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.

![Bar chart showing federal matching rates for select expenditures, 2017](chart)

- Eligibility systems upgrades: 90%
- ACA expansion: 95%
- Maintaining systems: 75%
- Admin: 50%

Source: ASPE, 2017
Medicaid is the Primary Source of Federal Funds to States

Share of total federal funds to state budgets, 2015

56% Medicaid
9% Elem. and Sec. Education
7% Transportation
4% Higher education
2% Public assistance
22% Other

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.

2009 costs per enrollee

<table>
<thead>
<tr>
<th>Health care spending (excluding OOP)</th>
<th>Source: Urban Institute, 2013</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$6,052</td>
</tr>
<tr>
<td>Employer-sponsored coverage</td>
<td>$7,752</td>
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</tbody>
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<th>Out-of-pocket spending (OOP)</th>
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<td>Employer-sponsored coverage</td>
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</tbody>
</table>
Medicaid Per-Beneficiary Costs Grow Slowly

Average annual growth rate per enrollee, 1987-2014

- Medicaid: 4.2%
- Private insurance: 7.0%

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

Percent cut in federal Medicaid funds, relative to current law

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

## Current Medicaid Financing System vs Capped Federal Medicaid Funding

<table>
<thead>
<tr>
<th></th>
<th>Federal Share</th>
<th>State Share</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>50% FMAP State</strong></td>
<td>$100</td>
<td>$50</td>
</tr>
<tr>
<td><strong>Higher spending (unexpected cost growth)</strong></td>
<td>$60</td>
<td>$40</td>
</tr>
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- Federal Share
- State Share
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.

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.

  \[\text{EMAP} = \text{State’s FMAP} + 0.3 \times (100 \text{ percent} - \text{state’s FMAP})\]

  • 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.