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# HealthCare Market Players

HealthCare Market Players generally means the parties or entities involved in a complete health care process. The players may include employers, insurers, brokers, provider, RX retailers, PBMs (Pharmaceutical Benefit Managers), reinsurers and TPA (Third Party Administrators who are directly or indirectly connected to any healthcare facility used by a patient or an employee.

The detailed description of the major market players are given below.

## Employers

Employers are the businesses that provide employment opportunities to anyone. Starting in 2014, the Affordable Care Act requires everyone to have health insurance or pay a penalty. This implied that every employee must be insured by their employer. Under the new law however, businesses with fewer than 50 full-time equivalent employees are not required to provide insurance to their employees [1].

Employer-sponsored health insurance is a health policy selected and purchased by your employer and offered to eligible employees and their dependents. These are also called group plans. The employer will typically share the cost of your premium with you [2].

## Insurers

Insurers are the individuals or companies that work with the employers to provide health insurance plans and policies for the employers. They are the individual or company who, through a contractual agreement, undertakes to compensate specified losses, liability, or damages incurred by another individual [3]. Insurers may run on their own but could also have tie ups with agents or brokers.

## Brokers

An agent or broker is a person or business who can help you apply for help paying for coverage and enroll in a Qualified Health Plan (QHP) through the Marketplace. They can make specific recommendations about which plan you should enroll in. They’re also licensed and regulated by states and typically get payments, or commissions, from health insurers for enrolling a consumer into an issuer's plans. Some brokers may only be able to sell plans from specific health insurers [4].

Agents may work for a single health insurance company; brokers may represent several companies. You won’t pay anything additional if you enroll with an agent or broker. Agents and brokers often get payments (“commissions”) from insurance companies for selling plans. Some may not sell plans of companies they don’t represent.

## Providers

Healthcare providers can be individual practitioners, small groups (i.e. primary and specialty care physicians), larger hospitals and health systems [5].

Under federal regulations, a "health care provider" is defined as: a doctor of medicine or osteopathy, podiatrist, dentist, chiropractor, clinical psychologist, optometrist, nurse practitioner, nurse-midwife, or a clinical social worker who is authorized to practice by the State and performing within the scope of their practice as defined by State law, or a Christian Science practitioner. A health care provider also is any provider from whom the University or the employee's group health plan will accept medical certification to substantiate a claim for benefits [6].

Here are some non-physician examples of health care providers:

* The physical therapist that helps you to recover from your knee injury.
* The Home Health Care Company that provides your visiting nurse.
* The durable medical equipment company that provides your home oxygen or wheelchair.
* Your pharmacy.
* The laboratory that draws and processes your blood tests.
* The imaging facility that does your mammograms, X-rays, and MRI scans.
* The speech therapist that works with you to make sure you can swallow food safely after a stroke.
* The outpatient surgery clinic where you had your colonoscopy done.
* The specialty laboratory that does your DNA test.
* The urgent care center or walk-in clinic in your neighborhood shopping center.
* The hospital where you receive inpatient (or in some cases, outpatient) care [7].

## Network

Network is the collaboration of service providers, patients and other various entities. Network is essentially a medium rather than some kind of entity. Networks helps to meet, collaborate and build solutions. Health networks helps to build the better health system [8]. Networks help build a circle of facilities around the employees taking into account the infrastructure and facilities of the hospital, track record, management background and IT infrastructure / computerization at the hospital.

## Reinsurers

Reinsurance, also known as insurance for insurers or stop-loss insurance, is the practice of insurers transferring portions of risk portfolios to other parties by some form of agreement to reduce the likelihood of paying a large obligation resulting from an insurance claim. The party that accepts a portion of the potential obligation in exchange for a share of the insurance premium is known as the reinsurer [9].

By covering the insurer against accumulated individual commitments, reinsurance gives the insurer more security for its equity and solvency and more stable results when unusual and major events occur. Insurers may underwrite policies covering a larger quantity or volume of risks without excessively raising administrative costs to cover their solvency margins. In addition, reinsurance makes substantial liquid assets available for insurers in case of exceptional losses.

## PBMs

PBMs are primarily responsible for developing and maintaining the formulary, contracting with pharmacies, negotiating discounts and rebates with drug manufacturers, and processing and paying prescription drug claims. For the most part, they work with self-insured companies and government programs striving to maintain or reduce the pharmacy expenditures of the plan while concurrently trying to improve health care outcomes [10].

Reduce prescription drug costs and improve convenience and safety for consumers, employers, unions, and government programs to lead the effort in promoting PBMs and the proven tools they utilize, which are recognized by consumers, employers, policymakers, and others as key drivers in lowering prescription drug costs and increasing access.

# Cotiviti Products

## Medical Intelligence

Fueled by industry-leading DxCG predictive science and evidence-based clinical intelligence, our user-friendly, web-based application facilitates identification and stratification and pinpoints opportunities for clinically sound, financially effective interventions. Medical Intelligence allows our clients to reduce inefficient use of resources, optimize clinical value and improve patient experience through measurement of variation in quality and efficiency [11].

**Features**

* Identify and stratify populations to detect high risk individuals or groups
* Provide member-level clinical decision support
* Benchmark cost, quality and efficiency against national and book-of-business norms
* Customizable and automated reporting and outreach
* Track outcomes and evaluate programs

**Benefits**

* Tailor care management and wellness initiatives to individual needs
* Manage network performance to reduce inefficiencies
* Drive accountable care strategies
* Measure and improve year around quality of care
* Evaluate the impact that your initiatives are having

## Provider Intelligence

Many provider organizations use DxCG Intelligence on its own because they rely on its scientifically proven models to make critical business decisions and have the expertise and infrastructure required to put the models to work. For others, the comprehensive approach of Provider Intelligence works best. Provider Intelligence puts the DxCG Intelligence risk adjustment and predictive models to work within a solution that helps you get up and running quickly, as well as streamline ongoing monitoring and reporting. With Provider Intelligence, you can quickly determine the best opportunities for cost, quality, and utilization improvement, turning them into short-term cost savings while developing new strategies for achieving long-term, sustainable results.

**Features**:

* Physician and Clinic Performance Assessment

The solution allows you to fairly evaluate performance based on risk-adjusted values, enabling you to identify the best practices of high-performing physicians, quantify practice variations, and manage quality-based contracting.

* In- and Out-of-Network Utilization

To address leakage and other factors influencing spending, Provider Intelligence delivers both graphical and tabular representations of healthcare utilization patterns.

* Quality and Risk Measures

Users can monitor and report on NCQA-certified, claims-based HEDIS® and other measures that support pay-for-performance contracting and provider performance evaluation. Case managers can view care gaps and all services received—a real 360-degree view.

* Population Monitoring and Program Assessment

Ongoing evaluation of the effectiveness of population health programs through comparison and trending of cost, utilization, and quality metrics optimizes your ACO and at-risk contract performance. Quality and case managers can also identify patients by disease state and risk stratify them to better direct care management and outreach activities, such as a focus on high utilizers of hospital care or emerging-risk patients.

**Benefits**

* Integrates additional data sources into a single, comprehensive application, delivering critical population-, member-, and provider-level insights
* Supports areas such as quality improvement, performance management, and out-of-network healthcare usage
* Puts tailored answers at your fingertips with simple ad hoc query functionality
* Facilitates communication with easy-to-digest, graphical reports
* Evaluate the impact that your initiatives are having [12]

## Quality Intelligence

Quality Intelligence is our software for measuring, reporting, and improving HEDIS® compliance. HEDIS (Healthcare Effectiveness Data and Information Set) — was created by the National Committee for Quality Assurance (NCQA) to measure the clinical quality performance of health plans.

HEDIS was designed to allow consumers to compare health plan performance to other national or regional benchmarks. The Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by more than 90 percent of America's health plans to measure performance on important dimensions of care and service. It consists of 71 measures across 8 domains of care.

Some examples of HEDIS measures are

* Comprehensive Diabetes Care
* Breast Cancer Screening
* Controlling High Blood Pressure
* Childhood and Adult Weight/BMI Assessment
* Antidepressant Medication Management [13]

HEDIS results are increasingly used to track year-to-year performance. Using Quality Intelligence, health plans can determine what drives changes in HEDIS and other quality metrics with the greatest transparency and flexibility.

At the same time, this powerful software reduces quality measurement and reporting workflow to its most efficient and effective point. With a smarter, smoother process in place, plans can both ease the burden of seasonal HEDIS reporting and implement a year-round measurement and reporting program that significantly improves health plan rankings.

**Features of quality intelligence**

**Chase logic**

Using multiple and customizable data points, we can fine-tune our chase logic to the most accurate degree in the industry, so you target the right providers and records, optimize resources, and minimize expense.

**Transparent data model**

With visibility and insight at every level—from the initial claim to intermediate tables for measure processing to the final results—you know exactly where to find your best improvement opportunities.

**Ease of use**

* Drill down to member-level claim detail for optimal insight and analysis
* Customize views to display the most meaningful data and facilitate smooth workflows
* Create and customize reports easily for deeper insights into how to improve provider-related and other key metrics
* Set goals and benchmarks to monitor progress in real time

**Benefits**

Because every health plan is unique, Cotiviti provides a comprehensive and flexible solution that allows you to measure and report on quality in your own way:

* Digital platform that minimizes your resource burden
* A single resource to analyze and report HEDIS and HEDIS-related metrics, including the Medicare Advantage Star Rating System, CAHPS survey, the Integrated Healthcare Association’s California Pay for Performance (P4P) program, the Qualified Health Plan (QHP) Quality Rating System (QRS), and custom and state-specific measures
* Integrated retrieval, abstraction, analysis, and reporting capabilities for end-to-end support, or help in your specific area of need [14].

## DxCG

Part of healthcare's DNA for 20 years, DxCG Intelligence is at the core of all Cotiviti Performance Analytics solutions. The gold standard in risk adjustment and predictive modeling, DxCG Intelligence analyzes and helps manage the clinical and financial risks associated with caring for populations.

DxCG Intelligence uses Cotiviti's proprietary predictive models to turn healthcare data into risk scores for individual patients. Scores correlate with the cost of the underlying illness burden that individuals carry. Aggregating the scores of individuals with key attributes generates group-level predictive results that can be applied to answer questions fundamental to the ability of providers, employers, and payers to manage clinical and financial risks.

**Features:**

* Budgeting and underwriting
  + Quantify the health risk of enrolled populations
  + Measure risk trends over time across lines of business
  + Budget for care delivery costs
  + Adjust premiums and payment rates
  + Assess reinsurance options based on risk tolerance
  + Substantiate insurance rate filing
* Medical management
  + Identify high-risk individuals
  + Stratify clinical groups to define outreach strategies
  + Prioritize individuals for targeted interventions
  + Enable member outreach to improve care compliance
* Performance assessment
  + Quantify physician panel risk burden
  + Establish risk-expected rate variation
  + Assess provider panel utilization variance
  + Support risk-based contracts and gains sharing
  + Promote accountability in healthcare systems
  + Analyze population health outcomes

**Benefits:**

* Superior predictive power

As documented in a Society of Actuaries study, DxCG models are best in class, outperforming other risk adjustment and prediction models studied in the analysis. With DxCG Intelligence, providers can trust that they will receive the most accurate predictions of healthcare costs available in the market.

* Robust models and applications

DxCG Intelligence fully addresses cost, utilization, and risk across all populations. Our transparent, credible measures of population health risk are both clinically and financially grounded, increasing buy-in and making it easier for physicians, medical professionals, and analysts to see the impact of comorbidities, among other benefits.

* Broad utility

DxCG Intelligence is used by the nation’s largest health insurers, business application integrators, commercial and Medicare ACOs, and reinsurance companies, as well as by leading academic institutions to inform their research [15].

## Enterprise Intelligence

By combining flexible and easy-to-use technologies with industry-leading clinical and financial analytics, we deliver internal insight and client reporting solutions focused on the real drivers of cost, quality and the risk in your population. Our online analytics, customizable dashboards, comprehensive report library and simple exporting capabilities help you uncover opportunities to improve your populations' results and performance.

**Features:**

* Integrate and access disparate data sources in a single application
* Analyze medical, Rx, financial, disability, network, HRA and wellness data
* Customizable executive dashboards and reporting features
* Geospatial and heat mapping capabilities to identify regions with opportunities

**Benefits:**

* Set healthcare strategies based on objective insights into drivers of cost, utilization and quality in your population
* Design programs, benefits and member outreach and engagement initiatives to reflect your unique challenges and opportunities
* Streamline enterprise, program and employer group reporting
* Objectively evaluate cost, quality and utilization performance of programs or vendors [16].

## Other Products

## MediConnect

Used by

Provider Services Legal Services Health Insurance Services Life Insurance Services

Quick access to medical information for law firms, insurance providers, employers

**Process:**

* Retrieval of raw data/ medical records
* Digitization and indexing of records
* Coding (128 bit encryption)
* Delivering the data (for facilities and providers in USA, Canada and Mexico) [17].

**Benefits:**

* Minimizes errors
* Cuts all associated costs
* Saves retrieval time
* Establishes billable and direct bill expenses

**Rapid Retrieve 5.0**

* User friendly environment
* Recognizes the sensitive nature of medical records
* Fully complies with HIPAA Privacy Act [18]

**Services: \*Acquired from demo video**

1. **Request Records:**

Ordering records is easy, fast and secure.

Files can be ordered after filling forms mentioned below:

* Patients Information
* Record Information
* Level of Service
* Requestors Information
* Provider Information

1. **Check Records:**

* One can check the status and track records
* Retrieval process can be known
* Review real time notes from retrieval staffs
* Communicate back to the staffs

1. **Search Options:**

Searching the records can be done using different criteria like Patients ID, Patient Name, Case Number, SSN, DOB, Doctors Name, Requestors Name, and others. Custom search is also available.

1. **Locate and Download Records:**

The health records that have been processed can be located as well as downloaded depending on the privilege of the document.

1. **Online Billing:**

Individual charges and total cost of a record can be tracked. Bill records can be checked using specific date range or invoice number.

Demo Video: <http://www.mediconnect.net/demo.asp>

## 

## Star Navigator

Five-Star Rating System

* The CMS Five-Star Rating System was created to assess performance of Medicare Advantage plans toward quality improvement.
* It's not just claims measures; some of them are prescription measures, some of them are based off surveys, some of it is based off other data that they have to pull from their system.
* The way that it works is the Star Ratings are based off the performance of the aggregate, so how a plan reaches three or four stars is based off the relative distribution of how everyone else is doing [19].

Star Navigator is a quality improvement solution that is designed to help Medicare Advantage plans determine the most direct path to higher Star Ratings, then track and communicate their progress toward those goals.

* Company’s goal with Star Navigator is to make sure that they've got the reporting they need to make that communication and collaboration effective.
* Star Navigator is designed to also help with taking action, helping plans decide what the right intervention is.
* Star Navigator generates dashboard type of view that makes it easier for them to understand, "where do I go next?" [20]

# Costs Associated with US Healthcare

## Billed Amount

* Billed amount is total charge for each service performed by the provider.
* This amount is based on the provider.
* Billed amount is not defined in rule by any of the states with an APCD.
* Billed amount can be either the total amount billed or the dollar amount charged on the service line for a service.
* The Medicaid definition is not definite on whether the billed charge is the total dollar amount or a line item charge.
* Billed amount is generated by the provider billing the health plan for services.
* Billed/submitted amount can also be generated by Group Health members when submitting charges for reimbursement.

## Allowed Amount

* Allowed amount is the maximum amount that a payer will pay a provider for a service.
* Allowed amount applies to services that are included or allowed in the health care plan or the government program.
* Allowed amount applies to services provided by providers who are contracted with the health care plan (in-network).
* Allowed amount varies for providers who are not contracted with the subscriber’s health care plan (out-of-network).
* Allowed amount may not cover all the provider’s charges. In some cases, subscribers may have to pay the difference.
* Allowed amount may be determined by a fee schedule such as Medicare’s.
* Usual customary and reasonable (UCR) amount is sometimes used to determine the allowed amount [21].

## PPO Discount

* A preferred provider organization is a subscription-based medical care arrangement.
* Members are allowed a substantial discount below the regularly charged rates of the designated professionals partnered with the organization. These group of partners are known as a network.
* The facilities and providers in such network provides medical services to the members in a low discounted rates.
* The deducted amount is known as PPO discount.
* If a member uses services from facilities outside of the network, the members have to pay a certain portion or the whole sum out of their own pocket [22].

## Copay

* Means a payment by the subscriber to the health care provider.
* Is a fixed dollar amount.
* Usually paid at the time of service.
* Applies to covered services.
* May be higher for covered services from an out-of-network provider.
* Is also the full cost of the service if the full cost is less than the fixed dollar amount [21]

## Coinsurance

* Means the subscriber’s share of the costs.
* Usually calculated as a percentage of the cost of the medical service.
* Coinsurance for an out-of-network provider is usually a higher percentage than coinsurance for an in-network provider.
* Medicare has per-day coinsurance for Part A and percentage coinsurance for Part B.
* Coinsurance is a payment in addition to any deductibles the subscriber pays [21].

## Deductible

* Means the amount a subscriber pays for health care services before the health plan begins to pay.
* There is a timeframe for deductibles, usually a year.
* Applies only to services covered in the health plan.
* May not apply to all services [21].

## Adjudication

Adjudication is the legal process by which an arbiter or judge reviews evidence and argumentation, including legal reasoning set forth by opposing parties or litigants to come to a decision which determines rights and obligations between the parties involved [23].

The five steps are:

* The initial processing review
* The automatic review
* The manual review
* The payment determination
* The payment [24]

# Types of Health Plans

## HMO

An HMO is a Health Maintenance Organization. With an HMO plan, you generally have a lower out-of-pocket expense but also have less flexibility in the choice of physicians or hospitals than other plans. An HMO may require you to choose a primary care physician (PCP). With a PCP, they will take care of most of your health care needs. Generally to see a specialist, you will need to obtain a referral from your PCP.

An HMO may be a good option for you and your family if you:

* Prefer lower premiums
* Like the tradeoff of in-network services
* Desire good preventive services such as coverage for checkups and immunizations [25].

What you pay:

* Premium
* Deductible
* Copays and/or co-insurance [26].

## PPO

A PPO plan is a Preferred Provider Organization. With a PPO plan, you are encouraged to use a network of preferred doctors and hospitals. These providers are contracted to provide service to plan members at a negotiated or discounted rate. You generally are not required to designate a Primary Care physician but will have the choice to see any doctors or specialists within the plans network.

A PPO may be a good option for you and your family if you:

* Need flexibility when choosing physicians and other providers
* Want the burden of obtaining a referral to see a specialist
* Like the balance of greater provider choice versus lower premiums [25].

What you pay:

* Premium
* Deductible
* Copay or coinsurance
* Other costs [26]

## POS

A POS is a Point of Service Plan. POS plans combine features of an HMO and a PPO plan. Just like an HMO, POS plans may require you to choose a Primary Care Physician (PCP) from the plan's network providers. Generally services rendered by the PCP are not subject to the plans deductible.

A POS may be a good option for you and your family if you:

* Need flexibility when choosing physicians and other providers
* Desire primary care physicians to coordinate care
* Like the balance of greater provider choice versus lower premiums [25].

## EPO

Exclusive Provider Organization (EPO) are similar to that of Health Maintenance Organization as they do not cover care outside the plan's provider network. However, EPO members have moderate amount of freedom to choose health care providers than that of HMO. HMOs generally may not need member to get refer from Primary Care Doctor to see a specialist [27].

What you pay:

* Premium
* Deductible
* Paperwork.
* Co-pay/co-insurance

An EPO may be a good option for you and your family if you:

* Like the balance of less provider choice in exchange for lower rates
* Can find the right services with a smaller panel of providers
* Can afford potentially higher costs for unplanned events [25].

# Government Plans

## Medicare

* Medicare is a federal health insurance plan for people over 65 who have worked and paid to the system through payroll tax.
* Also provided to people under 65 with disabilities and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a transplant, sometimes called ESRD) and amyotrophic lateral sclerosis.
* Medicare is managed by the Centers for Medicare & Medicaid Services (CMS).
* The Social Security Administration works with CMS by enrolling people in Medicare.
* United States Medicare is funded by a combination of a payroll tax, premiums and surtaxes from beneficiaries, and general revenue.
* Medicare covers about half of the healthcare charges for those enrolled. The enrollees must then cover their remaining costs either with supplemental insurance, separate insurance, or out of pocket.
* It doesn’t depend on one’s income [28].

## Medicaid

* Medicaid is a state and federal program to provide health coverage to people with low income and assets.
* Each state uses financial eligibility guidelines to determine whether one is eligible for Medicaid coverage. Generally, your income and assets must be below a certain amount to qualify, but this amount varies from state to state and from program to program.
* If you are eligible for Medicare and Medicaid (dually eligible), you can enroll in both.
* Medicaid is a joint federal-state program that provides health coverage or nursing home coverage to certain categories of low-asset people, including children, pregnant women, parents of eligible children, people with disabilities and elderly needing nursing home care.
* Medicaid is a social welfare or social protection program rather than a social insurance program [29].

# Others

## Healthcare Exchange

* Healthcare exchanges are organizations which have been setup to facilitate the purchase of health insurance in the United States.
* Every state has its own health exchange to ensure all individuals have access to government regulated standardized health care policies eligible for federal subsidies.
* Healthcare exchanges are not themselves insurers.
* They determine the insurance companies that can participate.
* They provide assistance to ensure insurers comply with consumer protection law, compete in cost effective ways, and expand health insurance coverage to more individuals [30].

**Who are eligible for Healthcare Exchange?**

* Everyone can use the Healthcare Exchange unless they qualify for Medicaid.
* Any individual who doesn’t like their current healthcare plan, or has yet to get coverage can visit the exchange to view their options.
* Why should you use an Exchange?
* It gathers data from numerous insurance providers in one database, ensuring that employees can take advantage of the best policy for the amount specified.
* Exchanges offer a wide variety of plans and coverage options for employees to choose from. Employees can select the policy benefits specific to their needs.
* It helps employees with administration to get set up with a health care plan, ensuring all of their needs are met and confirms with government requirements.

## Obama's Healthcare reform

Health care reforms was first introduced by John Dingell Sr. in 1943.Health care represents 1/6th of US economy. President Obama believes to build what works and fix rather than to build entirely new systems.

In 1960’s there were major reforms like Medicare and Medicaid which are basically kind of socialism (program). Major reforms have often been proposed but have rarely been accomplished.

The ObamaCare Health Insurance Exchange Marketplace opened Oct 1st, 2013. The ObamaCare health insurance exchanges, or ObamaCare exchanges, are online marketplaces for health insurance. Americans can use their state’s “Affordable” Insurance Exchange (Marketplace) to obtain coverage from competing private health care providers. Shoppers can use a price calculator to see if they qualify for cost assistance subsidies as well as Medicaid and CHIP and see side-by-side comparisons of qualified health plans ensuring the best deal for them and their family [31].

In spite of various Health care programs, about 48 million American still did not have any health insurance. In 2010, President Barack Obama signed into law a federal statute called the Patient Protection and Affordable Care Act (PPACA). The PPACA, which was later shorted to Affordable Care Act and later nicknamed Obamacare, is a health care reform that ensures all Americans can get health insurance. Most importantly, Obamacare wanted to lower the cost of health care as it had become quite expensive to access medical care. The Obamacare was designed to eliminate "some of the worst practices of the insurance companies"—pre-existing condition screening and premium loadings, policy cancellations on technicalities when illness seems imminent, annual and lifetime coverage caps [32] .

**What does Obamacare do?**

Obamacare does two main things: expand access to health insurance and change the way the federal government pays doctors.

Over the next decade, federal budget forecasters expect that 25 million people will gain health coverage because of Obamacare. And about 17 million people have so far become insured since the expansion started in 2014.

The number of people with insurance is rising because of three main provisions in the law.

* The expansion of Medicaid, a federal program that provides health coverage to low-income Americans.
* The creation of insurance exchanges, online portals including Healthcare.gov where Americans can shop for coverage — some with financial help from the federal government.
* The individual mandate: The requirement that nearly all Americans carry health insurance coverage or pay a penalty. This is meant to encourage people to take advantage of the two insurance expansions above [33].

Watch this for more info: https://www.youtube.com/watch?v=U1YNF9I25yU

## Accountable Care Organization (ACO)

* The term Accountable Care Organization was first coined in 2006 by Elliott Fisher, MD, Director of the Center for Health Policy Research at the Dartmouth Medical School [34].
* First implemented in 2011 to minimize the spiraling Health care costs
* The U.S. Department of Health and Human Services (HHS) released new rules under the Affordable Care Act (ACA), aimed at helping doctors, hospitals and other providers better coordinate care by way of ACOs.
* By February 2013, 49 states in the US had total of 428 ACOs [35].

**Definition:**

CMS (Center for Medicare and Medicate Services): “Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients [36]”.   
  
Accountable care organizations (ACOs) are provider and payer arrangements established to improve care coordination between primary care physicians, hospitals, specialists, and public or private health payers [37].

Why ACO? Watch this:   
<https://www.youtube.com/watch?v=CaUnQ2eRGCw>  
<https://www.youtube.com/watch?v=zQIf2ggEp6s>

**Benefits:**

* Accountable care means improved care, especially those with chronic disease
* Less waste in the Medicare system
* Less complications
* Access to files in a network
* Saves time
* Costs less

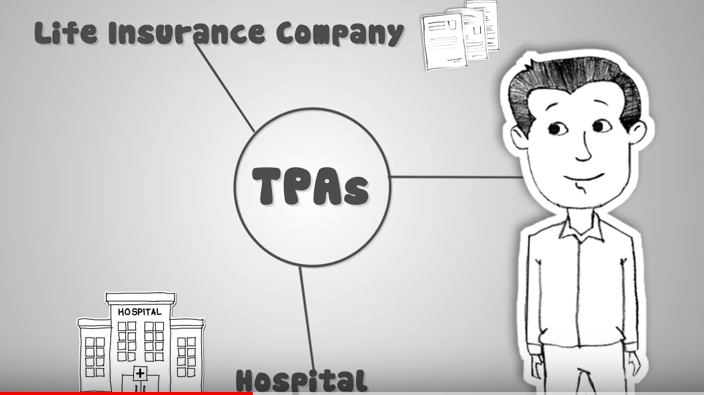
**Drawbacks:**

* Cost for setting up an ACO is high
* Rising Requirements
* Capitation
* Difficult Implementation [38].

## Third party Administrators (TPA)

* Financial crisis of 2008 (the worst in over 75 years).
* Affordable Care Act (ACA), 2010 brought stability in Healthcare industry expenses by bringing drastic changes.
* ACA added number of taxes and restrictions on self- insured companies [39].
* To handle the complications, intermediaries between the insurance provider and the policyholder came into play.

Third Party Administrator is a person or organization that performs administrative services, such as claims processing, adjudication or record-keeping, typically on behalf of an employer that self-insured health benefits [40].

TPA makes processing cost effective, timely, fair and hassle-free.

**Role of TPA in health insurance:**

* **Managing policyholder records** - As soon as a policy commences records of the customer or the Insured is provided to the TPA, almost all responsibility for the customer or the insured. Maintenance of the database of policyholders, issuing of identity cards, claim settlement and grievance redressal, all come under the responsibility of a TPA. Besides, the TPA is responsible for making payment to the hospital. A TPA in-turn receives Reimbursement from the insurance service provider once it sends all the supporting documents for the claim, along with the bills to the insurance company.
* **Building hospital network** - The TPA is also responsible to build a hospital network for cashless services and negotiate rates and discounts taking into account the infrastructure and facilities of the hospital, track record, management background and IT infrastructure / computerization at the hospital.
* **Claim settlement** - The hospital will share the bills for the treatment rendered to the insured with the TPA and the TPA will verify the same against the pre-negotiated tariff's and may also take a second medical opinion for complicated cases and may investigate hospital records in case of suspicion with regard to false claim or moral hazard. In some cases, the invoices may have to be re-priced.
* **Maintain customer service center** - The TPAs also maintain a 24-hour customer service center, where customers can speak to and get any information regarding the hospital network, understand eligibility for a claim and get status of claim benefit if reimbursement is pending. In case, treatment has been taken in a hospital which is not included in the list of empanelled hospital, then the policyholder will need to coordinate with the TPA for getting a reimbursement.
* **Additional services** - TPAs may also provide value-added services like ambulance services if mentioned in the policy, offer guidance to policyholders regarding specialist/doctor for the treatment of their medical condition and organize lifestyle management and well-being programs [41]**.**

**TPAs function:**

* TPAs function as intermediaries between the insurance provider and the policyholder and its key function is processing of claims and settlement.
* The TPA issues ID cards to policyholders, which have to be shown to the hospital authorities before availing any cashless hospitalization services.
* At the time of a claim, a policyholder has to inform the TPA. He will be directed to a hospital the TPA has a tie up with. He can opt for another hospital, but then payment will be a reimbursement.
* TPA issues an authorization letter to the hospital, after which they track the case and at discharge all bills are sent to TPA for payment.
* TPA sends all the documents necessary for consideration of claims, along with bills, to the insurer [42].

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