RESEARCH

Expanding Medicaid Will Not Stimulate the Economy or Create Jobs

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Executive Summary

Over the past year, several studies have claimed that the Affordable Care Act's (ACA) Medicaid expansion will create new jobs and economic activity, and that states that decline the expansion are needlessly forgoing jobs and economic growth that could be obtained at no cost. These studies—ranging from a nationwide study[1] from the President's Council of Economic Advisers (CEA), to state-specific studies from numerous interest groups and academics[2]—all use similar methodologies. They arrive at their results by ignoring necessarily offsetting factors, and thus their claims are unfounded. In this research, the American Action Forum (AAF) estimates of the impact of the Medicaid expansion on a state-by-state basis, taking into account all available offsetting factors. Expanding Medicaid may have many effects; however, we find that increased employment and economic activity are not among them. Instead we find that Medicaid expansion, if adopted by all states, would result in a direct net loss of up to $174 billion in economic growth nationwide over ten years, and would result in the loss of over 206,000 full-year-equivalent jobs for the years 2014 to 2017.

Background

The ACA allows states to expand Medicaid eligibility to previously ineligible individuals (mostly non-disabled childless adults under age 65) in households with incomes below 138 percent of the federal poverty level. For this "expansion population," the federal government will pay states a much higher percentage of the cost than for the previously eligible population, 100 percent through 2016, gradually decreasing to 90 percent by 2020. In some cases, the expansion will extend coverage to people who would not otherwise be covered. In other cases it will transfer people from subsidized exchange-based health plans to Medicaid, because Medicaid eligibility disqualifies an individual for exchange plan subsidies. It may also shift some individuals from dependent coverage through a family member's employer to Medicaid.[3]

Will the Medicaid Expansion Create Jobs and Economic Growth?

Recently, the CEA released a report stating that:[4]

> By pumping more Federal dollars into their economies, States' decisions to expand Medicaid create jobs. If the 24 States that have not yet expanded Medicaid had done so as of January 1, 2014, they would have boosted employment by 85,000 jobs in 2014, 184,000 jobs in 2015, and a total of 379,000 job-years through 2017. States that have already expanded Medicaid will boost employment by 79,000 jobs in 2014, 172,000 jobs in 2015, and a total of 356,000 job-years through 2017.

Further, the report states that overall economic activity, in the sense of Gross Domestic Product (GDP) will increase as well:

> By pumping more Federal dollars into their economies, States' decisions to expand Medicaid increase the overall level of economic activity. If the 24 States that have not yet expanded Medicaid had done so as of January 1, they would have created an additional $66 billion in total economic activity through 2017. States that have already expanded Medicaid will create $62 billion in total economic activity through 2017.

No one can seriously dispute that "more Federal dollars" devoted to a particular purpose will result in jobs and economic activity *directed at that purpose*. There is even a reasonable argument (also made by CEA) that there will be further jobs and economic activity "downstream" from the federal spending. For example, if Medicaid money is used to pay health care workers, those workers will spend that money on something else.

However, that does not necessarily mean that there will be a net increase of total jobs, or total economic activity, throughout the economy. The reason is simple. Those "more Federal dollars" spent on Medicaid come from somewhere. Before the dollars were "federal dollars," they were taxpayer dollars. Every dollar of increased federal spending must ultimately be a dollar of decreased spending by a taxpayer elsewhere in the economy.[5]

One state-level study partially took this into account.[6] In estimating the impact of the proposed expansion on the state of Georgia, William Custer subtracted Georgia's share of federal taxes from projected federal spending on the Medicaid expansion in Georgia. This adjustment is correct in principle, but it ignores the fact that Georgia taxpayers will also have to pay their share of taxes for the federal dollars spent on the Medicaid expansion in all the other states that implement it. In essence, Custer's calculation implicitly assumes that *only* Georgia expands Medicaid.[7]

It is possible that the Medicaid expansion will have macroeconomic impact on specific states. Because each state's proportion of federal taxes may be different from its proportion of Medicaid expansion funds, it is possible that jobs and economic activity could move around from state to state. However, the total level of jobs and economic activity cannot increase.

In fact, total GDP and employment will actually decrease, because taxation itself has a negative effect on economic activity, over and above the amount of tax collected. Every time some activity or product is taxed, the incentive to engage in that activity or buy that product is reduced. The amount of the product never consumed produces no benefit, and also no tax revenue. This phenomenon is referred to as "deadweight loss" and is a standard topic in introductory economics courses.[8]

Drawbacks of Previous Work

In addition to the CEA report discussed above, there has also been a nationwide study sponsored by the Commonwealth Fund (discussed below), and numerous state-level studies. A report by the Kaiser Family Foundation[9] tabulated 32 studies regarding 26 different states; there are at least two additional studies as well.[10,11]
Previous studies of the macroeconomic effects of the Medicaid expansion generally contain one or more of the following methodological flaws.

First, as explained above, a study may fail to account for the fact that the additional dollars spent on Medicaid have to come from somewhere. In particular, they have to come from taxes paid by Americans. Every dollar of increased economic activity due to Medicaid spending is offset by a dollar not spent somewhere else in order to pay the taxes that fund Medicaid.

Second, a study may fail to account for the offsetting change in premium subsidies for exchange coverage. Those eligible for Medicaid are not eligible for premium subsidies for ACA exchange coverage for which they would otherwise qualify, so some of the increased federal spending in states that expand Medicaid is offset by reduced federal spending on premium subsidies in those same states.

Third, some studies count the stimulus effect of "additional utilization of care" as well as "lower out-of-pocket medical costs," which are said to stimulate the economy because Medicaid coverage enables patients to spend more on non-health goods and services because they are spending less on health care. Of course, the reason for lower out-of-pocket spending by patients is higher spending by government. The study counts both the dollars spent by the government on health care, and the dollars spent by the patients on other things. Yet, "lower out-of-pocket medical costs" means that if the patients hadn't spent the money on other things, they would have spent it on the health care now paid for by the government. So, the additional spending should be that amount counted once (as government spending) not twice (as government spending and patient consumer spending).

As an example, suppose that, without the expansion, a particular patient in the expansion population would spend $100 out-of-pocket for medical care. That represents $100 of economic activity. If the state accepts the expansion, the federal government would spend that $100 for the patient's medical care, and the patient would spend the $100 on something else. This would represent $200 in economic activity, for an increase of $100. However, some studies take the $100 the government spends as "federal spending on medical care" and the $100 the patient spends on something else is "lower out-of-pocket medical costs," and both are counted for a total increase of $200. In reality, the actual increase for this particular patient is only $100–and that is offset by $100 in taxes, for a net increase in total spending of $0.

The CEA study discussed above did take into account the offsetting effect of the loss of exchange subsidies, but failed to account for the taxes needed to pay for the expansion, and included in their estimate of additional spending effects that are offset by the expansion itself, essentially counting the same spending twice. The CEA also makes a

double-counting error with respect to the costs of uncompensated care borne by state and local governments.

A study by the Commonwealth Fund[12] took into account the offsetting effect of federal taxes paid by each state, but failed to account for the loss of exchange subsidies. Oddly, even after accounting for federal taxes, they found a net loss of federal funds, if they chose to forgo the expansion, for each and every state, regardless of the proportion of federal taxes paid by that state. In other words, they are claiming that every state gains more in federal funds than they pay in taxes, a plain violation of the laws of arithmetic. Buried in a footnote is the "explanation": they include in the loss federal spending on previously eligible (non-expansion) individuals who enroll after the implementation of the ACA in January 2014. Not only is this unrelated to a state's decision to take the expansion, it requires assuming that non-expansion individuals enroll if states forgo the expansion, but do not enroll if states accept the expansion.[13]

Inherent in the assumption that Medicaid eligibility increases spending is the implicit assumption that there is enough unused capacity in the health care system—doctors with idle time, empty hospital beds, etc.—to treat the additional patients. In addition to assuming that this capacity exists, it must be assumed that the providers with this capacity are willing to accept Medicaid payment rates—something a significant percentage of physicians are already reluctant to do.[14] Furthermore, even if all desired services are obtainable by Medicaid patients, patients in the expansion population are, by definition, able-bodied, non-disabled, and non-elderly. It is quite possible that, on average, they need less health care than the average current Medicaid patient. Because Medicaid dollars are generally paid out only when a patient obtains services,[15] estimates of expansion spending based on current per-patient Medicaid spending may be somewhat overstated. Only one study of which we are aware explicitly considered the issue of health system capacity.[16]

The CEA report considered the different, but conceptually related, issue of excess capacity in the economy. The CEA's estimate of job growth as a result of the Medicaid expansion, according to their report, depends on their assumption that there is "slack in the economy and productive resources are not fully employed."[17] That assumption is almost certainly correct for the economy as a whole. However, the macroeconomic effects of the Medicaid expansion, by definition, starts with increased spending on, and production of, health care services. That is, it requires slack in the health care sector. Indeed, the fact that many existing providers (other than hospitals) already decline to take Medicaid patients due to low payment rates suggests that such resources are *not* underemployed at present.

In any case, the CEA report notes that its general macroeconomic model forecasts that the economy will return to full employment in 2017. Therefore, they predict zero additional jobs due to the Medicaid expansion beyond 2016.

The CEA's projection of zero job impact after 2016 is not followed by most of the state-level studies. For example, a Georgia study[18] included a forecast model for a single year

(2014), predicted some number of additional jobs, and assumed those jobs will be there every year for the ten years from 2014 to 2023.

The Georgia study is typical of many state-level studies in other respects as well. It failed to take into account the reduction in premium subsidies flowing into the state if the Medicaid expansion were implemented, and failed to account for the fact that Georgia already has an acute doctor shortage,[19] which calls into question its ability to collect the federal funds by actually serving the expansion population. Although the study attempted to account for taxes, it did so by offsetting the federal funds obtained through the expansion only by the percentage of the amount received by Georgia paid by Georgia taxpayers. This implicitly assumes that the only tax effect is money from other states flowing into Georgia. It does not take into account the fact that Georgia taxpayers would have to pay for the expansion in other states as well. This is equivalent to assuming that Georgia is the only state that takes the expansion. In fact, we know that as of this writing over half the states plus DC have already taken the expansion, and some additional states are still considering doing so.

One report[20] endorses many of these same fallacies, then goes on to note that:

> Some state officials worry that Congress may not sustain the high FMAP ACA provides for expansion, on which the above favorable fiscal analyses rely. …. Such fears can seem reasonable until one delves into Medicaid's current budget situation and past budget history. … Only once—in 1981—did Congress lower the federal share of Medicaid spending.

This is not, strictly speaking, correct. Congress increased the federal share of Medicaid spending in October 2008, renewed the increase in 2009, and then reduced it back to its previous level, just two years later, in 2011.[21]

A Better Methodology

In order to get a more accurate picture of the macroeconomic effects of the Medicaid expansion at the state[22] level we constructed a model that takes into account not only changes in federal Medicaid spending in each state, but also changes in state spending, changes in federal exchange premium subsidies, and the impact of taxes on each state, based on each state's average share of federal taxes.

Estimates of the direct impact of the expansion on federal and state spending in each state were obtained from published estimates from the Urban Institute's HIPSM model.[23] These estimates were for the 10-year period from 2013 – 2022. We adjusted these figures to the period 2014 – 2023 based on the relative spending in each year (taking into account take-up rates and population growth) estimated by the Congressional Budget Office (CBO).[24] The net federal inflow to each state as a direct result of the Medicaid expansion is taken to be the increase in federal spending, minus the increase in state spending (the

latter of which largely consists of the state's share of the expansion population after 2016).

We calculate the impact of the Medicaid expansion on premium subsidies in each state[25] by estimating the total potential premium subsidies in a given state with and without Medicaid Expansion. We define potential premium subsidies as the maximum health insurance premium tax-credit for which a household is eligible. The actual premium subsidy may be different if an eligible household purchases a health insurance plan with a lower premium value than the credit, or if an eligible household opts not to buy subsidized health insurance at all. Using the 2010 – 2012 American Community Survey, we calculate premium subsidy eligibility using household size, income, and health insurance coverage status. All households are eligible that earn between 100 and 400 percent of the federal poverty level and are previously uninsured or insured through direct purchase health insurance only (those with employer-sponsored insurance are not eligible). In the case of Medicaid expansion, only households with incomes between 138 and 400 percent of the federal poverty level are eligible for premium subsidies. Households with incomes between 100 and 138 percent become eligible for Medicaid and therefore lose their eligibility for subsidies.

The dollar amount of the potential premium subsidy for which a household is eligible varies by income and location. The expected premium contribution increases with income among eligible households, and the total premium varies based on the benchmark Silver plan cost in a particular rating area.[26] The total impact of Medicaid expansion on premium subsidies is equal to the difference between the sum of all potential premium subsidies in a given state with, and without, the Medicaid expansion in that state. We then adjusted these figures to the period 2014 – 2023 based on the relative spending for premium and cost-sharing subsidies in each year estimated by the CBO.[27]

The total net flow of funds due to the effect of the Medicaid expansion—before taxes—is the combination of the direct impact of the expansion, minus the reduction in exchange premium subsidies paid in that state due to the expansion.

To take into account the fact that the federal funds flowing into each state as a result of the expansion ultimately come from taxes paid by taxpayers, we estimated the impact of taxes on each state by taking the share of all federal taxes, including both personal, corporate, and excise taxes, attributable to each state[28] and multiplied that share by the total impact of the expansion for all states, assuming that every state accepts the Medicaid expansion.

In addition, to account for the negative effect of taxation on economic activity (the "deadweight loss" discussed above), we obtained estimates of the magnitude of the deadweight loss as a percentage of tax revenue. For corporate taxes, Austan Goolsbee provides a range estimate of 5 to 10 percent of revenue.[29] For individual taxes, Martin Feldstein calculated an estimate of 32.2 percent of revenue.[30] For each state, a state-specific deadweight loss was calculated as a weighted average of the deadweight losses for each type of tax, based on the relative shares of federal tax of each type collected

from that state. (See the Appendix for more information on the deadweight loss estimates, including an assessment of alternative assumptions regarding the deadweight loss parameters.)

In order to estimate the effect on jobs, we use the CEA's method, applied to estimates of economic impact that take into account deadweight loss. That is, we first apply the CEA's composite fiscal multiplier of 1.29 to the economic impact on each state.[31] Then, we use number of job-years[32] per million dollars of economic activity, derived from the CEA's estimates on a state-by-state basis.[33] Because the CEA projects that the job impact will occur only from 2014 to 2017, we counted only dollars of economic impact during those particular years when calculating the number of jobs gained or lost.

Results

The impact of the expansion on economic activity is presented in Table 1. The job impact is presented in Table 2. Table A in the Appendix summarizes the deadweight loss estimates for each state.

Table 1: Consolidated Effects of Medicaid Expansion by State (2014-2023)

State	Incremental Change in Medicaid Spending	Change in Exchange Subsidy Spending	State's Share of Federal Taxes for Net Impact	Deadweight Loss due to Additional Taxation (Dollars)	**State's Net Impact if all States Expand**	**State's Impact After CEA Fiscal Multiplier**
Alabama	15,365 mil	-6,457 mil	-3,902 mil	-1,199 mil	3,806 mil	4,910 mil
Alaska	1,516 mil	-475 mil	-919 mil	-287 mil	-165 mil	-213 mil
Arizona	11,832 mil	-8,342 mil	-6,213 mil	-1,860 mil	-4,582 mil	-5,911 mil
Arkansas	13,345 mil	-4,848 mil	-5,540 mil	-1,370 mil	1,586 mil	2,046 mil
California	72,182 mil	-86,452 mil	-53,611 mil	-15,240 mil	-83,121 mil	-107,226 mil
Colorado	10,925 mil	-8,084 mil	-7,705 mil	-2,288 mil	-7,153 mil	-9,227 mil
Connecticut	10,879 mil	-3,006 mil	-8,629 mil	-2,535 mil	-3,291 mil	-4,245 mil
Delaware	3,500 mil	-628 mil	-3,006 mil	-714 mil	-849 mil	-1,095 mil
D.C.	908 mil	-172 mil	-3,609 mil	-1,138 mil	-4,011 mil	-5,174 mil
Florida	70,232 mil	-41,860 mil	-21,841 mil	-6,651 mil	-120 mil	-155 mil
Georgia	36,036 mil	-21,186 mil	-11,867 mil	-3,461 mil	-478 mil	-617 mil
Hawaii	4,201 mil	-338 mil	-1,232 mil	-370 mil	2,262 mil	2,917 mil
Idaho	3,508 mil	-3,033 mil	-1,219 mil	-381 mil	-1,126 mil	-1,452 mil
Illinois	22,594 mil	-11,558 mil	-21,777 mil	-6,378 mil	-17,120 mil	-22,084 mil
Indiana	18,755 mil	-10,234 mil	-8,496 mil	-2,557 mil	-2,532 mil	-3,266 mil
Iowa	5,137 mil	-2,020 mil	-3,447 mil	-1,030 mil	-1,360 mil	-1,755 mil
Kansas	5,486 mil	-2,576 mil	-3,691 mil	-1,129 mil	-1,911 mil	-2,465 mil
Kentucky	19,116 mil	-4,869 mil	-4,586 mil	-1,393 mil	8,268 mil	10,666 mil
Louisiana	16,812 mil	-7,294 mil	-6,779 mil	-2,103 mil	637 mil	822 mil
Maine	4,271 mil	-1,464 mil	-1,156 mil	-361 mil	1,289 mil	1,663 mil
Maryland	16,190 mil	-3,496 mil	-9,350 mil	-2,823 mil	521 mil	673 mil
Massachusetts	16,055 mil	-1,720 mil	-14,007 mil	-4,240 mil	-3,912 mil	-5,047 mil
Michigan	18,325 mil	-10,000 mil	-10,551 mil	-3,245 mil	-5,471 mil	-7,057 mil
Minnesota	5,925 mil	-2,852 mil	-13,338 mil	-3,827 mil	-14,093 mil	-18,180 mil
Mississippi	15,551 mil	-6,211 mil	-1,783 mil	-547 mil	7,009 mil	9,042 mil
Missouri	18,754 mil	-7,271 mil	-9,041 mil	-2,641 mil	-200 mil	-258 mil
Montana	2,190 mil	-1,412 mil	-785 mil	-242 mil	-249 mil	-321 mil
Nebraska	3,252 mil	-1,884 mil	-3,460 mil	-870 mil	-2,962 mil	-3,821 mil
Nevada	5,904 mil	-5,792 mil	-2,526 mil	-769 mil	-3,183 mil	-4,106 mil
New Hampshire	2,577 mil	-931 mil	-1,643 mil	-519 mil	-516 mil	-666 mil
New Jersey	16,040 mil	-10,526 mil	-23,328 mil	-6,144 mil	-23,958 mil	-30,905 mil
New Mexico	5,385 mil	-2,856 mil	-1,493 mil	-465 mil	570 mil	736 mil
New York	103,415 mil	-26,318 mil	-39,266 mil	-11,520 mil	26,311 mil	33,942 mil
North Carolina	42,270 mil	-20,476 mil	-11,287 mil	-3,368 mil	7,140 mil	9,211 mil
North Dakota	2,481 mil	-510 mil	-840 mil	-260 mil	871 mil	1,124 mil
Ohio	57,023 mil	-12,979 mil	-20,884 mil	-6,269 mil	16,891 mil	21,790 mil
Oklahoma	9,101 mil	-3,818 mil	-4,589 mil	-1,348 mil	-654 mil	-844 mil
Oregon	14,262 mil	-4,410 mil	-4,146 mil	-1,276 mil	4,430 mil	5,714 mil
Pennsylvania	40,463 mil	-9,371 mil	-19,977 mil	-5,940 mil	5,176 mil	6,677 mil
Rhode Island	3,104 mil	-1,004 mil	-2,061 mil	-549 mil	-510 mil	-658 mil
South Carolina	16,962 mil	-7,293 mil	-3,405 mil	-1,040 mil	5,224 mil	6,739 mil
South Dakota	2,258 mil	-837 mil	-844 mil	-263 mil	314 mil	405 mil
Tennessee	24,077 mil	-5,639 mil	-8,739 mil	-2,609 mil	7,090 mil	9,146 mil
Texas	69,308 mil	-57,204 mil	-37,095 mil	-10,762 mil	-35,753 mil	-46,122 mil
Utah	5,676 mil	-2,986 mil	-2,653 mil	-812 mil	-775 mil	-1,000 mil
Vermont	2,210 mil	-332 mil	-629 mil	-193 mil	1,057 mil	1,363 mil
Virginia	15,421 mil	-8,034 mil	-11,366 mil	-3,332 mil	-7,312 mil	-9,432 mil

Washington	9,578 mil	-7,725 mil	-9,500 mil	-2,842 mil	-10,489 mil	-13,531 mil
West Virginia	9,393 mil	-2,018 mil	-1,177 mil	-366 mil	5,833 mil	7,525 mil
Wisconsin	14,464 mil	-4,812 mil	-7,494 mil	-2,222 mil	-65 mil	-83 mil
Wyoming	1,428 mil	-1,103 mil	-751 mil	-207 mil	-633 mil	-816 mil
Puerto Rico	925 mil	*	-705 mil	-222 mil	-1 mil	-2 mil
Other Territories	75 mil	*	-123 mil	-40 mil	-88 mil	-114 mil
Unallocated Taxes	**	**	-1,858 mil	N/A	N/A	N/A
NATIONAL TOTAL	**916 bil**	**-457 bil**	**-460 bil**	**-135 bil**	**-135 bil**	**-174 bil**

* Puerto Rico and other territories (besides D.C.) are treated differently. See footnote 19 in the main text.

** Unallocated taxes are note associated with any jurisdiction, and thus not with any health spending. They are included so that all tax revenue and sources are accounted for.

Table 2: Impact of Jobs on Medicaid Expansion, By State

	Job Impact, Including Deadweight Loss		
State	**State's Net Impact if all States Expand**	**State's Impact After CEA Fiscal Multiplier**	**Job-Years Gained/Lost (2014-2017)**
Alabama	3,806 mil	4,910 mil	**5,573**
Alaska	-165 mil	-213 mil	**-247**
Arizona	-4,582 mil	-5,911 mil	**-9,975**
Arkansas	1,586 mil	2,046 mil	**2,386**
California	-83,121 mil	-107,226 mil	**-123,047**
Colorado	-7,153 mil	-9,227 mil	**-10,790**
Connecticut	-3,291 mil	-4,245 mil	**-5,002**
Delaware	-849 mil	-1,095 mil	**-1,270**
D.C.	-4,011 mil	-5,174 mil	**-6,275**
Florida	-120 mil	-155 mil	**-180**
Georgia	-478 mil	-617 mil	**-713**
Hawaii	2,262 mil	2,917 mil	**3,364**
Idaho	-1,126 mil	-1,452 mil	**-1,726**
Illinois	-17,120 mil	-22,084 mil	**-25,897**
Indiana	-2,532 mil	-3,266 mil	**-4,133**
Iowa	-1,360 mil	-1,755 mil	**-2,349**
Kansas	-1,911 mil	-2,465 mil	**-3,117**
Kentucky	8,268 mil	10,666 mil	**12,217**
Louisiana	637 mil	822 mil	**969**
Maine	1,289 mil	1,663 mil	**1,918**
Maryland	521 mil	673 mil	**743**
Massachusetts	-3,912 mil	-5,047 mil	**-5,710**
Michigan	-5,471 mil	-7,057 mil	**-8,304**
Minnesota	-14,093 mil	-18,180 mil	**-23,621**
Mississippi	7,009 mil	9,042 mil	**10,280**
Missouri	-200 mil	-258 mil	**-301**
Montana	-249 mil	-321 mil	**-401**
Nebraska	-2,962 mil	-3,821 mil	**-4,987**
Nevada	-3,183 mil	-4,106 mil	**-4,655**
New Hampshire	-516 mil	-666 mil	**-789**

New Jersey	-23,958 mil	-30,905 mil	**-34,880**
New Mexico	570 mil	736 mil	**1,384**
New York	26,311 mil	33,942 mil	**38,594**
North Carolina	7,140 mil	9,211 mil	**10,568**
North Dakota	871 mil	1,124 mil	**1,269**
Ohio	16,891 mil	21,790 mil	**24,946**
Oklahoma	-654 mil	-844 mil	**-1,019**
Oregon	4,430 mil	5,714 mil	**7,846**
Pennsylvania	5,176 mil	6,677 mil	**7,820**
Rhode Island	-510 mil	-658 mil	**-744**
South Carolina	5,224 mil	6,739 mil	**7,888**
South Dakota	314 mil	405 mil	**500**
Tennessee	7,090 mil	9,146 mil	**10,557**
Texas	-35,753 mil	-46,122 mil	**-54,445**
Utah	-775 mil	-1,000 mil	**-1,848**
Vermont	1,057 mil	1,363 mil	**1,461**
Virginia	-7,312 mil	-9,432 mil	**-11,077**
Washington	-10,489 mil	-13,531 mil	**-16,461**
West Virginia	5,833 mil	7,525 mil	**8,571**
Wisconsin	-65 mil	-83 mil	**-99**
Wyoming	**-633 mil**	**-816 mil**	**-990**
NATIONAL TOTAL	**-135 bil**	**-174 bil**	**-206,196**

Note first that the nationwide result is net loss, over 10 years, of $135 billion in net economic activity. Applying CEA fiscal multiplier brings the loss up to $174 billion. The job impact is similar, but much smaller in magnitude than in models that ignore taxes and deadweight loss. The overall nationwide impact is a loss of about 21,300 jobs in 2014, a loss of 44,600 jobs in 2015, a loss of 65,900 jobs in 2016, and a loss of 74,400 jobs in 2017, for a total loss of 206,000 job-years in that four-year period.[34]

This is not evenly distributed across states; some states gain and some states lose—but the total of all the losses exceeds the total of all the gains. Overall, 20 states gain economic activity and jobs, and 30 states plus D.C. lose economic activity and jobs.

The states that gain the most are New York and Ohio; the states that lose the most are California and Texas. In fact, California loses even before taking into account taxes at all; the amount California gains from the Medicaid expansion ($72.2 billion) is less than the amount it loses by making the expansion population ineligible for exchange subsidies ($86.5 billion). The distribution of job impact across states is similar. New York gains 38,600job-years; Texas loses 54,400 job-years between 2014 and 2017.

This is in sharp contrast to the CEA's result—ignoring deadweight loss and the economic impact of taxation—which produced a forecast of 735,000 job-years gained over the same time period.[35] That estimate can be obtained only by assuming that federal dollars can flow in to every state without coming out in the form of taxation, and by further ignoring the effects of taxation above and beyond the dollars collected.

Conclusion

Previous studies predict large and beneficial macroeconomic effects of the ACA's Medicaid expansion, by calculating the economic benefits to individual states of the inflow of federal dollars predicted to ensue. However, in calculating those benefits, these studies typically ignore one or more offsetting factors, most notably the taxes necessary to pay for the Medicaid expansion, the deadweight loss associated with this taxation, and even the direct loss of premium subsidies that accompany eligibility for Medicaid.

When we take these offsetting factors into account, the picture changes considerably. Instead of an increase in economic growth and jobs, we find the opposite occurs—billions of dollars of economic activity, and thousands of jobs, are lost. Some states see small net gains, but the total losses incurred in other states substantially exceed the total gains.

APPENDIX: Deadweight Loss Due to Taxation

"Deadweight Loss" due to taxation is the loss in economic activity due to a tax, above and beyond the amount of the tax actually collected. It is the result of changes in behavior by individuals and businesses in response to the existence of the tax.

In order to estimate the impact of the Medicaid expansion, we must account for the deadweight loss of the taxes necessary to pay for it. In this paper, we consider only the taxes necessary to pay for the federal spending, which accounts for the overwhelming majority of the expansion spending. The IRS publishes the amount of federal tax collected in each state, broken down by the type of tax. Overall, in 2010, 11.85 percent of federal tax revenue was from taxes on business income (corporate profits), 85.29 percent was from taxes on personal income (including FICA taxes), 2.01 percent was on excise taxes (e.g., tobacco), and 0.84 percent was from estate and gift taxes.

The extent to which each tax is affected by deadweight loss can differ. For corporate taxes, Austan Goolsbee provides a range estimate of 5 to 10 percent of revenue.[1] For individual taxes, Martin Feldstein calculated an estimate of 32.2 percent of revenue.[2] We applied this estimate to excise taxes as well. There is a naïve theoretical argument that there should be no deadweight loss due to estate and gift taxes. We do not find that argument persuasive, and note that estimates of the deadweight loss due to the estate tax have a lower bound of 1.8 percent.[3] This debate is outside the scope of this paper, and out of an abundance of caution—and because the total revenue due to estate taxes is so small—we have ignored the deadweight loss due to estate and gift taxes. This does not significantly affect the results.

For each state, a state-specific deadweight loss was calculated as a weighted average of the deadweight losses for each type of tax, based on the relative shares of federal tax of each type collected from that state. The economic activity and job estimates in this paper are based on these state-specific estimates.

For the benefit of readers who might wish to make alternative assumptions, we also calculated each state's "break-even" deadweight loss, expressed as a percentage of tax revenue. That is, the deadweight loss at which the state is on the border between being a "net winner" and a "net loser" of economic activity due to the Medicaid expansion. If a state's actual DWL is above this figure, the state sustains a net loss. Because actual deadweight loss can never be negative, a state with a negative number in this column loses jobs and economic activity regardless of the particular assumptions made. Overall,

1 Austan Goolsbee, "Taxes, organizational form, and the deadweight loss of the corporate income tax," *Journal of Public Economics*, **69**(1998), pp.143-152. The difference between the high and low end of the range did not substantially affect the results.

2 Martin Feldstein, "Tax Avoidance and the Deadweight Loss of the Income Tax," *The Review of Economics and Statistics*, **81**:4 (Nov., 1999), pp. 674-680.

3 Douglas Holtz-Eakin and Donald Marples, "Distortion Costs of Taxing Wealth Accumulation: Income versus Estate Taxes," National Bureau of Economic Research, Working Paper 8261, April 2001.

19 states (plus D.C.) have negative break-even percentages, and 11 have break-even percentages between 0 and 30, indicating they are likely to sustain a loss.

Table A: State Deadweight Loss Estimates

State	State Estimated Deadweight Loss		State Break-Even Deadweight Loss Percentage*
	Percent of Revenue	Dollars	
Alabama	30.72%	-1199 mil	128.27%
Alaska	31.20%	-287 mil	13.22%
Arizona	29.93%	-1860 mil	-43.83%
Arkansas	24.73%	-1370 mil	53.35%
California	28.43%	-15240 mil	-126.62%
Colorado	29.70%	-2288 mil	-63.13%
Connecticut	29.37%	-2535 mil	-8.77%
Delaware	23.77%	-714 mil	-4.48%
D.C.	31.52%	-1138 mil	-79.62%
Florida	30.45%	-6651 mil	29.90%
Georgia	29.17%	-3461 mil	25.14%
Hawaii	30.04%	-370 mil	213.63%
Idaho	31.28%	-381 mil	-61.05%
Illinois	29.28%	-6378 mil	-49.33%
Indiana	30.10%	-2557 mil	0.30%
Iowa	29.88%	-1030 mil	-9.58%
Kansas	30.59%	-1129 mil	-21.17%
Kentucky	30.38%	-1393 mil	210.66%
Louisiana	31.02%	-2103 mil	40.42%
Maine	31.18%	-361 mil	142.69%
Maryland	30.20%	-2823 mil	35.77%
Massachusetts	30.27%	-4240 mil	2.34%
Michigan	30.76%	-3245 mil	-21.09%
Minnesota	28.69%	-3827 mil	-76.96%
Mississippi	30.66%	-547 mil	423.69%
Missouri	29.21%	-2641 mil	27.00%
Montana	30.89%	-242 mil	-0.86%
Nebraska	25.14%	-870 mil	-60.47%
Nevada	30.42%	-769 mil	-95.58%
New Hampshire	31.57%	-519 mil	0.15%
New Jersey	26.34%	-6144 mil	-76.36%
New Mexico	31.17%	-465 mil	69.36%
New York	29.34%	-11520 mil	96.35%
North Carolina	29.84%	-3368 mil	93.10%
North Dakota	30.92%	-260 mil	134.65%
Ohio	30.02%	-6269 mil	110.90%
Oklahoma	29.37%	-1348 mil	15.11%

Oregon	30.78%	-1276 mil	137.62%
Pennsylvania	29.73%	-5940 mil	55.64%
Rhode Island	26.63%	-549 mil	1.88%
South Carolina	30.55%	-1040 mil	183.98%
South Dakota	31.18%	-263 mil	68.34%
Tennessee	29.85%	-2609 mil	110.99%
Texas	29.01%	-10762 mil	-67.37%
Utah	30.61%	-812 mil	1.40%
Vermont	30.63%	-193 mil	198.57%
Virginia	29.32%	-3332 mil	-35.01%
Washington	29.92%	-2842 mil	-80.49%
West Virginia	31.06%	-366 mil	526.71%
Wisconsin	29.65%	-2222 mil	28.78%
Wyoming	27.55%	-207 mil	-56.71%
NATIONAL TOTAL	**29.30%**	**-135 bil**	**N/A**

1 Council of Economic Advisers, "Missed Opportunities: The Consequences of State Decisions not to Expand Medicaid," July 2014.

2 A not-quite-exhaustive list of state-specific studies is given in the appendix of "The Role of Medicaid in State Economies and the ACA," Kaiser Family Foundation Issue Brief #8522, November 2013.

3 It should be noted at the outset that this study is not an attempt to answer all policy questions related to the Medicaid expansion. For example, we will not address such issues as whether transferring some sectors of the population from subsidized private-sector exchange plans (for which everyone pays at least some premium) to Medicaid (no premium, but some known problems regarding access to health care) is a good tradeoff or not, or whether Medicaid is likely to produce better health outcomes in the expansion population. These issues are discussed elsewhere, and are beyond the scope of this study. This study is only about the question, raised by the CEA and others, of whether the Medicaid expansion will create jobs and increase GDP.

4 CEA, p.5.

5 One could argue that in the current situation of deficit spending, and additional federal dollar spent is not an additional dollar taxed. However, it is an additional dollar borrowed. When the federal government borrows money, it does so by selling bonds to savers or investors. These savers or investors then have that much less money available to save or invest in private sector activities; the total amount of activity in the economy still does not change. In addition, the money borrowed must in theory eventually be paid back, so ultimately it will still be taken from taxpayers.

6 William S. Custer, "The Economic Impact of Medicaid Expansion in Georgia," Healthcare Georgia Foundation, Publication #74, February 2013.

7 One could argue that Georgia (or any other state) could consider its own share of the taxes for its own expansion in isolation, ignoring the taxes it would have to pay for other states, on the basis that any given state has no influence on the expansion decisions of other states. While this basis may be true in a technical legal sense, it is in fact a strong – and unstated – assumption, given the political climate in which all states make decisions on a national issue, and in which politicians (and voters) identify with national parties. In any case, when evaluating the economic impact on the entire country, ignoring the taxes paid by each state for other states' expansions is clearly inappropriate. By the date of Custer's paper, six states plus DC had already exacted expansion legislation, and numerous other governors had announced their intent to enact it.

8 See, for example, Paul Krugman and Robin Wells, *Economics*, 3rd edition, Macmillan, 2012, chapter 7.

9 "The Role of Medicaid in State Economies and the ACA," Kaiser Family Foundation Issue Brief #8522, November 2013, *op. cit.*

10 Sean Riley, "Medicaid Expansion: The Economic Analysis Dilemma," Platte Institute, April 2013.

11 Scott Beaulier and Phillip A. Mixon, "Feasibility of Medicaid Expansion in Alabama," Manuel H. Johnson Center for Political Economy at Troy University, 2014.

12 Sherry Gleid and Stephanie Ma, "How States Stand to Gain or Lose Federal Funds by Opting In or Out of the Medicaid Expansion, Commonwealth Fund pub. 1718, December 2013, at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2013/Dec/1718_Glied_how_states_stand_gain_lose_Medicaid_expansion_ib_v2.pdf.

13 This would be the opposite of the so-called "woodwork effect," in which the publicity surrounding an eligibility expansion induces enrollment by people who were eligible before the expansion but didn't realize it. In the Commonwealth study, they implicitly assume that the reverse would happen – that

previously eligible people would enroll if a state declined the expansion, but would not enroll if a state enacted the expansion.

14 Sandra L. Decker, "In 2011 Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, but Rising Fees May Help," *Health Affairs*, **31**:8(2012), pp. 1673-1679.

15 In the case of Medicaid managed care, rather than paying a provider when a patient obtains services, the program pays a Medicaid managed care organization (e.g., an insurance company) a fixed monthly fee for enrolled patients. While the program pays the same amount per month regardless of services obtained by the patient, provider in the patient's state is still paid based on services obtained. Because the dollars ultimately follow the patients' services, this does not affect our analysis – especially given the fact that the Medicaid managed care organization may be located in another state.

16 Beaulier and Mixon, *op. cit.*

17 CEA *op. cit.*, p. 27.

18 Custer, *op. cit.*, p. 11.

19 Association of American Medical Colleges, Center for Workforce Studies, "2011 State Physician Workforce Data Book," at https://www.aamc.org/download/263512/data/statedata2011.pdf.

20 Stan Dorn, Meghan McGrath, and John Holahan, "What Is the Result of States Not Expanding Medicaid?" Robert Wood Johnson Foundation and Urban Institute, August 2014.

21 Amanda Cassidy, "Extra Federal Support For Medicaid," *Health Affairs*, August 11, 2010; updates July 14, 2011. http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=22. See also Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, http://kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier/#.

22 For the purposes of this study, the District of Columbia is treated as a state, because the ACA treats it the same was as it treats states with respect to the Medicaid expansion and the insurance exchanges. Puerto Rico and other U.S. territories are not eligible for the Medicaid expansion or for exchange subsidies. Instead, they were given block grants totaling $1 billion ($925 million for Puerto Rico and $75 million for the other territories) to allocate as they wishes between Medicaid and other types of subsidies. They could expand Medicaid along the same lines as states, expand it using different criteria, or give premium and/or cost-sharing subsidies using the same formula or different formulas. See Timothy Jost, "Implementing Health Reform," Health Affairs Blog, July 18, 2014, at http://healthaffairs.org/blog/2014/07/18/implementing-health-reform-hobby-lobby-response-the-aca-in-the-territories-and-more. For the purposes of this study, we treat the block grants as part of the total expansion/subsidy cost, and treat taxes paid by the territories as contributing to the total cost. The CEA did not estimate job impact for Puerto Rico or the other territories.

23 John Holahan, Matthew Buettgens, Caitlin Carroll, and Stan Dorn, "The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis," Kaiser Family Foundation Publication #8384, November 2012, at http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8384.pdf.

24 Congressional Budget Office, "Updated Estimates of the Effects of the Insurance Coverage Provisions of the Affordable Care Act, April 2014," CBO Pub. No. 4930, page 2, at http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf.

25 For this calculation I am indebted to Conor Ryan of the American Action Forum.

26 Breakaway Policy Strategies. (2014): HIX Compare Dataset.

27 Congressional Budget Office, "Insurance Coverage Provisions of the Affordable Care Act—CBO's April 2014 Baseline," page 4, at http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900-2014-04-ACAtables2.pdf.

28 Chief Financial Officer, Revenue Financial Management OS:CFO:R, "Internal Revenue Gross Collections, by Type of Tax and State, 2010."

29 Austan Goolsbee, "Taxes, organizational form, and the deadweight loss of the corporate income tax," *Journal of Public Economics*, **69**(1998), pp.143-152. The difference between the high and low end of the range did not substantially affect the results.

30 Martin Feldstein, "Tax Avoidance and the Deadweight Loss of the Income Tax," *The Review of Economics and Statistics*, **81**:4 (Nov., 1999), pp. 674-680.

31 CEA, *op. cit.*, p. 27.

32 A "job-year" is one full-time-equivalent job in existence for one year. So, for example, if a policy creates one job that lasts four years, that counts as four "job-years." Equivalently, if a policy creates four jobs that last only one year each, that is also four "job-years." The CEA projects the number of additional jobs that will exist each year from 2014 to 2017, and reports the total as the number of "job-years" gained during that period. The CEA projects no additional job creation (or equivalently, no additional job-years) due to the Medicaid expansion after 2017 compared to no-expansion baseline. The reason for this is that their model assumes that government spending can create jobs only during a recession, and they forecast that the recession will end shortly after 2017. All though in general we disagree with the base assumption, for an apples-to-apples comparison with the CEA model we calculate total job-years for 2014 to 2017.

33 CEA, *op. cit.*, Table 5, p. 31.

34 Note that many experts, including the CEA (p. 28), note that the Medicaid expansion may decrease labor supply by decreasing the number of people who work largely to get health coverage, more than to get pay. The job loss effects presented here are in addition to any such labor supply decreases that may occur.

35 The specific year-by-year jobs claimed by the CEA are noted above. See footnote .