Once upon a time in a city, there was a large healthcare company named **"HealthPlus"** that offered various insurance plans to its members. The company was looking for a way to manage its complex claims processing, provider relationships, and ensure its customers got the best healthcare benefits without getting tangled in too many rules. That’s when **Facets**, a software solution by **Cognizant's TriZetto**, came to their rescue.

**Scene 1: Setting Up Health Plans**

The company wanted to offer a variety of plans for different needs, like **Medical, Dental, and Vision**.  
HealthPlus categorized these options into **(Types of Policies)**:

1. **(Individual Policy)**: John, being a young bachelor, chose an individual policy where he himself would pay the premium directly.
2. **(Group Policy)**: His colleague Emma, on the other hand, was enrolled under a **(Group Policy)** where their company, as a **(Sponsor)**, paid the premium on behalf of her and other employees.
3. **(Government Policy)**: John’s friend, Mr. David, an elderly retired man, was under a **(Government Policy)** where the government took care of his premium payments.

Each of these Policy has many plans like Gold Plan (OOPs less), Silver Plan (OOPs medium) , and Bronze Plan (OOPs High).  
Products -> like **Medical, Dental, and Vision**  
  
**Policy** → Contains multiple **Plans**.  
Each **Plan** → Contains multiple **Policy.**  
Each **Plan** → Contains multiple **Products**.  
Each **Product** → Contains multiple **Plans**.  
  
Every plan needed to have detailed information like:

* Who can enroll in the plan (Eligibility)?
* What are the benefits? For example, **Routine Check-ups**, **Surgeries**, and **Emergency Visits**.
* How long the coverage will last for each person (Stop Age).
* When does the coverage start after someone enrolls (Waiting Period)?
* What are the Types of Transactions available under the plan? For instance:

Cashless Transaction: When the Provider raises an authorization request to the Payer. Once approved, all the covered expenses will be paid by the Insurance Company (IC). If there are any non-covered expenses, the member has to take care of them.

Cash Transaction: When the Member pays for the treatment upfront and later submits  
a Claim for reimbursement.

To organize all of this information, the team used **Facets**. They started by creating **Plans** and linking them to **Products**.

* **Plan**: A high-level category like "HealthPlus Gold Plan."
* **Product**: The detailed structure that includes all the benefits, rules, and pricing .

For instance, if a new member, **John**, joins the **HealthPlus Gold Plan** in January 2023, his coverage begins immediately because there’s no waiting period for new employees (Waiting Period = 0).

HealthPlus Gold Plan falls under the category of **(Health Insurance)**, where members pay a **(Premium)** on a **(Frequency)** basis, either Monthly, Yearly, or Semi-Annually.

The relationship between John and HealthPlus is defined through a **(Policy)**, a contract between the patient and the **(Insurance Company)**, which is represented by HealthPlus here.

John’s colleague, Emma, also had her family members covered. In her case, she was the **(Subscriber)**, and her spouse and children were her **(Dependents)**. Together, they formed a **(Member)** unit under her policy.

**Scene 2: John Visits a Doctor**

One day, John wasn't feeling well and decided to see a doctor. The doctor he chose was a part of the **HealthPlus Network** (Participating Provider), which meant he could go for treatment without paying extra charges. This relationship between **HealthPlus** and the doctor was pre-determined by a **Network Set** (Collection of Providers).

* If John visited a doctor outside this network, he would have to pay higher fees because that doctor would be considered **Out of Network**.

John’s visit to the doctor was logged in Facets using a special code called a **Procedure Code** (99215). This code was part of the **Standard Industry Codes** list that Facets maintained to ensure that services provided are billed correctly. Along with that, a **Diagnosis Code** was added to show what condition John was being treated for.

John received his treatment at a **Provider** location, which could be a **Physician's office, hospital, or a lab facility**. In this case, the **Provider** played a key role in delivering the healthcare service to John, and the **Provider** entity's details were stored in the **Facets** system.

John’s treatment type was recorded as an **Inpatient** or **Outpatient** service, depending on the duration and nature of the treatment:

* **Inpatient (Inpatient Claims)**: If John was admitted to the hospital for more than 24 hours, his treatment would be classified as **Inpatient**.
* **Outpatient (Outpatient Claims)**: If John’s treatment was completed within the same day and he returned home, it would be classified as **Outpatient**.

**Scene 3: Processing the Claim**

After the visit, the doctor generated a **Claim** for the services provided to John. The claim went through **Claims Adjudication** (the process of evaluating whether the claim is eligible for payment and how much should be paid). Facets uses several components to make this decision:

1. **Place of Service (POS)**: Defines where the service was provided, e.g., at a hospital or in a clinic.
2. **Explanation Codes**: Justifications added to clarify why a claim was approved, denied, or partially paid.
3. **Benefit Components**: Rules like whether the service was eligible under John’s plan, or if a deductible needs to be paid first.
4. **Eligibility (w.r.t. claims)**: Ensures that:

* The **Member** is **active** in the plan.
* The **Member** has **paid the premium**.
* The **treatment** was actually **given or not**.
* The **treatment** is **covered in the policy**.
* The **Sum Insured (SI)** limit has been met or not.
* The **claim** is not a **Duplicate Claim**.

Example: For John’s policy (Plan P1), his **Sum Insured (SI)** limit was set at **3 lakhs** (3L).

The **Sum Insured (SI)** limit is typically set by the **Insurance Company (IC)** based on the policy or plan selected by the member.   
  
Below is how it worked for different claims he made:

* On 2nd of the month, he made a claim **(C1)** for **1L** -> Insurance Company (IC) **Pays**.
* On 4th of the month, he made a second claim **(C2)** for **2L** -> IC **Pays**.
* On 9th of the month, he made a third claim **(C3)** for **50K** -> **IC will not pay**, as the  
   total claim amount has exceeded the SI limit.

Facets verified John’s claim by checking these rules, ensuring that it was processed accurately and met all eligibility requirements before deciding on the amount to be paid.

**Scene 4: Provider Payment**

After John’s claim was processed, **HealthPlus** had to pay the doctor **(Provider)**. This payment depends on how the doctor **(Provider)** is contracted (i.e Provider Payment Method) with **HealthPlus** .

There are TWO Models :-

* **Fee for Service (FFS)**: If John’s doctor is part of a **FFS contract** i.e charges per service, he gets paid for each visit or procedure done. This model often leads to unnecessary treatments and higher healthcare costs (HC cost), which can result in a **loss for the Insurance Company (IC)**.
* **Capitation**: If the doctor is part of a **Capitation contract**, he gets a fixed amount per member per month (PMPM), no matter how many times members visit him. Basically it is a type of **Risk-Sharing Arrangement model.** This encourages providers to focus on preventive care and avoid unnecessary treatments, helping manage costs effectively.

For example, if John’s doctor had a **Capitation Contract** of $2000 for 10 members, he would receive $20,000 monthly even if John and others didn’t visit him that month.

**Capitation in Action**

Prov1 (John's provider) has a Capitation Contract of $2000 PMPM.

* January: 10 enrolled members → $2000 × 10 = $20,000
* February: 5 enrolled members → $2000 × 5 = $10,000
* March: 15 enrolled members → $2000 × 15 = $30,000

In January:

* **M1 (Healthy Member)**: Does not visit the provider.
  + **IC pays** $2000 to the provider.
  + **Result**: IC incurs **$2000 loss**, provider gains **$2000 profit**.
* **M2 (Unhealthy Member)**: Visits the provider for a treatment costing $5000.
  + **IC pays** $2000 to the provider.
  + **Result**: IC earns **$3000 profit**, provider incurs **$3000 loss**.

This model prevents unnecessary treatments while encouraging **preventive care** and **wellness programs**, such as:

* **Education**
* **Health Camps**
* **Vaccination**
* **Diet Consultation**
* **Counselling Sessions**

This strategy ensures that providers focus on maintaining members' well-being, reducing long-term healthcare costs.

**Scene 5: Administrative Configurations**

Meanwhile, the **HealthPlus** admin team ensured that rules like **Stop Age** and **Waiting Period** were in place:

* **Stop Age**: If John turned 65, his coverage would automatically end, as 65 was the designated stop age.
* **Waiting Period**: If John joined the company on January 1st, 2023, and his plan had a 10-day waiting period, his coverage would start on January 11th, 2023.

**HealthPlus** also used a **(Rate Guarantee)** to keep premiums unchanged for the next two years, giving John peace of mind that his costs wouldn’t increase suddenly.

Additionally, the team needed to consider **Pre-existing Conditions** when setting up the policies:

* If a member like John’s colleague, **Mark**, joined the **HealthPlus Gold Plan** on January 1, 2022, without any prior health issues, any new condition developed after this date would be covered.
* However, if another member, **Sam**, who was already being treated for a heart condition since January 1, 2021, joined the plan on January 1, 2022, any expenses related to his heart condition wouldn’t be covered, as it would be considered a **Pre-existing Condition**.

To further manage the providers and treatment options, HealthPlus categorized providers using **Networks**:

* **Network**: A collection of doctors and hospitals.
* **Network Group**: A group of multiple networks.
* **Network Set**: A superset containing all the network groups.

For example, **CTS India** represents the Network Set with multiple groups within it:

* **CTS India**:
  + **NWGNW** (Network Group):
    - **Pun**
    - **Kol**
    - **Noi**
  + **SWGNW** (Network Group):
    - **CHN** (Network):
      * Apollo Hospital
      * Kauvery Hospital
    - **HYD** (Network)
    - **BLR** (Network)

This classification ensured members knew which doctors and hospitals were covered under their plan. For example, if John visited a doctor outside the **Network Set**, his claim might not be fully covered. This allowed HealthPlus to maintain clarity and control over which providers were **In-Network** or **Out-of-Network** for different plans and policies.

* **In-Network**: Providers that have a tie-up or contract with HealthPlus.
* **Out-of-Network**: Providers that do not have a contract with HealthPlus.

The **PCP (Primary Care Physician)** acted as a **Gatekeeper** to ensure members were directed to the right specialists within the network, helping to manage costs and care quality effectively.

**Scene 6: Complex Claims and Coordination of Benefits (COB)**

One day, John got injured and had to get treatment either **In-network** or **Out-of-network**. If Jhon has multiple insurance policies then **Coordination of Benefits (COB)** comes in to picture.

If John had another insurance policy, HealthPlus would decide whether to be the primary or secondary payer.

* **Primary Payer**: Pays first and covers the maximum allowed amount.
* **Secondary Payer**: Covers the remaining amount after the primary payer has made its contribution.

**Cost Shifting and Maximum Allowed Amount**

**Cost Shifting** ensures that any losses from one member’s claim can be balanced by the profit from another. HealthPlus also sets a Maximum Allowed Amount—the highest amount the insurance will pay for a specific service, ensuring effective payment management.

**Real-Life COB Example with Multiple Policies**

Let’s say John’s parents have two policies:

* **Mom’s Policy**: Coverage limit of **$6000**
* **Dad’s Policy**: Coverage limit of **$4000**

**Scenario 1: Treatment Costs $8000**

1. **Mom’s Policy** (Primary Payer) pays: **$6000**
2. **Dad’s Policy** (Secondary Payer) covers the remaining:
   * **$8000 - $6000 = $2000**
   * Dad’s policy covers the smaller amount: **$2000**

Total Coverage = **$8000**

**Scenario 2: Treatment Costs $12,000**

1. **Mom’s Policy** (Primary Payer) pays: **$6000**
2. **Dad’s Policy** (Secondary Payer) covers up to its limit:
   * **$12,000 - $6000 = $6000**
   * Dad’s policy pays **$4000**, its maximum coverage.

Total Coverage = **$10,000**  
The member will need to pay the remaining **$2000** out of pocket.

**Scene 7: Making Adjustments and Benefits Enhancement**

**HealthPlus** wanted to add new benefits like **Vaccination Camps** and **Counseling Sessions** under John’s plan. Using the **Benefit Components Table**, they updated the plan to include these new benefits and set new **Variable Components** for cost-sharing like copays or deductibles.

If John wanted to use these services, he could now do so without incurring extra charges. All these changes were stored in the **Administrative Information Table**, ensuring the system was always updated.  
  
  
In Making Adjustment section there is a term OOP expense Game comes in.  
COB (Coordination of Benefits) works across multiple policies

CSM (Cost-Sharing Mechanism) is within one policy like OOP

Policy -> Policy partially -> Policy fully active

-> Policy Deductible -> OOP (Max)  
  
Starts -> Deductible -> OOPs calculation will start -> COB  
  
**COB + OOP Example:**

1. **Mom’s Policy (Primary):**
   * **OOP Max = ₹3,000**
   * Deductible + Coinsurance + Copay already paid = ₹3,000
   * Policy is now **fully active**—no additional OOP expenses.
2. **Dad’s Policy (Secondary):**
   * **OOP Max = ₹2,000** (but not relevant unless secondary kicks in)

**Scenario: John Gets Hospitalized (Cost = ₹1,00,000):**

* **Primary Policy (Mom’s)**:  
  Since **OOP max** is reached, **John’s entire hospitalization** will be **covered by mom’s policy**. No need for the secondary policy to step in.
* **If a Treatment Exceeds Mom’s Policy Limits** (e.g., ₹1,20,000 limit for hospitalization):
  + **Mom’s policy** pays ₹1,20,000 (full limit).
  + **Dad’s policy** (secondary) can cover any remaining amount beyond that limit.

**cost-sharing mechanisms** OOP:

* **Copay:** John had to pay a small fixed amount (e.g., $30) for his next doctor consultation.
* **Coinsurance:** After meeting the deductible, John was responsible for 10% of future treatment costs, with the **insurance covering 90%**.
* **Deductible:** Before insurance began covering treatments, John needed to meet a **deductible amount**, say $500, from his own pocket.

**OOP Max**: $3000 reached -> benefit period start (reset per calendar year).

**OOP Lifetime Limit**: $999,999,999, -> Life time free service ON

**Copay, Coinsurance, Deductible, OOP Max**, and **OOP Lifetime Limit** are tracked with **Accumulators**.  
  
Accumulator = Summing up of all OOP expenses  
All Policy Pay = Sum Insured   
  
flow :-  
  
1st Total Expense = ?

2nd Deductible = ?  
  
3rd Coinsurance = ?  
  
4th Copay = ?  
  
5th OOP = ? ->  
  
6th If OOP = OOP max   
NO -> Member pay = OOP   
YES -> Member pay = OOP – OOP max  
  
7th Policy pay (IC) = Total expenses – Member pay   
  
8th Accumulator = Summing up of all OOP expenses  
  
  
  
  
**Pharmacy and Provider Flexibility**

For medications, HealthPlus partnered with a **PBM (Pharmacy Benefit Manager)** to keep prescription costs manageable. PBMs ensured that essential drugs were accessible at the lowest prices through effective formulary management.  
  
Referrals -> PCP (Primary Care Physician)

John also had various plan options based on his preference:

* **HMO (Health Maintenance Organization):** Lowest cost, **In-Network** only, Yes Referrals required.
* **PPO (Preferred Provider Organization):** High Cost, **In-Network** + **Out-Network**, No Referrals req.
* **EPO (Exclusive Provider Organization):** Moderate cost, **In-Network** only, No Referrals required.
* **POS (Point-of-Service):** Moderate cost, **In-Network** + **Out-Network**, Yes Referrals required  
    
    
  example -> HealthPlus Comprehensive Insurance Policy (**Policy**)  
   -> HealthPlus Gold Plan  
   -> HealthPlus Silver Plan  
   -> HMO , PPO, EPO, POS

**Automation and Information Exchange**

To keep the claims process efficient, HealthPlus used:

* **EDI (Electronic Data Interchange):** For seamless exchange of billing and claim-related data between providers and HealthPlus.
* **EOB (Explanation of Benefits):** Detailed summaries were sent to John after each claim, explaining what was covered and what wasn’t, ensuring transparency.

**Credentialing and Background Verification**

HealthPlus ensured that all doctors and healthcare providers in their network went through **Credentialing**—a thorough **background verification process** to maintain quality standards.

**Seamless Information Exchange and Credentialing**

HealthPlus used **EDI (Electronic Data Interchange)** to exchange billing and claims data efficiently with providers. After every claim, John received an **EOB (Explanation of Benefits)** detailing what was covered and what wasn’t.

To maintain service quality, HealthPlus required that all providers go through **Credentialing**—a thorough **background verification process** ensuring all doctors, hospitals, and other providers met HealthPlus' high standards.

**Final Scene: Putting It All Together**

By using **Facets** effectively, HealthPlus was able to create a comprehensive plan, manage claims, handle payments to providers, and even update benefits dynamically. This entire workflow was managed through **Facets Workflow**, which automated many manual processes, allowing the team to focus on delivering high-quality service to members like John.

In this way, **Facets** helped **HealthPlus** simplify its operations, reduce administrative costs, and provide better healthcare services to its members.