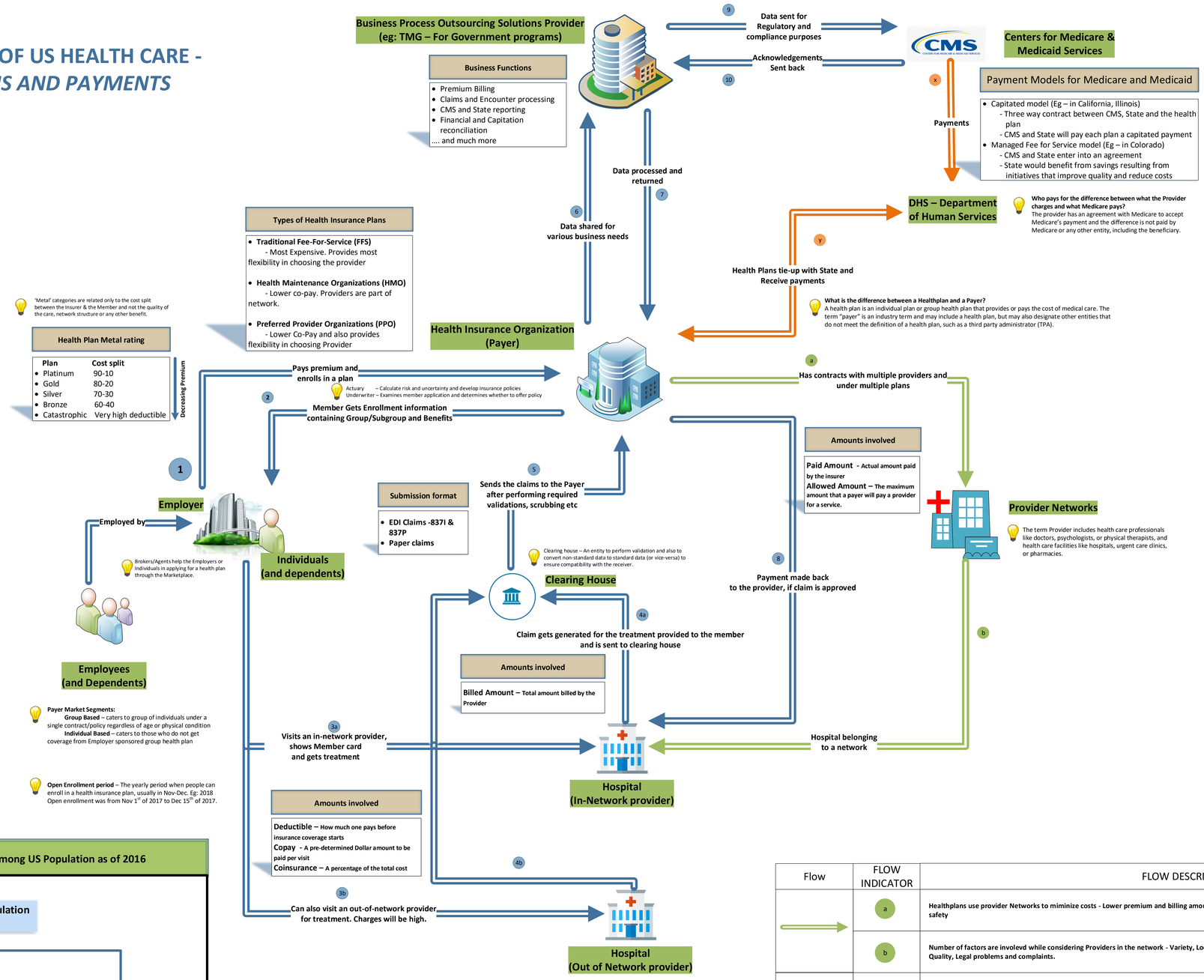
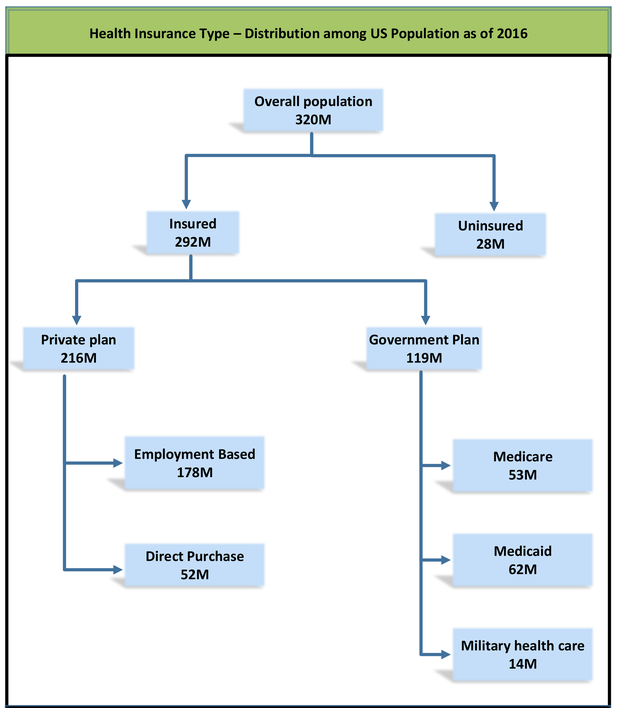
HIGH LEVEL SCHEMATIC OF US HEALTH CARE - *ENROLLMENT, CLAIMS AND PAYMENTS*



Health Insurance Type – Distribution among US Population as of 2016



Source: *Sep 2017 issue of "Current Population Reports - Health Insurance Coverage in the United States: 2016"*

Flow	FLOW INDICATOR	FLOW DESCRIPTION
→	a	Healthplans use provider Networks to miminize costs - Lower premium and billing amounts would be at contracted rates - and also to promote quality, efficiency and safety
→	b	Number of factors are involevd while considering Providers in the network - Variety, Location, Sufficient numbers of Doctors and hospitals, Credentials, Safety, Quality, Legal problems and complaints.
⇒	1	Eligibility information is sent to the Payer (or a Broker - an intermediary who helps in choosing the right plan) and the members get enrolled into a plan. The premium depends on the 'Metal' category to which the plan belongs to.
⇒	2	The Payer assigns a Member ID and a Group Number to all those who enroll. Group Numbers help in cost reduction, easy tracking of coverage and benefits, claims filing
⇒	3a	The member (or dependent) can then visit a Provider who is a part of their plan's Network and get treatment for their ailment.
⇒	3b	The Provider takes only the Member card details and provides treatment. The out-of-pocket payments like Deductible, Co-insurance, Co-payment are involved in this stage. Then the Provider files a claim for the treatment provided and sends it to the Clearing House.
⇒	4a	The member (or dependent) can then visit an out-of-network Provider and get treatment for their ailment. However it has to be noted that 1) The cost involved will be more, since the plan does not cover it 2) The resposibility of verifying the qualifications of hte Provider would fall on the Member, unlike an in-network Provider who would be verified by the Health Plan.
⇒	4b	The Out-of-Network Provider also files a claim for the treatment provided and sends it to the Clearing House.
⇒	5	Clearing House is an intermediary that forwards claims information from Healthcare Provider to Insurance payer. Helps in verifying the claims for errors and converting the non-standard formats to standard and vice-versa, to ensure compatibility with the receiver.
⇒	6	The Payer would adjudicate the claim internally (in-house processing systems) or can send the data to external Third Party vendors like TMG who take faciliate Business functions like Claims Adjudication, Billing, Encounter Processing and much more, aiming to reduce the Plan's operational costs, investment and risks involved.
⇒	7	The data is processed by these vendors and sent back to the Insurer/Payer.
⇒	8	The Payer receives the adjudicated claims information and pays the Provider back, for those claims which are to be paid. No payment is made for Denied claims. Denial could be for any reason - policy limitations, timeliness, procedure not part of coverage etc.
⇒	9	The Vendor also takes care of the Regulatory and Compliance obligations like sending reports to the State/Central bodies - CMS and DHS
⇒	10	For the data received by CMS/DHS, acknowledgements are sent back in the form of files - MAO-002, TA1, etc
⇒	x	For Medicare/Medicaid Claims, depending on the Payment Model agreed upon, the Payer gets reimbursed. In a Capitated model the CMS and the state will pay each health plan a prospective capitation payment. To name a few states which follow this capitated model - California, Illinois, Michigan In a Fee-For-Service model, the CMS and the State enter into an agreement through which the state would be eligible to benefit from savings resulting from initiatives that improve quality and reduce costs for both Medicare and Medicaid. Colorado and Washington follow this FFS model.
⇒	y	Insurers tie up with the state and offer Medicare and Medicaid Plans.

References

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ManagedFeeforServiceModel.html

https://marketplace.cms.gov/outreach-and-education/what-you-should-know-provider-networks.pdf

https://resources.ehealthinsurance.com/individual-and-family/different-types-health-insurance-plans

http://www.tmghealth.com/about/fact-sheet/

https://ofm.wa.gov/sites/default/files/public/legacy/healthcare/pricetransparency/pdf/phase_one/paper_3.pdf

https://speier.house.gov/sites/speier.house.gov/files/ahip-interactive-consumer-guide-compressed.pdf

https://questions.cms.gov/faq.php?id=5005&faqId=10692

https://www.cms.gov/Medicare-Medicaid-Coordination/Medicare-and-Medicaid-Coordination/Medicare-Medicaid-Coordination-Office/FinancialAlignmentInitiative/ManagedFeeforServiceModel.html