

# Medicaid Reform

Medicaid is the largest health insurance program in the US and, together with the Children's Health Insurance Program (CHIP), covered more than 75 million people in 2020. It is the leading payer of births, mental health services and long-term care, and is an indispensable safety net for low-income and disabled people.

Because Medicaid patients often face barriers to care, the AMA works diligently at the state and federal levels to improve Medicaid programs, expand coverage options, and make it easier for physicians to provide care to Medicaid patients. Medicaid reform advocacy is guided by AMA policy highlighted in the [AMA's Plan to Cover the Uninsured](#).

Medicaid is a countercyclical program, meaning that spending increases during economic downturns as job losses mount, incomes fall, and more people enroll in the program. Enrollment growth occurs just as states experience budget shortfalls that put pressure on state Medicaid spending. At the onset of the COVID-19 pandemic, Medicaid programs became integral to state efforts to care for low-income COVID-19 patients and provide coverage to the newly unemployed and uninsured.

Medicaid is the third largest domestic federal program and one of the largest budget items in most states. In 2018, Medicaid spending neared \$600 billion, with the federal share reaching over \$400 billion, accounting for 16.4 percent of national health care spending.

Growth in Medicaid spending per enrollee has generally been less than that of private insurance spending, in part because payment rates are significantly lower than rates paid by Medicare and private insurance for comparable services. Inadequate Medicaid payment rates often do not cover the full cost of patient care and have been associated with lower physician participation in Medicaid, which in turn negatively impacts patient access to care. Practices and facilities serving Medicaid patients operated on thin margins prior to the pandemic and are susceptible to great harm by state Medicaid cuts, which typically decrease provider payments. Accordingly, it is critical to safeguard Medicaid funding during economic downturns to help physicians and patients.

The greatest share (almost two-thirds) of all Medicaid spending goes toward the care of elderly and disabled persons, while a far smaller percentage pays for the Medicaid expansion population, which is financed primarily with federal dollars. Spending varies by state as do eligibility, coverage and payment policies, so one state's Medicaid program can look very different from another. Notably, disparities in eligibility and coverage are most pronounced between states that have and have not expanded Medicaid under the Affordable Care Act (ACA).

## Medicaid expansion

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The Supreme Court ruling that Medicaid expansion was optional allowed states to decline the opportunity to expand coverage to individuals with incomes up to 133 percent (138 percent including the ACA's five percentage point income disregard) of the federal poverty level (FPL). At the end of 2020, all but 12 states (AL, FL, GA, KS, MS, NC, SC, SD, TN, TX, WI, WY) had chosen to expand Medicaid.

Evidence from scores of studies has shown that Medicaid expansion is associated with increased access to care, decreased mortality, increased financial well-being, and improved self-reported health. Enrollees have been found to be more likely to obtain primary and preventive care, be diagnosed and treated for chronic conditions, and have access to prescription medications. Expansion states have experienced greater reductions in their uninsured populations, with coverage gains playing a significant role in addressing the opioid epidemic.

Evidence also points to a narrowing of disparities in coverage among people of different races and ethnicities, most notably in expansion states. Although Medicaid expansion has played a key role in reducing disparities in coverage and access to care, almost half of Black adults live in states that have not expanded the program. Expansion across all states would further narrow gaps in coverage, although disparities would likely remain for reasons unrelated to coverage.

## Increasing the FMAP during economic downturns

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Under Medicaid's joint financing model, the Centers for Medicare & Medicaid Services matches each state's Medicaid expenditures according to the federal medical assistance percentage (FMAP), which varies by state and is inversely related to a state's per capita income. Prior to the pandemic, the 2020 Medicaid FMAP ranged from the minimum 50 percent in 12 states to 77 percent in Mississippi.

In 2020, a temporary 6.2 percentage point increase in federal Medicaid matching funds was provided to states by the Families First Coronavirus Response Act (PL 116-127) to help them shoulder the costs of increased Medicaid enrollment and services, including COVID-19 testing and treatment. Although this increase in the FMAP was an important first step, it isn't sufficient to prevent Medicaid budget cuts in many states. Increasing the FMAP is widely recognized as a quick and easy way to provide fiscal relief to states during economic downturns and incentivize them to maintain current Medicaid levels and services. Further enhancements to the 6.2 percentage point increase in the FMAP enjoy broad support from a range of national medical specialty societies and other stakeholders, including the AMA.

## Where the AMA stands

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- Medicaid's role as a safety net must be supported and sustained. Increases in states' FMAP and other funding during economic downturns should be supported.
- Medicaid reform should be undertaken within the AMA's broader health insurance reform efforts, which support individually purchased and owned health insurance coverage as the preferred option.
- In the absence of private sector reforms enabling low-income people to purchase health insurance, eligibility expansions of Medicaid/CHIP should be supported.
- State efforts to expand Medicaid eligibility as authorized by the ACA should be supported, and states that newly expand eligibility should receive three years of 100 percent federal funding.
- Any public option shall be made available to uninsured individuals who fall into the "coverage gap" in states that do not expand Medicaid—having incomes above Medicaid eligibility limits but below the federal poverty level, which is the lower limit for premium tax credits—at no or nominal cost.
- State waivers should be supported, provided they promote improved access to quality medical care; are properly funded; have sufficient provider payment levels; and do not coerce physicians into participating.
- Caps on federal Medicaid funding should be opposed, as should mandatory enrollment in managed care plans.
- Tying work requirements to Medicaid eligibility should be opposed, as should lock-out provisions that block Medicaid patients from the program for lengthy time periods.
- Medicaid should pay physicians a minimum of 100 percent of Medicare rates.
- Increases in Medicaid payments to physicians, as well as improvements and innovations in Medicaid that will reduce administrative burdens and deliver health care more effectively, should be supported.
- Streamlined application and enrollment processes for Medicaid/CHIP programs should be supported.
- Basic national standards of uniform eligibility for Medicaid should be supported, as should continuous eligibility, presumptive assessment of eligibility, auto-enrollment, and retroactive coverage to the time at which an eligible person sought medical care.
- Expanded Medicaid coverage for management and treatment of substance use disorders and for twelve months postpartum should be supported.

The AMA Council on Medical Service studies and evaluates the social and economic aspects of medical care and recommends policies on these issues to the AMA House of Delegates. See [the Council's Report on Medicaid Reform](#) (fall 2020) for more information on AMA policy and advocacy efforts.