

Health Care Financing 101

A primer of the U.S. health care system including public health care, payment models, and levers for change



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Overview of 101

- Health System Overview
- Public Programs for Children: Medicaid
- Public Programs for Children: CHIP
- Facts About Medicaid/CHIP
- Glossary
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Health System Overview



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Three Main Types of Insurance



Employer Sponsored Insurance (ESI)

Insurance coverage a person receives through their employment; employer and employee share the cost of coverage

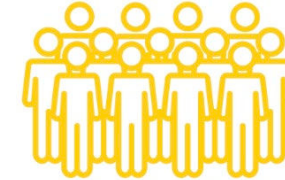
Covers about **155 million** nonelderly people



Individual Plans

Insurance coverage for those without access to ESI, such individuals who are self-employed, work for a place that does not provide insurance, or do not qualify for a public program

About **17 million** people are covered this way



Public Insurance

Insurance through federal or state governments in which people have all or most of their coverage covered by public dollars; eligibility based on income and/or age/disability

Medicaid covers about **70 million** and Medicare covers **50 million**

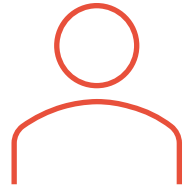


Facts About Insurance

- **ESI** access has been declining in recent years
- Access to and affordability of individual plans was improved through the **health benefits exchange under the Affordable Care Act (ACA)**
- Estimates suggest that about **25 million people** are **eligible** for either **Medicaid** or **subsidized coverage** through the exchange but are **unenrolled**

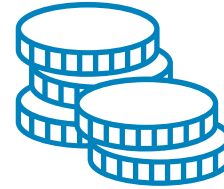


Different Roles in Health Insurance



Purchaser

The entity that buys the insurance, such as an employer, an individual, or the government



Payer

The entity that negotiates the rates, collects revenues through premium payments or tax dollars, processes the claims, and pays the providers, such as commercial plans, Medicaid, Medicare



Provider

The individuals and entities that deliver the care, such as doctors, nurses, hospitals, and other medical entities



Payer Types in the U.S. Health System

Medicare

 **Medicaid**



Commercial



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Who Are the Purchasers?

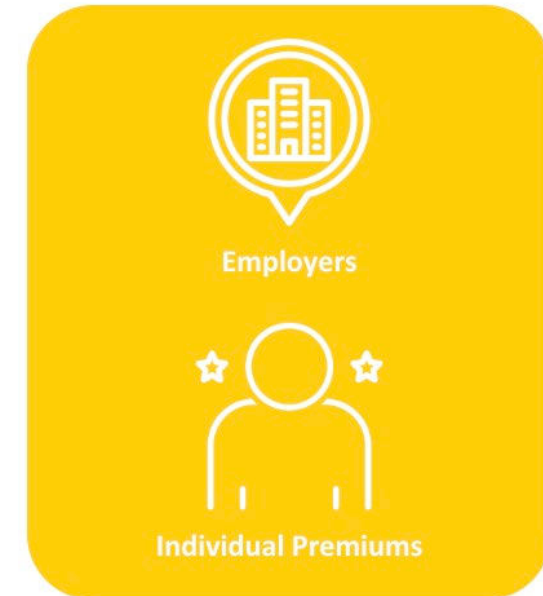
Medicare

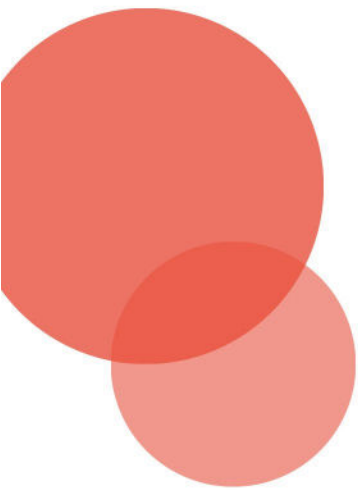


Medicaid



Commercial





Models of Payment

- **Fee-for-service:** Payer directly reimburses contracted providers for services; this theoretically incentivizes volume.
- **Capitated payments:** Payer pays a fixed fee to the contracted provider in return for medical care provided to the enrolled individual; this helps control costs for insurers by providing predictable payments.
 - **Managed care:** States pay a fixed monthly capitation rate per member per month per month (PMPM) and the managed care organizations (MCO) pay providers and coordinate services for enrollees. This is the dominant delivery system for Medicaid with 75% of beneficiaries enrolled.
- **Value-based payments (VBPs):** Payer reimburses the contracted provider based on patient outcomes. There are many different VBP models, many of which reward providers for the quality of the care they provide. This incentivizes high-quality patient outcomes and satisfaction rather than FFS models that incentivize the volume of services delivered.



FFS v. Managed Care: Who Decides?



Beneficiaries choose whether to enroll in “FFS” (traditional Medicare) or managed care (Part C).



States choose whether to obtain waivers to enable managed care; they may mandate certain populations into managed care.

Commercial

(or Private) Plan design in the commercial sector is mostly run through plans but may include FFS-like components.

Value Based Payment (VBP)

In VBP models, entities (payers or providers) take on varying degrees of risk for the outcomes of their populations. Risks range from bonus payments for good outcomes (no risk) to reallocation of cost savings with shortfalls covered internally (full risk). These arrangements exist at multiple levels within the health care system.

Purchasers may have VBP arrangements with payers (e.g., Medicaid and MCOs).

Example: An MCO incentivizes certain quality metrics and pays a bonus for meeting the metric.

Providers may have VBP arrangements with individual clinicians (e.g., hospital system and clinicians).

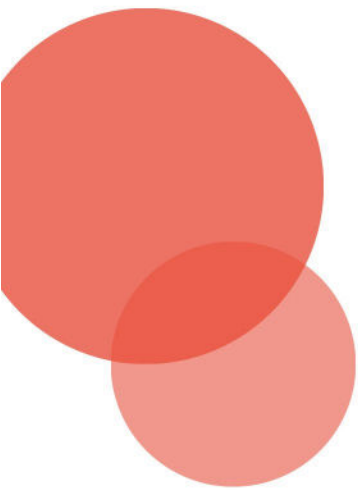
Example: Bundled payments for common treatment protocols rather than separate payments for each service.

Enrolling in Health Insurance

- Enrollment differs based on the type of insurance:
 - For private plans, there is an **open enrollment*** period.
 - For public programs, enrollment happens on a **continual basis**.

*Open enrollment is a defined window of time that only happens once a year when you can enroll in, change, or cancel your current health insurance plan





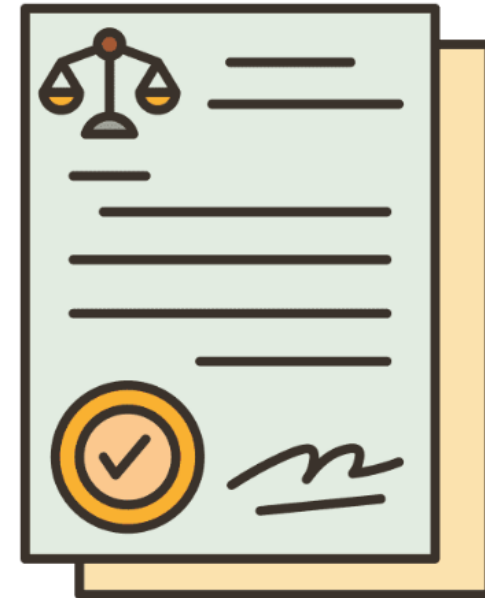
What Federal Requirements Apply to Health Insurance?

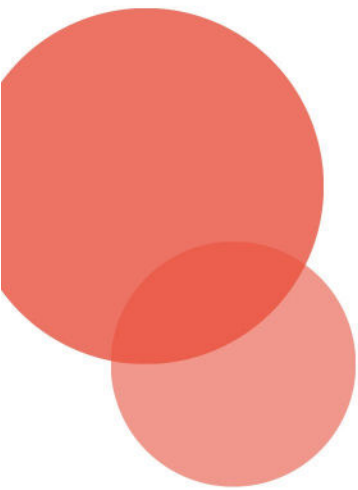
- States lead on insurance regulation, but most protections fall under federal oversight.
- The federal pension law – ERISA – limits the application of state law for those with private employer-sponsored coverage.
- Federal regulation of private health coverage can differ based on the market/source of coverage.
- Special exceptions allow certain types of private coverage to avoid meeting many insurance protections.
- Tax regulation matters for cost and access to health care and private insurance coverage.



The Affordable Care Act of 2010

- The passage of the ACA affected virtually all aspects of the health system, including insurers, providers, state governments, employers, taxpayers, and consumers.
- The law built on the existing health insurance system, making changes to Medicare, Medicaid, and employer-sponsored coverage.
- A fundamental change was the introduction of regulated health insurance exchange markets, or Marketplaces, which offer financial assistance for ACA-compliant coverage to those without traditional insurance sources.





Coverage Changes Enacted by the ACA

- The **ACA** expanded coverage for the uninsured and enacted comprehensive health reform to the health insurance marketplace.
- It created state-based insurance markets ("**health benefits exchange**") through which small businesses and individuals can purchase health insurance.
- ACA plans must meet certain requirements ("**qualified health plans**") to provide health insurance in the health benefits exchange.
- There are 10 categories of services that must be covered by all ACA plans ("**essential benefits**").
 - The law requires both individual plans and employer-sponsored plans that offer dependent child coverage to make the coverage available until a child reaches the age of 26.



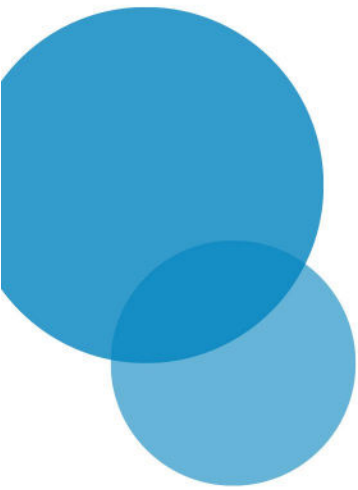
An Overview of Managed Care



What Is Managed Care?

- The concept of “managed care” was developed in the 1980s as a more cost-effective way to provide health care.
- It is a health delivery system organized to manage **cost, utilization, and quality**.
- Managed care uses risk-based financing.
- Today, most health insurance is run through managed care organizations (MCOs).





How Capitation Works

- **Fixed fee** (per member per month)
- Specific **period of time** (generally a month)
- Defined **set of services** (benefits)
- Assigned **population** of members
- Provider accepts "**risk**" for delivering services
- The vast majority of Medicaid is delivered through capitation with the purpose of making provider payments more predictable to control costs.



Managed Care Components

- **Network:** selective contracting with providers
- **Medical home:** primary care coordination in partnership with families
- **Prior Authorization/Pre-Certification:** oversight of specialty visits/elective procedures
- **Benefits Package:** defined set of covered services
- **Formulary:** rationalized and/or tiered pharmaceutical list
- **Utilization Review/Management:** managing in-patient admission and length of stay



Types of Managed Care Plans



Health Maintenance Organization (HMO)

- Centered on primary care provider as the organizer
- All non-emergency care (other than primary care) needs prior approval



Preferred Provider Organization (PPO)

- Member selects provider of choice
- Initial primary care provider visit/specialty prior authorization not required



Point of Service (POS)

- At time of need, member selects HMO or PPO pathway



Comparison of Managed Care Plans

	HMO Plan	Deductible HMO Plan	PPO Plan	POS Plan
What is it?	A plan that covers care provided by in-network physicians, with predictable copays and out-of-pocket maximums	An HMO plan that shares costs between the employer and employees, and offers lower premiums	A plan that offers referral-free access with the benefits of single-carrier administration	A plan that offers point-of-service (POS) care, with the option of choosing physicians and services from an external provider network
What's the advantage for employees?	- Lower out-of-pocket costs - Care coordinated by a primary care physician	- Lower premiums than regular HMO plans - Care coordinated by a primary care physician	- Broader choice of primary care physicians - No referrals required for specialist	Broader choice of primary care physicians
Is there out-of-network coverage?	No (except for emergencies)	No (except for emergencies)	Yes, but at a higher cost	Yes, but at a higher cost
Annual deductible?	No	Yes	Usually	No (for in-network coverage)
Copays?	Yes	Yes	No	Yes (for in-network coverage)
Is a primary care physician required?	Yes	Yes	No	Yes
Is a referral required to see a specialist?	Usually	Usually	No	Usually



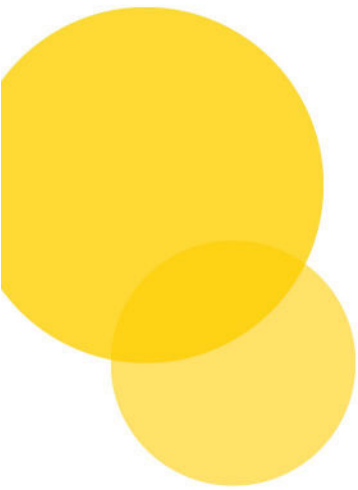
Public Programs for Children: Medicaid



What Is Medicaid?

- Medicaid is a family income and/or asset within a set limit health care entitlement.
 - Anyone who meets the eligibility rules has a right to enroll in Medicaid coverage.
- It was established under federal law through the 1965 amendments to the Social Security Act.
- It is funded jointly by the federal government and the states.
- One of its primary roles is to provide health insurance coverage to low-income adults and children.
- Each state's Medicaid program is distinct.





How Is Medicaid Administered?

- State Medicaid agencies design and administer their Medicaid programs under federal rules.
- The **state plan** is the agreement between the state and the federal agency that oversees Medicaid, which is the Centers for Medicare and Medicaid Services (CMS).
- The plan includes a description of how the individual state administers the program within federal requirements.
- It sets out what groups of individuals will be covered, services to be provide, methodologies for reimbursement, and administrative activities.



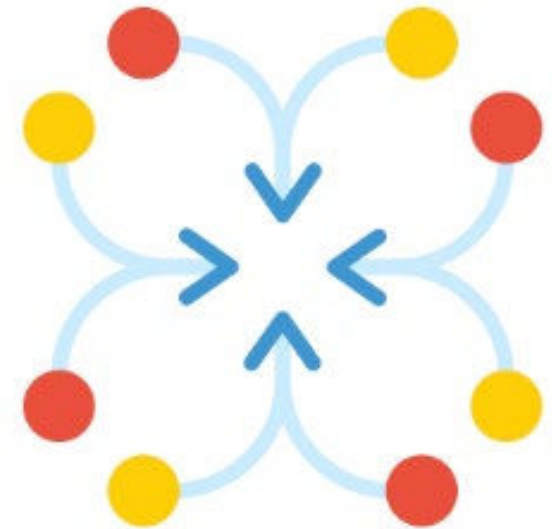
Who Is Eligible for Medicaid?

- States **must** cover:
 - Children through age 18 in families with income below 138% of the federal poverty line (FPL)
 - People who are pregnant and have income below 138% of FPL
 - Certain parents or caretakers with very low income
 - Most seniors and people with disabilities who receive cash assistance through the Supplemental Security Income (SSI) program
- States **can** cover optional populations including:
 - People in the mandatory coverage groups whose income exceeds the limit
 - Non-disabled adults with income below 138% FPL, including those without children
- Some states use their state only dollars to cover people with lawful immigration status who are not U.S. citizens and thus ineligible for federal funding.



Pathways to Medicaid for Children

- Eligibility based on income, not health status
- Eligibility based on income and functional level of disability
 - Low-income children with functional limitations who receive SSI
 - Middle-income children with high health-related expenses through Medicaid buy-in programs for disabled children
- Eligibility based on severe disability (institutional level of care)
 - TEFRA/Katie Beckett state plan option
 - 1915c Home- and Community-Based Services (HCBS) Waivers
- All children in foster care

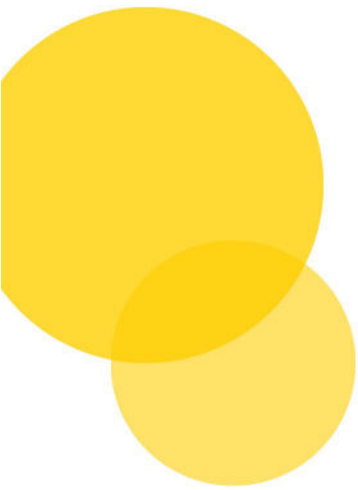


Enrollment in Medicaid

Because **Medicaid** is an entitlement, an eligible person can **enroll at any time**.

- Enrollment occurs at the local department of social service or through enrollment assisters.*
- In general, enrollees must renew eligibility annually.
- Some states have simplified enrollment and renewal processes.
 - The lack of standardization across states creates access challenges for families, especially for families whose closest care may be across state lines.





What Services Are Provided Under Medicaid?

- **Mandatory** services are those which states must provide, including many that benefit children:
 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)
 - Behavioral health services
 - Well-baby and well-child visits
- **Optional** services are those which states can choose to provide.
- A complete list of both types of services can be found [here](#).



EPSDT Is Medicaid's Child Benefit

Under the **E**arly and **P**eriodic **S**creening, **D**iagnostic, and **T**reatment benefit (§1905(r)), which was enacted in 1967 as an amendment to the Social Security Act, states must:

- Provide comprehensive services and offer all coverable, appropriate, and medically necessary services needed to correct and improve health conditions, even if such services are not included in the Medicaid state plan.
- Inform **all Medicaid-eligible individuals under age 21** that EPSDT services are available and of the need for age-appropriate immunizations.
- Provide any “medically necessary” services; definitions vary by state.



Components of EPSDT



Early: Assess and identify problems as early as possible.



Periodic: Check children's health status at regular, periodic, age-appropriate intervals.



Screening: Provide physical, mental, developmental, dental, hearing, vision, and other screening tests to detect potential problems.

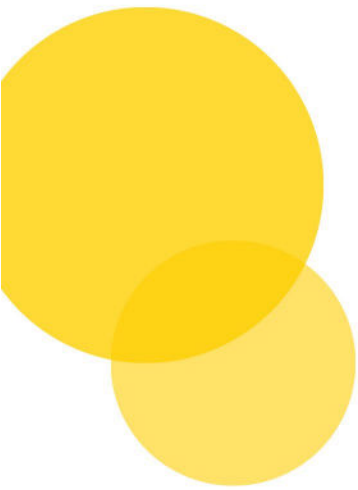


Diagnosis: Perform diagnostic tests to follow up (i.e., rule out or confirm) when screening identifies a risk or potential problems.



Treatment: Control, correct, or reduce health problems found.





Medicaid's Coverage of Early Intervention (EI) Services

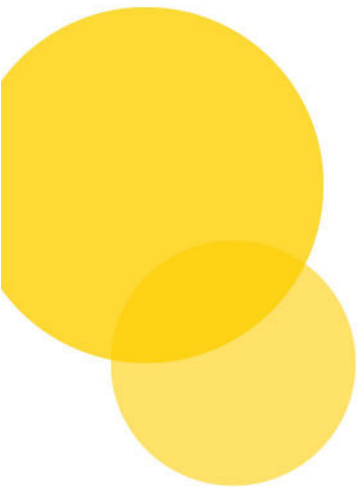
- Medicaid has been a major source of financing for EI services since the start of the Infants and Toddlers with Disabilities Program in 1986.
- Medicaid coverage for EI services is primarily through the EPSDT benefit.
- Examples of EI services covered by Medicaid include:
 - Speech-language therapy
 - Physical/occupational therapy
 - Hearing services



How Is Medicaid Financed?

- States have a guaranteed federal financial support for part of the cost of their Medicaid programs.
- The Medicaid program uses a formula known as the Federal Medical Assistance Percentage (FMAP) to determine the federal government's share of the cost of covered services in each state's program based on its per capita income compared to the nation.
- States that receive a 50% FMAP generally receive \$1 in federal funds for each state or local dollar spent on Medicaid. FMAP percentages range from 50%-77%.





How is Medicaid Delivered?

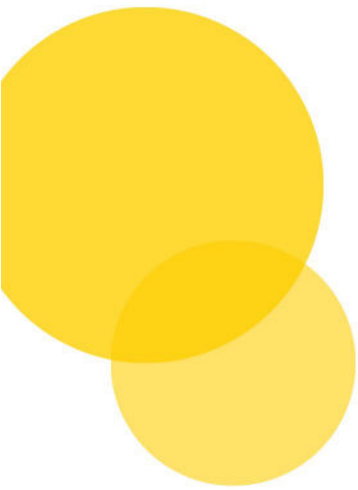
- **Fee for Service (FFS)**

- FFS is directly administered by the state.
- Enrollees choose their own doctors, hospitals, and other providers.
- State reimburses providers at an established fee for each service rendered.
- Licensed providers who agree to accept Medicaid rates as payment in full can participate.

- **Managed Care**

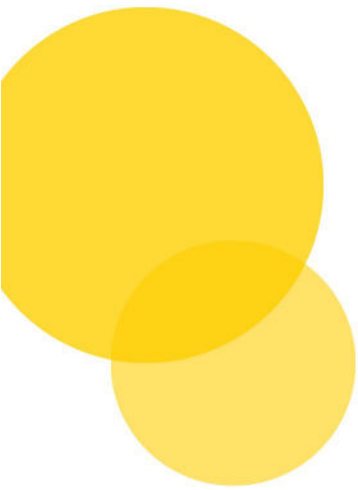
- Plans assume financial risk for managing care for a specific population.
- Plans include a closed network of contracted providers.
- MCOs are paid on a fixed, pre-arranged basis for a defined scope of benefits.
- Plans must meet network size and location standards; they can limit providers and credential them before accepting them into the network.





Medicaid Managed Care

- Within a managed care arrangement, entities are paid a capitated (per member) rate by the state Medicaid agency to run the program and pay providers for the care of people enrolled in MMC.
- MMC models by state and include:
 - Comprehensive risk-based managed care (MCO model)
 - Primary care case management (PCCM model)
 - Limited-benefit plans
- **41 states** use capitated managed care to deliver Medicaid.



EPSDT and Medicaid Managed Care

- Children enrolled in Medicaid managed care are still entitled to EPSDT.
- Some states have their MCOs provide and report on services under EPSDT, while others have the state Medicaid program responsible for covering services which fall outside of the MCO contract.
- States allow plans to use prior authorization for services, including EPSDT services.



Comparison of MMC Arrangements

Delivery System	Structure	Payment	Providers
MCO model	The state contracts with an MCO to perform some or all day-to-day operations of the program.	The state sets the capitation rate and can risk-adjust rates to account for enrollees' health status.	In addition to enrolling in Medicaid with the state, providers must separately contract with the MCO to be in the provider network.
PCCM model	Enrollees have a single designated primary care provider who handles their care management and coordination.	The state pays the designated primary care provider a monthly fee to cover a core set of case management services.	The state enrolls providers that meet the state's criteria and submits the necessary documentation.
Limited benefit plans	Plans manage a specific subset of benefits, only as behavioral health or long-term care services.	Same as MCO model	Same as MCO model

State Options for Making Changes to Medicaid

State Plan Amendment (SPA)

Allows states is to make a change to its program policies or operational approach, adopt optional flexibilities in the program, request program changes, make corrections, or update their Medicaid state plan with new information.

Waivers

Permit states and territories to waive federal requirements and continue to receive federal funding.



Main Types of Medicaid Waivers



Section 1115 demonstration waivers allow states to waive certain aspects of the Medicaid statute to experiment with different approaches to program operation, service delivery, and payment.



Section 1915 (b) allows states to adopt Medicaid managed care.



Section 1915 (c) allows states to offer home- and community-based services.



Public Programs for Children: CHIP



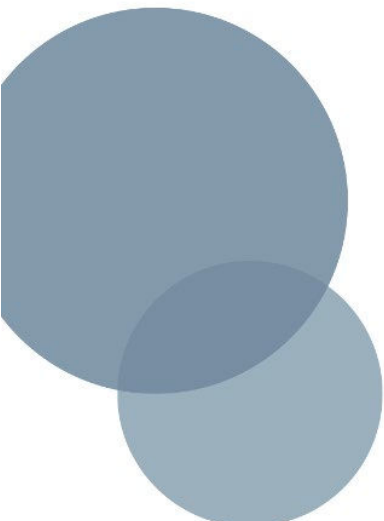
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Children's Health Insurance Program

- Enacted by The Balanced Budget Act of 1997
 - Encourages states to expand coverage to *uninsured* children
 - \$40 billion over 10 years
- The Children's Health Insurance Program Reauthorization Act of 2009 provided additional state options.
- The funding extension through the ACA included an additional federal match (23 percentage point bump) and requirement to maintain eligibility (MOE).





What Is CHIP?

- Health coverage for uninsured children in families who earn too much to qualify for Medicaid but too little to afford private coverage
- Provided enhanced federal matching rate to give states an incentive to adopt the Children's Health Insurance Program (CHIP)
- Block grant with capped annual allotments
- No entitlement to coverage
- States decide program design, which can include:
 - Separate program
 - Expand Medicaid
 - Combination of separate and Medicaid expansion



State Options for CHIP Program Design



Medicaid Expansion

All Medicaid rules apply for cost sharing, benefits, delivery system, and state-wide.

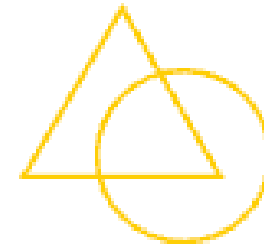


Separate CHIP Program

States have flexibility around administration, eligibility, benefits, and cost-sharing.

Waiting periods and cost-sharing requirements are permitted.

EPSDT is voluntary.



Combination Program

States can have both a separate CHIP program and use Title XXI funds for children in Medicaid.

38 states currently have such programs.



Who Is Eligible?

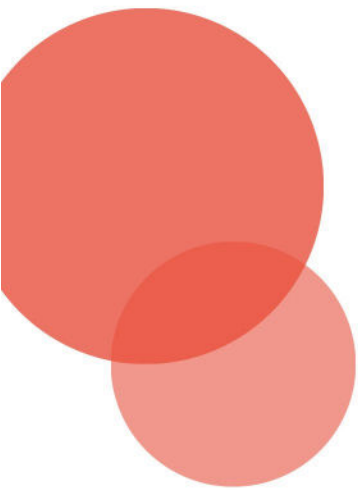
Children above Medicaid income levels at the state's option:

- 200% FPL upper limit or 50 percentage points greater than the Medicaid limit in place in 1997
- Pre-ACA, states used income disregards and deductions to achieve higher income eligibility thresholds; those levels are grandfathered as of enactment of the ACA
- Unborn children at the state's option



Facts About Medicaid/CHIP



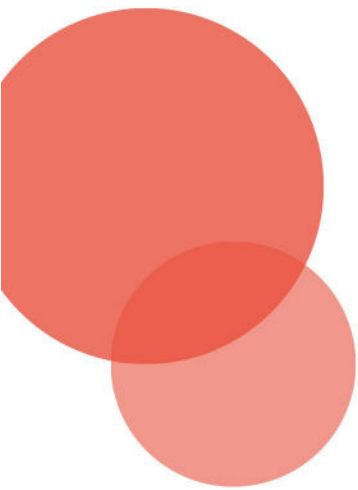


Medicaid Facts and Figures

- As of August 2024, Medicaid covered over **74.9 million people**.
- Medicaid represents **\$1 out of every \$6 spent** on health care.
- **2 in 5 children** are covered by Medicaid.
- **41% of all U.S. births** are covered by Medicaid.
- Research shows that Medicaid eligibility during childhood is associated with positive effects on health and beyond, such as improved long-term educational attainment.

[Medicaid in the United States](#)

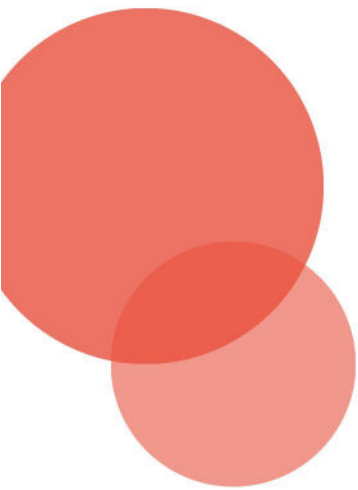




Facts about CHIP

- As of May 2026, CHIP enrolled over **7 million children**.
- CHIP covers nearly **12%** of the nations' children.
- Since the enactment of CHIP, the uninsured rate for children has **fallen from 14% to 4%**. [Medicaid in the U.S.](#)





Medicaid/CHIP's Role for Children and Youth With Special Health Care Needs (CYSHCN)

- Medicaid/CHIP is the sole source of coverage for nearly **4 in 10 CYSHCN**.
- Medicaid also provides **supplemental coverage** to CYSHCN who have commercial health insurance plans that do not fully cover their health care needs.
- Medicaid and some CHIP programs also provide coverage for **home- and community-based services** needed to meet the needs of this population.

GLOSSARY

CAPITATION: A fixed payment provided to a health provider from a managed care plan for the care of a patient, regardless of the type or number of services provided.

CONTINUOUS ELIGIBILITY: A child remains enrolled in a public program for a 12-month period of time in which their coverage cannot be altered or terminated regardless of a change in circumstances.

COST-SHARING: Any contribution consumers make towards the cost of their health care as defined in their health insurance policy.

HEALTH-RELATED SOCIAL NEEDS: Social and economic needs that individuals experience that affect their ability to maintain their health and well-being. These include needs such as employment, affordable and stable housing, healthy food, personal safety, transportation, and affordable utilities.

MAINTENANCE OF EFFORT (MOE): A federal requirement that requires funding recipients and/or sub-recipients to maintain a certain level of state/local fiscal effort to be eligible for full participation in federal funding.

MEDICALLY NECESSARY: Services required to preserve a patient's health status, in accordance with the standards of medical practice.

PRIOR AUTHORIZATION: Utilization management process used by health plans to determine if they will cover a prescribed procedure, service, or medication.



Sources Consulted

- KFF's Health Policy 101
- KFF's Summary of the Affordable Care Act
- NCSL Medicaid Toolkit
- Library of Congress Medicaid Overview
- Center on Budget and Policy Priorities
Introduction to Medicaid
- Georgetown University McCourt School of
Public Policy, Center for Children and
Families' EPSDT Primer



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