JUNE 2017

www.guinncenter.org

Medicaid Funding in Nevada

Executive Summary

The U.S. House of Representatives passed H.R. 1628, the American Health Care Act (AHCA) of 2017, on May 4, 2017, and the U.S. Senate released a discussion draft for its version of the bill, the Better Care Reconciliation Act (BCRA) of 2017, on June 22, 2017; both bills seek to roll back the Medicaid expansion, amongst other provisions.

We evaluate Medicaid funding in Nevada from a budgetary standpoint, examining expenditures and revenues for the program. We conclude with an assessment of the financial implications for Nevada, should the Medicaid expansion be rolled back due to congressional decisions to revise existing provisions of the Affordable Care Act (ACA).

- Medicaid spending in Nevada rose 18.5 percent between FY 2010 and FY 2013, and it is expected to rise 91.1 percent between FY 2014 and FY 2019, based on projections.
- Medicaid's share of the Department of Health and Human Services (DHHS) budget has increased significantly over this time frame. Medicaid expenditures, as a share of the total budget, nearly doubled between FY 2010 and the FY 2019 projection.
- A comparison of the pre-expansion period to the post-expansion period (FY 2013 to FY 2016) shows that spending on "Moms and Kids" increased by 45.0 percent; spending on the Aged, Blind, and Disabled increased by 24.6 percent; Other spending decreased by 1.5 percent; and total expenditures nearly doubled, with an increase of 85.4 percent.
- The Medicaid expansion is associated with an increase in overall health care costs, though real expenditures per Medicaid recipient have declined since FY 2010.
- Federal funding of Medicaid in Nevada has increased 179.0 percent between FY 2013 and FY 2016, while State funding has increased 45.1 percent in that period. Currently, every dollar provided by the State is matched by a federal contribution of three dollars. In FY 2016, nearly $3.2 billion was required to support Medicaid, with $764 million supplied by the State and just over $2.4 billion received from the federal government.
- If federal funding for the Medicaid expansion is phased out, Nevada would be faced with two choices. It could allow the new federal law to stand, meaning that the Medicaid expansion would be rolled back. Or, it could preserve the Medicaid expansion but would have less federal matching money for newly eligible individuals.
- Preservation of the Medicaid expansion would require a significant amount of State dollars to offset the loss from the federal government; Governor Sandoval has stated that Nevada would have to supply an additional $60 million in 2021, an extra $300 million over the following two years, and as much as $480 million more per year by 2024 and thereafter.
- The two fiscal instruments available to the Silver State would likely be decreased spending, the latter of which would result in cuts to services, enrollees, and/or in reimbursement rates, or increased taxes.
- As some analysts warned at the May 1, 2017, meeting of the Economic Forum, there is some likelihood that the economy could slow down around 2019-2020, as we reach the downslope in the business

cycle and possible recession in 2020. Under such conditions, there may not be enough money available via the current revenue structure, which is highly dependent on the Sales Tax, to finance programmatic and administrative operations of DHHS and Medicaid. (Revenue obtained from the Sales Tax tends to vary with consumer spending, which can be lower during economic downturns.)

- Nevada is considered a relatively poor state, as reflected in its higher-than-average federal matching rate, the basis of which is the state's per capita income. A rollback of the Medicaid expansion thus would constitute a double penalty: with a higher percentage of poor citizens relative to 33 other states, Medicaid service delivery is particularly salient yet more difficult to afford.
- The Silver State is likely to be one of the most deeply affected if the Medicaid changes were enacted into law.

Medicaid Funding in Nevada

Section 2001 of Title II of the Affordable Care Act (ACA) of 2010 "provide[s] that, beginning on January 1, 2014, nonelderly, non-pregnant individuals under the age of 65 with income below 133 percent of the federal poverty level (FPL) will be made newly eligible for Medicaid."[1] The legality of this section of ACA subsequently was called into question, as some interpreted the provision to mean that states that refused to expand Medicaid would lose *all* federal funds for the program.[2] The matter ultimately came before the United States Supreme Court in *National Federation of Independent Business v. Sebelius* (2012).[3]

The Supreme Court held that withholding funds for Medicaid in a punitive fashion in order to force state compliance with ACA was "coercive and unconstitutional."[4] States could opt to expand Medicaid, and, in so doing, would receive federal matching funds for those newly eligible under ACA, or they could choose not to expand the program, but would continue to receive federal funds for those already on Medicaid. In both cases, all pre-ACA Medicaid provisions would remain intact for pre-ACA beneficiaries.[5] The Court's decision essentially rendered Medicaid expansion optional for the states.

Under ACA, the federal government was responsible for 100 percent of the medical costs for the first three years of expansion (2014-2016), while states were accountable for administrative costs. Beginning in 2017, states were expected to assume a greater share of the medical costs, and by 2020 and beyond, the federal government would contribute at a level of 90 percent.[6] Nevada announced its opt-in to the Medicaid expansion in 2012.[7] Since expansion, Nevada's Medicaid caseloads have increased, with a sharp spike after the initial take-up followed by a steadier uptick over time. In October 2013, the total approved recipient count was 330,623; by October 2014, that number nearly doubled to 621,570.[8] By the end of the 2017-2019 biennium, Medicaid enrollees are projected to increase further, to almost 677,000.[9]

Nevada joins 31 other states (including the District of Columbia) that expanded Medicaid as of January 2017, including some of its Intermountain West neighbors: Arizona, California, Colorado, and New Mexico (Texas and Utah have not expanded Medicaid).[10] The effective date of Nevada's opt-in to the Medicaid expansion was January 1, 2014.[11]

This policy brief evaluates Medicaid funding in Nevada from a budgetary standpoint.[a] It examines expenditures and revenues for the program, with an emphasis on the State's expansion in 2014. We also analyze Nevada's Medicaid funding relative to other states in the Intermountain West. The final section concludes with an assessment of the financial implications for Nevada, should the Medicaid expansion be rolled back due to congressional decisions to revise existing provisions of the ACA.

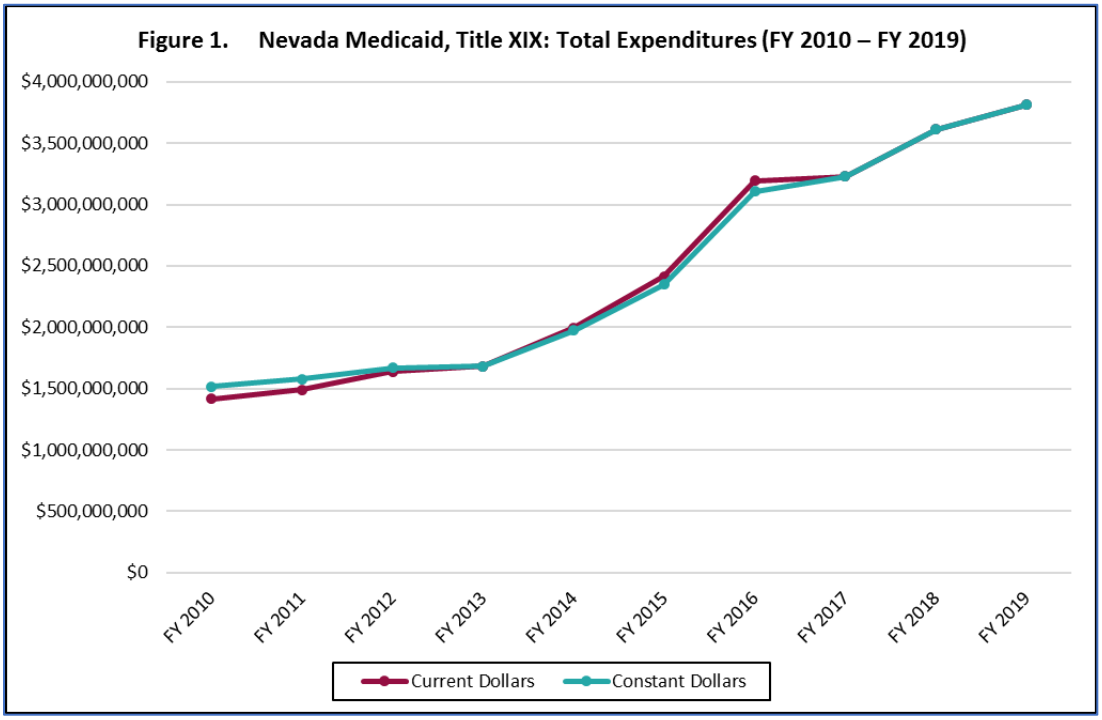
[a] Medicaid's official program name in the State is called "Nevada Medicaid, Title XIX," and the tables and figures will refer to it as such. In the text, we will adopt the conventional usage of the "Medicaid" shorthand.

Medicaid Expenditures

The Medicaid opt-in went into effect at the midpoint of Fiscal Year (FY) 2014. Thus, the reference year for the basis of comparison—that is, the last pre-expansion year—is FY 2013, as no money was allocated for Medicaid expansion during that year, while some money was directed toward expansion for half of FY 2014.

Figure 1 summarizes Medicaid expenditures in Nevada over time, in both current and constant dollars.[12]

Figure 1. Nevada Medicaid, Title XIX: Total Expenditures (FY 2010 – FY 2019)



As Figure 1 shows, Medicaid spending was relatively flat between FY 2010 and FY 2013. In constant dollars, amounts varied from a low of $1.5 billion in FY 2010 to a high of $1.7 billion in FY 2013, reflecting an increase of roughly $163 million (11 percent) over the four-year span. After FY 2013, Medicaid expenditures began to rise in somewhat systematic increments, until they spiked between FY 2015 and FY 2016. Medicaid spending grew from approximately $2.3 billion in FY 2015 to about $3.1 billion in FY 2016, amounting to a $759 million increase. Spending leveled off over FY 2016 – FY 2017 but is projected to grow again in FY 2018 and FY 2019, per the Governor's Recommended Budget. If the Governor's budgetary estimate for FY 2019 holds, the $3.8 billion projection is about $2.1 billion higher than the pre-expansion (FY 2013) Medicaid expenditures of $1.7 billion, reflecting a 127 percent increase over that period (in constant dollars).

Table 1 offers additional perspective on Medicaid spending, both in providing the actual dollar amounts and percent increases over time and by situating it in the broader budgetary context for the FY 2010 – FY 2019 period.[13]

Table 1. Nevada Medicaid, Title XIX: Expenditures and Summary Statistics for FY 2010 — FY 2019

Biennium	Fiscal Year	NV Medicaid, Title XIX Expenditures (Current Dollars)	Fiscal Year-Over-Year % Increase in NV Medicaid Expenditures	Biennium-Over-Biennium % Increase in NV Medicaid Expenditures	Total Nevada DHHS Budget (Current Dollars)	NV Medicaid, % of DHHS Budget	Total NV Budget (Current Dollars)	NV Medicaid, % of Total Budget
2009-2011	2010	$1,417,801,800	—	—	$2,812,382,898	50.4%	$9,547,256,103	14.9%
	2011	$1,489,685,302	5.1%		$2,925,399,899	50.9%	$9,342,243,098	15.9%
2011-2013	2012	$1,638,585,088	10.0%	14.2%	$3,054,760,647	53.6%	$9,130,300,631	17.9%
	2013	$1,680,484,318	2.6%		$3,125,227,301	53.8%	$9,150,880,536	18.4%
2013-2015	2014	$1,994,278,709	18.7%	32.8%	$3,481,105,673	57.3%	$9,923,625,476	20.1%
	2015	$2,414,437,820	21.1%		$3,932,263,156	61.4%	$10,243,726,127	23.6%
2015-2017	2016	$3,194,536,926	32.3%	45.7%	$4,859,466,506	65.7%	$11,776,745,752	27.1%
	2017	$3,229,736,606	1.1%		$4,917,693,305	65.7%	$11,997,154,657	26.9%
2017-2019*	2018	$3,611,847,983	11.8%	15.5%	$5,446,456,309	66.3%	$12,985,279,844	27.8%
	2019	$3,810,786,348	5.5%		$5,680,798,748	67.1%	$13,159,681,377	29.0%

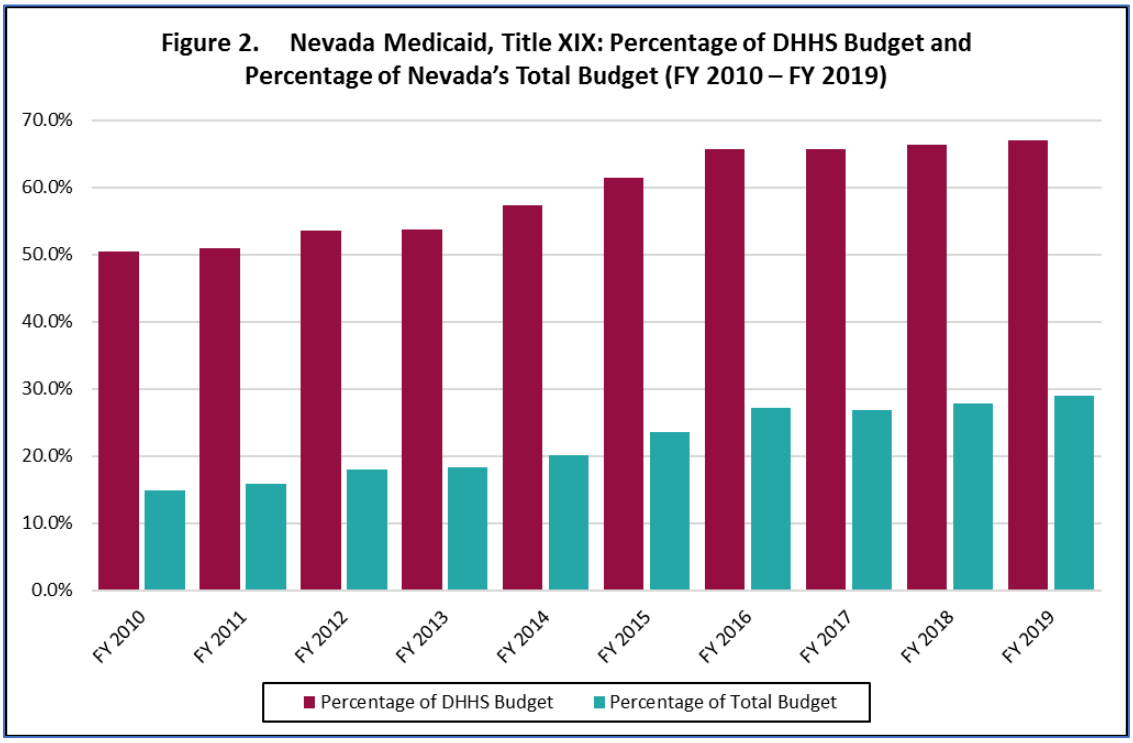
*Medicaid data for FY 2018 and FY 2019 (the 2017-2019 biennium) obtained from the Governor's Recommended Budget; data for all other fiscal years (biennia) is from the Legislatively Approved Budgets. DHHS refers to the Nevada Department of Health and Human Services.

The third column provides the amount of Medicaid spending that was displayed in Figure 1 (current dollars). The fourth column contains fiscal year over-year-year increases in Medicaid expenditures, while the fifth column presents biennial increases.[14] Consistent with the previous discussion, Medicaid spending increased moderately between FY 2010 and FY 2013, rose somewhat substantially in the first expansion year (FY 2014), increased slightly between the first and second expansion year, spiked in FY 2016, remained at the FY 2016 level for FY 2017, and is expected to rise gradually in FY 2018 and even more incrementally in FY 2019. With the expansion in place, the fiscal year-over-year increases return to pre-expansion rates; it is only in the immediate years surrounding the expansion itself that the amounts and rates of increase surged.

The biennial rates of increase follow this pattern, as well: between the 2009-2011 biennium and the 2011-2013 biennium, Medicaid expenditures increased by 14 percent. However, the percent increase between the 2011-2013 biennium and the 2013-2015 biennium—when Medicaid was expanded—more than doubled to nearly 33 percent. The biennium-over-biennium increase between 2013-2015 and 2015-2017 was approximately 46 percent, reflecting the $780 million current-dollar rise in Medicaid spending between FY 2015 and FY 2016. Between the 2015-2017 biennium and the 2017-2019 biennium, the percent increase returned to just slightly higher than the pre-expansion rate, at just under 16 percent.

Columns 6 and 8 of Table 1 provide expenditure amounts for the Nevada Department of Health and Human Services (DHHS) budget and Nevada's total budget, respectively, for FY 2010 through FY 2019 (current dollars). This data is provided so that we may express Nevada's Medicaid spending as shares of each the DHHS budget and total budget. These are presented in columns 7 and 9, respectively, and depicted graphically in Figure 2.[15]

Figure 2. Nevada Medicaid, Title XIX: Percentage of DHHS Budget and Percentage of Nevada's Total Budget (FY 2010 – FY 2019)



Medicaid's share of the DHHS budget has increased significantly over this time frame, though the year-to-year percent increases have been somewhat gradual. Between FY 2010 and FY 2013, Medicaid expenditures, as a percentage of the DHHS budget, increased by 3.4 percentage points; between FY 2013 and FY 2019, the percentage-point increase is expected to be 13.3; and over the entire time frame, Medicaid spending is expected to increase by 16.7 percentage points, from a 50.4 percent share of the DHHS budget in FY 2010 to a 67.1 share of the DHHS budget, as projected for FY 2019.

Medicaid expenditures, as a share of the total budget, nearly doubled between FY 2010 and the FY 2019 projection, from 14.9 percent in FY 2010 to 29.0 percent in FY 2019. As Figure 2 indicates, Medicaid spending—whether expressed as a percentage of the DHHS budget or Nevada's total budget—jumped most drastically in the years surrounding expansion (FY 2014 – FY 2016). The pre-expansion years (FY 2010 – FY 2013) and the later expansion years (FY 2017 – FY 2019) show flat spending or slow increases.

Among the questions raised by Table 1 are whether health care costs are increasing for Nevadans, from a budgetary standpoint, and if so, the extent to which Medicaid is driving those costs. Calculations based on Table 1 show that DHHS spending, as a percentage of the Nevada state budget, increased from nearly 30 percent in FY 2010 to about 43 percent in FY 2019 (as projected over the 10-year period). For the upcoming biennium, the Governor's proposed expenditures for DHHS of approximately $11.1 billion make it the largest department in the State, with a 42.6 share of total revenue.[16] To put this into perspective, education, which includes funding for the Nevada Department of Education (NDE) and the Nevada System of Higher Education (NSHE), accounts for just over one-quarter of the budget.[17]

Real expenditures per capita for DHHS corroborates the budgetary trend, and Medicaid does seem to be the engine of increase, as shown in Figure 3.[b, 18] Adjusted for inflation and population, DHHS and Medicaid spending closely track one another for the entire period; in fact, they are nearly perfectly correlated (r = 0.99).[c] In the pre-expansion period, however, real expenditures per capita are flat; while Medicaid expenditures and DHHS expenditures move in tandem, neither evinces more than an incremental increase. In the post-expansion period (post-FY 2013), both lines trend upwards at nearly identical rates. While correlation is not causation, the near-exact curves of the lines provide suggestive evidence that Medicaid spending has increased DHHS expenditures. To the extent that DHHS spending is a proxy for health care costs, it is reasonable to infer that Medicaid is associated with these increases.

However, as Figure 4 shows, real expenditures per Medicaid recipient have declined since FY 2010 and then again, since expansion in 2014.[d, 19] It is important to note that these numbers are averaged across *all* recipients, not a capped amount per recipient. That is, "Medicaid currently functions as an entitlement program, meaning that states must cover all people who meet eligibility requirements. The federal government reimburses states a certain percentage of Medicaid costs (which varies by state) for serving all people who qualify."[20] One possible explanation for this decrease over time is that while Medicaid expenditures have increased, the number of eligible recipients under expansion has outpaced funding, meaning that there could be a lower cost per recipient. Another possibility is economies of scale:

[b] Real expenditures are defined here as inflation-adjusted. Data is for FY 2010 through FY 2016 only, too many assumptions would be required for estimates inclusive of FY 2017 – FY 2019 (the Governor's proposed expenditures, the rate of inflation, *and* population size).

[c] The Guinn Center calculated the correlation coefficient.

[d] Real expenditures are defined as inflation-adjusted. Data is for FY 2010 through FY 2016 only.

as more individuals have been able to take up Medicaid, services can be delivered more cost-effectively. Finally, the additional enrollees may have diversified the risk pool, leading to lower average costs.

Figure 3. Real Expenditures per Capita: Nevada Medicaid, Title XIX, and Nevada DHHS (FY 2010 — FY 2016)

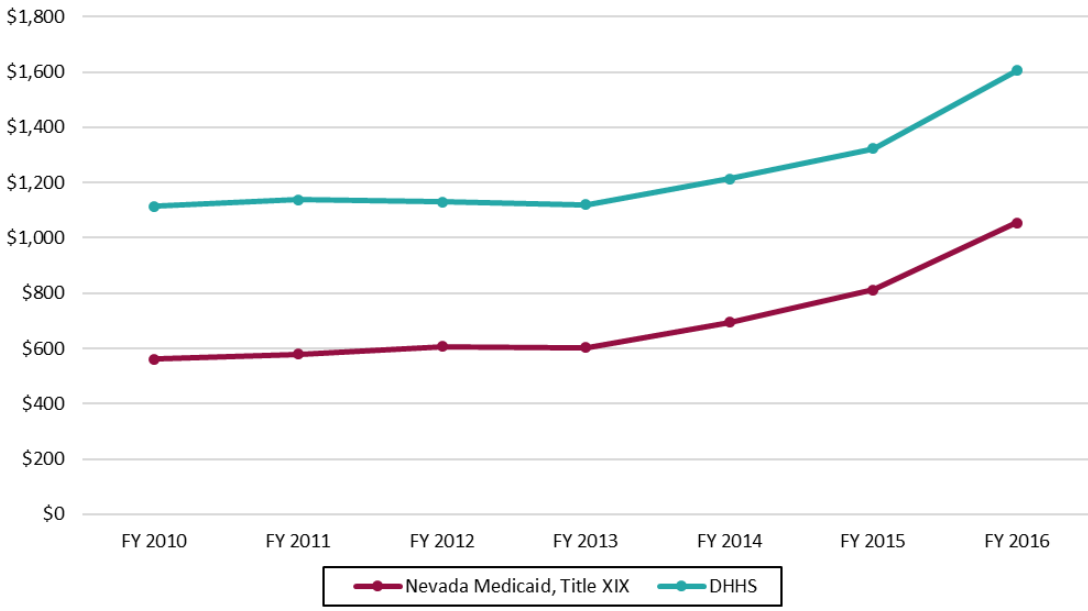


Figure 4. Nevada Medicaid, Title XIX: Real Expenditures per Recipient (FY 2010 — FY 2016)

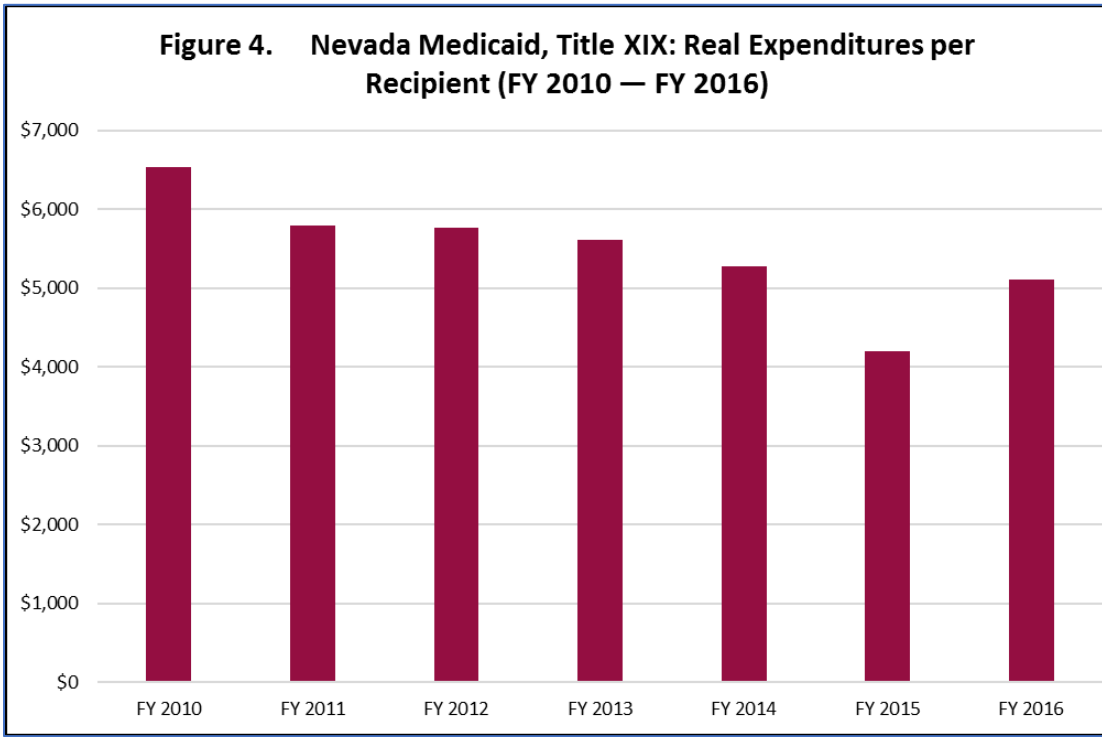


Table 2 provides expenditure data on selected categories of Nevada Medicaid recipients from FY 2010 through FY 2016.[e, 21]

Table 2. Nevada Medicaid Expenditures for Selected Eligibility Categories (FY 2010 — FY 2016)

Fiscal Year	"Moms and Kids"	Aged, Blind, and Disabled	Expansion Adults	Expansion Children (CHIP to Medicaid)	Other	TOTAL
FY 2010	$456,402,395	$521,963,621	—	—	$476,164,642	**$1,454,530,657**
FY 2011	$528,167,010	$550,283,674	—	—	$464,616,493	**$1,543,067,177**
FY 2012	$543,102,392	$550,176,171	—	—	$545,386,423	**$1,638,664,986**
FY 2013	$589,173,674	$601,587,198	—	—	$549,584,162	**$1,740,345,035**
FY 2014	$682,867,658	$656,921,525	$154,816,777	$2,958,759	$529,917,139	**$2,027,481,858**
FY 2015	$808,168,711	$680,098,976	$917,872,725	$13,831,792	$555,578,379	**$2,975,550,583**
FY 2016	$854,569,337	$749,733,609	$1,062,125,125	$19,118,683	$541,339,268	**$3,226,886,021**
Percent Change (FY2013—FY2016)	45.0%	24.6%	—	—	-1.5%	**85.4%**

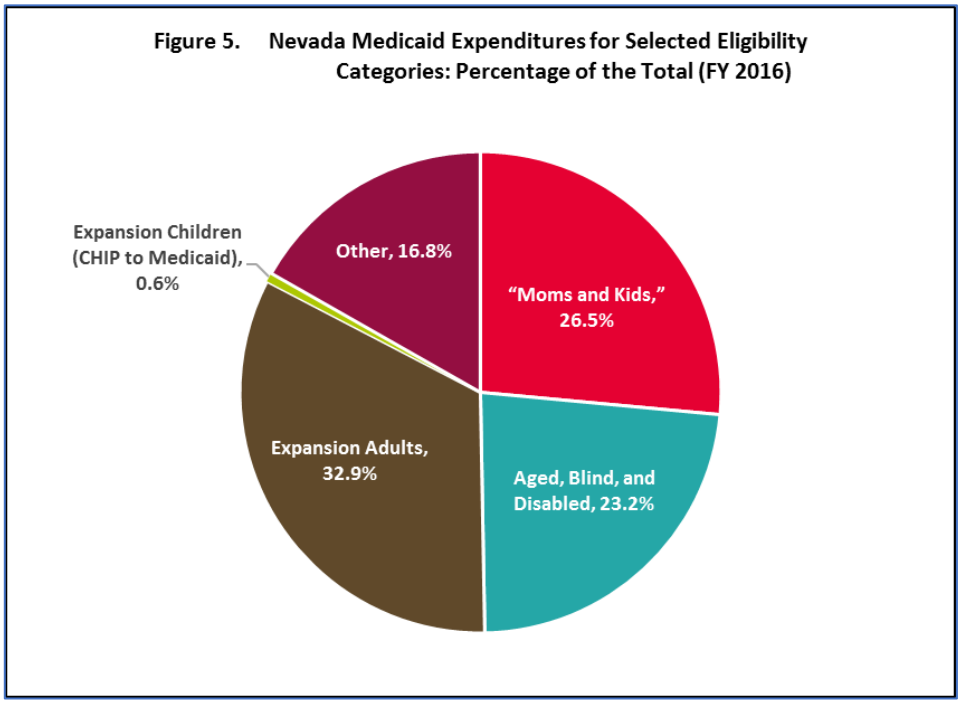
Note: Expansion adults adults refer to adults without children who meet the expansion eligibility criteria under ACA; they comprise childless adults, parent caretakers, and emergency medical services for undocumented individuals eligible under the Medicaid expansion. The pre-expansion population consists of "Moms and Kids" (Adults in Families with Dependent Children) and Aged, Blind, and Disabled. Other includes payments to other state agencies within DHHS, school-based services, pass-through to local governments, etc.

At the summary category level, we do observe an increase in spending over time for all Medicaid eligibles. The spending increases are evident in all categories, both pre-expansion and post-expansion. For example, in the "Moms and Kids" category, the dollar differences are as follows: FY 2010 – FY 2011: $71,764,615; FY 2011 – FY 2012: $14,935,382; FY 2012 – FY 2013: $46,071,282; FY 2013 – FY 2014: $93,693,984; FY 2014 – FY 2015: $125,301,053; and FY 2015 – FY 2016: $46,400,626. The largest fiscal year-over-year increase was in FY 2015, which was the second year of expansion. However, in FY 2016, where we have seen the most striking changes in our other Medicaid spending metrics, expenditures for "Moms and Kids" increased by about $46 million over FY 2015, which is approximately the same as that for FY 2013 over FY 2012, before Medicaid was expanded.

A comparison of the pre-expansion period to the post-expansion period (that is, FY 2013 to FY 2016) shows that spending on "Moms and Kids" increased by 45.0 percent; spending on the Aged, Blind, and Disabled increased by 24.6 percent; Other spending decreased by 1.5 percent; and total expenditures nearly doubled, with an increase of 85.4 percent. Expansion itself—the sum of Expansion Adults and Expansion Children—contributed roughly an additional $158 million in FY 2014, $932 million in FY 2015, and $1.1 billion in FY 2016 to the overall totals (7.8 percent of the total in FY 2014; 31.3 percent of the total in FY 2015; and 33.5 percent of the total in FY 2016). Expansion has increased Medicaid spending over this period and is responsible for almost one-third of Nevada's Medicaid budget.

[e] Medicaid expenditures in Table 3 do not match the Nevada Medicaid, Title XIX, budget data provided in Table 1 (page 5), as actual caseloads may differ from budgeted caseloads; DHHS is able to request additional spending authority by submitting a work program and getting approval from the Interim Finance Committee. Source: Guinn Center conversation with DHHS, June 22, 2017. Note, too, that data is not yet available for the selected categories for FY 2017 through FY 2019.

Figure 5 displays each category as a percentage of the total for FY 2016.[22]



Expansion adults represent the largest share of Medicaid expenditures for any recipient group, at 32.9 percent. Both "Moms and Kids" and the Aged, Blind, and Disabled, which are pre-expansion groups, jointly comprise almost half of total spending in FY 2016. Other is the fourth-largest share, at 16.8 percent, while Expansion Children make up the smallest percentage, at less than one percent (0.6 percent).

Medicaid Revenues

Table 3 presents a breakdown of the revenue sources for Medicaid in the State.[23] From the pre-expansion year (FY 2013) to the projected amount for FY 2019, Medicaid expenditures (in current dollars) increased by 126.8 percent. Federal funding has increased 179.0 percent over the same period, while State funding has increased 45.1 percent. The General Fund is the State's major operating fund.[24] It has provided the greatest contribution to Medicaid expenditures among State revenue sources, yet its contribution, between FY 2013 and FY 2019, has increased slightly more than the State's overall share at 47.3 percent.

For all fiscal years—both pre- and post-expansion—federal funding of Medicaid has been greater than the State's contribution. The difference between the two has mostly continued to widen after the expansion. For example, in FY 2010, federal money was approximately $402 million higher than that provided by the State; by FY 2016, when Medicaid funding spiked, that difference was nearly $1.7 billion.

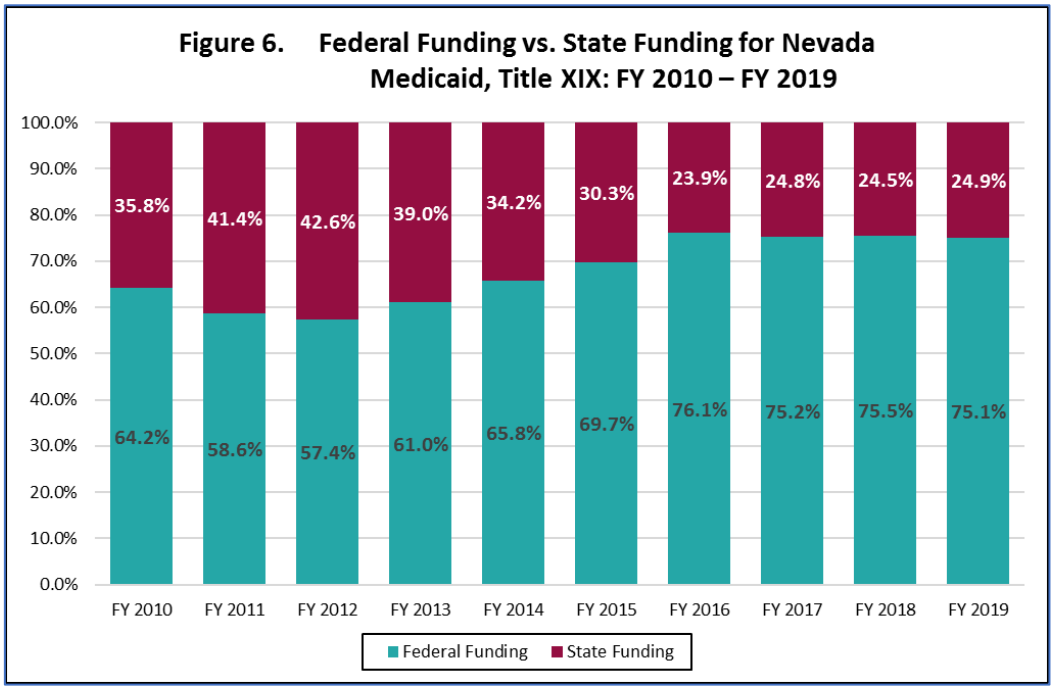
Figure 6 displays the federal and State contribution percentages to Medicaid funding over FY 2010 – FY 2019.[25] In the pre-expansion period, the ratio of federal funding to state funding peaked in FY 2010, declined in each of FY 2011 and FY 2012, and began to rise again in FY 2013, though not to the FY 2010 proportion. As on the expenditure side, the most significant change occurred in FY 2016. After FY 2016,

Table 3. Nevada Medicaid, Title XIX: Revenue Sources for FY 2010 — FY 2019							
			Federal Funding	*State Funding*			
Biennium	**Fiscal Year**	**NV Medicaid, Title XIX Program Total (Current Dollars)**	**Federal Fund**	**General Fund**	**Interagency Transfer**	**Other Fund**	**Total NV Medicaid Funding from State**
2009-2011	2010	$1,417,801,800	**$909,998,644**	$384,604,822	$102,207,519	$20,990,815	**$507,803,156**
	2011	$1,489,685,302	**$873,288,585**	$483,315,080	$106,334,010	$26,747,627	**$616,396,717**
2011-2013	2012	$1,638,585,088	**$941,016,079**	$506,794,541	$158,854,750	$31,919,718	**$697,569,009**
	2013	$1,680,484,318	**$1,025,381,817**	$489,621,665	$133,816,880	$31,663,956	**$655,102,501**
2013-2015	2014	$1,994,278,709	**$1,312,737,889**	$520,670,784	$131,352,843	$29,517,193	**$681,540,820**
	2015	$2,414,437,820	**$1,683,124,690**	$563,002,845	$138,680,555	$29,629,730	**$731,313,130**
2015-2017	2016	$3,194,536,926	**$2,430,487,758**	$530,882,511	$202,105,936	$31,060,721	**$764,049,168**
	2017	$3,229,736,606	**$2,427,680,773**	$593,863,690	$176,658,251	$31,533,892	**$802,055,833**
2017-2019*	2018	$3,611,847,983	**$2,726,884,960**	$659,743,519	$197,548,350	$27,671,154	**$884,963,023**
	2019	$3,810,786,348	**$2,860,523,254**	$721,450,466	$200,654,186	$28,158,442	**$950,263,094**

*Medicaid data for FY 2018 and FY 2019 (the 2017-2019 biennium) obtained from the Governor's Recommended Budget; data for all other fiscal years is from the Legislatively Approved Budgets; "Total NV Medicaid Funding from State" is equal to the sum of the General Fund, Interagency Transfer, and Other Fund amounts, as calculated by the Guinn Center.

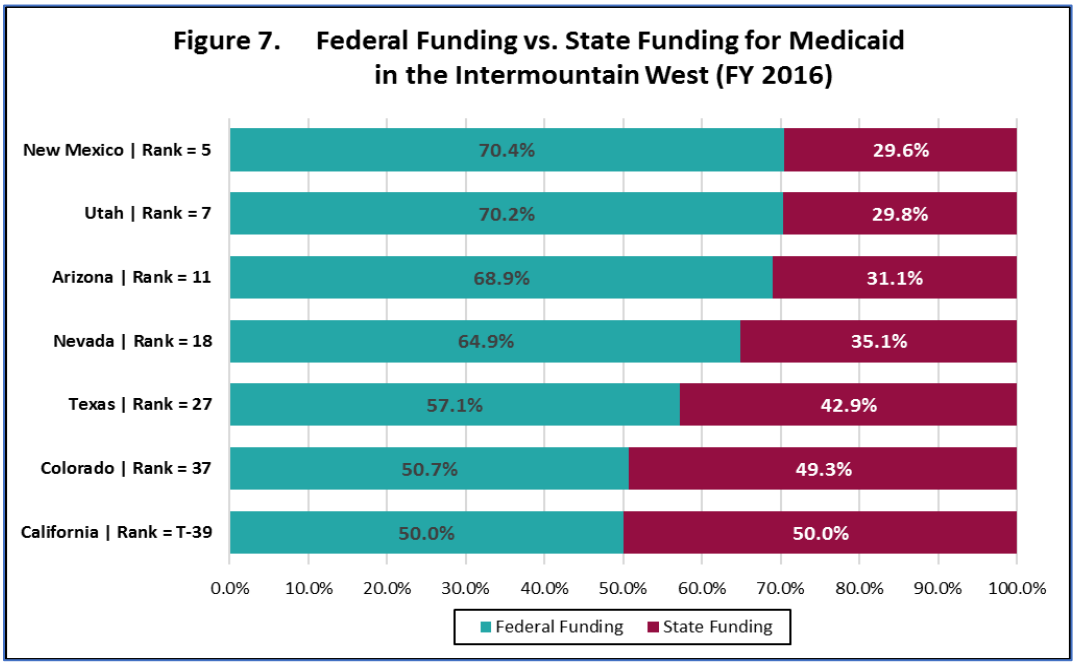
the federal share is projected to level off at about 75 percent, with the rest of the money contributed by the State. This means that if existing ACA provisions are preserved, then between FY 2017 through FY 2019, every dollar provided by the State is matched by a federal contribution of three dollars. The increase in the proportion of federal money between FY 2014 and FY 2016 is consistent with the Medicaid expansion population receiving 100 percent coverage of medical costs for that span of time.

Figure 6. Federal Funding vs. State Funding for Nevada Medicaid, Title XIX: FY 2010 – FY 2019



Medicaid Funding in Nevada vs. the Intermountain West

Across the Intermountain West, Nevada received the fourth-highest proportion of money from the federal government in FY 2016, as shown in Figure 7.[26]



The basis for the figure is the FY 2016 non-enhanced Federal Medical Assistance Percentages (FMAP) provided by the U.S. Department of Health and Human Services, referred to as "Federal Funding" in the figure.[f] FMAP is determined by a formula that is premised on a state's per capita income.[27] The Guinn Center ranked all states, including the District of Columbia, in order of highest percentage received to lowest (see Appendix A for the full table of states). Thirteen states tie for the lowest FMAP, as these states receive and contribute equally; that is, the federal match is 50 percent.

Nevada's ranking of 18 places it just above the top third of all states, with respect to the highest federal Medicaid matches.[g] The Intermountain West states figure prominently in the high recipient group, as New

[f] Non-enhanced FMAP data refers to federal Medicaid matching dollars only; that is, it excludes additional money for the Children's Health Insurance Program (CHIP), which is the basis for enhanced FMAP. (Source: U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2014. "FY2016 Federal Medical Assistance Percentages: October 1, 2015 – September 30, 2016 (Fiscal Year 2016)." Available: https://aspe.hhs.gov/basic-report/fy2016-federal-medical-assistance-percentages.)

[g] FMAP data is not comparable to actual federal money received by Nevada. For FY 2016, Nevada's actual federal contribution was 76.1 percent, and the State's percentage was 23.9 percent (as Figure 6 indicates). FMAP is the overall federal contribution, and it does not map directly to the State's budgetary data, as there are different FMAP percentages for different programs and populations (e.g., pre-expansion Medicaid recipients and expansion Medicaid recipients). Source: Guinn Center conversation with the Center for Children and Families, Health Policy Institute, McCourt School of Public Policy, Georgetown University, on June 19, 2017.

Mexico is ranked fifth, Utah is ranked seventh, and Arizona is ranked eleventh. Texas, like Nevada, is part of the middle group, though its state contribution is 7.8 percentage points higher. Of the Intermountain West states, Colorado and California receive the lowest proportions of money from the federal government. Notably, the Medicaid expansion does not seem to affect the federal government's share of Medicaid dollars. Among the Intermountain West states, only Texas and Utah opted out of expansion, as noted previously. However, Utah enjoys nearly the same federal match as New Mexico, and while Texas's match is lower, at 57.1 percent, it is not at the 1:1 ratio of California, which did choose to expand Medicaid.

Potential Medicaid Expansion Phase-Out: Implications for Nevada

The U.S. House of Representatives passed H.R. 1628, the American Health Care Act (AHCA) of 2017, on May 4, 2017.[28] Amongst other provisions, "…starting on January 1, 2020, the federal government would pay only the regular Medicaid matching rate — which averages 57 percent — rather than 90 percent for any new expansion enrollees. (Those already enrolled as of the end of 2019 would continue to receive the enhanced matching rate as long as they remain continuously enrolled.) States that want to continue enrolling low-income adults in expanded Medicaid coverage after 2019 thus would have to pay 2.8 to 5 times more from their own funds for each new enrollee, relative to current law. This higher cost would also apply to current enrollees who leave Medicaid for a month or more when their income rises but later seek to reenroll when they fall on hard times."[29] The House bill has not been enacted into law.

On June 22, 2017, the U.S. Senate released a discussion draft for its version of the bill, the Better Care Reconciliation Act (BCRA) of 2017. As they pertain to Medicaid, its provisions, amongst others, include:

- A rollback of federal funds to support Medicaid expansion; specifically, rather than the 90 percent matching rate provided by the federal government for expansion beneficiaries that would fix in 2020, BCRA would phase out the federal matching percentages to 85 percent in 2021, 80 percent in 2022, and 75 percent in 2023. Beginning in 2024, the federal matching rate would revert to the regular Medicaid matching rate.[30]
- A restructuring from Medicaid's current classification as an entitlement program, with no limits on overall spending, to a per capita cap structure, beginning in FY 2020, which would mean a set amount per beneficiary in each state, *or* the option for states to receive block grants in lieu of the per capita caps, whereby each state would receive a fixed sum of money not tied to number of enrollees, with discretion over spending allocation.[31] The cap would differ for five groups covered by Medicaid (i.e., the elderly, disabled adults, nondisabled children, adults made eligible for Medicaid by the ACA, and all other adults) based on the average per-enrollee cost of medical services "who received full Medicaid benefits over eight consecutive quarters of the state's choosing between the first quarter of federal fiscal year 2014 and the third quarter of 2017."[32]
- An applicable annual inflation factor would be instituted to allow the per capita caps to increase over time. It would be tied to the Consumer Price Index-Medical (CPI-M) beginning in FY 2020 and then switch to the Consumer Price Index for all Urban Consumers (CPI-U) in FY 2025.[33] However, one percentage point would be added to CPI-M for most disabled adult enrollees or those aged 65 from FY 2020 through FY 2024, after which growth would be pegged to CPI-U, as with other beneficiaries.[34] "The final limit on federal reimbursement for each state starting in 2020 would be the average cost per enrollee for the five specified groups of enrollees, reflecting growth from the base period in the relevant inflation factors multiplied by the number of enrollees in each category."[35]

Should the Senate approve its own bill, the House and Senate would need to align the two pieces of legislation through a conference committee, vote on the bill again, and then send it to the President for his signature or veto.

If the final piece of legislation retains some version of the Medicaid modifications in AHCA and BCRA, and it were to be enacted, Nevada would be confronted with two choices. It could allow the new federal law to stand, meaning that the Medicaid expansion would be rolled back in accordance with the federal provisions. Or, it could codify the Medicaid expansion in State law with less federal matching money for newly eligible individuals. Were the latter to be instituted, legislators and the Governor would again face two decisions, as Nevada would be especially vulnerable if the Medicaid expansion were rolled back but the State chose to keep the expansion in place.

The two fiscal instruments available to the Silver State would likely be decreased spending—the latter of which would result in cuts to services, enrollees, and/or in reimbursement rates—or increased taxes. Either could prove onerous or create economic hardship for Nevadans across the income and wealth spectrums.

Briefly, reducing reimbursement rates could be problematic. State-administered Medicaid pays 81 percent of Medicare allowable rates.[36] In Nevada, Medicare reimbursement rates for some services have not been adjusted in more than ten years. Providers have expressed concern given that many services cost more to provide than the average rate of Medicare reimbursement.[37]

The systemic change to a per capita cap scheme likely would have a disproportionate impact on Nevada, as well, if the BCRA provisions are not amended. While the State would have the option to select any eight consecutive quarters between September 1, 2013, and June 30, 2017—optimizing the highest per-enrollee amounts over that time span—Nevada's spending per enrollee has been amongst the lowest in the nation (as shown in Appendix B). While the categories do not match those designated under the BCRA exactly, they do provide a sense of the State's categorical Medicaid spending amounts in the period that maps to the temporal framework under the proposed legislation. Nevada's spending in federal fiscal year 2014 was as follows: $8,604 per Aged enrollee; $11,763 per Disabled enrollee; $2,222 per Adult enrollee; $1,523 per Child enrollee; and $3,620 per enrollee, overall. Caps set at relatively comparable amounts, which are already low—even though inflation would be taken into account—may be insufficient to cover the needs of the State's Medicaid recipients. As one recent report noted:

> The growth in medical spending tends to be uneven year over year, which means that states might hit the caps in one year and fall under them in another. [….] Medicaid advocates worry that a fixed growth rate doesn't account for this varying pattern of health expenditures, which might shoot up in a year where there's an epidemic or an important new treatment. Many Medicaid budgets increased in recent years after the introduction of expensive but effective medications for hepatitis C, for example. States had to pay more for the drug, but federal spending also increased to match it.[38]

Moreover, as historical data for the West region shows, CPI-M tends to grow at a faster rate than CPI-U, so there is greater purchasing power if CPI-M is employed. (See Appendix C.) This means that, under the per capita caps, Medicaid funding likely would be lower per year if caps were adjusted by CPI-U than if CPI-M were used as the applicable annual inflation factor continuously.

Preservation of the Medicaid expansion would require a significant amount of State dollars to offset the loss from the federal government. Based on the ratcheting-down of federal matching percentages in the

Senate discussion draft, Governor Sandoval relayed the following estimates of additional money that the State would need to contribute per year: $60 million in 2021; $120 million in 2022; $180 million in 2023; and an extra $480 million for the State's share in 2024 and beyond.[39]

Nevada's taxes, as they stand currently, are likely insufficient to make up the projected gaps. Table 4 shows the Economic Forum's forecasted major General Fund revenues for the 2017-2019 biennium.[40] Using FY 2019 as an example, of the major General Fund revenues, only the Sales Tax is projected to exceed a billion dollars (forecasted at $1.2 billion). The Gaming Percentage Fee Tax estimate is about $769 million, and the Modified Business Tax (including nonfinancial businesses, financial businesses, and mining businesses) is forecasted at nearly $671 million. The rest of the major funds have projected dollar amounts that amount to far less than these revenue sources. For some perspective, an additional $480 million per year in 2024 would be roughly the equivalent of the FY 2019 projections for the Commerce Tax, the Live Entertainment Tax–Gaming, and the Cigarette Tax, which combined, are just shy of $500 million.[h] Such a substantial per-year increase would require either a significant legislative revision to one source of revenue or across-the-board changes to multiple sources, as this money already finances the State's programs and operations.

Table 4. Economic Forum: Major General Fund Revenues, by Source—2017-2019 Biennium

Description	FY 2017 Forecast	FY 2018 Forecast	FY 2019 Forecast	Biennium Total (FY 2018 and FY 2019)
Sales Tax	$1,087,212,000	$1,154,724,000	$1,214,518,000	$2,369,242,000
Gaming Percentage Fee Tax	$730,974,000	$746,753,000	$768,683,000	$1,515,436,000
Live Entertainment Tax (LET)–Gaming	$101,737,000	$106,663,000	$109,398,000	$216,061,000
Commerce Tax	$203,411,000	$186,046,000	$194,976,000	$381,022,000
Cigarette Tax	$174,999,000	$172,577,000	$170,155,000	$342,732,000
Modified Business Tax (MBT)				
Nonfinancial Businesses	$558,908,000	$587,972,000	$615,734,000	$1,203,706,000
Financial Businesses	$28,224,000	$29,819,000	$31,372,000	$61,191,000
Mining Businesses	$22,234,000	$22,775,000	$23,403,000	$46,178,000
Insurance Premium Tax	$378,200,000	$395,753,000	$410,610,000	$806,363,000
Real Property Transfer Tax (RPTT)	$82,042,000	$86,628,000	$89,723,000	$176,351,000
TOTAL MAJOR GENERAL FUND REVENUES (ECONOMIC FORUM)*	**$3,367,941,000**	**$3,489,710,000**	**$3,628,572,000**	**$7,118,282,000**

* Before tax credits.

While Nevada maintains a "Rainy Day Fund" (technically, the Account to Stabilize the Operation of State Government), it is not a viable option to offset the proposed decrease in federal money. It is designed to cover unanticipated financial shortfalls, not predictable institutional outcomes. As a financial reserve,

[h] We cannot yet determine whether the Commerce Tax, the Live Entertainment Tax–Gaming, and the Cigarette Tax would increase or decrease over the FY 2019 projected levels, as these taxes can vary with the state of the economy; there is too much uncertainty over a seven-year time span to predict with any accuracy. They could be higher or lower than the estimates for FY 2019. They are meant to serve as a stylized construct for expressing the State's expected additional share for Medicaid in 2024 in our current revenue-generating sources.

certain provisions circumscribe its use.[41] Even if the legal constraints were amended, the "Rainy Day Fund" balance at the end of 2017-2019 biennium is projected to be $205.2 million.[42] Unless the Fund grows 100 percent over the next seven years, regardless, $200 million (or so) would be less than half the amount needed to fund Medicaid in 2024.

And while forecasters largely have been bullish on the economic prospects for the State, Nevada is just beginning to recover from the Great Recession.[43] Moreover, as some analysts warned at the May 1, 2017, meeting of the Economic Forum, there is some likelihood that the economy could slow down around 2019-2020, as we reach the downslope in the business cycle and possible recession in 2020.[44] Under such conditions, there may not be enough money available via the current revenue structure, which is highly dependent on the Sales Tax, to finance programmatic and administrative operations of DHHS and Medicaid.[45] (Revenue obtained from the Sales Tax tends to vary with consumer spending, which can be lower during economic downturns.)

Nevada is considered a relatively poor state, as reflected in its higher-than-average federal matching rate. Given that the basis of FMAP is the state's per capita income, a rollback of the Medicaid expansion thus would constitute a double penalty: with a higher percentage of poor citizens relative to 33 other states, Medicaid service delivery is particularly salient yet more difficult to afford. Furthermore, as one recent report suggests, Nevada meets three criteria that reflects the unequal distribution of potential impact: of all states, it spends the least money per enrollee (see Table 5, below, on federal fiscal year 2014 Medicaid spending per enrollee in the Intermountain West and Appendix B for the full list of states); it also has the largest growth in the low-income elderly population, which, along with persons with disabilities, constitute a relatively large share of Medicaid expenditures (despite these groups comprising a smaller proportion of enrollment); and it is an expansion state, which requires spending on an ever-growing number of eligible individuals.[46] Therefore, the Silver State is likely to be one of the most deeply affected if the Medicaid changes were enacted into law.

Table 5. Medicaid Spending per Enrollee in the Intermountain West—Full or Partial Benefit (Federal Fiscal Year 2014)[i, 47]

Location	Aged	Aged (Rank)	Individuals with Disabilities	Disabilities (Rank)	Adults	Adults (Rank)	Children	Children (Rank)	Total	Total (Rank)
Arizona	$9,306	44	$18,106	22	$4,107	24	$2,949	20	$5,490	33
California	$10,889	39	$20,653	15	$1,803	50	$2,368	35	$4,193	48
Colorado	$11,490	34	$15,708	29	$2,967	42	$2,033	45	$4,835	44
Nevada	**$8,604**	**45**	**$11,763**	**47**	**$2,222**	**48**	**$1,523**	**51**	**$3,620**	**51**
New Mexico	N/A	–	$15,379	32	$3,186	35	$5,136	1	$5,326	36
Texas	$11,890	33	$19,745	18	$2,976	40	$2,966	19	$6,154	25
Utah	$11,462	35	$19,375	20	$3,403	32	$2,482	33	$5,050	42

[i] Ranked by the Guinn Center in order of greatest spending per enrollee to least.

Appendix A. Federal Funding vs. State Funding for Medicaid, All States, Ranked (FY 2016)[j, 48]

State	Federal Funding	State Funding	Rank
Mississippi	74.2%	25.8%	1
West Virginia	71.4%	28.6%	2
Idaho	71.2%	28.8%	3
South Carolina	71.1%	28.9%	4
New Mexico	70.4%	29.6%	5
Kentucky	70.3%	29.7%	6
Utah	70.2%	29.8%	7
Arkansas	70.0%	30.0%	8
District of Columbia	70.0%	30.0%	9
Alabama	69.9%	30.1%	10
Arizona	68.9%	31.1%	11
Georgia	67.6%	32.5%	12
Indiana	66.6%	33.4%	13
North Carolina	66.2%	33.8%	14
Michigan	65.6%	34.4%	15
Montana	65.2%	34.8%	16
Tennessee	65.1%	35.0%	17
Nevada	**64.9%**	**35.1%**	**18**
Oregon	64.4%	35.6%	19
Missouri	63.3%	36.7%	20
Maine	62.7%	37.3%	21
Ohio	62.5%	37.5%	22
Louisiana	62.2%	37.8%	23
Oklahoma	61.0%	39.0%	24
Florida	60.7%	39.3%	25
Wisconsin	58.2%	41.8%	26
Texas	57.1%	42.9%	27
Kansas	56.0%	44.0%	28
Iowa	54.9%	45.1%	29
Delaware	54.8%	45.2%	30
Hawaii	54.0%	46.0%	31
Vermont	53.9%	46.1%	32
Pennsylvania	52.0%	48.0%	33
South Dakota	51.6%	48.4%	34
Nebraska	51.2%	48.8%	35
Illinois	50.9%	49.1%	36
Colorado	50.7%	49.3%	37
Rhode Island	50.4%	49.6%	38
Alaska	50.0%	50.0%	T-39
California	50.0%	50.0%	T-39
Connecticut	50.0%	50.0%	T-39
Maryland	50.0%	50.0%	T-39
Massachusetts	50.0%	50.0%	T-39
Minnesota	50.0%	50.0%	T-39
New Hampshire	50.0%	50.0%	T-39
New Jersey	50.0%	50.0%	T-39
New York	50.0%	50.0%	T-39
North Dakota	50.0%	50.0%	T-39
Virginia	50.0%	50.0%	T-39
Washington	50.0%	50.0%	T-39
Wyoming	50.0%	50.0%	T-39

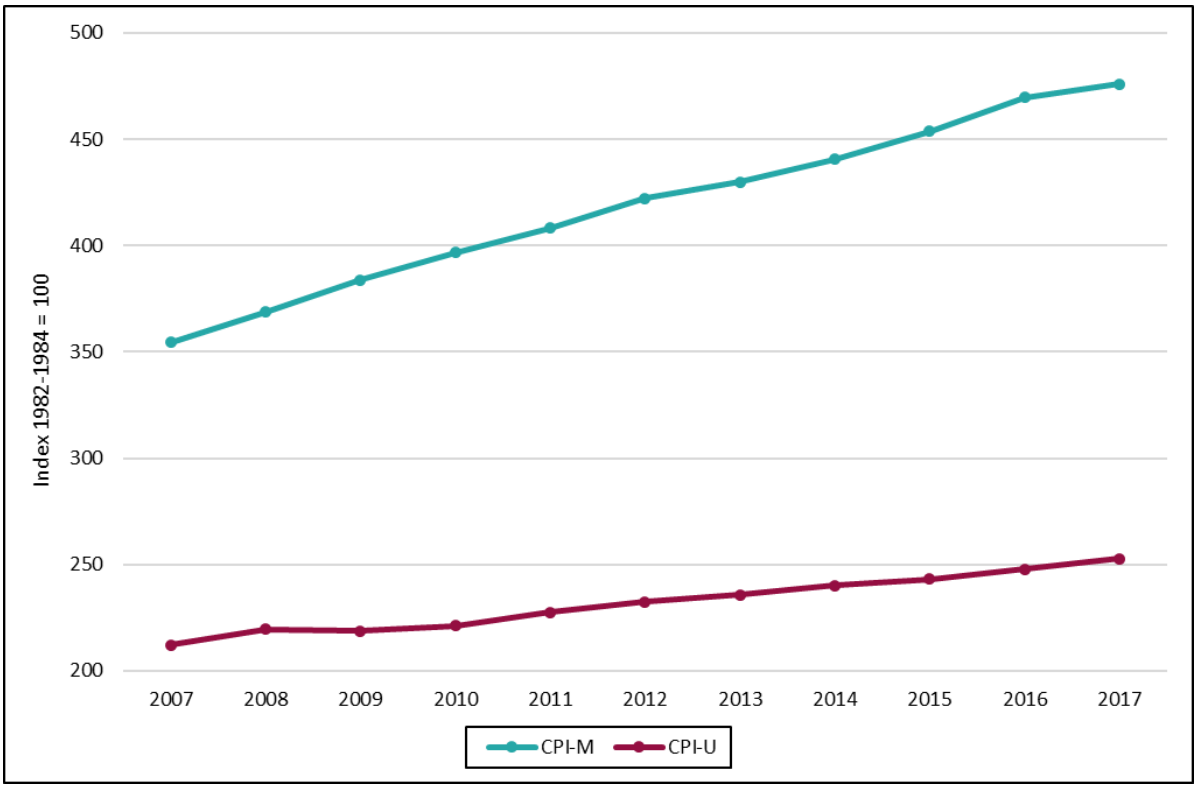
[j] Ranked by the Guinn Center in order of highest percentage of FMAP (federal funding) received to lowest. Shaded states are those in the Intermountain West.

Appendix B. Medicaid Spending per Enrollee—Full or Partial Benefit (Federal Fiscal Year 2014)[k, 49]

Location	Aged	Aged (Rank)	Individuals with Disabilities	Disabilities (Rank)	Adults	Adults (Rank)	Children	Children (Rank)	Total	Total (Rank)
Alabama	$7,987	46	$7,249	51	$2,043	49	$2,085	44	$3,837	49
Alaska	$25,792	1	$28,388	3	$6,893	1	$5,135	2	$9,956	2
Arizona	$9,306	44	$18,106	22	$4,107	24	$2,949	20	$5,490	33
Arkansas	$12,718	29	$13,195	39	$1,446	51	$3,334	10	$5,372	34
California	$10,889	39	$20,653	15	$1,803	50	$2,368	35	$4,193	48
Colorado	$11,490	34	$15,708	29	$2,967	42	$2,033	45	$4,835	44
Connecticut	$14,449	22	$24,798	6	$5,204	9	$3,380	8	$7,704	10
Delaware	$21,255	3	$21,875	10	$6,011	4	$3,799	6	$8,046	5
District of Columbia	$19,186	8	$20,696	14	$5,429	7	$4,442	4	$8,887	3
Florida	$7,281	47	$11,369	48	$2,894	43	$1,822	49	$4,243	47
Georgia	$6,162	50	$8,659	50	$4,766	14	$2,827	23	$4,398	46
Hawaii	$16,210	17	$20,536	16	$4,267	22	$2,577	31	$6,008	28
Idaho	$10,301	40	$15,381	31	$4,390	19	$2,226	39	$5,257	39
Illinois	$11,912	32	$16,284	26	$3,075	38	$2,108	43	$5,012	43
Indiana	$19,627	6	$20,205	17	$4,211	23	$2,145	42	$7,048	15
Iowa	$17,590	13	$19,742	19	$2,970	41	$2,208	40	$5,802	30
Kansas	$15,982	18	$13,242	38	$5,266	8	$2,662	27	$6,295	22
Kentucky	$10,941	38	$12,986	41	$4,813	13	$3,129	16	$6,161	24
Louisiana	$9,929	41	$12,679	42	$2,488	47	$1,933	48	$4,796	45
Maine	$7,143	48	$14,791	35	$3,867	29	$3,161	13	$6,551	18
Maryland	$17,407	14	$23,796	7	$4,494	17	$3,080	17	$7,324	13
Massachusetts	$19,223	7	$15,320	33	$3,372	33	$3,322	11	$7,458	12
Michigan	$13,380	24	$15,592	30	$2,700	45	$2,381	34	$5,230	40
Minnesota	$15,417	19	$28,854	2	$4,716	15	$3,538	7	$7,898	7
Mississippi	$11,267	37	$11,820	46	$3,923	28	$2,580	30	$5,912	29
Missouri	$18,735	11	$20,829	12	$3,100	37	$3,186	12	$7,776	9
Montana	$13,237	26	$12,040	45	$4,933	11	$3,140	15	$6,052	27
Nebraska	$14,582	21	$16,795	25	$4,975	10	$2,163	41	$6,333	21
Nevada	**$8,604**	**45**	**$11,763**	**47**	**$2,222**	**48**	**$1,523**	**51**	**$3,620**	**51**
New Hampshire	$16,864	16	$23,055	9	$4,354	20	$2,984	18	$7,096	14
New Jersey	$17,397	15	$23,659	8	$3,823	30	$2,518	32	$6,921	16
New Mexico	N/A	–	$15,379	32	$3,186	35	$5,136	1	$5,326	36
New York	$20,888	4	$24,905	5	$4,453	18	$2,627	28	$7,806	8
North Carolina	$9,679	42	$13,823	36	$3,669	31	$2,357	36	$5,356	35
North Dakota	$24,699	2	$33,765	1	$6,377	2	$4,370	5	$10,392	1
Ohio	$18,218	12	$18,682	21	$4,017	27	$2,589	29	$6,409	20
Oklahoma	$12,791	27	$14,890	34	$2,847	44	$2,733	25	$5,073	41
Oregon	$13,335	25	$16,252	27	$5,663	6	$2,737	24	$6,207	23
Pennsylvania	$20,787	5	$17,239	24	$3,154	36	$2,889	21	$8,780	4
Rhode Island	$18,972	9	$25,936	4	$4,898	12	$3,357	9	$7,983	6
South Carolina	$7,051	49	$9,674	49	$2,665	46	$1,945	47	$3,691	50
South Dakota	$12,155	31	$16,184	28	$4,090	25	$2,336	37	$5,599	32
Tennessee	$9,574	43	$12,576	43	$5,882	5	$3,143	14	$6,101	26
Texas	$11,890	33	$19,745	18	$2,976	40	$2,966	19	$6,154	25
Utah	$11,462	35	$19,375	20	$3,403	32	$2,482	33	$5,050	42
Vermont	$12,557	30	$20,806	13	$4,576	16	$4,611	3	$7,471	11
Virginia	$13,879	23	$17,772	23	$4,326	21	$2,843	22	$6,909	17
Washington	$11,313	36	$13,073	40	$6,018	3	$1,969	46	$5,296	38
West Virginia	$14,858	20	$12,372	44	$3,225	34	$2,675	26	$5,602	31
Wisconsin	$12,744	28	$13,289	37	$3,020	39	$1,762	50	$5,321	37
Wyoming	$18,920	10	$21,640	11	$4,064	26	$2,281	38	$6,466	19
United States	$13,063	–	$16,859	–	$3,278	–	$2,577	–	$5,736	–

[k] Ranked by the Guinn Center in order of greatest spending per enrollee to least. Shaded states are those in the Intermountain West.

Appendix C. Consumer Price Index–Medical (CPI–M) vs. Consumer Price Index–All Urban Consumers (CPI–U) in the West Region[I, 50]



[I] Annual averages (2007-2016) for CPI–M (medical care in West urban, for all urban consumers) and CPI–U (all items in West urban, for all urban consumers) are presented; data is not seasonally adjusted. For 2017, average is for the first five months of the year.

About the Kenny C. Guinn Center for Policy Priorities

The Kenny C. Guinn Center for Policy Priorities is a 501(c)(3) nonprofit, bipartisan, independent research center focused on providing fact-based, relevant, and well-reasoned analysis of critical policy issues facing Nevada and the Intermountain West. The Guinn Center engages policy-makers, experts, and the public with innovative, data-driven research and analysis to advance policy solutions, inform the public debate, and expand public engagement.

Contact information:
Kenny Guinn Center for Policy Priorities
c/o inNEVation Center
6795 Edmond Street, Suite 300/Box 10
Las Vegas, Nevada 89118
Phone: (702) 522-2178; Email: info@guinncenter.org

Nancy E. Brune, Ph.D.
Executive Director
Email: nbrune@guinncenter.org

Meredith A. Levine
Director of Economic Policy
Email: mlevine@guinncenter.org

Megan K. Rauch
Director of Education Policy | Director of Policy Outreach
Email: mrauch@guinncenter.org

Lorena Rodriguez Rios
Chief Office Organizer and Bilingual Policy Analyst
Email: lrodriguez@guinncenter.org

REFERENCES

[1] Kathleen S. Swendiman and Evelyne P. Baumrucker. "Memorandum: Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act." *Congressional Research Service*. July 16, 2012. Page 2. Available: http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf; Pub. L. 111–148, 124 Stat. 119. "The Patient Protection and Affordable Care Act." Available: https://www.gpo.gov/fdsys/pkg/PLAW-111publ148/pdf/PLAW-111publ148.pdf.

[2] Kathleen S. Swendiman and Evelyne P. Baumrucker. "Memorandum: Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act." *Congressional Research Service*. July 16, 2012. Available: http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf.

[3] No. 11-393, slip opinion (U.S. June 28, 2012). "N*ational Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al.*; Certiorari to the United States Court of Appeals for the Eleventh Circuit." Available: https://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf. While the Medicaid expansion was not the only portion of ACA taken under advisement, it is that relevant provision that will be addressed here.

[4] Kathleen S. Swendiman and Evelyne P. Baumrucker. "Memorandum: Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act." *Congressional Research Service*. July 16, 2012. Page 2. Available: http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf.

[5] Kathleen S. Swendiman and Evelyne P. Baumrucker. "Memorandum: Selected Issues Related to the Effect of *NFIB v. Sebelius* on the Medicaid Expansion Requirements in Section 2001 of the Affordable Care Act." *Congressional Research Service*. July 16, 2012. Available: http://www.ncsl.org/documents/health/aca_medicaid_expansion_memo_1.pdf.

[6] Anjeanette Damon. "Sandoval Opts to Expand Medicaid Coverage for Nevada's Neediest." *Las Vegas Sun*. December 11, 2012. Available: https://lasvegassun.com/news/2012/dec/11/sandoval-supports-medicaid-expansion-nevada/; and Editorial Board. "Medicaid Expansion in Red States." *New York Times*. March 16, 2015. Available: https://www.nytimes.com/2015/03/16/opinion/medicaid-expansion-in-red-states.html.

[7] Anjeanette Damon. "Sandoval Opts to Expand Medicaid Coverage for Nevada's Neediest." *Las Vegas Sun*. December 11, 2012. Available: https://lasvegassun.com/news/2012/dec/11/sandoval-supports-medicaid-expansion-nevada/.

[8] Nevada Department of Health and Human Services, State Division of Welfare and Supportive Services. 2014. "State Fiscal Year 2014 Fact Book." Available: http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/DWSS_2014_FactBook.pdf.

[9] State of Nevada, Governor Brian Sandoval. 2017. "Executive Budget: 2017-2019." Available: http://budget.nv.gov/uploadedFiles/budgetnvgov/content/StateBudget/2018-2019/FY2017-2019_GovExecBudgetBook-Online.pdf.

[10] Henry J. Kaiser Family Foundation. 2017. "Status of State Action on the Medicaid Expansion Decision (as of January 1, 2017)." Available: http://www.kff.org/health-reform/state-indicator/state-activity-around-expanding-medicaid-under-the-affordable-care-act/.

[11] Sean Whaley. "Nevada Medicaid Caseload Jumps; Obamacare Cited." *Las Vegas Review-Journal*. January 9, 2014. Available: https://www.reviewjournal.com/news/nevada-medicaid-caseload-jumps-obamacare-cited/.

[12] Nevada Medicaid, Title XIX: Expenditures (FY 2010 – FY 2017, Legislatively Approved Budgets; and FY 2018 – FY 2019, Governor's Recommended Line Item Budget). FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2013: http://openbudget.nv.gov/OpenGov/

ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2017: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=13&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2018: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=15&version=Gov&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; and FY 2019: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=15&version=Gov&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243. | Figure 1 constructed by the Guinn Center using the above data. Constant dollars (2013) calculated by the Guinn Center based on inflation data (Consumer Price Index [CPI]) provided to the Guinn Center on February 13, 2017, by Elliott Parker, Ph.D., Department of Economics, College of Business; University of Nevada, Reno. As no inflation data is available yet for FY 2017 – FY 2019, we assume equivalence of current dollars and constant dollars for those years.

[13] Nevada Medicaid, Title XIX: Expenditures (FY 2010 – FY 2017, Legislatively Approved Budgets; and FY 2018 – FY 2019, Governor's Recommended Line Item Budget). FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2013: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2017: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=13&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2018: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=15&version=Gov&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; and FY 2019: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=15&version=Gov&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243. | Nevada Department of Health and Human Services: Expenditures (FY 2010 – FY 2017, Legislatively Approved Budgets; and FY 2018 – FY 2019, Governor's Recommended Line Item Budget). FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=2&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=5&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2013: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2017:

http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=13&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2018: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=15&version=Gov&type=Exp&view=Division&departmentCode=40; and FY 2019: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=15&version=Gov&type=Exp&view=Division&departmentCode=40. | Nevada Legislatively Approved Budgets (FY 2010 – FY 2017) and Nevada Governor's Recommended Line Item Budgets (FY 2018 – FY 2019) — Department Summary. FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year1&budgetVersionId=2&version=Leg&type=Exp&view=Department; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Exp&view=Department; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year1&budgetVersionId=5&version=Leg&type=Exp&view=Department; FY 2013: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Exp&view=Department; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Exp&view=Department; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Exp&view=Department; FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Exp&view=Department; FY 2017: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year2&budgetVersionId=13&version=Leg&type=Exp&view=Department; FY 2018: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year1&budgetVersionId=15&version=Gov&type=Exp&view=Department; and FY 2019: http://openbudget.nv.gov/OpenGov/ViewBudgetSummary.aep?amountView=Year2&budgetVersionId=15&version=Gov&type=Exp&view=Department. All percentages in the Table 1 calculated by the Guinn Center using the data provided in the table.

[14] The Nevada Legislature meets biennially for a 120-day regular session in the calendar year following the election of its members. Legislators must approve a budget to finance the operations of the State for each biennium, which encompasses two fiscal years. Source: Guinn Center for Policy Priorities. 2017. "Nevada Budget 101: A Primer for the 2017-2019 Biennium." Available: https://guinncenter.org/wp-content/uploads/2014/01/Guinn_Budget-Primer-101_2017.pdf.

[15] Figure 2 constructed by the Guinn Center using the data from Table 1.

[16] Guinn Center for Policy Priorities. 2017. "Nevada Budget 101: A Primer for the 2017-2019 Biennium." Available: https://guinncenter.org/wp-content/uploads/2014/01/Guinn_Budget-Primer-101_2017.pdf.

[17] Guinn Center for Policy Priorities. 2017. "Nevada Budget 101: A Primer for the 2017-2019 Biennium." Available: https://guinncenter.org/wp-content/uploads/2014/01/Guinn_Budget-Primer-101_2017.pdf.

[18] Nevada Medicaid, Title XIX: Expenditures (FY 2010 – FY 2016, Legislatively Approved Budgets). FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2013: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; and FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243. | Nevada Department of Health and Human Services: Expenditures (FY 2010 – FY 2016, Legislatively Approved Budgets). FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1-&budgetVersionId=2&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&

budgetVersionId=5&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2013: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Exp&view=Division&departmentCode=40; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Exp&view=Division&departmentCode=40; and FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Exp&view=Division&departmentCode=40. | Data on inflation (Consumer Price Index [CPI]) and population provided to the Guinn Center on February 13, 2017, by Elliott Parker, Ph.D., Department of Economics, College of Business; University of Nevada, Reno. Figure 3 constructed by the Guinn Center.

[19] Nevada Medicaid, Title XIX: Expenditures (FY 2010 – FY 2016, Legislatively Approved Budgets). FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2013: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243; and FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Exp&view=Category&departmentCode=40&divisionCode=403&budgetAccountCode=3243. | Data on inflation (Consumer Price Index [CPI]) provided to the Guinn Center on February 13, 2017, by Elliott Parker, Ph.D., Department of Economics, College of Business; University of Nevada, Reno. | For Medicaid recipients, see: Nevada Department of Health and Human Services (DHHS), DHHS Director's Office. 2017. "Medicaid Chart Pack: May 2017." Available: http://dhhs.nv.gov/uploadedFiles/dhhsnvgov/content/Reports/MedicaidChartPack.pdf. | Figure 4 constructed by the Guinn Center.

[20] Lisa Waugh. 2017. "Medicaid: A Changing Federal/State Partnership." National Conference of State Legislatures (NCSL Blog). Available: http://www.ncsl.org/blog/2017/02/13/medicaid-a-changing-federal-state-partnership.aspx.

[21] Data provided to the Guinn Center by the Nevada Department of Health and Human Services (DHHS) on June 19, 2017.

[22] Figure 5 constructed by the Guinn Center using the data from Table 2.

[23] Nevada Medicaid, Title XIX: Revenue (FY 2010 – FY 2017, Legislatively Approved Budgets; and FY 2018 – FY 2019, Governor's Recommended Line Item Budget). FY 2010: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=2&version=Leg&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2011: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=2&version=Leg&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2012: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=5&version=Leg&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2013: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=5&version=Leg&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2014: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=10&version=Leg&type=Rev&view=ObjectType&budgetAccountCode=3243&departmentCode=40&divisionCode=403; FY 2015: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=10&version=Leg&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2016: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=13&version=Leg&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2017: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=13&version=Leg&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243; FY 2018: http://openbudget.nv.gov/OpenGov/

ViewBudgetDetail.aep?amountView=Year1&budgetVersionId=15&version=Gov&type=Rev&view=ObjectType&budgetAccountCode=3243&departmentCode=40&divisionCode=403; and FY 2019: http://openbudget.nv.gov/OpenGov/ViewBudgetDetail.aep?amountView=Year2&budgetVersionId=15&version=Gov&type=Rev&view=ObjectType&departmentCode=40&divisionCode=403&budgetAccountCode=3243. Note that Medicaid expenditure totals are available at each link and match the sum of the revenue sources.

[24] State of Nevada, Governor Brian Sandoval. 2017. "Executive Budget: 2017-2019." Available: http://budget.nv.gov/uploadedFiles/budgetnvgov/content/StateBudget/2018-2019/FY2017-2019_GovExecBudgetBook-Online.pdf.

[25] Figure 6 constructed by the Guinn Center using the data in Table 3.

[26] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2014. "FY2016 Federal Medical Assistance Percentages: October 1, 2015 – September 30, 2016 (Fiscal Year 2016)." Available: https://aspe.hhs.gov/basic-report/fy2016-federal-medical-assistance-percentages. Figure 7 constructed by the Guinn Center.

[27] Robin Rudowitz. 2016. "Medicaid Financing: The Basics." Henry J. Kaiser Family Foundation. Available: http://www.kff.org/report-section/medicaid-financing-the-basics-issue-brief/.

[28] U.S. House of Representatives. "H.R.1628 - American Health Care Act of 2017." Available: https://www.congress.gov/bill/115th-congress/house-bill/1628.

[29] Matt Broaddus and Edwin Park. 2017. "House Republican Health Bill Would Effectively End ACA Medicaid Expansion." Center on Budget and Policy Priorities. Available: http://www.cbpp.org/research/health/house-republican-health-bill-would-effectively-end-aca-medicaid-expansion.

[30] U.S. Senate. "Discussion Draft of H.R. 1628; the Better Care Reconciliation Act of 2017." Available: https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf.

[31] U.S. Senate. "Discussion Draft of H.R. 1628; the Better Care Reconciliation Act of 2017." Available: https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf.

[32] United States Congress, Congressional Budget Office. 2017. "Cost Estimate for H.R. 1628: Better Care Reconciliation Act of 2017 (Amendment in the Nature of a Substitute)." Page 29. https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

[33] U.S. Senate. "Discussion Draft of H.R. 1628; the Better Care Reconciliation Act of 2017." Available: https://www.budget.senate.gov/imo/media/doc/SENATEHEALTHCARE.pdf.

[34] United States Congress, Congressional Budget Office. 2017. "Cost Estimate for H.R. 1628: Better Care Reconciliation Act of 2017 (Amendment in the Nature of a Substitute)." https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

[35] United States Congress, Congressional Budget Office. 2017. "Cost Estimate for H.R. 1628: Better Care Reconciliation Act of 2017 (Amendment in the Nature of a Substitute)." Page 29. https://www.cbo.gov/system/files/115th-congress-2017-2018/costestimate/52849-hr1628senate.pdf.

[36] Henry J. Kaiser Family Foundation. 2017. "Medicaid-to-Medicare Fee Index; Timeframe: 2014." Available: http://www.kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/.

[37] Howard Baron, MD. "Reimbursement for Medical Services." Available: https://www.leg.state.nv.us/App/InterimCommittee/REL/Document/9071.

[38] Margot Sanger-Katz. "G.O.P. Health Plan Is Really a Rollback of Medicaid." *New York Times*. June 20, 2017. Available: https://www.nytimes.com/2017/06/21/upshot/gop-health-plan-is-really-a-rollback-of-medicaid.html.

[39] "Sen. Dean Heller and Gov. Brian Sandoval Comment on Healthcare in Las Vegas." Via *The Nevada Independent*. June 23, 2017. Available: https://www.youtube.com/watch?v=XnInEC1ZrxE.

[40] State of Nevada, Economic Forum. 2017. "General Fund Revenues - Economic Forum May 1, 2017, Forecast." Available: http://www.leg.state.nv.us/Division/Fiscal/Economic Forum/EF_MAY_2017_FORECAST_05012017.pdf. A major fund is one in which its "total assets, liabilities, revenues, or expenditures/expenses… are at least 10 percent of the corresponding total for all funds of that category or type." Source: State of Nevada, Department of Taxation. 2015. "Guidance Letter 15-001." Page 2. Available: https://tax.nv.gov/Boards/Committee_on_Local_Govt_Finance/CLGF_Meeting_Documents/CLGF_2015_Apr_24/15-001_Special_Revenue_Funds__Enterprise_Funds_(2)/.

[41] State of Nevada, Governor Brian Sandoval. 2017. "Executive Budget: 2017-2019." Pages: BUDGET OVERVIEW – 13-14. Available: http://budget.nv.gov/uploadedFiles/budgetnvgov/content/StateBudget/2018-2019/FY2017-2019_GovExecBudgetBook-Online.pdf.

[42] State of Nevada, Governor Brian Sandoval. 2017. "Executive Budget: 2017-2019." Pages: BUDGET OVERVIEW – 13-14. Available: http://budget.nv.gov/uploadedFiles/budgetnvgov/content/StateBudget/2018-2019/FY2017-2019_GovExecBudgetBook-Online.pdf.
[43] State of Nevada, Economic Forum. 2017. "Meeting of the Economic Forum: May 1, 2017." Available: http://nvleg.granicus.com/MediaPlayer.php?clip_id=8028.
[44] State of Nevada, Economic Forum. 2017. "Meeting of the Economic Forum: May 1, 2017: Testimony of Daniel White (Economist, Moody's Analytics)." Available: http://nvleg.granicus.com/MediaPlayer.php?clip_id=8028.
[45] On Nevada's reliance on the Sales Tax to finance operations statewide, see: Guinn Center for Policy Priorities. 2017. "Property Taxes in Nevada: An Overview." Available: https://guinncenter.org/wp-content/uploads/2014/01/Guinn-Center-Property-Taxes-2017.pdf.
[46] Haeyoun Park. "Republicans' Changes to Medicaid Could Have Larger Impact Than Their Changes to Obamacare." *New York Times*. March 7, 2017. Available: https://www.nytimes.com/interactive/2017/03/07/us/politics/medicaid-reform-impact-on-states.html.
[47] Henry J. Kaiser Family Foundation. 2017. "Medicaid Spending per Enrollee (Full or Partial Benefit); Timeframe: FY2014." Available: http://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/. Estimates include average state and federal payments to Medicaid per enrollee. Data for total Medicaid spending per enrollee for FY 2014 contained in Table 5 does not match that displayed in Figure 4 (page eight) for two reasons: (1) federal fiscal year 2014 ran from October 1, 2013 – September 30, 2014, while state fiscal year 2014 ran from July 1, 2013 – June 30, 2014, so there is temporal non-comparability; and (2) data for Figure 6 is inflation-adjusted (i.e., constant dollars), while data in Table 5 is presented in current dollars.
[48] U.S. Department of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation. 2014. "FY2016 Federal Medical Assistance Percentages: October 1, 2015 – September 30, 2016 (Fiscal Year 2016)." Available: https://aspe.hhs.gov/basic-report/fy2016-federal-medical-assistance-percentages.
[49] Henry J. Kaiser Family Foundation. 2017. "Medicaid Spending per Enrollee (Full or Partial Benefit); Timeframe: FY2014." Available: http://www.kff.org/medicaid/state-indicator/medicaid-spending-per-enrollee/. Estimates include average state and federal payments to Medicaid per enrollee. Data for total Medicaid spending per enrollee for FY 2014 contained in Appendix B does not match that displayed in Figure 4 (page eight) for two reasons: (1) federal fiscal year 2014 ran from October 1, 2013 – September 30, 2014, while state fiscal year 2014 ran from July 1, 2013 – June 30, 2014, so there is temporal non-comparability; and (2) data for Figure 6 is inflation-adjusted (i.e., constant dollars), while data in Appendix B is presented in current dollars.
[50] Data on the Consumer Price Index–Medical (CPI–M) for the West region provided to the Guinn Center by the U.S. Department of Labor, Bureau of Labor Statistics, on June 27, 2017. For data on the Consumer Price Index–All Urban Consumers (CPI-U), see: U.S. Department of Labor, Bureau of Labor Statistics. "CPI Historical Table - West Region." Available: https://www.bls.gov/regions/west/data/consumerpriceindex_west_table.pdf.