Research

Expanding Medicaid Will Not Stimulate the Economy or Create Jobs

ROBERT BOOK | DECEMBER 11, 2014

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.

*Assuming all states expand Medicaid

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.

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