DECEMBER 2013

THE COMMONWEALTH FUND

Issue Brief

How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion

SHERRY GLIED AND STEPHANIE MA

The mission of The Commonwealth Fund is to promote a high performance health care system. The Fund carries out this mandate by supporting independent research on health care issues and making grants to improve health care practice and policy. Support for this research was provided by The Commonwealth Fund. The views presented here are those of the authors and not necessarily those of The Commonwealth Fund or its directors, officers, or staff.

For more information about this brief, please contact:

Sherry Glied, Ph.D.
Dean
Robert F. Wagner Graduate School of Public Service
New York University
sherry.glied@nyu.edu

To learn more about new publications when they become available, visit the Fund's website and register to receive email alerts.

Commonwealth Fund pub. 1718
Vol. 32

Abstract: Following the Supreme Court's decision in 2012, state officials are now deciding whether to expand their Medicaid programs under the Affordable Care Act. While the states' costs of participating in the Medicaid expansion have been at the forefront of this discussion, the expansion has much larger implications for the flow of federal funds going to the states. This issue brief examines how participating in the Medicaid expansion will affect the movement of federal funds to each state. States that choose to participate in the expansion will experience a more positive net flow of federal funds than will states that choose not to participate. In addition to providing valuable health insurance benefits to low-income state residents, and steady sources of financing to state health care providers, the Medicaid expansion will be an important source of new federal funds for states.

★ ★ ★ ★ ★

OVERVIEW

A key provision of the Affordable Care Act is the expansion of the Medicaid program to residents with incomes at or below 138 percent of the federal poverty level ($15,856 for an individual and $32,499 for a family of four). The federal government will pay most of the costs of financing the Medicaid expansion, initially covering 100 percent of Medicaid costs for newly eligible enrollees. It will continue to cover those costs through 2016, and will then phase down its support. However, by 2020, the federal government will still pay 90 percent of the costs.[1]

In 2012, the Supreme Court ruled to allow states to choose whether to participate in the expansion. Many of the states declining to participate have pointed to a potential negative impact on their budgets, although research has shown that the costs to states of expanding Medicaid average less than 1 percent of state budgets.[2]

In this brief, we look at these outlays of federal funds in three different ways. First, we compare the expected flow of Medicaid expansion-related federal funds in 2022 (the year to which the Urban Institute projected Medicaid

House Vision 2020
1-21, 2015
Attachment 5

enrollment and spending under the law) to payments to state governments through federal highway subsidies and payments to state businesses through defense procurement contracts. Second, we compare the Medicaid payments to taxes raised by the federal government to fund the program. Like a substantial share of highway funds[3] and all funding for defense procurement contracts, federal funds that pay for state Medicaid programs are raised through federal general revenue collection. These revenues are raised from taxes paid by residents in all the states, whether or not they benefit from a specific federal spending program. Third, we compare the state's share of the cost of the Medicaid expansion in 2022—the match needed to draw these federal funds—to state expenditures that aim to draw private investments to states.

We find that the Medicaid expansion will be a relatively large source of federal revenue to state enterprises. The value of new federal funds flowing annually to states that choose to participate in the Medicaid expansion in 2022 will be, on average, about 2.35 times as great as expected federal highway funds going to state governments in that year and over one-quarter as large as expected defense procurement contracts to states.

No state would experience a positive flow of funds by choosing to reject the Medicaid expansion. Because the federal share of the Medicaid expansion is so much greater than the state share, taxpayers in nonparticipating states will nonetheless bear a significant share of the overall cost of the expansion through federal tax payments—and not enjoy any of the benefits.

Most states' budget costs of expanding Medicaid each year will be, on average, less than one-sixth the amount they pay to attract private businesses. In only four states, the costs of the Medicaid expansion in 2022 will be greater than the average amounts the states pay out annually to attract private funds.

States' decisions whether or not to expand Medicaid will have profound effects on their residents. State government officials should examine the incremental impact of the expansion on state budgets and the implications of the flow of federal money to their states.

BACKGROUND

In its 2012 decision, the Supreme Court gave state governments flexibility to decide whether to participate in the Affordable Care Act Medicaid expansions.[4] In making these decisions, states have largely focused on the implications of the expansion on state budgets. However, the flow of federal dollars to states related to the expansion is substantially greater than states' costs.

The Affordable Care Act's Medicaid Expansion

The Affordable Care Act includes a substantial expansion of eligibility for Medicaid. Beginning in January 2014, all documented residents under 65 years of age with incomes below 138 percent of the federal poverty level and who live in states choosing to participate in the expansion will be eligible for Medicaid.[5]

In states that do not participate in the expansion, analysts anticipate that some people already eligible for Medicaid who have not participated in the past will enroll. The federal government will fund a share of Medicaid costs for these participants who meet eligibility levels that predate the Affordable Care Act. The share is determined by states' current federal medical assistance percentages (FMAP), which range from 50 percent in Connecticut and New Jersey to 73 percent in Mississippi.[6] In states that choose to participate in the Medicaid expansion, Medicaid eligibility will expand to cover more people. Between 2014 and 2016, the federal government will pay 100 percent of the Medicaid costs for these newly eligible enrollees, declining to 90 percent by 2020.[7] In addition, the Affordable Care Act provides an enhanced federal matching rate to states that significantly expanded their Medicaid programs under waivers prior to the Affordable Care Act.[8]

State Options for Financing Medicaid Programs

States have used many strategies to fund their shares of the Medicaid program: transferring financing of existing state programs to Medicaid, for example, by including state-financed mental health clinics as Medicaid providers, or by raising funds through income taxes, sales taxes, tobacco taxes, corporate

5-2

taxes, or health care provider taxes.[9] Some states have used other sources, including funds obtained through the conversion of nonprofit insurers or hospitals to for-profit entities.[10] Because hospitals expect to see their uncompensated care costs decrease considerably if the expansion is implemented,[11] hospitals in some states have offered to accept new taxes in exchange for their states' participation in the Medicaid expansion.[12]

How Federal Funds Move to States

Most federal government programs disperse funds to residents, businesses, and governments in the states, for example, through the purchase of services from state businesses, the provision of social security benefits to retirees, or through federal matching grants for social service provision. The Medicaid expansion offers states an opportunity to draw new federal funds by choosing to participate in the program. Highway funds pay local road contractors and generate jobs and benefits for local residents, and defense procurement funds pay local businesses and generate local jobs. Similarly, new Medicaid expansion funds will pay local health care providers and generate jobs and health insurance benefits for residents.

Like state highway or defense procurement funds, federal funds that will be used to pay for the state Medicaid program expansions will be raised through federal revenue collection. Revenues are routinely collected from taxes paid by residents in all the states, including states that do not participate in a particular federal spending program. They are raised through income taxes (71%), corporate taxes (15%), and estate, gift, and excise taxes (14%).[13] Social insurance tax payments (mainly for Medicare and Social Security) cannot be used to fund Medicaid.

Overall, the Congressional Budget Office has estimated that the Affordable Care Act will reduce the federal deficit by $143 billion between 2010 and 2019.[14] Savings in some programs, such as reductions in payments to Medicare managed care plans, and new revenue collections in others, such as new taxes on tanning salons, will more than cover the costs of the new subsidies available for people purchasing coverage in the marketplaces and the Medicaid expansions. However, these savings and new revenue sources will not be formally earmarked for the subsidies and expansions.

There is substantial research that estimates the impact of federal revenue collections and disbursements at the state level.[15] Since most federal general revenues—income and corporate taxes—are collected through a progressive tax system (i.e., people with higher income pay more taxes), it is no surprise that the professional literature consistently finds that states with higher-income populations pay more in federal taxes than they receive in federal disbursements.[16] In the United States, the income tax system levies higher rates on those who earn more income, generating higher levels of federal tax payments in rich states. Federal spending follows a different pattern, based largely on state industrial and demographic composition. States with more defense industry suppliers and those with a higher share of agriculture tend to receive more net federal funding.[17]

FINDINGS

Federal Funds Going to States for Medicaid Expansion

States that choose to participate in the Medicaid expansion will gain considerable new federal funds. Exhibit 1 compares the additional expected federal funds that will go to states that participate in the Medicaid expansion in 2022 with the estimated amount of federal highway funds going to states and the estimated amount of federal defense procurement contracts going to states.

In all but eight states, the new federal funds that states receive from participating in the Medicaid expansion will exceed federal highway funds. On average, in 2022, states will receive about 2.35 times as much in new federal funds from participating in the Medicaid expansion than from the federal highway program.

Annual defense procurement contracts are expected to considerably exceed the total federal disbursements associated with the Medicaid expansion in 2022. On average, the Medicaid expansion in 2022 will draw slightly more than one-quarter as much federal funding to states as defense contracts will. In eight states, however, the Medicaid expansion is expected to draw more federal funding to the state than procurement contracts do.

Federal Funds Moving In and Out of States

Like other federal programs, including a portion of highway spending and all of defense procurement spending, funds used to pay for the Medicaid expansion will be drawn from federal general revenues. To assess the effect of the Medicaid participation decision on federal funds moving into and out of each state, we compare the flow of federal funds to states with the states' sources of general revenue (i.e., tax dollars) required to pay for the Medicaid expansion costs.

Exhibit 2 shows the distribution of federal funds across states in 2022. For each state, the exhibit shows the share of general tax revenue collected from the state and the federal funds going to the state—assuming that the state does not participate in the Medicaid expansion, but every other state does. In every case, choosing not to participate in the expansion generates a net loss of federal funds. Column 1 shows the share of general tax revenue that is likely to be collected from the state in this scenario. Column 2 shows the net loss of federal funding when states choose not to participate in the expansion.

As of November 2013, 20 states have decided to opt out of the Medicaid expansion.[18] By choosing not to participate, Texas, for example, will forgo an estimated $9.58 billion in federal funding in 2022. Taking into account federal taxes paid by Texas residents, the net cost to taxpayers in the state in 2022 will be more than $9.2 billion. Similarly, Florida's decision to not participate will cost its taxpayers more than $5 billion in 2022. In Georgia, the state will forgo $4.9 billion in federal funding without the expansion of Medicaid, and in turn, $2.8 billion will flow out of the state in 2022. In other states, the costs of not participating will be lower. In South Dakota and Wyoming, for instance, taxpayers will face a net cost of $224 million and $166 million in 2022, respectively.

Paying for Medicaid After 2020

Initially, states can participate in the Medicaid expansion without contributing new funding. After 2020, however, states will be required to pay 10 percent of the cost of coverage for the expansion population.

One way to look at these state payments is to compare them with other efforts to attract investments to the state. In Exhibit 3, we compare the states' costs with average annual state expenditures to attract private businesses, such as tax breaks provided to companies. On average, the states' costs in 2022 will be less than one-sixth the amount they pay out annually to attract private businesses.

POLICY IMPLICATIONS AND CONCLUSION

If adopted by all states, the Medicaid expansion is expected to provide health insurance to as many as 21.3 million Americans by 2022, improving their access to care and financial protection.[19] For states, this expansion in coverage will mean reductions in state uncompensated care costs and in spending for some state programs. It will also mean substantial changes in federal funding.

States often seek to increase their share of federal funds, lobbying for military bases, procurement contracts, and highway funds. Federal funding provides direct benefits and bolsters local economies. The opportunity to participate in the Medicaid expansion has potentially important benefits to states. In most states, for example, the increase in federal funding in 2022 from participating in the Medicaid expansion is roughly equivalent to one-quarter of the total value of federal procurements for that year and more than twice as much as all federal funding for highways.[20] In most cases, the investment to attract this federal funding is modest. For example, the gain in federal funds in Louisiana from participating in Medicaid is nearly twice as large as annual federal defense procurement spending in the state.[21] Even states that do not value the health and health system benefits of expanding Medicaid may value the expansion as a source of funds that benefits the state economy.

5-4

Notes

[1] J. Holahan, M. Buettgens, C. Carroll et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Nov. 2012).

[2] Ibid.

[3] U.S. Government Accountability Office, *Highway Trust Fund: All States Received More Funding Than They Contributed in Highway Taxes from 2005 to 2009* (Washington, D.C.: GAO, Sept. 2011).

[4] J. Banthin, H. Harvey, and J. Hearne, *Updated Estimates for the Coverage Provisions of the Affordable Care Act* (Washington, D.C.: Congressional Budget Office, March 2012).

[5] Holahan, Buettgens, Carroll et al., *Cost and Coverage Implications,* 2012.

[6] A. Mitchell and E. P. Baumrucker, *Medicaid's Federal Medical Assistance Percentage (FMAP), FY2014* (Washington, D.C.: Congressional Research Service, Jan. 2013).

[7] Holahan, Buettgens, Carroll et al., *Cost and Coverage Implications,* 2012.

[8] J. Holahan and I. Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, May 2010).

[9] T. A. Coughlin and S. Zuckerman, *States' Use of Medicaid Maximization Strategies to Tap Federal Revenues: Program Implications and Consequences* (Washington, D.C.: Urban Institute, June 2002).

[10] C. Burke and K. Fox, *State Financing for Health Coverage Initiatives: Observations and Options* (Albany, N.Y.: Nelson A. Rockefeller Institute of Government, State University of New York, June 2009).

[11] Holahan, Buettgens, Carroll et al., *Cost and Coverage Implications,* 2012.

[12] A. Beam, "Hospitals Could Pay to Expand Medicaid in South Carolina," *The State,* Jan. 30, 2013.

[13] Congressional Budget Office, "The Budget and Economic Outlook: Fiscal Years 2013 to 2023," (Washington, D.C.: CBO, Feb. 2013).

[14] Congressional Budget Office, *Selected CBO Publications Related to Health Care Legislation, 2009–2010* (Washington, D.C.: CBO, Dec. 2010), p. 4.

[15] H. B. Leonard and J. H. Walder, *The Federal Budget and the States: Fiscal Year 1999* (Cambridge, Mass.: Taubman Center for State and Local Government, John F. Kennedy School of Government, Harvard University, Dec. 2000).

[16] C. Dubay, *Federal Taxing and Spending Benefit Some States, Leave Others Paying Bill* (Washington, D.C.: Tax Foundation, Oct. 2007).

[17] C. Dubay, *Federal Tax Burdens and Expenditures by State* (Washington, D.C.: Tax Foundation, March 2006).

[18] Data on state Medicaid expansion from The Commonwealth Fund: http://www.commonwealthfund.org/Maps-and-Data/Medicaid-Expansion-Map.aspx.

[19] Holahan, Buettgens, Carroll et al., *Cost and Coverage Implications,* 2012.

[20] U.S. Census Bureau, *Consolidated Federal Funds Report for Fiscal Year 2010: State and County Areas* (Washington, D.C.: U.S. Department of Commerce, Sept. 2011).

[21] Ibid.

METHODOLOGY

This study combines data on the expenditures anticipated under the Medicaid expansion with information on the composition of federal revenues, on other federal expenditures, and on other state expenditures. We drew estimates of state and federal spending on Medicaid under alternative Affordable Care Act scenarios from John Holahan et al.'s report, *The Cost and Coverage Implications of the Affordable Care Act Medicaid Expansion: National and State-by-State Analysis.*[a] That report uses the Urban Institute's Health Insurance Policy Simulation Model (HIPSM) and Congressional Budget Office estimates to project the costs of Medicaid expansion at the federal and state level. Urban Institute projected Medicaid enrollment and spending under the law in the year 2022.

We obtained data on federal highway spending from the Federal Highway Authority, U.S. Department of Transportation, Obligation of Federal Funds Administered by the Federal Highway Administration during Fiscal Year 2011, Table FA–4B.[b] Highway funds are drawn from earmarked taxes contributed to the highway trust fund, but since 2005, a portion of funding for the trust fund has been drawn from general revenues. We obtained data on defense procurement contracts in fiscal year 2010 from Census Bureau, U.S. Department of Commerce, Consolidated Federal Funds Report, FY 2010, Table 5. We updated these figures to 2022 dollars using the Consumer Price Index from the Congressional Budget Office Economic and Budget Outlook 2012–2022.

The main source used to estimate the sources of federal general revenue collections was the Internal Revenue Service's "Gross Collections, by Type of Tax and State, Fiscal Year 2011."[c] The IRS 2011 reports railroad retirement and unemployment taxes separately, but combines "income tax not withheld" with SECA tax and combines "income tax withheld" with FICA tax. We adjust these figures using data from the 2010 Social Security Administration's Statistics of Old Age, Survivors, and Disability Insurance, which provides estimates on payroll tax payments by state.[d] Finally, we omit corporate tax payments from our calculation of the state share of federal general revenue receipts, because corporate tax payments are assigned to the state of corporate incorporation (often Delaware) and need not reflect the states of residence of the corporation's shareholders. For each of the data sets, we then calculated state shares of total federal general revenue collections (Exhibit 2, Column 1). Note that these calculations are all based on the distribution of federal revenues in 2010–2011. The flow of funds across states varies with changes in tax rates. Thus, the American Taxpayer Relief Act of 2012, which made changes to federal tax rates that will change the distribution of revenues raised, mainly by increasing marginal tax rates for the highest earners, will tend to raise tax revenue collections from those higher-income states that already pay a larger share of federal revenues.[e]

---

a J. Holahan, M. Buettgens, C. Carroll et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Nov. 2012).

b U.S. Government Accountability Office, *Highway Trust Fund: All States Received More Funding Than They Contributed in Highway Taxes from 2005 to 2009* (Washington, D.C.: GAO, Sept. 2011).

c Internal Revenue Service, "Gross Collections, by Type of Tax and State, Fiscal Year 2011" (Washington, D.C.: IRS, 2011), available at http://www.irs.gov/uac/SOI-Tax-Stats-Gross-Collections,-by-Type-of-Tax-and-State,-Fiscal-Year-IRS-Data-Book-Table-5.

d U.S. Social Security Administration, Office of Retirement and Disability Policy, *Annual Statistical Supplement, 2012,* "Old Age, Survivors, and Disability Insurance" (Washington, D.C.: SSA), Tables 4.B10 and 4.B12.

e C. Dubay, *Federal Tax Burdens and Expenditures by State* (Washington, D.C.: Tax Foundation, March 2006).

5-6

METHODOLOGY (CONTINUED)

In order to determine the effect on the flow of federal funds of a state opting out of the Medicaid expansion, we calculated projected federal Medicaid spending in each state and federal Medicaid-related taxes paid by each state in this scenario. We obtained projected federal Medicaid spending in each state from the Holahan et al. report. We computed federal taxes paid by each state under the assumption that only that state opted out of expansion. To do this, we subtracted the increase in federal Medicaid spending anticipated in that state if it expanded coverage from the aggregate change in federal spending assuming all states participated in the expansion. We then multiplied the resulting adjusted aggregate federal cost by the state's share of U.S. general revenue to obtain the total federal taxes paid by that state if it alone chose not to participate in the expansion. We obtained data on state incentive payments to private businesses from the New York Times Government Incentives Database.[f] We adjusted the figures to 2022 dollars using the Consumer Price Index from the Congressional Budget Office Economic and Budget Outlook 2012–2022.

---

f *New York Times*, "United States of Subsidies: A Series Examining Business Incentives and Their Impact on Jobs and Local Economies," 2012, available at http://www.nytimes.com/interactive/2012/12/01/us/government-incentives.html?_r=0.

5-7

Exhibit 1. Federal Funds Associated with Medicaid Expansion, Compared with Federal Highway Transportation Funds and Federal Defense Procurement Contracts, by State, 2022 (in $ millions)

State	Federal Funds Associated with Medicaid Expansion	Federal Highway Transportation Funds	Federal Defense Procurement Contracts
Alabama	2,102	975	10,414
Alaska	213	644	2,273
Arizona	1,530	940	13,857
Arkansas	1,828	665	1,455
California	10,008	4,717	52,866
Colorado	1,503	687	7,205
Connecticut	1,196	645	14,218
Delaware	292	217	279
District of Columbia	123	205	5,950
Florida	9,645	2,435	16,393
Georgia	4,918	1,659	10,717
Hawaii	486	217	3,007
Idaho	477	368	339
Illinois	3,160	1,827	9,107
Indiana	2,591	1,225	5,591
Iowa	572	618	1,992
Kansas	767	486	2,483
Kentucky	2,627	854	6,628
Louisiana	2,312	902	7,473
Maine	457	237	1,709
Maryland	1,749	770	15,374
Massachusetts	1,135	781	16,213
Michigan	2,567	1,353	5,220
Minnesota	818	838	1,945
Mississippi	2,121	622	2,090
Missouri	2,590	1,217	13,221
Montana	301	527	400
Nebraska	444	371	1,015
Nevada	816	467	1,682
New Hampshire	351	212	1,397
New Jersey	2,209	1,283	10,052
New Mexico	732	472	1,944
New York	8,642	2,157	11,270
North Carolina	5,781	1,338	4,639
North Dakota	341	319	369
Ohio	7,809	1,723	7,758
Oklahoma	1,252	815	3,083
Oregon	1,913	642	1,140
Pennsylvania	5,505	2,109	15,225
Rhode Island	429	281	994
South Carolina	2,312	807	5,753
South Dakota	307	362	717
Tennessee	3,328	1,086	3,967
Texas	9,582	4,056	38,804
Utah	784	414	3,226
Vermont	156	261	910
Virginia	2,144	1,308	51,656
Washington	1,221	871	6,589
West Virginia	1,278	562	441
Wisconsin	1,753	967	10,834
Wyoming	198	329	199

Note: Federal highway funds and defense procurement contracts updated to 2022 dollars using the Consumer Price Index from the Congressional Budget Office Economic and Budget Outlook 2012–2022.
Sources: Federal funds associated with Medicaid expansion from J. Holahan, M. Buettgens, C. Carroll et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Nov. 2012), Table 8; highway spending from Federal Highway Administration, "Obligation of Federal Funds Administered by the Federal Highway Administration During Fiscal Year 2011" (Washington, D.C.: U.S. Department of Transportation, Oct. 2012), Table FA-4B, available at http://www.fhwa.dot.gov/policyinformation/statistics/2011/fa4b.cfm; defense procurement contracts from U.S. Census Bureau, *Consolidated Federal Funds Report for Fiscal Year 2010: State and County Areas* (Washington, D.C.: U.S. Department of Commerce, Sept. 2011), Table 5.

5-8

Exhibit 2. Net Flows of Federal Funds if a State Chooses Not to Participate in the Medicaid Expansion, Assuming All Other States Participate, 2022

State	Share of General Tax Revenue Collected from State	Net Loss of Federal Funds ($ millions)
States that are not expanding Medicaid		
Alabama	0.8%	-943
Alaska	0.2%	-229
Florida	4.7%	-5,038
Georgia	2.5%	-2,862
Idaho	0.3%	-297
Kansas	0.8%	-950
Louisiana	1.4%	-1,655
Maine	0.3%	-294
Mississippi	0.4%	-431
Missouri	2.0%	-2,249
Nebraska	0.6%	-738
North Carolina	2.3%	-2,591
Oklahoma	1.1%	-1,264
South Carolina	0.7%	-807
South Dakota	0.2%	-224
Texas	8.6%	-9,217
Utah	0.6%	-719
Virginia	2.5%	-2,839
Wisconsin	1.6%	-1,848
Wyoming	0.1%	-166
States that are undecided about expanding Medicaid		
Indiana	1.8%	-2,044
Montana	0.2%	-196
New Hampshire	0.3%	-409
Tennessee	1.9%	-2,111
States that are expanding Medicaid		
Arizona	1.3%	-1,561
Arkansas	1.1%	-1,320
California	11.8%	-12,695
Colorado	1.7%	-1,941
Connecticut	1.9%	-2,219
Delaware	1.0%	-1,191
District of Columbia	0.8%	-891
Hawaii	0.3%	-292
Illinois	5.0%	-5,763
Iowa	0.7%	-846
Kentucky	1.0%	-1,144
Maryland	2.0%	-2,299
Massachusetts	3.2%	-3,675
Michigan	2.2%	-2,569
Minnesota	3.1%	-3,597
Nevada	0.5%	-619
New Jersey	4.8%	-5,493
New Mexico	0.3%	-379
New York	8.4%	-9,132
North Dakota	0.2%	-232
Ohio	4.6%	-5,080
Oregon	0.9%	-1,044
Pennsylvania	4.3%	-4,780
Rhode Island	0.5%	-533
Vermont	0.1%	-158
Washington	2.2%	-2,516
West Virginia	0.3%	-298

Notes: Assumes funding of expansion cost through general revenue collection (personal income only). Net loss of federal funds accounts for new federal spending for people who are currently eligible for Medicaid who newly enroll.

Sources: Data on state Medicaid expansion from The Commonwealth Fund: http://www.commonwealthfund.org/Maps-and-Data/Medicaid-Expansion-Map.aspx; personal income tax shares of general revenue calculated from Internal Revenue Service, "Gross Collections, by Type of Tax and State, Fiscal Year 2011" (Washington, D.C.: IRS, 2011), available at http://www.irs.gov/uac/SOI-Tax-Stats-Gross-Collections,-by-Type-of-Tax-and-State,-Fiscal-Year-IRS-Data-Book-Table-5.

5-9

Exhibit 3. States' Costs for Medicaid Expansion Compared with Spending to Attract Private Business, 2022 (in $millions)

State	States' Share of Medicaid Expansion Costs	State Incentive Payments to Attract Private Business
Alabama	246	343
Alaska	31	872
Arizona	166	1,821
Arkansas	212	534
California	1,347	5,164
Colorado	188	1,232
Connecticut	−109	1,065
Delaware	−168	53
District of Columbia	15	116
Florida	1,186	4,929
Georgia	573	1,734
Hawaii	-36	324
Idaho	55	419
Illinois	455	1,870
Indiana	279	1,141
Iowa	-40	276
Kansas	108	1,251
Kentucky	301	1,746
Louisiana	280	2,217
Maine	−70	624
Maryland	−150	686
Massachusetts	-1,031	2,799
Michigan	351	8,236
Minnesota	108	296
Mississippi	241	515
Missouri	336	120
Montana	41	125
Nebraska	55	1,721
Nevada	109	41
New Hampshire	42	48
New Jersey	307	840
New Mexico	74	313
New York	-5,186	5,028
North Carolina	690	817
North Dakota	45	41
Ohio	920	4,013
Oklahoma	154	2,712
Oregon	164	1,071
Pennsylvania	645	5,994
Rhode Island	55	441
South Carolina	265	1,110
South Dakota	36	34
Tennessee	390	1,957
Texas	1,222	23,654
Utah	88	256
Vermont	−135	504
Virginia	285	1,598
Washington	77	2,910
West Virginia	144	1,944
Wisconsin	56	1,895
Wyoming	26	111

Notes: Figures in database adjusted to 2022 dollars using the Consumer Price Index from the Congressional Budget Office Economic and Budget Outlook 2012–2022. States with negative dollar amounts in Column 1 have previously expanded eligibility for their Medicaid programs prior to the enactment of the Affordable Care Act. These states will get enhanced matches on the expansion populations; thus, their total spending will fall.
Sources: State expenditures from J. Holahan, M. Buettgens, C. Carroll et al., *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis* (Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured, Nov. 2012); state incentives from New York Times, "United States of Subsidies: A Series Examining Business Incentives and Their Impact on Jobs and Local Economies," 2012, available at http://www.nytimes.com/interactive/2012/12/01/us/government-incentives.html?_r=0.

5-10

About the Authors

Sherry Glied, Ph.D., is dean of the Robert F. Wagner Graduate School of Public Service at New York University. From 1989–2012, she was professor of Health Policy and Management at Columbia University's Mailman School of Public Health. Dr. Glied served as assistant secretary for Planning and Evaluation at the U.S. Department of Health and Human Services from July 2010 through August 2012. She is a member of the Institute of Medicine of the National Academy of Sciences and of the National Academy of Social Insurance, and is a research associate of the National Bureau of Economic Research. Dr. Glied's principal areas of research are in health policy reform and mental health care policy. She is the author of *Chronic Condition* (Harvard University Press, 1998), coauthor (with Richard Frank) of *Better But Not Well: Mental Health Policy in the U.S. Since 1950* (Johns Hopkins University Press, 2006), and coeditor (with Peter C. Smith) of *The Oxford Handbook of Health Economics* (Oxford University Press, 2011).

Stephanie Ma is a junior research scientist at New York University's Robert F. Wagner Graduate School of Public Service. She conducts research in the areas of health policy and healthcare reform. She is currently pursuing a master of public administration degree in Health Policy and Management at Wagner.

Editorial support was provided by Deborah Lorber.

THE COMMONWEALTH FUND

www.commonwealthfund.org

5-12

Economic and Employment Effects of Expanding KanCare in Kansas

Chris Brown, Rod Motamedi, Corey Stottlemyer
Regional Economic Models, Inc.

Brian Bruen, Leighton Ku
George Washington University

February 2013

Introduction

Kansas will soon decide whether it will expand its Medicaid program, KanCare, the publicly funded health insurance program for low-income residents. Under the Patient Protection and Affordable Care Act (ACA, sometimes known as Obamacare), states may decide whether to expand eligibility for their Medicaid programs to non-elderly adults whose family incomes are less than 133 percent of the federal poverty line (an annual income of about $31,000 for a family of four in 2013). To avoid creating undue financial burdens for states, the federal government will pay 100 percent of the medical costs of serving the newly eligible from 2014 to 2016, but its share will phase down to 90 percent for 2020 and the years thereafter.[1] The original intent of the ACA was that all states undertake this expansion, but the Supreme Court's decision in *National Federation of Independent Businesses v. Sebelius* established that states effectively had the option of whether to expand Medicaid eligibility. States may decide whether and when to implement an expansion, but, if it is adopted, Medicaid eligibility must rise to the 133 percent level.

The purpose of this report is to offer a balanced and comprehensive view of the economic, employment and budgetary effects of the decision of whether or not to expand

[1] States that had already expanded Medicaid coverage will have an enhanced matching rate for childless adults, eventually reaching 90 percent by 2020 and beyond.

This is an independent analysis of the economic impact of a Medicaid expansion, conducted by researchers at Regional Economic Models, Inc. (REMI) and the George Washington University (GW). This report was prepared for the Kansas Hospital Association and funded by the American Hospital Association. All opinions and conclusions in this report are those of the authors and do not represent institutional views of REMI, GW, the American Hospital Association or the Kansas Hospital Association.

5-13

Medicaid in Kansas. In considering whether to adopt the Medicaid expansion, a state must consider the budgetary and economic consequences of its decision, as well as the health consequences. In the normal course of consideration, a state office prepares a budget estimate of the cost to the state of adopting a new policy. While the budget estimates that are usually prepared are important, they often fail to provide a comprehensive view of the effects because they are focused solely on the direct costs that must be borne by the state.

This report offers a more comprehensive view of the total effect of a Medicaid expansion by also looking at the effect on:

- The level of additional federal funds that will be earned in Kansas due to the Medicaid expansion,
- Kansas' economic activity (that is, the gross state product),
- Employment levels in Kansas,
- State tax revenues that would increase due to higher economic activity, and
- Other budgetary savings, such as savings in other health care costs that may occur if Medicaid covers more low-income patients.

It is important to note that this report focuses on the effects of Kansas' decision to implement a Medicaid expansion, not the impact of the overall federal health law. Under the Supreme Court decision, other changes required by the ACA, such as the establishment of health insurance exchanges, increases in Medicaid primary care payment rates, or changes in how income is counted in Medicaid, will occur regardless of whether a state expands Medicaid or not. This report examines only the additional consequences of expanding Medicaid and assumes the other changes will take place as specified in the federal law.

Kansas' Medicaid Program

Currently, Kansas' Medicaid program serves adults with dependent children (i.e., non-elderly parents) who have family incomes below the standards used for the cash assistance program (TANF) offered by state's Department for Children and Families (DCF). The standard varies by family size, where in the state the family lives, and whether additional people live in the home. According to state eligibility documents, a typical family of four qualified in 2012 if its countable income is less than $471 per month.[2] Including disregarded income, the eligibility standard is about 32 percent of the federal poverty level, or roughly $7,540 in annual income for a family of four in 2013. Only adult caregivers such as parents and guardians are eligible;

---

[2] Kansas Department of Health and Environment. KanCare/Medicaid eligibility guidelines for parents/caregivers (updated October 5, 2012). Retrieved February 12, 2013, from http://www.kdheks.gov/hcf/medical_assistance/apply_for_assistance.html.

Kansas does not provide coverage to childless adults under age 65 unless they qualify because of a disability.

Kansas shares the expense of providing Medicaid coverage with the federal government. Today, Kansas' is responsible for 43.5% of most Medicaid spending in the state, and the federal government covers the remaining percentage.[3] The ACA substantially increased the federal matching rates for persons who are newly eligible through the Medicaid expansions, which will reduce state costs for this population. From 2014 to 2016, the federal government will fund 100 percent of spending for this population. This enhanced federal match declines to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and thereafter.

Estimates by the non-partisan Urban Institute indicate that implementation of the Medicaid expansion will increase the number of people in Kansas covered by Medicaid by 169,000 people by 2022.[4] These results are similar to those recently released by the Kansas Department of Health and Environment which estimated that an expansion would increase Medicaid enrollment by about 157,000 by 2022.[5] The Urban Institute projects that an additional 53,000 people who are eligible under today's eligibility rules but not currently enrolled will subsequently sign up due to the publicity and outreach related to health reform; sometimes people call this a "woodwork" effect. Kansas will have to pay the regular matching rate (currently 43.5%) for any Medicaid-covered services obtained by these individuals. Our estimates account for this woodwork effect, but it is worth noting that there will be a woodwork effect regardless of whether Kansas implements a Medicaid expansion or not. There will be substantial publicity and outreach because of the creation of the Health Insurance Exchange and other aspects of the ACA, and individuals with incomes in the Medicaid range should be referred to the Medicaid agency even if they initially applied for the Health Insurance Exchange. The woodwork effect would be somewhat smaller if Kansas does not expand Medicaid, as outreach efforts would likely focus on higher income populations eligible for the Health Insurance Exchange.

If Kansas does not expand Medicaid to 133 percent of poverty, some residents with incomes between 100 and 133 percent of poverty may instead get health insurance through the Health Insurance Exchange. These individuals likely will be fewer in number than those who enroll in Medicaid because the Exchanges will require greater contributions from recipients to enroll and to receive health care. Our analyses account for the fact that some in the 100 to 133

---

[3] The 43.5% matching rate applies to expenditures from October 2012 through September 2013.

[4] Holahan, J., Buettgens, M., Carroll, C. and Dorn, S. "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis." Kaiser Commission on Medicaid and the Uninsured. Nov. 2012.

[5] Kansas Department of Health and Environment. Analysis of Affordable Care Act Impact to Kansas Medicaid/CHIP Program, Feb. 13, 2013. Report by Aon Hewitt.

percent of poverty bracket will instead enroll in Health Insurance Exchanges if Medicaid is not expanded. Barring changes to the eligibility standards for the Exchanges set forth in the ACA, childless adults with family incomes below 100 percent of poverty ($23,550 for a family of four in 2013), but above the eligibility level for Kansas' Medicaid program ($7,540 for a family of four in 2013), will not be eligible for either the Exchange or for Medicaid.

Methods

The underlying purpose of this report is to illustrate the broad economic and employment consequences of a Medicaid expansion in Kansas. It is fundamental to understand that a Medicaid expansion has very broad economic impact, beyond the state budgetary costs. Since most of the increased costs will be borne by the federal government, there will be a substantial inflow of federal funds to Kansas, although some will also be paid by the state government. These funds will initially be paid to health care providers, such as hospitals, clinics, pharmacies and health insurance plans, as health care payments for Medicaid services. That represents the initial flow of funds. Next, the health care providers distribute these funds as salaries to health care staff, payments for other goods and services (such as the costs of rent, equipment, medical supplies, and other goods and services), and as state and local tax payments. This represents the secondary flow of funds. Finally, these funds flow into the broader state economy as workers and businesses use their income to pay for general goods and services, such as mortgages or rent, utility bills, food bills, transportation and educational services. In turn, the real estate, grocery and other firms distribute these funds as salaries to their employees and to buy other goods and services. Thus, the Medicaid funds trickle through the broader state economy and the total economic impact ends up being larger than the initial amount of Medicaid payments, since the money is recycled through many layers of the state economy. Economists sometimes refer to this phenomenon as the "multiplier effect," although the REMI model uses a more sophisticated approach.

Researchers from the George Washington University (GW) estimated the additional state and federal Medicaid expenditures (or savings) resulting from Medicaid expansion, based on recent estimates published by the Kaiser Commission on Medicaid and the Uninsured, based on the non-partisan Urban Institute's Health Insurance Policy Simulation Model.[6] The GW experts allocated these estimated expenditures among four health care sectors used in the fiscal and economic effects model, described below. The allocations rely on information from several sources, including state Medicaid expenditure data from the Centers on Medicare and Medicaid Services, Medicaid spending and enrollment projections from the Congressional Budget Office,

[6] Holahan et al., Nov. 2012

and publicly available reports and projections from the Kansas Department of Health and Environment, its contractors, and other Kansas-based analysts.

Using these inputs, experts at Regional Economic Models, Inc. (REMI) used a structural macroeconomic model to quantify the impact of the ACA on the broader Kansas economy, with and without the Medicaid expansion. Using its Tax-PI software, REMI simulated the statewide net fiscal and economic effects of expansion, and assessed the net effect of the changes in healthcare spending along with the direct costs to the state from additional enrollees, while considering the federal contribution both in the short and longer term. REMI's models have been used in thousands of national and regional economic studies, including studies of health care reform and health care issues around the United States. More information about the Tax-PI model is available in a technical appendix to this report.

The model used in this analysis covers the state of Kansas and includes 70 industry sectors, three of which pertain most closely to the health care industry data used in this analysis. The three health care sectors used in the model are outlined below with definitions from the U.S. Census Bureau's North American Industry Classification System along with one consumption category:

Ambulatory Health Care Services: Establishments in this sector provide health care services directly or indirectly to ambulatory patients and do not usually provide inpatient services. Health practitioners in this sector provide outpatient services, with the facilities and equipment not usually being the most significant part of the production process.

Hospitals: This sector provides medical, diagnostic, and treatment services that include physician, nursing, and other health services to inpatients and the specialized accommodation services required by inpatients. Hospitals may also provide outpatient services as a secondary activity. Establishments in the hospitals sector provide inpatient health services, many of which can only be provided using the specialized facilities and equipment that form a significant and integral part of the production process.

Nursing and Residential Care Facilities: Industries in the Nursing and Residential Care Facilities subsector provide residential care combined with either nursing, supervisory, or other types of care as required by the residents. In this subsector, the facilities are a significant part of the production process and the care provided is a mix of health and social services with the health services being largely some level of nursing services.

Spending on Pharmaceuticals: Pharmaceutical costs fall into two broad areas: distribution and manufacturing costs. Distribution costs include the retail, wholesale and transportation related costs, which are primarily local in nature. Pharmaceutical manufacturing often occurs in another state. REMI assumes that a portion of manufacturing costs may remain in the state, based on estimates of state manufacturing for pharmaceuticals obtained from other REMI models.

State Government Spending: This analysis does not include the state's share of funding for the Medicaid expansion. Given the balanced budget requirement, any additional dollar spent on Medicaid must come from somewhere else in the state. Revenue can come from economic growth, reallocation from other spending, new revenue sources, and cost savings in other health care programs. The net result of all these spending changes is likely to be negligible and thus it is excluded from this simulation.

Table 1 shows a summary of the estimated annual federal Medicaid expenditures by sector associated with the incremental federal funds received for a Medicaid expansion. These represent the "inputs" to the Tax-PI model. (We do not include the state funds on the assumption that the state would have used these funds on an alternative expenditure which would also have a multiplier impact, whereas the federal funds represent new money that would not otherwise be available to the state.)

Table 1: Inputs to Tax-PI Rounded (millions of nominal dollars)

Detail	2014	2015	2016	2017	2018	2019	2020
Ambulatory health care services	$160	$189	$215	$220	$238	$255	$275
Hospitals	$84	$93	$104	$106	$114	$122	$132
Nursing and residential care facilities	$40	$42	$44	$42	$42	$42	$43
Pharmaceutical and other medical products	$50	$58	$65	$67	$72	$78	$84
Adjustment for manufacturing costs	-$27	-$31	-$35	-$36	-$39	-$42	-$45
Adjustment for in-state manufacturing	$2	$3	$3	$3	$3	$4	$4
Total increase in federal funding	$334	$382	$428	$435	$466	$498	$533

The REMI model treats the input data as demand variables for the health care sectors. The demand variable induces increased growth of those industries, which simulates the effect of expanding government spending on health care. We note that only a portion of the health care expenditures result in increased output by state firms. For example, some patients, particularly those living near state borders, may receive care in an out-of-state facility. The most populous region in Kansas is the northeastern part of the state, along the border with Missouri, with many providers in the greater Kansas City area. Consequently, not all of the new Medicaid spending will be in-state. The regional purchase coefficient estimates the amount of demand satisfied locally. (Of course, in turn, if a bordering state expands Medicaid, Kansas health care providers would have increased revenue. But since this report focuses only on Kansas policies we effectively assume that no bordering states expand Medicaid. In this respect, these estimates may be a conservative representation of increased demand by Kansas health care providers.)

Table 2: Regional Purchase Coefficients - Averages 2014 - 2020

Category	Average
Ambulatory health care services	81%
Hospitals	74%
Nursing and residential care facilities	90%

Table 3: Estimated Demand for Health Services In-State and Out-of-State, 2014-2020 ($ millions)

Industry	Total In-State Inputs	Funds Out-of-State
Ambulatory health care services	$1,265	$287
Hospitals	$556	$197
Nursing and residential care facilities	$266	$29

Results

Any expansion of Medicaid will have economic impacts. This section estimates the inputs and results, and describes the cause and effect relationship between them. The results reflect the projected economic growth created by the ACA and its expansion of Medicaid coverage in Kansas. These outputs include an array of economic and demographic indicators including total state employment, gross state product, personal income, and total revenues. All following amounts are in nominal (i.e. not inflation adjusted) dollars.

State and Federal Expenditures for Expansion

Our estimates differ somewhat from other estimates currently available to the public, although they fall comfortably within the range of projections.[7] All estimates—others and ours—are approximate since it is impossible to know in advance exactly what the condition will be of the state's economy, how many people will participate or how high medical costs will be in the future. However, our projections provide a general sense of the overall magnitude and direction of expected economic and budgetary impacts. We compared our estimates of state costs with those produced by other organizations, such as the Kansas Department of Health and Environment, The Lewin Group and the Kansas Legislative Research Department. The estimates we have used are broadly comparable to most of the other estimates. For example, the Department of Health and Environment estimated that the state Medicaid cost associated with an

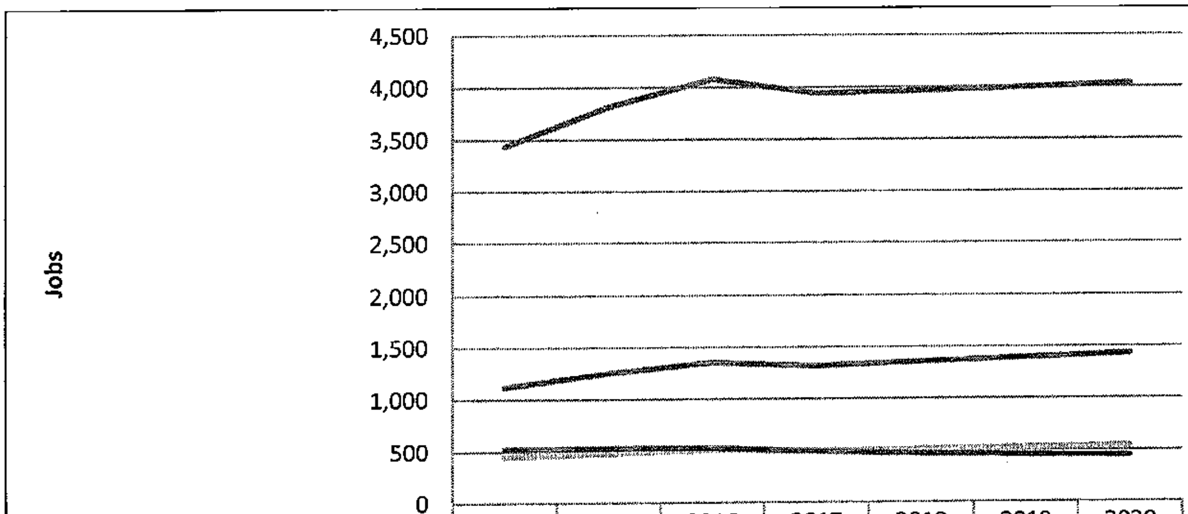
[7] A compilation of estimates from various sources by the Kansas Legislative Research Department is available at http://www.khi.org/documents/2013/feb/08/summary-cost-estimates-medicaid-expansion/. The Kansas Department of Health and Environment, Analysis of Affordable Care Impact to Kansas Medicaid/CHIP Program (by consulting firm Aon Hewitt) on February 13, 2013.

expansion would be $421 million from 2014 to 2022. Our estimate is slightly higher, $525 million from 2014 to 2022, but these estimates are comparable given the uncertainties of any long-term budgetary projections.

Total Change in Employment and Earnings

One of the most obvious ways that the economy affects people's lives is through creation of new jobs. The additional spending made necessary by expanding Medicaid will lead to millions of dollars of new money going into the health care industries noted above. Most beneficial to Kansas is the commitment of the federal government to cover 100% of the cost through 2016. The small reduction in the federal money coming into Kansas explains the small decrease in employment gains in 2017 and the steady increase thereafter. Figure 1 shows the expected change in employment resulting from the increase in demand for health care and the ripple effects and these changes. The net increase in overall state employment will be between 3,500 and 4,000 jobs. While the majority of these jobs will be in the health care sector, a substantial share will occur in other economic sectors, reflecting the broad multiplier effect of the Medicaid expansion on many sectors of the state economy. For example, to the extent that health care facilities need to expand to serve the newly covered patients, there will be real estate and construction costs that will boost employment in those sectors as well.

Figure 1: Changes in Employment Levels Due to Medicaid Expansion

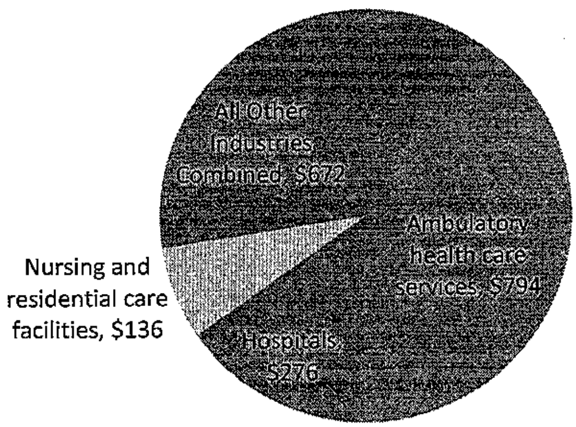


	2014	2015	2016	2017	2018	2019	2020
Total Employment	3,441	3,815	4,080	3,941	3,966	3,995	4,033
Ambulatory health care services	1,118	1,252	1,355	1,319	1,357	1,393	1,432
Hospitals	453	482	516	501	517	530	548
Nursing and residential care facilities	528	533	535	499	473	460	446

5-20

Each of the jobs shown in Figure 1 will come with a paycheck. Those paychecks together form Total Earnings by Place of Work, which is the sum of wages, benefits, and proprietors' income paid to employees working in Kansas. These earnings form the basis of Personal Income and increased consumption in the state. As such, they are of primary importance in driving changes in income and sales tax revenues. Figure 2 shows the cumulative change in earnings paid to those employed in Kansas.

Figure 2: Cumulative Earnings (2014-2020) (millions of nominal $)



Total Economic Activity

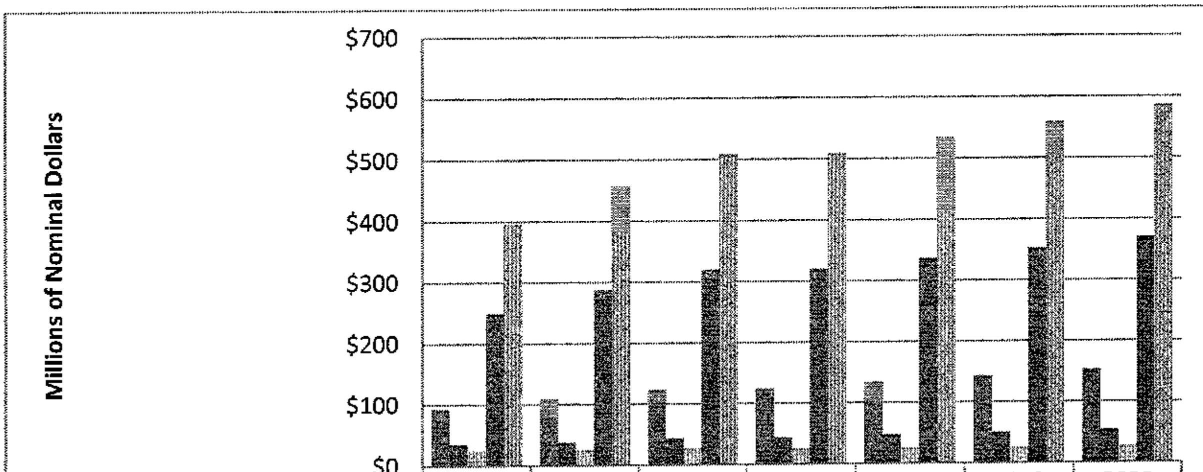
Because there is some leakage out of the state when using the demand variable, it is not a fair assessment of the results to equate the input amounts with the direct, *local* impacts. If we do this, we are underestimating the effect each dollar of local spending has had on the local economy. For example, we estimate that about 25 percent of the inputs in the hospital sector will be received by out-of-state hospitals. Therefore, it is unreasonable to use the full value of spending in the Hospital sector as the increase in revenues going to in-state hospitals.

There are two concepts commonly used to quantify economic growth: output and gross state product. Output is the same as revenues so every time a transaction is completed where money is exchanged output increases whether it is a business-to-business sale or one to the household consumer. As a result of the Medicaid expansion, output in Kansas is expected to increase by an average of $507 million per year for a cumulative increase of $3.55 billion from 2014 through 2020.

Gross State Product (GSP) is a subset of output and is the total new value created within Kansas. GSP can be thought of as all net new economic activity or output minus the goods and serves used as inputs to production. Which transactions are counted is the key difference between GSP and output: where output counts every transaction, GSP only counts the final transaction. As a result of the Medicaid expansion, GSP in Kansas is expected to increase by an average of $319 million per year for a cumulative increase of $2.24 billion from 2014 through 2020.

When choosing between the two concepts output is most appropriate when referring to changes in business activity, as it shows the total amount of new revenues received by all businesses in the state. However, when referring to new growth or value created in the state's economy, GSP is the best measure to use.

Figure 3: Contributions to Gross State Product by Industry and Other Totals Due to Medicaid Expansion



	2014	2015	2016	2017	2018	2019	2020
Ambulatory health care services	$94	$109	$123	$125	$134	$143	$154
Hospitals	$36	$39	$44	$44	$48	$51	$55
Nursing and residential care facilities	$25	$27	$28	$27	$27	$27	$28
Gross State Product	$249	$287	$319	$320	$336	$353	$371
Total Output	$396	$457	$508	$510	$534	$559	$586

State Tax Revenue Changes

The economic growth created by expanding Medicaid will create more revenue for the state. A simple way to understand where these revenues come from is to use the output growth shown in Figure 3 as an example. Each of these dollars means greater income for businesses which means more corporate income tax revenue for the state. This example can easily be expanded to understand how economic growth supports greater general tax revenues. Table 4 shows state revenues gained from economic growth.

Table 4: Change in State Revenues (millions of nominal $)

Category	2014	2015	2016	2017	2018	2019	2020	Total
Total Revenues	$6.1	$13.5	$15.9	$17.4	$18.5	$19.9	$21.3	$112.5

Other State Savings

The expansion of Medicaid eligibility has the potential to reduce other state or local expenditures for health care. Two prominent examples are state mental health expenditures and other state Medicaid-related eligibility categories including; MediKan, the state-funded health insurance program for general assistance enrollees waiting for disability determinations, and the medically needy for families component of Medicaid. Enrollees from both of these existing programs would be eligible for the Medicaid expansion instead.

Table 5 below provides a rough estimate of the value of state-funded community mental health expenditures[8] that might be instead covered by a Medicaid expansion. We assume that by 2016, one-third of those expenditures could be averted because the mental health patients could be served under Medicaid, and that savings ramp up gradually in 2014 and 2015. We also assume that MediKan and medically needy eligibility would no longer be needed because these adults could be served by the Medicaid expansions instead.[9]

Table 5: Potential Offsetting Health Care Savings If Medicaid is Expanded (millions of nominal $)

Category	2014	2015	2016	2017	2018	2019	2020	Total
Community Mental Health	$10.5	$22.8	$37.0	$40.0	$43.3	$46.8	$50.7	$251.1
MediKan & Medically Needy For Families	$7.8	$8.1	$8.4	$8.8	$9.1	$9.5	$9.9	$61.5
Total Offsetting Savings	$18.3	$30.9	$45.4	$48.8	$52.4	$56.3	$60.5	$312.7

[8] Data for state community mental health funding for years 2005 to 2010 came from the National Association of State Mental Health Directors Research Institute and were projected, assuming growth rates comparable to historical levels. This excludes funding for psychiatric hospitals, prevention, research, training and administration costs. Medicaid can cover the costs of ambulatory mental health services, but not inpatient psychiatric costs for adults.

[9] Data are based on FY 2012 Medicaid expenditures reported by the state Medicaid agency for MediKan and medically needy for families. We projected these expenditures assuming 4% annual growth.

It is likely that other savings are possible, such as costs of other miscellaneous state health programs or prison-related care, but we do not have a reasonable basis for providing estimates at this time. We note that such savings may not be possible if there are other needs for these services that are not now being met. For example, it is plausible that there are additional mental health needs that are not now being met by state funds; if a Medicaid expansion reduced the need for some current funding, these funds might instead be used to address other behavioral health needs.

Net State Costs

Table 6 summarizes overall net state costs for the Medicaid expansion. Again, we note that these costs are the incremental costs associated with expanding Medicaid vs. not expanding Medicaid. The state will have to cover ongoing Medicaid expenditures and other ACA-related changes regardless of the decision to expand Medicaid eligibility or not. These estimates suggest that the combination of new state revenues and offsetting savings could actually lead to substantial state savings in 2014 to 2016 and would be essentially almost budget neutral from 2017 to 2020, saving about $89 million from 2014 to 2020. While the state will incur small state costs in the years 2017 to 2020, it is worth remembering that the federal government will provide about $1.9 billion in matching funds in those years, far outweighing the modest state costs.

Table 6: Net State Government Costs of a Medicaid Expansion (in millions of nominal $)

Kansas Fiscal Impacts

Year	Increased State Medicaid Costs	New State Revenues	Offsetting State Health Savings	Net State Savings
2014	$13.0	$6.1	$18.3	$11.4
2015	$13.9	$13.5	$30.9	$30.5
2016	$14.8	$15.9	$45.4	$46.5
2017	$68.4	$17.4	$48.8	($2.2)
2018	$72.9	$18.5	$52.4	($2.0)
2019	$77.6	$19.9	$56.3	($1.4)
2020	$82.7	$21.3	$60.5	($0.9)
Total	**$343.2**	**$112.5**	**$312.7**	**$82.0**

Conclusion

Expanding KanCare to non-elderly adults with family incomes up to 133 percent of the federal poverty level will provide considerable economic benefits to Kansans on top of providing health insurance coverage for more than one hundred thousand Kansans. Our estimates of the enrollment increases and state costs are similar to, but not exactly the same as the estimates of the Kansas Department of Health and Environment; projections of future impacts always have some uncertainty. This analysis shows that expansion will increase direct Medicaid costs to the state, particularly after 2016 when the federal support for the expansion population begins to decrease. However, the state investments also enable the state to draw down billions of dollars in additional federal funding that will support jobs and maintain the state's health care infrastructure. The increases in employment and economic activity will occur both within the health care sector as well as in other sectors of the state economy. While Medicaid costs will increase, the state will realize additional state tax revenues that should offset a portion of the higher Medicaid costs. In addition, there are other potential offsetting state health care savings that could further reduce overall state costs, so there would be a net savings to the state's budget.

Robert Wood Johnson Foundation

Urban Institute

What Is the Result of States Not Expanding Medicaid?

Stan Dorn, Megan McGrath, John Holahan

Timely Analysis of Immediate Health Policy Issues **AUGUST 2014**

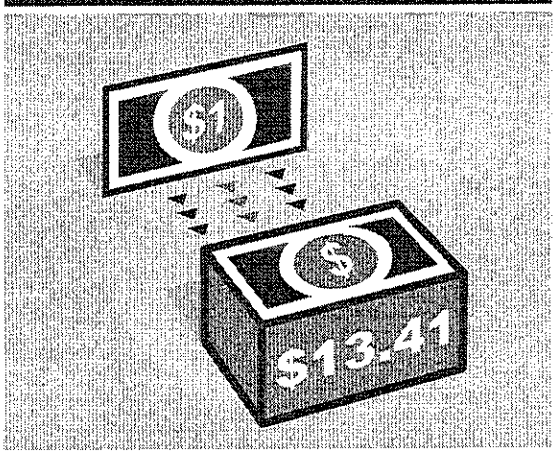
Results In-Brief

In the 24 states that have not expanded Medicaid, 6.7 million residents are projected to remain uninsured in 2016 as a result. These states are foregoing $423.6 billion in federal Medicaid funds from 2013 to 2022, which will lessen economic activity and job growth. Hospitals in these 24 states are also slated to lose a $167.8 billion (31 percent) boost in Medicaid funding that was originally intended to offset major cuts to their Medicare and Medicaid reimbursement.

A review of state-level fiscal studies found comprehensive analyses from 16 diverse states. Each analysis concluded that expansion helps state budgets. State savings and new state revenues exceeded increased state Medicaid expenses, with the federal government paying a high share of expansion costs. Even if future lawmakers reduce federal Medicaid spending, high federal matching rates are likely to remain at the ACA's enhanced rates, given historic patterns. Facing bipartisan gubernatorial opposition, Congress lowered the federal share of Medicaid spending just once since 1980, while cutting Medicaid eligibility, services, and provider payments more than 100 times. Medicaid expansion thus offers significant state-level fiscal and economic benefits, along with increased health coverage.

	State Price Tags to Expand Medicaid	Consequences of NOT Expanding Medicaid	
	10-year total cost to expand Medicaid (millions)	Federal Medicaid funding LOST (billions)	Hospital reimbursement LOST (billions)
Alabama	$1,081	$14.4	$7.0
Alaska	$147	$1.5	$0.6
Florida	$5,364	$66.1	$22.6
Georgia	$2,541	$33.7	$12.8
Idaho	$246	$3.3	$1.5
Indiana	$1,099	$17.3	$9.2
Kansas	$525	$5.3	$2.6
Louisiana	$1,244	$15.8	$8.0
Maine	$(570)	$3.1	$0.9
Mississippi	$1,048	$14.5	$4.8
Missouri	$1,573	$17.8	$6.8
Montana	$194	$2.1	$1.1
Nebraska	$250	$3.1	$1.6
North Carolina	$3,075	$39.6	$11.3
Oklahoma	$689	$8.6	$4.1
Pennsylvania	$2,842	$37.8	$10.6
South Carolina	$1,155	$15.8	$6.2
South Dakota	$157	$2.1	$0.8
Tennessee	$1,715	$22.5	$7.7
Texas	$5,669	$65.6	$34.3
Utah	$364	$5.3	$3.1
Virginia	$1,326	$14.7	$6.2
Wisconsin	$(248)	$12.3	$3.7
Wyoming	$118	$1.4	$0.4
Total:	$31.6 BILLION	$423.6 BILLION	$167.8 BILLION

For States that EXPAND Medicaid



For every $1 a state invests in Medicaid expansion, $13.41 in federal funds will flow into the state. Expanding Medicaid will likely also generate state savings and revenues that exceed expansion costs.

Urban Institute Robert Wood Johnson Foundation

Notes: Some states are shown with state Medicaid savings, indicated by placing numbers in parentheses, based on the assumed continuation of pre-ACA Medicaid eligibility for adults. State costs do not include offsetting savings and revenues.

5-26

Introduction

Twenty-four states have not expanded Medicaid eligibility to adults with incomes at or below 138 percent of the federal poverty level (FPL), as permitted by the Patient Protection and Affordable Care Act (ACA).[1] Here, we describe some coverage, fiscal, and macroeconomic implications of this choice, including previous results from the Health Insurance Policy Simulation Model. We also summarize state-specific fiscal analyses and examine the high federal matching rates on which those analyses rely.

The estimates we present generally are projections. They accordingly involve inherent uncertainty. However, the effects on states not expanding Medicaid are already being seen, even at this early date:

- **Coverage.** Between September 2013 and June 2014, the proportion of nonelderly uninsured adults in non-expansion states fell from 20.0 to 18.3 percent, compared to a drop from 16.2 to 10.1 percent in states that expanded Medicaid. Put differently, the number of uninsured declined by 9 percent in nonexpanding states and 38 percent in states that expanded Medicaid.[2] The proportion of America's uninsured living in nonexpanding states rose from 49.7 percent in September 2013 to 60.6 percent in June 2014.[3]
- **Hospital finances.** First-quarter, 2014 earnings reports from several interstate hospital chains described major differences between states that expanded Medicaid—where hospital finances improved as uncompensated care fell and Medicaid revenue rose, both by significant amounts —and nonexpanding states, where hospital finances worsened, with uncompensated care and self-pay patient caseloads rising and Medicaid revenue falling.[4]

Coverage

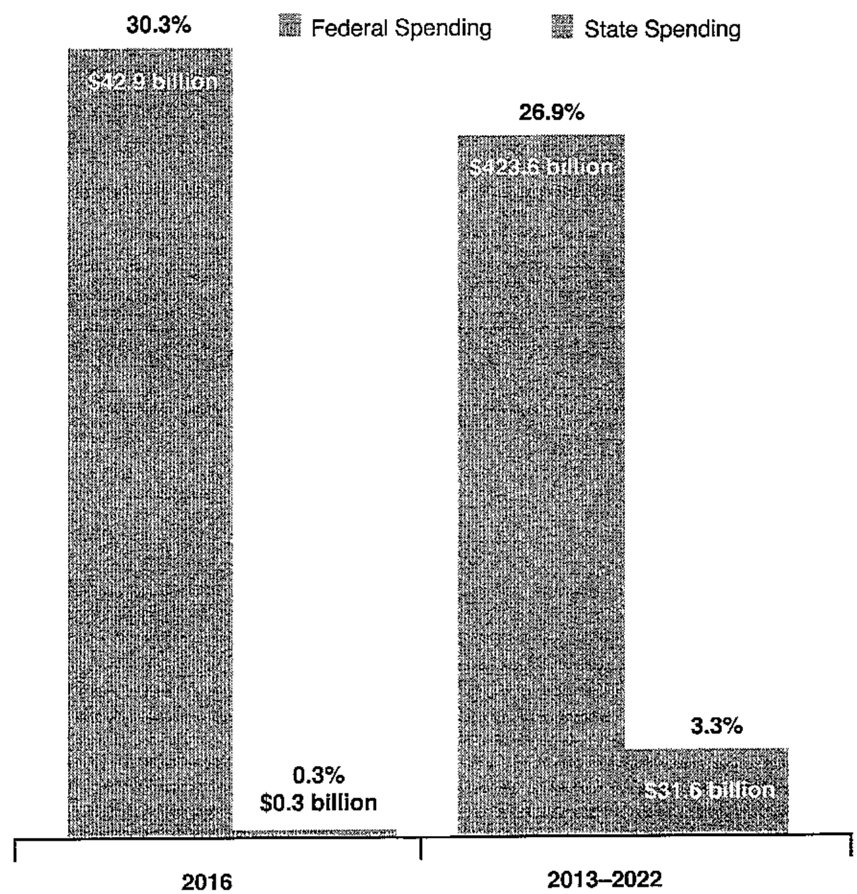
In the 24 states that have not expanded Medicaid, 6.7 million residents are projected to be uninsured in 2016 unless their states expand eligibility (table 2).[5] They will be ineligible for tax credits in health insurance marketplaces for two reasons: most have incomes below 100 percent FPL, the minimum income threshold for general tax credit eligibility in nonexpanding states; but some have incomes slightly above that level and are disqualified because of employer-sponsored insurance the ACA classifies as affordable. Coverage that firms offer to employees and their dependents is deemed affordable if worker-only insurance costs 9.5 percent of family income or less.

State Economies

The 24 nonexpanding states have rejected federal Medicaid funds projected to equal $42.9 billion in 2016, which would have increased such states' federal Medicaid receipts by 30.3 percent. To claim those resources, states would need to spend $0.3 billion ($291 million), representing a 0.3 percent increase over state Medicaid costs without expansion. Each additional state dollar would thus yield an extra $147.42 in federal funds.[6]

From 2013 to 2022, these states would forgo an estimated $423.6 billion in federal Medicaid funding, representing a 26.9 percent increase above federal Medicaid dollars received without expansion. The required state contribution is $31.6 billion, raising projected state Medicaid spend-

Figure 1. Increase in Federal and State Medicaid Spending That Would Result From Expansion: 2016 and 2013–2022 (States Not Currently Expanding Eligibility)



Source: Health Insurance Policy Simulation Model 2012.

Note: The figure shows how total Medicaid spending would change compared with spending under the ACA, without expansion. The figure does not include state savings or revenues resulting from expansion. States included in the figure had not expanded eligibility as of July 2014. They include Indiana, Pennsylvania, and Utah, which have pending waiver proposals to expand eligibility.

ing by 3.3 percent. Each new state dollar would accordingly draw down $13.41 in additional federal funds over this 10-year time period (figure 1).

The Council of Economic Advisers (CEA) recently concluded that expanding Medicaid under the ACA boosts state economic growth and employment, primarily by bringing in significant new federal funding to buy additional health care within the state. According to CEA's estimates, Medicaid expansion would add, in non-expanding states, 78,600 jobs in 2014, 172,400 jobs in 2015, and 98,200 jobs in 2016.[7] CEA expects the economy to return to full employment by 2017, after which CEA does not anticipate continued employment gains from Medicaid expansion, "because an increase in labor demand in one sector will mostly tend to reallocate workers away from other sectors." Many state-level analysts appear to assume less than full employment and project that Medicaid expansion would continue to boost job growth well beyond 2017.[8]

Ordinarily, health coverage expansions have little effect on net economic activity, because the increased growth triggered by additional health care spending is offset by economic shrinkage caused by paying for that spending. In this case, however, federal law rather than state decisions determine the ACA's financing mechanisms. The only question within state policymakers' control is whether to counter the adverse economic effects of those mechanisms by bringing in federal Medicaid dollars to buy additional health care. Adding these federal dollars to a state's economy while leaving the ACA's funding sources unchanged can generate economic growth and employment, as found by both CEA and state-level analysts.

To place state policy choices in perspective, the 24 states not expanding Medicaid spent an estimated $44.9 billion on tax reductions and other subsidies to attract private business during the most recent single year for which data are available.[9] Nonexpansion states thus spend on these business incentives more than 14 times the $3.16 billion average annual amount that would be required to finance Medicaid expansion during 2013–2022 (table 1).

Table 1. Cost to Expand Medicaid Compared with State Incentive Payments to Attract Private Business (Millions) (States Not Currently Expanding Eligibility)

	State cost to expand Medicaid (without considering offsetting savings and revenue)		Incentive payments to attract private business
	2013–2022		Most recent year for which data are available *Usually 2012, sometimes earlier*[10]
	10-year total	*Average annual amount*	
Alabama	$1,081	$108	$277
Alaska	$147	$15	$991
Florida	$5,364	$536	$3,980
Georgia	$2,541	$254	$1,400
Idaho	$246	$25	$338
Indiana	$1,099	$110	$1,010
Kansas	$525	$52	$1,790
Louisiana	$1,244	$124	$379
Maine	$(570)	$(57)	$416
Mississippi	$1,048	$105	$97
Missouri	$1,573	$157	$101
Montana	$194	$19	$1,390
Nebraska	$250	$25	$39
North Carolina	$3,075	$307	$2,190
Oklahoma	$689	$69	$896
Pennsylvania	$2,842	$284	$28
South Carolina	$1,155	$115	$19,100
South Dakota	$157	$16	$207
Tennessee	$1,715	$171	$1,290
Texas	$5,669	$567	$1,530
Utah	$364	$36	$89
Virginia	$1,326	$133	$921
Wisconsin	$(248)	$(25)	$4,840
Wyoming	$118	$12	$1,580
Total:	**$31,605**	**$3,160**	**$44,879**

Sources: Holahan, Buettgens, et al., July 2013; New York Times, December 2012, cited in Glied and Ma 2013.

Notes: Listed states had not expanded eligibility as of July 2014. They include Indiana, Pennsylvania, and Utah, which have pending waiver proposals to expand eligibility. Some states are shown with state Medicaid savings, indicated by placing numbers in parentheses, based on the assumed continuation of pre-ACA Medicaid eligibility for adults. Incentive payments to attract private business include tax reductions, grants, loans, loan guarantees, free services, and other subsidies. Totals may not add because of rounding.

Hospitals

The combination of increased private and Medicaid coverage is expected to yield hospital revenue that offsets the ACA's $22 billion in Medicaid cuts to disproportionate share hospital payments, $34 billion in Medicare disproportionate share hospital cuts, and $260 billion in Medicare fee-for-service cuts during 2013–2022.[11] In nonexpansion states, hospitals will pay the full cost of the ACA's funding mechanisms. However, they will receive only part of the increased revenue for the newly insured that was included in the ACA's original design, before the Supreme Court made Medicaid expansion optional for states.

The 24 states that have not expanded Medicaid are projected to cost their hospitals an estimated $15.9 billion in Medicaid revenue for 2016 and $167.8 billion for 2013–2022 (table 2). These sums would have raised hospitals' Medicaid payments by 32.3 percent and 30.7 percent, respectively.

Medicaid expansion increases hospital costs by increasing utilization. In addition, expansion modestly lowers hospitals' private insurance revenue, mainly by raising the lower bound of financial eligibility for marketplace subsidies from 100 to 138 percent FPL. However, these two factors are significantly outweighed by the increased Medicaid revenue resulting from expansion.[12]

State Budgets

In many states, both private- and public-sector organizations have analyzed the fiscal impact of Medicaid expansion. Comprehensive assessments considered effects in four categories:[13]

1. **Increased state costs because of new enrollees.** Expanded eligibility increases enrollment among people who qualify within pre-ACA eligibility categories, for whom states pay their standard share of Medicaid costs. This is sometimes called the "welcome mat" or "woodwork" effect. Beginning in 2017, states that expand coverage also pay a small percentage of costs for newly eligible adults.

Table 2. Projected consequences of States Not Expanding Medicaid

	Uninsured not qualifying for coverage (thousands)	Federal Medicaid funding lost (billions)		Hospital reimbursement lost (billions)	
	2016	2016	2013–2022	2016	2013–2022
Alabama	254	$1.5	$14.4	$0.7	$7.0
Alaska	25	$0.1	$1.5	$0.1	$0.6
Florida	1,060	$6.7	$66.1	$2.1	$22.6
Georgia	572	$3.4	$33.7	$1.2	$12.8
Idaho	78	$0.3	$3.3	$0.1	$1.5
Indiana	291	$1.8	$17.3	$0.9	$9.2
Kansas	109	$0.5	$5.3	$0.2	$2.6
Louisiana	287	$1.6	$15.8	$0.8	$8.0
Maine	30	$0.3	$3.1	$0.1	$0.9
Mississippi	201	$1.5	$14.5	$0.5	$4.8
Missouri	274	$1.8	$17.8	$0.6	$6.8
Montana	50	$0.2	$2.1	$0.1	$1.1
Nebraska	57	$0.3	$3.1	$0.1	$1.6
North Carolina	414	$4.0	$39.6	$1.1	$11.3
Oklahoma	182	$0.9	$8.6	$0.4	$4.1
Pennsylvania	381	$3.8	$37.8	$1.0	$10.6
South Carolina	237	$1.6	$15.8	$0.6	$6.2
South Dakota	34	$0.2	$2.1	$0.1	$0.8
Tennessee	257	$2.3	$22.5	$0.7	$7.7
Texas	1,552	$6.6	$65.6	$3.2	$34.3
Utah	98	$0.5	$5.3	$0.3	$3.1
Virginia	268	$1.5	$14.7	$0.6	$6.2
Wisconsin	11	$1.3	$12.3	$0.4	$3.7
Wyoming	20	$0.1	$1.4	$0.0	$0.4
Total:	**6,740**	**$42.9**	**$423.6**	**$15.9**	**$167.8**

Sources: Buettgens, et al. May 2014; Holahan, Buettgens, et al., July 2013; Dorn, Buettgens, et al., March 2013.

Notes: Listed states had not expanded eligibility as of July 2014. They include Indiana, Pennsylvania, and Utah, which have pending waiver proposals to expand eligibility. Totals may not add because of rounding.

2. **State Medicaid savings.** With expansion, some pre-ACA coverage qualifies for a higher federal medical assistance percentage (FMAP). For example, in a state with standard FMAP at the national average of 57 percent, suppose a Medicaid application is submitted by an adult with income below 138 percent of FPL who is eventually found to have a disability that qualifies him for Medicaid under pre-ACA rules. Such determinations typically take months to obtain. At that point, Medicaid retroactively covers care furnished while the application was pending.[14] If the state does not expand eligibility, it gets 57 percent FMAP for services provided before the disability determination. By contrast, if the state expands eligibility, the applicant is immediately classified as a newly eligible adult, and the state receives 100 percent FMAP for care provided before the disability determination, eliminating the state share of those costs.[15]

3. **Non-Medicaid savings.** For example, states generally fund mental health treatment for poor, uninsured adults. A state expanding eligibility can place most of these adults on Medicaid and shift many (but not all) of their mental health care costs to Medicaid, with the federal government taking over significant financial responsibilities from the state.

4. **Increased revenue.** Expansion raises state and local general revenue to the extent that increased federal Medicaid funding boosts economic activity. Also, many states tax provider or insurer revenue, which can rise with expansion.[16]

To illustrate, economic consulting firms commissioned by a consortium of Pennsylvania foundations concluded that, on balance, Medicaid expansion would help that state's budget by $5.1 billion during 2013-2022. Analysts reached the following conclusions about the four, above-listed categories of state fiscal effects:[17]

- Expansion would increase state Medicaid costs by $2.8 billion during 2013-2022, including $0.3 billion in "welcome mat" or "woodwork" expenses;

- State Medicaid costs for medically needy coverage and certain services for women would decline by $390 million, due to higher FMAP paid for affected beneficiaries;

- Pennsylvania would save $4.0 billion on non-Medicaid costs, including a pre-ACA health insurance program for childless adults, state mental health and substance abuse services, inpatient care for state prisoners, and state uncompensated care payments; and

- State personal and corporate income tax, sales tax, and insurance gross receipts tax revenue would increase by $3.6 billion.

After an intensive search, we found 57 fiscal analyses from 35 states estimating the impact of Medicaid expansion. For 16 states, we found comprehensive studies, like the Pennsylvania analysis, that included effects in all four categories. Each of those 16 comprehensive analyses found that expansion would help overall state budgets.[18] Given the ACA's very high FMAP for low-income adults, state-level savings and revenue exceeded increased state costs in every case, over whatever multi-year period was studied.[19]

The costs, savings, and revenues that result from expansion are highly context-specific, so a future comprehensive analysis in a different state might reach a different result. But that would be surprising, given the unanimous findings thus far in these 16 diverse states—California, Colorado, Kansas, Kentucky, Maryland, Michigan, Missouri, Montana, New Hampshire, New Mexico, Ohio, Oregon, Pennsylvania, Texas, Virginia, and Utah—as well as conclusions from other heterogeneous states like Indiana, Mississippi, New York, South Carolina, and Wyoming that expansion would help each state's overall budget, based on partial rather than full analyses of potential fiscal gains.[20] To illustrate the latter analyses:

- Researchers from the Universities of Alabama and South Carolina found that, in 2014-2020, increased general revenue resulting from expansion would exceed the state cost of expansion by $935 million, $848 million and $9 million for Alabama, Mississippi, and South Carolina, respectively—creating state budget gains even without considering possible state savings from enhanced FMAP or reduced spending on non-Medicaid programs;[21] and

- The Wyoming Department of Health found that savings resulting from enhanced FMAP and reduced spending on non-Medicaid programs would exceed increased state costs from higher Medicaid enrollment by $126.8 million, yielding overall state fiscal gains without considering any revenues resulting from expansion.[22]

Federal Matching Payments

Some state officials worry that Congress may not sustain the high FMAP ACA provides for expansion, on which the above favorable fiscal analyses rely.[23] These officials believe the federal government must someday focus on deficit reduction and, when it does, they fear it will have little choice but to cut ACA's unusually high FMAP for low-income adults.

Such fears can seem reasonable until one delves into Medicaid's current budget situation and past budget history. The federal Medicaid budget contains many other places to cut. For 2015, the Congressional Budget Office (CBO) estimates the federal government will spend $330 billion on Medicaid,[24] of which $42 billion results from the ACA's coverage expansion.[25] Within the latter amount, enhanced FMAP accounts for less than $21 billion,[26] or 6.4 percent of all federal Medicaid spending for 2015 (21/330=6.4%). Throughout all of 2015-2024, enhanced FMAP for expansion is projected to consume less than 7.4 percent of federal Medicaid spending (table 3).[27]

Historically, Congress has cut almost any other part of Medicaid before low-

Table 3. Increased Federal Matching Funds for Newly Eligible Adults as a Percentage of Total Federal Medicaid Spending, 2015–2027

	1. Increased federal Medicaid/CHIP costs resulting from ACA (billions of dollars)	2. Upper bound to increased federal costs resulting from enhanced FMAP (billions of dollars)	3. Total federal Medicaid spending (billions of dollars)	Maximum possible percentage of total federal Medicaid spending due to enhanced FMAP (2/3)
2015	42.0	21.0	330.0	6.4%
2016	62.0	31.0	368.0	8.4%
2017	70.0	31.5	397.0	7.9%
2018	77.0	33.9	418.0	8.1%
2019	82.0	35.3	441.0	8.0%
2020	84.0	33.6	464.0	7.2%
2021	87.0	34.8	490.0	7.1%
2022	91.0	36.4	516.0	7.1%
2023	96.0	38.4	545.0	7.0%
2024	101.0	40.4	576.0	7.0%
2025	107.1	42.8	610.6	7.0%
2026	113.5	45.4	647.2	7.0%
2027	120.3	48.1	686.0	7.0%
2015–24	792.0	336.2	4,545.0	**7.4%**
2016–25	857.1	358.1	4,825.6	**7.4%**
2017–26	908.5	372.5	5,104.8	**7.3%**
2018–27	958.8	389.1	5,393.8	**7.2%**

Source: CBO April 2014.[28]

***Notes:** FMAP is federal medical assistance percentage. CHIP is Children's Health Insurance Program. Enhanced FMAP costs estimated by CBO are necessarily below the amounts shown here as upper bounds, which are calculated based on the following assumptions: (1) All increased federal Medicaid/CHIP spending projected by CBO to result from the ACA is for newly eligible adults, the only group qualifying for enhanced FMAP; and (2) CBO's projection assumed that the only states implementing the Medicaid expansion: (a) receive the legal minimum 50 percent for standard FMAP, so increased FMAP for expansion consumes as much of the projection as possible, and standard FMAP consumes as little of the projection as possible; and (b) receive full increased FMAP, not the reduced increase to FMAP provided to states that expanded eligibility for poor adults before 2019. CBO estimates are through 2024. We extrapolated estimates for later years by assuming a continuation of 6 percent annual increases to Medicaid costs.*

ering the federal share of Medicaid costs, largely due to bipartisan gubernatorial resistance. Since 1980, 11 federal laws have made more than 100 different cuts to reduce projected Medicaid spending by eliminating benefits, raising consumer charges, cutting eligibility, reducing provider payments, etc.[29] Only once—in 1981—did Congress lower the federal share of Medicaid spending.[30] More recent budget bills actually *raised* the federal Medicaid share, even while making other federal Medicaid cuts.[31]

CONCLUSION

The states that did not expand Medicaid left nearly 7 million uninsured residents without help. While the number of uninsured in other states fell by 38 percent since September 2013, nonexpanding states experienced a decline of just 9 percent.

If they expand Medicaid, nonexpanding states would obtain more than $400 billion in federal funding over ten years, creating 172,400 jobs during 2015, according to the Council of Economic Advisers. Their hospitals would receive $168 billion in new revenue, offsetting the ACA's cuts to Medicare and Medicaid reimbursement. Every comprehensive state-level budget analysis of which we know found that expansion helps state budgets, because it generates state savings and additional revenues that exceed increased Medicaid costs. The current structure and past history of federal Medicaid spending show that, when federal leaders turn to deficit reduction, they will almost certainly seek and find other ways to cut Medicaid without lowering the federal share of Medicaid spending below the ACA's statutory level.

In nonexpanding states, officials face the challenge of securing expansion's practical benefits for their constituents without violating lawmakers' core principles. States have thus made creative expansion proposals that incorporate privatization, personal responsibility, and commercial-style benefits. Federal agencies receiving such proposals then face the challenge of accommodating state leaders' philosophical commitments without setting precedents that could endanger what federal officials view as Medicaid's essential features. Low-income Americans' access to care now depends on these diverse leaders working together effectively.

The views expressed are those of the authors and should not be attributed to the Robert Wood Johnson Foundation or the Urban Institute, its trustees, or its funders.

ABOUT THE AUTHORS & ACKNOWLEDGMENTS

Stan Dorn, Megan McGrath, and John Holahan are a senior fellow, a research assistant, and an Institute Fellow, respectively, at the Urban Institute's Health Policy Center. The authors appreciate the comments and suggestions of Genevieve Kenney of the Urban Institute. The authors are grateful to the Robert Wood Johnson Foundation for supporting this research.

ABOUT THE URBAN INSTITUTE

The Urban Institute is a nonprofit, nonpartisan policy research and educational organization that examines the social, economic and governance problems facing the nation. For more information, visit http://www.urban.org. Follow the Urban Institute on Twitter www.urban.org/twitter or Facebook www.urban.org/facebook. More information specific to the Urban Institute's Health Policy Center, its staff, and its recent research can be found at www.healthpolicycenter.org.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

For more than 40 years the Robert Wood Johnson Foundation has worked to improve the health and health care of all Americans. We are striving to build a national Culture of Health that will enable all Americans to live longer, healthier lives now and for generations to come. For more information, visit www.rwjf.org. Follow the Foundation on Twitter at www.rwjf.org/twitter or on Facebook at www.rwjf.org/facebook.

Notes

1 We include a state in this category if, as of July 2014, the state had not implemented Medicaid expansion. We therefore include Indiana, Pennsylvania, and Utah, notwithstanding those states' pending waiver proposals to expand eligibility.

2 Among uninsured adults with incomes at or below 138 percent FPL, states that expanded Medicaid saw uninsurance rates fall by 13.7 percentage points; non-expansion states did not experience a statistically significant decline. Sharon K. Long, Genevieve M. Kenney, Stephen Zuckerman, Douglas Wissoker, Adele Shartzer, Michael Karpman, Nathaniel Anderson, and Katherine Hempstead. *Taking Stock at Mid-Year: Health Insurance Coverage under the ACA as of June 2014.* July 29, 2015, Washington, DC: Urban Institute and Robert Wood Johnson Foundation, http://hrms.urban.org/briefs/taking-stock-at-mid-year.html. See also Sommers, BD, T Musco, K Finegold, MZ Gunja, A Burke, AM McDowell. "Health Reform and Changes in Health Insurance Coverage in 2014." *New England Journal of Medicine,* July 23, 2014, DOI: 10.1056/NEJMsr1406753. To similar effect regarding adults with incomes below poverty, see Collins, SR, PW Rasmussen, and MM. Doty. *Gaining Ground: Americans' Health Insurance Coverage and Access to Care After the Affordable Care Act's First Open Enrollment Period,* July 2014, New York, NY: The Commonwealth Fund, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2014/jul/1760_collins_gaining_ground_tracking_survey.pdf.

3 Adele Shartzer, Genevieve M. Kenney, Sharon K. Long, Katherine Hempstead, and Douglas Wissoker. *Who Are the Remaining Uninsured as of June 2014?* July 29, 2015, Washington, DC: Urban Institute and Robert Wood Johnson Foundation, http://hrms.urban.org/briefs/who-are-the-remaining-uninsured-as-of-june-2014.html.

4 See, e.g., Tenet Healthcare Corporation, "Tenet: Q1 '14," May 5, 2014, http://www.tenethealth.com/Investors/Documents/Earnings/Q1%202014%20SLIDES_2014_Q1_D_16_trr_FINAL%205_5_2014.pdf; Community Health Systems, Inc., "First Quarter 2014 Financial and Operating Results Conference Call," May 7, 2014; Hospital Corporation of American, "First Quarter 2014 Earnings Conference Call," April 29, 2014. The latter calls are summarized at Millman, J. "Hospitals see blue-red divide early into Obamacare's coverage expansion." *Washington Post Wonkblog,* May 12, 2014, http://www.washingtonpost.com/blogs/wonkblog/wp/2014/05/12/hospitals-see-blue-red-divide-early-into-obamacares-coverage-expansion/. See also Center for Health Information and Data Analytics. *Impact of Medicaid Expansion on Hospital Volumes,* June 2014, Denver, CO: Colorado Hospital Association. The latter analysis compared data from 465 hospitals in 15 expanding and 15 nonexpanding states, concluding as follows:

- "The Medicaid proportion of patient volume at hospitals in states that expanded Medicaid increased substantially in the first quarter of 2014. At the same time, the proportion of self-pay and overall charity care declined in expansion-state hospitals.... The Medicaid proportion of total charges increased over three percentage points to 18.8 percent in 2014 from 15.3 percent in 2013, representing a 29 percent growth in the volume of Medicaid charges. When compared to the first quarter of 2013, there was a 30 percent drop in average charity care per hospital across expansion states, to $1.9 million from $2.8 million. Similarly, total self-pay charges declined 25 percent in expansion states, bringing its proportion of total charges down to 3.1 percent from 4.7 percent."
- "Medicaid, self-pay and charity care showed no change outside normal variation for hospitals in non-expansion states in 2014."

5 Buettgens M, Kenney GM, and Recht H. *Eligibility for Assistance and Projected Changes in Coverage Under the ACA: Variation Across States, May 2014 Update.* Washington, D.C.: Urban Institute and Robert Wood Johnson Foundation, 2014. http://www.urban.org/url.cfm?ID=413129.

6 Holahan J, Buettgens M and Dorn S. *The Cost of Not Expanding Medicaid.* Washington, D.C.: Urban Institute, 2013. http://kaiserfamilyfoundation.files.wordpress.com/2013/07/8457-the-cost-of-not-expanding-medicaid4.pdf.

7 Council of Economic Advisers. *Missed Opportunities: The Consequences of State Decisions Not to Expand Medicaid,* July 2014, Washington, DC: http://www.whitehouse.gov//sites/default/files/docs/missed_opportunities_medicaid_0.pdf.

8 See, e.g., Missouri Office of Administration, Division of Budget & Planning. *Medicaid Restructuring Budget background.* February 2013, Springfield, MO, http://www.mobudget.org/files/Medicaid_Expansion_Save_MO_Money.pdf; Custer WS. *The Economic Impact of Medicaid Expansion in Georgia.* February 2013, Atlanta, GA: Institute of Health Administration, J. Mack Robinson College of Business, Georgia State University, 2013. For a comprehensive list of state macroeconomic analyses as of November 2013, see Kaiser Commission on Medicaid and the Uninsured, *The Role of Medicaid in State Economies and the ACA,* November 2013, https://kaiserfamilyfoundation.files.wordpress.com/2013/11/8522-the-role-of-medicaid-in-state-economies-looking-forward-to-the-aca.pdf.

9 New York Times, "United States of Subsidies: A Series Examining Business Incentives and Their Impact on Jobs and Local Economies," December 1, 2012, http://www.nytimes.com/interactive/2012/12/01/us/government-incentives.html?_r=0. In no state was the year in question more recent than 2012. This article is cited in Glied S and S Ma. *How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion.* New York: The Commonwealth Fund, 2013. http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2013/dec/1718_glied_how_states_stand_gain_lose_medicaid_expansion_ib_v2.pdf.

10 The date for which information about incentive payments is available varies by state and program. For example, the New York Times describes California as making at least $4.17 billion per year in incentive payments. All quantified payments are estimated for FY 2012 except $38.9 million in sales and use tax exemptions for clean technology manufacturing, estimated for calendar year 2011; $36.4 million for employment training services, estimated for FY 2009; and $211 million for the alternative and renewable fuel and vehicle technology program (involving cash grants, loans, or loan guarantees), estimated for calendar year 2010. The latter three incentive programs combined represent less than 7 percent of the state's quantified incentive payments as estimated by the New York Times, with the rest coming in FY 2012. Additional unquantified incentive payments are listed for pre-2012 time periods. Story, L, T Fehr and D Watkins, "California," *New York Times,* December 1, 2012, http://www.nytimes.com/interactive/2012/12/01/us/government-incentives.html?_r=1&.

11 Dorn S, Buettgens M, Holahan J and Carroll C. *The Financial Benefit to Hospitals from State Expansion of Medicaid.* Washington, D.C.: Urban Institute, 2013. http://www.urban.org/uploadedpdf/412770-The-Financial-Benefit-to-Hospitals-from-State-Expansion-of-Medicaid.pdf.

12 Dorn, Buettgens, Holahan, Carroll; Dorn, S, B Garrett, J Holahan. *Redistribution Under the ACA is Modest in Scope.* Washington, D.C.: Urban Institute, 2014. http://www.urban.org/UploadedPDF/413023-Redistribution-Under-the-ACA-is-Modest-in-Scope.pdf.

13 Expansion will also affect administrative costs. Some will rise—for example, more applications and renewals will need to be processed. Others will fall—for example, states with pre-ACA medically needy, "spend-down" coverage will carry out fewer labor-intensive spend-down determinations, because some former "spend-downers" will qualify as newly eligible adults. We are not aware of any state-level analysis that has analyzed administrative costs in a comprehensive way, taking into account specific factors like these, which are described in Holahan, Buettgens and Dorn, *The Cost of Not Expanding Medicaid.*

14 Coverage extends retroactively to care provided up to three months before the date of application.

15 After 2016, the state will start paying some of those costs, with its share rising to 10 percent in 2020 and beyond—still substantially less than the 43 percent it must finance if it does not expand eligibility.

16 When the Medicaid program pays state taxes or fees on providers or insurers, the state share of Medicaid payments is a "wash" fiscally—that is, the state Medicaid program pays the state revenue office—but the federal share is a transfer from the federal Treasury to the state. With expanded eligibility, most new Medicaid dollars are federal.

17 Pennsylvania Economy League, Inc., and Econsult Solutions, Inc. *The Economic And Fiscal Impact Of Medicaid Expansion In Pennsylvania.* April 2013, Harrisburg, PA: PA Health Funders Collaborative, http://economyleague.org/files/PEL_MEDICAID_EXPANSION_REPORT_FINAL.pdf.

18 For Colorado, Maryland, Michigan, New Mexico, Oregon, and Virginia, see Dorn S, Holahan J, Carroll C, et al. *Medicaid Expansion Under the ACA: How States Analyze the Fiscal and Economic Trade-Offs.* Washington, D.C.: Urban Institute, 2013. http://www.urban.org/UploadedPDF/412840-Medicaid-Expansion-Under-the-ACA.pdf. In addition, comprehensive analyses were conducted analyzing state fiscal effects in California, Ohio, Kansas, Kentucky, Missouri, Montana, New Hampshire, Pennsylvania, Texas, and Utah. For links to studies of the latter states, see the supplement to this paper, available at http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid-appendix.pdf.

19 Many (but not all) of these analyses find that, by the end of the estimated multi-year periods, when the federal share of costs for newly eligible adults falls to 90 percent, increased costs exceed, by a small amount, the combination of savings and revenues resulting from expansion. However, none of the estimates that we found considered state savings, which are likely to be significant, allowed by CMS's guidance permitting states to claim enhanced FMAP for health care costs provided for certain adults with disabilities at or below 138 percent FPL, including for services provided while such adults are awaiting their disability determinations. CMS. "Medicaid and the Affordable Care Act: FMAP Final Rule Frequently Asked

Questions." August 29, 2013, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Financing-and-Reimbursement/Downloads/FMAP-FAQs.pdf. On the other hand, if CEA's analysis of the impact of future labor markets on Medicaid expansion's macroeconomic effects is correct, revenue gains from Medicaid expansion may fall below projected levels, in some states.

20 The studies that considered only some of the above categories of state budget gains reached mixed conclusions. While most such studies found expansion had a negative overall impact, in 10 states analysts found net state budget gains even without considering all potential categories of state fiscal benefits. In addition to Minnesota and New York, (Dorn, Holahan, Carroll, et al., *Medicaid Expansion Under the ACA*) those states were Alabama, Indiana, Louisiana (under a scenario that did not increase provider reimbursement), Mississippi, South Carolina, Tennessee, Wisconsin (in one of several analyses), and Wyoming. For links to the latter studies, as well as the more numerous state-level analyses that failed to consider all categories of potential state fiscal gains and concluded that Medicaid expansion would harm state budgets, see the on-line supplement to this paper, available at http://www.urban.org/UploadedPDF/413192-What-is-the-Result-of-States-Not-Expanding-Medicaid-appendix.pdf.

21 The estimates for Alabama and Mississippi are for the "intermediate take-up scenario," Becker DJ and MA Morrisey. *An Economic Evaluation of Medicaid Expansion In Alabama under the Affordable Care Act.* Department of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham. 2012, http://www.soph.uab.edu/files/faculty/mmorrisey/Becker-Morrisey%20Study%20of%20Alabama%20Medicaid%20Expansion%202012.pdf; Becker DJ and MA Morrisey. *An Economic Analysis of the State and Local Impact of Medicaid Expansion in Mississippi.* Department of Health Care Organization and Policy, School of Public Health, University of Alabama at Birmingham. 2013. For the South Carolina estimates, see Von Nessen, J. *Medicaid Expansion in South Carolina: The Economic Impact of the Affordable Care Act.* December 2013, Columbia, SC: Moore School of Business, University of South Carolina, prepared for the South Carolina Hospital Association, http://www.scha.org/files/documents/medicaid_expansion_in_sc_report.pdf. Note that if CEA is correct and labor market slack completely disappears, Medicaid expansion may not yield the economic growth forecast by these state-level analysts, leading to less general revenue growth than anticipated.

22 Wyoming Department of Health. *The Optional Expansion of Medicaid in Wyoming: Costs, Offsets, and Considerations for Decision-Makers.* Cheyenne, WA: November 2012, http://www.health.wyo.gov/Media.aspx?mediaId=13196.

23 See, for example, New York Times Editorial Board, "A Health Care Showdown in Virginia," *New York Times*, May 10, 2014, http://www.nytimes.com/2014/05/11/opinion/sunday/a-health-care-showdown-in-virginia.html; Howell WJ and Cox K, "Medicaid Expansion: Promises on Future Costs Don't Ring True," *Richmond Times-Dispatch*, February 2, 2014, http://www.timesdispatch.com/opinion/their-opinion/columnists-blogs/guest-columnists/howell-and-cox-medicaid-expansion-promises-on-future-costs-don/article_0285f36b-9652-5a5a-9524-ae0f914d4afc.html; Associated Press, "Kansas Legislature Extends Ban on Medicaid Expansion," *Modern Healthcare*, April 5, 2014, http://www.modernhealthcare.com/article/20140405/INFO/304059935; Miller D, "Medicaid—To Expand or Not to Expand?" *Capitol Ideas: Council of State Governments E-Newsletter*, May/June 2014, http://www.csg.org/pubs/capitolideas/enews/issue108_1.aspx; Shorman J, "Shouting Protestors Shut Down Senate, Some Arrested," *Springfield News-Leader*, May 7, 2014, http://www.news-leader.com/story/news/local/ozarks/2014/05/06/shouting-protestors-shut-state-senate/8765497/.

24 CBO. *Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline.* April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf.

25 CBO. *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act*, April 2014. April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

26 That estimate is based on the following assumptions:, all of which assume the maximum possible proportion of federal Medicaid funding devoted to increased FMAP: (1) All increased federal Medicaid/CHIP spending projected by CBO to result from the ACA is for newly eligible adults, the only group qualifying for elevated FMAP; and (2) that CBO projection of increased spending assumed that the only states implementing the Medicaid expansion: (a) receive the legal minimum 50 percent for standard FMAP, so increased FMAP for expansion consumes as much of the projection as possible, and standard FMAP consumes as little of the projection as possible; and (b) receive full increased FMAP, not the reduced increase to FMAP provided to states, such as New York, that expanded eligibility for poor parents and childless adults before 2019.

27 That percentage will decline in the future as CBO's 10-year "scoring window" moves forward to include additional years with 90 percent FMAP and fewer years with 100 percent FMAP. That is why, as shown by table 3, the percentage of total federal Medicaid spending consumed by enhanced FMAP drops from an upper bound of 7.4 percent in 2015–2024 to an upper bound of 7.2 percent in 2018–2027.

28 Congressional Budget Office (CBO). *Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014.* April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf; CBO. *Detail of Spending and Enrollment for Medicaid for CBO's April 2014 Baseline.* April 2014. Washington, DC, http://www.cbo.gov/sites/default/files/cbofiles/attachments/44204-2014-04-Medicaid.pdf.

29 Omnibus Reconciliation Act of 1980 (P.L. 96-499), Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35), Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), Omnibus Budget Reconciliation Act of 1986 (P.L. 99-509), Omnibus Budget Reconciliation Act of 1987 (P.L. 100-203), Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508), Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P.L. 104-193), Balanced Budget Act of 1997 (P.L. 105-33), Deficit Reduction Act of 2005 (P.L. 109-171).

30 Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35). At that time, Medicaid's contribution to state budgets (hence governors' motivation to resist cuts) was a third of current levels. In 1981, state general fund expenditures totaled $145.0 billion, and the federal government spent $16.9 billion on Medicaid—the equivalent of 12 percent of state general fund dollars. By 2012, those two amounts rose to $666.8 billion and $237.9 billion, respectively. Federal Medicaid dollars thus equaled 36 percent of state general fund expenditures. See Center on Medicare and Medicaid Services. "National Health Expenditures by Type of Service and Source of Funds, CY 1960–2012," http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/NHE2012.zip; National Governors Association Office of Research and Development and National Association of State Budget Officers. *Fiscal Survey of the States: 1981-1982.* Washington D.C.: National Governors Association Office of Research and Development and National Association of State Budget Officers, 1982, http://www.nasbo.org/sites/default/files/pdf/fs1981-1982.PDF; National Governors Association Office of Research and Development and National Association of State Budget Officers. *The Fiscal Survey of States: Fall 2013.* Washington, D.C.: National Governors Association Office of Research and Development and National Association of State Budget Officers, 2013, http://www.nasbo.org/sites/default/files/NASBO%20Fall%202013%20Fiscal%20Survey%20of%20States.pdf.

31 For example, the two most recent budget reconciliation bills that made Medicaid cuts were the Balanced Budget Act of 1997 (BBA) and the Deficit Reduction Act of 2005 (DRA). The BBA eliminated the need for federal waivers before states could force Medicaid beneficiaries into closed-panel managed care plans; repealed the so-called "Boren Amendment," thereby letting states cut payments to hospitals and nursing homes; cut payments to federally qualified health centers, pediatricians, and obstetricians; cut payments to providers serving Medicare Savings Program beneficiaries; and limited states' use of disproportionate share hospital payments and provider donations and taxes. At the same time, the BBA raised FMAP for Alaska and the District of Columbia and increased the dollar ceiling on FMAP claimable by U.S. territories. Several years later, the DRA cut Medicaid payments for prescription drugs; cut Medicaid eligibility for long-term care; required states to take specified anti-fraud measures; increased private insurers' third-party liability payments to Medicaid; let states raise beneficiaries' premiums and co-payments; let states cut benefits for adults; limited states' use of managed care taxes; ended coverage of certain case management services for children; made it harder for applicants to prove U.S. citizenship; capped emergency payments to out-of-network providers for managed care enrollees; and terminated states' authority to grant new CHIP waivers to cover childless, nonpregnant adults. At the same time, the DRA raised FMAP for Alaska, Louisiana, and the District of Columbia and increased the dollar cap on FMAP for U.S. territories. Other examples of increased FMAP include enhanced FMAP to provide state Medicaid programs with fiscal relief in 2003 and 2009, neither of which was accompanied by Medicaid cuts; an elevated federal match rate for covering children through CHIP, enacted as part of the BBA in 1997, that exceeded the federal match rate available through previous Medicaid coverage expansions for children; and still higher match rates for covering newly eligible adults enacted through the ACA in 2010.