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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

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.

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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

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

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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

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.

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]

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[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).

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.

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[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.

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.

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.

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.

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.

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