📘 Comprehensive Guide to U.S. Healthcare System

🔷 1. HealthCare Overview

📌 What is Health Insurance?

Health insurance is a contractual agreement where an insurer covers all or part of an individual's medical expenses in exchange for a monthly premium. It ensures financial protection against high healthcare costs and promotes access to necessary medical services.

Types of Coverage:

- Preventive services (checkups, screenings)
- Hospitalization and emergency services
- Prescription drugs
- Maternity and newborn care

Example:
A $5,000 surgery may only cost a patient $500 if they meet their deductible and coinsurance with insurance coverage.

📌 Health Insurance Entities – Provider, Member, and Payer

Entity	Description
Provider	Healthcare professionals/facilities offering care (e.g., doctors, hospitals)
Member	Individual enrolled in a health plan (subscriber or dependent)
Payer	Organization paying the claim (insurance companies, PBMs, TPAs)

📌 Types of Health Insurance – Medicaid, Medicare, Commercial

Type	Description
Medicaid	State-run program for low-income individuals and families
Medicare	Federal program for individuals 65+ and those with disabilities
Commercial	Employer-sponsored or privately purchased insurance

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📌 Types of Health Plan – HMO/PPO/EPO/POS

Plan Type	Key Features
HMO	Requires PCP & referrals; in-network only; low cost
PPO	No referral needed; out-of-network allowed; higher premiums
EPO	Like HMO but no PCP/referral requirement; in-network only
POS	Hybrid of HMO and PPO; referrals required for OON care

📌 Understanding Provider Networks and Contracts

Insurance companies form networks by contracting with providers. These contracts define:

- Reimbursement rates
- Scope of services
- Authorization requirements

Example:
INN providers charge negotiated rates. OON providers may bill full price.

📌 Understanding Benefit Plan and Policy Holders

- **Subscriber**: Primary person who holds the insurance
- **Dependents**: Spouse, children, etc.
- **Plan**: Defines what services are covered, under what conditions, and the cost-sharing involved.

📌 Understanding Code Sets & Cost-Shares

Medical Code Sets:

- **ICD-10**: Diagnoses (e.g., J45.909 – Asthma)
- **CPT**: Procedures/services (e.g., 99213 – Office visit)
- **HCPCS**: Ancillary services, drugs, DME
- **NDC**: Drug identification

Cost-Share Terms:

Term	Meaning
Deductible	Amount paid by member before insurance starts covering
Copayment	Fixed amount per service (e.g., $30 per visit)
Coinsurance	% of cost shared after deductible (e.g., 20%)
OOP Max	Max a member pays in a year; insurance covers the rest

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📌 Understanding EDI Transactions

Electronic Data Interchange (EDI) is used to standardize healthcare data exchange.

EDI File	Purpose
834	Enrollment and maintenance
837	Claim submission
835	Remittance/payment advice
278	Authorization requests/responses
999/277CA	Acknowledgment and validation responses

📌 Medical Management – Utilization and Care Management

- **Utilization Management (UM):** Ensures medical necessity before providing services (e.g., prior authorizations)
- **Care Management (CM):** Coordinates care for chronic conditions and complex cases (e.g., heart failure)

📌 What is a Claim? Types and Lifecycle

Claim: A formal request by provider to payer for reimbursement.

Type	Description
Institutional	Hospital-based services (837I)
Professional	Physician-based services (837P)
Pharmacy	Prescription drug claims (NCPDP)

Lifecycle Stages:

1. **Claim Submission (837)**
2. **Compliance Validation (TA1, 999, 277CA)**
3. **Adjudication** – Eligibility, benefit checks, clinical edits
4. **Payment/Denial** – EOB/RA (835)
5. **Appeals/Adjustments**

📌 Understanding an E2E Data Flow

End-to-End Flow:

Member → Provider Visit → Claim (837) → Payer (Adjudication) → Payment (835/EOB) → Portal/Repository

Touchpoints:

- Member Portals → Eligibility, ID card, benefits
- Provider Portals → Submit pre-auth, view remits
- Data Repositories → Store all EDI, audit logs

🔷 2. Provider

📌 Provider Identifiers

Healthcare providers use standard identifiers to ensure accurate billing, communication, and regulatory compliance.

Identifier	Description
NPI (National Provider Identifier)	Unique 10-digit ID for all providers in the U.S.
TIN (Tax Identification Number)	Used for tax purposes and payment processing
DEA Number	Required for providers authorized to prescribe controlled substances
CAQH	Provider credentialing database used for enrollment

📌 Concept of INN and OON Provider

Term	Description
INN (In-Network)	Provider has a contract with payer; services are covered at lower cost
OON (Out-of-Network)	Provider is not contracted; higher out-of-pocket expenses for members

Example:

- A member sees an **INN dermatologist** – copay = $30
- Sees an **OON dermatologist** – may owe 60–80% of the full charge.

📌 Provider Types, Specialty, Network, Agreement, Terms, and Fee Schedule

Aspect	Description
Provider Types	PCPs, Specialists, Facilities, Labs, Pharmacies
Specialty	Cardiology, Pediatrics, Radiology, etc.
Networks	Broad (national) vs. Narrow (regional/local)
Agreements	Define terms for reimbursements, documentation, audit clauses
Fee Schedule	CPT/HCPCS-based rate sheet negotiated between payer and provider

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📌 Provider Enrollment – Credentialing and Contracting

Credentialing:

A detailed vetting process verifying:

- Licenses and certifications
- Education and training
- Work history and malpractice records.

Contracting:

A legal agreement signed between payer and provider defining:

- Covered services.
- Reimbursement terms (FFS, bundled, capitation)
- Responsibilities on both sides (e.g., pre-auth, timely filing)

✅ Example Process:

1. Apply via CAQH or payer portal.
2. Submit licenses, W-9, malpractice info.
3. Sign agreement with negotiated fee schedule.

📌 Capitation

Capitation is a **value-based payment model** in which a provider is paid a **fixed amount per patient per month (PMPM)**, regardless of how many times the patient is seen.

Example:

- Provider receives $30 per member/month for managing 500 patients.
- Encourages preventive care and reduces unnecessary services.

Pros	Cons
Incentivizes care efficiency	Risk of under-providing care
Predictable revenue	May discourage complex care cases

📌 Provider Details – Portals

Provider portals are secure web interfaces that enable provider-payer digital interaction:

Functionality	Description
Eligibility Check	Search member ID and view active coverage
Claim Submission	Submit 837P/I forms online or via clearinghouse
Prior Authorization	Request or track 278 authorizations
Remittance Advice	View/download 835 ERAs
Disputes/Appeals	Submit rework/appeals for denied claims

Common Portals: Availity, Change Healthcare, payer-specific platforms.

🔷 3. Member

📌 Understanding Member Enrollment, Void, Reinstatement

Term	Description
Enrollment	Member is added to a health plan, typically via employer (group) or ACA exchange (individual). Details shared via EDI 834 file.
Void	Member's enrollment is cancelled due to ineligibility or voluntary withdrawal. Retroactive or prospective.
Reinstatement	Previously voided/cancelled enrollment is restored, often after eligibility verification or appeal.

Example Workflow:

HR adds employee to health plan → 834 transmitted to payer → Member activated in system.

📌 Billing Overview

Members receive **monthly premium bills**, which must be paid to maintain active coverage.

Type	Description
Premium	Fixed monthly fee for insurance coverage
Grace Period	Usually 30 days to make late payment
Subsidies	ACA subsidies available for individual plans based on income
Group Billing	Employer receives single invoice for all employees

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📌 EDI 834 Transaction – Benefit Enrollment and Maintenance

EDI 834 is the standard transaction used to enroll, terminate, or update a member's information in a health plan.

Key Segments:

Segment	Description
INS	Member relationship (Add/Change/Terminate)
NM1	Member's full name and identifier
REF	Subscriber IDs, policy numbers
DTP	Effective dates

Segment	Description
HD	Benefit coverage (e.g., medical, dental)
LX	Looping control
SE	End of transaction

✅ **Example (Simplified)**:

INS*Y*18*030*XN*A*E**FT~

NM1*IL*1*DOE*JOHN****MI*123456789~

REF*0F*789654123~

DTP*348*D8*20240101~

HD*030**HLT~

📌 Welcome Kit & ID Card

After enrollment, members receive:

- **Welcome Letter**: Coverage start date, policy number, plan type
- **ID Card**: Includes member ID, group number, RxBIN/RxPCN (if applicable), co-pay info

✅ *Digital ID cards* are increasingly available via mobile apps (e.g., Aetna, Cigna).

📌 Member Eligibility Extracts

Eligibility extracts are regularly shared (daily/weekly) with downstream systems such as:

- Clinical systems
- Pharmacy Benefit Managers (PBMs)
- Care Management Platforms

Fields typically included:

- Member demographics
- Plan start/end dates
- PCP assignment
- Dependent list

📌 Member Details – Portals

Member self-service portals provide access to:

Feature	Purpose
Benefits Overview	See what's covered
Find Provider	Search in-network doctors and specialists
ID Card	View/download physical or digital card
Claim Status	Track processed claims, EOBs
Premium Payments	Pay bills or setup auto-debit
Authorizations	View prior auth status
Communication Hub	Chat or message support

✅ Example: myCigna, myUHC, BlueAccess for Members

🔷 4. EDI 834 – Benefit Enrollment and Maintenance

📌 What is EDI 834?

EDI 834 is a transaction set under the ANSI X12 standard, used by employers, government agencies, or enrollment platforms to electronically submit member enrollment information to health plans (payers).

It's a HIPAA-mandated transaction for enrollment data exchange.

📌 Key Use Cases

- **Initial Enrollment**: Adding a new subscriber and dependents
- **Termination**: Cancel coverage due to resignation or disqualification
- **Change in Coverage**: Updating address, plan, or dependent info
- **Reinstatement**: Re-activating a previously terminated policy

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📌 Structure of an 834 Transaction

EDI 834 files follow a **hierarchical segment format**:

Segment	Purpose
ST	Start of transaction

Segment	Purpose
BGN	Beginning of transaction (timestamp, control info)
N1	Name of sponsor (e.g., Employer or Exchange)
INS	Member enrollment action: add, change, terminate
NM1	Member or subscriber name
REF	Member identifiers (Policy #, Member ID)
DTP	Effective and termination dates
HD	Health coverage type
SE	End of transaction

📌 Sample EDI 834 File with Annotations

ST*834*0001~ ← Transaction Start

BGN*00*123456789*20240601*1200*ET***4~ ← File ID, Timestamp

N1*P5*ACME INSURANCE COMPANY~ ← Sponsor Name (Payer)

INS*Y*18*030*XN*A*E**FT~ ← Add Dependent, Full-time

REF*0F*MEM123456~ ← Subscriber Identifier

NM1*IL*1*DOE*JOHN****MI*MEM123456~ ← Member Name

PER*IP**HP*8005551212~ ← Contact Info

DTP*336*D8*20240601~ ← Coverage Start Date

HD*030**HLT~ ← Health Coverage Line

DTP*348*D8*20240601~ ← Benefit Start Date

SE*10*0001~ ← Segment End

📌 Companion Guide and Trading Partner Agreements

- Each payer may publish a **Companion Guide** describing:
    - Required loops
    - Custom validation rules
    - Field usage

- **Trading Partner Agreements (TPAs)** govern:
    - Frequency of file submissions (daily, weekly)
    - File naming conventions
    - Error response handling

📌 Common Errors in 834 Files

Error Code	Description
1001	Invalid Member ID or SSN
2002	Overlapping enrollment dates
3003	Unmatched dependent without subscriber
TA1/999	Structural/format validation failures

📌 System Integration Touchpoints

System	Purpose
Eligibility Engine	Stores current eligibility
CRM/Call Center	Customer service tools reference member data
Portals	Reflect real-time plan status
PBM Systems	Enable pharmacy access and Rx plan linkage

🔷 5. Claims Processing and Payment

📌 Overview

Claims processing is the central function in health insurance where the **payer evaluates, adjudicates, and reimburses** providers for services rendered to members.

The process spans from **claim intake** to **payment or denial**, involving multiple validation, pricing, and clinical steps.

📌 Claims Intake – Compliance Validation (TA1, 999, 277CA)

EDI 837 files submitted by providers undergo structural and compliance checks before adjudication begins.

Acknowledgment	Description
TA1	Confirms receipt of EDI file; checks envelope structure
999	Validates EDI syntax (X12 rules)
277CA	Claims acknowledgment – identifies accepted or rejected claims

✅ Example:

If a provider sends 100 claims, TA1 confirms receipt, 999 confirms format, and 277CA tells how many are clean vs rejected.

📌 Claims Adjudication

Adjudication is the **systematic evaluation of a claim** to determine reimbursement. It includes:

Step	Description
Provider Match	Validates if NPI/TIN is contracted and active
Member Match	Checks member eligibility and plan enrollment
Benefit Check	Validates if service is covered (based on CPT/ICD codes)
Pricing	Applies contracted rates (fee schedule, DRG, APC, capitation)
Clinical Edits	Checks for coding accuracy and fraud using tools like **CCI, MUE**
External Vendors	May route to third-party services for editing or eligibility (e.g., Optum CES, Truven)

✅ Tools: McKesson ClaimsXten, Optum CES, Change Healthcare InterQual

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📌 Claims Payment Integrity

Payment Integrity teams ensure **correct payment** and prevent fraud/waste/abuse. This includes:

- **Duplicate claim detection**
- **Bundling/unbundling rules**
- **Upcoding audits**
- **Post-payment audits**
- **Prepay logic edits**

Vendors involved: Cotiviti, SCIO, Performant

📌 Claims Payment: EOB, RA, AR/AP, Recoupment

Term	Description
EOB (Explanation of Benefits)	Sent to member summarizing what was paid or denied
RA/ERA (Remittance Advice)	Sent to provider listing claim payments/denials
AR (Accounts Receivable)	Payment owed to provider from payer
AP (Accounts Payable)	Funds the payer needs to disburse
Recoupment	Reversal of overpayment to provider

Payment File Format:

- **EDI 835** for remittance
- Can be integrated with bank systems for EFT

📌 Encounter Claim Processing

Encounters are claim-like submissions sent by Medicaid MCOs to state/federal agencies for reporting purposes.

Difference	Claims	Encounters
Purpose	Payment to provider	Regulatory reporting
Processing	Adjudicated	Accepted/Rejected only
Submission	837, but with specific encounter identifiers	
Frequency	Real-time/daily	Weekly/monthly batches

📌 Additional Touchpoints in Claims

Module	Function
Audit Systems	Internal audit logs and history
Appeals/Grievances	Routing of denied claims for reprocessing
Care Management	Claims data helps identify high-cost or chronic members
BI/Reporting	Claims drive cost/utilization dashboards

✅ **Tip:**
Payers often use a **Rules Engine** or **Business Rule Management System (BRMS)** to apply edits dynamically.

🔷 6. EDI 837 – Health Care Claim

📌 What is EDI 837?

EDI 837 is the HIPAA-mandated standard for submitting healthcare claims electronically. It transmits data about services provided by a healthcare professional or facility to a payer for reimbursement.

📌 Types of 837 Transactions

Type	Used For	File Type
837P	Professional Claims (e.g., doctor visit, office-based services)	837 Professional
837I	Institutional Claims (e.g., inpatient hospital, outpatient facilities)	837 Institutional
837D	Dental Claims (e.g., fillings, root canals)	837 Dental

📌 When is 837 Used?

- After a provider renders services
- To request payment from payer
- To submit encounter data to regulatory agencies (Medicaid)

Trigger Example:

A patient visits a dermatologist. After diagnosis and procedure, the clinic's billing software generates an 837P and sends it to the payer via a clearinghouse.

📌 Core Structure of an 837 Transaction

837 files follow a **loop and segment format** defined by ANSI ASC X12.

Segment	Description
ISA/GS/ST	Envelope headers
NM1	Name information (provider, subscriber, payer)
CLM	Claim information – amount, visit ID

Segment	Description
HI	Diagnosis codes (ICD-10)
SV1	Service line (CPT/HCPCS)
REF/DTP	References (e.g., auth #, service dates)
SE/GE/IEA	Transaction closing segments

📌 Sample EDI 837P File (Simplified & Annotated)

ISA*00* *00* *ZZ*SENDERID *ZZ*RECEIVERID *240601*1200*^*00501*000000905*1*T*:~

GS*HC*SENDER*RECEIVER*20240601*1200*905*X*005010X222A1~

ST*837*0001*005010X222A1~

NM1*85*2*JOHN SMITH MEDICAL GROUP*****XX*1234567890~ ← Billing Provider

NM1*IL*1*DOE*JANE****MI*789456123~ ← Subscriber

NM1*PR*2*AETNA*****PI*60054~ ← Payer

CLM*12345*250***11:B:1*Y*A*Y*I~ ← Claim: $250, office visit

HI*ABK:J0299*ABF:R101~ ← Diagnoses

SV1*HC:99213*100*UN*1***1~ ← Procedure: 99213 ($100)

DTP*472*D8*20240601~ ← Date of Service

SE*10*0001~

GE*1*905~

IEA*1*000000905~

📌 Common Validation Checks

Check Type	Examples
Provider ID Valid	NPI registered and active
Eligibility Match	Subscriber enrolled on service date
Code Set Compliance	ICD-10 and CPT valid for date of service
Duplication	Same CLM ID submitted twice
Modifier Validity	Correct modifier pair (e.g., 25 with E&M codes)

📌 Interactions with Clearinghouses

Clearinghouses act as intermediaries that:

- Validate EDI format
- Batch and forward clean claims to payers
- Return rejection reports (277CA)

Examples: Availity, Change Healthcare, Office Ally

📌 Post-Submission Workflow

1. Claim sent (837)
2. TA1 confirms receipt
3. 999 validates structure
4. 277CA indicates acceptance/rejection
5. 835 issued after adjudication
6. Appeals or adjustments if denied

✅ **Pro Tip:**
837 is not just for payment – it's also used in Medicaid **Encounter Reporting**, and **claim corrections/resubmissions** using frequency codes.

🔷 7. Medical Management

📌 What is Medical Management?

Medical Management refers to a set of processes and programs health plans use to ensure members receive appropriate, cost-effective, and high-quality care. It includes:

- **Utilization Management (UM)**
- **Care/Case Management (CM)**
- **Quality Management (QM)**
- **Referral & Authorization Management**

These functions reduce unnecessary treatments, improve member outcomes, and control healthcare costs.

📌 Utilization Management (UM)

UM is the **review process** used to determine whether healthcare services are medically necessary.

Type of Review	Description
Prior Authorization	Approval required before service (e.g., MRI, elective surgeries)
Concurrent Review	Ongoing review of inpatient stay
Retrospective Review	Review of care after it's delivered
Level of Care Review	Ensures care setting is appropriate (e.g., outpatient vs inpatient)

Example:

A CT scan costing $1,500 may require prior auth to avoid unnecessary radiation and cost.

📌 Clinical Practice Management

Focuses on aligning clinical care with **evidence-based guidelines** and measuring **provider performance**.

Core Components:

- Clinical Pathways for chronic conditions
- Peer Review Committees
- Provider Scorecards (Quality/Cost metrics)
- Intervention alerts via EMRs

✅ Often integrated with platforms like InterQual or MCG Guidelines.

📌 Quality Management

Ensures care delivery meets predefined standards for safety, efficiency, and member satisfaction.

Program	Description
HEDIS Measures	Health Effectiveness Data and Information Set – 90+ clinical quality metrics
NCQA Accreditation	National standard for plan quality
CAHPS Surveys	Measures member satisfaction
STARS Ratings	Used in Medicare Advantage plans (1–5 star scale)

Example HEDIS Metric:

% of diabetic members with A1C tests in past 12 months.

📌 Referral and Pre-Auth Management

These processes manage **access to specialized or expensive care**.

Process	Purpose
Referral	PCP refers member to specialist (common in HMO plans)
Pre-Authorization	Approval required before services are rendered

Common Pre-Auth Services:

- Surgeries
- MRI/CT scans
- Inpatient admissions
- Home health, DME

Workflow Example:

Provider submits EDI 278 → Payer system evaluates → Decision returned (approve/deny)

📌 Medical Management Tools & Integration

System	Role
Care Management Platforms	e.g., ZeOmega, Medecision – track patient interventions
Authorization Engines	Apply rules to determine medical necessity
Utilization Review Vendors	MCG, InterQual support coverage decisions
EMRs/Portals	Used to submit/track requests

📌 Medical Management & Claims

- Prior auth decisions are linked to claims via **auth ID**
- Clinical edits on claims validate if auth was obtained
- Medical necessity denials are cited with specific UM documentation

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✅ **Real-World Tip:**
Medical management decisions are tightly regulated—especially for **Medicare/Medicaid** where timelines and appeal rights must be honored (e.g., 14-day determination rule for Medicaid pre-auth).

🔷 8. EDI 278 – Health Care Services Review (Authorization)

📌 What is EDI 278?

EDI 278 is the HIPAA-standard electronic transaction used to **request and respond to authorization or referral services** between healthcare providers and payers.

This transaction supports:

- **Prior Authorization Requests**
- **Referral Authorizations**
- **Response Notifications (Approval/Denial/Pend)**

📌 When is EDI 278 Used?

A provider must often get **payer approval** before performing services like:

- Elective surgeries (e.g., knee replacement)
- Advanced imaging (MRI, CT)
- Inpatient admission
- Durable Medical Equipment (DME)
- Home health services

Process Flow:

Provider → Sends 278 Request → Payer Reviews → Sends 278 Response → Provider proceeds or appeals

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📌 Core Segments in EDI 278

Segment	Purpose
ST	Transaction set header
BHT	Transaction metadata (timestamp, IDs)
NM1	Identifies requestor (provider) and subscriber
HL	Hierarchical loops
TRN	Tracking numbers
UM	Utilization Management request details
HI	Diagnosis codes

Segment	Purpose
SV2	Service information (procedure code, location)
DTP	Dates (start, end, admission)
SE	Transaction set trailer

📌 Sample EDI 278 Request (Simplified)

ST*278*0001~

BHT*0007*13*AUTHREQ123*20240601*1200*RP~

NM1*X3*2*ABC HOSPITAL*****46*6543217890~ ← Requesting Provider

NM1*IL*1*DOE*JANE****MI*789456123~ ← Subscriber

UM*AR*I*2**11:B:1*Y~

HI*ABK:J449~ ← Asthma Diagnosis

SV2*0300*HC:99223**1*UN~

DTP*472*D8*20240605~ ← Date of Service

SE*10*0001~

📌 278 Response (Approval/Denial)

A **response file** (also EDI 278) is sent back to the provider with status:

Code	Meaning
A1	Certification approved
A3	Certification denied
A2	Certification pending

Example (Authorization Approved):

UM*A1*I*2**11:B:1*Y~

📌 Response Timeframes (Regulated Plans)

Plan Type	Required Turnaround
Medicaid	14 calendar days (standard); 72 hours (expedited)
Medicare Advantage	14 calendar days

Plan Type	Required Turnaround
Commercial	Defined in contract (typically 3–5 days)

📌 Integration with Medical Management & Claims

- Pre-authorization decisions are stored and linked to member records
- **Claims adjudication** systems validate if approved services match claim details
- Appeals can be initiated based on denial reason from 278 response

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📌 Common Tools/Portals Used

Platform	Purpose
Availity/CoverMyMeds	Submit and track auths online
InterQual/MCG	Review criteria used by payers
HealthEdge/GuidingCare	Internal UM decision support

✅ EDI 278 is often automated within EHR or EMR systems for real-time prior auth checks.

🔷 9. Regulatory Compliance in U.S. Healthcare

📌 Overview of Healthcare Regulations

U.S. healthcare is governed by strict federal and state regulations designed to protect **patient rights**, **ensure data privacy**, and **enforce ethical payer and provider practices**.

Key regulatory bodies and frameworks include:

- **HHS (U.S. Department of Health & Human Services)**
- **CMS (Centers for Medicare & Medicaid Services)**
- **OCR (Office for Civil Rights)**

📌 HIPAA – Health Insurance Portability and Accountability Act

Passed in 1996, HIPAA sets the **national standard for protecting patient data (PHI)** and streamlines electronic healthcare transactions.

HIPAA Component	Description
Privacy Rule	Regulates use/disclosure of PHI
Security Rule	Safeguards for electronic PHI (ePHI)
Transaction Standards	Standard EDI formats (e.g., 834, 837, 278, 835, 999)
Breach Notification Rule	Requires reporting data breaches to affected individuals and HHS

✅ **Protected Health Information (PHI)** includes:

- Name, DOB
- SSN, member ID
- Medical history, prescriptions
- Email, phone, address

📌 COBRA – Consolidated Omnibus Budget Reconciliation Act

COBRA allows employees and dependents to **continue health insurance coverage** for 18–36 months after leaving a job, if they pay the full premium.

Example:

John leaves his job in May. Under COBRA, he can continue his employer-sponsored health plan by paying the entire monthly premium plus a small administrative fee.

📌 HITECH – Health Information Technology for Economic and Clinical Health Act

HITECH enhances HIPAA by:

- Expanding obligations for breach notifications
- Increasing penalties
- Promoting **EHR (Electronic Health Record)** adoption
- Empowering patients to access their health data electronically

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📌 HIPAA Violations and Penalty Structure

Violation Tier	Penalty Range	Example Scenario
Tier 1 – Unaware	$100–$50,000 per incident	Lost laptop, no encryption
Tier 2 – Reasonable Cause	$1,000–$50,000	Inadequate data access controls

Violation Tier	Penalty Range	Example Scenario
Tier 3 – Willful Neglect (Corrected)	$10,000–$50,000	Failure to act, but corrected later
Tier 4 – Willful Neglect (Not Corrected)	$50,000+	Known risk, no action taken

Maximum annual cap: **$1.5 million per violation category**

📌 PHI – Protected Health Information

PHI is any **identifiable health information** used, stored, or transmitted in any form—paper, electronic, or oral.

Type	Is it PHI?
Name + Diagnosis	✅ Yes
Lab result + DOB	✅ Yes
Zip code + Age	❌ Not PHI unless identifiable
De-identified Claims Data	❌ No

📌 Do's and Don'ts of HIPAA Compliance

✅ **Do:**

- Use secure channels (e.g., SFTP, HTTPS) for data exchange
- Limit PHI access to minimum necessary
- Encrypt data at rest and in transit
- Log access and monitor audits

❌ **Don't:**

- Share PHI over personal email or messaging apps
- Leave printed PHI unattended
- Ignore breach reporting timelines

✅ **Quick Tip:**
Healthcare vendors handling PHI must sign a **Business Associate Agreement (BAA)** ensuring they comply with HIPAA rules.
