Cal Benefits? To see if you qualify based on income, look at the chart below.

### ~~Do You Qualify? | Medi-Cal Eligibility~~

The Health Service Executive issues Income Guidelines to assist in determining entitlement to Medical Cards/GP Visit Cards. In revising the Income Guidelines, the Health Service Executive has regard to government policy as outlined by the Minister for Health, increases in the Consumer Price Index and to other issues which may be relevant.

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.

Historically, Medicaid eligibility has generally been limited to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities; however, as of January 1, 2014, states have the option to extend Medicaid coverage to most nonelderly, low-income individuals. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148 as amended) established 133% of the federal poverty level (FPL) (effectively 138% of FPL with an income disregard of 5% of FPL) as the new mandatory minimum Medicaid income eligibility level for most nonelderly individuals. On June 28, 2012, the U.S. Supreme Court issued its decision in *National Federation of Independent Business v. Sebelius*, finding that the enforcement mechanism for the ACA Medicaid expansion violated the Constitution, which effectively made the ACA Medicaid expansion optional for states. If a state accepts the ACA Medicaid expansion funds, it must abide by the expansion coverage rules. For instance, modified adjusted gross income (MAGI) counting rules are used for determining eligibility for the ACA Medicaid expansion population, and individuals covered under the ACA Medicaid expansion are required to receive alternative benefit plan (ABP) coverage. The ACA provides different federal Medicaid matching rates for the individuals who receive Medicaid coverage through the ACA Medicaid expansion. The federal government's share of most Medicaid expenditures is determined according to the federal medical assistance percentage (FMAP) rate, but exceptions to the regular FMAP rate have been made for certain states, situations, populations, providers, and services. The ACA adds a few FMAP exceptions for the ACA Medicaid expansion: the "newly eligible" FMAP rate, the "expansion state" FMAP rate, and the additional FMAP increase for certain expansion states. Due to these ACA FMAP rates, the federal government pays for a vast majority of the cost of the ACA Medicaid expansion. On January 1, 2014, when the ACA Medicaid expansion went into effect, 24 states and the District of Columbia had included the ACA Medicaid expansion as part of their Medicaid programs. Michigan and New Hampshire implemented the expansion on April 1, 2014, and July 1, 2014 (respectively). Pennsylvania recently received approval to implement the ACA Medicaid expansion beginning on January 1, 2015.

Studies before the ACA's implementation in 2014 found that veterans were less likely than the general population to be uninsured: 1 in 10 nonelderly veterans neither had comprehensive health insurance coverage nor used health care available through the Department of Veterans Affairs (VA) (Chokshi and Sommers, 2014; Haley and Kenney, 2013, 2012). Some uninsured veterans may qualify for VA care, but not all take up the available coverage or meet the eligibility requirements, which are based on service-connected disability status, veteran discharge status, income, and other factors (Panangala, 2015). The ACA's new options offered veterans the potential to gain coverage through increased Medicaid enrollment, enrollment in VA care, or participation in the new marketplaces. Before 2014, an estimated 4 in 10 uninsured veterans had incomes below 138 percent of Federal Poverty Level. Uninsured veterans in that income group living in states that expanded Medicaid would qualify for Medicaid in 2014 (Haley and Kenney, 2013).

In the United States, some populations suffer from far greater disparities in health than others. Those disparities are caused not only by fundamental differences in health status across segments of the population, but also because of inequities in factors that impact health status, so-called determinants of health. Only part of an individual's health status depends on his or her behavior and choice; community-wide problems like poverty, unemployment, poor education, inadequate housing, poor public transportation, interpersonal violence, and decaying neighborhoods also contribute to health inequities, as well as the historic and ongoing interplay of structures, policies, and norms that shape lives. When these factors are not optimal in a community, it does not mean they are intractable: such inequities can be mitigated by social policies that can shape health in powerful ways. *Communities in Action: Pathways to Health Equity* seeks to delineate the causes of and the solutions to health inequities in the United States. This report focuses on what communities can do to promote health equity, what actions are needed by the many and varied stakeholders that are part of communities or support them, as well as the root causes and structural barriers that need to be overcome.

The objectives of this study are to describe experiences in price setting and how pricing has been used to attain better coverage, quality, financial protection, and health outcomes. It builds on newly commissioned case studies and lessons learned in calculating prices, negotiating with providers, and monitoring changes. Recognising that no single model is applicable to all settings, the study aimed to generate best practices and identify areas for future research, particularly in low- and middle-income settings. The report and the case studies were jointly developed by the OECD and the WHO Centre for Health Development in Kobe (Japan).

### Benefits, Expenditures, and Other Characteristics of State Premium Assistance Programs

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.

Historically, Medicaid eligibility has generally been limited to certain low-income children, pregnant women, parents of dependent children, the elderly, and individuals with disabilities; however, as of January 1, 2014, states have the option to extend Medicaid coverage to most nonelderly, low-income individuals. The Patient Protection and Affordable Care Act established 133% of the federal poverty level (FPL) as the new mandatory minimum Medicaid income eligibility level for most nonelderly individuals. This book provides an overview of the ACA Medicaid expansion, and the impact of the Supreme Court decision on the ACA Medicaid expansion. Then, the book describes who is covered under the expansion, the expansion rules, and how the expansion is financed. In addition, enrollment and expenditure estimates for the ACA Medicaid expansion are provided. The book reviews state decisions whether or not to implement the ACA Medicaid expansion, and the implications of those decisions on certain individuals, employers, and hospitals.

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