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What Is the Result of States Not Expanding Medicaid?

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Timely Analysis of Immediate Health Policy Issues

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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	For States that **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 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.

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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.

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

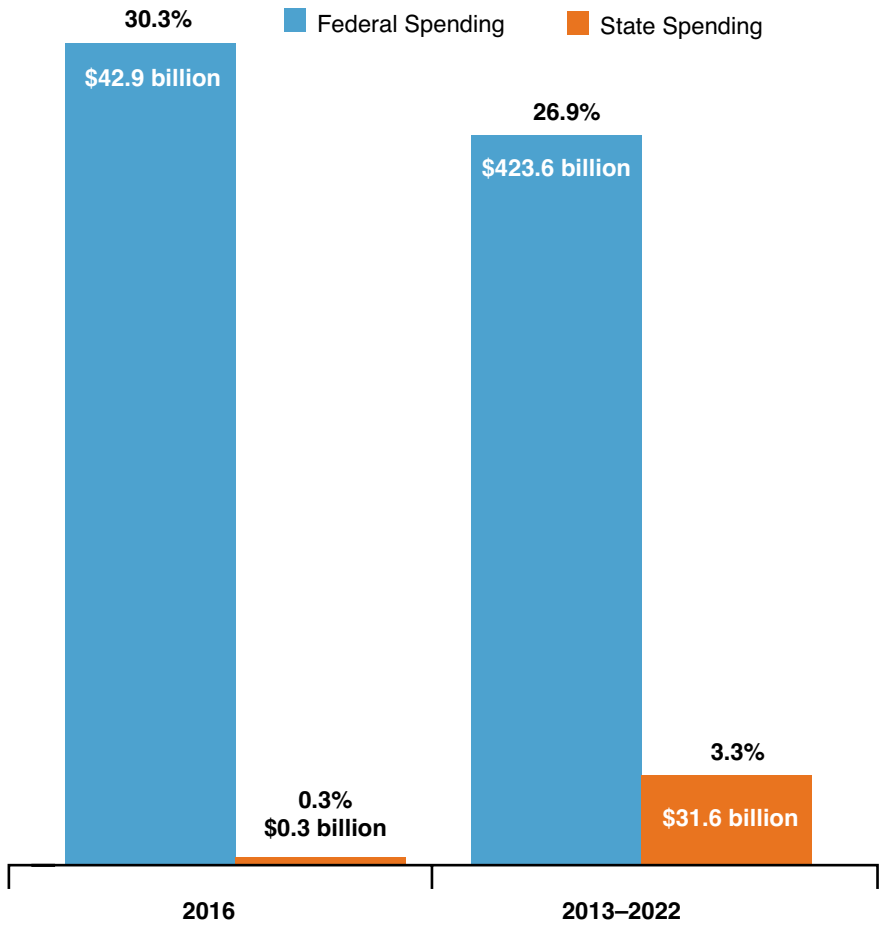
In the 24 states that have not expanded Medicaid, 6.7 million residents are projected to be uninsured in 2016 unless their states expand eligibility (table 2).[5] They will be ineligible for tax credits in health insurance marketplaces for two reasons: most have incomes below 100 percent FPL, the minimum 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 nonexpanding 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.

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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.

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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."

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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.