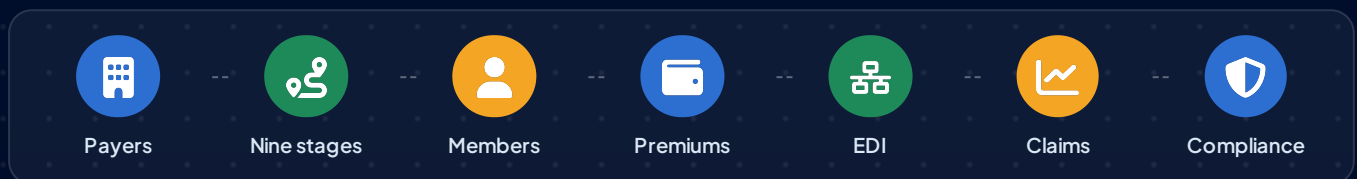
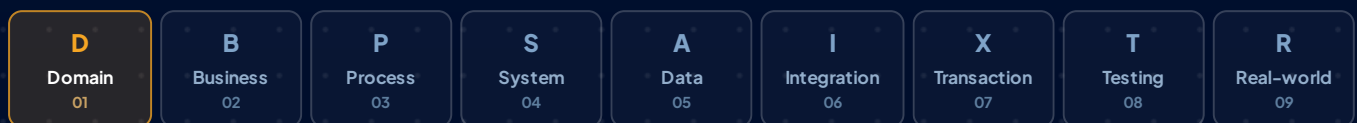




Healthcare — Payer at a Glance

Summary Notes

How a health plan actually works — who it covers, who funds it and how a claim gets paid. The nine-stage payer journey, the systems and EDI transactions behind it, and what QA must test.



Inside these notes

1. What a payer is — and the four main types
2. The nine-stage payer journey
3. Building the plan, and following the money
4. The member journey, claim by claim
5. The systems behind a payer
6. X12 transactions, code sets and identifiers
7. Claim adjudication, end to end
8. Compliance and the QA view
9. Real-world incidents and your first week



Watch the full session

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What a healthcare payer is

An organisation that pays for care on behalf of its members — a health plan, insurer or managed care organisation. To work it has to do four jobs at once, and each one depends on the others.

Cover members

Enrol people, keep eligibility right and answer “am I covered for this?”

Build a network

Credential and contract doctors, hospitals and agencies, and agree the prices.

Pay claims correctly

The right amount, to the right provider, on time — with a clear reason for anything not paid.

Manage cost & quality

Authorise care, support members with chronic illness, and earn quality ratings.

A The four main types of US payer

PAYER TYPE	WHO IT COVERS AND HOW IT WORKS	WHAT TO REMEMBER
Commercial / employer	Plans bought by employers for their staff. Fully insured : the payer carries the risk. Self-funded : the employer pays the claims and the payer administers them for a fee (ASO).	Ask which one — it changes who owns the money
Medicare	Federal programme for people aged 65+ and some people with disabilities. Original Medicare (Parts A and B), private Medicare Advantage plans (Part C) and drug plans (Part D).	Medicare Advantage plans are paid monthly by CMS
Medicaid & CHIP	State programmes for low-income adults and children, funded jointly with the federal government and mostly run through managed care organisations.	Every state has its own rules and reporting
Exchange / individual	Plans people buy for themselves on the ACA marketplace, often with income-based subsidies.	One open enrollment window a year

B Plan designs you will hear named every day

HMO

In-network care only, usually through a primary care doctor who refers to specialists.

PPO

Wider choice; out-of-network care is covered but costs the member more.

EPO

In-network only like an HMO, but usually without referrals.

High-deductible plan

Lower premium, higher deductible — often paired with a health savings account.

Medicare Advantage

A private plan replacing Original Medicare, often with extra benefits such as dental or in-home care.

Medicaid managed care

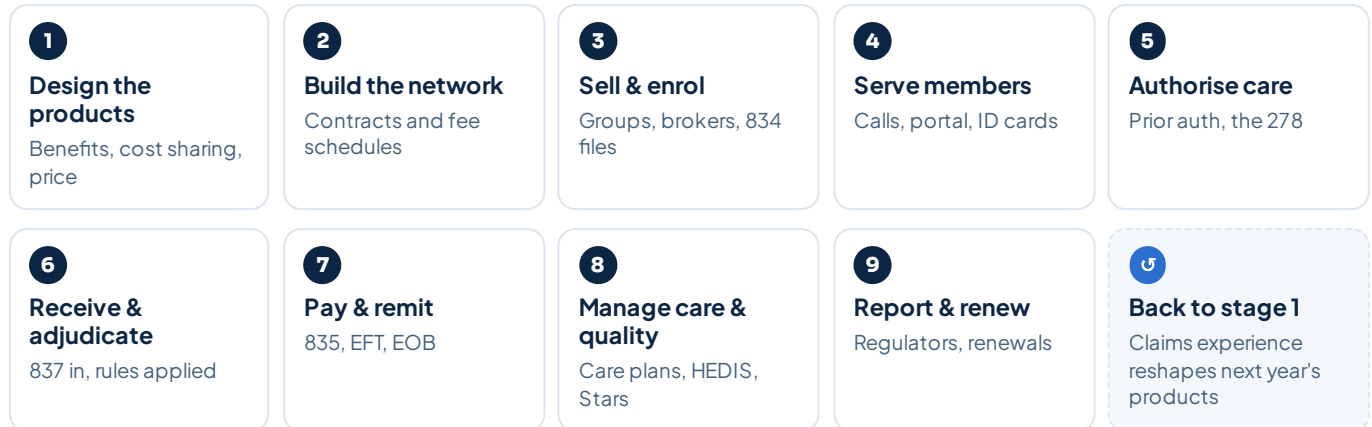
The state pays a plan per member per month to manage all of a member's care.

The two words that tie it together: subscriber and member

The **subscriber** holds the coverage — usually the employee. Every covered person, the subscriber and each dependent, is a **member** with their own benefits and history. India works on the same pattern: insurers and TPAs settle cashless claims, Ayushman Bharat PM-JAY funds care for eligible families, and IRDAI regulates.

The nine-stage payer journey

From designing a product to renewing it next year. Stages 1–3 build the plan; stages 4–9 run every day for every member and every claim. It is a yearly cycle — what this year's claims cost decides next year's premiums and benefits.



A What a beginner should hold on to at each stage

#	STAGE	THE ONE THING TO REMEMBER
1	Design the products	Every benefit rule — deductible, copay, covered service — becomes configuration in the claims system later.
2	Build the network	Whether a provider is in network decides what the member pays and what the claim is priced at.
3	Sell & enrol	Enrollment arrives as files from employers and the exchange. An error here becomes a denied claim next month.
4	Serve members	Members only see the plan at a few moments — the ID card, a call, an EOB. Each one has to be right.
5	Authorise care	Some services need approval before they happen. The claim must later carry the matching authorisation.
6	Receive & adjudicate	The rules engine decides whether, and how much, to pay. The best claims never touch a person.
7	Pay & remit	The provider is paid by EFT and told exactly why with an 835; the member gets an explanation of benefits.
8	Manage care & quality	Care management and quality scores (HEDIS, Medicare Stars) drive outcomes — and bonus payments.
9	Report & renew	Regulators, employers and the government all expect reports. Renewal pricing uses this year's claims.

Building the plan — and following the money

Four things a payer must get right before it pays a single claim — each becomes configuration, a file feed or a compliance rule.

1 • Design the products

- Benefits, deductibles, copays, coinsurance, out-of-pocket maximum
- Covered services and the drug formulary
- Premiums priced by actuaries and filed with regulators

2 • Build the network

- Credential doctors, hospitals and care agencies
- Negotiate contracts and fee schedules
- Keep the provider directory accurate — members rely on it

3 • Sell & enrol

- Employer groups, brokers and the exchange
- Open enrollment once a year, plus life events in between
- Enrollment arrives as 834 files; ID cards go out

4 • Serve members

- Call centre, member portal and mobile app
- Eligibility and benefit questions, claim status
- Explanations of benefits, grievances and appeals

A Who funds the plan — follow the money



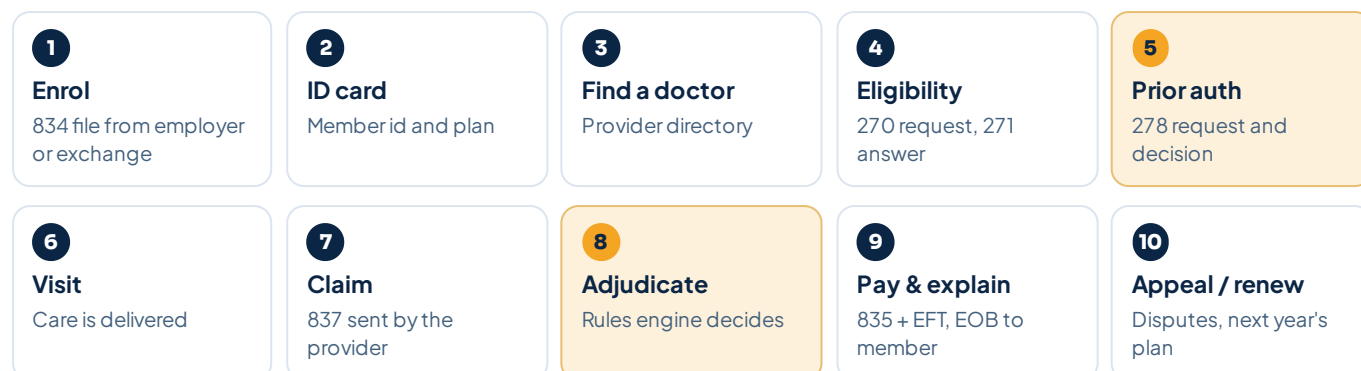
FUNDING MODEL	HOW IT WORKS	WHO CARRIES THE RISK
Fully insured	The employer or member pays a fixed premium; the payer pays the claims	The payer
Self-funded (ASO)	The employer pays its own claims; the payer administers them for a fee	The employer
Medicare Advantage	CMS pays the plan a monthly, risk-adjusted amount per member	The plan
Medicaid managed care	The state pays the plan a fixed amount per member per month	The plan

Medical loss ratio — the 80/85 rule

US rules require plans to spend at least 80% of premium on care and quality improvement in the individual and small-group markets, and 85% in the large-group market and Medicare Advantage. Admin and margin have to fit in what is left — which is why automation and clean claims matter so much to a payer.

The member journey, claim by claim

The loop that runs every day. Each step creates data the next step depends on — and a gap anywhere shows up later as a denied claim or a call to the member service centre.



A What each step must capture

STEP	INFORMATION CREATED — AND WHO NEEDS IT NEXT
Enrollment (834)	Subscriber and dependents, relationship codes, plan, coverage start and end dates, address. Every eligibility answer and claim decision reads this.
Eligibility (270/271)	Is this member covered today, for this service? Copay, deductible met so far, primary care provider. The provider uses it before the visit.
Authorisation (278)	Requested service, clinical reason, approved units and dates, authorisation number. The claim must carry it, or it denies.
Claim (837)	Member, billing and rendering provider, diagnosis and procedure codes, dates of service, charges, authorisation number.
Adjudication	Allowed amount, member share, adjustment reason codes, payment decision. Finance, the EOB and the 835 all come from here.
Payment (835 + EFT)	Paid amount per claim and per line, every adjustment explained with CARC/RARC codes, matched to the bank deposit.

“If it's not on the enrollment file, the member doesn't exist”

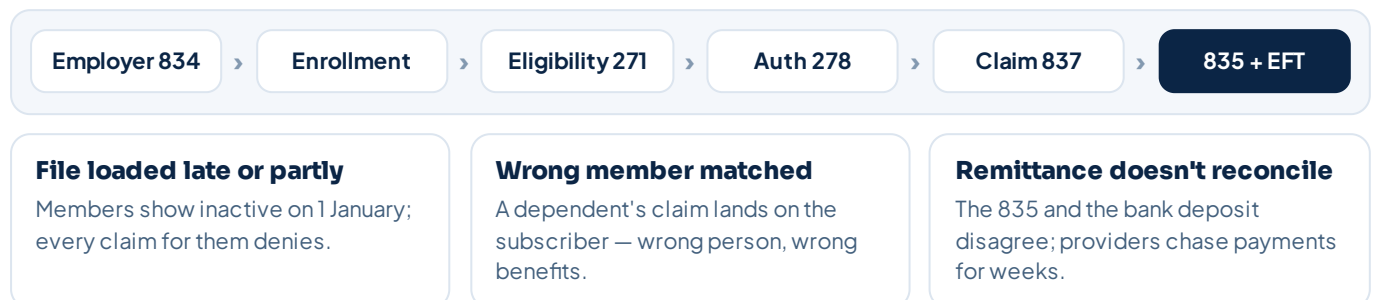
Every payer analyst has said it. Late, partial or mismatched enrollment is the single biggest source of avoidable denials — and of angry phone calls on the first working days of January.

The systems behind a payer

A health plan runs on a core administrative system surrounded by specialist systems and file feeds. Learn what each one owns and you can place almost any payer requirement in seconds.

SYSTEM	WHAT IT OWNS
Core admin system Facets, QNXT, HealthRules Payer...	Members, groups, benefit plans, provider records and claims adjudication. The payer's backbone.
Enrollment & premium billing	834 loads and reconciliation, premium invoices to employers, 820 premium payments.
Provider data management	Credentialing, contracts, fee schedules, NPI and taxonomy, the provider directory.
Utilisation & care management	Prior authorisation requests and reviews, care plans, case management for complex members.
Pricing & claim editing	Contract pricing, repricing for rented networks, coding and clinical edits.
EDI gateway / clearinghouse	Receives 837s and 270s, returns 999, 277CA, 271 and 835, with acknowledgements and tracking.
Portals & CRM	Member and provider portals, ID cards, EOBs, claim status, call-centre case history.
Data warehouse & analytics	HEDIS and Star ratings, risk adjustment, encounter reporting to states and CMS.

A How the data moves — and where it breaks



The question that orients you on any payer project

“Which system is the source of truth for the member, and which one for the money paid?” Most payer data moves as files between organisations — employers, clearinghouses, banks, government. Test the file and the reconciliation report, not just the screen.

Transactions, code sets and identifiers

On a payer project people use transaction numbers as nouns — “the 834 failed”, “the 835s are late”. Learn these and the meetings make sense.

A The X12 transactions (version 5010)

834 Enrollment Adds, changes and terms for members	820 Premium payment Employer or government pays premium	270/271 Eligibility Is the member covered for this?
278 Prior authorisation Request and decision	837 Claim P professional · I institutional · D dental	276/277 Claim status Where is my claim?
999 File acknowledgement Is the file well formed?	277CA Claim acknowledgement Was each claim accepted?	835 Remittance advice What was paid, and why not the rest

B What the codes mean

ICD-10-CM Diagnoses — why the member was treated.	CPT / HCPCS Procedures and supplies — what was done.	Revenue codes · DRG Hospital claims — line types, and one price per inpatient stay.	CARC / RARC Adjustment reasons — why the payer paid less than billed.
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C Identifiers you will see on every screen

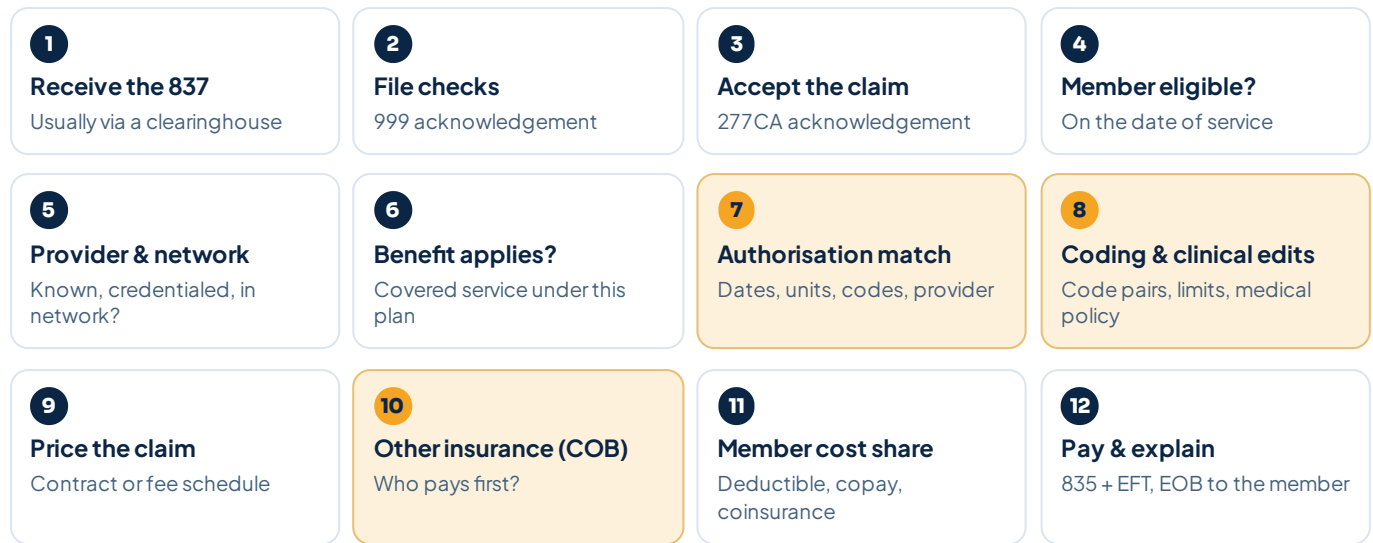
Member id + suffix	The subscriber's id, with a suffix or sequence for each dependent. One family, one id, several people.
Group / plan id	Which employer group and which benefit plan the member is on.
NPI — billing vs rendering	The organisation that bills and the clinician who treated. Swapping them is a top cause of rejections.
TIN + taxonomy	The tax id the money goes to, and the specialty code the contract keys on.
Claim number (ICN / DCN)	The payer's own id for a claim — used for status, adjustments and appeals.
Authorisation number	Issued with an approved 278; the claim must carry it with matching dates and units.
MBI (Medicare)	The Medicare Beneficiary Identifier, which replaced Social Security-based numbers on Medicare cards.

The modern layer: FHIR APIs

Under CMS's Interoperability and Prior Authorization rule (CMS-0057-F), Medicare Advantage, Medicaid, CHIP and federal-exchange plans must offer FHIR R4 APIs — Patient Access, Provider Access, Payer-to-Payer and Prior Authorization — from January 2027. X12 is not going away; the two will run side by side.

Claim adjudication, end to end

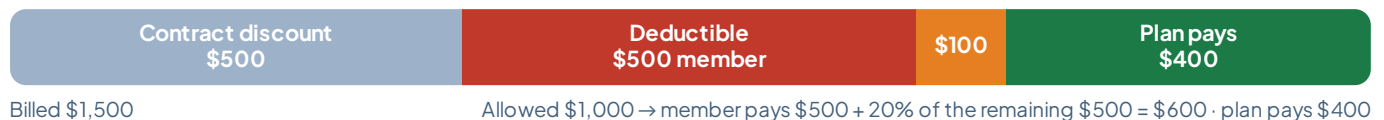
Stage 6 deserves its own page, because this is where the payer decides whether — and how much — to pay. A claim arrives as an 837 and passes through these twelve steps.



The three highlighted steps — authorisation, coding edits and coordination of benefits — are where most payment disputes start.

A A worked example: who pays what

A member with \$500 of deductible still to meet and 20% coinsurance has a procedure. The provider bills \$1,500; the contract allows \$1,000.



B The numbers a payer watches

MEASURE	WHAT IT TELLS YOU
Medical loss ratio	Share of premium spent on care and quality — regulated and reported every year.
Cost PMPM	Medical cost per member per month — the trend finance watches most closely.
Auto-adjudication rate	Share of claims paid with no human touch. Low rates point to configuration or data quality.
Claims turnaround	Days from receipt to payment. Many states set prompt-pay deadlines with interest penalties.
Denials & appeal overturns	How often the plan says no — and how often an appeal proves it wrong.
Star ratings / HEDIS	Medicare and quality scores that drive bonus payments and reputation.

Compliance and the QA view

Payers are among the most regulated businesses in healthcare. Member data is protected health information, and timelines for decisions and payments are set in law.

HIPAA

Privacy and Security Rules for protected health information: minimum-necessary access, audit trails, and business associate agreements with every vendor.

CMS rules

Medicare Advantage and Part D requirements. Under CMS-0057-F, prior auth decisions within 72 hours (urgent) or 7 calendar days (standard) from January 2026.

States & the ACA

State insurance departments, prompt-pay laws, member appeal rights, and the medical loss ratio rule.

A What this means for an IT or QA team

- **Never test with real member data.** Mask or synthesise PHI in every lower environment — and check that masking really happened.
- **Access is role-based and recertified.** Quarterly access reviews are common, and auditors ask for the evidence.
- **Every view is auditable.** “Who opened this member's record, when and why” must be answerable months later.
- **Every EDI change needs a test file** for each transaction set before release — the trading partner will not test it for you.

B The QA view — what to test in a payer system

AREA	WHAT GOES WRONG	WHAT TO TEST
Enrollment (834)	Members missing, duplicated or on the wrong plan	Adds, changes, terms, retro dates, full-file vs change-file reconciliation
Eligibility (270/271)	Covered members told they are not	Boundary dates, dependents, benefit details returned
Authorisation (278)	Approved care still denied at claim time	Auth-to-claim matching on dates, units, provider and codes
Claims adjudication	Wrong amount, wrong reason, manual pends	Benefit and pricing rules, edits, COB, accumulators, every expected CARC
Payment & 835	Remittance doesn't match payment	835 balancing, adjustment mapping, claims-to-remittance reconciliation
Portals & privacy	Another member's data shown; PHI in logs	Role matrices, masking, audit trail, directory accuracy

Unmasked PHI in test is not a minor finding

Treat it as a priority—one risk: bring in security and the client's compliance lead, fix it with automated masking, and put a recurring access recertification in place before the next audit.

Two incidents, and your first week

Layer 9 of the framework: what actually happens on a live payer project. Both incidents are real, anonymised, and both were caught too late by testing that was not there yet.

The open-enrollment file that failed

WHAT HAPPENED

A health plan's 834 full file failed to load just before the 1 January effective date, leaving several thousand new members without access. The plan's VP escalated.

THE FIX

A war room the same day, a corrected mapping within 48 hours, the file reprocessed and reconciled, daily updates to both executive teams.

Would have caught it: a mandatory pre-production test file, and change control on the companion guide.

The remittance that stopped reconciling

WHAT HAPPENED

835 remittances stopped matching submitted claims, delaying payments to care agencies and caregivers and drawing escalations from the payer partner.

THE FIX

Joint triage with the clearinghouse traced it to claim-level adjustment (CAS) mapping. The backlog was cleared within two weeks.

Would have caught it: a daily claims-to-remittance reconciliation report — still used by operations.

A Your first week on a payer project

- Pick one paid claim and find the member on the 834
- Check what the 271 said for the date of service
- Find the authorisation, if one was needed
- Read the 837 — billing vs rendering NPI, codes, charges
- Trace which adjudication rules fired and why
- Match the 835 and every CARC to the bank deposit
- Write down every identifier at each step
- Ask for last month's top five denial reasons

The delivery lesson

When a partner's late change puts a go-live at risk, raise it in the RAID log and at steering three weeks out — not on the deadline — and offer a phased launch: core eligibility on the committed date, the rest in the next release. A phased go-live beats a missed one.

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Sources: CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), 2024 · ACA medical loss ratio requirements (45 CFR Part 158) · ASC X12 version 5010 transaction sets · HIPAA Privacy and Security Rules. **Important:** payer regulation varies by programme and state, and changes often — check current CMS and state guidance.