

U.S. Health Reform—Monitoring and Impact

Redistribution of Federal Funding Across States Due to the Financing of Medicaid and CHIP

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By John Holahan and Jennifer M. Haley



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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of health reform. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform to help states, researchers and policymakers learn from the process as it unfolds. Reports that have been prepared as part of this ongoing project can be found at www.rwjf.org and www.healthpolicycenter.org.

BACKGROUND

Recent discussions about how to manage state budget crises related to the coronavirus outbreak and accompanying recession have revived long-standing debates about the distribution of federal dollars across states. Specifically, discussion has centered on how much each state receives from the federal government compared with the amount each state contributes in federal tax revenues. In this paper, we examine spending on Medicaid and the Children's Health Insurance Program (CHIP), together the largest joint federal-state programs in the US, comparing the distribution of federal spending to the states with states' contributions to the federal treasury. We show that most high-income states receive fairly high levels of federal Medicaid/CHIP spending but contribute even more to the federal treasury. Lower-income states spend considerably less on Medicaid/CHIP and thus receive less federal money for the programs, but at the same time contribute even less to the federal treasury.

Past research has compared all federal spending provided to states with the federal tax payments from individuals and businesses across states and found considerable resulting income redistribution. A recent analysis found that New York accounts for the largest share of tax contributions from individuals and businesses of all states, but in 2018 it received \$22.0 billion less in federal spending than it contributed. The difference is redistributed to other states, and in 2018, that meant New York's taxpayers received \$1,125 less per resident in federal funding than they paid in federal taxes.¹ Other high-income states, such as Connecticut, Massachusetts, and New Jersey, also contributed more to the federal treasury than they received. Overall in 2018, residents and businesses in eight states made greater federal tax contributions than

their state received in overall federal spending, whereas the other 42 states received more payments from the federal government than they paid in federal taxes.

The financing structures of Medicaid and CHIP, specifically, are intended to redistribute funds from higher-income to lower-income states. Medicaid and CHIP financing is based on total Medicaid/CHIP spending in the state, with costs shared between federal and state governments. For most types of Medicaid/CHIP spending, the share paid by the federal government, called the federal medical assistance percentage (FMAP), varies inversely with state per capita income, meaning the federal government pays a higher share of Medicaid/CHIP expenses in states with lower per capita incomes (hereafter called low-income states) and a lower share of such expenses in states with higher per capita incomes (hereafter called high-income states). In 2020, state Medicaid FMAPs range from the mandated 50.0 percent minimum (which applies to 12 states) to a high of 77.0 percent in Mississippi, with the CHIP matching rate proportionally higher in each state.

As noted, the federal Medicaid/CHIP payments made to a state depend on overall state spending on those programs. They vary both by the generosity of the programs (i.e., expansiveness of eligibility and benefits provided, which states can extend beyond federal minimum requirements) and the state's federal matching rate. If a state has a low federal matching rate but broad eligibility and a rich benefit package, it could receive considerable federal dollars. In contrast, a state with a high federal matching rate but limited eligibility and benefits could receive fewer federal dollars.

In a state where a high share of the population has low incomes, a higher share of the population may or may not be enrolled in Medicaid/CHIP, depending on the state's eligibility rules and the ease with which residents can enroll in the programs (i.e., related to administrative hurdles, enrollment assisters, and outreach efforts).

But whether a state's contribution to the federal government is balanced with the funding they receive from the federal government also depends on each state's relative contribution to the federal treasury. Individuals and businesses in states pay various federal taxes that finance federal programs and costs, including Medicaid and CHIP; Medicaid accounts for about 9 percent of all federal spending, and CHIP accounts for a lower share.² Because federal taxes tend to be progressive, states with lower incomes tend to pay a smaller share of federal revenues per capita than states with higher incomes. Thus, lower-income states benefit from both receiving the higher federal matching rate and paying less to the federal treasury. Higher-income states have a lower federal matching rate and contribute more to the federal treasury.

In this paper, we focus on how federal dollars for financing Medicaid and CHIP are distributed across states and how this distribution differs from states' contributions to the federal treasury. We calculate total federal dollars paid to all states for Medicaid and CHIP, splitting the funds between traditional Medicaid/CHIP (including coverage for children and nonelderly adults, long-term care, and disproportionate share hospital payments) and Medicaid expansion to people with incomes up to 138 percent of the federal poverty level under the Affordable Care Act (ACA). We then examine how each state's share of total federal Medicaid/CHIP spending differs from the share of federal individual and business taxes it pays. For example, if California contributes 13.3 percent of all federal taxes paid by individuals and businesses, we estimate how federal Medicaid/CHIP payments to California under current law differ from what they would be if California received 13.3 percent of total federal spending on Medicaid/CHIP. We also assess how relative payments and contributions vary depending on whether a state has expanded Medicaid eligibility under the ACA, and we assess the federal Medicaid/CHIP funding distribution if every state had adopted the expansion.

DATA AND METHODS

We analyze prepandemic federal Medicaid/CHIP spending for 2020 under current law and a scenario where each state receives a share of total Medicaid/CHIP spending equal to their contribution to federal household and business taxes. First, to assess spending under current law, we compile detailed 2020 spending by state for six categories of program spending encompassing most Medicaid/CHIP expenditures:

1. **Traditional spending on Medicaid for the nonelderly, including payments to managed-care organizations**
2. **CHIP spending**
3. **Disproportionate share hospital spending**
4. **Medicaid spending on Medicare beneficiaries ages 65 and older, including premiums, cost-sharing requirements, and payments for acute care**
5. **Long-term services and supports**
6. **Adults eligible for Medicaid under the ACA's Medicaid expansion in the District of Columbia and the 35 states that expanded Medicaid eligibility as of mid-2020**

We use the Urban Institute's Health Insurance Policy Simulation Model (HIPSM)³ to estimate 2020 spending for nonelderly people enrolled in Medicaid/CHIP, which includes the traditional Medicaid population, CHIP enrollees, and

the ACA Medicaid expansion population. HIPSM merges two years of data from the American Community Survey, so sample sizes are large enough to generate state-specific estimates. The model simulates each state's eligibility rules, including whether the state has expanded Medicaid under the ACA, and estimates expenditures separately for the traditional Medicaid/CHIP and Medicaid expansion populations for states that expanded Medicaid. The model calibrates state-specific enrollment and spending estimates to the most recent publicly available data sources from late 2019.

HIPSM is limited to health insurance coverage and acute care spending for the nonelderly. Thus, we use other data sources for spending on acute care for the elderly, Medicare premium payments, long-term services and supports, and disproportionate share hospital spending. The most recent available data on acute care for the elderly are from the 2013–14 Medicaid Statistical Information System, and 2018 spending data on Medicare premiums and long-term services and supports are from the Medicaid and CHIP Payment and Access Commission.⁴ For these data elements, we inflate estimates to 2020 levels based on actuarial data on program spending growth from the Centers for Medicare & Medicaid Services. Finally, 2020 disproportionate share hospital allotments are published by the Medicaid and CHIP Payment and Access Commission.^{5,6} Together, these

sources provide comprehensive, state-specific data on most Medicaid/CHIP spending components.⁷

We compute federal spending under a 2020 baseline scenario⁸ that excludes changes to the FMAP enacted in the Families First Coronavirus Response Act.⁹ Further, estimates are based on prepandemic spending in 2020 and do not account for changes to enrollment or spending per enrollee likely to occur during the pandemic and associated recession. This means we may understate Medicaid/CHIP spending by the federal government. Further, though the duration of the public health emergency and financial crisis are unknown, this analysis assumes prepandemic spending levels throughout the 2020 calendar year. We present spending estimates separately for the traditional Medicaid/CHIP population (categories 1 through 5 above) and for the ACA Medicaid expansion population (category 6), both in dollars and as each state's share of total federal spending.

For our analysis of Medicaid expansion spending, we also assess an alternative scenario in which the remaining nonexpansion states have adopted the ACA's Medicaid expansion, using estimates of additional federal Medicaid/CHIP spending that would have been provided to nonexpansion states had they expanded eligibility in 2020.¹⁰ Modeling adoption of the expansion in additional states not only adds expansion spending in those states but increases overall spending, in turn affecting the distribution of dollars across states.

Next, we estimate each state's federal tax contribution. We use data on the gross amount of taxes collected from

each state by the Internal Revenue Service in fiscal year 2019.¹¹ Taxes include business income taxes, individual income taxes withheld and FICA tax, individual income tax payments and self-employment tax, unemployment insurance tax, railroad retirement tax, estate and trust income tax, estate tax, gift tax, and excise taxes. Some of these categories are largely dedicated to Medicare, Social Security, and unemployment compensation, but the data available do not allow for disaggregating these specific types by state.¹² We calculate the share of taxes paid to the federal treasury by each state and then estimate how the distribution of federal Medicaid/CHIP spending would differ if it were calculated according to the state's share of federal taxes paid. We then compare these hypothetical federal Medicaid/CHIP dollars with the distribution of federal Medicaid/CHIP spending under current law.

In addition, to rank states by the current-law generosity of their Medicaid/CHIP benefits, we sum estimated federal and state Medicaid/CHIP spending in 2020 from HIPSM (for all of the Medicaid/CHIP spending types listed above, including for the ACA expansion population), and we estimate the low-income population in each state (the number of state residents with incomes below 200 percent of the federal poverty level in 2020, according to HIPSM) to compute Medicaid/CHIP spending per low-income resident. We then rank each state by their relative spending levels. We also indicate each state's FMAP for federal fiscal year 2020 and each state's per capita income in 2019.¹³

RESULTS

Table 1 shows states ranked by their total federal and state Medicaid/CHIP spending per resident with low income (income at or below 200 percent of the federal poverty level). It also shows each state's FMAP and per capita income. The states with the highest Medicaid/CHIP spending (higher than \$9,500 per low-income resident) tend to have high per capita incomes and lower FMAPs. These include Connecticut, DC, Maryland, Massachusetts, Minnesota, New York, Pennsylvania, and Vermont. Maine and Montana are also among the 10 highest-spending states, but they have below-average per capita incomes. Nearly all of these states' Medicaid FMAPs are at or close to 50 percent (except in Maine and Montana), reflecting their high per capita incomes.¹⁴ States with the lowest spending tend to have lower incomes and be in the South or West; Alabama, Florida, Georgia, Kansas, Nevada, Oklahoma, and

South Carolina each had total Medicaid/CHIP spending below \$5,000 per low-income resident, and nearly all had Medicaid FMAPs above 60 percent. Illinois' spending also fell below this level, but it does not have low per capita income, as shown in Table 1. These results suggest that despite the higher Medicaid/CHIP matching rates in lower-income states that would seem to encourage spending, lower-income states spend considerably less, on average, per resident with low income than do higher-income states.

Table 2 shows federal Medicaid/CHIP spending for each state for traditional Medicaid (all types of Medicaid/CHIP spending listed above, except ACA expansion spending) under the current funding structure and how this spending would be allocated across states if it were consistent with the state's share of federal tax contributions. The difference, shown in the far-right column, shows whether the state's

Table 1: Medicaid/CHIP Spending per Low-Income Resident, FMAP, Low-Income Population, and per Capita Income, by State

State	Estimated Federal and State Medicaid and CHIP Spending per Low-Income Resident, 2020		FY 2020 Baseline Medicaid FMAP	Estimated Low-Income Population (Thousands)	Per Capita Income, 2019	
	Dollars	Rank			Dollars	Rank
DC	15,585	1	70%	215	84,538	1
Connecticut	14,120	2	50%	882	79,087	2
Minnesota	12,857	3	50%	1,346	59,683	14
Vermont	12,582	4	54%	183	56,691	19
Massachusetts	11,618	5	50%	1,908	74,967	3
Maine	10,823	6	64%	384	50,950	30
Pennsylvania	10,252	7	52%	3,695	58,775	16
New York	9,847	8	50%	7,501	71,440	4
Maryland	9,647	9	50%	1,530	65,683	7
Montana	9,500	10	65%	322	49,074	35
New Hampshire	9,308	11	50%	294	63,880	9
Delaware	9,129	12	58%	285	54,264	22
Oregon	8,723	13	61%	1,300	52,937	26
Kentucky	8,375	14	72%	1,624	44,017	47
Alaska	8,112	15	50%	295	62,102	11
West Virginia	8,090	16	75%	668	42,336	50
North Dakota	8,073	17	50%	183	57,501	17
Washington	8,065	18	50%	2,048	64,898	8
Ohio	8,022	19	63%	3,589	50,546	32
Louisiana	7,986	20	67%	1,803	48,008	40
Rhode Island	7,959	21	53%	298	56,542	20
New Mexico	7,685	22	73%	935	43,984	48
Missouri	7,656	23	66%	1,998	49,589	34
California	7,648	24	50%	13,587	66,661	6
Indiana	7,551	25	66%	2,179	48,657	37
New Jersey	7,548	26	50%	2,235	70,979	5
Arkansas	7,502	27	71%	1,177	44,845	46
Michigan	7,439	28	64%	3,125	50,320	33
Colorado	7,296	29	50%	1,550	61,348	12
Wisconsin	6,921	30	59%	1,555	53,583	24
Iowa	6,637	31	61%	827	52,636	27
Virginia	6,483	32	50%	2,356	60,116	13
Arizona	6,289	33	70%	2,547	46,233	43
Mississippi	6,093	34	77%	1,256	39,368	51
Wyoming	5,927	35	50%	162	63,316	10
South Dakota	5,919	36	58%	252	53,925	23
Tennessee	5,915	37	65%	2,402	48,761	36
North Carolina	5,908	38	67%	3,670	47,803	42
Idaho	5,867	39	70%	627	45,642	44
Nebraska	5,425	40	55%	537	54,871	21
Hawaii	5,127	41	53%	469	57,450	18
Utah	5,101	42	68%	1,002	48,395	38
Texas	5,042	43	61%	10,619	52,504	28
Illinois	4,991	44	50%	3,865	58,935	15
Oklahoma	4,773	45	66%	1,516	47,951	41
Alabama	4,691	46	72%	1,837	43,880	49
South Carolina	4,558	46	71%	1,889	45,314	45
Nevada	4,405	48	64%	1,117	50,883	31
Georgia	4,288	49	67%	3,892	48,199	39
Florida	4,091	50	61%	7,348	51,989	29
Kansas	3,395	51	59%	886	53,453	25
Average/Total	7,012			107,771		

Source: Authors' analysis of estimated Medicaid/Children's Health Insurance Program prepandemic spending data for 2020 and 2019 per capita income from the Federal Reserve Bank of St. Louis (see note 13).

Notes: FMAP = federal medical assistance percentage. FPL = federal poverty level. CHIP = Children's Health Insurance Program. FY = fiscal year. Low-income populations have incomes below 200 percent of the federal poverty level. FMAPs shown apply to most Medicaid spending types (e.g., Affordable Care Act expansion and CHIP matching rates are calculated differently) and reflect prepandemic levels.

Table 2: Federal Spending on Traditional (Nonexpansion) Medicaid/CHIP under Current Law and a Scenario Where Such Spending Aligns with State Federal Tax Contributions, 2020

State	Federal Spending under Current Law		Federal Spending When Aligned with State Federal Tax Contributions		Difference (Millions of Dollars)
	Millions of Dollars	% of Total Federal Spending	Millions of Dollars	% of Total Federal Spending	
Alabama	6,334	1.6%	2,978	0.7%	3,355
Alaska	1,315	0.3%	606	0.2%	709
Arizona	8,766	2.2%	5,364	1.3%	3,402
Arkansas	5,370	1.3%	3,435	0.9%	1,935
California	45,211	11.4%	53,032	13.3%	-7,821
Colorado	4,941	1.2%	6,737	1.7%	-1,795
Connecticut	5,579	1.4%	6,414	1.6%	-836
Delaware	1,332	0.3%	2,255	0.6%	-924
DC	2,165	0.5%	3,093	0.8%	-928
Florida	18,860	4.7%	23,596	5.9%	-4,736
Georgia	11,508	2.9%	10,595	2.7%	913
Hawaii	1,102	0.3%	1,039	0.3%	63
Idaho	2,075	0.5%	1,274	0.3%	801
Illinois	8,919	2.2%	18,231	4.6%	-9,312
Indiana	9,070	2.3%	6,811	1.7%	2,258
Iowa	3,001	0.8%	2,799	0.7%	202
Kansas	1,853	0.5%	2,959	0.7%	-1,106
Kentucky	7,333	1.8%	3,999	1.0%	3,334
Louisiana	7,508	1.9%	4,430	1.1%	3,078
Maine	2,516	0.6%	913	0.2%	1,603
Maryland	6,601	1.7%	8,816	2.2%	-2,216
Massachusetts	10,667	2.7%	13,486	3.4%	-2,819
Michigan	12,101	3.0%	9,166	2.3%	2,935
Minnesota	7,866	2.0%	11,532	2.9%	-3,666
Mississippi	5,958	1.5%	1,267	0.3%	4,691
Missouri	10,204	2.6%	7,207	1.8%	2,997
Montana	1,531	0.4%	714	0.2%	816
Nebraska	1,624	0.4%	2,871	0.7%	-1,247
Nevada	2,651	0.7%	2,670	0.7%	-20
New Hampshire	1,254	0.3%	1,372	0.3%	-118
New Jersey	7,560	1.9%	15,758	4.0%	-8,198
New Mexico	3,588	0.9%	1,042	0.3%	2,546
New York	32,123	8.1%	34,266	8.6%	-2,142
North Carolina	14,953	3.8%	9,862	2.5%	5,091
North Dakota	673	0.2%	746	0.2%	-73
Ohio	15,910	4.0%	16,257	4.1%	-347
Oklahoma	4,882	1.2%	3,273	0.8%	1,609
Oregon	5,862	1.5%	3,937	1.0%	1,926
Pennsylvania	18,597	4.7%	15,951	4.0%	2,646
Rhode Island	1,111	0.3%	1,609	0.4%	-499
South Carolina	6,178	1.6%	3,133	0.8%	3,046
South Dakota	898	0.2%	902	0.2%	-4
Tennessee	9,479	2.4%	7,838	2.0%	1,640
Texas	33,699	8.5%	32,843	8.3%	856
Utah	2,978	0.7%	2,734	0.7%	244
Vermont	1,110	0.3%	506	0.1%	604
Virginia	6,000	1.5%	9,389	2.4%	-3,390
Washington	6,717	1.7%	11,303	2.8%	-4,586
West Virginia	3,475	0.9%	791	0.2%	2,684
Wisconsin	6,512	1.6%	5,940	1.5%	572
Wyoming	492	0.1%	265	0.1%	226
Total	398,007	100.0%	398,007	100.0%	

Source: Authors' analysis of estimated 2020 Medicaid/Children's Health Insurance Program spending data and federal revenue data for fiscal year 2019 from the Internal Revenue Service (see note 11).

Notes: CHIP = Children's Health Insurance Program. Estimates are based on pre-COVID-19 baseline spending and do not account for changes to enrollment or spending per enrollee that may occur under the pandemic and associated recession. Traditional Medicaid includes Medicaid for the nonelderly and Children's Health Insurance Program coverage (both fee-for-service and managed care), disproportionate share hospital spending, spending on long-term services and supports, and Medicaid spending on Medicare beneficiaries ages 65 and older, including premiums, cost-sharing requirements, and payments for acute care. Federal tax contributions include business income taxes, individual income tax payments and self-employment taxes, railroad retirement taxes, estate and trust income taxes, estate taxes, gift taxes, and excise taxes.

traditional Medicaid/CHIP allocation would have been higher or lower if allocated according to its federal tax contributions, and by what amount. As shown in Table 2, Alabama receives 1.6 percent of federal Medicaid/CHIP dollars under the pre-COVID-19 structure, whereas it contributed 0.7 percent of tax contributions to the federal treasury. Therefore, Alabama receives more federal dollars for traditional Medicaid/CHIP than it contributes toward the program. Conversely, California receives 11.4 percent of federal Medicaid/CHIP spending but contributes 13.3 percent of federal taxes. Therefore, California pays more toward the program than it receives. Table 2 shows that 22 states, including DC, contribute a higher share of federal revenue than the share of federal Medicaid/CHIP spending they receive; the opposite is true for the remaining 29 states.

The largest net contributors, defined as states with a net contribution (tax payments less federal matching payments) of \$3.0 billion or more, are California, Florida, Illinois, Minnesota, New Jersey, Virginia, and Washington. On the other hand, seven states receive \$3.0 billion or more in federal Medicaid/CHIP payments than would be the case if they received their state's share of total tax revenue. These states are Alabama, Arizona, Kentucky, Louisiana, Mississippi, North Carolina, and South Carolina.

Among the states with the highest Medicaid/CHIP spending (Table 1), several are large net contributors despite also making significant federal tax contributions. That is, Connecticut, DC, Minnesota, Maryland, Massachusetts, and New York are among the states with Medicaid/CHIP programs spending the most per low-income resident, but all contribute a higher share to the federal treasury than the share of federal Medicaid/CHIP spending they receive. Many states spending far less per low-income resident are net recipients, including Alabama, Georgia, and South Carolina. Some of the less generous programs, however, are in states that contribute a higher share to the treasury than they receive in federal matching payments, such as Florida, Illinois, Kansas, and Nevada.

In Table 3, we examine the amount of federal funding for states' ACA Medicaid expansion populations, along with state contributions to the federal Treasury. For each state, we compare spending on the expansion population with what that spending would be if it were allocated to align with tax contributions by state residents and businesses. The resulting redistribution is considerably different than that for traditional Medicaid/CHIP. All of the nonexpansion states are, by definition, net contributors to expansion population spending: they pay their share of federal taxes to finance care for the expansion population, but they receive no federal dollars from the program because they have declined to participate. A handful of states that have adopted the expansion are, nonetheless, net contributors, with the largest being DC, Illinois, Massachusetts, Minnesota, and New Jersey. The largest net recipients of federal Medicaid expansion funds are California (\$5.4 billion) and New York (\$2.7 billion). Arizona, Kentucky, Louisiana, and Michigan are also significant net recipients.

If we assume all states had chosen to adopt the ACA's Medicaid expansion by 2020, using HIPSM estimates of the amount of federal spending each of the current nonexpansion states would receive had they expanded, the redistribution changes yet again. As shown in Table 4, almost all of the current nonexpansion states would become net federal funding recipients if they expanded Medicaid eligibility for their residents. A few, such as Florida, Kansas, Tennessee, and Wisconsin, would remain net funding contributors, but their net contributions would be much smaller than if they had not expanded (as shown in table 3). In addition, states like Alabama, Georgia, Mississippi, Missouri, North Carolina, Oklahoma, South Carolina, and West Virginia would all become significant net recipients of federal dollars. These net recipient and contributor patterns are similar to those that emerged for traditional programs only, as shown in Table 2.

Table 3: Federal Spending on ACA Medicaid Expansion under Current Law and a Scenario Where Such Spending Aligns with State Federal Tax Contributions, 2020

State	Federal Spending under Current Law		Federal Spending When Aligned with State Federal Tax Contributions		Difference (Millions of Dollars)
	Millions of Dollars	% of Total Federal Spending	Millions of Dollars	% of Total Federal Spending	
Alabama	0	0.0%	599	0.7%	-599
Alaska	232	0.3%	122	0.2%	110
Arizona	3,377	4.2%	1,078	1.3%	2,299
Arkansas	1,364	1.7%	690	0.9%	673
California	16,044	20.1%	10,658	13.3%	5,387
Colorado	1,884	2.4%	1,354	1.7%	530
Connecticut	1,342	1.7%	1,289	1.6%	53
Delaware	316	0.4%	453	0.6%	-138
DC	218	0.3%	622	0.8%	-403
Florida	0	0.0%	4,742	5.9%	-4,742
Georgia	0	0.0%	2,129	2.7%	-2,129
Hawaii	366	0.5%	209	0.3%	158
Idaho	704	0.9%	256	0.3%	448
Illinois	1,875	2.3%	3,664	4.6%	-1,789
Indiana	2,619	3.3%	1,369	1.7%	1,250
Iowa	763	1.0%	563	0.7%	201
Kansas	0	0.0%	595	0.7%	-595
Kentucky	3,272	4.1%	804	1.0%	2,469
Louisiana	3,024	3.8%	890	1.1%	2,134
Maine	231	0.3%	184	0.2%	48
Maryland	1,996	2.5%	1,772	2.2%	224
Massachusetts	1,520	1.9%	2,710	3.4%	-1,190
Michigan	4,320	5.4%	1,842	2.3%	2,478
Minnesota	1,446	1.8%	2,317	2.9%	-871
Mississippi	0	0.0%	255	0.3%	-255
Missouri	0	0.0%	1,448	1.8%	-1,448
Montana	763	1.0%	144	0.2%	620
Nebraska	0	0.0%	577	0.7%	-577
Nevada	786	1.0%	537	0.7%	249
New Hampshire	245	0.3%	276	0.3%	-30
New Jersey	2,091	2.6%	3,167	4.0%	-1,076
New Mexico	2,187	2.7%	209	0.3%	1,978
New York	9,617	12.0%	6,886	8.6%	2,731
North Carolina	0	0.0%	1,982	2.5%	-1,982
North Dakota	143	0.2%	150	0.2%	-7
Ohio	3,498	4.4%	3,267	4.1%	230
Oklahoma	0	0.0%	658	0.8%	-658
Oregon	1,902	2.4%	791	1.0%	1,111
Pennsylvania	3,369	4.2%	3,206	4.0%	164
Rhode Island	330	0.4%	323	0.4%	7
South Carolina	0	0.0%	630	0.8%	-630
South Dakota	0	0.0%	181	0.2%	-181
Tennessee	0	0.0%	1,575	2.0%	-1,575
Texas	0	0.0%	6,600	8.3%	-6,600
Utah	786	1.0%	549	0.7%	236
Vermont	223	0.3%	102	0.1%	121
Virginia	3,239	4.0%	1,887	2.4%	1,352
Washington	3,128	3.9%	2,272	2.8%	857
West Virginia	764	1.0%	159	0.2%	605
Wisconsin	0	0.0%	1,194	1.5%	-1,194
Wyoming	0	0.0%	53	0.1%	-53
Total	79,986	100.0%	79,986	100.0%	

Source: Authors' analysis of estimated 2020 Medicaid/Children's Health Insurance Program spending data and federal revenue data for fiscal year 2019 from the Internal Revenue Service (see note 12).

Notes: ACA = Affordable Care Act. Estimates are based on pre-COVID-19 baseline spending and do not account for changes to enrollment or spending per enrollee that may occur under the pandemic and associated recession. Federal tax contributions include business income taxes, individual income tax payments and self-employment taxes, railroad retirement taxes, estate and trust income taxes, estate taxes, gift taxes, and excise taxes.

Table 4: Federal Spending on ACA Medicaid Expansion under Current Law and a Scenario Where Such Spending Aligns with State Federal Tax Contributions, Assuming All States Adopted Medicaid Expansion by Mid-2020, 2020

State	Federal Spending under Current Law		Federal Spending When Aligned with State Federal Tax Contributions		Difference (Millions of Dollars)
	Millions of Dollars	% of Total Federal Spending	Millions of Dollars	% of Total Federal Spending	
Alabama	2,203	1.8%	923	0.7%	1,280
Alaska	232	0.2%	188	0.2%	44
Arizona	3,377	2.7%	1,663	1.3%	1,714
Arkansas	1,364	1.1%	1,065	0.9%	299
California	16,044	13.0%	16,443	13.3%	-398
Colorado	1,884	1.5%	2,089	1.7%	-205
Connecticut	1,342	1.1%	1,989	1.6%	-647
Delaware	316	0.3%	699	0.6%	-384
DC	218	0.2%	959	0.8%	-741
Florida	7,092	5.7%	7,316	5.9%	-225
Georgia	3,937	3.2%	3,285	2.7%	652
Hawaii	366	0.3%	322	0.3%	44
Idaho	704	0.6%	395	0.3%	309
Illinois	1,875	1.5%	5,653	4.6%	-3,778
Indiana	2,619	2.1%	2,112	1.7%	507
Iowa	763	0.6%	868	0.7%	-105
Kansas	840	0.7%	917	0.7%	-78
Kentucky	3,272	2.7%	1,240	1.0%	2,033
Louisiana	3,024	2.5%	1,374	1.1%	1,651
Maine	231	0.2%	283	0.2%	-52
Maryland	1,996	1.6%	2,734	2.2%	-738
Massachusetts	1,520	1.2%	4,181	3.4%	-2,661
Michigan	4,320	3.5%	2,842	2.3%	1,478
Minnesota	1,446	1.2%	3,575	2.9%	-2,129
Mississippi	1,543	1.3%	393	0.3%	1,150
Missouri	2,744	2.2%	2,235	1.8%	509
Montana	763	0.6%	221	0.2%	542
Nebraska	554	0.4%	890	0.7%	-336
Nevada	786	0.6%	828	0.7%	-42
New Hampshire	245	0.2%	425	0.3%	-180
New Jersey	2,091	1.7%	4,886	4.0%	-2,795
New Mexico	2,187	1.8%	323	0.3%	1,864
New York	9,617	7.8%	10,624	8.6%	-1,007
North Carolina	5,472	4.4%	3,058	2.5%	2,415
North Dakota	143	0.1%	231	0.2%	-89
Ohio	3,498	2.8%	5,041	4.1%	-1,543
Oklahoma	1,765	1.4%	1,015	0.8%	751
Oregon	1,902	1.5%	1,221	1.0%	682
Pennsylvania	3,369	2.7%	4,946	4.0%	-1,576
Rhode Island	330	0.3%	499	0.4%	-169
South Carolina	2,227	1.8%	971	0.8%	1,256
South Dakota	337	0.3%	280	0.2%	57
Tennessee	2,047	1.7%	2,430	2.0%	-384
Texas	11,756	9.5%	10,183	8.3%	1,573
Utah	786	0.6%	848	0.7%	-62
Vermont	223	0.2%	157	0.1%	66
Virginia	3,239	2.6%	2,911	2.4%	327
Washington	3,128	2.5%	3,505	2.8%	-376
West Virginia	764	0.6%	245	0.2%	519
Wisconsin	729	0.6%	1,842	1.5%	-1,113
Wyoming	174	0.1%	82	0.1%	92
Total	123,404	100.0%	123,404	100.0%	

Source: Authors' analysis of estimated 2020 Medicaid/Children's Health Insurance Program spending data and federal revenue data for fiscal year 2019 from the Internal Revenue Service (see note 11).

Notes: ACA = Affordable Care Act. Estimates are based on pre-COVID-19 baseline spending and do not account for changes to enrollment or spending per enrollee that may occur under the pandemic and associated recession. Federal tax contributions include business income taxes, individual income tax payments and self-employment taxes, railroad retirement taxes, estate and trust income taxes, estate taxes, gift taxes, and excise taxes.

CONCLUSION

This analysis produced three central findings. First, Medicaid/CHIP spending significantly contributes to the distribution of federal funding across states. Second, funding is generally redistributed from high-income states to low-income states through the traditional Medicaid and CHIP programs. Third, there is considerable redistribution from some low-income states to other states in the financing of the ACA's Medicaid expansion, because of the former having refused to expand Medicaid eligibility.

The redistribution from the traditional public insurance programs largely transfers funding from higher-income states to lower-income states, with state income measured by per capita income. This redistribution mostly occurs because of the higher Medicaid/CHIP federal matching rates low-income states receive, but it also owes to the smaller tax contributions such states make to the federal treasury. Many higher-

income states receive high shares of total federal Medicaid/CHIP spending (and have more generous programs than average), but their residents and businesses contribute even more to federal revenues. At the same time, many lower-income states receive low shares of national Medicaid/CHIP spending (and have less generous programs per low-income resident), but their residents and business make even smaller contributions to the treasury. We also show that states that have not expanded Medicaid eligibility under the ACA make net contributions to the other states that have expanded, and many of these nonexpansion states have low per capita incomes. If the remaining states were to expand Medicaid eligibility, however, they would receive more in federal dollars than they contribute in taxes, as is the case with the traditional programs.

ENDNOTES

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- 2 Bogusz C, Feinstein A, Ready D, Salazar J. The federal budget in 2019. Congressional Budget Office website. <https://www.cbo.gov/system/files/2020-04/56324-CBO-2019-budget-infographic.pdf>.
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- 4 Medicaid and CHIP Payment and Access Commission. *MACStats: Medicaid and CHIP Data Book*. Washington: Medicaid and CHIP Payment and Access Commission; 2019. <https://www.macpac.gov/publication/macstats-medicaid-and-chip-data-book-2/>. Accessed September 15, 2020.
- 5 Baseline disproportionate share hospital (DSH) spending was derived from Medicaid and CHIP Payment and Access Commission data on state-level fiscal year (FY) 2020 DSH allotments; see table IA-2 in Medicaid and CHIP Payment and Access Commission. *Report to Congress on Medicaid and CHIP*. Washington: Medicaid and CHIP Payment and Access Commission; 2020. <https://www.macpac.gov/wp-content/uploads/2020/03/March-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>. Accessed September 15, 2020. Congress had previously planned a \$4 billion reduction in federal DSH allotments in FY 2020. However, the Coronavirus Aid, Relief, and Economic Security, or CARES, Act eliminated these cuts in FY 2020 and reduced and delayed cuts planned for FY 2021. To account for these changes, we use the Medicaid and CHIP Payment and Access Commission's total and federal "unreduced allotments" (which exclude the previously planned reductions) and then calculate state shares and implied federal matching rates.
- 6 Medicaid and CHIP Payment and Access Commission. *Report to Congress on Medicaid and CHIP*. Washington: Medicaid and CHIP Payment and Access Commission; 2020. <https://www.macpac.gov/wp-content/uploads/2020/03/March-2020-Report-to-Congress-on-Medicaid-and-CHIP.pdf>. Accessed September 15, 2020.
- 7 This analysis includes most types of federal and state-level Medicaid spending, but we exclude the following: administrative expenses, family planning services, expenditures fully financed by the federal government for beneficiaries in the Qualifying Individual program, Community First Choice expenditures, and spending on home health services and the National Breast and Cervical Cancer Early Detection Program. We also do not account for effects on Medicare claw-back payments related to Medicare Part D. However, we include services provided to American Indians and Alaska Natives eligible for the Indian Health Service at Indian Health Service facilities or tribal or urban Indian centers.
- 8 Holahan J, Haley J, Buettgens M, Elmendorf C, Wang R. Increasing federal Medicaid matching rates to provide fiscal relief to states during the COVID-19 pandemic. Urban Institute. 2020. <https://www.urban.org/research/publication/increasing-federal-medicaid-matching-rates-provide-fiscal-relief-states-during-covid-19-pandemic>. Published April 23, 2020. Accessed September 15, 2020.
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- 10 Simpson M. The implications of Medicaid expansion in the remaining states: 2020 update. Urban Institute. 2020. <https://www.urban.org/research/publication/implications-medicaid-expansion-remaining-states-2020-update>. Published June 9, 2020. Accessed September 15, 2020. We use estimates of federal spending provided by the author that exclude spending on marketplace subsidies.
- 11 SOI tax stats – Gross collections, by type of tax and state – IRS data book table 5. Internal Revenue Service website. <https://www.irs.gov/statistics/soi-tax-stats-gross-collections-by-type-of-tax-and-state-irs-data-book-table-5>. Accessed September 15, 2020.
- 12 As indicated in the Internal Revenue Service source above: "Collections of withheld individual income tax are not reported by taxpayers separately from Old-Age, Survivors, Disability, and Hospital Insurance (OASDHI) taxes on salaries and wages (under the Federal Insurance Contributions Act or FICA) and individual income tax payments along with taxes on self-employment income (under the Self-Employment Insurance Contributions Act or SECA). Thus, while Table 1 shows these amounts separately for the United States total, separate amounts are not available by state."
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