Health Insurance Marketplace Paper Application

During 2012, many states took steps to form state-based health insurance exchanges (also referred to as marketplaces) provided for in the Patient Protection and Affordable Care Act (ACA), either through legislation or executive order. The purpose of the new exchanges is to ease the process of purchasing and enrolling in health plans, and to increase access to affordable health insurance for individuals, households, and small employers. These will be the exchanges through which low-income households can purchase individual/family insurance and gain access to tax credits to subsidize premiums. States establishing the Small Business Health Options Program will be managing the market for small firms to select health plans and for those who are eligible to receive tax credits toward premium costs. In early 2013 nine states (Arkansas, Delaware, Illinois, New Hampshire, Iowa, Michigan, Ohio, South Dakota, and Virginia) applied to participate as partners in federally facilitated exchanges. This paper examines the elements of state-based exchanges using the rubric established by a previous RUPRI Center paper and the implications of those elements for rural health care markets. When we began analyzing state plans for this paper, 15 states (and the District of Columbia) had taken the initial steps to set up a state-based marketplace. Subsequently (on January 3, 2013), the Center for Consumer Information & Insurance Oversight in the Centers for Medicare & Medicaid Services (CMS) announced that 17 states were conditionally approved to operate health insurance exchanges, including the states used in this analysis. West Virginia enacted a statute in 2011 but has not chosen to create a state exchange, so we did not include that state in this analysis, leaving the 14 states listed in the appended tables. Minnesota and New Mexico are not included in our analysis because they had not yet established the exchange by statute or executive order. Given the rural interests of this paper, we excluded the District of Columbia from the analysis.

The objectives of this study are to describe experiences in price setting and how pricing has been used to attain better coverage, quality, financial protection, and health outcomes. It builds on newly commissioned case studies and lessons learned in calculating prices, negotiating with providers, and monitoring changes. Recognising that no single model is applicable to all settings, the study aimed to generate best practices and identify areas for future research, particularly in low- and middle-income settings. The report and the case studies were jointly developed by the OECD and the WHO Centre for Health Development in Kobe (Japan).

Inhaltsangabe:Abstract: A true revolution has taken place in the financing of health care in America. Today, managed care is dominating the way Americans receive and pay for their health care. With the rise of managed care medicine has been wrenched out of its atomized world of solo physician practices and community hospitals and has been transformed into a modern industry of giant for-profit companies traded on Wall Street. The current marketplace is characterized by mergers, acquisitions and the establishment of giant multi-billion dollar healthcare networks. Hospitals and managed care plans run big advertisement campaigns in the media, praising their products and services in order to get the biggest share possible of the $1.1 trillion America spends on health care each year. All parties involved in providing health care lobby for their interests at all levels of political decision-making in order to influence legislators and policymakers. Today s health care market changes quickly and at a high rate. New variations of managed care arise constantly making any analysis of managed care an ongoing game of "catch-up" with the marketplace. While writing this paper, for example, UnitedHealthcare dropped one of the major managed care instruments, utilization review, to address public s concerns and pending legislation. This paper will take a snapshot of managed care on the eve of the new millennium by using the most recent information available. After this introduction, the paper will give a description of the current American health care system in chapter two (The U.S. Health Care System). Then, the paper will focus on two aspects: A detailed description of managed care in chapter three (Managed Care) and an introduction of the main issues connected with this way of providing health care in chapter four (Managed Care issues). The paper will argue in chapter five (Results and Future Developments), that managed care of the future will be a light version of what is currently existing, resulting in less strict restrictions and more freedom for patients and doctors. Finally, the report will focus on recent developments in Germany, where policy-makers have started to adopt particular elements of managed care. In chapter six (Managed Care Approaches in Germany), the paper will argue, that Germany should pay more attention to the American experiences regarding managed care in order to prevent harm for patients in [...]

What does that term mean? How is it even pronounced? Make sense of the complex world of health care with Mosby's Pocket Dictionary of Medicine, Nursing & Health Professions, 8th Edition. This comprehensive, portable dictionary offers a unique, strong focus on nursing and health science terminology. Featuring over 56,600 authoritative definitions of diseases, procedures, equipment, drugs, and more, it ensures you have the most reliable health science information right at your fingertips. Word roots and pronunciations help you learn and correctly use medical terminology, and alphabetized screened thumb tabs make finding definitions quick and easy. Emphasis on nursing and health science terminology supports health science students and practicing professionals. Over 56,600 definitions provide you with necessary information. Revised by an experienced educator, Marie O'Toole, and an expert team of health professionals, nurses, and doctors, so definitions are brief, pertinent, and — most important of all — accurate! Practical alphabetical organization without subentries makes it easier for you to find terms. British spellings assist you in recognizing alternate spellings. Pronunciations for key terms help you use terminology correctly in everyday practice. A Spanish/English Appendix and commonly used abbreviations, printed on the front and back endsheets, make dictionary an indispensable reference. Alphabetized screened thumb tabs save you time locating terms. Included etymologies build professional vocabulary and understanding of medical terminology. Small trim size makes dictionary easy to transport.

Mosby's Pocket Dictionary of Medicine, Nursing & Health Professions - E-Book

Obamacare Implementation

Health Reform

An Update from the Administration : Hearing Before the Committee on Finance, United States Senate, One Hundred Thirteenth Congress, First Session, November 6, 2013

U.S. Tax Guide for Aliens

Navigating Health Insurance

Government Advertising in Market-Based Public Programs

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.

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

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.

We experimentally varied information mailed to 87,000 households in California's health insurance marketplace to study the role of frictions in insurance take-up. Reminders about the enrollment deadline raised enrollment by 1.3 pp (16 percent), in this typically low take-up population. Heterogeneous effects of personalized subsidy information indicate systematic misperceptions about program benefits. Consistent with an adverse selection model with frictional enrollment costs, the intervention lowered average spending risk by 5.1 percent, implying that marginal respondents were 37 percent less costly than inframarginal consumers. We observe the largest positive selection among low income consumers, who exhibit the largest frictions in enrollment. Finally, the intervention raised average consumer WTP for insurance by $25 to $54 per month. These results suggest that frictions may partially explain low measured WTP for marketplace insurance, and that interventions reducing them can improve enrollment and market risk in exchanges.

Too Little, Too Late

Law and Practice of Private Health Insurance and Managed Care

What's Next? : Hearing Before the Subcommittee on Health of the Committee on Energy and Commerce, House of Representatives, One Hundred Thirteenth Congress, First Session, December 11, 2013

Hidden Costs, Value Lost

Elder Law Practice in Tennessee

The Role of Behavioral Frictions in Health Insurance Marketplace Enrollment and Risk

An Employee's Guide to Health Benefits Under COBRA

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

We estimate the demand for health insurance in the California Affordable Care Act marketplace (Covered California) without using parametric assumptions about the unobserved components of utility. To do this, we develop a computational method for constructing sharp identified sets in a nonparametric discrete choice model. The model allows for endogeneity in prices (premiums) and for the use of instrumental variables to address this endogeneity. We use the method to estimate bounds on the effects of changing premium subsidies on coverage choices, consumer surplus, and government spending. We find that a $10 decrease in monthly premium subsidies would cause between a 1.6% and 7.0% decline in the proportion of low-income adults with coverage. The reduction in total annual consumer surplus would be between $63 and $78 million, while the savings in yearly subsidy outlays would be between $238 and $604 million. Comparable logit models yield price sensitivity estimates towards the lower end of the bounds.

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.

Navigating Health Insurance examines health insurance from the perspective of the consumer. Students are introduced to basic health insurance principles and terminology as well as types of insurance such as Medicaid, Medicare, Medigap, Exchanges, and others.The impacts of the ACA on health insurance are explored as well as essential services and coverage decisions, long term care, workers compensation, administration/paper work, filing claims and more.Students will also be challenged to consider market and social justice philosophies, for example the impact on health insurance and access to health care services, international comparisons, and advantages and disadvantages of the U.S. system.

A Consumer's Guide

TIDES.Network

Health Care Coverage for Children

For Use in Preparing ... Returns

The Medicare Handbook

Medical and Dental Expenses

State Health Insurance Exchanges

The United States has the highest per capita spending on health care of any industrialized nation but continually lags behind other nations in health care outcomes including life expectancy and infant mortality. National health expenditures are projected to exceed $2.5 trillion in 2009. Given healthcare's direct impact on the economy, there is a critical need to control health care spending. According to The Health Imperative: Lowering Costs and Improving Outcomes, the costs of health care have strained the federal budget, and negatively affected state governments, the private sector and individuals. Healthcare expenditures have restricted the ability of state and local governments to fund other priorities and have contributed to slowing growth in wages and jobs in the private sector. Moreover, the number of uninsured has risen from 45.7 million in 2007 to 46.3 million in 2008. The Health Imperative: Lowering Costs and Improving Outcomes identifies a number of factors driving expenditure growth including scientific uncertainty, perverse economic and practice incentives, system fragmentation, lack of patient involvement, and under-investment in population health. Experts discussed key levers for catalyzing transformation of the delivery system. A few included streamlined health insurance regulation, administrative simplification and clarification and quality and consistency in treatment. The book is an excellent guide for policymakers at all levels of government, as well as private sector healthcare workers.

This paper studies government and private marketing activities in the context of the Affordable Care Act health insurance marketplace. Using detailed TV advertising data, we present evidence that government and private advertising are targeted to different geographical areas and provide different messaging content. Then, we estimate the impacts of government and private advertising on consumer demand by exploiting discontinuities in advertising along the borders of local TV markets. We find that government advertising has a market-expansion effect and enhances welfare. We also find that private advertising is not more effective than government advertising in increasing total program enrollment. Although private advertising is still effective in increasing insurer's own enrollment, it does not have positive spillovers to other insurers but has a modest business-stealing effect. We then develop and estimate an equilibrium model of marketplaces to illustrate mechanisms through which government advertising affects the market equilibrium. Our simulation suggests that government advertising can simultaneously increase total program enrollment and reduce excessive advertising spending among private insurers.

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.

Elder Law Practice in Tennessee covers all aspects of elder law as it currently exists in Tennessee. This one volume treatise addresses senior citizens and the law relevant to the legal practitioner and others providing allied services. Using this book as a guide, you can feel confident when: • planning for medical, financial, and quality of life decisions, • setting up a conservatorship, • making ethical considerations in elder law practice, • choosing housing options for an elderly client, and • planning for long-term care. The appendices include an Elder Law Planning Questionnaire for client use, a table of current public benefits figures, life estate and life expectancy tables, as well as a resource directory.

Coordinating Government Roles in Improving Health Care Quality

Nonparametric Estimates of Demand in the California Health Insurance Exchange

Investing in the Health and Well-Being of Young Adults

Connected Strategy

The Affordable Care Act

Health Insurance and Access to Care

Who are the Navigators? : Hearing Before the Committee on Oversight and Government Reform, House of Representatives, One Hundred Thirteenth Congress, First Session, December 16, 2013

This briefing paper outlines the insurance marketplace reforms included in the Affordable Care Act, related changes in Kansas law, and the interaction of the market and Exchange and available options following the June 2012 U.S. Supreme Court decision. This paper also highlights the remaining implementation time line and policy considerations for state policy makers, as established by the Act.

Medicare Made Easy describes the nuts and bolts of Medicare and Health Insurance in an easily understandable, orderly and readable fashion. This edition is a primer for Medicare and Health Insurance for 2013 and 2014. Things you need to know about Medicare and Health Insurance are covered. Every day, all across America, approximately ten thousand people will turn sixty-five years of age and become eligible for Medicare. It will continue at this rate until the year 2022.

TIDES.Network's white paper detailing an open-source generic protocol for pooling assets for mutual insurance, applied to a peer-to-peer health insurance network. v0.8 is an archived white paper, originally published in early 2018, and now made available in ebook format. ABSTRACT: Health insurance today is extremely centralized and has lost cost-effectiveness for most consumers. The distortions caused by asymmetric information, incentive misalignments, and regulatory and political overload have caused an ongoing dramatic increase in premiums, while reducing the quality of coverage. Moreover, traditional insurance companies' incentives are diametrically opposed to those of its customers, making these problems intractable. Tides is a peer-to-peer insurance network that uses a decentralized system of functionaries to completely disintermediate the insurance "company". In Tides' peer-to-peer health insurance model, the "insurance company" is disintermediated and self-organizing pools of people set their own governance on all aspects of their insurance, such as coverage, limits, terms, etc., utilizing a decentralized network of actuaries, underwriters and claims processors. Thus, all critical functions in a traditional insurance "company" become disaggregated and distributed across a decentralized network. Built-in incentive structures keep all functionaries honest and efficient. Moreover, members are thoroughly incentivized to exercise judgment in consumption of healthcare resources, as any paid but unspent premiums may be distributed back to members, based on the pool contract terms. Anyone can run a peer-to-peer insurance pool as long as they also run a compliance module to keep compliant with the laws that govern mutual insurances in their jurisdiction. This model of insurance eliminates asymmetric information and incentive problems that have plagued health insurance for decades. Tides will redefine insurance to once again become an efficient societal safety net. Let's make health insurance open, transparent, and decentralized. ABOUT TIDES.NETWORK: Creators of the TIDES.Network Protocol have the perfect balance of Life Sciences, Deep Technical knowledge and Crypto experience. Together, Dr. Chandra Duggirala, M.D., George Burke, and Manoj Duggirala previously founded and ran a hyper-personalized digital nutritionist/nutrition delivery startup that integrated subscribers' digital health analytics (TryFuel.com) with DNA and other biomarkers to deliver hyper-personalized meals nationwide. They took the concept from idea through successful product development, fundraising, and market execution, building a 7-figure annual run rate (ARR) company in less than 1 year. The team envisioned the TIDES project during 2018. Together, they have developed several blockchain initiatives and proofs-of-concept that reenvision Biotech R&D, Intellectual Property rights, Insurance, Cryptoeconomics, Crowdfunding, and Digital Asset Trading/Exchange.

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.

PPACA Implementation Failures

Building Continuous Customer Relationships for Competitive Advantage

Health Insurance in America

Decentralized protocol for a peer-to-peer health insurance network on the blockchain

Health Benefits Coverage Under Federal Law--.

Evidence from a Field Experiment

Care Without Coverage

When you hear the words "Health Insurance" do you break out into a cold-sweat? When you call your insurance company are you more confused and frustrated about your coverage after you hang up? You are not alone. Some studies say that more than one in four people in America have avoided care or treatment because they were unsure of what their health insurance covered, and a surprisingly large number of people were unsure if they even had health insurance. Health Insurance in America, a consumer's guide, is the first comprehensive health insurance guide written specifically for you; the consumer, to help you navigate the complex and often confusing world of Health Insurance, and make better decisions. It's written in easy to understand language and filled with real-life examples. Regardless of your prior experience or knowledge of insurance, you will find this guide to be an important part of your library. Now includes a look at the health insurance impact during the coronavirus pandemic of 2019/2020.

Consumer health websites have garnered considerable media attention, but only begin to scratch the surface of the more pervasive transformations the Internet could bring to health and health care. Networking Health examines ways in which the Internet may become a routine part of health care delivery and payment, public health, health education, and biomedical research. Building upon a series of site visits, this book: Weighs the role of the Internet versus private networks in uses ranging from the transfer of medical images to providing video-based medical consultations at a distance. Reviews technical challenges in the areas of quality of service, security, reliability, and access, and looks at the potential utility of the next generation of online technologies. Discusses ways health care organizations can use the Internet to support their strategic interests and explores barriers to a broader deployment of the Internet. Recommends steps that private and public sector entities can take to enhance the capabilities of the Internet for health purposes and to prepare health care organizations to adopt new Internet-based applications.

The Affordable Care ActGreenhaven Publishing LLC

Hidden Cost, Value Lost, the fifth of a series of six books on the consequences of uninsurance in the United States, illustrates some of the economic and social losses to the country of maintaining so many people without health insurance. The book explores the potential economic and societal benefits that could be realized if everyone had health insurance on a continuous basis, as people over age 65 currently do with Medicare. Hidden Costs, Value Lost concludes that the estimated benefits across society in health years of life gained by providing the uninsured with the kind and amount of health services that the insured use, are likely greater than the additional social costs of doing so. The potential economic value to be gained in better health outcomes from uninterrupted coverage for all Americans is estimated to be between $65 and $130 billion each year.

The Expansion-Related Effects of Short-Term, Limited Duration Insurance on Policyholders and the Affordable Care Act Individual Marketplace

Understanding Consumer Health Insurance Decision-Making Under the Affordable Care Act

Health Insurance Exchanges/Market Reforms/State Options

Lowering Costs and Improving Outcomes: Workshop Series Summary

Price Setting and Price Regulation in Health Care

Workshop Summary : Forum on Medical and Public Health Preparedness for Catastrophic Events

Evidence from the Health Insurance Marketplace

This paper explains certain federally mandated notices concerning insurance including Grandfathered notice, Summaries of Benefits and Coverage, Notice of Privacy Practices, HIPAA Notice of Special Enrollment Rights, Women's Health and Cancer Rights Act, Newborn's and Mother's Health Protection Act, New Health Insurance Marketplace coverage options and your health coverage, Premium assistance under Medicaid and the Children's Health Insurance Program (CHIP) and Medicare Part D creditable coverage letter.

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.

Short-term, limited-duration insurance (STLDI) is an umbrella term used to describe certain health insurance policies sold by major medical carriers. These policies are unique in that they do not have to comply with regulations set forth in the Affordable Care Act, including covering preexisting conditions and inability to deny or underwrite applicants based on health. For this reason, these plans are often cheaper than ACA-compliant plans for many healthy individuals. Sustained enrollment in these plans used to be very restrictive, as prior to 2017 an individual could only hold an STLDI plan for 90 days. However, short-term plans can now be purchased for one year, with an option to renew for up to two more years. This change in legislation dramatically altered the market for STLDI plans and has had some unintended effects on the individual market for ACA-compliant plans as well, even though many states have restricted or banned STLDI plans altogether. This paper will examine these continuing effects on the ACA marketplace and will evaluate the financial risk that individual policyholders may face under coverage of an STLDI plan.

Business Models for Transforming Customer Relationships What if there were a way to turn occasional, sporadic transactions with customers into long-term, continuous relationships--while simultaneously driving dramatic improvements in operational efficiency? What if you could break your existing trade-offs between superior customer experience and low cost? This is the promise of a connected strategy. New forms of connectivity--involving frequent, low-friction, customized interactions--mean that companies can now anticipate customer needs as they arise, or even before. Simultaneously, enabled by these technologies, companies can create new business models that deliver more value to customers. Connected strategies are win-win: Customers get a dramatically improved experience, while companies boost operational efficiency. In this book, strategy and operations experts Nicolaj Siggelkow and Christian Terwiesch reveal the emergence of connected strategies as a new source of competitive advantage. With in-depth examples from companies operating in industries such as healthcare, financial services, mobility, retail, entertainment, nonprofit, and education, Connected Strategy identifies the four pathways--respond-to-desire, curated offering, coach behavior, and automatic execution--for turning episodic interactions into continuous relationships. The authors show how each pathway creates a competitive advantage, then guide you through the critical decisions for creating and implementing your own connected strategies. Whether you're trying to revitalize strategy in an established company or disrupt an industry as a startup, this book will help you: Reshape your connections with your customers Find new ways to connect with existing suppliers while also activating new sources of capacity Create the right revenue model Make the best technology choices to support your strategy Integrating rich examples, how-to advice, and practical tools in the form of "workshop chapters" throughout, this book is the ultimate resource for creating competitive advantage through connected relationships with your customers and redefined connections in your industry.

Health Insurance is a Family Matter

PPACA Pulse Check, Serial No. 113-78, August 1, 2013, 113-1 Hearing

Federally Mandated Notices

The Consolidated Omnibus Budget Reconciliation Act

The End of Employer-Provided Health Insurance

Networking Health

The Impacts of the Affordable Care Act on Preparedness Resources and Programs

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

Following the implementation of the Affordable Care Act (ACA), millions of Americans have gained coverage, many for the first time in their lives. The law has created more options for affordable coverage and put millions into the driver seat when it comes to selecting their coverage and enrolling in a health plan. The individual health insurance market has undergone significant changes under the ACA, including the creation of state-based and federally facilitated marketplaces where individuals in all states can go to shop for and enroll in potentially subsidized individual market coverage. This dissertation seeks to improve our understanding of consumer decision-making in this new health insurance landscape. Through three sets of analyses of consumer behavior during the insurance decision-making process, this dissertation will provide needed updates to the literature on this topic. It also highlights key considerations for policymakers and agencies to weigh when evaluating how consumers might respond to policies that change their available coverage options. The first paper examines two key components of health plans that individuals weigh when making enrollment decisions - cost and quality. The ACA requires both federally facilitated and state-based marketplaces to provide easy to understand plan quality information to customers shopping for coverage. Through two hypothetical choice experiments, this paper examines how consumers weighed health plan costs and quality in different choice environments and explored the consumer characteristics associated with a preference for high quality plans as well as with the selection of inferior plans. In each experiment, participants responded to a series of choice scenarios that asked them to choose between five health plans that differed only in their costs and quality ratings, represented by stars. Overall, between scenarios individuals were willing to pay more for higher quality plans when the quality ratings of all available plans were lower, when the higher quality plan's rating was two stars higher rather than one star higher than other plans, and when the price differential was lower. More risk averse participants had higher predicted probabilities of consistently choosing the higher quality, more expensive plan. However, a significant portion of the study population made poor decisions: more than a third of participants chose a dominated plan at least once. The less numerate, those with higher risk-seeking tendencies, and those with low health insurance literacy had the highest predicted probabilities of choosing poorly. The second experiment also found that individuals are more likely to choose a dominated plan when the quality star ratings are similar across plans. The second and third papers use data from California's health insurance marketplace, Covered California, to examine consumer behavior following the implementation of silver loading in 2018. Silver loading is a policy California and other states put into place after the cancellation of federal funding for a set of subsidies included in the ACA that reduce the amount of cost-sharing required by low-income enrollees in silver tier marketplace plans, known as cost-sharing reductions (CSRs). Silver loading placed the cost of providing CSRs in the absence of federal funding onto the premiums of silver plans, subsequently raising premium subsidies which are tied to the cost of silver coverage. The second paper focuses on enrollment in silver plans that became dominated because of silver loading. This paper looks at enrollment in these plans over time (both before and after they became dominated) and by enrollees' prior year enrollment decisions to examine differences in enrollment by pre-existing biases regarding metal tier labeling and the potential role of status quo bias. Overall, more than 60,000 Californians enrolled in a dominated plan in 2018 and, on average, households enrolled in dominated plans in 2018 spent an additional $38.87 per month in premiums. Households that were enrolled in silver coverage in the year before the examined silver plans became dominated had the highest predicted probability of enrolling in a dominated plan in 2018. The third paper examines Covered California consumers' decisions to switch health plans during open enrollment over the first four open enrollment periods where individuals could renew their coverage (2015-2018). Under the ACA, switching rates in the individual market have been much higher than those previously seen in other markets. Looking at re-enrollees in Covered California, this paper provides data on consumer switching behavior over time and identifies the consumer, plan, and choice environment characteristics associated with consumers' decisions to change their coverage during open enrollment. The percentage of re-enrollees in Covered California who made changes to their coverage steadily increased between the 2014-15 and 2017-18 open enrollment periods. Following the implementation of silver loading the proportion of consumers who moved into gold plans during the 2017-18 open enrollment period drastically increased, compared to previous years. Among bronze or silver plan enrollees who switched metal tiers during open enrollment, those who could enroll in gold plans that were no more than $49 per month more expensive than their initial bronze or silver plan had a significantly higher probability of switching into gold coverage than those who faced larger premium differences. The results of this dissertation identify several consumer, health plan, and choice environment characteristics that can influence consumer health insurance decision-making. Policymakers and marketplace regulators can use this work to help inform the decisions they make around marketplace choice architecture, policies aimed at retaining enrollees and recruiting new consumers, and decisions about re-enrollment for consumers who do not actively renew their coverage during annual re-enrollment periods.

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.

Assessing Rural Implications of Statues

Why It's Good for You and Your Company

Leadership by Example

Hearing Before the Committee on Finance, United States Senate, One Hundred First Congress, First Session, June 20, 1989

The Healthcare Imperative

Health-Care Utilization as a Proxy in Disability Determination

America's Children