Fact Sheet

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Kem C. Gardner POLICY INSTITUTE
THE UNIVERSITY OF UTAH
DAVID ECCLES SCHOOL OF BUSINESS

Medicaid: What is FMAP and Why Does It Matter?

Summary

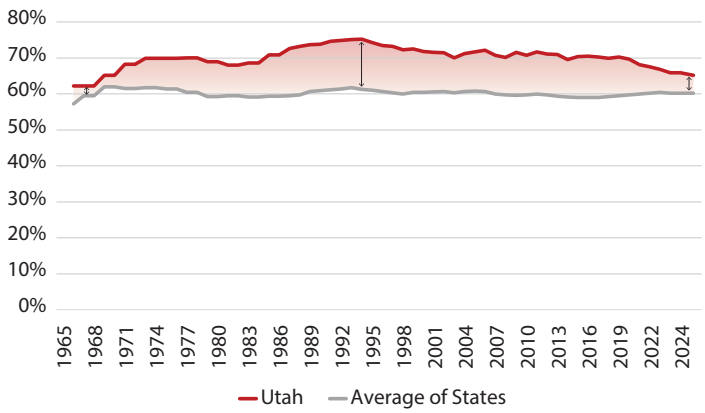
The Federal Medical Assistance Percentage (FMAP) is the share of Medicaid costs funded by the federal government. As Utah's per capita income grew faster than the U.S. average, Utah's traditional Medicaid FMAP declined from 70.26% to 65.90% over the past five years. Projections forecast a further decline to 65.35% in FY 2025. A strong economy generally creates downward pressure on Medicaid enrollment, while FMAP declines place upward pressure on state Medicaid costs. Policymakers may wish to consider how to address these cost pressures driven by Utah's strong economic growth.

What is Medicaid?

Medicaid and CHIP (the Children's Health Insurance Program) fund health care services for about 487,000 low-income Utah individuals as of April 2023, which makes up about 14% of Utah's population.[1] At the national level, these programs enroll 94.2 million Americans as of April 2023 (28% of all Americans).[2] Utah's population share on Medicaid is about half of the national average share and ranks lowest nationally.

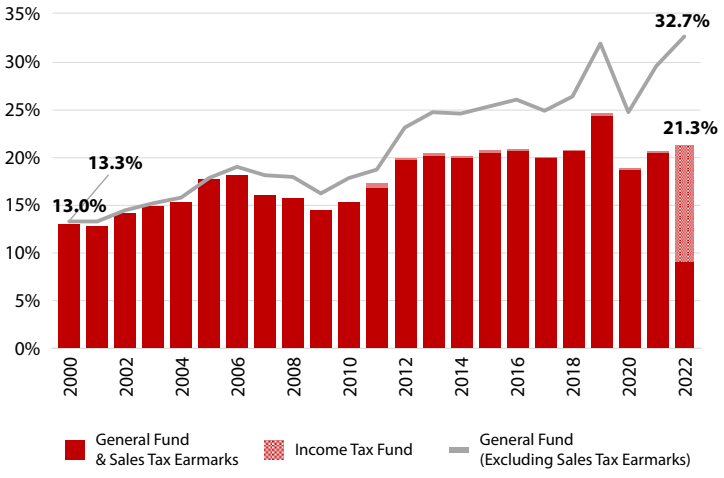
Although administered by states, the federal government and states jointly fund Medicaid. While states may choose whether or not to participate in Medicaid, all states and territories elect to do so given the large federally-funded benefit. States choosing to participate must provide certain mandatory benefits, such as physician, hospital, and laboratory services, as well as provide services to mandatory populations (e.g., low-income children, pregnant women, etc.). States may design and administer other benefits that meet certain federal rules, such as prescription drugs, dental services, or physical therapy. They can also expand benefits to additional populations or change certain eligibility requirements for mandatory populations. This flexibility means that eligibility levels and covered services vary among states. As an entitlement program, every person who meets the required eligibility qualifications can access Medicaid.

Figure 1: Utah and State Average FMAPs, FY 1965-2024



Source: U.S. Department of Health and Human Services

Figure 2: Utah Medicaid Spending from Major Funds as a Share of General Fund Spending, FY 2000-2022



Note: "General Fund (Excluding Sales Tax Earmarks)" includes Income Tax Fund spending. In FY 2022, the Legislature shifted nearly $375 million of Medicaid spending from the General Fund to the Income Tax Fund (renamed from Education Fund in 2022) following voter passage of Amendment G.
Source: Governor's Office of Planning and Budget and Office of the Legislative Fiscal Analyst

How is Medicaid Funded in Utah?

In FY 2022, Utah's Medicaid spending totaled over $4.6 billion. This includes nearly $3.6 billion in federal funds, $665 million in state General Fund and Income Tax Fund revenues, and nearly $375 million from other sources.

Medicaid has long been the State of Utah's single largest General Fund program (Figure 2). Voter passage of Amendment G to the Utah Constitution in 2020 allowed Income Tax Fund dollars to fund programs for children and people with disabilities in addition to education. Using this flexibility, the Legislature shifted some Medicaid spending from the General Fund to the Income Tax Fund.

While the Income Tax Fund historically provided around $6 million to Medicaid, it provided $381 million in FY 2022. The shift dramatically reduced General Fund Medicaid spending from $634 million in FY 2021 to $283 million in FY 2022. Prior to the passage of Amendment G, Medicaid spending made up 20% of General Fund spending (including earmarked sales and use taxes historically deposited into the General Fund), yet in FY 2022 it made up 9%.

What is FMAP and How is it Calculated?

A federal statutory funding formula determines the percentage of Medicaid services paid by the federal government, leaving the remainder funded from state and local coffers.[3] This percentage is known as the state's traditional FMAP. State FMAP rates cannot be less than 50% or greater than 83%. Territories and the District of Columbia have different calculations and caps.[4]

The FMAP calculation uses a three-year average per capita income for each state. For example, in November 2022, the U.S. Department of Health and Human Services used per capita personal income data from 2019, 2020, and 2021 to calculate FY 2024 FMAP rates. Using a three-year average aims to stabilize fluctuations

FMAP Calculation

$$\text{FMAP} = 1 - \left(0.45 \times \frac{\left(\text{3-year Average Per Capita Income}_{\text{State}}\right)^2}{\left(\text{3-year Average Per Capita Income}_{\text{U.S.}}\right)^2}\right)$$

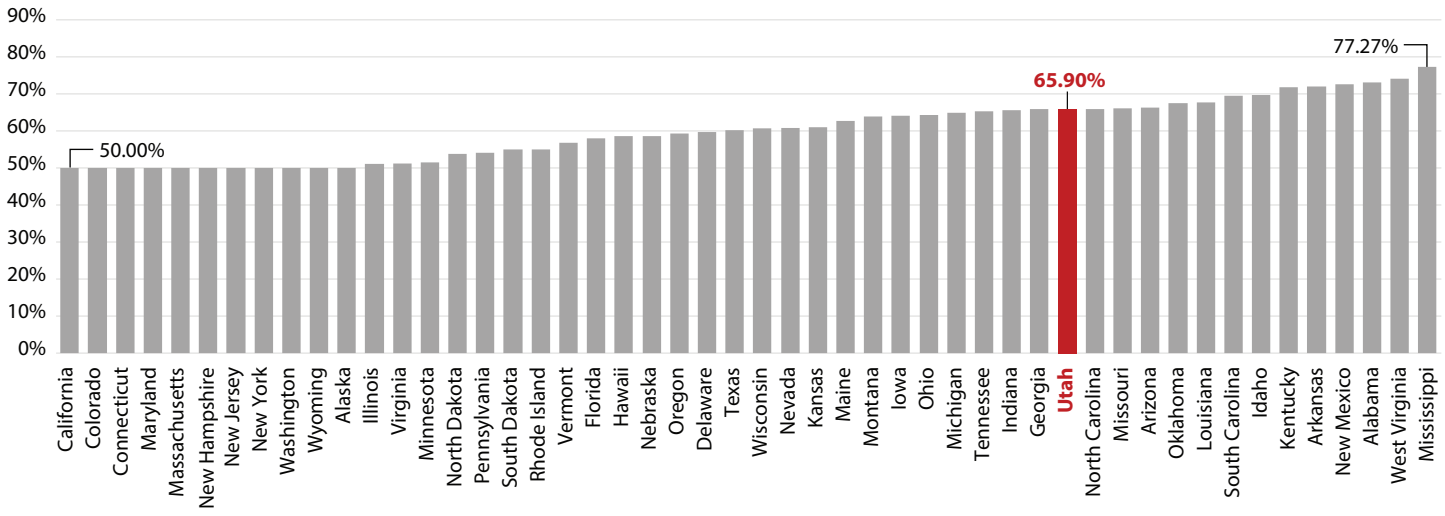
$$\text{Utah FMAP} = 1 - \left(0.45 \times \frac{(\$52{,}275)^2}{(\$60{,}053)^2}\right) = 65.90\% \text{ Federal Share}$$

Table 1: Traditional FMAP for Select States, FY 2024

	Utah	Mississippi	Connecticut
State Per Capita Income (2019-2021)	2019: $48,580	$39,445	$75,533
	2020: $52,225	$42,716	$78,463
	2021: $56,019	$45,881	$83,294
	3-year average: $52,275	**$42,681**	**$79,097**
U.S. Per Capita Income (2019-2021)	2019: $56,250		
	2020: $59,765		
	2021: $64,143		
	3-year average: $60,053		
FMAP Rate (Federal Funding Share) FY 2024	65.90%	77.27%	21.93% calculation / 50% with statutory minimum
State Funding Share	34.10%	22.73%	78.07% calculation / 50% with statutory minimum

Note: Mississippi currently has the highest FMAP rate; Connecticut is one of ten states receiving the statutory minimum FMAP rate in FY 2024.
Source: U.S. Bureau of Economic Analysis

Figure 3: Traditional Federal Medical Assistance Percentage (FMAP) by State, FY 2024



Source: U.S. Department of Health and Human Services

in states' FMAP rates over time. However, critics highlight that this long lag does not address real-time economic needs.[5]

The U.S. Bureau of Economic Analysis (BEA) publishes personal income data. BEA regularly revises per capita personal income data to incorporate changes in population and personal income. In turn, these changes influence FMAP rates. Notably, the BEA personal income definition does not capture all economic income. In particular, BEA excludes capital gains, an especially important income source for high-income households. However, in addition to labor income such as salaries and wages, the BEA income definition does include most transfer receipts, an important source for low-income households.

The U.S. Department of Health and Human Services calculates and publishes FMAPs in the Federal Register each November for the upcoming federal fiscal year. FMAP rates apply beginning October 1 of the year following this publication, aligning with the federal fiscal year. Forty-six states begin their fiscal year on July 1, while the remaining four states begin their fiscal year in April, September, or October. Publishing FMAP rates in the prior November allows states time to prepare their budgets accordingly for the following year.

What FMAP Variations Exist?

FMAPs vary for both populations and type of cost. For example, federal Medicaid matching funds can be claimed for both direct service costs as well as administrative costs. The amount the federal government reimburses for direct service costs is typically tied to the state's traditional FMAP, but this may vary based on the type of service delivered. A few FMAP variations follow below for reference, but this fact sheet focuses on the impacts of the traditional FMAP.

CHIP ENHANCED FMAP (E-FMAP). A separate statutory formula determines the federal government's share of CHIP expenses. Utah's E-FMAP is 76.13% in FY 2024, meaning Utah pays a smaller share of CHIP costs than traditional Medicaid costs.

MEDICAID EXPANSION FMAP. The federal government provides an enhanced 90% FMAP for the Medicaid expansion population established by the Affordable Care Act. Utah voters expanded Medicaid in 2018 via ballot initiative. After some legislative adjustments, full expansion took effect in 2020 with a 90% FMAP for that portion of the Medicaid population.

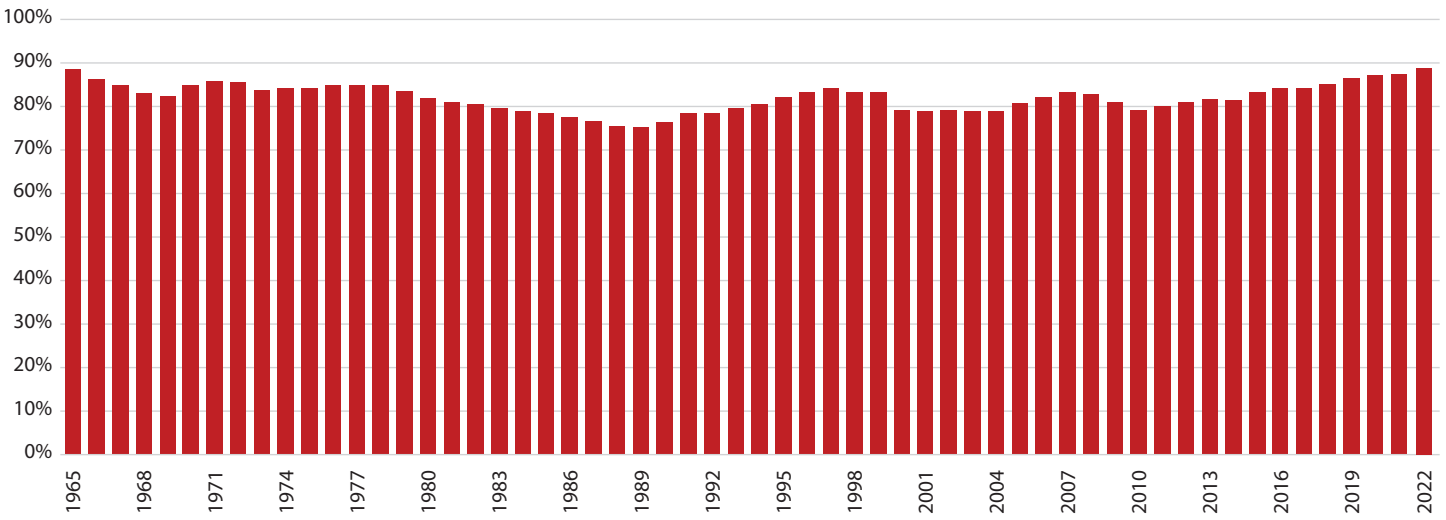
TEMPORARY FMAP ENHANCEMENTS. During times of severe economic downturn, the federal government may offer aid to states by temporarily enhancing FMAP rates. This one-time federal aid helps states financially, but may also create state budget uncertainty via attached strings, such as disenrollment limitations.

For example, the American Recovery and Reinvestment Act of 2009 (ARRA) increased FMAP rates by 6.2 percentage points through the first quarter of FY 2011, after which rates gradually fell to their pre-enhancement levels. More recently, the federal government increased FMAP rates by 6.2 percentage points as a response to the COVID-19 pandemic. Under the recently-enacted Consolidated Appropriations Act of 2023, this rate increase will phase out by the end of the 2023 calendar year.[6]

How Does Per Capita Personal Income Influence Utah's Medicaid Funding Share?

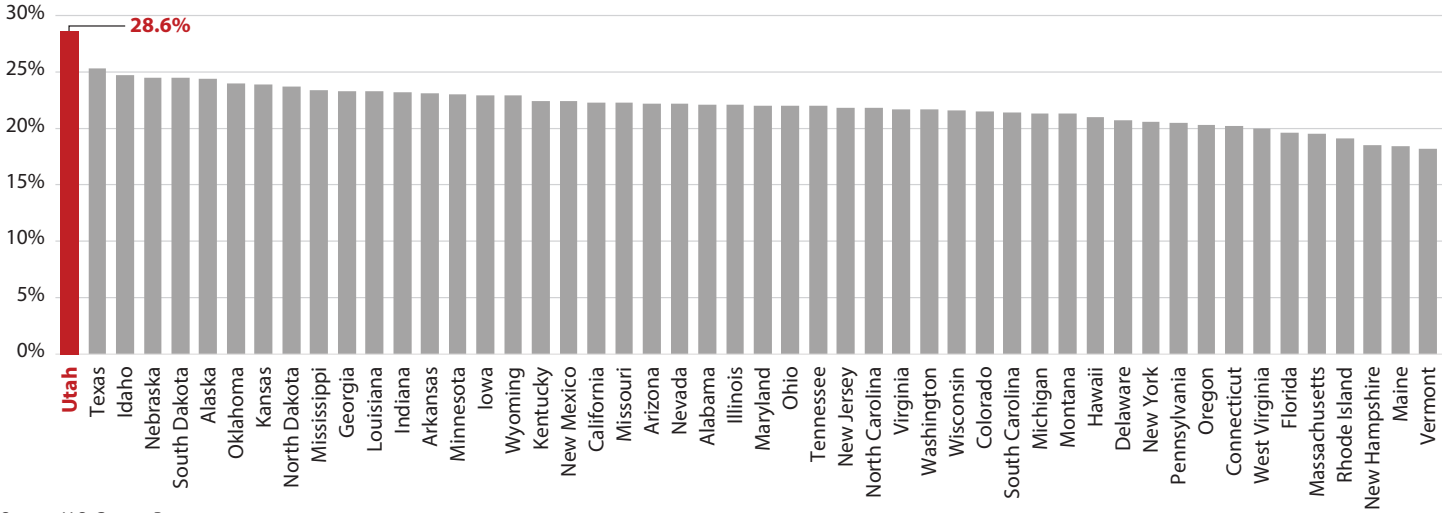
States with per capita income below the national average receive a higher share of federal Medicaid funding than relatively high per-capita-income states. States with per capita income equal to the national average have a traditional FMAP rate of 55%, meaning those states cover 45% of most Medicaid service-related costs. In FY 2024, ten states have a 50% FMAP, meaning these states cover 50% of Medicaid costs. No state reaches the statutory maximum of 83%, but Mississippi

Figure 4: Utah Per Capita Personal Income as a Percentage of U.S. Per Capita Personal Income, 1965-2022



Source: U.S. Bureau of Economic Analysis

Figure 5: Share of Population Under 18 by State, 2020



Source: U.S. Census Bureau

comes closest at 77.27% (meaning it covers 22.73% of its Medicaid service costs).

Although Utah's household income is among the highest in the country, Utah's per capita income ranks low (Figure 4). Utah's unique demographics drive this seeming paradox. Utah's larger household sizes lead to more workers per household, which increases household income. But the large number of Utah youths reduce per capita income, since a larger share of Utah's population falls outside normal working ages (Figure 5).

How has Utah's FMAP Changed Over Time?

Utah's per capita personal income growth outpaced national growth in recent decades, decreasing Utah's traditional FMAP. Utah's FMAP peaked in FY 1993 at just over 75%. For the past two decades, Utah's FMAP funded about 70% of traditional Medicaid costs (Figure 1). In recent years, Utah's FMAP declined to about 66%. Preliminary estimates indicate Utah's FY 2025 traditional FMAP will be 65.35%, furthering declines from recent years. This FMAP decline decreases the federal funding share and increases the state's Medicaid obligation. The average of state FMAP rates generally hovers around 60%, so Utah's FMAP remains higher than average after this decline.

Factors contributing to Utah's recent FMAP decline likely include some combination of Utah's strong economic growth outperforming the nation and workforce composition shifts.

What Does the Future Hold?

After several years of decline, Utah's FY 2024 FMAP remains the same as FY 2023. However, estimates project an additional decline in FY 2025. If recent trends continue, strong economic growth and subsequent increases in per capita personal income could push a larger share of traditional Medicaid service costs onto the state, leading to state taxpayers picking up a larger share of costs over time.

If Utah's FMAP drops four percentage points over the next five years like it has over the last five years, this could increase annual state costs by approximately $40-$70 million by FY 2028 with no changes in enrollment trends or health care costs. Higher traditional Medicaid costs driven by a declining FMAP could impact state budget flexibility. If not addressed, these ongoing costs could potentially pose risks to Utah's long-term state structural budget balance or funding for other programs. Options include pre-funding projected FMAP declines, annually funding costs as they occur, or other budget adjustments. In sum, policymakers may wish to consider the fiscal impacts of potential future FMAP declines as they make budget decisions.

Authored by: Natalie Roney, Research Economist and Phil Dean, Chief Economist and Public Finance Senior Research Fellow

Endnotes

1. In March 2020, the federal government offered aid to states by increasing the federal share of traditional Medicaid costs by 6.2 percentage points and in turn required that states "freeze" disenrollment. This policy inflated Medicaid enrollment by allowing individuals to remain enrolled throughout the declared public health emergency, despite potential eligibility changes. Beginning in April 2023, states may again disenroll based on eligibility status. Although uncertain, estimates predict 10-20% of enrollees may be disenrolled.
2. Medicaid.gov. (2023). April 2023 Medicaid & CHIP Enrollment Data Highlights. Retrieved from https://www.medicaid.gov/medicaid/national-medicaid-chipprograminformation/medicaid-chip-enrollment-data/index.html
3. The federal government generally matches costs for Medicaid administration at 50%, with some exceptions for certain types of administrative functions.
4. Federal statute imposes (a) a 55% rate for U.S. territories (American Samoa, Guam, Northern Mariana Islands, Puerto Rico, and Virgin Islands), subject to an annual cap and (b) a 70% rate for the District of Columbia without an annual cap.
5. Peters, CP. (2008, Dec 11). How the FMAP Formula Works and Why It Falls Short. National Institutes of Health. Retrieved from https://www.ncbi.nlm.nih.gov/books/NBK561168/
6. H.R.2617 - 117th Congress (2021-2022): Consolidated Appropriations Act, 2023. (2022, December 29). https://www.congress.gov/bill/117th-congress/house-bill/2617