

RESEARCH SUMMARY

The Medicaid FMAP under the ACA *Disparate Treatment of Eligible Populations Warrants Scrutiny*

Congress is currently pursuing Medicaid reform as part of the American Health Care Act. Since the beginning of the Medicaid program, the level of federal reimbursement, also known as the Federal Medical Assistance Program (FMAP), has remained relatively stable. However, the Affordable Care Act (ACA) changed this level, requiring the government to reimburse over 90 percent of the medical costs for nondisabled, nonpregnant, low-income adults. This requirement has led to an increase in FMAP for states that have expanded their Medicaid coverage. Among the more contentious issues currently before Congress is whether the FMAP for the expanded population should be reduced and how quickly such a reduction should be phased in.

Most people agree that Medicaid should help the poor, particularly those whose poverty is related to their age and disability. In states that expanded Medicaid, however, the ACA requires the federal government to pay a much greater share of the medical bills for nondisabled, nonpregnant adults than it does for elderly individuals, people with disabilities, children, and pregnant women. In [“The Medicaid FMAP under the ACA: Disparate Treatment of Eligible Populations Warrants Scrutiny,”](#) Galen Institute Senior Fellow Doug Badger argues that Congress should reexamine this arrangement as it considers legislation to repeal and replace the ACA.

FMAP AND THE ACA’S CHANGES

Before the ACA, the formula for calculating the FMAP was based on a state’s per capita income relative to the national average. The ACA capped the FMAP at 83 percent and set a floor at 50 percent.

- What does this mean? Consider New York, which has an FMAP of 50 percent. For every net dollar it spends on Medicaid, it receives \$1 from the federal government. This may at first seem counterintuitive. But suppose New York spent \$1 on Medicaid. It would receive a reimbursement of 50 cents in federal funding, reducing its net expenditure to 50 cents. An additional \$1 in state spending would generate an additional 50 cents in federal money.
- On the other hand, Mississippi has the highest FMAP of any state—74.63 percent. Every net state Medicaid expenditure of \$1 results in \$2.94 reimbursement from the federal government.

The ACA made several changes to federal reimbursement:

- Initially, every state was required to enroll in Medicaid nondisabled, nonpregnant adults with income up to 138 percent of the federal poverty level. But the Supreme Court found this requirement to be unconstitutional, calling it “economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.” The expansion was ultimately left to state decisions, with the FMAP scheme for expansion states still intact.

- The FMAP became significantly larger for the states that accepted expansion. From 2014 to 2016, federal reimbursement for the expansion population covered 100 percent of medical expenses. In 2017, when the FMAP dropped to 95 percent, an expansion state received \$19 for every \$1 it spent on services.
- People who do not fall into traditional eligibility categories qualify for Medicaid entirely based on their current income. This obliterates the distinction the program formerly made, no longer targeting only the poor who were especially vulnerable.
- Now the FMAP is no longer on a state's income; every state that applies the expansion will receive the same FMAP irrespective of the state's resources.

With the expansion, states where the average income of residents is lower qualify for the same FMAP as states with high average incomes. This means that the expansion benefits states with high per capita income at the expense of low-income states.

Some may argue that federal reimbursement for the expansion population is so great that it imposes little or no burden on state budgets. That argument overlooks a long-recognized Medicaid phenomenon known as the “welcome mat” effect.

- Expansions bring individuals out of the woodwork who were already eligible for Medicaid before the expansion.
- Thus, expanding the program leads to higher enrollment among categories of individuals for whom states cannot claim the higher FMAP.

CONCLUSION AND POLICY IMPLICATIONS

The FMAP formula remained relatively unchanged throughout the history of Medicaid, until Congress and the executive branch instituted changes that have created two significant problems:

- The federal government rewards states much more generously for providing services to those individuals who fit the new criteria than to individuals who arguably are more in need of assistance.
- The new FMAP formula overlooks differences among states in their capacity to fund services for this newly eligible population.

Congress should seek to devise a Medicaid financing structure that treats eligible populations equitably and recognizes the differences in fiscal capacity among states.