Health Insurance Today Chapter 4

Since 2014, millions of individuals have purchased coverage through the health insurance exchanges established under Patient Protection and Affordable Care Act (PPACA). PPACA altered the individual health insurance market by setting federal standards for coverage and subsidizing exchange coverage for certain low-income individuals. In the first 5 years of exchanges, issuers have moved in and out of the market and increased premiums, but little is known about issuers' claims costs or the factors driving their business decisions. Chapter 1 examines (1) claims costs of issuers participating in exchanges, and (2) factors driving selected issuers' changes in exchange participation, premiums, and plan design. GAO reviewed data from nine issuers participating in five states, which were selected to represent a range in size, tax status, and exchange participation. During open enrollment, eligible returning consumers may re-enroll in their existing health insurance exchange plan or choose a different plan. Those who do not actively enroll in a plan may be automatically re-enrolled into a plan. Chapter 2 examines 1) the extent to which plans identified as benchmark plans remained the same plans from year to year, and how premiums for benchmark plans changed; 2) the proportion of exchange consumers who were automatically re-enrolled into the same or similar plans, and how these proportions compared to those for consumers who actively re-enrolled, and 3) the extent to which consumers' financial responsibility for premiums changed for those who were automatically re-enrolled compared to those who actively re-enrolled. Chapter 3 discussed the amendments to title XIX of the Social Security Act to ensure health insurance coverage continuity for former foster youth. Certain individuals without access to subsidized health insurance coverage may be eligible for premium tax credits, as established under the Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended). The dollar amount of the premium credit varies from individual to individual, based on a formula specified in statute. Individuals who are eligible for the premium credit, however, generally are still required to contribute some amount toward the purchase of health insurance as described in chapter 4. During the summer of 2018, the Trump Administration issued final rules governing coverage offered through association health plans (AHPs) and short-term, limited-duration insurance. Chapter 5 describes how the Congressional Budget Office and the staff of the Joint Committee on Taxation (JCT) analyzed the new rules and determined how those rules would affect the agencies' projections of the number of people who obtain health insurance and the costs of federal subsidies for that coverage.

The anthrax incidents following the 9/11 terrorist attacks put the spotlight on the nation's public health agencies, placing it under an unprecedented scrutiny that added new dimensions to the complex issues considered in this report. The Future of the Public's Health in the 21st Century reaffirms the vision of Healthy People 2010, and outlines a systems approach to assuring the nation's health in practice, research, and policy. This approach focuses on joining the unique resources and perspectives of diverse sectors and entities and challenges these groups to work in a concerted, strategic way to promote and protect the public's health. Focusing on diverse partnerships as the framework for public health, the book discusses: The need for a shift from an individual to a population-based approach in practice, research, policy, and community engagement. The status of the governmental public health infrastructure and what needs to be improved, including its interface with the health care delivery system. The roles nongovernment actors, such as academia, business, local communities and the media can play in creating a healthy nation. Providing an accessible analysis, this book will be important to public health policy-makers and practitioners, business and community leaders, health advocates, educators and journalists.

This is your source for authoritative and comprehensive guidance from the British Medical Association (BMA) Medical Ethics Department covering both routine and highly contentious medico-legal issues faced by health care professionals. The new edition updates the information from both the legal and ethical perspectives and reflects developments surrounding The Mental Capacity Act, Human Tissue Act, and revision of the Human Fertilisation and Embryology Act.

Second in a series of publications from the Institute of Medicine's Quality of Health Care in America project Today's health care providers have more research findings and more technology available to them than ever before. Yet recent reports have raised serious doubts about the quality of health care in America. Crossing the Quality Chasm makes an urgent call for fundamental change to close the quality gap. This book recommends a sweeping redesign of the American health care system and provides overarching principles for specific direction for policymakers, health care leaders, clinicians, regulators, purchasers, and others. In this comprehensive volume the committee offers: A set of performance expectations for the 21st century health care system. A set of 10 new rules to guide patient-clinician relationships. A suggested organizing framework to better align the incentives inherent in payment and accountability with improvements in quality. Key steps to promote evidence-based practice and strengthen clinical information systems. Analyzing health care organizations as complex systems, Crossing the Quality Chasm also documents the causes of the quality gap, identifies current practices that impede quality care, and explores how systems approaches can be used to implement change.

The United States is unique among economically advanced nations in its reliance on employers to provide health benefits voluntarily for workers and their families. Although it is well known that this system fails to reach millions of these individuals as well as others who have no connection to the work place, the system has other weaknesses. It also has many advantages. Because most proposals for health care reform assume some continued role for employers, this book makes an important contribution by describing the strength and limitations of the current system of employment-based health benefits. It provides the data and analysis needed to understand the historical, social, and economic dynamics that have shaped present-day arrangements and outlines what might be done to overcome some of the access, value, and equity problems associated with current employer, insurer, and government policies and practices. Health insurance terminology is often perplexing, and this volume defines essential concepts clearly and carefully. Using an array of primary sources, it provides a store of information on who is covered for what services at what costs, on how programs vary by employer size and industry, and on what governments do--and do not do--to oversee employment-based health programs. A case study adapted from real organizations' experiences illustrates some of the practical challenges in designing, managing, and revising benefit programs. The sometimes unintended and unwanted consequences of employer practices for workers and health care providers are explored. Understanding the concepts of risk, biased risk selection, and risk segmentation is fundamental to sound health care reform. This volume thoroughly examines these key concepts and how they complicate efforts to achieve efficiency and equity in health coverage and health care. With health care reform at the forefront of public attention, this volume will be important to policymakers and regulators, employee benefit managers and other executives, trade associations, and decisionmakers in the health insurance industry, as well as analysts, researchers, and students of health policy.

A new edition of the standard insurance text, revised to reflect changes that have occurred in the insurance industry and its environment since 1986. Incorporates changes wrought by the Risk Retention Act of 1986, the Tax Reform Act of 1986, the Revenue Act of 1987, and the Medicare Expansion Act of 1988. Covers legal changes, revisions in policy forms, and the introduction of new forms of insurance. As in previous editions, emphasis is on the insurance product and its use within a risk-management framework. The three sections cover the

concept of risk, the nature of the insurance device, and the principles of risk management. Specific contracts are examined in detail in order to illustrate insurance principles in action. An appendix contains specimen copies of most major types of policies.

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.

This new edition incorporates revised guidance from H.M Treasury which is designed to promote efficient policy development and resource allocation across government through the use of a thorough, long-term and analytically robust approach to the appraisal and evaluation of public service projects before significant funds are committed. It is the first edition to have been aided by a consultation process in order to ensure the guidance is clearer and more closely tailored to suit the needs of users.

The Institute of Medicine study Crossing the Quality Chasm (2001) recommended that an interdisciplinary summit be held to further reform of health professions education in order to enhance quality and patient safety. Health Professions Education: A Bridge to Quality is the follow up to that summit, held in June 2002, where 150 participants across disciplines and occupations developed ideas about how to integrate a core set of competencies into health professions education. These core competencies include patient-centered care, interdisciplinary teams, evidence-based practice, quality improvement, and informatics. This book recommends a mix of approaches to health education improvement, including those related to oversight processes, the training environment, research, public reporting, and leadership. Educators, administrators, and health professionals can use this book to help achieve an approach to education that better prepares clinicians to meet both the needs of patients and the requirements of a changing health care system.

Roughly 40 million Americans have no health insurance, private or public, and the number has grown steadily over the past 25 years. Who are these children, women, and men, and why do they lack coverage for essential health care services? How does the system of insurance coverage in the U.S. operate, and where does it fail? The first of six Institute of Medicine reports that will examine in detail the consequences of having a large uninsured population, Coverage Matters: Insurance and Health Care, explores the myths and realities of who is uninsured, identifies social, economic, and policy factors that contribute to the situation, and describes the likelihood faced by members of various population groups of being uninsured. It serves as a guide to a broad range of issues related to the lack of insurance coverage in America and provides background data of use to policy makers and health services researchers.

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.

In the realm of health care, privacy protections are needed to preserve patients' dignity and prevent possible harms. Ten years ago, to address these concerns as well as set guidelines for ethical health research, Congress called for a set of federal standards now known as the HIPAA Privacy Rule. In its 2009 report, Beyond the HIPAA Privacy Rule: Enhancing Privacy, Improving Health Through Research, the Institute of Medicine's Committee on Health Research and the Privacy of Health Information concludes that the HIPAA Privacy Rule does not protect privacy as well as it should, and that it impedes important health research.

Getting the right diagnosis is a key aspect of health care - it provides an explanation of a patient's health problem and informs subsequent health care decisions. The diagnostic process is a complex, collaborative activity that involves clinical reasoning and information gathering to determine a patient's health problem. According to Improving Diagnosis in Health Care, diagnostic errors-inaccurate or delayed diagnoses-persist throughout all settings of care and continue to harm an unacceptable number of patients. It is likely that most people will experience at least one diagnostic error in their lifetime, sometimes with devastating consequences. Diagnostic errors may cause harm to patients by preventing or delaying appropriate treatment, providing unnecessary or harmful treatment, or resulting in psychological or financial repercussions. The committee concluded that improving the diagnostic process is not only possible, but also represents a moral, professional, and public health imperative. Improving Diagnosis in Health Care a continuation of the landmark Institute of Medicine reports To Err Is Human (2000) and Crossing the Quality Chasm (2001) finds that diagnosis-and, in particular, the occurrence of diagnostic errorsâ€"has been largely unappreciated in efforts to improve the quality and safety of health care. Without a dedicated focus on improving diagnosis, diagnostic errors will likely worsen as the delivery of health care and the diagnostic process continue to increase in complexity. Just as the diagnostic process is a collaborative activity, improving diagnosis will require collaboration and a widespread commitment to change among health care professionals, health care organizations, patients and their families, researchers, and policy makers. The recommendations of Improving Diagnosis in Health Care contribute to the growing momentum for change in this crucial area of health care quality and safety.

Drawing on an extensive range of resources, including government reports, scholarly publications, and analyses from a range of private organizations, Introduction to US Health Policy provides scholars, policymakers, and health care providers with a comprehensive platform of ideas that is key to understanding and influencing the changes in the US health care system.

In this book the authors explore the state of the art on efficiency measurement in health systems and international experts offer insights into the pitfalls and potential associated with various measurement techniques. The authors show that: - The core idea of efficiency is easy to understand in principle - maximizing valued outputs relative to inputs, but is often difficult to make operational in real-life situations - There have been numerous advances in data collection and availability, as well as innovative methodological approaches that give valuable insights into how efficiently health care is delivered - Our simple analytical framework can facilitate the development and interpretation of efficiency indicators.

CHAPTER 1 Introduction 1. Definition of health inequality(health inequity) 2. Necessity of the study on health inequality in the elderly 3. Purpose of this study CHAPTER 2 Contents and methods of study 1. Contents of study 2. Study methods CHAPTER 3 Status of inequality in health and health care utilization in the elderly 1. Health equity 2. Equity in health care utilization CHAPTER 4 Results of study 1. General status of study subjects 2. Inequality in the health of the elderly 3. Inequality in the health care utilization of the elderly CHAPTER 5 Conclusion Reference

Covers the business of insurance and risk management, and is a tool for market research, strategic planning, competetive intelligence or employment searches. This book contains trends, statistical tables and an industry glossary. It also provides profiles of more than 300 of the world's leading insurance companies.

This is the third edition of this publication which contains the latest information on vaccines and vaccination procedures for all the vaccine preventable infectious diseases that may occur in the UK or in travellers going outside of the UK, particularly those immunisations that comprise the routine immunisation programme for all children from birth to adolescence. It is divided into two sections: the first section covers principles, practices and procedures, including issues of consent, contraindications, storage, distribution and disposal of vaccines, surveillance and monitoring, and the Vaccine Damage Payment Scheme; the second section covers the range of different diseases and vaccines.

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.

This dissertation has four chapters. The first three chapters examine health insurance markets in the U.S., focusing in particular on

contexts where there are important interactions between health insurance plans. The fourth chapter is on the U.S. budget, examining the implications of annual budget cycles on the quantity and quality of end-of-year spending. Chapter 1, entitled "Bankruptcy as Implicit Health Insurance" examines the interaction between health insurance and the implicit insurance that people have because they can file (or threaten to file) for bankruptcy. With a simple model that captures key institutional features, I demonstrate that the financial risk from medical shocks is capped by the assets that could be seized in bankruptcy. For households with modest seizable assets, this implicit "bankruptcy insurance" can crowd out conventional health insurance. I test these predictions using variation in the state laws that specify the type and level of assets that can be seized in bankruptcy. Because of the differing laws, people who have the same assets and receive the same medical care face different losses in bankruptcy. Exploiting the variation in seizable assets that is orthogonal to wealth and other household characteristics, I show that households with fewer seizable assets are more likely to be uninsured. This finding is consistent with another: uninsured households with fewer seizable assets end up making lower out-of-pocket medical payments. The estimates suggest that if the laws of the least debtor-friendly state of Delaware were applied nationally, 16.3 percent of the uninsured would buy health insurance. Achieving the same increase in coverage would require a premium subsidy of approximately 44.0 percent. To shed light on puzzles in the literature and examine policy counterfactuals, I calibrate a utility-based, micro-simulation model of insurance choice. Among other things, simulations show that "bankruptcy insurance" explains the low take-up of high-deductible health insurance. Chapter 2, entitled "Pricing and Welfare in Health Plan Choice", is coauthored with M. Kate Bundorf and Jonathan Levin. The starting point for the paper is the simple observation that when insurance premiums do not reflect individual differences in expected costs, consumers may choose plans inefficiently. We study this problem in health insurance markets, a setting in which prices often do not incorporate observable differences in expected costs. We develop a simple model and estimate it using data on small employers. In this setting, the welfare loss compared to the feasible risk-rated benchmark is around 2-11% of coverage costs. Three-quarters of this is due to restrictions on risk-rating employee contributions; the rest is due to inefficient contribution choices. Despite the inefficiency, the benefits from plan choice relative to each of the single-plan options are substantial. Chapter 3, entitled "The Private Coverage and Public Costs: Identifying the Effect of Private Supplemental Insurance on Medicare Spending, " is coauthored with Marika Cabral. While most elderly Americans have health insurance coverage through Medicare, traditional Medicare policies leave individuals exposed to significant financial risk. Private supplemental insurance to "fill the gaps" of Medicare, known as Medigap, is very popular. In this Chapter, we estimate the impact of this supplemental insurance on total medical spending using an instrumental variables strategy that leverages discontinuities in Medigap premiums at state boundaries. Our estimates suggest that Medigap increases medical spending by 57 percent--or about 40 percent more than previous estimates. Back-of-the-envelope calculations indicate that a 20 percent tax on premiums would generate combined revenue and savings of 6.2 percent of baseline costs; a Pigovian tax that fully accounts for the fiscal externality would yield savings of 18.1 percent. Chapter 4, entitled "Do Expiring Budgets

The federal government operates six major health care programs that serve nearly 100 million Americans. Collectively, these programs significantly influence how health care is provided by the private sector. Leadership by Example explores how the federal government can leverage its unique position as regulator, purchaser, provider, and research sponsor to improve care - not only in these six programs but also throughout the nationâ€™s health care system. The book describes the federal programs and the populations they serve: Medicare (elderly), Medicaid (low income), SCHIP (children), VHA (veterans), TRICARE (individuals in the military and their dependents), and IHS (native Americans). It then examines the steps each program takes to assure and improve safety and quality of care. The Institute of Medicine proposes a national quality enhancement strategy focused on performance measurement of clinical quality and patient perceptions of care. The discussion on which this book focuses includes recommendations for developing and pilot-testing performance measures, creating an information infrastructure for comparing performance and disseminating results, and more. Leadership by Example also includes a proposed research agenda to support quality enhancement. The third in the series of books from the Quality of Health Care in America project, this well-targeted volume will be important to all readers of To Err Is Human and Crossing the Quality Chasm - as well as new readers interested in the federal governmentâ€™s role in health care.

Regional health care databases are being established around the country with the goal of providing timely and useful information to policymakers, physicians, and patients. But their emergence is raising important and sometimes controversial questions about the collection, quality, and appropriate use of health care data. Based on experience with databases now in operation and in development, Health Data in the Information Age provides a clear set of guidelines and principles for exploiting the potential benefits of aggregated health data--without jeopardizing confidentiality. A panel of experts identifies characteristics of emerging health database organizations (HDOs). The committee explores how HDOs can maintain the quality of their data, what policies and practices they should adopt, how they can prepare for linkages with computer-based patient records, and how diverse groups from researchers to health care administrators might use aggregated data. Health Data in the Information Age offers frank analysis and guidelines that will be invaluable to anyone interested in the operation of health care databases.

This dissertation has four chapters. The first three chapters examine health insurance markets in the U.S., focusing in particular on contexts where there are important interactions between health insurance plans. The fourth chapter is on the U.S. budget, examining the implications of annual budget cycles on the quantity and quality of end-of-year spending. Chapter 1, entitled "Bankruptcy as Implicit Health Insurance" examines the interaction between health insurance and the implicit insurance that people have because they can file (or threaten to file) for bankruptcy. With a simple model that captures key institutional features, I demonstrate that the financial risk from medical shocks is capped by the assets that could be seized in bankruptcy. For households with modest seizable assets, this implicit "bankruptcy insurance" can

crowd out conventional health insurance. I test these predictions using variation in the state laws that specify the type and level of assets that can be seized in bankruptcy. Because of the differing laws, people who have the same assets and receive the same medical care face different losses in bankruptcy. Exploiting the variation in seizable assets that is orthogonal to wealth and other household characteristics, I show that households with fewer seizable assets are more likely to be uninsured. This finding is consistent with another: uninsured households with fewer seizable assets end up making lower out-of-pocket medical payments. The estimates suggest that if the laws of the least debtor-friendly state of Delaware were applied nationally, 16.3 percent of the uninsured would buy health insurance. Achieving the same increase in coverage would require a premium subsidy of approximately 44.0 percent. To shed light on puzzles in the literature and examine policy counterfactuals, I calibrate a utility-based, micro-simulation model of insurance choice. Among other things, simulations show that "bankruptcy insurance" explains the low take-up of high-deductible health insurance. Chapter 2, entitled "Pricing and Welfare in Health Plan Choice", is coauthored with M. Kate Bundorf and Jonathan Levin. The starting point for the paper is the simple observation that when insurance premiums do not reflect individual differences in expected costs, consumers may choose plans inefficiently. We study this problem in health insurance markets, a setting in which prices often do not incorporate observable differences in expected costs. We develop a simple model and estimate it using data on small employers. In this setting, the welfare loss compared to the feasible risk-rated benchmark is around 2-11% of coverage costs. Three-quarters of this is due to restrictions on risk-rating employee contributions; the rest is due to inefficient contribution choices. Despite the inefficiency, the benefits from plan choice relative to each of the single-plan options are substantial. Chapter 3, entitled "The Private Coverage and Public Costs: Identifying the Effect of Private Supplemental Insurance on Medicare Spending, " is coauthored with Marika Cabral. While most elderly Americans have health insurance coverage through Medicare, traditional Medicare policies leave individuals exposed to significant financial risk. Private supplemental insurance to "fill the gaps" of Medicare, known as Medigap, is very popular. In this Chapter, we estimate the impact of this supplemental insurance on total medical spending using an instrumental variables strategy that leverages discontinuities in Medigap premiums at state boundaries. Our estimates suggest that Medigap increases medical spending by 57 percent--or about 40 percent more than previous estimates. Back-of-the-envelope calculations indicate that a 20 percent tax on premiums would generate combined revenue and savings of 6.2 percent of baseline costs; a Pigovian tax that fully accounts for the fiscal externality would yield savings of 18.1 percent. Chapter 4, entitled "Do Expiring Budgets Lead to Wasteful Year-End Spending? Evidence from Federal Procurement, " is coauthored with Jeffrey Liebman. Many organizations fund their spending out of a fixed budget that expires at year's end. Faced with uncertainty over future spending demands, these organizations

have an incentive to build a buffer stock of funds over the front end of the budget cycle. When demand does not materialize, they then rush to spend these funds on lower quality projects at the end of the year. We test these predictions using data on procurement spending by the U.S. federal government. Using data on all federal contracts from 2004 through 2009, we document that spending spikes in all major federal agencies during the 52nd week of the year as the agencies rush to exhaust expiring budget authority. Spending in the last week of the year is 4.9 times higher than the rest-of-the-year weekly average. We examine the relative quality of year-end spending using a newly available dataset that tracks the quality of $130 billion in information technology (I.T.) projects made by federal agencies. Consistent with the model, average project quality falls at the end of the year. Quality scores in the last week of the year are 2.2 to 5.6 times more likely to be below the central value. To explore the impact of allowing agencies to roll unused spending over into subsequent fiscal years, we study the I.T. contracts of an agency with special authority to roll over unused funding. We show that there is only a small end-of-year I.T. spending spike in this agency and that the one major I.T. contract this agency issued in the 52nd week of the year has a quality rating that is well above average.

CHAPTER 1 CHAPTER 2 Existing Studies, Theoretical Background, and Study Topic 1. Generation 2. Metrics for Intergenerational Equity 3. Theoretical Background for Identifying Study Topic 4. Study Agenda CHAPTER 3 Linear Simulation Model and Data in National Health Insurance 1. Simplifying Assumption 2. National Health Insurance 3. Data Used for Simulation Model Calculation CHAPTER 4 Analysis Results of Equity Improvements Simulation 1. Analysis Methodology 2. Analysis on Health Insurance Results CHAPTER 5 Conclusion and Policy Implications Reference

2004 Green Book, Background Material and Data on Programs Within the Jurisdiction of the Committee on Ways and Means, March 2004. 18th edition. Provides information about Federal assistance programs, including: social security; medicare; supplemental security income; unemployment compensation; railroad retirement; trade adjustment assistance; Aid to Families with Dependent Children; child support enforcement; child care; child protection, foster care and adoption assistance; tax provisions; and the Pension Benefit Guaranty Corporation. 108th Congress, 2d Session.

Corresponding to the chapters in Health Insurance Today, 4th 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. 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. Critical Thinking activities strengthen your ability to apply health insurance concepts to a variety of challenging situations. Performance objectives include hands-on, application-based learning activities 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. Chapter assessments test your knowledge of text content with multiple choice, true/false, short answer, fill-in-the-blank, and matching questions. Application exercises ask you to apply your knowledge and skills to real-world situations. Defining Chapter Terms help you review and understand key terms in each chapter. Problem solving/collaborative (group) activities emphasize the importance of teamwork in the health care field. 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! Key coverage of new topics includes medical identity theft and prevention, National Quality Forum (NQF) patient safety measures, ACSX12 Version 5010 HIPAA transaction standards, EMS rule on mandatory electronic claims submission, and standards and implementation specifications for electronic health record technology. UPDATED! Additional ICD-10 coding content prepares you for the upcoming switch to the new coding system. UPDATED! Medicare chapter reflects updates and changes from the new presidential administration.

"This book presents readers with a comprehensive overview of the U.S. health care delivery system. The third edition has been significantly revised throughout to explain the Patient Protection and Health Care Affordability Act as it unfolds. Other key updates include more detailed discussions of health insurance, expanded information on health systems in other countries, and new case studies"--Provided by publisher.

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

These reports summarize the current state of what is known about various health and healthcare issues that affect the United States. An introductory chapter gives an overview of the report as a whole, along with a look at the science and preparation of the report. Along with the findings, reports may present directories of related resources.

Care Without CoverageToo Little, Too LateNational Academies Press

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.

America's Children is a comprehensive, easy-to-read analysis of the relationship between health insurance and access to care. The book addresses three broad questions: How is children's health care currently financed? Does insurance equal access to care? How should the nation address the health needs of this vulnerable population? America's Children explores the changing role of Medicaid under managed care; state-initiated and private sector children's insurance programs; specific effects of insurance status on the care children receive; and the impact of chronic medical conditions and special health care needs. It also examines the status of "safety net" health providers, including community health centers, children's hospitals, school-based health centers, and others and reviews the changing patterns of coverage and tax policy options to increase coverage of private-sector, employer-based health insurance. In response to growing public concerns about uninsured children, last year Congress voted to provide $24 billion over five years for new state insurance initiatives. This volume will serve as a primer for concerned federal policymakers and regulators, state agency officials, health plan decisionmakers, health care providers, children's health advocates, and researchers.

Risk Adjustment, Risk Sharing and Premium Regulation in Health Insurance Markets: Theory and Practice describes the goals, design and evaluation of health plan payment systems. Part I contains 5 chapters discussing the role of health plan payment in regulated health insurance markets, key aspects of payment design (i.e. risk adjustment, risk sharing and premium regulation),

and evaluation methods using administrative data on medical spending. Part II contains 14 chapters describing the health plan payment system in 14 countries and sectors around the world, including Australia, Belgium, Chile, China, Columbia, Germany, Ireland, Israel, the Netherlands, Russia, Switzerland and the United States. Authors discuss the evolution of these payment schemes, along with ongoing reforms and key lessons on the design of health plan payment. Provides a conceptual toolkit that describes the goals, design and evaluation of health plan payment systems in the context of policy paradigms, such as efficiency, affordability, fairness and avoidance of risk selection Brings together international experience from many different countries that apply regulated competition in different ways Delivers a practical toolkit for the evaluation of health plan payment modalities from the standpoint of efficiency and fairness

This User’s Guide is intended to support the design, implementation, analysis, interpretation, and quality evaluation of registries created to increase understanding of patient outcomes. For the purposes of this guide, a patient registry is an organized system that uses observational study methods to collect uniform data (clinical and other) to evaluate specified outcomes for a population defined by a particular disease, condition, or exposure, and that serves one or more predetermined scientific, clinical, or policy purposes. A registry database is a file (or files) derived from the registry. Although registries can serve many purposes, this guide focuses on registries created for one or more of the following purposes: to describe the natural history of disease, to determine clinical effectiveness or cost-effectiveness of health care products and services, to measure or monitor safety and harm, and/or to measure quality of care. Registries are classified according to how their populations are defined. For example, product registries include patients who have been exposed to biopharmaceutical products or medical devices. Health services registries consist of patients who have had a common procedure, clinical encounter, or hospitalization. Disease or condition registries are defined by patients having the same diagnosis, such as cystic fibrosis or heart failure. The User’s Guide was created by researchers affiliated with AHRQ’s Effective Health Care Program, particularly those who participated in AHRQ’s DEcIDE (Developing Evidence to Inform Decisions About Effectiveness) program. Chapters were subject to multiple internal and external independent reviews.