Application For Medicaid And Affordable Health Coverage

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.

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.

"Many of the elements of the Affordable Care Act (ACA) went into effect in 2014, and with the establishment of many new rules and regulations, there will continue to be significant changes to the United States health care system. It is not clear what impact these changes will have on medical and public health preparedness programs around the country. Although there has been tremendous progress since 2005 and Hurricane Katrina, there is still a long way to go to ensure the health security of the Country. There is a commonly held notion that preparedness is separate and distinct from everyday operations, and that it only affects emergency departments. But time and time again, catastrophic events challenge the entire health care system, from acute care and emergency medical services down to the public health and community clinic level, and the lack of preparedness of one part of the system places preventable stress on other components. The implementation of the ACA provides the opportunity to consider how to incorporate preparedness into all aspects of the health care system. The Impacts of the Affordable Care Act on Preparedness Resources and Programs is the summary of a workshop convened by the Institute of Medicine's Forum on Medical and Public Health Preparedness for Catastrophic Events in November 2013 to discuss how changes to the health system as a result of the ACA might impact medical and public health preparedness programs across the nation. This report discusses challenges and benefits of the Affordable Care Act to disaster preparedness and response efforts around the country and considers how changes to payment and reimbursement models will present opportunities and challenges to strengthen disaster preparedness and response capacities."--Publisher's description.

MEDICAID EXPANSION: States' Implementation of the Patient Protection and Affordable Care Act

Hidden Cost, Value Lost, the fifth of a series of six books on the consequences of uninsurance in the United States, illustrates some of the economic and social losses to the country of maintaining so many people without health insurance. The book explores the potential economic and societal benefits that could be realized if everyone had health insurance on a continuous basis, as people over age 65 currently do with Medicare. Hidden Costs, Value Lost concludes that the estimated benefits across society in health years of life gained by providing the uninsured with the kind and amount of health services that the insured use, are likely greater than the additional

social costs of doing so. The potential economic value to be gained in better health outcomes from uninterrupted coverage for all Americans is estimated to be between $65 and $130 billion each year.

After a great deal of discussion and debate across all levels of government, President Obama signed the Affordable Care Act (ACA) into law in March 2010. Since President Trump's election into office, the ACA has stayed in the headlines. Trump has continued to call for the replacement and repeal of the ACA, and several efforts have spawned in both the House and the Senate to accomplish this goal. Unlike welfare reform, which was generally embraced by all states, the ACA has proven very divisive in some states, with some states actively seeking to block implementation. Alternative solutions continue to prove elusive. To better understand the major factors driving decision-making process and state-level dynamics influencing state support or opposition of the ACA, this book examines the initial implementation through established support and opposition factors across four states: Alabama, Michigan, California, and New Hampshire. The choices made by states are a direct consequence of long-term forces, and the choices made at the national level. State Politics and the Affordable Care Act will be of interest to scholars researching in public administration, policy formulation and implementation, and policy analysis.

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

Purpose: The study’s purpose was to identify barriers to healthcare that will exist after implementation of the Affordable Care Act (ACA), and address the potential effect of the ACA on a free health clinic. Methodology: To determine the impact of the ACA on patients who obtain health care at a free clinic, a survey was generated to assess knowledge of the ACA, Medicare accessibility, and barriers to obtaining health care. In addition, demographic information regarding medical care needs, gender, permanent residence, income and household size was collected. The survey was offered to adults seeking care at an urban free clinic. A

total of eighty-seven surveys were collected. Data were entered into a spreadsheet for analysis using SPSS. Results: 87 surveys were completed, 45 by females and 42 by males. Age range of those who completed the survey ranged between 19 to 65 years of age. 73 (84%) were US citizens, and 96% had an annual income less than $30,000. $3 % reported their health as good/excellent, and 57% reported their health as fair/poor. 5y% had unmet health care needs while 43% identified that their healthcare needs are being met. 67% of patients either did not know about or were unsure if they understood the Affordable Care Act. 82.7% reported they believed they would not be or were unsure if they would be eligible for insurance under the ACA but if offered, 65% of patients would sign up. The barrier to obtaining health care is further supported by the difficulty patients at the free clinic had when attempting to sign up for Medicaid: 45.8% of patients have applied for Medicaid In the past and 82.4% of these patients were denied. 37.8% reported that the Medicaid application was long and complicated, 23.4 % reported difficulty obtaining Medicaid documents, and 18.5% said it was difficult to apply for Medicaid due to limited hours and difficulty finding transportation. 55% of patients would like to continue receiving care at the free clinic even after they obtain insurance. Several patients expressed concerns about the affordability of health care even after the implementation of the ACA. This is a potential concern of medication co-pays that will still exist for the 59% of diabetes patients,34% of hypertension patients, and 41% of hypercholesterolemia patients that primarily come to Oasis of Hope for the drug prescription assistance program. Conclusion: The ACA was developed to provide health care to all individuals through free or government subsidized health insurance. However, the results of this study identified a lack of knowledge of the ACA from individuals who are currently uninsured seeking care at the free health clinic. In addition, the survey identified that the process of obtaining health care coverage is difficult due to hours of operation, and difficulty navigating the application. With a majority of the patients in the clinic having health care needs unmet and a majority having difficulty navigating government documents to obtain health insurance, there will be patients who may fall through the gaps in the ACA.

Estimates the costs of SF 5 to Stearns County, Minnesota.

Patient Protection and Affordable Care Act - Exchange Functions - Standards for Navigators and Non-Navigator Assistance Personnel (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Patient Protection and Affordable Care Act - Exchange Functions - Standards for Navigators and Non-Navigator Assistance Personnel (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule addresses various requirements applicable to Navigators and non-Navigator assistance personnel in Federally-facilitated Exchanges, including State Partnership Exchanges, and to non-Navigator assistance personnel in State Exchanges that are funded through

federal Exchange Establishment grants. It finalizes the requirement that Exchanges must have a certified application counselor program. It creates conflict-of-interest, training and certification, and meaningful access standards; clarifies that any licensing, certification, or other standards prescribed by a state or Exchange must not prevent application of the provisions of title I of the Affordable Care Act; adds entities with relationships to issuers of stop loss insurance to the list of entities that are ineligible to become Navigators; and clarifies that the same ineligibility criteria that apply to Navigators apply to certain non-Navigator assistance personnel. This book contains: - The complete text of the Patient Protection and Affordable Care Act - Exchange Functions - Standards for Navigators and Non-Navigator Assistance Personnel (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section

Medicaid Program - Increased Federal Medical Assistance Percentage Changes under the Affordable Care Act of 2010 (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Medicaid Program - Increased Federal Medical Assistance Percentage Changes under the Affordable Care Act of 2010 (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule implements the provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act) relating to the availability of increased Federal Medical Assistance Percentage (FMAP) rates for certain adult populations under states' Medicaid programs. This final rule implements and interprets the increased FMAP rates that will be applicable beginning January 1, 2014 and sets forth conditions for states to claim these increased FMAP rates. This book contains: - The complete text of the Medicaid Program - Increased Federal Medical Assistance Percentage Changes under the Affordable Care Act of 2010 (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section

Power is an important factor in assessing the likely validity of a statistical estimate. An analysis with low power is unlikely to produce convincing evidence of a treatment effect even when one exists. Of greater concern, a statistically significant estimate from a low-powered analysis is likely to overstate the magnitude of the true effect size, often finding estimates of the wrong sign or that are several times too large. Yet statistical power is rarely reported in published economics work. This is in part because modern research designs are complex enough that power cannot always be easily ascertained using simple formulae. Power can also be difficult to estimate in observational settings where researchers may not know--and have no ability to manipulate--the true treatment effect or other parameters of interest. Using an ap-plied example--the link between gaining health insurance and mortality--we conduct a simulated power

analysis to outline the importance of power and ways to estimate power in complex research settings. We find that standard difference-in-differences and triple differences analyses of Medicaid expansions using county or state mortality data would need to induce reductions in population mortality of at least 2% to be well powered. While there is no single, correct method for conducting a simulated power analysis, our manuscript outlines decisions relevant for applied researchers interested in conducting simulations appropriate to other settings.

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.

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.

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.

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.

The Patient Protection and Affordable Care Act (PPACA), signed into law on March 23, 2010, made significant changes to the way eligibility for the Medicaid program will be determined and who the program will cover. Under PPACA, eligibility for Medicaid--a joint federal-state program that finances health care for

certain categories of low-income individuals--must be expanded to non-elderly individuals with incomes at or below 133 percent of the federal poverty level (FPL) beginning on January 1, 2014. Through this expansion, states will provide Medicaid coverage to eligible low-income parents and childless adults. PPACA also requires the establishment of American Health Benefit Exchanges (referred to as exchanges)--marketplaces where eligible individuals can purchase private health insurance in each state. The Centers for Medicare & Medicaid Services' (CMS) Office of the Actuary has estimated that, as a result of the expansion, the number of Medicaid enrollees will increase by 14.9 million in 2014 and by 25.9 million in 2020. State governments will play a key role in implementing many aspects of this reform, which must be in place by the beginning of 2014. Specifically, states will need to make major changes to the way they conduct Medicaid eligibility determinations for individuals and families. States also will need to develop streamlined eligibility and enrollment systems that allow for the coordination of enrollment across Medicaid, the Children's Health Insurance Program (CHIP), and exchanges. At the same time, states will need to address the financial implications of implementing this Medicaid expansion and accompanying enrollment systems. The federal government will initially provide states with full funding to cover the cost of adults who are newly eligible for Medicaid due to the expansion. Congress asked us to report on the actions states are taking to implement the Medicaid expansion. This report addresses the following questions: 1. What are states' responsibilities for implementing the Medicaid expansion provisions under PPACA? 2. What actions have selected states taken to prepare for the Medicaid expansion provisions of PPACA and what challenges have they encountered? 3. What are states' views on the fiscal implications of the Medicaid expansion on state budget planning?

Eligibility Changes under Affordable Care Act (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Eligibility Changes under Affordable Care Act (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule implements several provisions of the Patient Protection and Affordable Care Act of 2010 and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). The Affordable Care Act expands access to health insurance coverage through improvements to the Medicaid and Children's Health Insurance (CHIP) programs, the establishment of Affordable Insurance Exchanges (''Exchanges''), and the assurance of coordination between Medicaid, CHIP, and Exchanges. This final rule codifies policy and procedural changes to the Medicaid and CHIP programs related to eligibility, enrollment, renewals, public availability of program information and coordination across insurance affordability programs. This book contains: - The complete text of the Eligibility Changes under Affordable Care Act (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of

each section
Medicaid Eligibility Quality ControlSection 3, the Review ProcessThe Affordable Care ActGreenhaven Publishing LLC
The Health Care Reform Law makes many significant changes to the private and public markets for health insurance, as well as modifications to aspects of the publicly financed health care delivery system. It represents the most significant reform to the Medicaid program since its establishment in 1965. This new and important book details some of the major changes to the Medicaid and CHIP programs and provides a timeline of effective dates for these provisions.
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
Health Insurance is a Family Matter is the third of a series of six reports on the problems of uninsurance in the United Sates and addresses the impact on the family of not having health insurance. The book demonstrates that having one or more uninsured members in a family can have adverse consequences for everyone in the household and that the financial, physical, and emotional well--being of all members of a family may be adversely affected if any family member lacks coverage. It concludes with the finding that uninsured children have worse access to and use fewer health care services than children with insurance, including important preventive services that can have beneficial long-term effects.
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.

On March 23, 2010, the Patient Protection and Affordable Care Act (ACA) became law, requiring most U.S. citizens and legal residents to have health insurance and establishing a state-based system of health benefit Exchanges through which individuals can purchase coverage, with financial support for those between 133--400% of the federal poverty level, and expanding Medicaid eligibility to those with income below that level. A number of provisions in the ACA require states to design and operate coordinated, technology-supported enrollment processes to assist Americans who lack access to affordable employer-based coverage in obtaining health coverage through Medicaid, the Children's Health Insurance Program (CHIP), or the Exchange. The law requires states to develop consumer-friendly application processes for these health subsidy programs, coordinate across them to enable seamless transitions, and reduce the burdens of application and renewal by minimizing the up-front information and documentation required to establish eligibility and instead developing procedures that tap available data from other sources.

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.

One key component of the Affordable Care Act is the creation of integrated and coordinated eligibility processes for Medicaid, CHIP, and Exchange coverage that are supported by technology. As part of these processes, states will be required to provide a single application that individuals can use to apply for these programs that is available in multiple formats, including online. Online applications offer a number of potential advantages relative to paper applications. They can minimize burdens on individuals and lead to increased enrollment by making the application available on a 24/7 basis, enabling faster or real-time eligibility determinations, and streamlining and simplifying the application process. States can also benefit from online applications through reduced administrative burdens and increased accuracy and efficiency. However, the extent to which an online application realizes these advantages depends on its structure and capabilities. This analysis provides an overview of current online applications for Medicaid and/or CHIP and examines the extent to which they incorporate features that streamline and simplify the enrollment process for individuals.

Patient Protection and Affordable Care Act - Benefit and Payment Parameters for 2019 (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Patient Protection and Affordable Care Act - Benefit and Payment Parameters for 2019 (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule sets forth payment parameters and provisions related to the risk adjustment and risk adjustment data validation programs; cost-sharing parameters; and user fees for Federally-facilitated Exchanges and State Exchanges on the Federal platform. It finalizes changes that provide additional flexibility to States to apply the definition of essential health benefits (EHB) to their markets, enhance the role of States regarding the certification of qualified health plans (QHPs); and provide States with additional flexibility in the operation and establishment of Exchanges, including the Small Business Health Options Program (SHOP) Exchanges. It includes changes to standards related to Exchanges; the required functions of the SHOPs; actuarial value for stand-alone dental plans; the rate review program; the medical loss ratio program; eligibility and enrollment; exemptions; and other related topics. This book contains: - The complete text of the Patient Protection and Affordable Care Act - Benefit and Payment Parameters for 2019 (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each

section

If you are you a Medicaid patient, or if you are a patient without any health insurance, I'm aware of the difficulty you have had, and are having, obtaining your healthcare services, and I agree with you. The existing investor owned and profit driven healthcare delivery system is not a friendly delivery system for those patients unable to pay for their healthcare services. But, in its place, if you are supporting the Affordable Care Act, please reconsider your support, and consider the recommendations in this book. In this book, I'm offering everyone without the ability to pay for their healthcare services, the opportunity to obtain the same quality, comprehensive, and easily available healthcare services as the services provided patients who are purchasing their health-care services. Neither Medicaid nor the Affordable Care Act can provide those same services, and the reasons why are discussed in this book. Furthermore, in addition to the difficulty patients with Medicaid and without Medicaid are having obtaining their healthcare services, patients with health insurance, regardless of its source, need to be prepared for the probability, not the possibility, of their having difficulty obtaining their healthcare services in two years when the Affordable Care Act becomes their healthcare delivery system. The frustration with Medicaid's inadequate services is understandable, and the confusion about the future among patients with health insurance is understandable. The problem for both is the many articles written about what is happening, and will be happening, in healthcare have not correctly identified the causes of, or offered realistic solutions for, what is happening, and will be happening, in healthcare. The problem with those article's is their misinformation and their use of conjecture. Misinformation is offered in some of those articles to support the author's agenda. Conjecture is used by other authors. They are too young to have witnessed what happened during the 1950s and 1960s to cause what has happened in healthcare.

Patient Protection and Affordable Care Act - Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) The Law Library presents the complete text of the Patient Protection and Affordable Care Act - Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition). Updated as of May 29, 2018 This final rule specifies additional options for annual eligibility redeterminations and renewal and re-enrollment notice requirements for qualified health plans offered through the Exchange, beginning with annual redeterminations for coverage for benefit year 2015. This final rule provides additional flexibility for Exchanges, including the ability to propose unique approaches that meet the specific needs of their state, while streamlining the consumer experience. This book contains: - The complete text of the Patient Protection and Affordable Care Act - Annual Eligibility Redeterminations for Exchange Participation and Insurance Affordability Programs (US Centers for Medicare and Medicaid Services Regulation) (CMS) (2018 Edition) - A table of contents with the page number of each section

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.