How American Healthcare Is Funded

Medicare, Medicaid, Insurance, and How Providers Get Paid

The US healthcare system has no single payer. Coverage depends on age, income, employment, and military service. As an APP, you will practice across all of these payers — sometimes in the same clinic day.

Part 1 — The Five Major Coverage Categories

Payer	Who Qualifies	Key Points
Medicare	Age 65+; or disabled; or ESRD/ALS	Federal program. Parts A, B, C, D (see below).
Medicaid	Low-income adults, children, pregnant women, disabled	Federal-state partnership. Income-based, not age-based. Expanded under ACA. Varies by state.
Private Insurance	Working-age adults (employer) or marketplace enrollees	Employer-sponsored covers most working adults. ACA marketplace for self-employed or uninsured. COBRA continues employer coverage temporarily after job loss.
VA / TRICARE	Veterans (VA); active military and dependents (TRICARE)	Federal programs. VA is comprehensive care for veterans. TRICARE functions like private insurance for military families.
Uninsured	Those who fall through every gap	Emergency care required (EMTALA). Charity care and safety net hospitals absorb costs. Patients often delay care until crisis.

Medicare Parts — what each covers:

Part	Covers	Note
Part A	Hospital inpatient, SNF, hospice	Premium-free for most; funded by payroll taxes
Part B	Outpatient visits, professional fees, DME	Monthly premium; covers your services as an APP
Part C	Medicare Advantage (bundled A+B, often D)	Offered by private insurers under Medicare contract; prior auth common
Part D	Prescription drugs	Separate plan; formulary varies by plan

Private insurance — terms every APP must know:

Term	What It Means
Premium	Monthly payment to maintain coverage (whether or not care is used)
Deductible	Amount patient pays out-of-pocket before insurance starts covering costs
Copay	Fixed dollar amount per visit or service (e.g., $30 per office visit)
Coinsurance	Patient's percentage share after deductible is met (e.g., 20% of the bill)
Out-of-pocket max	Annual cap on patient spending; insurance covers 100% beyond this
In-network	Providers who have contracted rates with the insurer; lower cost to patient
Out-of-network	Non-contracted providers; patient pays significantly more

Part 2 — How Providers Get Paid

There are two dominant payment models in the US. Both affect how you practice.

Model	How It Works	Implication for APPs
Fee-for-Service (FFS)	Payment per service rendered (visit, procedure, test). More volume = more revenue.	Still dominant. Incentivizes volume, not necessarily outcomes.
Value-Based Care	Payment tied to quality metrics, outcomes, or cost targets. Includes APMs, bundled payments, and shared savings programs (e.g., Medicare ACOs).	Incentivizes efficiency, care coordination, and keeping patients out of the hospital.

> **Prior Authorization:** Before many high-cost services (advanced imaging, specialist referrals, branded drugs) can be performed, the insurer must approve them in advance. Denial requires appeal. This is a daily reality in outpatient cardiology.
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> **Formularies:** Each insurance plan publishes a drug formulary — a tiered list of covered medications. A medication you prescribe may be covered at Tier 1 (low cost) or Tier 3 (high cost) or not covered at all. Formulary status directly determines whether your patient fills the prescription.

CLINICAL RULE

Every clinical decision has a payment context. Before prescribing, ordering, or referring, know what your patient's coverage looks like — because coverage determines access. A medication without coverage is a medication the patient will not take.