KFF

The independent source for health policy research, polling, and news.

5 Key Facts About Medicaid Expansion

Jessica Mathers (https://www.kff.org/person/jessica-mathers/),

Jennifer Tolbert (https://www.kff.org/person/jennifer-tolbert/),

Priya Chidambaram (https://www.kff.org/person/priya-chidambaram/), and

Sammy Cervantes (https://www.kff.org/person/sammy-cervantes/)

Published: Apr 25, 2025

Congress has passed a budget resolution (https://www.kff.org/quick-take/the-rubber-is-about-to-hit-the-road-on-medicaid-cuts/) that targets up to $880 billion or more in federal spending cuts from Medicaid over ten years. While specific proposals are not yet known, policies under discussion could limit financing (https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/) and coverage for the Affordable Care Act (ACA) expansion group. Recent KFF polling (https://www.kff.org/medicaid/poll-finding/kff-health-tracking-poll-public-views-on-potential-changes-to-medicaid/) shows there is little support for cuts to federal Medicaid spending overall, and a majority of adults (59%) oppose eliminating the enhanced federal match rate for adults covered under Medicaid expansion specifically.

The ACA expanded Medicaid coverage to nearly all adults with incomes up to 138% of the Federal Poverty Level ($21,597 for an individual in 2025 (https://aspe.hhs.gov/topics/poverty-economic-mobility/poverty-guidelines)) and provided states with an enhanced federal matching rate (FMAP) of 90% for their expansion populations over time, which is greater than the matching rate for Medicaid generally. While federal funding finances 90% of spending on the expansion population, states are responsible for the remaining 10% of costs for enrollees eligible under Medicaid expansion. As a result of a Supreme Court ruling in 2012, the expansion is effectively optional for states, and as of April 2025, all but 10 states have adopted the expansion. While expansion has led to higher government spending on Medicaid, a large body of literature (https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/) shows (https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/) that it is linked to reduced rates of uninsurance, increased health care affordability, improvements in access and health and outcomes, and economic benefits for states and providers (https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/). KFF polling (https://www.kff.org/medicaid/poll-finding/public-opinion-on-the-future-of-medicaid-kff-medicaid-unwinding-kff-health-tracking-poll/) shows that of people living in non-expansion states, two-thirds (66%) said their state should expand Medicaid to cover more low-income uninsured people.

This issue brief examines Medicaid expansion enrollment and Medicaid spending in expansion and non-expansion states and describes the characteristics of adults covered by the Medicaid expansion.

1. Medicaid expansion is widely adopted by both red and blue states.

Over the past 11 years, Medicaid expansion has been broadly adopted. The 41 states including the District of Columbia that have adopted Medicaid expansion are split (https://www.kff.org/medicaid/issue-brief/medicaid-expansion-is-a-red-and-blue-state-issue/) nearly evenly between states that voted for Trump (21 states) and those that voted for Harris (20 states) in the 2024 Presidential election (Figure 1). Over half (27) of states adopted Medicaid expansion (https://www.kff.org/status-of-state-medicaid-expansion-decisions/) in 2014, while 14 states have implemented expansion since 2014, with South Dakota and North Carolina adopting (https://www.kff.org/policy-watch/an-update-on-aca-medicaid-expansion-what-to-watch-in-north-carolina-and-beyond/) most recently in 2023. Most states adopted expansion through legislation; however, in seven states, the expansion was adopted via a ballot measure. As of June 2024, over 20 million people (https://www.kff.org/affordable-care-act/state-indicator/medicaid-expansion-enrollment/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D) were enrolled through Medicaid expansion, representing nearly a quarter of total Medicaid enrollment across all states and 31% of total enrollment in expansion states.

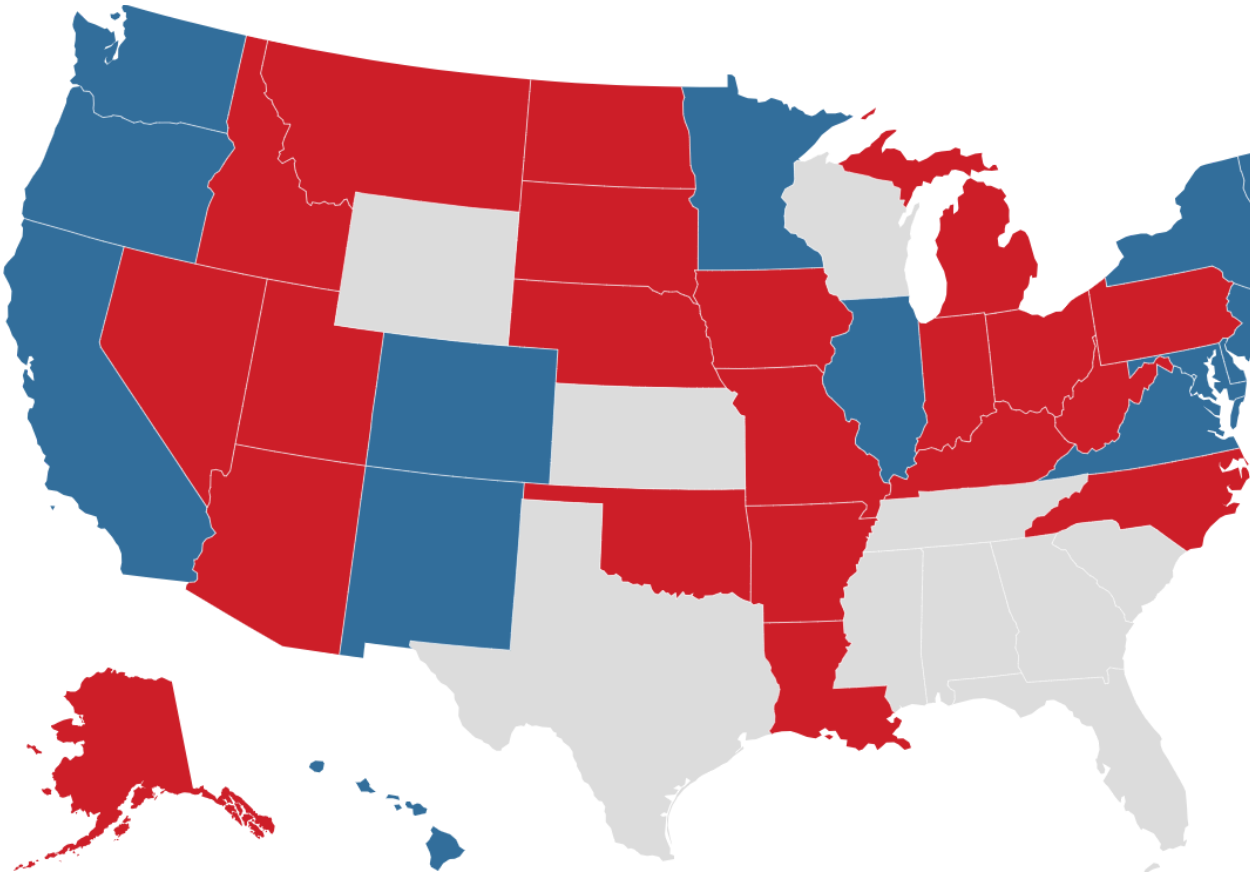
Medicaid expansion is linked (https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/) to gains in coverage, access, increased health care (https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/) affordability (https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/), and economic benefits for states and providers (https://www.kff.org/medicaid/issue-brief/what-does-the-recent-literature-say-about-medicaid-expansion-economic-impacts-on-providers/). Although establishing direct causality between health insurance and health outcomes is complex, evidence (https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/) generally shows Medicaid expansion is associated with improved health outcomes, including increased early-stage cancer diagnosis, improved disease management, and lower mortality rates for many chronic conditions.

Figure 1

Medicaid Expansion is Widely Adopted by Both Red and Blue States

Voted for Harris (20 states including DC)

Voted for Trump (21 states)



Source: KFF tracking of state Medicaid expansion decisions • Get the data • Download PNG

KFF

2. Medicaid median income eligibility for children, pregnancy, and parents, and Medicaid spending per enrollee are higher in expansion states compared to non-expansion states.

Overall, per enrollee spending for the expansion group was higher than for other adults and children but well below per enrollee spending for enrollees over age 65 and people with disabilities. While some critics (https://paragoninstitute.org/newsletter/medicaid-financing-reform-stopping-discrimination-against-the-most-vulnerable/) of Medicaid expansion have argued that expansion diverts resources away from other groups of Medicaid enrollees, including people with disabilities and children, data show that expansion states spend (https://www.kff.org/medicaid/issue-brief/a-look-at-variation-in-medicaid-spending-per-enrollee-by-group-and-across-states/) more per enrollee overall and on each eligibility group than non-expansion states. Per enrollee spending for people with disabilities in expansion states is nearly 2.5 times the spending in non-expansion states ($25,170 per enrollee vs. $10,494) (Figure 2). The difference in per-enrollee spending for expansion and non-expansion states holds true for more detailed eligibility pathways for people based on age or disability (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-eligibility-for-seniors-and-people-with-disabilities/). Expansion states also spent nearly $2,000 more per child enrollee than non-expansion states ($6,001 vs $4,295). The differences in per enrollee spending may reflect state policy choices about benefits and eligibility, in addition to payment rates, regional variation in health care costs, and state demographics.

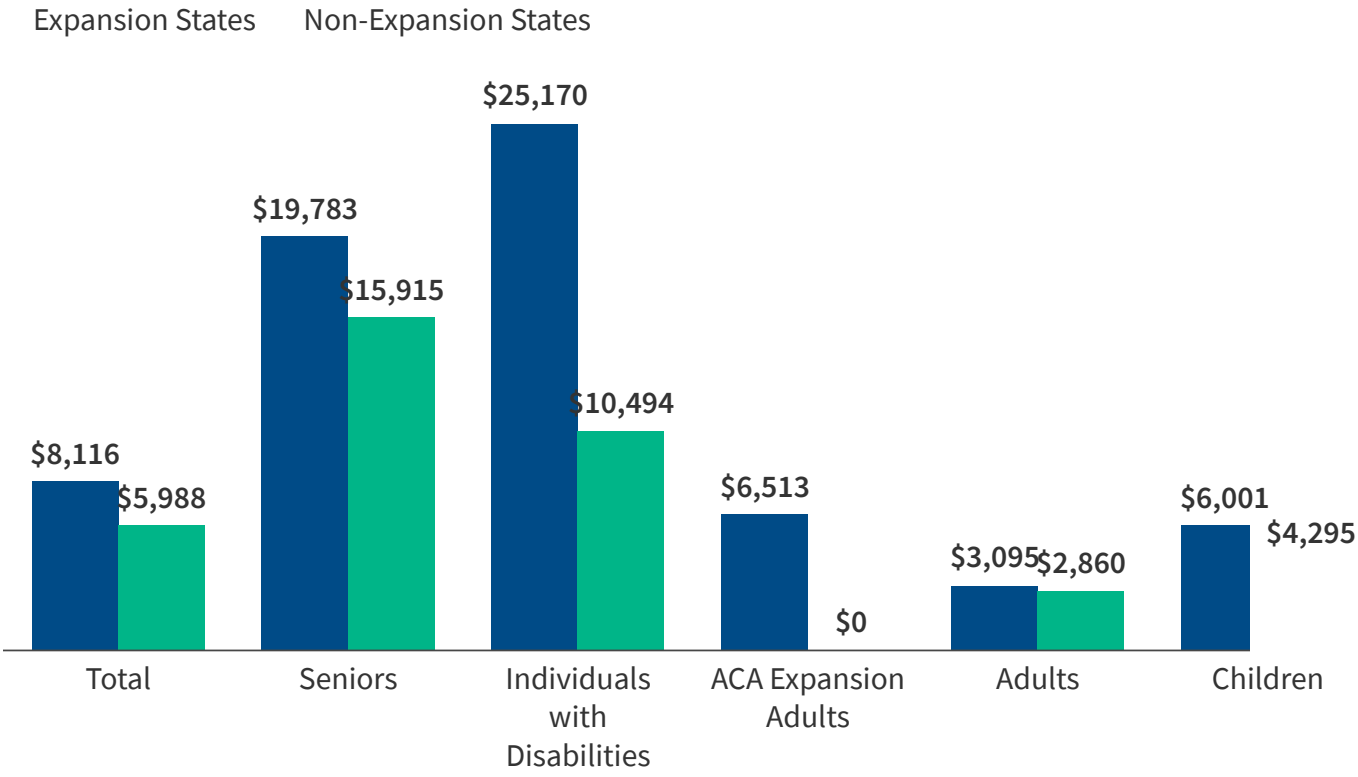
In addition to difference in spending, expansion states have higher median income-based eligibility limits (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-report/#enrollment) compared to non-expansion states for children (266% FPL in expansion states compared to 234% in non-expansion states), pregnant individuals (213% FPL compared to 203% FPL), and

parents (138% FPL compared to 33% FPL). There is substantial variation in adoption of optional eligibility (https://www.kff.org/report-section/medicaid-and-chip-eligibility-enrollment-and-renewal-policies-as-states-resume-routine-operations-report/#enrollment) and other policies for seniors and people with disabilities, with state expansion status not a strong predictor (https://www.kff.org/medicaid/issue-brief/state-variation-in-medicaid-ltss-policy-choices-and-implications-for-upcoming-policy-debates/) of these policy choices.

Figure 2

Per-Enrollee Spending in States That Expanded Medicaid Is Higher for All Eligibility Groups Than in Non-Expansion States

Per-enrollee spending by eligibility group and Medicaid expansion status



Note: Data include full-benefit enrollees who were enrolled in at least one month of Medicaid in 2021. They may not have actually used any services during this period, but they are reported as enrolled in the program. Per-enrollee spending data exclude West Virginia or Mississippi. See Methods for more details.

Source: KFF analysis of the T-MSIS Research Identifiable Files, CY 2021 • Get the data • Download PNG

KFF

3. Nearly four in ten women of reproductive age and over six in ten 50-64 year olds enrolled in Medicaid are covered through Medicaid expansion.

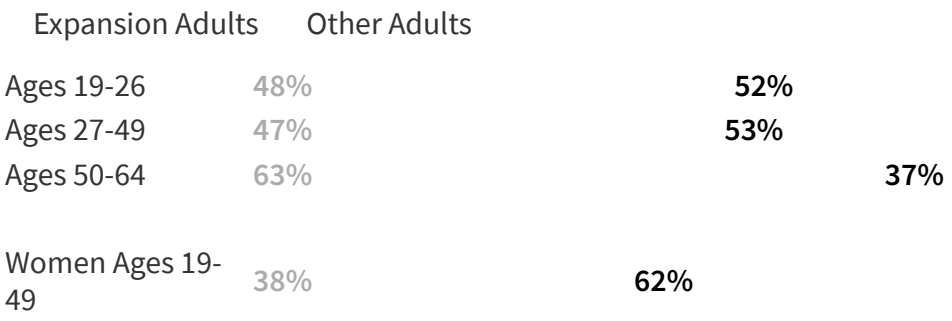
Medicaid expansion provides coverage across age groups for those 19 to 64 (Figure 3). Many expansion adults are working (https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/); however, they work for employers and in industries that are less likely to offer health insurance, leaving them without affordable health coverage options. As discussed below, older enrollees are more likely to have chronic conditions and may face more barriers to work.

Medicaid expansion also provides an important eligibility pathway for women of reproductive age, covering 38% of women ages 19-49 enrolled in Medicaid. For those who become pregnant, Medicaid coverage prior to pregnancy can promote pre-pregnancy health care (https://www.cdc.gov/mmwr/preview/mmwrhtml/rr5506a1.htm), which can lead to healthier pregnancies and help reduce the risk (https://www.nichd.nih.gov/health/topics/pregnancy/conditioninfo/prenatal-care) of complications. Previous KFF analyses (https://www.kff.org/medicaid/issue-brief/how-does-the-aca-expansion-affect-medicaid-coverage-before-and-during-pregnancy/) show that in expansion states, pregnant individuals are more than twice as likely to be enrolled in Medicaid prior to pregnancy (59%) than in non-expansion states (26%) (the difference in income eligibility levels for pregnant adults vs. other adults is large in non-expansion states, explaining the difference in pre-pregnancy enrollment rates). Medicaid expansion can provide stable coverage to pregnant individuals after the postpartum coverage period ends. Medicaid expansion coverage of parents also increases enrollment of their children: evidence (https://www.healthaffairs.org/doi/full/10.1377/hlthaff.2017.0347) shows that if children are eligible for Medicaid or CHIP coverage but unenrolled, when their parents gain coverage through Medicaid expansion it has a spillover, or "welcome mat" effect (https://www.macpac.gov/subtopic/medicaid-enrollment-changes-following-the-aca/), increasing the number of children who enroll in health coverage. Medicaid expansion also covers adults as they age – more than six in ten Medicaid enrollees ages 50-64 are covered through expansion – and before they become eligible for Medicare.

Figure 3

Nearly Four in Ten Women of Reproductive Age and Over Six in Ten Adults Ages 50-64 Enrolled in Medicaid are Covered Through Medicaid Expansion

Adults enrolled through the Medicaid expansion pathway and other eligibility pathways, by age and sex.



Note: Enrollees were included if they were coded as receiving Medicaid through the ACA expansion in a state that expanded Medicaid in 2021 or earlier. Idaho and Virginia expanded Medicaid prior to 2021, but are not reflected in this figure. See Methods for more details.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021 • Get the data • Download PNG

KFF

4. One third of Medicaid expansion enrollees have a chronic physical health condition and a quarter have a chronic behavioral health condition.

Nearly half (44%) of expansion adults have at least one chronic condition, including 33% that have a chronic physical condition and 24% that have a behavioral health condition. Of Medicaid enrollees with at least one chronic condition, 53% are enrolled through Medicaid expansion (data not shown). Similar to all adults (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/) on Medicaid, the share of expansion adults with at least one chronic physical condition increases with age (Figure 4). Nearly six in ten (57%) expansion adults ages 50-64 have at least one physical health condition

compared to just 16% of expansion adults ages 19-26. While the share of expansion adults with physical health conditions increases with age, the share with behavioral health conditions remains relatively stable, ranging from 19% to 26% across age groups.

Figure 4

One Third of Medicaid Expansion Enrollees Have a Diagnosed Chronic Physical Health Condition and One in Four Have a Diagnosed Chronic Behavioral Health Condition

Share of expansion adults with a physical, behavioral, or any chronic condition, by age

	Any physical health condition	Any behavioral health condition	Any chronic condition
Ages 19-26	16%	19%	**29%**
Ages 27-49	29%	26%	**43%**
Ages 50-64	57%	22%	**61%**
All enrollees	33%	24%	**44%**

Note: Enrollees were included if they were coded as receiving Medicaid through the ACA expansion in a state that expanded Medicaid in 2021 or earlier. Idaho and Virginia expanded Medicaid prior to 2021, but are not reflected in this figure. There are a total of 35 chronic conditions captured in this figure. See Methods for more details.

Source: KFF analysis of the T-MSIS Research Identifiable Files, 2021 • Get the data • Download PNG

KFF

Research (https://www.kff.org/report-section/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021-report/) finds that expansion is associated with improved access to care and outcomes related to behavioral health conditions. For other chronic conditions, expansion has positive impacts on access to care and may improve certain health outcomes. Medicaid coverage helps expansion enrollees manage chronic conditions and supports workforce (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/) participation. Medicaid expansion also provides coverage to individuals who have chronic conditions (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-adults-with-chronic-conditions/) or disabilities (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-people-with-disabilities/) that may limit their ability to work. Although some people with disabilities qualify (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-people-with-disabilities/) for Medicaid because they receive Supplemental Security Income, most are eligible for Medicaid through other pathways, including the expansion group. While many adults who need long-term care may qualify for coverage through other Medicaid pathways, Medicaid expansion covers some individuals with costly health needs who may otherwise be unable to afford care; two percent (2%) of expansion enrollees, or 395,000 individuals, use long-term care services (https://www.kff.org/medicaid/issue-brief/10-things-about-long-term-services-and-supports-ltss/) (LTC) which support activities of daily living such as eating, bathing, or dressing (data not shown). Medicaid expansion is also the primary pathway for Medicaid coverage for people with HIV (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-coverage-for-people-with-hiv/).

5. Policy changes targeting Medicaid expansion would reduce government spending but also could put coverage for 20 million enrollees at risk.

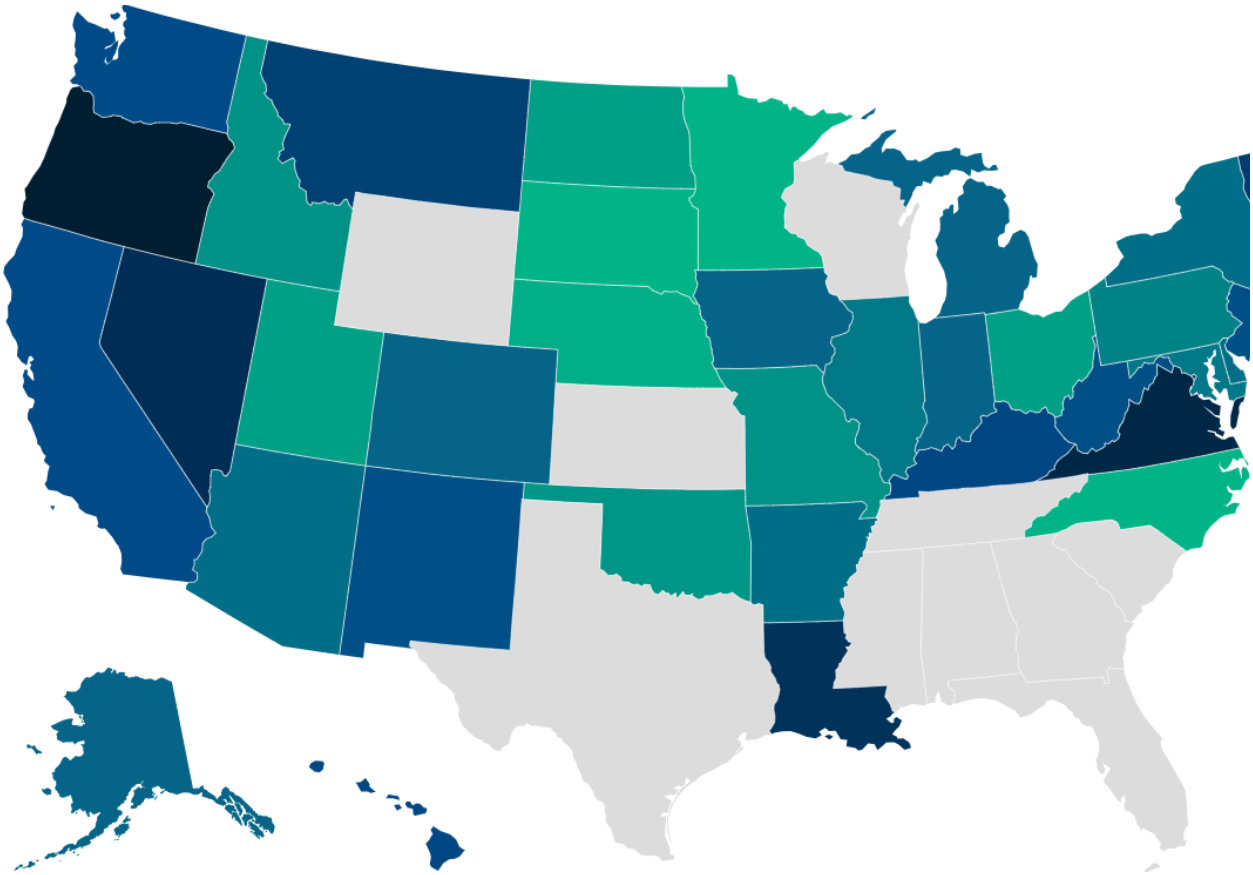
There are several options (https://www.politico.com/f/?id=00000194-74a8-d40a-ab9e-7fbc70940000) under consideration in Congress to reduce (https://www.kff.org/quick-take/the-math-is-conclusive-major-medicaid-cuts-are-the-only-way-to-meet-house-budget-resolution-requirements/) federal Medicaid spending that could have implications for enrollees in the expansion group, including work requirements (https://www.kff.org/medicaid/issue-brief/5-key-facts-about-medicaid-work-requirements/) and changes in financing (https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/) for the expansion. Congress may debate federal legislation requiring states to impose work requirements as a condition of Medicaid coverage. Most adult Medicaid enrollees are already working (https://www.kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work-an-update/) without a work requirement; estimates (https://www.cbo.gov/system/files/2023-04/59102-Arrington-Letter_LSG%20Act_4-25-2023.pdf) of national work requirements show $109 billion in federal savings over 10 years, and an increase in the number of uninsured, but no increase in employment. Beyond legislative changes, a number of states are pursing waivers (https://www.kff.org/report-section/section-1115-waiver-tracker-work-requirements/) to condition Medicaid expansion coverage on meeting work requirements since work requirement waivers were encouraged and approved during the first Trump administration (https://www.kff.org/medicaid/issue-brief/medicaid-work-requirements-current-waiver-and-legislative-activity/).

Congress may also consider proposals that would alter the financing for the Medicaid expansion. Any approach to reduce federal Medicaid spending for the expansion would shift (https://www.kff.org/medicaid/issue-brief/what-the-outcome-of-the-election-could-mean-for-medicaid/) costs to states, forcing governors to make tough choices about whether to drop the ACA Medicaid expansion, provide alternative coverage options or make up the loss of federal funding by cutting other state programs or raising taxes. Twelve states have “trigger” laws in place that would automatically end expansion or require other changes if the share of federal funding drops (https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/) below 90%, and two additional states, Ohio and South Dakota, are considering similar action. But all states, including those without trigger laws in place, would examine their ability to maintain the ACA Medicaid expansion if Medicaid expansion financing was altered. An analysis (https://www.kff.org/medicaid/issue-brief/eliminating-the-medicaid-expansion-federal-match-rate-state-by-state-estimates/) of the impact on Medicaid enrollment if all states eliminated the expansion shows the decline in enrollment would vary across states, ranging from 19% in Massachusetts, Minnesota, North Carolina, and South Dakota to 49% in Oregon (Figure 5).

Figure 5

Eliminating the ACA Expansion Match Rate Could Reduce Total Medicaid Enrollment By 19% to 49% Across Expansion States

Estimated percent decline in Medicaid enrollment (FY 2034) if current expansion states dropped the expansion



Source: KFF analysis of Medicaid enrollment and spending data from various sources. See Methods of "Eliminating the Medicaid Expansion Federal Match Rate: State-by-State Estimates " for more information about projections and assumptions. • Get the data • Download PNG

KFF

If states eliminate the Medicaid expansion, individuals with incomes 100-138% FPL would be eligible for subsidies in the Marketplace, but could face barriers transitioning to Marketplace coverage and could face higher out of pocket costs, especially if the enhanced subsidies expire (https://www.kff.org/affordable-care-act/issue-brief/congressional-district-interactive-map-how-much-will-aca-premium-payments-rise-if-enhanced-subsidies-expire/) at the end of 2025. However, current Medicaid expansion enrollees with incomes below 100% FPL are not eligible for subsidies in the Marketplace and could fall into the "coverage gap" and become uninsured if they are unable to qualify for Medicaid under a different eligibility pathway, for example based on a disability. Currently, 1.4 million adults are in the coverage gap (https://www.kff.org/medicaid/issue-brief/how-many-uninsured-are-in-the-coverage-gap-and-how-many-could-be-eligible-if-all-states-adopted-the-medicaid-expansion/) in the ten non-expansion states; however, that number would likely increase significantly under proposed policy changes targeting the Medicaid expansion. Eliminating the Medicaid expansion could have additional spillover effects (https://www.urban.org/research/publication/reducing-federal-support-medicaid-expansion-would-shift-costs-states-and), including children whose eligibility status is unchanged but become uninsured after their parents lose Medicaid coverage. People without insurance (https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/) have more difficulty accessing care and are more likely to have medical debt, with almost one in four uninsured adults in 2023 not receiving needed medical treatment due to cost. Uninsured individuals (https://www.kff.org/uninsured/issue-brief/key-facts-about-the-uninsured-population/) are also less likely than those with insurance to receive preventive care and treatment for major health conditions and chronic diseases.

Methods

Medicaid Claims Data: This analysis uses the 2021 T-MSIS (https://www.medicaid.gov/medicaid/data-systems/macbis/transformed-medicaid-statistical-information-system-t-msis/t-msis-data-dictionary/index.html) Research Identifiable Demographic-Eligibility and Claims Files (T-MSIS data) to identify Medicaid expansion enrollees, spending, and chronic conditions in Figures 2-4.

State Inclusion Criteria:

- Expansion states: Though Idaho and Virginia expanded Medicaid prior to 2021, adult expansion enrollees primarily show up in the traditional adult eligibility group. Therefore, those expansion states are excluded from Figures 2-4. West Virginia is excluded from Figure 2 (but included in Figures 3-4) of this analysis due to unusable spending data, according to quality assessments from the DQ Atlas (https://www.medicaid.gov/dq-atlas/landing/topics/info).
- Non-expansion states: Mississippi was also excluded from Figure 2-3 this analysis due to data quality concerns flagged by the DQ Atlas (https://www.medicaid.gov/dq-atlas/landing/topics/info).

Enrollee Inclusion Criteria: Enrollees were included if they were ages 19-64, had full Medicaid coverage for at least one month, and were not dually enrolled in Medicare. Dually enrolled individuals were excluded from these calculations since they may not have had sufficient claims in T-MSIS to identify chronic conditions.

Calculating Spending (Figure 2): This figure reflects spending from all states except Idaho, Virginia, West Virginia, and Mississippi. Average annual per capita spending calculations include fee-for-service spending and payments to managed care plans. Spending was calculated by summing the total spending of all claims per enrollee in the T-MSIS claims files. Estimates here do not include prescription drug rebates and most supplemental payments to providers.

Defining Chronic Conditions (Figure 4): This figure reflects chronic conditions from all expansion enrollees in expansion states that expanded prior to 2021 except for Idaho and Virginia. This analysis used the CCW algorithm (https://www2.ccwdata.org/web/guest/condition-categories-chronic) for identifying chronic conditions (updated in 2020). This analysis also included in its definition of chronic conditions substance use (https://www.kff.org/mental-health/issue-brief/sud-treatment-in-medicaid-variation-by-service-type-demographics-states-and-spending/) disorder, mental health, obesity (https://www.kff.org/medicaid/issue-brief/obesity-rates-among-children-a-closer-look-at-implications-for-children-covered-by-medicaid/), HIV, hepatitis C (https://www.kff.org/hivaids/issue-brief/medicaid-and-people-with-hiv/), and intellectual and developmental disabilities (https://aspe.hhs.gov/reports/definition-iddd-administrative-claims-data). In total, 35 chronic conditions were included and were further grouped into 3 broad categories: behavioral health, physical health, and cognitive impairment conditions. Specific conditions within these groupings include:

- **Behavioral health conditions**: Any mental health condition and any substance use disorder. See KFF's brief (https://www.kff.org/mental-health/issue-brief/5-key-facts-about-medicaid-coverage-for-adults-with-mental-illness/), "5 Key Facts About Medicaid Coverage for Adults with Mental Illness," KFF brief (https://www.kff.org/mental-health/issue-brief/sud-treatment-in-medicaid-variation-by-service-type-demographics-states-and-spending/) "SUD Treatment in Medicaid: Variation by Service Type, Demographics, States

and Spending," and the Urban Institute (https://www.urban.org/), Behavioral Health Services Algorithm for additional details (Victoria Lynch, Lisa Clemans-Cope, Doug Wissoker, and Paul Johnson. Behavioral Health Services Algorithm. Version 4. Washington, DC: Urban Institute, 2024).

- **Physical health conditions**: Hypertension, transient ischemic attack, acute myocardial infarction, hyperlipidemia, ischemic heart disease, atrial fibrillation, heart failure, obesity, chronic obstructive pulmonary disease, pneumonia, asthma, diabetes, arthritis, hip fracture, osteoporosis, cataracts, glaucoma, chronic kidney disease, colorectal cancer, endometrial cancer, urologic cancer, prostate cancer, lung cancer, breast cancer, hepatitis, HIV, anemia, hypothyroidism
- **Cognitive impairment conditions**: Alzheimer's, intellectual and developmental delay, Parkinson's, and dementia

---

Appendix

Appendix Table 1

Medicaid Expansion Enrollment

Location	Expansion Group Enrollment	Total Medicaid Enrollment	State Election Result	Footnotes
United States	20,271,616	83,121,984		
Alabama	N/A	1,097,436	Trump	
Alaska	71,212	236,414	Trump	
Arizona	631,710	2,156,441	Trump	
Arkansas	242,602	812,769	Trump	
California	4,956,615	14,478,012	Harris	
Colorado	350,083	1,142,953	Harris	
Connecticut	322,407	1,085,951	Harris	
Delaware	70,019	237,013	Harris	
District of Columbia	118,303	256,959	Harris	
Florida	N/A	4,343,214	Trump	
Georgia	N/A	2,240,163	Trump	
Hawaii	156,126	441,394	Harris	
Idaho	93,337	354,682	Trump	
Illinois	843,458	2,941,752	Harris	
Indiana	568,700	1,833,150	Trump	
Iowa	182,541	603,298	Trump	
Kansas	N/A	358,416	Trump	

Kentucky	488,080	1,394,715	Trump	
Louisiana	784,585	1,855,653	Trump	
Maine	112,072	395,873	Harris	
Maryland	422,601	1,469,244	Harris	
Massachusetts	392,790	1,989,455	Harris	
Michigan	742,156	2,386,748	Trump	
Minnesota	221,348	1,170,996	Harris	
Mississippi	N/A	666,722	Trump	1
Missouri	326,915	1,223,109	Trump	
Montana	79,606	218,449	Trump	2
Nebraska	72,113	346,451	Trump	
Nevada	312,696	737,583	Trump	
New Hampshire	60,857	181,309	Harris	
New Jersey	567,989	1,721,810	Harris	
New Mexico	289,236	877,577	Harris	
New York	2,111,796	6,985,692	Harris	3
North Carolina	480,836	3,011,926	Trump	
North Dakota	24,356	105,070	Trump	
Ohio	729,295	3,081,179	Trump	4
Oklahoma	245,688	984,181	Trump	
Oregon	641,243	1,268,286	Harris	
Pennsylvania	831,819	2,986,165	Trump	
Rhode Island	78,989	308,855	Harris	
South Carolina	N/A	1,310,481	Trump	5
South Dakota	24,241	125,473	Trump	
Tennessee	N/A	1,524,162	Trump	
Texas	N/A	4,419,948	Trump	
Utah	78,443	336,538	Trump	
Vermont	64,675	167,586	Harris	
Virginia	683,528	1,519,807	Harris	
Washington	625,573	1,860,025	Harris	

West Virginia	170,977	522,117	Trump	
Wisconsin	N/A	1,278,155	Trump	
Wyoming	N/A	70,627	Trump	

Note: Enrollment from the Medicaid Budget and Expenditure System (MBES) is reported for each month.
1. Missouri expanded its Medicaid program by adopting the VIII Group on October 1, 2021.
2. Nebraska expanded its Medicaid program by adopting the VIII Group on October 1, 2020.
3. North Carolina expanded its Medicaid program by adopting the VIII Group on December 1, 2023.
4. Oklahoma expanded its Medicaid program by adopting the VIII Group on July 1, 2021.
5. South Dakota expanded its Medicaid program by adopting the VIII Group on July 1, 2023.

Source: KFF analysis of Medicaid enrollment data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES) • Get the data • Download PNG

KFF

Appendix Table 2

Medicaid Expansion Spending

Location	Expansion Group - Federal Spending	Expansion Group - State Spending	Traditional Medicaid - Federal Spending	Traditiona Medicaid - Spending
United States	$158,331,563,500	$19,910,232,500	$432,862,903,000	$252,759,7
Alabama	N/A	N/A	$6,115,858,000	$1,760,443
Alaska	$619,243,700	$38,918,200	$1,381,949,900	$536,218,8
Arizona	$6,742,457,500	$709,590,200	$11,123,060,900	$3,571,947
Arkansas	$2,329,491,100	$277,126,900	$4,562,147,600	$1,411,953
California	$28,775,203,200	$3,268,018,800	$50,713,624,800	$40,034,89
Colorado	$2,914,745,700	$332,704,000	$5,293,192,500	$4,332,011
Connecticut	$2,477,498,500	$484,935,900	$4,096,914,100	$3,316,166
Delaware	$826,860,500	$92,409,500	$1,539,699,900	$882,445,2
District of Columbia	$696,915,300	$77,432,200	$2,401,120,600	$785,071,6
Florida	N/A	N/A	$22,566,038,000	$12,004,28
Georgia	N/A	N/A	$11,399,940,300	$4,601,344
Hawaii	$929,989,300	$103,935,500	$1,287,827,300	$773,296,2
Idaho	$775,087,100	$86,314,200	$2,060,471,200	$677,496,9
Illinois	$8,708,492,500	$1,895,262,700	$11,270,177,000	$9,161,030

Indiana	$3,947,067,200	$453,552,600	$9,522,057,000	$3,963,653
Iowa	$1,416,242,700	$158,525,300	$3,640,257,200	$1,709,546
Kansas	N/A	N/A	$3,373,617,700	$1,834,211
Kentucky	$5,189,196,600	$578,826,600	$8,031,034,100	$2,373,743
Louisiana	$5,485,590,600	$708,047,200	$6,602,937,600	$2,471,742
Maine	$665,752,700	$92,354,200	$2,355,402,300	$1,095,761
Maryland	$3,591,477,500	$399,059,600	$6,894,196,400	$5,601,686
Massachusetts	$3,369,682,700	$373,670,100	$10,756,437,900	$8,783,816
Michigan	$5,658,509,000	$710,094,100	$11,191,489,400	$4,826,753
Minnesota	$3,263,687,500	$354,687,500	$8,341,536,700	$6,581,915
Mississippi	N/A	N/A	$4,505,694,800	$915,879,0
Missouri	$2,530,045,500	$281,864,300	$9,585,913,300	$3,071,388
Montana	$932,547,900	$94,964,700	$978,281,000	$382,319,4
Nebraska	$766,965,400	$93,805,700	$1,885,777,300	$1,110,846
Nevada	$1,980,420,500	$217,824,300	$2,079,082,900	$968,700,7
New Hampshire	$415,928,500	$50,356,100	$1,088,044,700	$893,713,1
New Jersey	$5,594,358,300	$621,022,700	$9,350,631,600	$7,607,774
New Mexico	$2,026,725,000	$211,870,300	$4,739,079,800	$1,195,829
New York	$15,055,383,800	$2,689,050,600	$43,834,093,100	$33,691,31
North Carolina	N/A	N/A	$13,752,491,600	$5,141,666
North Dakota	$382,999,100	$47,138,000	$668,863,900	$484,329,3
Ohio	$7,113,678,100	$789,815,500	$15,926,150,200	$7,270,843
Oklahoma	$2,561,933,600	$233,386,800	$5,139,232,800	$1,454,355
Oregon	$4,551,561,600	$506,854,800	$6,573,075,500	$3,197,105
Pennsylvania	$7,083,684,700	$787,076,100	$19,543,836,300	$14,676,55
Rhode Island	$758,536,900	$88,602,700	$1,622,248,100	$1,120,896
South Carolina	N/A	N/A	$6,652,683,100	$2,173,945
South Dakota	$11,769,600	$960,000	$786,090,500	$368,898,0

Tennessee	N/A	N/A	$8,607,066,600	$3,486,525
Texas	N/A	N/A	$36,190,073,700	$19,362,03
Utah	$1,045,833,800	$113,261,900	$2,424,306,500	$998,819,0
Vermont	$292,646,900	$32,495,600	$1,021,937,000	$659,602,7
Virginia	$6,211,485,600	$692,144,700	$8,036,045,800	$6,386,482
Washington	$9,348,678,300	$1,016,797,100	$10,195,002,000	$7,833,652
West Virginia	$1,283,189,500	$145,475,300	$3,009,628,700	$803,999,7
Wisconsin	N/A	N/A	$7,714,619,100	$4,107,314
Wyoming	N/A	N/A	$431,964,700	$303,549,3

Source: KFF analysis of Medicaid spending data collected from the Centers for Medicare and Medicaid Services (CMS) Medicaid Budget and Expenditure System (MBES) • Get the data • Download PNG

KFF

KFF

KFF Headquarters: 185 Berry St., Suite 2000, San Francisco, CA 94107 | Phone 650-854-9400

Washington Offices and Barbara Jordan Conference Center: 1330 G Street, NW, Washington, DC 20005 | Phone 202-347-5270

www.kff.org | Email Alerts: kff.org/email | facebook.com/KFF | twitter.com/kff