

Evidence Of Coverage And Plan Document Health Net

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.

The *Model Rules of Professional Conduct* provides an up-to-date resource for information on legal ethics. Federal, state and local courts in all jurisdictions look to the *Rules* for guidance in solving lawyer malpractice cases, disciplinary actions, disqualification issues, sanctions questions and much more. In this volume, black-letter *Rules of Professional Conduct* are followed by numbered *Comments* that explain each *Rule's* purpose and provide suggestions for its practical application. The *Rules* will help you identify proper conduct in a variety of given situations, review those instances where discretionary action is possible, and define the nature of the relationship between you and your clients, colleagues and the courts.

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.

Designing Benefits for Universal Health Coverage

A Special Way of Caring for the Terminally Ill

Confronting Racial and Ethnic Disparities in Health Care (with CD)

Evaluating the Evidence for Improving Health Outcomes Among People Experiencing Chronic Homelessness

Medicare and Other Health Benefits

Hearing Before the Subcommittee on Health of the Committee on Ways and Means, House of Representatives, One Hundred First Congress, Second Session, March 13, 1990

New York State Service

Cash transfers have become a key social protection tool in developing countries and have expanded dramatically in the last two decades. However, the impacts of cash transfers programmes, especially in Sub-Saharan Africa, have not been substantially documented. This book presents a detailed overview of the impact evaluations of these programmes, carried out by the Transfer Project and FAO's From Protection to Production project. The 14 chapters include a review of eight country case studies: Kenya, Ghana, Ethiopia, Zambia, Zimbabwe, Lesotho, Malawi, South Africa, as well as a description of the innovative research methodologies, political economy issues and good practices to design cash transfer programmes. The key objective of the book is to enhance the understanding of these development programmes, how they lead to a broad range of social and productive impacts and also of the role of programme evaluation in the process of developing policies and implementing programmes.

We analyze detailed data on plan designs from the Kaiser Family Foundation Employer Health Benefits Survey for 331 firms that offered employees both a qualifying high-deductible health plan and a lower-deductible option. For an employee at these firms selecting the lower-deductible option will decrease the deductible by \$1,300 on average. However, the cost of that additional coverage for the employee, from increased employee premiums and forgone firm contributions to health savings accounts, is nearly as large, averaging \$1,100. In 65% of firms the high-deductible option would result in lower maximum possible spending for the employee for the year. Further, we estimate based on simplified plan representations that the high-deductible plan financially dominates the lower-deductible option for employees at roughly half of the firms. Employees facing a range of possible medical-spending distributions would save on average over \$500 per year with the high-deductible option, often with no additional annual financial risk. While we cannot pin down the mechanism behind these patterns conclusively, the evidence is consistent with firms passing through lower average costs for high-deductible plans generated by adverse selection patterns to the employees choosing those plans. These results raise questions about the net effect of offering employees choices over plans with different coverage levels. Rather than creating a classic trade-off between risk and expected spending, at many firms plan options generate disparities in overall benefit value for employees who opt into different levels of coverage.

In 2015, building on the advances of the Millennium Development Goals, the United Nations adopted Sustainable Development Goals that include an explicit commitment to achieve universal health coverage by 2030. However, enormous gaps remain between what is achievable in human health and where global health stands today, and progress has been both incomplete and unevenly distributed. In order to meet this goal, a deliberate and comprehensive effort is needed to improve the quality of health care services globally. Crossing the Global Quality Chasm: Improving Health Care Worldwide focuses on one particular shortfall in health care affecting global populations: defects in the quality of care. This study reviews the available evidence on the quality of care worldwide and makes recommendations to improve health care quality globally while expanding access to preventive and therapeutic services, with a focus in low-resource areas. Crossing the Global Quality Chasm emphasizes the organization and delivery of safe and effective care at the patient/provider interface. This study explores issues of access to services and commodities, effectiveness, safety, efficiency, and equity. Focusing on front line service delivery that can directly impact health outcomes for individuals and populations, this book will be an essential guide for key stakeholders, governments, donors, health systems, and others involved in health care.

Evidence from the Affordable Care Act's Dependent Coverage Mandate

Who Pays First?

Why Today's Super-Connected Kids Are Growing Up Less Rebellious, More Tolerant, Less Happy--and Completely Unprepared for Adulthood--and What That Means for the Rest of Us

iGen

Preferred Provider Organization

Guide for All-Hazard Emergency Operations Planning

A User's Guide

Collects together data compiled from 177 World Health Organization Member States/Countries on mental health care. Coverage includes policies, plans and laws for mental health, human and financial resources available, what types of facilities providing care, and mental health programmes for prevention and promotion.

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.

Universal basic income (UBI) is emerging as one of the most hotly debated issues in development and social protection policy. But what are the features of UBI? What is it meant to achieve? How do we know, and what don't we know, about its performance? What does it take to implement it in practice? Drawing from global evidence, literature, and survey data, this volume provides a framework to elucidate issues and trade-offs in UBI with a view to help inform choices around its appropriateness and feasibility in different contexts. Specifically, the book examines how UBI differs from or complements other social assistance programs in terms of objectives, coverage, incidence, adequacy, incentives, effects on poverty and inequality, financing, political economy, and implementation. It also reviews past and current country experiences, surveys the full range of existing policy proposals, provides original results from micro+tax benefit simulations, and sets out a range of considerations around the analytics and practice of UBI.

Essential Health Benefits

Evidence of Coverage : California PERS Administered by Blue Shield of California, HEALTHMARC, and MEDCO for the Board of Administration of the Public Employees' Retirement System

Permanent Supportive Housing

Pain Management and the Opioid Epidemic

Crossing the Global Quality Chasm

Medicare & You

Balancing Coverage and Cost

Meant to aid State & local emergency managers in their efforts to develop & maintain a viable all-hazard emergency operations plan. This guide clarifies the preparedness, response, & short-term recovery planning elements that warrant inclusion in emergency operations plans. It offers the best judgment & recommendations on how to deal with the entire planning process -- from forming a planning team to writing the plan. Specific topics of discussion include: preliminary considerations, the planning process, emergency operations plan format, basic plan content, functional annex content, hazard-unique planning, & linking Federal & State operations.

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.

Drug overdose, driven largely by overdose related to the use of opioids, is now the leading cause of unintentional injury death in the United States. The ongoing opioid crisis lies at the intersection of two public health challenges: reducing the burden of suffering from pain and containing the rising toll of the harms that can arise from the use of opioid medications. Chronic pain and opioid use disorder both represent complex human conditions affecting millions of Americans and causing untold disability and loss of function. In the context of the growing opioid problem, the U.S. Food and Drug Administration (FDA) launched an Opioids Action Plan in early 2016. As part of this plan, the FDA asked the National Academies of Sciences, Engineering, and Medicine to convene a committee to update the state of the science on pain research, care, and education and to identify actions the FDA and others can take to respond to the opioid epidemic, with a particular focus on informing FDA's development of a formal method for incorporating individual and societal considerations into its risk-benefit framework for opioid approval and monitoring.

Model Rules of Professional Conduct

Assessing Genomic Sequencing Information for Health Care Decision Making

Health Insurance Coverage and Health Care Utilization

Care Without Coverage

Extending Medicare Coverage for Preventive and Other Services

Centers for Medicare & Medicaid Services

This report, which was developed by an expert committee of the Institute of Medicine, reviews the first three services listed above. It is intended to assist policymakers by providing syntheses of the best evidence available about the effectiveness of these services to Medicare of covering them. For each service or condition examined, the committee commissioned a review of the scientific literature that was presented and discussed at a public workshop. As requested by Congress, this report includes explicit estimates of costs to beneficiaries, their families, or others. It also does not include cost-effectiveness analyses. That is, the extent of the benefits relative to the costs to Medicare or to society generally is not evaluated for the services examined. The method for the generic estimation practices of the Congressional Budget Office (CBO). The objective was to provide Congress with estimates that were based on familiar procedures and could be compared readily with earlier and later CBO estimates. For each condition, the report intended to suggest the order of magnitude of the costs to Medicare of extending coverage, but the estimates could be considerably higher or lower than what Medicare might actually spend were coverage policies changed. The estimates cover the five-year period from 2007 to 2012. The conclusions about specific coverage issues, the report examines some broader concerns about the processes for making coverage decisions and about the research and organizational infrastructure for these decisions. It also briefly examines the limits of evidence for improving health services and outcomes and the limits of evidence as a means of resolving policy and ethical questions.

In 2010, an estimated 50 million people were uninsured in the United States. A portion of the uninsured reflects unemployment rates; however, this rate is primarily a reflection of the fact that when most health plans meet an individual's needs, most times they are affordable. Research shows that people without health insurance are more likely to experience financial burdens associated with the utilization of health care services. But even among the insured, underinsurance has emerged as a barrier to care. The Patient Protection and Affordable Care Act (ACA) has made the most comprehensive changes to the provision of health insurance since the development of Medicare and Medicaid by requiring all Americans to have health insurance by 2016. An estimated 30 million individuals who would otherwise be expected to obtain insurance through the private health insurance market or state expansion of Medicaid programs. The success of the ACA depends on the design of the essential health benefits (EHB) package and its affordability. Essential Health Benefits (EHB) defines, monitoring, and updating the EHB package. The book is of value to Assistant Secretary for Planning and Evaluation (ASPE) and other U.S. Department of Health and Human Services agencies, state insurance agencies, Congress, state governors, health care providers, and consumer advocates.

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 current system 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, the 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.

Evidence of Coverage

Coverage Matters

Workshop Summary

Communicating Risks and Benefits

The Medicare Handbook

Managed Care Plans

Registries for Evaluating Patient Outcomes

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.

Effective risk communication is essential to the well-being of any organization and those people who depend on it. Ineffective communication can cost lives, money and reputations. Communicating Risks and Benefits: An Evidence-Based User's Guide provides the scientific foundations for effective communications. The book authoritatively summarizes the relevant research, draws out its implications for communication design, and provides practical ways to evaluate and improve communications for any decision involving risks and benefits. Topics include the communication of quantitative information and warnings, the roles of emotion and the news media, the effects of age and literacy, and tests of how well communications meet the organization's goals. The guide will help users in any organization, with any budget, to make the science of their communications as sound as the science that they are communicating.

Evidence of CoverageSupplement to Medicare PlanThe Medicare HandbookEvidence of CoveragePreferred Provider OrganizationPERS CareEvidence of Coverage : California PERS Administered by Blue Shield of California, HEALTHMARC, and MEDCO for the Board of

Administration of the Public Employees' Retirement SystemEvidence of CoverageUniformed Services Active Duty Dependents Dental PlanCare Without CoverageToo Little, Too LateNational Academies Press

How Common are Dominated Health Plan Options? Evidence from Employer Health Benefits with High-Deductible Plans

An Evidence Based User's Guide

PERS Care

What's In, What's Out

Medicare and You 2006

Mental Health Atlas 2017

Insurance and Health Care

As seen in Time, USA TODAY, The Atlantic, The Wall Street Journal, and on CBS This Morning, BBC, PBS, CNN, and NPR, iGen is crucial reading to understand how the children, teens, and young adults born in the mid-1990s and later are vastly different from their Millennial predecessors, and from any other generation. With generational divides wider than ever, parents, educators, and employers have an urgent need to understand today's rising generation of teens and young adults. Born in the mid-1990s up to the mid-2000s, iGen is the first generation to spend their entire adolescence in the age of the smartphone. With social media and texting replacing other activities, iGen spends less time with their friends in person—perhaps contributing to their unprecedented levels of anxiety, depression, and loneliness. But technology is not the only thing that makes iGen distinct from every generation before them; they are also different in how they spend their time, how they behave, and in their attitudes toward religion, sexuality, and politics. They socialize in completely new ways, reject once sacred social taboos, and want different things from their lives and careers. More than previous generations, they are obsessed with safety, focused on tolerance, and have no patience for inequality. With the first members of iGen just graduating from college, we all need to understand them: friends and family need to look out for them; businesses must figure out how to recruit them and sell to them; colleges and universities must know how to educate and guide them. And members of iGen also need to understand themselves as they communicate with their elders and explain their views to their older peers. Because where iGen goes, so goes our nation—and the world.

Rapid advances in technology have lowered the cost of sequencing an individual's genome from the several billion dollars that it cost a decade ago to just a few thousand dollars today and have correspondingly greatly expanded the use of genomic information in medicine. Because of the lack of evidence available for assessing variants, evaluation bodies have made only a few recommendations for the use of genetic tests in health care.

For example, organizations, such as the Evaluation of Genomic Applications in Practice and Prevention working group, have sought to set standards for the kinds of evaluations needed to make population-level health decisions. However, due to insufficient evidence, it has been challenging to recommend the use of a genetic test. An additional challenge to using large-scale sequencing in the clinic is that it may uncover "secondary," or "incidental," findings - genetic variants that have been associated with a disease but that are not necessarily related to the conditions that led to the decision to use genomic testing. Furthermore, as more genetic variants are associated with diseases, new information becomes available about genomic tests performed previously, which raises issues about how and whether to return this information to physicians and patients and also about who is responsible for the information. To help develop a better understanding of how genomic information is used for healthcare decision making, the Roundtable on Translating Genomic-Based Research for Health of the Institute of Medicine held a workshop in Washington,DC in February 2014. Stakeholders, including clinicians, researchers, patients, and government officials, discussed the issues related to the use of genomic information in medical practice. Assessing Genomic Sequencing Information for Health Care Decision Making is the summary of that workshop. This report compares and contrasts evidence evaluation processes for different clinical indications and discusses key challenges in the evidence evaluation process.

Racial and ethnic disparities in health care are known to reflect access to care and other issues that arise from differing socioeconomic conditions. There is, however, increasing evidence that even after such differences are accounted for, race and ethnicity remain significant predictors of the quality of health care received. In Unequal Treatment, a panel of experts documents this evidence and explores how persons of color experience the health care environment. The book examines how disparities in treatment may arise in health care systems and looks at aspects of the clinical encounter that may contribute to such disparities. Patients' and providers' attitudes, expectations, and behavior are analyzed. How to intervene? Unequal Treatment offers recommendations for improvements in medical care financing, allocation of care, availability of language translation, community-based care, and other arenas. The committee highlights the potential of cross-cultural education to improve provider-patient communication and offers a detailed look at how to integrate cross-cultural learning within the health professions. The book concludes with recommendations for data collection and research initiatives. Unequal Treatment will be vitally important to health care policymakers, administrators, providers, educators, and students as well as advocates for people of color.

Medicare Supplement Insurance Policies

Uniformed Services Active Duty Dependents Dental Plan

Medicare and You 2009

The story of cash transfers and impact evaluation in sub-Saharan Africa

Too Little, Too Late

Exploring Universal Basic Income

Health-Care Utilization as a Proxy in Disability Determination

Addressing the challenge of covering health care expenses—while minimizing economic risks. Moral hazard—the tendency to change behavior when the cost of that behavior will be borne by others—is a particularly tricky question when considering health care. Kenneth J. Arrow ' s seminal 1963 paper on this topic (included in this volume) was one of the first to explore the implication of moral hazard for health care, and Amy Finkelstein—recognized as one of the world ' s foremost experts on the topic—here examines this issue in the context of contemporary American health care policy. Drawing on research from both the original RAND Health Insurance Experiment and her own research, including a 2008 Health Insurance Experiment in Oregon, Finkelstein presents compelling evidence that health insurance does indeed affect medical spending and encourages policy solutions that acknowledge and account for this.

The volume also features commentaries and insights from other renowned economists, including an introduction by Joseph P. Newhouse that provides context for the discussion, a commentary from Jonathan Gruber that considers provider-side moral hazard, and reflections from Joseph E. Stiglitz and Kenneth J. Arrow. " Reads like a fireside chat among a group of distinguished, articulate health economists. " —Choice

This paper investigates the impact of the Affordable Care Act's (ACA's) dependent coverage mandate on health insurance coverage rates and health care utilization among young adults. Using data from the Medical Panel Expenditure Survey, I exploit the discontinuity in health insurance coverage rates at age 26, the new dependent coverage age cutoff enforced by the ACA. Under alternative regression discontinuity design models, I find that 2.5% to 5.3% of young adults lose their health insurance coverage once they turn 26. This effect is mainly driven by those who lose their private health insurance plan coverage and those who lose their health insurance plan coverage, whose main holder resides outside of the household. I also find that the discrete change in health insurance coverage rates at age 26 is associated with significant changes in office-based physician and dental visits, but does not have a significant impact on the utilization of outpatient or emergency department services. Furthermore, the effects of the ACA's dependent coverage mandate on health care spending and out-of-pocket costs are insignificant. These results are robust under alternative model specifications.

Chronic homelessness is a highly complex social problem of national importance. The problem has elicited a variety of societal and public policy responses over the years, concomitant with fluctuations in the economy and changes in the demographics of and attitudes toward poor and disenfranchised citizens. In recent decades, federal agencies, nonprofit organizations, and the philanthropic community have worked hard to develop and implement programs to solve the challenges of homelessness, and progress has been made. However, much more remains to be done. Importantly, the results of various efforts, and especially the efforts to reduce homelessness among veterans in recent years, have shown that the problem of homelessness can be successfully addressed. Although a number of programs have been developed to meet the needs of persons experiencing homelessness, this report focuses on one particular type of intervention: permanent supportive housing (PSH). Permanent Supportive Housing focuses on the impact of PSH on health care outcomes and its cost-effectiveness. The report also addresses policy and program barriers that affect the ability to bring the PSH and other housing models to scale to address housing and health care needs.

Balancing Societal and Individual Benefits and Risks of Prescription Opioid Use

The Future of the Public's Health in the 21st Century

Medicare Hospice Benefits

Closing the Quality Gap

Improving Health Care Worldwide

Health Benefits Coverage Under Federal Law---

From Evidence to Action

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.

A Guide to Navigating Concepts, Evidence, and Practices

Unequal Treatment:

Moral Hazard in Health Insurance

The Affordable Care Act

Supplement to Medicare Plan

A Critical Analysis of Quality Improvement Strategies