The Medicaid FMAP under the ACA

Disparate Treatment of Eligible Populations Warrants Scrutiny

Doug Badger

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Abstract

Until the enactment of the Affordable Care Act (ACA), the Federal Medical Assistance Percentage (FMAP) formula for federal Medicaid reimbursement had remained largely unchanged throughout the history of Medicaid. The ACA requires the federal government to finance 90–100 percent of the medical costs incurred by nondisabled, nonpregnant, low-income adults. But the ACA retains a significantly lower FMAP for previously eligible populations. As a result of that change, expansion states (states that expanded Medicaid eligibility after the ACA) receive an increased share of federal payments at the expense of nonexpansion states (those that did not). In fiscal year 2015, expansion states received 70.36 percent of all federal Medicaid reimbursement, an increase of 4.9 percentage points (7.5 percent) over fiscal year 2013. This $16.45 billion in additional federal Medicaid reimbursement was financed in part by the transfer of $8.01 billion from nonexpansion states. As lawmakers confront issues surrounding Medicaid expansion, they should examine the current financing structure and consider proposals that treat eligible populations and states more equitably.

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Introduction

The Affordable Care Act (ACA) has resulted in a substantial increase in the number of people with public and private health coverage. The National Health Interview Survey reported that only 10.3 percent of the nonelderly adult population in the United States lacked health insurance coverage in September 2016, compared with 16.6 percent in December 2013, the month before the ACA was fully implemented.[1]

Some studies of these coverage gains have attributed them largely to the law's Medicaid expansion.[2] The ACA expanded Medicaid eligibility to nondisabled, nonpregnant adults with incomes below 138 percent of the federal poverty level (FPL).[3] Although some states had covered some of this population through waivers before January 2014, this expansion fundamentally changed Medicaid from a program that established eligibility only for poor people who fell into certain categories (low-income children, pregnant women, people with disabilities, and frail elderly people) to one that established eligibility for people solely on the basis of income.

For this new population, the ACA provided an elevated level of federal reimbursement, known as the Federal Medical Assistance Percentage (FMAP), which is substantially higher than for people in traditional eligibility categories. And it provided this same higher FMAP to all states for the expansion population, rather than extending more generous matching funds to

[1] Michael E. Martinez, Emily P. Zammitti, and Robin A. Cohen, *Health Insurance Coverage: Early Release of Estimates from the National Health Interview Survey, January–September 2016* (Atlanta, GA: National Center for Health Statistics, February 2017), table 1.
[2] Edmund F. Haislmaier, "The Real Changes in Health Insurance Enrollment under the Affordable Care Act" (Testimony before the House Committee on the Budget, January 24, 2017).
[3] Section 1902(a)(10)(A)(i)(VIII) of the Social Security Act, 42 U.S.C. §.1396a(a)(10)(A)(i)(VIII).

states with below-average per capita incomes, a departure from the federal reimbursement policy that the government had practiced for more than half a century.

This paper will examine the history of the Medicaid FMAP and recommend that policymakers consider instituting a Medicaid financing structure that treats eligible populations more equitably and properly accounts for differences in fiscal capacity among states.

Background

Medicaid is a program of medical assistance funded jointly by the states and the federal government. Originally confined to certain categories of individuals with limited incomes and assets, Medicaid has grown to become a major source of health coverage. More than one in four Americans—81 million people—were enrolled in Medicaid at some point during 2015.[4] Total program costs rose to $526 billion in that year, of which $331 billion was paid by the federal government.[5] Medicaid accounted for 9.5 percent of federal spending.[6] Spending on the program consumed 15.3 percent of state budgets, making it the second-largest expenditure after elementary and secondary education.[7]

The ACA is responsible for a recent surge in the number of Medicaid beneficiaries. Average monthly enrollment in Medicaid and the related Children's Health Insurance Program (CHIP) grew by 30 percent between the fourth quarter of fiscal year (FY) 2013 and December

[4] Medicaid and CHIP Payment and Access Commission [MACPAC], *MACStats: Medicaid and CHIP Data Book* (Washington, DC: MACPAC, December 2016), 3, exhibit 1. Average monthly enrollment in 2015 was 67.3 million, or nearly 21 percent of the population.
[5] MACPAC, *MACStats*, 45–46, exhibit 16.
[6] MACPAC, *MACStats*, 13, exhibit 4.
[7] MACPAC, *MACStats*, 14, exhibit 5. Two states—Ohio and Rhode Island—spent more on Medicaid in 2015 than on elementary and secondary education. Ohio's Medicaid spending consumed 32.4 percent of its budget, by far the greatest share among states.

2016.[8] Beginning in 2014, states could take advantage of very high federal matching rates if they expanded their programs to cover nondisabled, nonpregnant adults with incomes up to 138 percent of FPL. As of June 2017, 31 states and the District of Columbia had implemented this expansion.

The expansion, as previously noted, marks a substantial change from long-standing Medicaid policy. Congressional Republicans and the Trump administration have pledged to repeal and replace the ACA. The Medicaid expansion is at the heart of that policy debate. Policymakers are considering a range of options, including repealing the expansion outright or continuing it at a lower federal matching rate.[9]

This paper traces the history of the FMAP, including exceptions and temporary changes Congress has made to it during the program's history. It then analyzes the changes to the FMAP made by the ACA and offers policy considerations for lawmakers as they consider whether to reverse or modify these changes. In particular, lawmakers should consider the policy objectives behind establishing a more generous FMAP for a particular population, whether such disparities in federal reimbursement among eligible populations are equitable, and whether these policies favor states with high per capita incomes to the disadvantage of states with low per capita incomes.

Federal Medical Assistance Percentage (FMAP)

The formula for calculating FMAP has remained largely unchanged since 1965. FMAP has generally not varied by eligibility category. The federal government pays the same percentage of

[8] The Henry J. Kaiser Family Foundation [KFF], "Total Monthly Medicaid and CHIP Enrollment—Timeframe: December 2016," accessed April 18, 2017.
[9] In March 2017, the House Budget Committee favorably reported H. R. 1628, which would have continued the Medicaid expansion but would have reimbursed states at the standard FMAP for services provided to nondisabled, nonpregnant adults who enroll after December 31, 2019.

medical costs in a given state, whether those costs are incurred by an elderly nursing home resident or by a healthy child.[10]

The FMAP formula is based on a state's per capita income relative to the national average.[11] The federal government provides a higher FMAP to states with low per capita incomes. The Medicaid statute caps the federal share of medical costs at 83 percent and sets a floor at 50 percent. No state qualifies for an FMAP in excess of the cap. In 2017, Mississippi has the highest FMAP (74.63 percent).[12] Thirteen states are protected by the floor, receiving a 50 percent match for medical services.[13]

Medicaid is administered by the states. The federal government helps pay for its administration. The federal share of administrative costs is generally set at 50 percent for every state.

One way of thinking about the variation in FMAP among states is in terms of leverage: How much in federal reimbursement does a net dollar of state Medicaid spending generate? The Henry J. Kaiser Family Foundation refers to these state leverage ratios as *multipliers*.[14] These multipliers vary according to state FMAP.

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[10] The federal government does offer an enhanced FMAP under CHIP. But CHIP is a block grant program, rather than an open-ended entitlement, and is separate from (albeit closely related to) Medicaid.

[11] The computation of the state FMAP begins with the following formula: *State FMAP* = 1 – ((*State per capita income*)^2 / (*US per capita income*)^2 × 0.45). The last factor (0.45) sets the FMAP for a state with average per capita income at 55 percent. Although it provides for higher reimbursements to states with lower-than-average per capita incomes, it protects states with above-average per capita incomes by not allowing the FMAP to fall below 50 percent. Without the floor, FMAP would fall below 50 percent in any state whose per capita income is 5.5 percent or more above the national average. If that formula produces a number that is less than 0.5, then the state's FMAP is set at 50 percent. The FMAP is capped at 83 percent. Although 13 states benefit from the floor, no state's FMAP exceeds the ceiling. Data on per capita incomes are from the Commerce Department's Bureau of Economic Analysis (BEA). The Department of Health and Human Services (HHS) uses a three-year rolling average to minimize fluctuations. The 2017 FMAP is based on BEA data for 2012–2014.

[12] MACPAC, *MACStats*, 17, exhibit 6.

[13] These "floor" states are Alaska, California, Connecticut, Maryland, Massachusetts, Minnesota, New Hampshire, New Jersey, New York, North Dakota, Virginia, Washington, and Wyoming. The District of Columbia also would get a 50 percent FMAP under the formula, but by law it has an FMAP of 70 percent. MACPAC, *MACStats*, 17–18, exhibit 6.

[14] KFF, "Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier," accessed June 9, 2017.

Consider New York, which has an FMAP of 50 percent. For every net dollar the state spends on Medicaid, it receives $1 from the federal government.[15] It thus has a multiplier of 1.00. This multiplier amount may at first seem counterintuitive. But suppose New York spent a dollar on Medicaid. It would receive a reimbursement of 50 cents in federal money, reducing its net expenditure to 50 cents. An additional $1 in state spending would generate an additional federal reimbursement of 50 cents. In this example, the state will have spent, on net, $1 and received $1 from the federal government, resulting in $2 of additional medical spending. Hence, New York's multiplier is 1.00.

At the other end of the spectrum is Mississippi, with an FMAP of 74.63 percent. Every net state Medicaid expenditure of $1 results in $2.94 reimbursement from the federal government.[16] Figure 1 illustrates the difference in multipliers between Mississippi and the 13 states, including New York, with a 50 percent FMAP.

Mississippi's multiplier is the highest among states because its per capita income is the lowest. The FMAP formula serves as a proxy for a state's financial wherewithal to finance medical care for its poorest citizens. It presumes that states with higher per capita incomes will have larger bases from which to draw public resources and fewer people to assist. Poorer states, by contrast, have fewer resources and are likely to have a larger percentage of people who qualify for assistance. In such states, the formula requires the federal government to assume a greater share of the financial burden.

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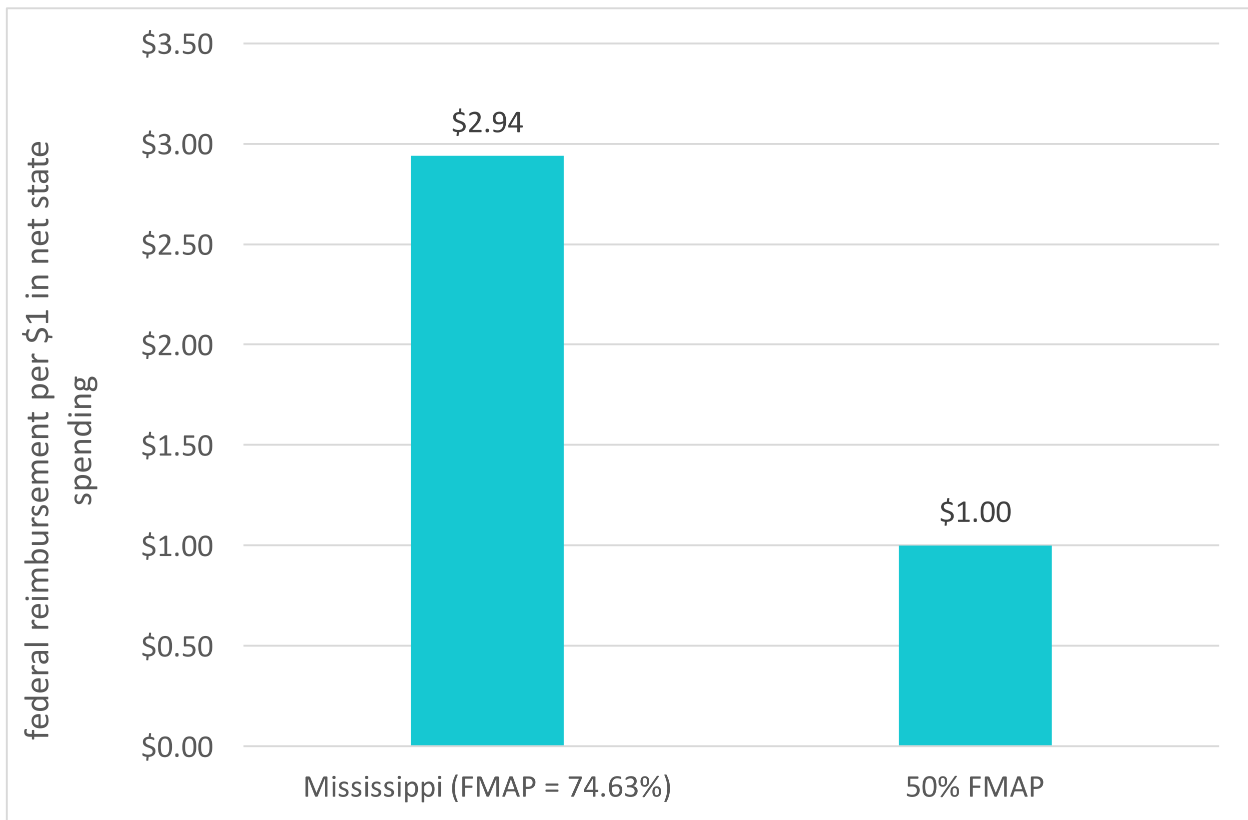
[15] The formula for computing the multiplier is *FMAP* / (1 – *FMAP*).
[16] 0.7463 / (1 – 0.7463) = 2.94.

Figure 1. Range of FMAP Multipliers



Some have recommended that the formula be revised to better achieve this policy aim. The Government Accountability Office (GAO), for example, has argued that relying solely on differences in per capita income among states "does not adequately address the demand for services, geographic cost differences, and state resources" and has outlined criteria for devising an FMAP formula that would account for a variety of factors that more accurately reflect the capacity of states to cover medical expenses incurred by low-income people.[17] GAO has recommended that Congress revise the formula to reflect state differences in demand for services

[17] US Government Accountability Office [GAO], *Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably* (GAO-13-434, Government Accountability Office, Washington, DC, May 2013), 4.

among low-income people, geographic cost differences, and state resources, replacing average per capita income with total taxable resources as a key measure.

Exceptions to FMAP

Congress has nevertheless left the FMAP formula unchanged for more than half a century, although it has from time to time made certain exceptions to the formula. Some of those exceptions relate to specific services. Others distinguish among different categories of costs that states incur in administering the program. Congress also has temporarily revised FMAP in response to changing economic conditions. Finally, in the most significant departure from Medicaid's allocation of burden-sharing between the federal government and the states, the ACA assigned the federal government an unprecedented share of the medical costs incurred by low-income, nondisabled, nonpregnant adults.

Table 1 provides an overview of these exceptions. This paper will discuss each category of exceptions at greater length.

Table 1. Exceptions to FMAP

Exception	Explanation
Services	Congress has adjusted the FMAP formula to provide higher matching rates for certain medical services.
Administrative costs	Although administrative costs are generally matched at a 50 percent rate, Congress has provided more generous reimbursement for certain services.
Temporary changes	Congress has occasionally adjusted the FMAP on a temporary basis to respond to economic downturns and natural disasters.
ACA changes	The ACA made the most consequential adjustments to FMAP, including establishing an FMAP of 90–100 percent for services provided to nondisabled, nonpregnant, low-income adults.

Certain Services Matched at Higher Rates

Over the years, Congress has singled out particular services for a higher matching rate. The longest-standing exception is for family planning services. The FMAP for such services has stood at 90 percent since 1972.[18] Another long-standing exception applies to medical services provided at Indian Health Service facilities. The FMAP for such services is 100 percent.[19] Unlike similar FMAP rates established by the ACA, these adjustments pertain to particular categories of services or sites of care and do not provide preferential reimbursement rates for a particular eligibility group. Medicaid beneficiaries in multiple eligibility categories use family planning services, for example. And the decision to fully reimburse Indian Health Service centers for services they provide to Medicaid beneficiaries is intended as a supplementary revenue stream for these federally funded facilities.

The ACA increased the FMAP for several categories of services, including clinical preventive services,[20] smoking cessation for pregnant women,[21] and the cost of providing "health homes" to individuals with chronic conditions.[22] It also required the federal government to bear a greater share of the costs of providing attendant services to help people with disabilities remain in their homes.[23]

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[18] PL 92-603. See section 1903(a)(5) of the Social Security Act, 42 U.S.C. § 1396b(a)(5).
[19] PL 94-437. See section 1905(b) of the Social Security Act, 42 U.S.C. § 1396d(b).
[20] States receive FMAP + 1 (i.e., the state's FMAP, increased by one percentage point) for these services (section 1905(b) of the Social Security Act, 42 U.S.C. § 1396d(b)).
[21] States receive FMAP + 1 for these services (section 1905(b) of the Social Security Act, 42 U.S.C. § 1396d(b)).
[22] States that choose to establish such programs receive a 90 percent FMAP for the first eight quarters that the home health option is in effect (section 1945(c)(1) of the Social Security Act, 42 U.S.C. § 1396w-4(c)(1)).
[23] The services are available to people with disabilities with incomes up to 150 percent of FPL. Federal reimbursement is set at FMAP + 6 percentage points (section 1915(k) of the Social Security Act, 42 U.S.C. § 1396n(k)).

The federal government also helps to finance treatment of breast and cervical cancer for uninsured women who are ineligible for Medicaid. States that choose to pay these medical costs receive the same enhanced FMAP used in the CHIP program.[24]

Certain Administrative Activities Matched at Higher Rates

As previously noted, the federal government generally pays half the Medicaid administrative costs incurred by states. The ACA, however, makes several exceptions. The federal government pays 100 percent of the costs states incur in implementing and operating immigration status verification systems.[25]

The Medicaid statute also provides a 75 percent match of state administrative costs to train skilled medical personnel and their staffs,[26] control fraud,[27] perform preadmission screenings and resident review for nursing facility residents with mental illness,[28] survey and certify nursing homes,[29] provide translation and interpretation services,[30] and perform utilization review and external review of Medicaid managed-care organizations.[31]

The secretary of Health and Human Services (HHS) by regulation also required the federal government to provide a 90 percent match for state spending on the "design, development and installation or enhancement of eligibility determination systems" required by

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[24] PL 106-354, as amended by PL 107-121 (section 1905(b) of the Social Security Act, 42 U.S.C. § 1396d(b)). The CHIP FMAP ranges from a minimum of 65 percent to a maximum of 89 percent. For fiscal years 2016–2019, it is increased to a range of 88–100 percent. The program's authorization is due to expire September 30, 2017, but its extension is highly probable.

[25] Section 1903(a)(6) of the Social Security Act, 42 U.S.C. § 1396b(a)(6).

[26] Sections 1903(a)(2)(A) and (B) of the Social Security Act, 42 U.S.C. § 1396b(a)(2)(A), (B).

[27] Section 1903(a)(6) of the Social Security Act, 42 U.S.C. § 1396b(a)(6).

[28] Section 1903(a)(2)(C) of the Social Security Act, 42 U.S.C. § 1396b(a)(2)(C).

[29] Section 1903(a)(2)(D) of the Social Security Act, 42 U.S.C. § 1396b(a)(2)(D).

[30] Section 1903(a)(3)(A) of the Social Security Act, 42 U.S.C. § 1396b(a)(3)(A). See also Letter from Cindy Mann, Director of the Centers for Medicare and Medicaid Services, to State Medicaid Director and State Health Official, SHO # 10-007, CHIPRA # 18, July 1, 2010.

[31] Section 1903(a)(3)(C) of the Social Security Act, 42 U.S.C. § 1396b(a)(3)(C).

the ACA.[32] The 90 percent match was originally applicable only to expenses incurred between April 2011 and December 2015. The secretary subsequently amended the rule to make the 90 percent match rate permanent.[33]

Temporary Changes to FMAP

Congress has from time to time adjusted the FMAP for fiscal or economic reasons, as well as to help communities recover from natural disasters. The earliest adjustment occurred in 1981, when Congress enacted the Omnibus Budget Reconciliation Act.[34] Although this act did not technically change the FMAP, it did reduce federal Medicaid spending by applying an across-the-board reduction in federal payments to states for FY 1982–1984. States could recover a portion of the withheld federal funds if they established federally approved hospital cost review programs or if their fraud and review recoveries exceeded a certain threshold. The cuts could also be reduced if the state's unemployment rate was at least 50 percent higher than the national average.

That last exception to the federal Medicaid cuts was the first instance in which the FMAP would be used in response to economic conditions. It would not be the last. With the recession of 2001, Congress for the first time used the FMAP as a stimulus measure.[35] The notion was that the FMAP provided a ready and efficient conduit for transferring vast sums of federal money to

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[32] The secretary authorized these expenditures through waiver authority under section 1102 of the Social Security Act, 42 U.S.C. § 1302. The regulation also cited sections 1903(a)(3)(A) and (B) of the act (42 U.S.C. § 1396b(a)(3)(A), (B)). The regulation was finalized April 19, 2011 (76 Fed. Reg. 21,950), and it is codified at 42 C.F.R. 433.112.

[33] 80 Fed. Reg. 75,842, December 4, 2015.

[34] Pub. L. 97-35 § 2161, 95 Stat. 803-05 (1981).

[35] GAO has recently questioned the value of such FMAP increases, arguing that the "FMAP formula does not reflect current state economic conditions, and that past efforts to provide states with temporary increases in the FMAP were not as timely or responsive as they could have been." The GAO testimony proposes that future FMAP boosts be based on increases in state unemployment and reductions in total wages and salaries. Carolyn L. Yocom, "Medicaid: Changes to Funding Formula Could Improve Allocation of Funds to States" (Testimony before the House Energy and Commerce Subcommittee on Health, GAO-16-377T, Government Accountability Office, Washington, DC, February 10, 2016).

the states, allowing them to divert money to non-Medicaid programs without reducing overall healthcare spending.[36] The 2001 law temporarily increased the FMAP for each state by 2.95 percentage points.[37] The FMAP increase was applied to the last two quarters of FY 2003 and the first three quarters of FY 2004. In all, states received an estimated $10 billion more in federal reimbursement than they would have under the standard FMAP.

Less than a decade later, Congress provided a much larger FMAP boost over a longer period of time in response to the Great Recession. The American Recovery and Reinvestment Act (ARRA) increased the FMAP by 6.2 percentage points for the period between the first quarter of FY 2009 and the first quarter of FY 2011.[38] The provision is estimated to have given states $84 billion in additional federal funds over that period. Congress subsequently expended an additional $16 billion by increasing the FMAP by lesser amounts for an additional six months.[39]

Congress also sought to adjust the FMAP rates for states that temporarily domiciled Hurricane Katrina evacuees.[40] The provision, known somewhat misleadingly as a "hold harmless for Katrina impact," established a rather complex methodology for adjusting the FMAP of affected states. Although the bill was enacted early in 2006, HHS didn't finalize regulations until the summer of 2007.[41] The provision ultimately affected the FMAP for only one state (Texas) and for only one year (FY 2008).[42]

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[36] See, for example, Kaiser Commission on Medicaid and the Uninsured, "State Fiscal Conditions and Medicaid," January 2009.
[37] Pub. L. 108-27 § 401(a) (2003).
[38] Pub. L. 111-5 § 5001 (2009).
[39] Pub. L. 111-226 § 201 (2010).
[40] Pub. L. 109-171 § 6053(b) (2006).
[41] 72 Fed. Reg. 44,146 (August 7, 2007).
[42] Alison Mitchell, "Medicaid's Federal Medical Assistance Percentage (FMAP)," Congressional Research Service, February 9, 2016.

Political Changes to FMAP

Senate passage of the ACA was a politically difficult undertaking. Efforts to attract Republican support for the measure faltered. The Senate parliamentarian ruled that the bill could not be considered under budget reconciliation rules that would have exempted it from filibuster and allowed the majority party to pass it on a simple majority vote. As a result, the measure required the support of all 60 Democratic senators to overcome procedural obstacles and gain enactment.

Senator Mary Landrieu (D-LA) had numerous concerns about the overall bill. To obtain her support, the Senate crafted convoluted language that had the effect of providing a higher FMAP to Louisiana.[43] Section 2006 of the bill provided "a special adjustment to FMAP determination for certain states recovering from a major disaster." Louisiana—and only Louisiana—qualified for that assistance, which was predicated on damage from Hurricane Katrina, which had devastated the region more than four years earlier. The temporary increase to FMAP for all states that had been added by ARRA was scheduled to expire after the first quarter of 2011. This expiration resulted in a fairly steep drop in FMAP that was scheduled to take effect on January 1, 2011. Section 2006 softened the blow for Louisiana by creating a special FMAP for that state. Unlike all other states, Louisiana's special formula created a blend of the expired rate established by ARRA and its regular FMAP rate. The resulting increases to Louisiana's FMAP are shown in table 2.

[43] The provision created new section 1905(aa) of the Social Security Act, which provided a higher FMAP to any state that (1) had been declared a disaster area by the president during one of the preceding seven years and (2) had incurred a downward FMAP adjustment of more than 3 percent. 42 U.S.C. § 1396d(aa). Louisiana was the only state that qualified for the adjustment. The state received it from FY 2011 (the first year it was available) through FY 2014, but no payments have been made to Louisiana or any other state since FY 2014.

Table 2. Special FMAP for Louisiana, FY 2011–2014

Fiscal year	Regular FMAP	Adjusted FMAP
2011	63.61	68.04
2012	61.09	69.78
2013	61.24	65.51
2014	60.98	62.11

The "Louisiana Purchase," as it became known to its critics, was limited to a single state and gained enactment. A second political provision, derided as the "Cornhusker Kickback," had a less auspicious outcome. Reportedly added at the urging of then senator Ben Nelson (D-NE), it would have paid all the costs of covering Nebraska's newly eligible Medicaid enrollees in perpetuity.[44] The bill would have reduced the FMAP to rates below 100 percent for all other states beginning in 2017. This proposal became highly controversial and, although enacted, was quickly repealed and therefore never took effect.[45]

Medicaid Expansion Population

The final version of the ACA, as modified by the reconciliation bill, required every state to enroll nondisabled, nonpregnant adults with incomes up to 138 percent of FPL, beginning in January 2014. Table 3 presents the FMAP rates for this new population.

[44] Letter from Douglas W. Elmendorf, CBO Director, to Rep. Paul Ryan (R-WI), January 21, 2010. For an example of press reports on Senator Nelson's involvement in adding the provision, see Jordan Fabian, "Obama Health Care Plan Nixes Ben Nelson's 'Cornhusker Kickback' Deal," *The Hill*, February 22, 2010.

[45] The provision was included in section 2001 of Pub. L. 111-148, which created a new subsection 1905(y) of the Social Security Act, 42 U.S.C. § 1396d(y). It provoked immediate controversy. President Obama voiced strong opposition, releasing a document that called on Congress to "eliminat[e] the Nebraska FMAP provision and provid[e] significant additional Federal financing to all States for the expansion of Medicaid." See "The President's Proposal," *The Hill*, February 22, 2010. Senator Nelson himself called for its removal from the measure. David M. Drucker, "Nelson Asks Reid to Drop Medicaid Deal for Nebraska," *Roll Call*, January 15, 2010.) A "budget reconciliation" bill, enacted shortly after the House adopted the Senate version of the ACA, stripped away the provision. Pub. L. 111-152 (2010).

Table 3. Medicaid Expansion FMAP

Calendar year	FMAP (%)
2014–2016	100
2017	95
2018	94
2019	93
2020 and thereafter	90

Note: See section 1905(y)(1) of the Social Security Act, 42 U.S.C. § 1396d(y)(1).

The requirement that states implement this expansion did not withstand Supreme Court scrutiny. Under the ACA, states that declined to make such expansion would be ineligible to receive Medicaid matching funds for any of their beneficiaries. The court held that this penalty amounted to an unconstitutional "economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion."[46]

The court consequently prohibited the secretary from penalizing states that declined to expand their programs, but it left untouched the FMAP scheme for expansion populations. States could decide whether to enlarge their programs. As of June 2017, 31 states and the District of Columbia had done so.

The expansion was groundbreaking for several reasons. Most notably, it transformed Medicaid by allowing people who did not fall into traditional eligibility categories to qualify for the program entirely on the basis of current income, irrespective of household assets.[47] Before 2014, Medicaid largely assisted those who fell into defined categories—elderly individuals,

[46] National Federation of Independent Business v. Sebelius, 567 U.S. 519 (2012).
[47] The ACA retained the asset test for SSI recipients, children in foster care, and elderly individuals. Austin Frakt, "Bye-Bye Medicaid Asset Test," *The Incidental Economist*, accessed April 25, 2017. In addition, 31 states and the District of Columbia provide Medicaid to "medically needy" individuals—those whose incomes, less medical expenses, are below their state Medicaid income thresholds. Individuals in this category also must meet the Medicaid asset test. MACPAC, "Medically Needy Program Thresholds as a Percent of FPL, 2016," accessed June 12, 2017.

people with disabilities, children and pregnant women, and the "medically needy"—whose income and assets were below specified levels. States generally had to obtain a waiver from the federal government to provide coverage to people outside those core populations.[48]

The program had long targeted medical assistance to people who were not only poor but also especially vulnerable. The expansion obliterated that distinction. It made any adult who reported income below 138 percent of FPL in any year eligible for Medicaid.[49] Additionally, the federal government gave preferential financial treatment to this new group of nondisabled, nonpregnant adults. This higher federal matching rate allows states to leverage more federal money per state dollar spent on a nondisabled adult with $15,000 in earnings than on a part-time minimum wage worker with developmental disabilities, who earns barely half that amount.

Table 4 illustrates the magnitude of this leverage in the 31 states and the District of Columbia that expanded their programs.

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[48] Before 2014, the District of Columbia, Hawaii, and Vermont had obtained waivers to provide full Medicaid benefits to childless, nondisabled adults with incomes of 133 percent of FPL. An additional 10 states (AR, CA, ID, IN, MA, NM, OR, UT, WA, and WI) provided less comprehensive benefits to this category of adults. Adults with dependent children and incomes of 133 percent of FPL were eligible for Medicaid benefits in 12 states (CT, DC, HI, IL, MA, ME, MN, NJ, NY, RI, VT, WI) as the result of waivers. In all cases, the states received the standard FMAP under these waivers. See Kaiser Commission on Medicaid and the Uninsured, "Getting into Gear for 2014," January 2013, 3, table 4. The FMAP for parents was increased to 100 percent in each of these states. Beginning January 1, 2014, states could claim 100 percent FMAP for that portion of the expansion population that would not have been eligible for Medicaid in the state as of December 1, 2009, or who were eligible under a waiver but not enrolled because of limits or caps on waiver enrollment. The Centers for Medicare and Medicaid Services (CMS) estimates that there were 8.7 million adults in this category as of June 2015, 64.5 percent (5.6 million) of whom were eligible for the 100 percent FMAP. States could claim a higher FMAP for many of the remaining 3.1 million adults who had Medicaid coverage before 2014. Under this formula, the FMAP would gradually rise to 90 percent between 2014 and 2018 for childless adults who had been covered by Medicaid waivers. By 2020, all states will receive a 90 percent FMAP for the expansion population. See MACPAC, "State and Federal Spending under the ACA," accessed June 12, 2017.

[49] The act also gives states the option of extending Medicaid coverage to residents with incomes in excess of 138 percent of FPL, but at the standard FMAP. Section 1903(a)(10)(ii) of the Social Security Act, 42 U.S.C. § 1396b(a)(10)(ii).

Table 4. FMAP and State Leverage for Various Medicaid Populations in Expansion States

State	2014–2016				2017				Number of beneficiaries for whom state claimed 100% FMAP as of December 2016[a]
	Pregnant women, aged, disabled, and child beneficiaries		Nondisabled, nonpregnant adult beneficiaries		Pregnant women, aged, disabled, and child beneficiaries		Nondisabled, nonpregnant adult beneficiaries		
	FMAP (%)	Multiplier ($)	FMAP (%)	Multiplier ($)	FMAP (%)	Multiplier ($)	FMAP (%)	Multiplier ($)	
AK[b]	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	N/A
AR	70.00	2.33	100	Unlimited	69.69	2.30	95	19.00	230,080
AZ	68.92	2.22	100	Unlimited	69.24	2.25	95	19.00	88,286
CA[c]	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	2,999,555
CO	50.72	1.03	100	Unlimited	50.02	1.00	95	19.00	360,284
CT	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	155,237
DC	70.00	2.33	100	Unlimited	70.00	2.33	95	19.00	60,636
DE	54.83	1.21	100	Unlimited	54.20	1.18	95	19.00	9,418
HI	53.98	1.17	100	Unlimited	54.93	1.22	95	19.00	33,899
IA	54.91	1.22	100	Unlimited	56.74	1.31	95	19.00	128,901
IL	50.89	1.04	100	Unlimited	51.30	1.05	95	19.00	644,083
IN	66.60	1.99	100	Unlimited	66.74	2.01	95	19.00	159,005
KY	70.32	2.37	100	Unlimited	70.46	2.39	95	19.00	415,888
LA[b]	62.21	1.65	100	Unlimited	62.28	1.65	95	19.00	N/A
MA[d]	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	0
MD	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	217,409
MI	65.60	1.91	100	Unlimited	65.15	1.87	95	19.00	550,595
MN	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	193,567
MT[b]	65.24	1.88	100	Unlimited	65.56	1.90	95	19.00	N/A
ND	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	18,024
NH	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	43,915
NJ[c]	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	591,705
NM	70.37	2.37	100	Unlimited	71.13	2.46	95	19.00	218,456
NY	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	255,736
NV	64.93	1.85	100	Unlimited	64.67	1.83	95	19.00	163,252
OH	62.47	1.66	100	Unlimited	62.32	1.65	95	19.00	584,452
OR	64.38	1.81	100	Unlimited	64.47	1.81	95	19.00	453,684
PA	52.01	1.08	100	Unlimited	51.78	1.07	95	19.00	422,776
RI	50.42	1.02	100	Unlimited	51.02	1.04	95	19.00	58,325
VT[d]	53.90	1.17	100	Unlimited	54.46	1.20	95	19.00	0

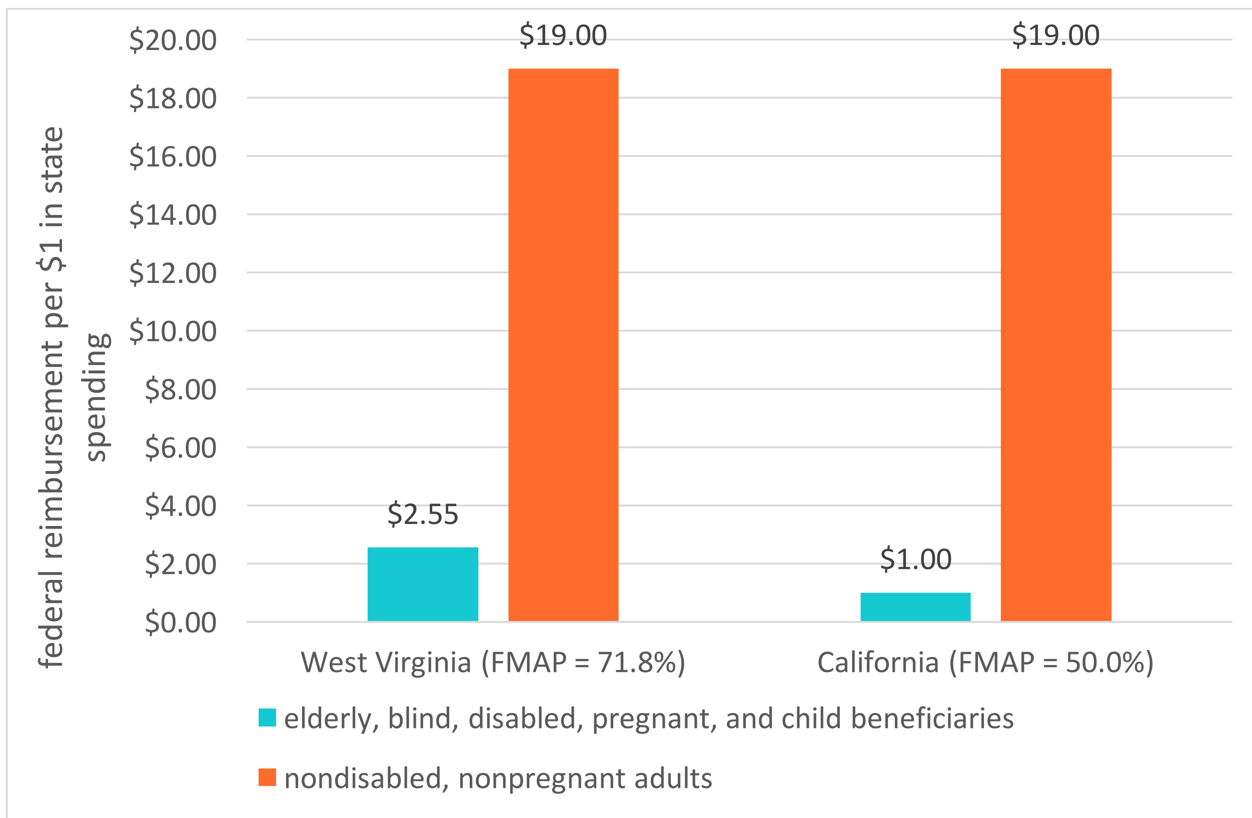
WA	50.00	1.00	100	Unlimited	50.00	1.00	95	19.00	538,673
WV	72.04	2.58	100	Unlimited	71.80	2.55	95	19.00	165,706

Notes: Mississippi, which had the highest FMAP, is omitted from table 4 because it did not expand its Medicaid program. Table 4 shows only expansion states.

[a] CMS, "Total Medicaid Enrollees: VIII Group Breakout Report," June 2015 (updated December 2016).
[b] Alaska, Louisiana, and Montana did not expand their programs until late in 2015 or in 2016.
[c] CMS is undertaking a "reasonableness review" of Group VIII data submitted by California and New Jersey.
[d] Massachusetts and Vermont reported that none of their Group VIII population were newly eligible.

This disparity is substantial. From 2014 to 2016, federal reimbursement for the expansion population was unlimited, covering 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 for this expansion population. Even the expansion state with the highest FMAP (West Virginia at 72.04 percent) netted more than seven times as much in federal dollars for every state dollar it spent on a nondisabled adult than it did for a dollar it spent on a person with developmental disabilities. In California and other states with a 50 percent match, the ratio was $19 to $1. Figure 2 illustrates these disparities.

Figure 2. FMAP Multipliers for Elderly, Blind, Disabled, Pregnant, and Child Beneficiaries vs. Nondisabled, Nonpregnant Adults



No obvious policy reason exists for the federal government to disproportionately reward states for providing services to nondisabled low-income adults. It was not an inducement for states to expand their programs because the law as enacted, as we have seen, required states to expand their programs.

As will be discussed later in this paper, this higher FMAP has been a disproportionate advantage for some states at the expense of all others, particularly those that did not expand the Medicaid program. It is worth noting that, of the 9.8 million enrollees for whom the federal government provided 100 percent FMAP as of December 2016, nearly 31 percent resided in California.

Some ACA advocates have challenged the policy of providing a much higher rate of federal reimbursement for the expansion population. A year after signing the ACA into law, President Obama proposed to modify federal policy by instituting a "blended FMAP." He proposed that Congress "replace the current complicated Federal matching formulas with a single matching rate for all program spending."[50] His proposal was not enacted.

It has been argued that the Supreme Court's ruling in *National Federation of Independent Business v. Sebelius*, in which the court held that Congress could not require states to expand their Medicaid programs, made the higher FMAP a necessary inducement to states to expand their programs. But that after-the-fact policy justification doesn't take into account the differing fiscal capacities among states to undertake such an expansion.

The decision by 19 states not to enlarge their programs has largely been seen as a political one. But there also may be economic reasons behind states' decisions not to expand their programs. It is worth noting that every state with a 50 percent FMAP except two (Virginia

[50] White House Office of the Press Secretary, "Fact Sheet: The President's Framework for Shared Prosperity and Shared Fiscal Responsibility," April 3, 2011.

and Wyoming) adopted the expansion. The median FMAP in 2017 among expansion states is 54.3 percent, while the median among nonexpansion states is 63.8 percent.[51] Thus, states with higher per capita incomes have been more likely to expand their programs than those with lower per capita incomes.

This disparity points to a third major break with long-standing Medicaid policy that the expansion entails: it provides the same FMAP to all states for the expansion population, irrespective of the state's resources. As discussed earlier, the FMAP formula is based on each state's per capita income relative to the national per capita income. Although the methodology is no doubt imperfect, the formula attempts to assess a state's ability to pay for medical care for its low-income residents. A state with a low per capita income is presumed to have a larger population living in poverty (and therefore more likely to qualify for assistance) and fewer state resources to provide that assistance. Such states receive a higher FMAP than more affluent states. States with a higher per capita income relative to the national average receive a lower FMAP.

This formula does not apply to the expansion population. Although Mississippi (median household income: $40,037) received an FMAP of 73.58 and Connecticut (median household income: $72,889) received an FMAP of 50 for their core Medicaid populations, both qualify for the same FMAP for the expansion population.[52] It should cause little surprise, then, that Mississippi and other states with a high FMAP were less likely to expand their programs than were more affluent ones.

This aspect of FMAP may also have induced two states with relatively high uninsurance rates and large numbers of people who would qualify for Medicaid under expanded criteria to

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[51] The median FMAP for all states is 59.2 percent.
[52] KFF, "Median Annual Household Income for 2015," Kaiser Family Foundation, http://kff.org/other/state-indicator/median-annual-income/?currentTimeframe=0 FMAP.

refuse to expand their programs. Florida (FMAP = 61.10) and Texas (FMAP = 56.18) have per capita incomes that are below the national average. Their Medicaid spending already consumes large portions of their state budgets: Florida spends 21 percent of its budget on the program, while Texas spends 19.7 percent.[53] Both devote a far larger proportion of their state budgets to Medicaid than the national average of 15.3 percent, despite the fact that they have not expanded their programs. California, by contrast, which has enrolled more people in Medicaid than any other state—11.9 million, or more than 30 percent of its residents—devotes just 15 percent of its budget to Medicaid.[54]

One might 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 "woodworking" or "welcome mat" effect. An unknown number of uninsured people who are eligible for Medicaid have not enrolled. Medicaid expansions tend to bring many of those people "out of the woodwork," so to speak, and into the program.[55] Research by Molly Frean, Jonathan Gruber, and Benjamin D. Sommers finds that nearly half the increase in the Medicaid rolls attributable to the ACA is among people who would have been eligible for Medicaid under pre-ACA criteria.[56] Thus, expanding the program

[53] MACPAC, *MACStats*, 14–15, exhibit 5. Percentages are for state FY 2014. Other states that chose not to expand their programs also devote a large percentage of their budgets to Medicaid. Medicaid consumes 25.4 percent of the Missouri budget, 19.7 percent of the Tennessee budget, and 18.8 percent of the Maine budget. Even a small marginal increase in Medicaid spending would add to an already significant fiscal burden.

[54] California Medicaid data are from MACPAC, *MACStats*, exhibit 11 (July 2016 enrollment) and exhibit 5 (share of state budget). Population is taken from US Census Bureau, "QuickFacts: California," accessed June 12, 2017.

[55] Signing up previously eligible but unenrolled people is especially costly to states because individuals are enrolled retroactively. For example, someone who is uninsured and gets treatment in a hospital's emergency department can be enrolled in Medicaid, which will pay the bill for that person's care.

[56] Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act" (NBER Working Paper 22213, National Bureau of Economic Research, Cambridge, MA, April 2016).

leads to higher enrollment among categories of individuals for whom states cannot claim the higher FMAP.[57]

In contrast to the FMAP formula that has generally prevailed in the Medicaid program since its inception, the enhanced federal matching rates for nondisabled, nonpregnant adults have tended to benefit states with high per capita incomes at the expense of states with low per capita incomes. That observation is particularly true with respect to the District of Columbia and the 13 states that benefit both from the higher matching payments for their expansion population and the statutory FMAP floors.

Absent the FMAP floor, states with per capita incomes greater than 105.5 percent of the national average would have to bear more than half the medical costs incurred by their Medicaid recipients. By requiring the federal government to match at least half the Medicaid costs of a state (70 percent in the case of the District of Columbia), the federal government compensates states with relatively high per capita incomes more generously than it does nonfloor states. Per capita income in Connecticut averaged $63,238 over the years 2012–2014. That was 40 percent higher than the national per capita income during that period ($45,054). The floor raised Connecticut's FMAP from 11.35 percent to 50 percent.

This effect of the FMAP floor is offset, to some degree, by the fact that states with higher average incomes contribute a disproportionate share of federal taxes. Some portion of the FMAP they receive thus comes not from other states, but from their own contributions to the federal fisc. The FMAP floor compensates them for much of this increased contribution.

[57] Some researchers have posited that some number of uninsured people may regard themselves as "conditionally covered." That is, they recognize that they are eligible for Medicaid and that they can enroll at the time they receive treatment. These individuals may be motivated by the individual mandate to sign up for Medicaid rather than waiting until they need medical care. See, for example, Charles Courtemanche et al., "Early Impacts of the Affordable Care Act on Health Insurance Coverage in Medicaid Expansion and Non-Expansion States," *Journal of Policy Analysis and Management* 36, no. 1 (2017): 178–210.

Appendix table A1 takes a more systematic look at this issue, comparing the percentage of taxes paid in FY 2015 by individuals and businesses in each state with the percentage of federal Medicaid reimbursement claimed by each state. In the aggregate, expansion states in FY 2015 paid more than 65 percent of all federal taxes but received more than 70 percent of federal Medicaid reimbursement. Nonexpansion states, by contrast, paid a little more than 34 percent of federal taxes but received less than 30 percent of federal Medicaid reimbursement.

Some of the expansion states that paid the largest percentages of federal taxes benefited most from federal Medicaid reimbursement. California, for example, accounted for 12.36 percent of federal tax revenue but collected just under 16 percent of federal Medicaid money in FY 2015. Similarly, New Yorkers paid taxes that amounted to 8.21 percent of federal collections but received 9.79 percent of federal Medicaid money in FY 2015.

Nonexpansion states with large federal tax payments did not fare as well under Medicaid. Texas supplied 8.52 percent of federal tax collections—slightly more than New York did—but collected only 6.31 percent of federal Medicaid payments. Floridians bore 5.4 percent of the federal tax load but received just 3.88 percent of federal Medicaid payouts. Table 5 shows aggregate figures for expansion and nonexpansion states for fiscal years 2013 and 2015.

Table 5. Comparison of Medicaid and Tax Percentage Sums, FY 2013 and FY 2015

	Fiscal year 2013		Fiscal year 2015	
	Percentage of federal Medicaid received	Percentage of federal taxes paid in by states	Percentage of federal Medicaid received	Percentage of federal taxes paid in by states
Expansion states	65.44	65.44	70.36	65.69
Nonexpansion states	34.56	34.56	29.64	34.31

Tax sources: Internal Revenue Service [IRS], *2013 Data Book* (Washington, DC: IRS), table 5; IRS, *2015 Data Book* (Washington, DC: IRS), table 5.
Medicaid sources: MACPAC, *MACStats: Medicaid and CHIP Program Statistics* (Washington, DC: MACPAC, 2014), table 6; MACPAC, *MACStats: Medicaid and CHIP Program Statistics* (Washington, DC: MACPAC, 2016), exhibit 5.

Before the introduction of 100 percent FMAP rates for nondisabled, nonpregnant adults, states that would later expand Medicaid eligibility and those that would not were at parity with respect to tax contributions and federal Medicaid receipts. Expansion states provided 65.44 percent of federal revenues and received 65.44 percent of federal Medicaid compensation. Those figures suggest that the standard FMAP formula produced, in the aggregate at least, an equitable distribution of federal Medicaid funds commensurate with state contributions to the federal treasury.

By providing a much higher federal match to expansion states for a particular category of individuals, Congress upset this equilibrium. The share of federal Medicaid money claimed by expansion states grew from 65.44 percent in FY 2013 to 70.36 percent in FY 2015 (4.92 percentage points, or 7.5 percent). Those states received $16.45 billion more in federal Medicaid money in FY 2015 than if their share had remained at FY 2013 levels.

These gains by expansion states came, to a great extent, at the expense of nonexpansion states. Nonexpansion states saw their share of federal Medicaid matching funds drop from 34.56 percent in FY 2013 to 29.64 percent in FY 2015. Even with the fact that nonexpansion states provided a smaller share of federal revenue in FY 2013 than in FY 2015 (34.31 percent vs. 34.56 percent), they still financed much of the increase in federal Medicaid reimbursement collected by expansion states.

On net, the higher FMAP for nondisabled, nonpregnant adults produced a transfer of $8.01 billion from nonexpansion states to expansion states in FY 2015 alone. This redistribution adversely affected nonexpansion states, all of which received a smaller portion of federal Medicaid money in 2015 than in 2013.

It might be argued that this effect was a consequence of decisions by those states not to expand their programs. But as we have seen, those states, on the whole, had lower average per capita incomes than expansion states and, at least in some cases, already devoted a larger portion of their state budgets to Medicaid. Like their counterparts in the expansion states, the nonexpansion states made their decisions for a variety of reasons. Medicaid had always been based on categorical eligibility, taking into account both income and the circumstances that may have contributed to an individual's poverty (e.g., age, disability, pregnancy, being born to impoverished parents, being medically needy). It is not surprising that some states have been unwilling to break with this understanding of Medicaid by making nondisabled, nonpregnant adults eligible for medical assistance.

Nor is it surprising that states that had obtained waivers to cover nontraditional low-income populations would expand their Medicaid programs. Under the waivers, those states received the standard FMAP for this broader universe of Medicaid recipients. With the expansion, federal matching rates improved considerably. To some extent, the federal government paid those states more to cover people they already were covering pursuant to their waivers. This financial benefit was not available to states that had not obtained waivers to expand coverage, making expansion a less attractive proposition to many states.

Another factor that may have influenced a state's decision on whether to expand Medicaid eligibility is the political influence of hospitals and others in the healthcare industry, many of whom benefit financially from Medicaid expansion. The fiscal capacity of states to handle greater Medicaid spending also has likely been a factor. That capacity, which is taken into account in the base FMAP formula, is entirely ignored with respect to the expansion population.

It is also worth noting that this shift in federal Medicaid reimbursement in favor of expansion states was not evenly distributed. In the year before the introduction of the higher FMAP, California received 13 percent of all federal Medicaid funds. In 2015, that amount had risen to just under 16 percent.[58] California's share of federal Medicaid funds was $9.9 billion more in 2015 than if it had received the same percentage of those funds as it had in 2013. That single state captured 64.3 percent of the additional federal Medicaid funds claimed by the expansion states.[59]

California's consumption of a significantly larger portion of federal Medicaid money came at the expense of some expansion states, as well as every state that chose not to expand its program. Not only did every nonexpansion state receive a smaller percentage of federal Medicaid funds in 2015 than in 2013, but 11 expansion states also saw their slice of the pie reduced. California's prodigious expansion thus affected both expansion and nonexpansion states.

In deviating from the FMAP formula by providing a disproportionately high level of federal reimbursement for nondisabled, nonpregnant adults, Congress produced inequities between states and between eligible populations. It is unclear whether Congress intended or foresaw these results when it instituted these reimbursement changes in the ACA. Now that these results are evident, lawmakers should consider revising Medicaid reimbursement to produce a more equitable allocation of federal resources.

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[58] CMS data updated through December 2016 show that California was receiving a 100 percent FMAP for nearly three million "Group VIII" enrollees (adults covered under expanded Medicaid criteria). Before 2014, California had obtained a waiver to receive its standard 50 percent FMAP for certain categories of adults. Unlike other states that undertook similar Medicaid expansions before 2014, the CMS data show that none of the three million were "newly eligible enrollees." Thus, California could claim the 100 percent FMAP for all three million nondisabled, nonpregnant adult enrollees. As of December 2016, CMS noted that it was awaiting further reporting from the state of California and that a federal "reasonableness review" was in progress. CMS, "Total Medicaid Enrollees: VIII Group Breakout Report," June 2015 (updated December 2016).

[59] CMS, "Total Medicaid Enrollees: VIII Group Breakout Report," June 2015 (updated December 2016).

Conclusion and Policy Implications

Although the FMAP formula has remained unchanged throughout the program's history, Congress has at times crafted narrow exceptions. It has provided permanent exceptions for certain services and administrative activities, as well as temporary exceptions to address specific circumstances, such as economic downturns and natural disasters.

With the ACA, Congress and the executive branch instituted changes that have effectively altered that formula. Sometimes the motivations were political, as when Louisiana was granted a higher FMAP for a period of years to obtain an affirmative vote for the ACA of its then senior senator. In other circumstances, the motivations were less clear, as when HHS administratively instituted a permanent 90 percent match for states to establish eligibility determination systems.

The most dramatic breach from the long-standing policy was the establishment of a very high FMAP for services provided to nondisabled, nonpregnant adults. This expansion fundamentally changed the nature of Medicaid from one intended to serve certain categories of people with low incomes (e.g., elderly individuals, people with disabilities, children, pregnant women) to a purely income-related program. It also introduced two significant inequities: (1) it rewards states much more generously for providing services to the expansion population than for providing services to those who arguably are more in need of assistance, and (2) it overlooks differences among states in their capacity to fund services for this new population, providing the same elevated FMAP to affluent states as to less affluent ones.

The policy rationale for these disparities is not obvious. One could argue that the higher FMAP is advantageous to the federal government because it costs less to cover people under Medicaid than to subsidize private coverage through the exchanges, but that disparity appears to be

relatively small. And even if the disparity were larger, it would not address the issue of whether the federal government should provide preferential financial treatment to nondisabled adults or overlook differences in capacity among states to finance medical assistance to needy residents.

As previously stated, congressional Republicans and the Trump administration have pledged to repeal and replace the ACA. The issue of how to deal with the law's Medicaid expansion is among the more nettlesome issues they will confront. Rescinding that expansion would negatively affect states that have expanded coverage under the provision and potentially hospitals, physicians, and other medical professionals who provide care to program participants. Various changes to the ACA provisions have been suggested, including grandfathering those who enrolled in Medicaid by a certain date.[60]

Policymakers who support Medicaid expansion should consider whether the federal government should continue to provide an FMAP for the expansion population that is disproportionately higher than for elderly people bereft of assets, people with disabilities, children in low-income households, and pregnant women. They also should consider whether it is appropriate to apply the same FMAP to the expansion population in affluent states as in less affluent ones.

For many years, Congress has ignored recommendations from policy experts to revise the FMAP formula to make it more equitable.[61] The changes in federal Medicaid reimbursement made by the ACA have made it less equitable. As lawmakers confront the contentious issues surrounding the Medicaid expansion, they should seek to devise a financing structure that treats eligible populations equitably and that recognizes the differences in fiscal capacity among states.

[60] In May 2017, the House passed the American Health Care Act, H.R. 1628, which would continue the Medicaid expansion but would reimburse states at the standard FMAP for services provided to nondisabled, nonpregnant adults who enroll after December 31, 2019.
[61] See, for example, GAO, "Medicaid: Alternative Measures Could Be Used to Allocate Funding More Equitably" (GAO-13-434, US Government Accountability Office, Washington, DC, May 2013).

Appendix: Medicaid Reimbursement and Tax Revenue

Table A1 compares the portion of federal revenue provided by each expansion and nonexpansion state with the portion of federal Medicaid reimbursement each state received in fiscal years 2013 and 2015. The higher federal FMAP for the expansion population took effect in FY 2014. In the table, federal tax receipt data for the two fiscal years, by state, are from editions of the *Data Book* published by the IRS, and federal Medicaid reimbursement data, by state, are from editions of *MACStats: Medicaid and CHIP Program Statistics*, published by the Medicaid and CHIP Payment Access Commission (MACPAC).

Table A1. Federal Medicaid Reimbursement versus Federal Tax Revenue for Expansion and Nonexpansion States, FY 2013 and FY 2015.

	FY 2013		FY 2015		
	Percentage of federal Medicaid	Percentage of federal taxes	Percentage of federal Medicaid	Percentage of federal taxes	Percentage change in Medicaid
Expansion states					
Alaska	0.32	0.19	0.25	0.17	–0.07
Arizona	2.25	1.30	2.37	1.30	0.12
Arkansas	1.19	1.01	1.30	0.99	0.11
California	13.03	11.78	15.99	12.36	2.96
Colorado	1.03	1.64	1.33	1.44	0.30
Connecticut	1.31	1.89	1.38	1.80	0.07
Delaware	0.36	0.71	0.33	0.69	–0.02
District of Columbia	0.63	0.86	0.53	0.78	–0.10
Hawaii	0.35	0.25	0.39	0.25	0.04
Illinois	3.24	4.83	3.06	4.81	–0.18
Indiana	2.15	1.80	1.92	1.77	–0.23
Iowa	0.88	0.75	0.87	0.73	–0.01
Kentucky	1.60	0.98	2.26	1.00	0.66
Maryland	1.58	1.99	1.71	1.95	0.13
Massachusetts	2.65	3.19	2.61	3.29	–0.04
Michigan	3.28	2.43	3.47	2.37	0.19
Minnesota	1.82	3.20	1.91	3.26	0.09
Nevada	0.44	0.56	0.70	0.56	0.26
New Hampshire	0.26	0.35	0.30	0.34	0.05
New Jersey	2.15	4.51	2.61	4.69	0.46
New Mexico	0.93	0.30	1.17	0.27	0.24
New York	10.51	8.17	9.79	8.21	–0.72
North Dakota	0.17	0.27	0.20	0.23	0.03

Ohio	4.20	4.40	4.46	4.29	0.25
Oregon	1.33	0.91	1.88	0.95	0.54
Pennsylvania	4.53	4.24	3.91	4.14	–0.62
Rhode Island	0.41	0.46	0.46	0.44	0.05
Vermont	0.32	0.14	0.30	0.14	–0.03
Washington	1.63	2.11	2.06	2.23	0.43
West Virginia	0.87	0.24	0.84	0.22	–0.03
Total	**65.44**	**65.44**	**70.36**	**65.69**	**4.92**
Nonexpansion states					
Alabama	1.37	0.84	1.10	0.76	–0.27
Florida	4.30	4.98	3.88	5.40	–0.42
Georgia	2.37	2.62	1.97	2.63	–0.40
Idaho	0.48	0.31	0.37	0.30	–0.11
Kansas	0.59	0.87	0.52	0.82	–0.08
Louisiana[a]	1.80	1.42	1.51	1.30	–0.28
Maine	0.71	0.24	0.48	0.23	–0.23
Mississippi	1.38	0.37	1.14	0.35	–0.23
Missouri	2.19	1.92	1.84	1.95	–0.35
Montana[a]	0.28	0.18	0.23	0.18	–0.04
Nebraska	0.41	0.84	0.30	0.76	–0.11
North Carolina	3.14	2.33	2.67	2.40	–0.47
Oklahoma	1.18	1.06	0.95	1.03	–0.23
South Carolina	1.33	0.72	1.26	0.73	–0.06
South Dakota	0.19	0.22	0.14	0.24	–0.05
Tennessee	2.29	1.90	1.78	1.91	–0.51
Texas	6.66	8.81	6.31	8.52	–0.35
Utah	0.59	0.62	0.47	0.61	–0.12
Virginia	1.49	2.51	1.23	2.44	–0.27
Wisconsin	1.70	1.63	1.40	1.58	–0.30
Wyoming	0.12	0.19	0.09	0.16	–0.03
Total	**34.56**	**34.56**	**29.64**	**34.31**	**–4.92**

[a]Louisiana and Montana expanded their respective Medicaid programs in 2016.

Tax sources: IRS, *2013 Data Book* (Washington, DC: IRS), table 5; IRS, *2015 Data Book* (Washington, DC: IRS), table 5.
Medicaid sources: MACPAC, *MACStats: Medicaid and CHIP Program Statistics* (Washington, DC: MACPAC, March 2014), table 6; MACPAC, *MACStats: Medicaid and CHIP Program Statistics* (Washington, DC: MACPAC, December 2016), exhibit 5.