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Care Without Coverage Coverage Matters Health-Care Utilization as a Proxy in Disability Determination The Affordable Care Act Health Insurance is a Family Matter Health Insurance How to Make Sense of Health Insurance in America America's Children What's In, What's Out National Health Insurance Resource Book Health Insurance Persons Denied Private Health Insurance Due to Poor Health Introduction to U.S. Health Policy Explaining Divergent Levels of Longevity in High-Income Countries The Health Care Dilemma Disease Control Priorities, Third Edition (Volume 9) Understanding Racial and Ethnic Differences in Health in Late Life Marching Toward Coverage Health Insurance Coverage for 55- to 64-year-olds America's Health Care Crisis Solved Health Insurance Systems Small Businesses Access to Health Insurance The Medicare Handbook Developing the National Health Plan: Decision papers for the Secretary Health Insurance Statistics An American Sickness The Company That Solved Health Care The Economics of Health and Medical Care Scaling Up Affordable Health Insurance Source Book of Health Insurance Data, 2002 Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA) Estimates of Federal Tax Expenditures Health Care Reform Government-Sponsored Health Insurance in India One Nation, Uninsured Unequal Coverage The Road to Universal Health Coverage Universal Health Coverage in China Health Insurance and Related Proposals for Financing Personal Health Services The Ethics of Universal Health Insurance

This study investigates the situation of Universal Health Care (UHC) in China from a health economic perspective. The first chapter introduces the historical background, analyzes the relevance of UHC and sheds light on the current health insurance status. In this chapter a new holistic health insurance theory is proposed that allows the inclusion of preventive medicine. The second chapter introduces the "Definition and concept" consisting of three dimensions: Firstly, the height dimension with the leading question "What proportion of the costs is covered?". Secondly, the depth dimension that is concerned with the question "Which benefits are covered?". This chapter puts a special focus on the important economic role of non-communicable diseases. Thirdly, the breadth dimension which investigates the question "Who is insured?". The third chapter, looking at the first dimension, found a high but shrinking amount of out-of-pocket payments and catastrophic health payments. Comparing the payment and benefit distributions, it found the ability to pay principle and insufficient separation of health service payments from its consumption. The second dimension discovered problems concerning the roles of ministries, financing and the benefit package. Reforming these areas will be necessary to provide people with appropriate health care. The third dimension showed that migrant workers are exposed to more health risks, have less access to health care and a lower health status. The de facto coverage rate for the Chinese population (including migrant workers) was calculated to be 81.19% in 2011 and 82.16% in 2020. The goals of the Chinese Communist Party (90% in 2011 and nearly 100% in 2020) are hence not reached. The study closes with a "Summary and conclusion, a "Boundaries and discussion" and an "Outlook" section. A lively, clear explanation of the American healthcare reform movement from a noted expert—giving women the tools they need to demand fair and affordable coverage for all people Healthcare is one of America’s most dysfunctional and confusing industries, and women bear the brunt of the problem when it comes to both access and treatment. Women, who make 80 percent of healthcare decisions for their families, are disproportionately impacted by the complex nature of our healthcare system—but are also uniquely poised to fix it. Founder and CEO of Day Health Strategies Rosemarie Day wants women to recognize their trouble with accessing affordable care as part of a national emergency. Day encourages women throughout the country to share their stories and get involved, and she illustrates how a groundswell of activism, led by everyday women, could create the incentives our political leaders need to change course. Marching Toward Coverage gives women the clear information they need to move this agenda forward by breaking down complicated topics in an accessible manner, like the ACA (Affordable Care Act), preexisting conditions, and employer-sponsored plans. With more than 25 years working in healthcare strategy and related fields, Day helps the average American understand the business of national health reform and lays out a pragmatic path forward, one that recognizes healthcare as a fundamental human right. "A graphic explanation of the PPACA act"--Provided by publisher. As the culminating volume in the DCP3 series, volume 9 will provide an overview of DCP3 findings and methods, a summary of messages and substantive lessons to be taken from DCP3, and a further discussion of cross-cutting and synthesizing topics across the first eight volumes. The introductory chapters (1-3) in this volume take as their starting point the elements of the Essential Packages presented in the overview chapters of each volume. First, the chapter on intersectoral policy priorities for health includes fiscal and intersectoral policies and assembles a subset of the population policies and applies strict criteria for a low-income setting in order to propose a "highest-priority" essential package. Second, the chapter on packages of care and delivery platforms for universal health coverage (UHC) includes health sector interventions, primarily clinical and public health services, and uses the same approach to propose a highest priority package of interventions and policies that meet similar criteria, provides cost estimates, and describes a pathway to UHC. 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. Explains how employers can take control of the increasing burden of health care costs, using the approach taken by Serigraph, a company that focused on consumer responsibility, primary care, and centers of value, as a model for improving health care while lowering the cost. History of Health Insurance in the United States -- The Affordable Care Act -- A Summary of Insurance Coverage -- The Demand for Insurance -- Adverse Selection -- Underwriting and Rate Making -- Risk Adjustment -- Moral Hazard and Prices -- Utilization Management -- Managed Care, Selective Contracting, and the Insurance Industry -- Provider Consolidation, Monopsony Power, and the Managed Care Backlash -- Insurance Market Structure, Conduct, and Performance -- Premium Sensitivity and Health Insurance -- Compensating Differentials -- Taxes and Employer-Sponsored Health Insurance -- Employers as Agents -- Health Savings Accounts and Consumer-Directed Health Plans -- The Small-Group Market -- The Individual Insurance Market -- Health Insurance Regulation -- High-Risk Pools -- An Overview of Medicare -- Retiree Coverage -- Medicaid, Crowd-Out, and Long-Term Care Insurance. Vaccinate children against deadly pneumococcal disease, or pay for cardiac patients to undergo lifesaving surgery? Cover the costs of dialysis for kidney patients, or channel the money toward preventing the conditions that lead to renal failure in the first place? Policymakers dealing with the realities of limited health care budgets face tough decisions like these regularly. And for many individuals, their personal health care choices are equally stark: paying for medical treatment could push them into poverty. Many low- and middle-income countries now aspire to universal health coverage, where governments ensure that all people have access to the quality health services they need without risk of impoverishment. But for universal health coverage to become reality, the health services offered must be consistent with the funds available—and this implies tough everyday choices for policymakers that could be the difference between life and death for those affected by any given condition or disease. The situation is particularly acute in low- and middle income countries where public spending on health is on the rise but still extremely low, and where demand for expanded services is growing rapidly. What’s In, What’s Out: Designing Benefits for Universal Health Coverage argues that the creation of an explicit health benefits plan—a defined list of services that are and are not available—is an essential element in creating a sustainable system of universal health coverage. With contributions from leading health economists and policy experts, the book considers the many dimensions of governance, institutions, methods, political economy, and ethics that are needed to decide what’s in and what’s out in a way that is fair, evidence-based, and sustainable over time. Every industrial nation in the world

guarantees its citizens access to essential health care services--every country, that is, except the United States. In fact, one in eight Americans--a shocking 43 million people--do not have any health care insurance at all. One Nation, Uninsured offers a vividly written history of America's failed efforts to address the health care needs of its citizens. Covering the entire twentieth century, Jill Quadagno shows how each attempt to enact national health insurance was met with fierce attacks by powerful stakeholders, who mobilized their considerable resources to keep the financing of health care out of the government's hands. Quadagno describes how at first physicians led the anti-reform coalition, fearful that government entry would mean government control of the lucrative private health care market. Doctors lobbied legislators, influenced elections by giving large campaign contributions to sympathetic candidates, and organized "grassroots" protests, conspiring with other like-minded groups to defeat reform efforts. As the success of Medicare and Medicaid in the mid-century led physicians and the AMA to start scaling back their attacks, the insurance industry began assuming a leading role against reform that continues to this day. One Nation, Uninsured offers a sweeping history of the battles over health care. It is an invaluable read for anyone who has a stake in the future of America's health care system. During the last 25 years, life expectancy at age 50 in the United States has been rising, but at a slower pace than in many other high-income countries, such as Japan and Australia. This difference is particularly notable given that the United States spends more on health care than any other nation. Concerned about this divergence, the National Institute on Aging asked the National Research Council to examine evidence on its possible causes. According to Explaining Divergent Levels of Longevity in High-Income Countries, the nation's history of heavy smoking is a major reason why lifespans in the United States fall short of those in many other high-income nations. Evidence suggests that current obesity levels play a substantial part as well. The book reports that lack of universal access to health care in the U.S. also has increased mortality and reduced life expectancy, though this is a less significant factor for those over age 65 because of Medicare access. For the main causes of death at older ages-cancer and cardiovascular disease-available indicators do not suggest that the U.S. health care system is failing to prevent deaths that would be averted elsewhere. In fact, cancer detection and survival appear to be better in the U.S. than in most other high-income nations, and survival rates following a heart attack also are favorable. Explaining Divergent Levels of Longevity in High-Income Countries identifies many gaps in research. For instance, while lung cancer deaths are a reliable marker of the damage from smoking, no clear-cut marker exists for obesity, physical inactivity, social integration, or other risks considered in this book. Moreover, evaluation of these risk factors is based on observational studies, which-unlike randomized controlled trials-are subject to many biases. America’s Health Care Crisis Solved highlights the major pitfalls of our current health care system and shows why, without changes, health care costs will soon demolish the American economy as well as the opportunity to receive quality care. However, contrary to the increasingly popular idea of a government health plan, the alternative presented by authors J. Patrick Rooney and Dan Perrin brings the self-interest of you, the American consumer, into the equation. Millions of Americans lack health insurance, and as a result, thousands suffer and die every year. Philosophers have argued that an ideal society would avoid these problems by guaranteeing universal access to health insurance, but what about concerns that a universal health insurance system would be inefficient, create excessive fiscal risk, or impose excessive taxes or other personal costs? In The Ethics of Universal Health Insurance, Alex Rajczi shows how defenders of universal health insurance can address the ethical issues raised by these objections and make the moral case for an American universal health insurance system that improves on the gains made in the Affordable Care Act. Engaging with these objections helps us uncover fascinating philosophical issues that have been previously overlooked. It also leads us to a deeper understanding of progressive and conservative views on distributive justice and provides us with a framework for examining debates about any part of the social safety net- in America and elsewhere. This book presents the first comprehensive review of all major government-supported health insurance schemes in India and their potential for contributing to the achievement of universal coverage in India are discussed. The fundamental purpose of a health insurance exchange is to provide a structured marketplace for the sale and purchase of health insurance. The authority and responsibilities of an exchange may vary, depending on statutory or other requirements for its establishment and structure. The Patient Protection and Affordable Care Act (ACA, P.L. 111-148, as amended) requires health insurance exchanges to be established in every state by January 1, 2014. ACA provides certain requirements for the establishment of exchanges, while leaving other choices to be made by the states. Qualified individuals and small businesses will be able to purchase private health insurance through exchanges. Issuers selling health insurance plans through an exchange will have to follow certain rules, such as meeting the private market reform requirements in ACA. While the fundamental purpose of the exchanges will be to facilitate the offer and purchase of health insurance, nothing in the law prohibits qualified individuals, qualified employers, and insurance carriers from participating in the health insurance market outside of exchanges. Moreover, ACA explicitly states that enrollment in exchanges is voluntary and no individual may be compelled to enroll in exchange coverage. Exchanges may be established either by the state itself as a “state exchange” or by the Secretary of Health and Human Services (HHS) as a “federally facilitated exchange.” All exchanges are required to carry out many of the same functions and adhere to many of the same standards, although there are important differences between the types of exchanges. States will need to declare their intentions to establish their own exchanges by no later than November 16, 2012. ACA and regulations require exchanges to carry out a number of different functions. The primary functions relate to determining eligibility and enrolling individuals in appropriate plans, plan management, consumer assistance and accountability, and financial management. ACA gives various federal agencies, primarily HHS, responsibilities relating to the general operation of exchanges. Federal agencies are generally responsible for promulgating regulations, creating criteria and systems, and awarding grants to states to help them create and implement exchanges. A state that is approved to operate its own exchange has a number of operational decisions to make, including decisions related to organizational structure (governmental agency or a nonprofit entity); types of exchanges (separate individual and Small Business Health Options Program (SHOP) exchanges, or a merged exchange); collaboration (a state may independently operate an exchange or enter into contracts with other states); service area (a state may establish one or more subsidiary exchanges in the state if each exchange serves a geographically distinct area and meets certain size requirements); contracted services (an exchange may contract with certain entities to carry out one or more responsibilities of the exchange); and governance (governing board and standards of conduct). In general, health plans offered through exchanges will provide comprehensive coverage and meet all applicable private market reforms specified in ACA. Most exchange plans will provide coverage for “essential health benefits,” at minimum; be subject to certain limits on cost-sharing, including out-of-pocket costs; and meet one of four levels of plan generosity based on actuarial value. To make exchange coverage more affordable, certain individuals will receive premium assistance in the form of federal tax credits. Moreover, some recipients of premium credits may also receive subsidies toward cost-sharing expenses. As the population of older Americans grows, it is becoming more racially and ethnically diverse. Differences in health by racial and ethnic status could be increasingly consequential for health policy and programs. Such differences are not simply a matter of education or ability to pay for health care. For instance, Asian Americans and Hispanics appear to be in better health, on a number of indicators, than White Americans, despite, on average, lower socioeconomic status. The reasons are complex, including possible roles for such factors as selective migration, risk behaviors, exposure to various stressors, patient attitudes, and geographic variation in health care. This volume, produced by a multidisciplinary panel, considers such possible explanations for racial and ethnic health differentials within an integrated framework. It provides a concise summary of available research and lays out a research agenda to address the many uncertainties in current knowledge. It recommends, for instance, looking at health differentials across the life course and deciphering the links between factors presumably producing differentials and biopsychosocial mechanisms that lead to impaired health. "The Affordable Care Act set off an unprecedented wave of health insurance enrollment as the most sweeping overhaul of the U.S. health insurance system since 1965. In the years since its enactment, some 20 million uninsured Americans gained access to coverage. And yet, the law remained unpopular and politically vulnerable. While the ACA extended social protections to some groups, its implementation was troubled and the act itself created new forms of exclusion. Access to affordable coverage options were highly segmented by state of residence, income, and citizenship status. Unequal Coverage documents the everyday experiences of individuals and families across the U.S. as they attempted to access coverage and care in the five years following the passage of the ACA. It argues that while the Affordable Care Act succeeded in expanding access to care, it did so unevenly, ultimately also generating inequality and stratification. The volume investigates the outcomes of the ACA in communities throughout the country and provides up-close, intimate portraits of individuals and groups trying to access and

provide health care for both the newly insured and those who remain uncovered. The contributors use the ACA as a lens to examine more broadly how social welfare policies in a multiracial and multiethnic democracy purport to be inclusive while simultaneously embracing certain kinds of exclusions"--Publisher's website. Health care reform has dominated public discourse over the past several years, and the recent passage of the Affordable Care Act, rather than quell the rhetoric, has sparked even more debate. Donald A. Barr reviews the current structure of the American health care system, describing the historical and political contexts in which it developed and the core policy issues that continue to confront us today. This comprehensive analysis introduces the various organizations and institutions that make the U.S. health care system work—or fail to work, as the case may be. A principal message of the book is the seeming paradox of the quality of health care in this country—on the one hand it is the best medical care system in the world, on the other it is one of the worst among developed countries because of how it is organized. Barr introduces readers to broad cultural issues surrounding health care policy, such as access, affordability, and quality. He discusses specific elements of U.S. health care, including insurance, especially Medicare and Medicaid, the shift to for-profit managed care, the pharmaceutical industry, issues of long-term care, the plight of the uninsured, medical errors, and nursing shortages. The latest edition of this widely adopted text updates the description and discussion of key sectors of America’s health care system in light of the Affordable Care Act. 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 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. 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. 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. Does your employer have to cover maternity? Are cash-based physicians changing the way Americans access health care? How to Make Sense of Health Insurance in America explains the nuances of group and individual health insurance and the emerging trends in health care delivery and financing. Srinath Reddy, Yasmine Rouai, Jeffrey L. Sturchio, Cicely Thomas, Tana Wuliji, Snow Yang, Pascal Zurn This book presents an in-depth review on the role of health care financing in improving access for low-income populations to needed care, protecting them from the impoverishing effects of illness, and addressing the important issues of social exclusion in government financed programs. Health Insurance Systems: An International Comparison offers united and synthesized information currently available only in scattered locations - if at all - to students, researchers, and policymakers. The book provides helpful contexts, so people worldwide can understand various healthcare systems. By using it as a guide to the mechanics of different healthcare systems, readers can examine existing systems as frameworks for developing their own. Case examples of countries adopting insurance characteristics from other countries enhance the critical insights offered in the book. If more information about health insurance alternatives can lead to better decisions, this guide can provide an essential service. Delivers fundamental insights into the different ways that countries organize their health insurance systems Presents ten prominent health insurance systems in one book, facilitating comparisons and contrasts, to help draw policy lessons Countries included are Australia, Canada, France, Germany, Japan, the Netherlands, Sweden, Switzerland, the United Kingdom, and the United States Helps students, researchers, and policymakers searching for innovative designs by providing cases describing what countries have learned from each other 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. Finance/Accounting/Economics A New York Times bestseller/Washington Post Notable Book of 2017/NPR Best Books of 2017/Wall Street Journal Best Books of 2017 "This book will serve as the definitive guide to the past and future of health care in America.”—Siddhartha Mukherjee, Pulitzer Prize-winning author of The Emperor of All Maladies and The Gene At a moment of drastic political upheaval, An American Sickness is a shocking investigation into our dysfunctional healthcare system - and offers practical solutions to its myriad problems. In these troubled times, perhaps no institution has unraveled more quickly and more completely than American medicine. In only a few decades, the medical system has been overrun by organizations seeking to exploit for profit the trust that vulnerable and sick Americans place in their healthcare. Our politicians have proven themselves either unwilling or incapable of reining in the increasingly outrageous costs faced by patients, and market-based solutions only seem to funnel larger and larger sums of our money into the hands of corporations. Impossibly high insurance premiums and inexplicably large bills have become facts of life; fatalism has set in. Very quickly Americans have been made to accept paying more for less. How did things get so bad so fast? Breaking down this monolithic business into the individual industries—the hospitals, doctors, insurance companies, and drug manufacturers—that together constitute our healthcare system, Rosenthal exposes the recent evolution of American medicine as never before. How did healthcare, the caring endeavor, become healthcare, the highly profitable industry? Hospital systems, which are managed by business executives, behave like predatory lenders, hounding patients and seizing their homes. Research charities are in bed with big pharmaceutical companies, which surreptitiously profit from the donations made by working people. Patients receive bills in code, from entrepreneurial doctors they never even saw. The system is in tatters, but we can fight back. Dr. Elisabeth Rosenthal doesn't just explain the symptoms, she diagnoses and treats the disease itself. In clear and practical terms, she spells out exactly how to decode medical doublespeak, avoid the pitfalls of the pharmaceuticals racket, and get the care you and your family deserve. She takes you inside the doctor-patient relationship and to hospital C-suites, explaining step-by-step the workings of a system badly lacking transparency. This is about what we can do, as individual patients, both to navigate the maze that is American

healthcare and also to demand far-reaching reform. An American Sickness is the frontline defense against a healthcare system that no longer has our well-being at heart.

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