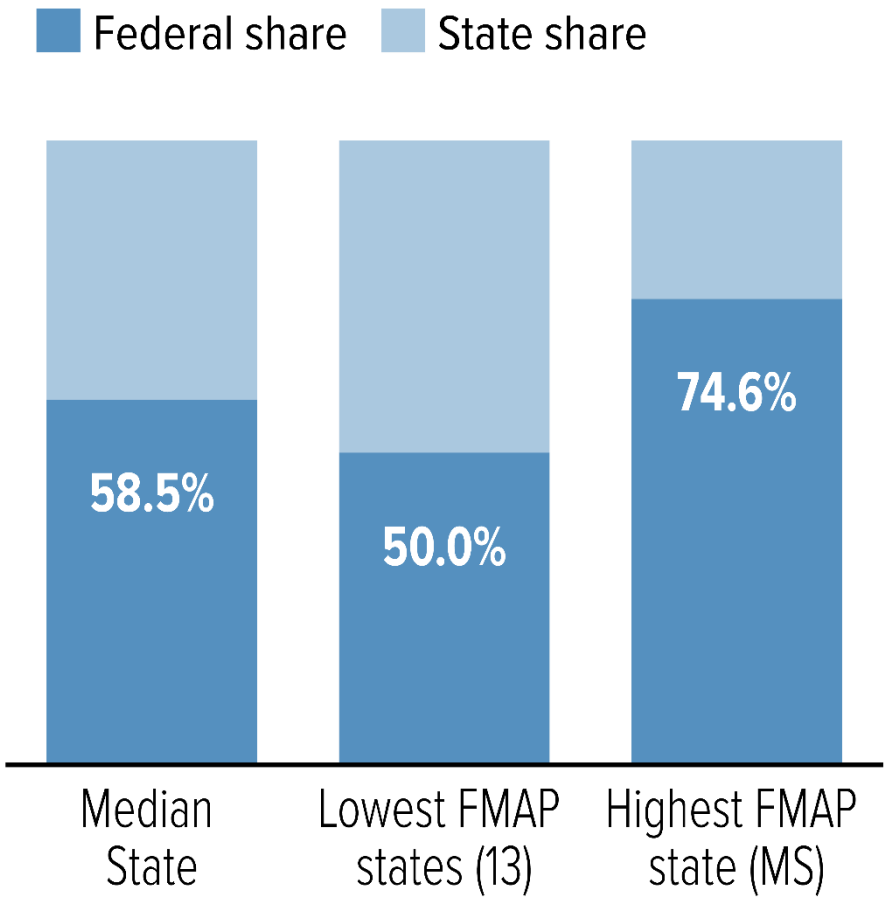
Federal Government Pays the Majority of Medicaid Costs

- Federal government pays state-specific share of total Medicaid costs (FMAP).
- FMAP higher for poorer states, lower for wealthier states.
- 50% minimum and 83% maximum.
- Some Medicaid costs not matched at standard FMAP.
- Mandatory entitlement funding.



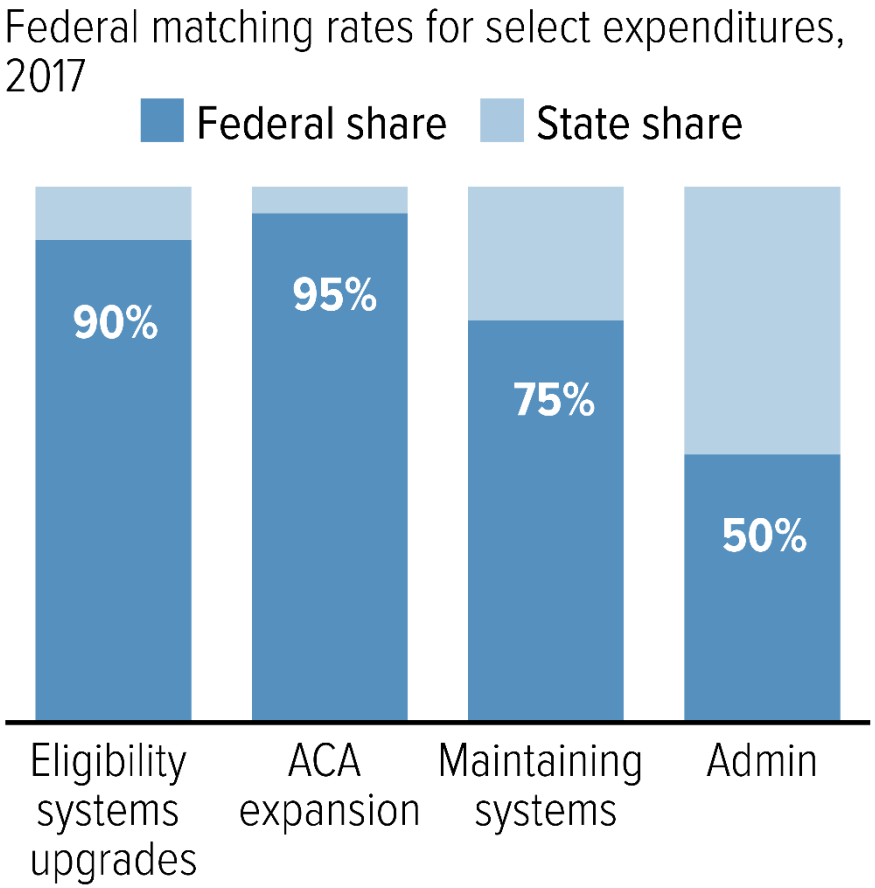
Source: CMS, 2017

Calculating a State's FMAP

- **Federal Medicaid Assistance Percentage (FMAP) =** 100 percent – state percentage
- **State percentage =** 45 percent * (state per capita income^2/ national per capita income^2)
  - Capped at min. of 50% and max. of 83%
  - Per capita income based on three year rolling average.
- **Results.** A state with per capita income at the national average will have an FMAP of 55 percent; poorer states have a higher FMAP and wealthier states a lower FMAP.
- **Why per capita income?** Considered a measure both of state financing capacity and state need.

Some Medicaid Expenditures are Not Matched at State-Specific FMAP Rates

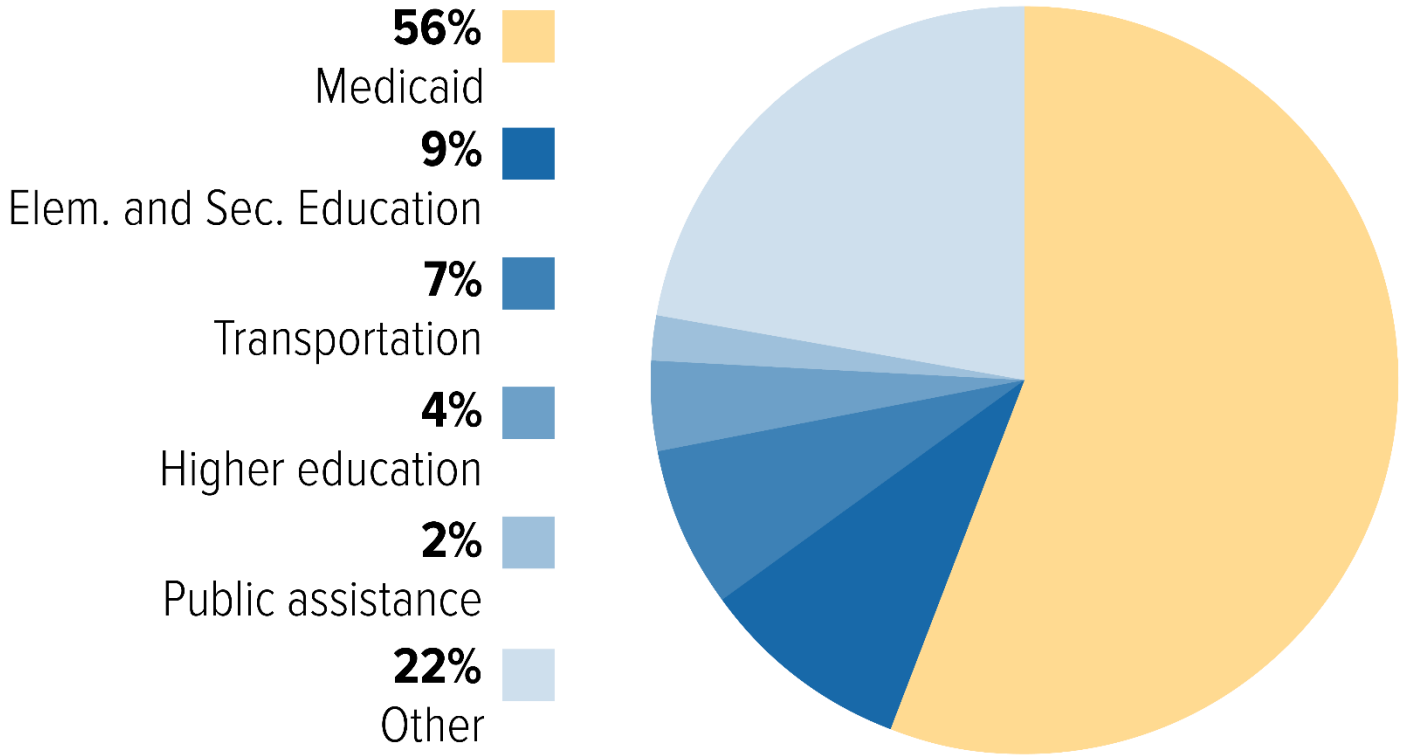
- Certain Medicaid expenditures are not matched by the federal government at a state's regular FMAP rate.
- Can be mix of ongoing activities, or new actions that the federal government is encouraging.



Source: ASPE, 2017

Medicaid is the Primary Source of Federal Funds to States

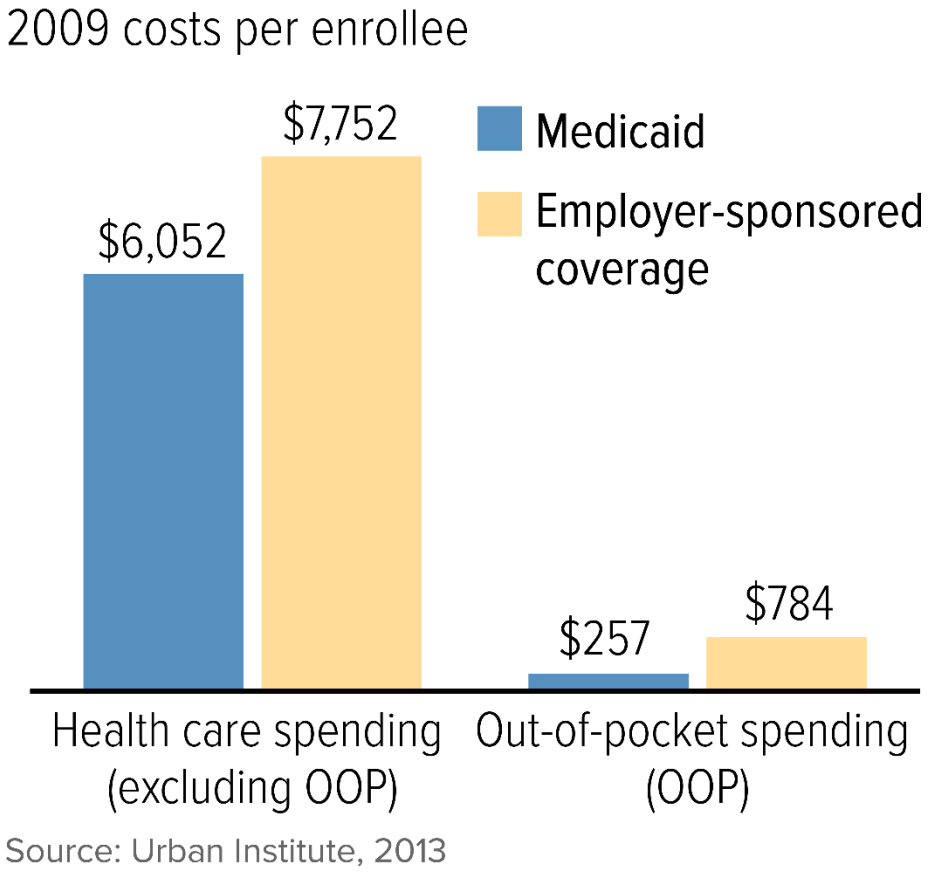
Share of total federal funds to state budgets, 2015



Source: NASBO, 2015.

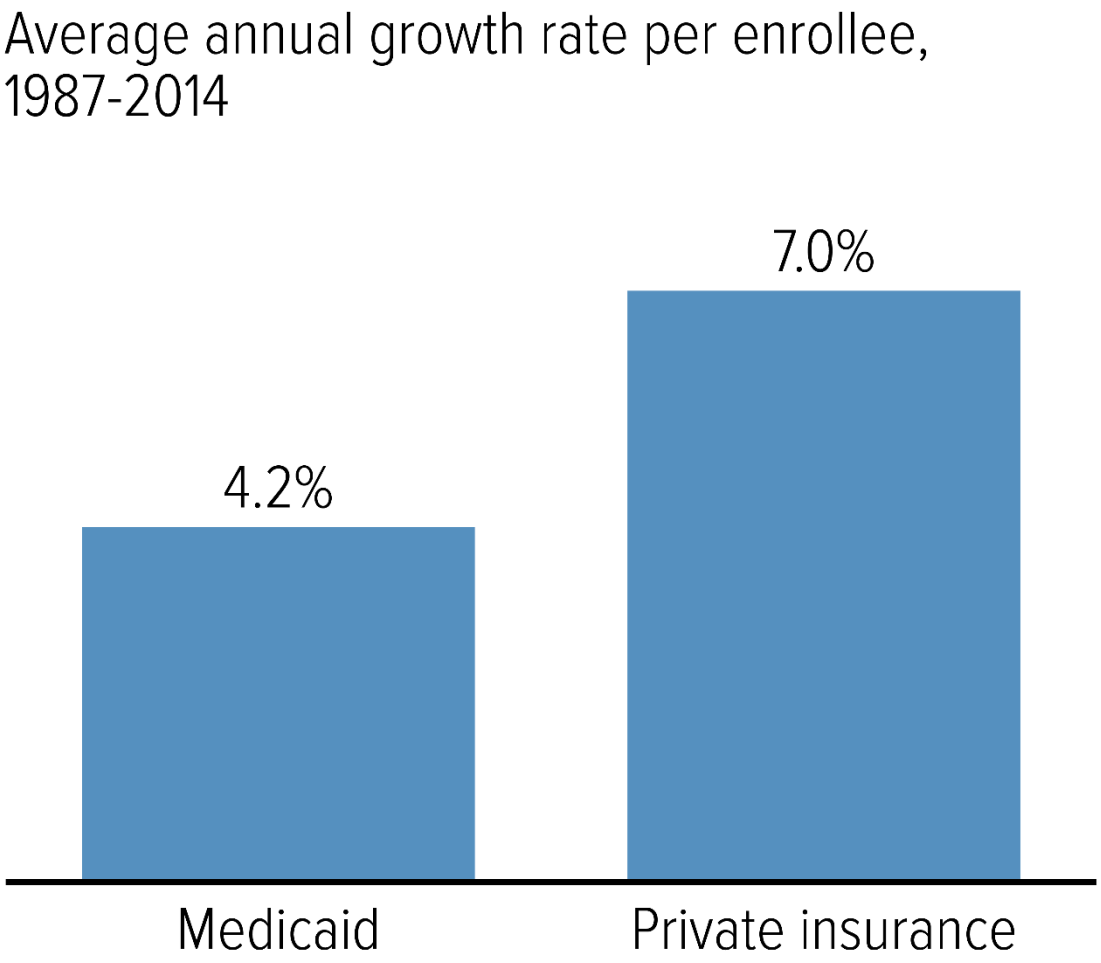
Medicaid Is Efficient

- Urban Institute modeled if Medicaid enrollees instead enrolled in ESI.
- Spending $1,700 higher (28 percent) in ESI.
- Beneficiary out-of-pocket spending more than three times higher in ESI.



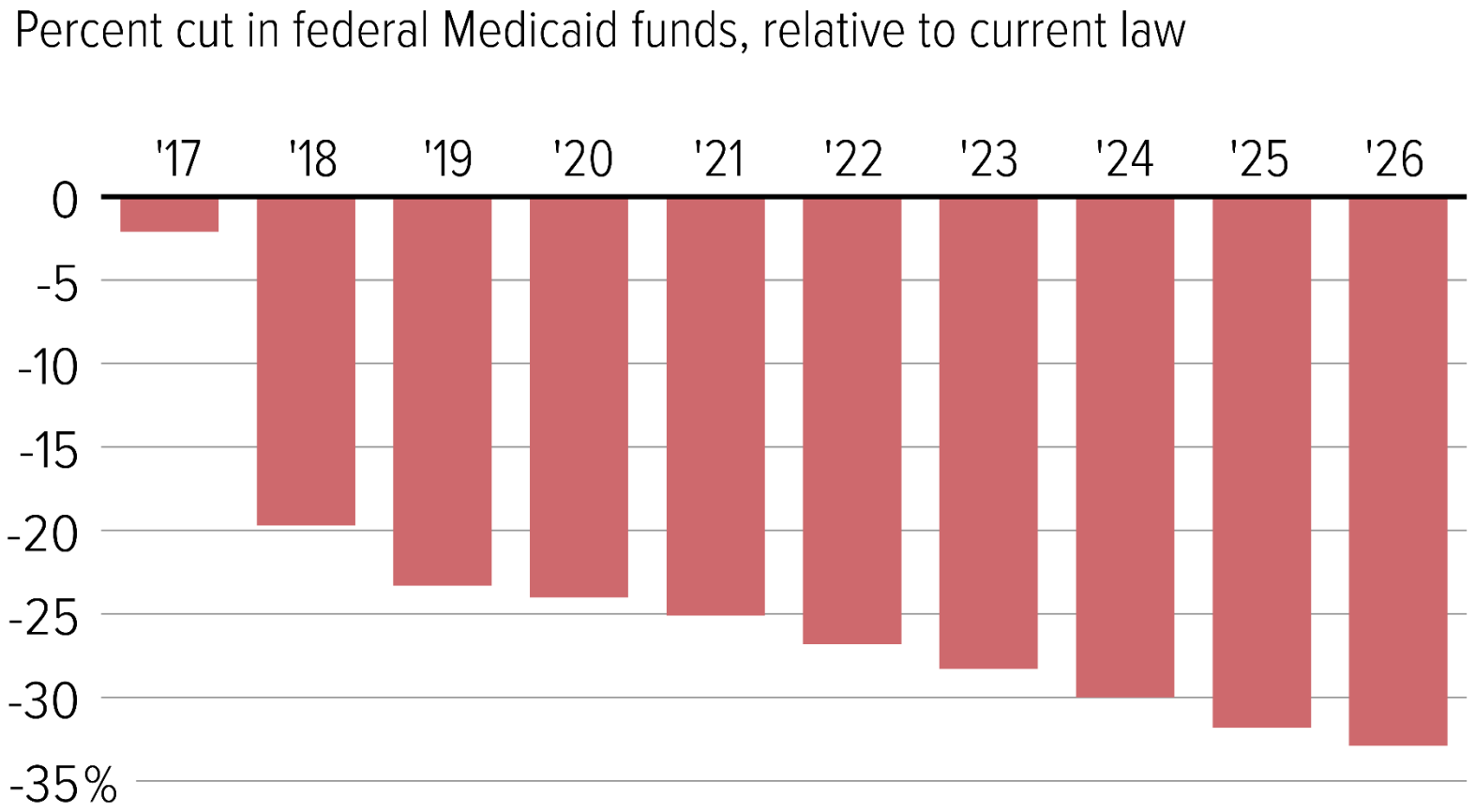
Source: Urban Institute, 2013

Medicaid Per-Beneficiary Costs Grow Slowly



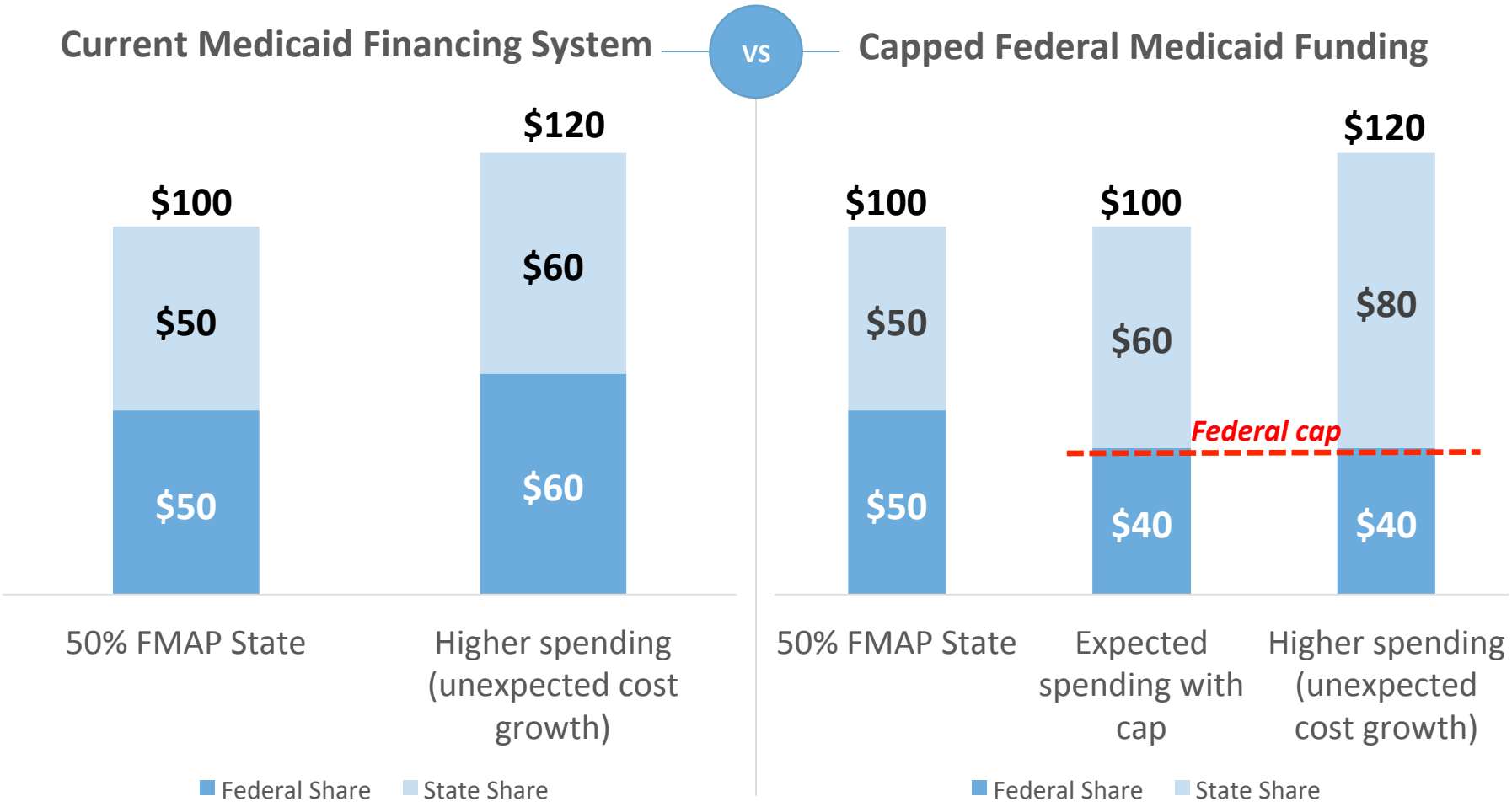
Source: Centers for Medicare & Medicaid Services, National Health Expenditure Tables, December 2015, Table 21

Medicaid Cuts Would Grow Over Time Under House Budget Plan Block Grant/Cap



Source: CBPP analysis using Jan. 2016 Congressional Budget Office Medicaid baseline and House Budget Committee documents.

Medicaid Block Grants and Per Capita Caps: Shift Costs to States



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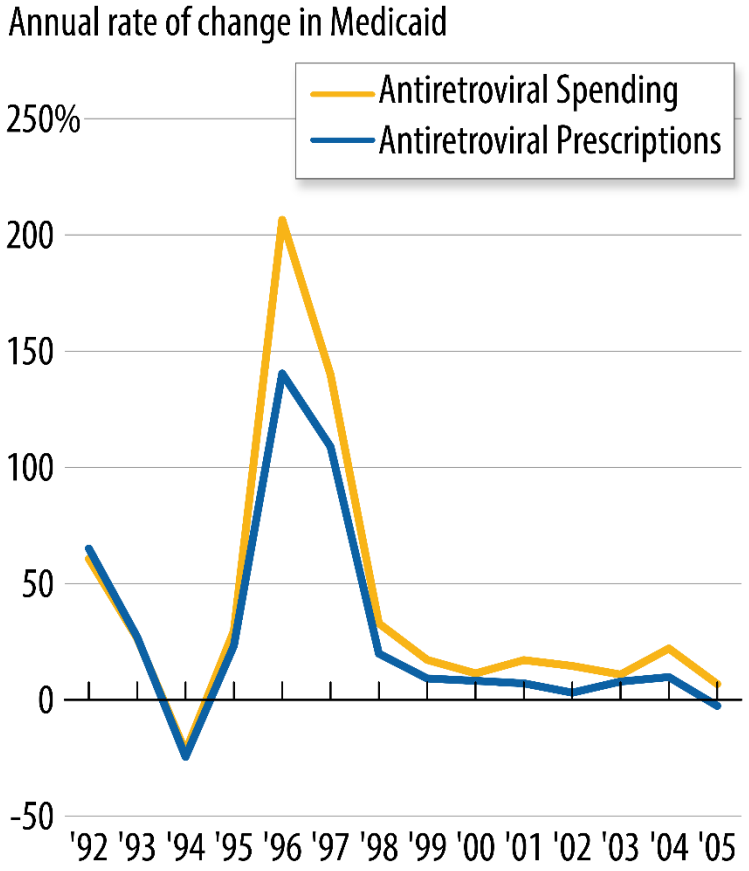
Medicaid Anti-Retroviral Drug Spending and Use More Than Doubled in 1996

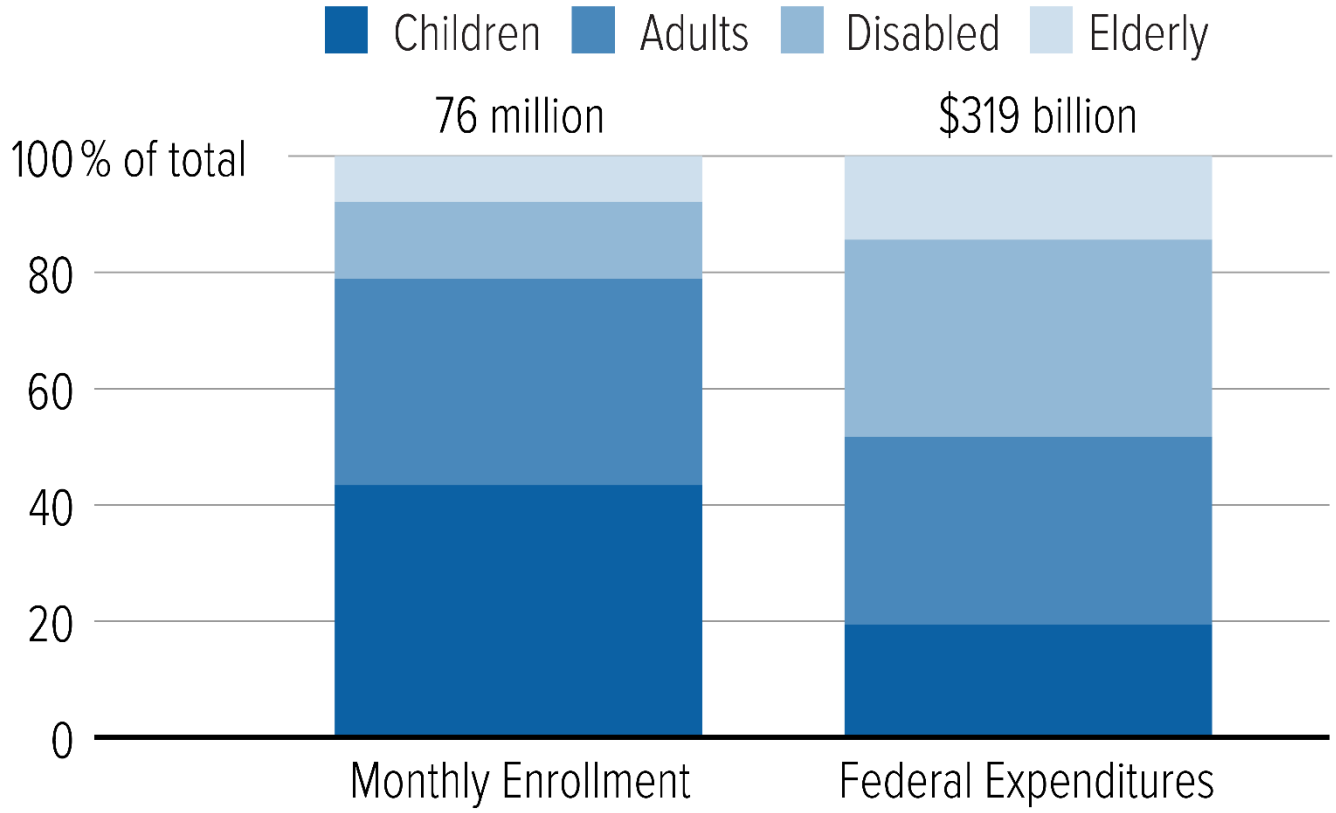
- The onset of the HIV/ AIDS epidemic in the 1980s and early 1990s led to unexpected Medicaid costs.
- Anti-retroviral prescriptions increased from 170,000 to 3 million from 1991 to 2005.
- Anti-retroviral prescription spending increased from $31 million to $1.6 billion.



Source: Yonghua Jing, et.al, Utilization and spending trends for antiretroviral medications in the US Medicaid program from 1991 to 2005, AIDS Research and Therapy, October 2007.

Distribution of Medicaid Spending Means No Groups Can Be Protected

- About 20 percent of Medicaid enrollment is among seniors and people with disabilities.
- But they account for 50 percent of federal spending.



Source: Congressional Budget Office.

New Flexibility: Flexibility to Cut

- **Individual entitlement**
- **Eligibility**
- **Benefits**
- **Work requirements**
- **Premiums and cost-sharing**

CHIP Financing Differs from Medicaid

- **Block grant, not full federal-state partnership.** Federal CHIP funding is limited to annual appropriated levels. If there is no specific appropriation, there is no CHIP funding.
- **States receive annual allocations.** A formula determines distribution of annual federal CHIP funding among states.
- **Annual increases.** Based on population growth and health care inflation.
- **Periodic rebasing.** States' annual allotments are rebased every two years to account for state-specific program financing changes.
- **Federal funding shortfalls are possible.** States' CHIP financing needs may exceed available federal funds with states having to finance entire excess.

Federal Matching Payments in CHIP (EMAP)

- **Enhanced matching assistance percentage (EMAP).** CHIP spending is matched with federal dollars at an enhanced rate, up to the state's allotted federal dollars.

- **EMAP =** State's FMAP + 0.3 * (100 percent – state's FMAP)

  - Reduces state's share of total CHIP costs by 30 percent as compared to state's share in Medicaid.

- **ACA EMAP increase.** Beginning in FFY2016, states' EMAPs are increased by 23 percentage points. This increase is in place through end of FFY2019.

CHIP Allotment Distribution and Rebasing

- **Annual national budget authority.** Determined by legislation. $20.4 billion in FFY2017.
- **Annual allotments to states.** Based on a combination of state-level historical spending and child population growth, and national-level health care spending growth.
  - **In even-numbered years:** a state's allotment is determined as the previous year's *allotment* increased by child population growth in the state and national health care cost inflation.
  - **In odd-numbered years:** a state's allotment is rebased on its previous year *spending* increased by population and cost.

CHIP Not a Typical Block Grant

- **Adequate initial funding levels.** The program's original ten-year authorization more than met states' projected need.
- **Redistribution.** Unused funds from low-spending states are redistributed to states in need of additional funds.
- **Shortfall funding.** Congress stepped in multiple times to provide additional targeted funds allowing states to operate their CHIP programs as if they weren't capped.
- **Funding extension permits growth.** CHIP's later funding extensions included increases to accommodate health care cost inflation, population growth, and program growth.
- **Contingency fund.** Dedicated fund to prevent enrollment-related shortfalls.

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