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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.

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).

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.

Mandated Benefits 2014 Compliance Guide is a comprehensive and practical reference manual covering key federal regulatory issues that must be addressed by human resources managers, benefits specialists, and company executives in all industries. Mandated Benefits 2014 Compliance Guide includes in-depth coverage of these and other major federal regulations: Patient Protection and Affordable Care Act (PPACA) Health Information Technology for Economic and Clinical Health (HITECH) Act Mental Health Parity and Addiction Equity Act (MHPAEA) Genetic Information Nondiscrimination Act (GINA) Americans with Disabilities Act (ADA) Employee Retirement Income Security Act (ERISA) Health Insurance Portability and Accountability Act (HIPAA) Heroes Earnings Assistance and Relief Tax Act (HEART Act) Consolidated Omnibus Budget Reconciliation Act (COBRA) Mandated Benefits 2014 Compliance Guide helps take the guesswork out of managing employee benefits and human resources by clearly and concisely describing the essential requirements and administrative processes necessary to comply with each regulation. It offers suggestions for protecting employers against the most common litigation threats and recommendations for handling various types of employee problems. Throughout the Guide are numerous exhibits, useful checklists and forms, and do's and don'ts. A list of HR audit questions at the beginning of each chapter serves as an aid in evaluating your company's level of regulatory compliance. The Mandated Benefits 2014 Compliance Guide has been updated to include: Updated best practices for organizing the human resources department Information on Federal Insurance Contributions Act (FICA) and severance pay New regulations and guidelines for health care reform as mandated by the Patient Protection and Affordable Care Act (PPACA) New information on de-identified protected health information (PHI) and the effect of the omnibus final rules on business associates and notification requirements in case of a breach of PHI Information on the revised model election notice as required under PPACA A completely revised section on the final rules implementing HIPAA's nondiscrimination requirements for wellness programs and updated information on providing employee benefits to legally married same-sex couples based on the Supreme Court's decision in United States v. Windsor A new section on the ADA's direct threat provisions Updated information on caregiver leave under military family leave and survey data regarding the FMLA's impact Updated information on completing the newest Form I-9 and the E-Verify system The OFCCP's final rules for developing and implementing AAPs for veterans and individuals with disabilities and new policy directive for compensation compliance evaluations A new section on bring your own device to work and its impact on employee privacy Information on the final rule revising the hazard communication standard, and the requirements for safety data sheets, which will replace material safety data sheets New information on medical marijuana in the workplace

How to save 20 to 60 percent on health insurance! The End of Employer-Provided Health Insurance is a comprehensive guide to utilizing new individual health plans to save 20 to 60 percent on health insurance. This book is written to ensure that you, your family, and your company get your fair share of the trillions of dollars the U.S. government will spend subsidizing individual health insurance plans between now and 2025. You will learn how to navigate the Affordable Care Act to save money without sacrificing coverage, and how to choose the plan that offers exactly what you, your family and your company need. Over the next 10 years, 100 million Americans will move from employer-provided to individually purchased health insurance. The purpose of The End of Employer-Provided Health Insurance is to show you how to profit from this paradigm shift while helping you, your family, and your employees get better and safer health insurance at lower cost. It will help you save thousands of dollars per person each year and protect you from the greatest threat to your financial future—our nation's broken employer-provided health insurance system. We are at the beginning of a paradigm shift in the way businesses offer employee health benefits and the way Americans get health insurance—a shift from an employer-driven defined benefit model to an individual-driven defined contribution model. This parallels a similar shift in employer-provided retirement benefits that took place two to three decades ago from defined benefit to defined contribution retirement plans. Written by a world-renowned economist and New York Times best-selling author, this insightful guide explains how individual health insurance offers more to employees than employer-provided plans. Using the techniques outlined in this book, you and your employer will save money on health insurance by migrating from employer-provided health insurance coverage to employer-funded individual plans at a total cost that is 20 percent to 60 percent lower for the same coverage. That's $4,000 to $12,000 in savings per year for a family of four for the same hospitals, same doctors, and same prescriptions.

Young adulthood - ages approximately 18 to 26 - is a critical period of development with long-lasting implications for a person's economic security, health and well-being. Young adults are key contributors to the nation's workforce and military services and, since many are parents, to the healthy development of the next generation. Although 'millennials' have received attention in the popular media in recent years, young adults are too rarely treated as a distinct population in policy, programs, and research. Instead, they are often grouped with adolescents or, more often, with all adults. Currently, the nation is experiencing economic restructuring, widening inequality, a rapidly rising ratio of older adults, and an increasingly diverse population. The possible transformative effects of these features make focus on young adults especially important. A systematic approach to understanding and responding to the unique circumstances and needs of today's young adults can help to pave the way to a more productive and equitable tomorrow for young adults in particular and our society at large. Investing in The Health and Well-Being of Young Adults describes what is meant by the term young adulthood, who young adults are, what they are doing, and what they need. This study recommends actions that nonprofit programs and federal, state, and local agencies can take to help young adults make a successful transition from adolescence to adulthood. According to this report, young adults should be considered as a separate group from adolescents and older adults. Investing in The Health and Well-Being of Young Adults makes the case that increased efforts to improve high school and college graduate rates and education and workforce development systems that are more closely tied to high-demand economic sectors will help this age group achieve greater opportunity and success. The report also discusses the health status of young adults and makes recommendations to develop evidence-based practices for young adults for medical and behavioral health, including preventions. What happens during the young adult years has profound implications for the rest of the life course, and the stability and progress of society at large depends on how any cohort of young adults fares as a whole. Investing in The Health and Well-Being of Young Adults will provide a roadmap to improving outcomes for this age group as they transition from adolescence to adulthood.

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 Patient Protection and Affordable Care Act (ACA) introduced several new policies in 2014, including an individual mandate, expanded Medicaid eligibility, and subsidized private coverage. Private subsidies include advance premium tax credits (APTCs) and cost-sharing reductions (CSRs). Individuals gain eligibility for APTCs and CSRs at 100% (138% in Medicaid expansion states) of the Federal Poverty Level (FPL), lose eligibility for CSRs at 250% FPL, and lose eligibility for the APTCs at 400% FPL. Using the Current Population Survey (CPS) and a regression discontinuity design, this study exploits the exogenous differences in subsidy eligibility in 2014 at three cutoffs to identify the separate and combined effects of the APTCs and CSRs on private insurance coverage. I estimate a 4.8 to 5.4 percentage point increase in private insurance coverage just above 138% FPL in Medicaid expansion states and a smaller effect above 100% FPL in non-expansion states attributable to the combined incentives. I calculate a demand elasticity for health insurance of -0.65 to -0.58, which is higher than most estimates in the literature, suggesting low-income individuals may be relatively more price responsive. There is no evidence of an effect on private health insurance at 250% FPL, attributable solely to the CSRs, and suggestive effects at 400% FPL, attributable to only the APTCs. Coverage increases do not appear to be driven by adverse selection, and there is no evidence of crowding-out or income manipulation around the cutoffs. APTC and CSR levels would need to be raised at higher incomes to induce more participation.