Quick Health Financing Stats for U.S.

Basic statistics (2013, WHO Global Health Observatory)	**United States**
Population	320 million
GDP per capita (USD) [data.worldbank.org]	$52,980
Total health expenditure per capita (USD)	$9,146
Total health expenditure as % of GDP	17.1%
Government health expenditure as % of total government expenditure	20.7%
Government health expenditure as % of total health expenditure	47.1%
OOP spending as % of total health expenditure [note, OOP as % of total private expenditure on health]	22.3%

DEMAND-SIDE PROGRAMS

In this framework we define demand-side UHC programs as programs that aim to reduce economic barriers and expand access to more and better services.

Many major national, demand-side health system programs either target a specific population (*poor and vulnerable people*, the *non-poor informal sector*, or the *formal sector*) or have distinct design features depending on the beneficiary's economic and work status. Therefore, this matrix includes questions specific to the program's design features for each specific population.

		Medicaid Program / State Children's Health Insurance Program (CHIP)	**Health Insurance Marketplace for Individuals and Families / Small Business Health Options Program (SHOP) Marketplace**
Identify each major, nationwide program / system that aims to reduce economic barriers and expand access to more and better health services for the population, and when the program started or was reformed. List one program per column.		• Medicaid enacted in 1965 under Title XIX of the Social Security Act • CHIP created as part of the Balanced Budget Act of 1997, builds on Medicaid to provide insurance coverage to uninsured, low-income children above Medicaid income eligibility thresholds • National reform in 2010 to expand Medicaid/CHIP eligibility (Affordable Care Act) • States establish their own Medicaid and CHIP programs and design them within federal guidelines • Medicaid expansion allows but does not require states to expand eligibility, with most costs covered by federal government	• Legislation enacted 2010 (Affordable Care Act) • The Marketplace is a web-based platform on which private for-profit and non-profit insurers can sell insurance coverage to individuals, families and small businesses • Individuals/families that buy coverage through the Marketplace can access "premium tax credit"[1] • Small businesses avoid tax penalty by offering coverage to employees
Population Covered: • How are beneficiaries identified and targeted? • What are the eligibility rules?	Poor/vulnerable	• State Medicaid/CHIP programs perform outreach and enroll eligible beneficiaries in their state[2]. • Targeting through: direct advertising; Connecting Kids to Coverage National Campaign,[3] "Presumptive Eligibility," "Express Lane Eligibility"[4] • Eligibility varies by state and is based on percent of family income above the federal poverty level ($11,770/year for an individual and $24,250/year for a family of four in 2016). • Income eligibility threshold often differs depending on beneficiary category: children 0-1, children 1-5, children 6-18, pregnant women, parents, other adults[5]; and differs between states.	• Individuals/families with annual income up to 400% of federal poverty level, and who do not qualify for CHIP or Medicaid, are eligible for premium tax credit. • Targeting through direct advertising; tax penalties.
	Non-poor informal sector	N/A	• All individuals/families that wish to buy coverage on the Marketplace platform may do so even if they are not eligible for premium tax credit.

		Medicaid Program / State Children's Health Insurance Program (CHIP)	Health Insurance Marketplace for Individuals and Families / Small Business Health Options Program (SHOP) Marketplace
			• Targeting through direct advertising; tax penalties.
	Formal sector employees	N/A	• Formal sector employees that do not have employer-based health insurance (where the employer subsidizes some or all out of pocket (OOP) costs for coverage) may buy coverage on the Marketplace, but in general large employers that do not offer employer-based coverage are subject to penalties. • Small businesses can participate in the Marketplace. • Targeting through direct advertising; tax penalties.
Services and Benefit entitlements: • Summarize the services or benefit entitlements for each population group. • Specify whether the services or benefits are defined in the form of a positive list, a negative list, or not explicitly defined. • How are benefit packages selected? • How are they updated over time? For example; health technology assessment.	Poor/vulnerable	• States develop benefit entitlements, often through a combination positive/negative list. • Benefit entitlements must be within federal rules and are subject to federal government review. **Medicaid**[6] • Per federal law, states are required to cover the following mandatory benefits: – Inpatient hospital services – Outpatient hospital services – Early and Periodic Screening, Diagnostic, and Treatment Services – Nursing Facility Services – Home health services – Physician services – Rural health clinic services – Federally qualified health center services – Laboratory and X-ray services – Family planning services – Nurse Midwife services – Certified Pediatric and Family Nurse Practitioner services – Freestanding Birth Center services (when licensed or otherwise recognized by the state) – Transportation to medical care – Tobacco cessation counseling for pregnant women • Optional benefits (state's discretion): – Prescription Drugs – Clinic services – Physical therapy – Occupational therapy – Speech, hearing and language disorder services – Respiratory care services – Other diagnostic, screening, preventive and rehabilitative services – Podiatry services – Optometry services – Dental Services – Dentures, Prosthetics, Eyeglasses – Chiropractic services – Other practitioner services – Private duty nursing services – Personal Care – Hospice – Case management – Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD) – Services in an intermediate care facility for Individuals with Intellectual Disability	• Essential Health Benefits: a set of health care service categories that must be covered by certain plans, starting in 2014. • The Affordable Care Act (ACA) ensures health plans offered in the individual and small group markets, both inside and outside of the Health Insurance Marketplace, offer a comprehensive package of items and services, known as essential health benefits. • Must include items and services within at least the following 10 categories: – ambulatory patient services – emergency services – hospitalization – maternity and newborn care – mental health and substance use disorder services, including behavioral health treatment; prescription drugs – rehabilitative and habilitative services and devices – laboratory services – preventive and wellness services and chronic disease management – pediatric services, including oral and vision care • Insurance policies must cover these benefits in order to be certified and offered in the Health Insurance Marketplace.[8]

		Medicaid Program / State Children's Health Insurance Program (CHIP)	Health Insurance Marketplace for Individuals and Families / Small Business Health Options Program (SHOP) Marketplace
		– State Plan Home and Community Based Services- 1915(i) – Self-Directed Personal Assistance Services- 1915(j) – Community First Choice Option- 1915(k) – Tuberculosis- Related Services – Inpatient psychiatric services for individuals under age 21 – Other services approved by the Secretary – Health Homes for Enrollees with Chronic Conditions – Section 1945 **CHIP**[7] • Provides comprehensive benefits called "benchmark coverage" or "benchmark equivalent" • Benchmark coverage based on the standard Blue Cross/Blue Shield preferred provider option service benefit plan offered to Federal employees, state employee's coverage plan, or the HMO plan that has the largest commercial, non-Medicaid enrollment within the state. • Benchmark equivalent must be actuarially equivalent and include the following: – Inpatient and outpatient hospital services – Physician's services – Surgical and medical services – Laboratory and X-ray services – Well-baby and well-child care, including immunizations	
	Non-poor informal sector	N/A	
	Formal sector employees	N/A	
MANAGING MONEY/ FINANCING UHC			
Financing sources	• Government source of revenue (e.g., taxes) for this program? Earmarked taxes, sin taxes, general taxes? • Mandatory contributions by formal sector workers (payroll taxes)? • Beneficiary premiums? • Beneficiary cost sharing at the point of service? • Provide specific information about any separate features of the beneficiary contribution model covering poor and vulnerable people, the non-poor informal sector, and the formal sector (if applicable). • Summarize how each source of financing is collected.	**Medicaid** • Jointly financed by state and federal governments through annual appropriations. • States may rely on local government contributions as well. • Federal government contributes different percentages to different states based on different measures such as state per capita income (Federal Medical Assistance Percentages)[9] – Computed from a formula that takes into account the average per capita income for each state relative to the national average, recomputed every three years to account for changes in the economy – Minimum federal percentage for any state is 50%[10] **CHIP** • Jointly financed by state and federal governments through annual appropriations. • As an incentive for states to expand their coverage programs for children, Congress created an "enhanced" federal matching rate for CHIP that is generally about 15 percentage points higher than the Medicaid rate — averaging 71% nationally[11]. **Medicaid cost sharing**[12] • Premiums billed via mail. • Other cost sharing collected by provider at the point of service or billed via mail. • States can charge premiums and establish OOP requirements for Medicaid beneficiaries. • OOP costs cannot be imposed for emergency services, family planning services, pregnancy-related services, or preventive services for children. **CHIP cost sharing**[13]	• Most financing comes from premiums and cost-sharing paid by consumers, but other sources exist. • General tax revenue pays for the advance payments of the premium tax credit (help low- and middle-income individuals pay their premiums). The cost-sharing reduction program can further reduce the out-of-pocket spending for health services for low- and middle-income individuals, and Native Americans. • Premium stabilization programs designed to reduce incentives for health insurance issuers to avoid enrolling sicker people, and to stabilize premiums in the individual and small group health insurance markets inside and outside the Marketplaces: – The permanent risk adjustment program will assist health plans that provide coverage to individuals with higher health care costs and will help ensure that those who are sick have access to the coverage they need. – The transitional reinsurance program is a three-year program designed to reduce premiums and ensure market stability for issuers. – The temporary risk corridors program protects qualified health plans from uncertainty in rate setting from 2014 to 2016 by having the federal government share risk in losses and gains.[14]

		Medicaid Program / State Children's Health Insurance Program (CHIP)	Health Insurance Marketplace for Individuals and Families / Small Business Health Options Program (SHOP) Marketplace
		• Premiums billed via mail. • Other cost sharing collected by provider at the point of service or billed via mail. • States can choose to impose limited enrollment fees, premiums, deductibles, coinsurance, and copayments for children and pregnant women enrolled in CHIP, generally limited to 5% of a family's annual income. • Cost sharing is prohibited for some services, like well-baby and well-child visits.	
Risk pooling	• Is there one national pool, separate national risk pools for distinct beneficiary groups, or subnational level pools? • Are the poor cross-subsidized by higher income people? Discuss for each program.	• Risk is pooled at the state level (or at the managed care plan level). • Limited cross-subsidization within the program (slightly higher income beneficiaries may have to pay slightly higher cost-sharing, but still well below actual cost). • Cross-subsidization from higher income people occurs indirectly due to state and federal financing coming from general tax revenue.	• Risk is mainly pooled at the sub-national level in each individual health insurance plan offered by the different insurers. • Additionally, the premium stabilization programs are in place to spread the risk at a more aggregate level (see above). • The poor are quasi cross-subsidized through general tax revenue that pays for premium subsidies for low- and middle-income individuals.
Financial management	• What institution manages the program? • How does the program remain solvent? • Are there mechanisms in place, such as caps or utilization review, that maintain the financial viability of the system?	• State government, regulated by federal government. • Annual state and federal budget appropriations, draw down daily as needed, unlimited[15]. • Congress and state governments have to appropriate funds annually; in reality the only way to reduce costs would be to reduce coverage and benefits.	• Centers for Medicare & Medicaid runs the federal marketplace and regulates state marketplaces, state governments run state marketplace if they chose to do so. • Insurers attempt to set premiums and cost sharing for the pool of enrollees to fully cover all expenses for the plan in that year. • Insurance plans usually include annual and lifetime limits on the money the plan will pay for the beneficiary's care.
Financial protection	• Financial protection for households: Are there caps on cost sharing or other safeguards that protect households against impoverishment due to health costs?	**Medicaid** • 5% of family income (Cap on Total Premium and Cost Sharing Charges for all family members)[16].	• Plans include cost sharing caps such as annual OOP maximums • Actuarial value of the plan is the percentage of total average costs for covered benefits that a plan will cover, and the marketplace includes plans with varying actuarial values: • Bronze plan = AV of 60% • Silver plan = AV of 70% • Gold plan = AV of 80% • Platinum plan = AV of 90%[17]
Provider payment	• Describe the payment mechanisms used to pay primary health care (including preventive and promotive care). • Describe the payment mechanisms used to pay for hospital level care. • Are payments tied to quality of care, and if so, how does this work? • Do the systems contract private providers or private health plans? If so, describe the payment mechanisms incorporated into contracts.	• States can establish their own Medicaid provider payment rates. • Providers are mix of public and private. • States generally pay providers directly fee-for-service; or, pay capitation payments per beneficiary to private managed care delivery systems which pays health workers fee-for-service, salaries or other methods.[18] • State Medicaid programs make Disproportionate Share Hospital payments to qualifying hospitals that serve a large number of Medicaid and uninsured individuals. • Payment based on quality is at state's discretion; Centers for Medicare & Medicaid Services (CMS) is encouraging states to adopt integrated care models and quality-based payments[19].	• Providers paid differently depending on the insurer and plans. Various payment models: • FFS • Capitation • Population-based payments • Hospital DRGs • Episode groupers[20] • In network/out-of-network providers • Shared savings/losses models • Value-based purchasing based on quality measurement • Etc.

		Medicare Part A	Medicare Part B	Medicare Parts C & D
Identify each major, nation-wide program / system that aims to reduce economic barriers and expand access to more and better health services for the population, and when the program started or was reformed. List one program per column.		• Also known as Hospital Insurance program • Established 1965 under Title XVIII of Social Security Act • Expanded in 1972 to disabled and ESRD patients • Expanded in 2001 to those with ALS	• Also known as Supplementary Medical Insurance program • Established at same time as Part A	• Part C also known as Medicare Advance Plan • Part D also known as the outpatient prescription drug benefit • Established by the Medicare Modernization Act of 2003 (MMA) and launched in 2006
Population Covered: • How are beneficiaries identified and targeted? • What are the eligibility rules?	Poor/vulnerable Non-poor informal sector Formal sector employees	• Low-income people can dual-qualify for Medicaid and Medicare; Medicare is their primary source of coverage and Medicaid fills in gaps in coverage such as dental care and non-skilled long term services and support (e.g. in-home care) • Beneficiaries with limited income (less than 150 percent of the federal poverty level) and limited assets are eligible for the Low-Income Subsidy (LIS) program for Part D, or "extra help," which helps pay for some or all of the Part D monthly premium and cost-sharing amounts • Qualify at age 65 if US citizen and individual or spouse has worked long enough to be eligible for Social Security or railroad retirement benefits (individual needs to enroll) • Qualify under age 65 if: – Individual has been entitled to Social Security disability benefits for at least 24 months (need not be consecutive)(auto enrollment); or – Individual receives a disability pension from the Railroad Retirement Board and meet certain conditions (auto enrollment); or – Individual has Lou Gehrig's disease (ALS)(auto enrollment); or – Individual has end stage renal disease (individual needs to enroll) • For most individuals who become entitled to Part A, enrollment in Part B is automatic unless the individual declines enrollment • Individuals elect to enroll in Part C and D plans		
Services and Benefit entitlements • Summarize the services or benefit entitlements for each population group • Specify whether the services or benefits are defined in the form of a positive list, a negative list, or not explicitly defined. • How are benefit packages selected? • How are they updated over time? For example; health technology assessment	Poor/vulnerable Non-poor informal sector Formal sector employees	Mix of positive and negative list In general, Part A covers: • Hospital care • Skilled nursing facility care • Nursing home care (as long as custodial care isn't the only care you need) • Hospice • Home health services[21]	Mix of positive and negative list In general, Part B covers 2 types of services • Medically necessary services: Services or supplies that are needed to diagnose or treat your medical condition and that meet accepted standards of medical practice. • Preventive services: Health care to prevent illness (like the flu) or detect it at an early stage, when treatment is most likely to work best. – You pay nothing for most preventive services if you get the services from a health care provider who accepts assignment • Part B covers things like: – Clinical research – Ambulance services – Durable medical equipment (DME) – Mental health – Inpatient – Outpatient – Partial hospitalization – Getting a second opinion before surgery – Limited outpatient prescription drugs[22]	• Each Part D Prescription Drug Plan has its own list of covered drugs called a formulary. Many Medicare drug plans place drugs into different "tiers" on their formularies. Drugs in each tier have a different cost. – Positive list • In general, Part C Medicare Advantage Plans must cover all of the services that Original Medicare (Parts A and B) covers except hospice care. Original Medicare covers hospice care even if the beneficiary is in a Medicare Advantage Plan. • The plan can choose not to cover the costs of services that aren't medically necessary under Medicare • Plans may offer extra coverage, like vision, hearing, dental, and/or health and wellness programs. • Most Medicare Advantage Plans include Medicare prescription drug coverage (Part D). In addition to the Part B premium, the enrollee usually pays a monthly premium for the Medicare Advantage Plan.[23] – Usually mix of positive and negative list
MANAGING MONEY/ FINANCING UHC				
Financing sources	• Government source of revenue (e.g. taxes) for this program? Earmarked taxes, sin taxes, general taxes?	• Beneficiaries do not pay premiums for Part A coverage • Medicare HI Trust Fund funded by a tax of 2.9 percent of earnings paid by employers and workers (1.45 percent each), along	• Medicare SMI Trust Fund funded by general revenues and beneficiary premiums. • Beneficiaries who have higher annual incomes (more than $85,000/single	• Enrollees pay premiums to private insurers for Parts C plans • Part D is financed through general revenues, beneficiary premiums, and state payments for dual-eligible beneficiaries

		Medicare Part A	Medicare Part B	Medicare Parts C & D
	• Mandatory contributions by formal sector workers (payroll taxes)? • Beneficiary premiums? • Beneficiary cost sharing at the point of service? • Provide specific information about any separate features of the beneficiary contribution model covering poor and vulnerable people, the non-poor informal sector, and the formal sector (if applicable). • Summarize how each source of financing is collected.	with an additional 0.9 percent paid by higher-income taxpayers (wages above $200,000/individual and $250,000/couple)[24]	person, $170,000/married couple) pay a higher, income-related monthly Part B premium[25]	(who received drug coverage under Medicaid prior to 2006). • The monthly premium paid by enrollees is set to cover 25.5 percent of the cost of standard drug coverage, and Medicare subsidizes the remaining 74.5 percent. • Similar to Part B, higher-income beneficiaries pay a larger share of the cost of standard drug coverage. [26]
Risk pooling	• Is there one national pool, separate national risk pools for distinct beneficiary groups, or subnational level pools? • Are the poor cross-subsidized by higher income people? Discuss for each program.	• One national pool • Yes, see above	• One national pool • Yes, see above	• Each insurance plan is it's own risk pool. • Poor are not cross-subsidized for Part C. • Poor are indirectly cross-subsidized for Part D through state payments for dual-eligible beneficiaries.
Financial management	• What institution manages the program? • How does the program remain solvent? • Are there mechanisms in place, such as caps or utilization review, that maintain the financial viability of the system?	• Managed by CMS. • Medicare HI Trust Fund, as of 2014 estimate will exhaust in 2030. Solvency is an issue.	• Managed by CMS. • In most cases, if individual doesn't sign up for Medicare Part B when first eligible, they pay a late enrollment penalty for as long as they have Part B (If individual or spouse is still working and covered under employer-based insurance, late enrollment penalty doesn't apply.)[27] • Part B and Part D do not have financing challenges similar to Part A, because both are funded by beneficiary premiums and general revenues that are set annually to match expected outlays. • Future increases in spending will require increases in general revenue funding and higher premiums paid by beneficiaries.	• Regulated by CMS and managed by private insurers. • Part D funded by beneficiary premiums and general revenues that are set annually to match expected outlays. • Future increases in spending will require increases in general revenue funding and higher premiums paid by beneficiaries.
Financial protection	• Financial protection for households: are there caps on cost sharing or other safeguards that protect households against impoverishment due to health costs?	• Deductible, then coinsurance requirements for many services. • No OOP max, so safeguards are very limited. • Many beneficiaries choose to purchase Medigap or other private supplemental insurance to reduce exposure to catastrophic health costs.		• With Part C plans, OOP costs depend on the benefit plan. • With Part D, copayments for drugs vary depending on yearly OOP payments already made for drugs[28].
Provider payment	• Describe the payment mechanisms used to pay primary health care (including preventive	• Current payment systems in traditional Medicare have evolved over the last several decades, but have maintained a fee-for-service payment structure for most types of providers. • Payment reforms included in ACA and new approaches being tested by the CMS Innovation Center. CMS recently announced a set of explicit targets to be met in the coming years that		• CMS awards stars to Medicare managed care plans for seniors based on benefits, member satisfaction and management of chronic conditions.[30]

		Medicare Part A	Medicare Part B	Medicare Parts C & D
	and promotive care) • Describe the payment mechanisms used to pay for hospital level care. • Are payments tied to quality of care, and if so, how does this work? • Do the systems contract private providers or private health plans? If so, describe the payment mechanisms incorporated into contracts.	would tie an increasing share of traditional Medicare payments to provider performance on quality and spending.[29]		• Since 2006, Medicare has paid private plans under a bidding process: plans submit bids that estimate their costs per enrollee for services covered under Medicare Parts A and B. If plans bid higher than the county-level benchmark, enrollees pay the difference in the form of monthly premiums. If plans bid lower than the benchmark, the plan and Medicare split the difference between the bid and the benchmark; the plan's share is known as a "rebate," which must be used to provide supplemental benefits to enrollees.[31]

SUPPLY-SIDE PROGRAMS

In this framework we define supply-side UHC programs as nationwide programs that aim to reform and upgrade the production of health services.

		CMS payment reforms
Identify each major, nationwide program / system that aims to reform and upgrade the production of health services. List one program per column.		CMS is testing several different provider payment models through the Medicare program. Due to its huge market share, Medicare reforms have large impact on supply-side issues in the U.S.
Human Resources	• Summarize design features of programs aiming to improve distribution of health workers, retention of health workers, or outreach by health workers.	• Outreach by health workers is incentivized through integrated care delivery models. See below
Managerial Flexibility	• Do managers of facilities or at subnational level have the flexibility to hire and fire, manage money, procure commodities? Summarize design features of programs aiming to improve managerial flexibility in public facilities.	N/A
Private Providers	• Summarize design features of programs aiming to increase participation of or oversee quality of private providers.	• Medicare Part C plans allow participation in the Medicare program by private insurers. Further information in previous section. • CMS runs a star ratings program for hospitals that bill Medicare. • For health workers that bill Medicare, CMS runs several quality initiatives: Physician Quality Reporting System (PQRS), the Value-Based Payment Modifier (VM), and the Medicare Electronic Health Records (EHR) Incentive Program[32]
Health Care Provision / Accreditation and Other Regulation of Quality	• Summarize design features of programs aiming to accredit health facilities or regulate quality of service provision in another way.	• The Hospital Readmission Reduction Program financially penalizes hospitals that have relatively higher rates of Medicare readmissions following initial hospitalizations for certain conditions (heart attack, pneumonia, hip replacement).
Health Care Provision / Integrating the Health System	• How is beneficiary care coordinated across levels of care? Is there a system of referrals and counter-referrals and the information system to manage this? Please describe.	Integrated care models: • Accountable Care Organizations are groups of providers (such as physician practices and hospitals) that collectively accept responsibility for the overall care of Medicare beneficiaries assigned to them, and share in financial savings if they meet aggregate spending and quality targets. • Also known as episode-of-care payments, bundled payments reimburse for all services provided to a patient for a defined course of treatment, rather than paying each provider and site separately. Participating providers share in any savings that they generate or losses if total spending exceeds payment. • The medical home, also called an "advanced primary care practice," is a team-based approach to care that focuses on providing and coordinating all of a patient's ongoing care from within a primary care medical practice. Medical home models commonly receive a monthly payment for each patient, which is intended to offset the costs of activities that occur outside of face-to-face physician visits (e.g., phone call or email follow-up with other specialists, electronic health record activities, after-hours access to clinical staff).

ACCOUNTABILITY IN THE HEALTH SECTOR

		CMS payment reforms
Accountability	To what extent is health sector governance characterized by decentralization and regulation, or what *Going Universal* refers to as "arm's length" relationships-, for example, an actor who delegates the task (e.g., MoH; purchaser of health services) and a separate actor who is responsible for carrying it out (e.g., local government; service providers)? Summarize the governance structure of the health sector and features of the purchaser-provider split, where one exists.	• Federal and state governments share responsibility for regulating the health sector. • For programs with federal funding, national legislation is passed by the legislative branch of government (Congress), which then hands over regulatory control to the executive branch of government (Centers for Medicare & Medicaid). • CMS regulates major health care purchasing programs: – Medicaid and CHIP (run and regulated by the states, within general confines set by federal government) – Medicare Parts A, B, C and D – Federally-run Marketplace • States regulate: – Private insurance industry within the state – Medicaid and CHIP within the state – State-run Marketplace • There is an arm's length relationship between purchasers and providers because providers are mainly private non-profit or private for-profit, and can accept both public and private financing at discretion.

[1] https://www.healthcare.gov/
[2] https://www.medicaid.gov
[3] http://www.insurekidsnow.gov/professionals/index.html
[4] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/outreach-and-enrollment/enrollment-strategies.html
[5] https://www.medicaid.gov/medicaid-chip-program-information/program-information/downloads/medicaid-and-chip-eligibility-levels-table.pdf
[6] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html
[7] https://www.medicaid.gov/chip/benefits/chip-benefits.html
[8] https://www.healthcare.gov/glossary/essential-health-benefits/
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[10] http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/
[11] https://www.medicaid.gov/chip/financing/financing.html
[12] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/benefits/medicaid-benefits.html
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[14] https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/
[15] https://www.medicaid.gov/medicaid-chip-program-information/by-topics/financing-and-reimbursement/downloads/medicaid-actuarial-report-2014.pdf
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[22] https://www.medicare.gov/what-medicare-covers/part-b/what-medicare-part-b-covers.html
[23] https://www.medicare.gov/what-medicare-covers/medicare-health-plans/medicare-advantage-plans-cover-all-medicare-services.html
[24] Kaiser Family Foundation. March 2015. "A Primer on Medicare: key facts about the Medicare program and the people it covers."
[25] Kaiser Family Foundation. March 2015. "A Primer on Medicare: key facts about the Medicare program and the people it covers."
[26] Kaiser Family Foundation. March 2015. "A Primer on Medicare: key facts about the Medicare program and the people it covers."
[27] https://www.medicare.gov/sign-up-change-plans/get-parts-a-and-b/when-sign-up-parts-a-and-b/when-sign-up-parts-a-and-b.html
[28] Kaiser Family Foundation. March 2015. "A Primer on Medicare: key facts about the Medicare program and the people it covers."
[29] Kaiser Family Foundation. March 2015. "A Primer on Medicare: key facts about the Medicare program and the people it covers."
[30] http://khn.org/news/5-reasons-feds-are-overhauling-regs-on-medicaid-outsourcing/
[31] Kaiser Family Foundation. March 2015. "A Primer on Medicare: key facts about the Medicare program and the people it covers."
[32] https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/qualityinitiativesgeninfo/index.html