A Budget Crisis in Three Parts:
How ObamaCare is Bankrupting Taxpayers

AUTHORED BY:
Jonathan Ingram
Vice President of Research
Nic Horton
Research Director
**KEY FINDINGS**

1. **Pre-Obamacare, total Medicaid spending had already more than doubled** since 2000, with states spending one out of every four dollars on Medicaid.

2. States that expanded Obamacare have signed up more than twice as many able-bodied adults as promised.

3. Obamacare expansion per-person costs have exceeded original estimates by 76 percent.

4. This enrollment explosion, combined with higher per-person costs, has led to cost overruns of 157 percent.

5. Policymakers in the states and in Washington D.C. need to work together to roll back existing expansions and stop new ones.

**Bottom Line:**

Obamacare expansion is costing taxpayers billions and fueling budget crises across the country. Its days should be numbered.
Background on ObamaCare’s Medicaid expansion

Under ObamaCare, states have the option to expand Medicaid to a new class of able-bodied, working-age adults. Given that the safety net was originally designed to serve the truly needy, this population was previously ineligible for long-term welfare. ObamaCare changed that, creating a new group of able-bodied adult enrollees to directly compete with the truly needy for limited resources.

By 2016, 31 states and the District of Columbia had adopted the expansion. Although expansion was fully funded by federal taxpayers for the first three years—with the exception of some administrative costs which were borne by states—the federal share of these costs began to ratchet down in 2017.

By 2020, states will pay at least 10 percent of expansion costs, although Congress continues to pursue ways to reduce or even eliminate federal spending on ObamaCare expansion.

While states have yet to feel the full impact, policymakers are faced with a large, imminent problem: they do not have the money. Now, they are witnessing an explosion in both enrollment and costs which puts funding for the truly needy and other critical priorities in jeopardy.
PART 1: STATES EXPANDED A PROGRAM THAT WAS ALREADY OUT OF CONTROL

Medicaid was often the largest and fastest-growing line item in state budgets even before ObamaCare's Medicaid expansion was implemented. In fact, Medicaid spending more than doubled between 2000 and 2013. But ObamaCare expansion escalated this spending surge even more.

ObamaCare expansion has driven a large share of this increase. Medicaid spending on able-bodied adults has more than doubled since 2013, the year before expansion took effect. Roughly three quarters of this new spending is being driven by able-bodied adults made eligible for the program by ObamaCare.

Medicaid was already one of the largest and fastest growing line items in the budget, crowding out resources for virtually all other priorities.

Before expansion, nearly one out of every four dollars in state budgets went to Medicaid. But thanks to ObamaCare, this problem will only get worse. In fact, after just four years of expansion, Medicaid spending has grown to now consume one out of every three dollars in state budgets.

DID YOU KNOW...
NEARLY ONE OUT OF EVERY THREE STATE DOLLARS GOES TO MEDICAID?
Even if states had hit enrollment projections exactly, their budgets would have already been stretched. ObamaCare expansion was never going to be sustainable for them. But the reality is worse than that.

States have consistently and grossly missed their expansion enrollment projections, already signing up more than twice as many able-bodied adults than they anticipated would sign up at any point in the future. Some states have enrolled more able-bodied adults than they thought would ever even be eligible.

Third-party projections and estimates from the federal government have proven to be off-base as well. The Centers for Medicare and Medicaid Services, for example, underestimated enrollment by more than 36 percent. Independent groups like the Kaiser Family Foundation, Urban Institute, and Lewin Group underestimated enrollment by up to 60 percent. And actual enrollment has been roughly double what the Congressional Budget Office expected.

Ultimately, the takeaway is simple: everyone got it wrong. As a result, taxpayers are on the hook for more than twice as many able-bodied adults as promised, significantly contributing to the pending budget crises in states.
ObamaCare expansion is also proving to be tremendously more expensive per person than anticipated. For example, the Congressional Budget Office underestimated per-person spending by nearly 10 percent during the first three years of expansion. The Lewin Group similarly underestimated per-person expenditures by roughly 10 percent.

And worst of all, the Centers for Medicare and Medicaid Services underestimated per-person costs by a whopping 76 percent during the first three fiscal years.

Higher-than-promised enrollment and higher-than-promised per-person costs have culminated into significant budget overruns in states.

Altogether, a review of every state with available spending projections and actual cost data reveals that taxpayers have spent roughly 124 percent more on ObamaCare expansion than state officials initially predicted, leaving less money to fund other core priorities, including education, public safety, and services for the truly vulnerable.
ObamaCare expansion has cost taxpayers 157 percent more than expected

Projected and actual Medicaid expansion costs, by state (in millions)

<table>
<thead>
<tr>
<th>STATE</th>
<th>PROJECTED COST</th>
<th>ACTUAL COST</th>
<th>COST OVERRUNS</th>
<th>PERCENT OVER</th>
<th>YEARS OF DATA AVAILABLE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alaska</td>
<td>$320</td>
<td>$593</td>
<td>$273</td>
<td>85%</td>
<td>2 years</td>
</tr>
<tr>
<td>Arizona</td>
<td>$4,652</td>
<td>$5,350</td>
<td>$698</td>
<td>15%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Arkansas</td>
<td>$1,800</td>
<td>$3,225</td>
<td>$1,425</td>
<td>79%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>California</td>
<td>$11,558</td>
<td>$43,679</td>
<td>$32,122</td>
<td>278%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Colorado</td>
<td>$2,233</td>
<td>$3,270</td>
<td>$1,036</td>
<td>46%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Hawaii</td>
<td>$236</td>
<td>$625</td>
<td>$389</td>
<td>165%</td>
<td>2 years</td>
</tr>
<tr>
<td>Illinois</td>
<td>$4,596</td>
<td>$9,230</td>
<td>$4,633</td>
<td>101%</td>
<td>3 years</td>
</tr>
<tr>
<td>Iowa</td>
<td>$1,378</td>
<td>$1,734</td>
<td>$356</td>
<td>26%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Kentucky</td>
<td>$3,068</td>
<td>$5,971</td>
<td>$2,903</td>
<td>95%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Louisiana</td>
<td>$1,164</td>
<td>$2,509</td>
<td>$1,344</td>
<td>115%</td>
<td>1 year</td>
</tr>
<tr>
<td>Maryland</td>
<td>$1,475</td>
<td>$4,707</td>
<td>$3,232</td>
<td>219%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Michigan</td>
<td>$5,458</td>
<td>$6,664</td>
<td>$1,206</td>
<td>22%</td>
<td>2.25 years</td>
</tr>
<tr>
<td>Montana</td>
<td>$473</td>
<td>$802</td>
<td>$329</td>
<td>70%</td>
<td>2 years</td>
</tr>
<tr>
<td>New Hampshire</td>
<td>$899</td>
<td>$1,066</td>
<td>$168</td>
<td>19%</td>
<td>2.75 years</td>
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<td>New Mexico</td>
<td>$2,150</td>
<td>$2,877</td>
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<td>34%</td>
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<tr>
<td>North Dakota</td>
<td>$208</td>
<td>$547</td>
<td>$339</td>
<td>163%</td>
<td>2.5 years</td>
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<tr>
<td>Ohio</td>
<td>$7,383</td>
<td>$14,467</td>
<td>$7,084</td>
<td>96%</td>
<td>3.5 years</td>
</tr>
<tr>
<td>Oregon</td>
<td>$3,185</td>
<td>$6,162</td>
<td>$2,977</td>
<td>93%</td>
<td>2.5 years</td>
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<tr>
<td>Pennsylvania</td>
<td>$1,463</td>
<td>$2,813</td>
<td>$1,350</td>
<td>92%</td>
<td>1 year</td>
</tr>
<tr>
<td>Washington</td>
<td>$3,611</td>
<td>$6,456</td>
<td>$2,845</td>
<td>79%</td>
<td>2.5 years</td>
</tr>
<tr>
<td>West Virginia</td>
<td>$1,268</td>
<td>$1,835</td>
<td>$567</td>
<td>45%</td>
<td>2.5 years</td>
</tr>
</tbody>
</table>
Before Gov. Bill Walker unilaterally expanded Medicaid in Alaska, his administration predicted that just 23,000 able-bodied adults would enroll in the first two years and taxpayers would spend less than $320 million on expansion during that time.\textsuperscript{38}

In reality, more than 36,000 able-bodied adults signed up during the first two years, costing taxpayers nearly $593 million—roughly 85 percent more than expected.\textsuperscript{39} If this pattern continues, policymakers will be scrambling to find more than $50 million in state funds over the next four years just to cover ObamaCare overruns.\textsuperscript{40}

Meanwhile, as tens of thousands of able-bodied adults are now at the front of the line, more than 500 Alaskans with intellectual or developmental disabilities are trapped on Medicaid waiting lists to receive needed home- and community-based services.\textsuperscript{41} And their outlook is not good.

In 2015, the Walker administration announced plans to reduce the number of people moved off the waiting list each year by up to 75 percent.\textsuperscript{42} In 2017, the Alaska Department of Health and Social Services proposed additional cuts to services for individuals with developmental disabilities who are already on the program.\textsuperscript{43}

Even more tragic, the state could eliminate this waiting list altogether for less than the state share of ObamaCare expansion costs.\textsuperscript{44,45}

California state officials predicted expansion enrollment would top out at 910,000 able-bodied adults and would cost taxpayers $11.6 billion during the first two and a half years of operation.\textsuperscript{46,47} But by July 2017, total enrollment exceeded a staggering 3.8 million.\textsuperscript{48} The actual cost to taxpayers during that time: a whopping $43.7 billion, nearly four times what was expected.\textsuperscript{49,59}

California’s Medicaid program has spiraled out of control. More than a third of all Californians are now dependent on the program.\textsuperscript{60,62} Over the past decade, the state’s Medicaid budget has nearly tripled, reaching more than $100 billion per year.\textsuperscript{63,64} And more than 62 percent of all new state spending over the last decade has gone to Medicaid, crowding out funding for other critical priorities including education, public safety, and infrastructure—a problem that will only worsen as ObamaCare continues to put extreme pressure on the budget.\textsuperscript{65,67}
As officials from then-Governor Pat Quinn’s administration lobbied Illinois state legislators to expand Medicaid under ObamaCare, they promised low and predictable enrollment. Specifically, the Illinois Department of Healthcare and Family Services projected 380,000 able-bodied adults would ever be eligible for the expansion, with just 342,000 of them expected to ever enroll. But in under three months, Illinois shattered its maximum projections.

By March 2017, more than 655,000 able-bodied adults had signed up for the state’s ObamaCare expansion. That means nearly twice as many able-bodied adults than the state thought would ever even be eligible have enrolled in the expansion.

This has resulted in significant cost overruns. While state officials pegged expansion costs at nearly $4.6 billion for its first three years, actual ObamaCare expansion costs totaled more than $9.2 billion during that timeframe—more than twice what was expected. Because these costs are far higher than state officials expected and lawmakers did not set aside a dedicated funding source for the program, policymakers are now scrambling to find funds to cover the state’s growing share of the costs.

Right now in the state, more than 19,000 children and adults with autism, epilepsy, developmental disabilities, and other critical conditions are currently languishing on a Medicaid waiting list for needed home- and community-based services. Nearly 70 percent of those individuals have reported an emergency or critical need for services. And tragically, since January 2014, when the statewide expansion began, more than 800 individuals on the waiting list have died before ever getting the services they so desperately needed.

Cost overruns for ObamaCare’s Medicaid expansion are only making these problems worse because every dollar spent on ObamaCare expansion is a dollar that cannot go to the truly vulnerable.

In 2013, Ohio lawmakers passed legislation prohibiting Governor John Kasich from expanding Medicaid under ObamaCare. Kasich proceeded to use a line-item veto to scrap that provision from the budget and expand Medicaid unilaterally.

His office initially predicted that no more than 447,000 able-bodied adults would ever sign up for the expansion and it would cost taxpayers just $7.4 billion during the first three and a half years. But actual enrollment blew past the state’s projected maximum in less
than a year. By May 2017, more than 725,000 able-bodied adults had signed up for Ohio’s ObamaCare expansion.

To make matters worse, per-person costs have also been significantly higher than anticipated, putting even further strain on Ohio’s Medicaid budget. Altogether, Ohio’s ObamaCare expansion costs hit $14.5 billion for the first three and a half years—nearly twice what was initially forecast. Lawmakers have scrambled to find funding to cover the state’s share of the costs. Medicaid already makes up roughly half of the state’s general operating budget, leaving little room for policymakers to sweep existing funding from other priorities.

Gov. Kasich has already proposed slashing payments to pediatric hospitals and cutting eligibility levels for pregnant women in order to rein in the Medicaid budget. In 2016, the Kasich administration also eliminated Medicaid eligibility for more than 34,000 seniors and individuals with disabilities. With ObamaCare expansion cost overruns mounting, these cuts may simply be a sign of what is to come.

In West Virginia, Democratic Governor Earl Ray Tomblin unilaterally expanded Medicaid through executive order, predicting 95,000 able-bodied adults would ever enroll and the program would cost less than $1.3 billion during the first two and a half years. But actual enrollment shattered that supposed maximum in fewer than three months, with enrollment continuing the climb thereafter. By December 2016, more than 181,000 able-bodied adults had signed up for the state’s ObamaCare expansion—nearly twice as many as the state said would ever enroll.

Cost overruns are now mounting as a result, with costs during the first two and a half years hitting more than $1.8 billion—roughly 45 percent more than anticipated. Even if expansion costs flatline, state policymakers must find tens of millions of dollars in new funds to cover these higher-than-expected costs.

Similar enrollment explosions and cost overruns have occurred in expansion states across the country. Altogether, Medicaid expansion has cost taxpayers nearly 157 percent more than state officials initially expected. Higher-than-expected enrollment and higher costs in these states will ultimately leave fewer resources available for all other priorities—including services for the truly vulnerable, education, and public safety.
ObamaCare’s massive enrollment explosion and cost overruns are pushing taxpayers to the edge of fiscal insolvency. The out-of-control program is diverting resources away from individuals who truly rely on the Medicaid program to survive. Policymakers at the state and federal levels should act quickly to end the ObamaCare nightmare once and for all.

First and foremost, Congress should ensure no new states go down the ObamaCare path.

Short of an outright prohibition on new expansions, Congress could accomplish this easily by eliminating the enhanced federal funding for additional states. It is the right thing to do: this enhanced funding encourages states to prioritize able-bodied adults over the truly needy.\(^{176}\)

Secondly, non-expansion states should continue to hold the line against ObamaCare.

As expansion enrollment and costs continue to soar, states that rejected expansion look smarter by the day. Reversing course now would be a horrible decision for their budgets, their taxpayers, and the truly needy in their states.

Finally, states that wrongly expanded ObamaCare should work to roll it back.

States can begin unwinding ObamaCare expansion and they should do so with great urgency. One simple strategy would be to freeze enrollment in the expansion immediately. Under this approach, no new applications for ObamaCare’s Medicaid expansion would be approved, but those already enrolled would be allowed to stay in the program until their situations improved and they became ineligible. After closing the front door, enrollment would immediately begin to decline, freeing up limited resources for the truly needy. States have successfully used this approach in the past to unwind earlier expansions.\(^{177}\)

ObamaCare has wreaked havoc on taxpayers and the truly needy since its inception, trapping more than twice as many able-bodied adults in welfare as promised and costing more than twice as much as expected. Policymakers in the states and in Washington D.C. should work together to undo it.
REFERENCES

5. Ibid.
10. Ibid.
12. Authors’ calculations based upon the Centers for Medicare and Medicaid Services’ 2013 projections of enrollment and the share of the expansion eligible population living in expansion states and the Centers for Medicare and Medicaid Services’ 2016 estimates of enrollment and the share of the expansion eligible population living in expansion states.
13. In 2013, the Centers for Medicare and Medicaid Services estimated that 12.6 million people would eventually enroll in ObamaCare’s Medicaid expansion, assuming that roughly 65 percent of the eligible population lived in states that would expand. If all states were to expand Medicaid under ObamaCare, approximately 19.4 newly eligible adults were predicted to enroll. See, e.g., Centers for Medicare and Medicaid Services, “2013 actuarial report on the financial outlook for Medicaid,” U.S. Department of Health and Human Services (2013), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/medicaidreport2013.pdf.
14. In 2016, the Centers for Medicare and Medicaid Services estimated that 11.2 million people had enrolled in the expansion and that 50 percent of the expansion eligible population lived in states that opted into the expansion. It further estimated that approximately 13.2 million would enroll by 2025 and that 55 percent of the expansion eligible population would live in states that opted into the expansion. If all states were to expand Medicaid under ObamaCare, approximately 24 million would be predicted to enroll. See, e.g., Centers for Medicare and Medicaid Services, “2016 actuarial report on the financial outlook for Medicaid,” U.S. Department of Health and Human Services (2016), https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2016.pdf.
16. Authors’ calculations based upon the Congressional Budget Office’s 2010 projections of enrollment assuming all states expanded and the Congressional Budget Office’s 2017 estimate of enrollment and the share of the expansion eligible population living in expansion states.
20. The Congressional Budget Office’s estimate of 13 million adults enrolled in ObamaCare’s Medicaid expansion and only
half of the expansion eligible population living in expansion states suggests that total enrollment would be approximately 26 million if all states had expanded.

21. Authors’ calculations based upon the Congressional Budget Office’s 2013 projections of enrollment and per-enrollee spending during calendar years 2014 through 2016 and the Congressional Budget Office’s 2017 estimate of actual enrollment and per-enrollee spending during calendar years 2014 through 2016.


24. Authors’ calculations based upon the Lewin Group’s 2014 projections of enrollment and per-enrollee spending in the states that ultimately opted into ObamaCare’s Medicaid expansion and the actual enrollment and total expenditures reported by the Centers for Medicare and Medicaid Services from July 2015 through June 2016.


34. Authors’ calculations based upon the Centers for Medicare and Medicaid Services’ 2012 projections of enrollment and per-enrollee spending during fiscal years 2014 through 2016 and the Centers for Medicare and Medicaid Services’ 2016 estimate of enrollment and per-enrollee spending during fiscal years 2014 through 2016.


37. Authors’ calculations based upon each state’s Medicaid expansion overrun. Because the amount of expenditures data available varied by state, each state’s cost overruns were weighted by current estimated annual spending, derived from each state’s most recent per-person costs multiplied by each state’s most recent enrollment data.


40. Authors’ calculations based upon Alaska’s cost overrun during the first two years of expansion and its initial state cost...
projections for the next four years.


44. Authors’ calculations based upon annualized quarterly Medicaid expansion expenditures in Alaska between September 2017 and November 2017 and the state matching rate for Medicaid expansion in calendar year 2018.

45. The Alaska Department of Health and Social Services estimates that eliminating the waiting list would cost approximately $41 million per year, with roughly half of those costs borne by the state. See, e.g., Division of Seniors and Disabilities Services, “Individuals with developmental disabilities registration and review report: Fiscal year 2016,” Alaska Department of Health and Social Services (2016), http://dhss.alaska.gov/dsds/Documents/dd/2016ddregistryreport.pdf.


49. Authors’ calculations based upon newly eligible expenditures made between January 2014 and June 2016.


60. Authors’ calculations based upon Medicaid enrollment and population estimates in California.

61. Nearly 13.4 million people were enrolled in Medicaid in June 2017. See, e.g., Research and Analytic Studies Division, “Medi-Cal certified eligible data table by county, age groups, ACA aid groups, race/ethnicity, and language – June 2017;”


65. Authors’ calculations based upon California’s estimated fiscal year 2007 and 2017 expenditures, disaggregated by budget category.


69. Ibid.


73. Authors’ calculations based upon the unduplicated count of individuals on Illinois’ Prioritization of Urgency of Needs and Services’ waiting list who report a critical or emergency need as a share of the total unduplicated count of individuals on the waiting list. See, e.g., Division of Developmental Disabilities, "Summary of PUNS by type of support needed," Illinois Department of Human Services (2018), http://www.dhs.state.il.us/page.aspx?item=56036.

74. Authors’ calculations based upon the unduplicated count of individuals removed from the Illinois’ Prioritization of Urgency of Needs and Services’ waiting list between January 9, 2014 and January 10, 2018.

75. The state reported that 885 individuals had been removed from the waiting list because they had died before receiving services between when it began tracking these deaths and January 9, 2014—a little more than a week after the state expanded Medicaid under ObamaCare. See, e.g., Division of Developmental Disabilities, “PUNS data by support needed,” Illinois Department of Human Services (2014), https://files.illinoispolicy.org/wp-content/uploads/2016/11/2013-2016PUNS.pdf.

76. By January 10, 2018, 1,688 individuals had been removed from the waiting list because they had died before receiving services. See, e.g., Division of Developmental Disabilities, "Summary of PUNS by type of support needed," Illinois Department of Human Services (2018), http://www.dhs.state.il.us/page.aspx?item=56036.


79. Ibid.


82. Authors’ calculations based upon monthly reports of Medicaid expansion expenditures between January 2014 and June 2017.


Department of Medicaid, “Medicaid expenditures and eligible report: January 2017,” Ohio Department of Medicaid
Authors’ calculations based upon newly eligible expenditures made between January 2014 and June 2016.


130. Authors’ calculations based upon projected and actual fiscal year 2016 Medicaid expansion expenditures and the state’s share of Medicaid expansion costs in calendar years 2018 and beyond.
143. Authors’ calculations based upon projected and actual Medicaid expansion expenditures in all states with available data.


150. Louisiana initially expected Medicaid expansion to cost $5.8 billion during the first five years, or an average of roughly $1.2 billion per year. Because the state did not disaggregate these costs by year, nor describe the assumed phase-in, the average annual cost likely overstates—possibly significantly—the actual first-year cost projections. Accordingly, it is likely that the cost overrun in Louisiana is actually higher than what is presented in this report. See, e.g., Shawn Hotstream, Medicaid expansion: Fiscal note on HCR 3,” Louisiana Legislative Fiscal Office (2015), http://www.legis.la.gov/legis/ViewDocument.aspx?id=942163.


153. Montana initially expected Medicaid expansion to cost $691 million during the first three full fiscal years of expansion. Montana’s actual Medicaid expansion took effect halfway through the fiscal year and current expenditures data only covers 6.5 months of the third fiscal year. Accordingly, the fiscal year 2016 estimates were reduced by half to reflect the 6 months that expansion was not in the fiscal year 2018 estimates were reduced by 45 percent to reflect the 5.5 months of expenditure data that was not yet available. The adjusted Medicaid expansion projection for the period of January 1, 2016 through January 15, 2018 is approximately $473 million. See, e.g., Lewin Group, “An evaluation of the impact of Medicaid expansion in New Hampshire: Phase I report,” New Hampshire Department of Health and Human Services (2013), https://dhhs.nh.gov/ombp/documents/nhimpactofmedicaidexpansion8550719.pdf.

154. New Hampshire initially expected Medicaid expansion to cost $931 million during the first three years. Because the state expanded in mid-August, rather than at the beginning of a fiscal year, expansion only operated for approximately 10.5 months of fiscal year 2015. Accordingly, the fiscal year 2015 estimates were reduced by 12.5 percent to reflect the 10.5 months that expansion was not in effect. The adjusted Medicaid expansion projection for the first 2.75 years is approximately $899 million. See, e.g., Lewin Group, “An evaluation of the impact of Medicaid expansion in New Hampshire: Phase I report,” New Hampshire Department of Health and Human Services (2013), https://dhhs.nh.gov/ombp/documents/nhimpactofmedicaidexpansion8550719.pdf.

155. New Mexico initially expected Medicaid expansion to cost $2.2 billion during the first three fiscal years, with expansion only in operation for half of fiscal year 2014. See, e.g., Lee A. Reynis, “Economic and fiscal impacts of the proposed Medicaid expansion in New Mexico,” University of New Mexico Bureau of Business and Economic Research (2012), http://bber.unm.edu/media/publications/Medicaid_Expansion_10-12.pdf.


160. This analysis excludes states that did not produce publicly available expenditure projections, had expanded Medicaid eligibility to childless adults prior to ObamaCare, or failed to produce expenditure projections and/or actual expenditure data.

161. Actual expenditures through June 2016, as reported by the Centers for Medicare and Medicaid Services, were used to compare to initial state projections for all states except Alaska, Illinois, Louisiana, Montana, Ohio, and Pennsylvania.


175. Authors’ calculations based upon each state’s Medicaid expansion overrun. Because the amount of expenditures data available varied by state, each state’s cost overruns were weighted by current estimated annual spending, derived from each state’s most recent per-person costs multiplied by each state’s most recent enrollment data.

