No. 11-400

IN THE

Supreme Court of the United States

STATE OF FLORIDA, *ET AL.*,

Petitioners,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *ET AL.*,

Respondents.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE ELEVENTH CIRCUIT

BRIEF FOR *AMICI CURIAE* ECONOMISTS IN SUPPORT OF STATE PETITIONERS REGARDING MEDICAID EXPANSION

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OTHER AUTHORITIES

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Centers for Medicare & Medicaid Servs., *Medicaid Enrollment by State*, http:// www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html (last visited Jan. 16, 2012) .... 6 , 11

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Richard Niska et al., *National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary*, National Health Statistics Reports, No. 26 (Aug. 6, 2010), http://www.cdc.gov/nchs/data/ nhsr/nhsr026.pdf... 10

U.S. Census Bureau, *State Government Tax Collections: 2009*, http://www2.census.gov/ govs/statetax/09staxss.xls..................................... 6

INTEREST OF THE *AMICI CURIAE*[1]

Amici Curiae are 101 economists who have studied, researched, and participated in the national policy discussion relating to the healthcare markets. *Amici* include Nobel laureates, former senior government officials, and faculty from research universities around the country. *Amici* support the need for reform but believe that the Affordable Care Act ("ACA" or the "Act") will likely exacerbate, rather than constrain, the inflation in healthcare costs that poses a serious long-term challenge to the U.S. economy. A complete list of *amici* can be found in the Appendix, beginning on page 1a.

Most of *amici* previously filed a brief with the Court of Appeals for the Eleventh Circuit addressing the economic premises on which the Government relied in seeking to defend the ACA's individual mandate as a regulation of interstate commerce. The Eleventh Circuit expressly relied upon *amici*'s analysis in finding the mandate unconstitutional. *See Florida ex rel. Att'y Gen. v. U.S. Dep't of Health & Human Servs.*, 648 F.3d 1235, 1299 & nn.108-111, 113 (11th Cir. 2011).

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[1] No counsel for any party has authored this brief in whole or in part. Several of *amici curiae* are affiliated with the American Action Forum ("AAF"), an independent and nonpartisan research institution, and AAF has made a monetary contribution to the preparation and submission of the brief. Save for AAF, no person other than *amici* or their counsel has made a monetary contribution to the preparation or submission of this brief. *See* Sup. Ct. R. 37.6. All parties have consented to the filing of this brief through universal letters of consent on file with the Clerk of this Court.

Before this Court, most of *amici* filed a brief in support of Petitioners on the severability question. *Amici* also intend to file a brief addressing the economic issues relating to the constitutionality of the individual mandate, according to the schedule this Court has ordered.

Amici submit this brief in support of the State Petitioners' position that the Medicaid expansion provisions of the Act unconstitutionally coerce the States by threatening a loss of all federal Medicaid funds if a State does not accept the Act's considerable expansion of Medicaid eligibility. *Amici* seek to assist the Court in understanding the concrete effects that declining federal Medicaid funding would have on States' budgets. As those numbers make clear, the States are left with no realistic choice but to accept the new conditions Congress has imposed on them.

SUMMARY OF ARGUMENT

An expenditure of federal funds is unconstitutional when it coerces rather than merely encourages States to enact a federal policy. To have any substance, this anti-coercion principle of federalism must mean that a federal statute must preserve for the States a real, and not merely a theoretical, choice between adopting Congress's policy preferences and forgoing the funds that Congress has tied to compliance. As more than 20 percent of all state spending from any source, Medicaid is a major part of state budgets. Under the ACA, Congress has taken the dramatic step of transforming Medicaid from a program designed to provide assistance to the impoverished and special needs groups, such as the disabled, into a mandatory federal entitlement – effec-

tively obligatory on both the States and beneficiaries alike – that reaches even working adults whose incomes fall well above the poverty level. States that do not accept the substantial expansion of eligibility, elimination in flexibility, and other reforms will lose *all* federal Medicaid funds and indeed will no longer be running a Medicaid program at all.

To quantify the effect of such a major fiscal loss and to test whether States could realistically choose to decline Congress's offer, *amici* analyzed public data from governmental sources to compare federal Medicaid spending to the current magnitude of States' budgets, tax collection, and population. *See* Appendix at 10a-11a.

These data confirm and quantify what is already clear from the many declarations submitted by the States Petitioners to the district court in support of summary judgment: The States are in no realistic position to fill the enormous gap that the loss of federal Medicaid funding would leave. If the States suddenly were forced to add 2009 federal Medicaid expenditures to their total 2009 state budgets (excluding federal funds and bonds), the States' total budgetary expenditures would jump by 22.5 percent. Expressed another way, federal Medicaid spending represents an even more imposing 34.4 percent of taxes collected by the States nationwide. The States are not in any position to forgo federal funds and turn to their own means of raising revenue or cutting other spending to fill the gap.

Nor are the States in a position simply to drop Medicaid coverage and allow their neediest residents to fend for themselves. The social, not to say political, costs of such a drastic change in the safety net of

a State would plainly be unacceptable. Even if a State were to take the drastic measure of declining federal funds and refusing to set up an alternative Medicaid-like program, that State's healthcare providers would still be subject to federal mandates requiring them to provide emergency stabilization care to all, regardless of ability to pay. If any State withdrew from Medicaid and did not seek to provide subsidies to its healthcare providers to match the rise in uncompensated care, many providers in that State would simply be unable to sustain those costs and would go out of business.

While Congress's decision to compel Americans to purchase health insurance was the ground upon which the Court of Appeals held the ACA's individual mandate to be unconstitutional, this Court should not overlook an equally important constitutional limitation trampled by the Act. The States, as co-equal sovereigns in our Nation's constitutional scheme, may not be compelled to adopt the policy preferences of the federal government. Congress's decision to tie a State's entire federal Medicaid funding to the State's endorsement of the ACA's dramatic expansion of Medicaid is manifestly coercive and thus unconstitutional.

ARGUMENT

THE ACA'S EXPANSION OF MEDICAID LEAVES STATES WITH NO ECONOMICALLY FEASIBLE CHOICE OTHER THAN TO ACCEDE TO FEDERAL COERCION

The ACA's Medicaid expansion provisions, ACA §§ 2001, 2002, 42 U.S.C. § 1396a, impose on the States a vast enlargement of the federal-state public

healthcare program. Rather than provide the States with a choice as to whether to adopt, and to fund in part, this expansion, the price of a State's refusal is the loss of all existing federal Medicaid contributions.

These provisions plainly impose an unconstitutional condition of federal spending by coercing the States into accepting and participating in the federal government's enormously expanded program because the States could only "in theory," not "in fact," opt to forgo receipt of all federal Medicaid contributions. *South Dakota v. Dole*, 483 U.S. 203, 211, 212 (1987). As *Dole*'s analysis makes clear, in determining what is unconstitutionally coercive the focus must be on "the financial inducement offered by Congress" – specifically the magnitude of the loss that the States would sustain if they declined to comply. *Id.* at 211; *see also* Pet. Br. (Medicaid) at 46-47. Where, as here, the alternative of turning down Congress's new conditions would be fiscally devastating to the States, the States have no meaningful choice but to acquiesce. The federal government's imposition of such overbearing and coercive conditions on the exercise of state policy goes well beyond what is permitted by our Constitution's system of federalism.

A. States Could Not Realistically Turn Down Federal Medicaid Funding While Maintaining Their Existing Levels Of Medicaid Coverage

In an attempt to quantify the devastating economic effect on States of losing all federal Medicaid funds, *amici* have drawn upon data from publicly available governmental sources – the U.S. Census Bureau, the Centers for Medicare and Medicaid Ser-

vices, and the National Association of State Budget Officers – to compare the federal Medicaid funds that each State receives to that State's expenditures and tax collections.[2] By law, the federal government commits to contribute between 50 and 83 percent of each State's total Medicaid expenditures. 42 U.S.C. § 1396d(b). As of 2009, federal dollars amounted to roughly two-thirds of all Medicaid expenditures nationwide. *See* Appendix at 11a. Given that Medicaid is a substantial part of every State's total budgetary expenditures, it should thus come as no surprise that the loss of federal Medicaid funds would have a catastrophic effect on States' fiscal wellbeing.

Amici's analysis of the publicly available data shows that if a State were to forgo federal Medicaid funding while retaining the same level of coverage

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[2] *Amici* used data from fiscal year 2009, the most recent year for which State-by-State Medicaid data were available in sufficient detail. *Amici* drew the Medicaid and population data used in their analysis from Centers for Medicare and Medicaid Services ("CMS"), *Medicaid Enrollment by State*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-State/By-State.html (follow hyperlinks to individual States' data) (last visited Jan. 16, 2012) (providing Medicaid data from CMS and population data from the U.S. Census Bureau). For *amici*'s state tax collection data, see U.S. Census Bureau, *State Government Tax Collections: 2009*, http://www2.census.gov/govs/statetax/09staxss.xls. For *amici*'s state budget data, see National Association of State Budget Officers, *Fiscal Year 2010 State Expenditure Report: Examining Fiscal 2009-2011 State Spending* 7 (2011), http://nasbo.org/LinkClick.aspx?fileticket=C3LJlSFxbdo%3d&tabid=79. *Amici* drew from this source figures for fiscal year 2009 total state expenditures minus federal funds and funds from bonds, which are from previously issued bonds and therefore are not a source of potential new funding. *Amici*'s complete findings are set forth in the Appendix beginning at page 10a.

for its citizens, then the State's fiscal picture would become unrecognizable. For instance, on a nationwide basis, federal Medicaid spending is the equivalent of one-third of *all* state tax collection. Six States, moreover, would have to come up with more than 50 percent of their current tax revenue in order to make up for the lack of federal Medicaid funding. For well over half of the States, this figure would exceed 25 percent.[3] Put another way, the federal government expends an average of $778 dollars per year on Medicaid for every state resident, and that figure is more than $1,000 per resident in nine States. *See* Appendix at 10a-11a.

While States certainly have more than one means to raise revenue or cut spending, it is clear that an abrupt 50 percent or even 33 percent increase in state taxes across the board would be politically impossible. Such measures also would be economically infeasible, given the practical limits on States' borrowing ability, as well as the power of both labor and capital within a State to vote with their feet, in the event that one State's tax burden becomes too onerous as compared to its neighbors'.

Furthermore, a State's current federal Medicaid funding, if anything, underestimates the costs that a State that turned down federal Medicaid funds would incur in order to maintain current Medicaid

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[3] The States whose total tax collections are less than twice what the federal government gives that State in Medicaid funds are Arizona, Maine, Mississippi, Missouri, New Mexico, and Tennessee. Federal Medicaid expenditures exceed one-third of state tax collections in an additional 17 States and exceed one-quarter of state tax collections in an additional 13 States. *See* Appendix at 10a-11a.

coverage levels. As the State Petitioners have pointed out, such a State would incur substantial start-up costs to create an alternative Medicaid-like, State-only program. *See* Pet. Br. (Medicaid) at 45. Similarly, a State that withdrew from Medicaid might lose other federal funds, such as Temporary Assistance for Needy Families, which is premised on the expectation that States will participate in Medicaid. *See id.* at 11; *see also* Decl. of Deborah K. Bowman, Sec'y, Dep't of Soc. Servs., S.D., at JA 175-76 ¶ 16 (explaining that "[t]hough theoretically possible, South Dakota cannot cease participation in the Medicaid Program" because if it lost federal funds, including those recently provided by the American Recovery and Reinvestment Act, it "would be required to expend 75.58% of its total state general fund budget" to maintain the same levels of Medicaid coverage).[4] Medicaid has thus become an entrenched part of States' ability to meet their many budgetary commitments. Putting aside the fact that many States already are having historic difficulty in meeting their current budgetary commitments, there is no practical way in which a State could maintain its current level of Medicaid coverage while declining federal funds.

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[4] While the district court took Ms. Bowman's declaration as a concession that South Dakota could "cease participation in the Medicaid Program," *Florida ex rel. Bondi v. U.S. Dep't of Health & Human Servs.*, 780 F. Supp. 2d 1256, 1268 (N.D. Fla. 2011), the exact opposite is true. Short of *explicit* commandeering like that this Court struck down in *New York v. United States*, 505 U.S. 144, 175-76 (1992), declining Congress's spending inducements is always "theoretically possible." This Court has made clear, however, that the relevant question is whether opting out is practical in reality. *See, e.g.*, *Dole*, 483 U.S. at 211-12.

B. States Could Not Realistically Turn Down Federal Medicaid Funding Without Providing Some Alternative Healthcare Funding For Low-Income State Citizens

Equally unthinkable would be dropping all Medicaid-like coverage. The Government has not seriously contested the numerous declarations that the State Petitioners have submitted attesting to the unsurprising conclusion that a loss of public health insurance for States' most vulnerable populations would create nothing short of a "health care emergency affecting its poorest and neediest citizens." Decl. of Elizabeth Dudek, Interim Sec'y, Agency for Health Care Admin., Fla., at JA 81 ¶ 33 (citing "severe health repercussions, including possible loss of life").

If a State did not offer a Medicaid-like program, the State would experience a profound crisis in both the health of its neediest citizens and the finances of its healthcare providers because the absence of Medicaid would lead to a massive increase in uncompensated health care provided to former Medicaid recipients. As noted, federal funds constitute two-thirds of Medicaid spending nationwide, and more than 80 percent of some States' Medicaid spending. *See* Appendix at 10a-11a. Any State that attempted to set up a new program without expending any more state funds than it currently expends would be forced to make very deep cuts in services, even before factoring in the start-up costs of establishing such an alternative program.

Even leaving aside the extreme human cost of such cuts, States could not avoid significant outlays

to prevent their healthcare systems from plunging into crisis. As the Government notes elsewhere in support of the ACA's individual mandate, various laws require providers to care for patients under some circumstances even if those patients cannot pay for the care. *See, e.g.*, Emergency Medical Treatment and Active Labor Act ("EMTALA"), 42 U.S.C. § 1395dd (requiring stabilization care); Pet. Br. (Minimum Coverage Provision) at 39-40 (citing EMTALA and other laws, including state laws).

Amici are not aware of data that specifically separate the costs of legally required stabilization care from the costs of all emergency care. Thus, it is difficult to quantify the precise increase in uncompensated care that would follow from the (entirely theoretical) decision of a State to end its existing Medicaid program. Research does show, however, that in 2007, Medicaid was the sole or partial payer in approximately 32.9 million emergency room visits. *See* Richard Niska et al., *National Hospital Ambulatory Medical Care Survey: 2007 Emergency Department Summary*, National Health Statistics Reports, No. 26, at 12 (Aug. 6, 2010), http://www.cdc.gov/nchs/data/nhsr/nhsr026.pdf.[5] This represents 28.2 percent of all emergency room visits in 2007, disproportionate to the percentage of the population that was covered by Medicaid in 2007 – 19.7 per-

[5] This source combines Medicaid and Children's Health Insurance Program (CHIP). More than half of the States provide CHIP through Medicaid at least in part. *See* Centers for Medicare & Medicaid Servs., *Children's Health Insurance Program (CHIP)*, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Childrens-Health-Insurance-Program-CHIP/Childrens-Health-Insurance-Program-CHIP.html (last visited Jan. 17, 2012).

cent. *See* CMS, *Medicaid Enrollment by State*. Of those 32.9 million total Medicaid emergency room visits, approximately 18.1 million visits were triaged as being "urgent," or needing medical attention within 60 minutes or less of arrival.

Thus, any State that did not provide Medicaid-like coverage would at least need to provide significant support to its hospitals and other providers that serve current Medicaid recipients; without such assistance, many such providers simply could not stay in business. The impact of such a collapse would be widespread, as "Medicaid members rely on the very same providers" as other patients. Decl. of Jerry L. Phillips (Undersecretary, La. Dep't of Health & Hospitals) at JA 135 ¶ 3; *see also, e.g.*, *id.* ("Eliminating Medicaid would mean that hospital uncompensated care would skyrocket, hospitals would have to close certain departments, stop expansion projects, and physicians would see a loss in revenue."); Decl. of Michael J. Willden, Dir., Dep't of Health & Human Servs., Nev., at JA 162 ¶ 5 ("Nursing facilities . . . would be at risk of closure," and "those with chronic medical conditions [would be] at serious risk.").

The ripple effect from such massive changes in the healthcare landscape would be simply huge. Putting States to the false fiscal "choice" imposed by the ACA's Medicaid expansion provisions – of either assuming such colossal federal funding cuts, requiring vast new state expenditures to maintain existing healthcare coverage levels for their neediest citizens, or else going along with Congress's policy preference by participating in a greatly enlarged Medicaid program – is plainly coercive and therefore unconstitutional.

CONCLUSION

For the foregoing reasons, this Court should reverse the decision of the Court of Appeals that the ACA's Medicaid expansion provisions do not unconstitutionally coerce States into adopting Congress's preferred policy program.

Respectfully submitted,

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FINDINGS

Appendix

		Medicaid Data Analysis				State Impact Analysis				
	Population (thousand)	Medicaid Enrollment (thousand)	Total Medicaid Expenditure (million)	Federal Share of Total Medicaid Expenditure (million)	Federal % of Total Medicaid Expenditure	Total State Expenditures (Excluding Bonds and Federal Funds) (million)	Total State Tax Collections (million)	Federal Medicaid Expenditure Expressed as a % of State Expenditures**	Federal Medicaid Expenditure Expressed as a % of State Tax Collections**	**Federal Medicaid Expenditure Per State Resident**
AL	4,709	955	$ 4,389	$ 3,354	76.4%	$ 11,898	$ 8,306	*28.2%*	40.4%	$ 712
AK	698	129	$ 1,065	$ 707	66.4%	$ 9,230	$ 4,956	7.7%	14.3%	$ 1,012
AZ	6,596	1,783	$ 8,665	$ 6,588	76.0%	$ 16,007	$ 11,134	41.2%	**59.2%**	$ 999
AR	2,889	756	$ 3,388	$ 2,707	79.9%	$ 12,717	$ 7,468	21.3%	36.2%	$ 937
CA	36,962	11,168	$ 40,848	$ 24,477	59.9%	$ 114,784	$ 101,007	21.3%	24.2%	$ 662
CO	5,025	702	$ 3,533	$ 2,116	59.9%	$ 22,359	$ 8,683	9.5%	24.4%	$ 421
CT	3,518	587	$ 5,668	$ 3,349	59.1%	$ 15,586	$ 12,160	21.5%	*27.5%*	$ 952
DE	885	207	$ 1,211	$ 739	61.0%	$ 7,204	$ 2,806	10.3%	*26.3%*	$ 834
FL	18,538	3,422	$ 14,991	$ 10,124	67.5%	$ 38,907	$ 32,065	*26.0%*	*31.6%*	$ 546
GA	9,829	2,048	$ 7,499	$ 5,592	74.6%	$ 27,559	$ 16,078	20.3%	34.8%	$ 569
HI	1,295	267	$ 1,276	$ 848	66.5%	$ 9,333	$ 4,713	9.1%	18.0%	$ 655
ID	1,546	251	$ 1,252	$ 990	79.1%	$ 3,982	$ 3,172	*24.9%*	*31.2%*	$ 640
IL	12,910	2,908	$ 13,012	$ 7,806	60.0%	$ 43,327	$ 29,363	18.0%	*26.6%*	$ 605
IN	6,423	1,197	$ 5,864	$ 4,356	74.3%	$ 16,561	$ 14,901	*26.3%*	*29.2%*	$ 678
IA	3,008	533	$ 2,896	$ 2,011	69.4%	$ 12,233	$ 6,985	16.4%	*28.8%*	$ 668
KS	2,819	373	$ 2,423	$ 1,637	67.6%	$ 9,864	$ 6,695	16.6%	24.5%	$ 581
KY	4,314	948	$ 5,363	$ 4,205	78.4%	$ 15,827	$ 9,741	*26.6%*	43.2%	$ 975
LA	4,492	1,258	$ 6,272	$ 4,950	78.9%	$ 16,456	$ 10,202	*30.1%*	48.5%	$ 1,102
ME	1,318	367	$ 2,492	$ 1,829	73.4%	$ 5,204	$ 3,489	35.2%	**52.4%**	$ 1,388
MD	5,699	961	$ 6,341	$ 3,834	60.5%	$ 23,112	$ 15,286	16.6%	*25.1%*	$ 673
MA*	NA	NA	NA	NA	NA	$ 43,769	$ 19,700	NA	NA	NA
MI	9,970	2,124	$ 10,527	$ 7,348	69.8%	$ 28,510	$ 22,758	*25.8%*	*32.3%*	$ 737
MN	5,266	885	$ 7,301	$ 4,455	61.0%	$ 21,736	$ 17,161	20.5%	*26.0%*	$ 846
MS	2,952	754	$ 3,927	$ 3,278	83.5%	$ 9,221	$ 6,472	35.5%	**50.6%**	$ 1,110
MO	5,988	1,147	$ 7,648	$ 5,477	71.6%	$ 15,654	$ 10,302	35.0%	**53.2%**	$ 915
MT	975	135	$ 868	$ 672	77.4%	$ 3,699	$ 2,407	18.2%	*27.9%*	$ 689
NE	1,797	274	$ 1,576	$ 1,054	66.9%	$ 6,587	$ 4,001	16.0%	*26.3%*	$ 587
NV	2,643	291	$ 1,377	$ 871	63.3%	$ 6,712	$ 5,612	13.0%	15.5%	$ 330
NH	1,325	166	$ 1,308	$ 740	56.6%	$ 3,125	$ 2,126	23.7%	34.8%	$ 559
NJ	8,708	1,305	$ 9,481	$ 5,607	59.1%	$ 34,262	$ 27,187	16.4%	20.6%	$ 644
NM	2,010	604	$ 3,245	$ 2,556	78.8%	$ 9,953	$ 4,829	*25.7%*	**52.9%**	$ 1,272
NY	19,541	5,208	$ 47,679	$ 28,271	59.3%	$ 83,751	$ 64,756	33.8%	43.7%	$ 1,447
NC	9,381	1,974	$ 10,888	$ 7,819	71.8%	$ 31,609	$ 20,526	24.7%	38.1%	$ 833
ND	647	80	$ 567	$ 401	70.7%	$ 2,569	$ 2,414	15.6%	16.6%	$ 620

	Medicaid Data Analysis						State Impact Analysis				
	Population (thousand)	Medicaid Enrollment (thousand)	Total Medicaid Expenditure (million)	Federal Share of Total Medicaid Expenditure (million)	Federal % of Total Medicaid Expenditure		Total State Expenditures (Excluding Bonds and Federal Funds) (million)	Total State Tax Collections (million)	Federal Medicaid Expenditure Expressed as a % of State Expenditures**	Federal Medicaid Expenditure Expressed as a % of State Tax Collections**	**Federal Medicaid Expenditure Per State Resident**
OH	11,543	2,297	$ 14,003	$ 9,898	70.7%		$ 45,291	$ 23,950	21.9%	<u>41.3%</u>	$ 858
OK	3,687	852	$ 3,767	$ 2,859	75.9%		$ 11,739	$ 8,188	24.4%	<u>34.9%</u>	$ 775
OR	3,826	608	$ 3,630	$ 2,623	72.3%		$ 18,354	$ 7,115	14.3%	<u>36.9%</u>	$ 686
PA	12,605	2,304	$ 17,113	$ 10,917	63.8%		$ 40,820	$ 30,071	*26.7%*	<u>36.3%</u>	$ 866
RI	1,053	224	$ 1,875	$ 1,184	63.2%		$ 4,934	$ 2,586	24.0%	<u>45.8%</u>	$ 1,124
SC	4,561	930	$ 4,546	$ 3,560	78.3%		$ 13,516	$ 7,637	*26.3%*	<u>46.6%</u>	$ 781
SD	812	139	$ 708	$ 507	71.6%		$ 2,075	$ 1,334	24.4%	<u>38.0%</u>	$ 624
TN	6,296	1,525	$ 7,247	$ 5,307	73.2%		$ 17,550	$ 10,433	*30.2%*	**50.9%**	$ 843
TX	24,782	4,488	$ 23,000	$ 15,711	68.3%		$ 58,190	$ 41,780	*27.0%*	<u>37.6%</u>	$ 634
UT*	NA	NA	NA	NA	NA		$ 8,553	$ 5,423	NA	NA	NA
VT	622	185	$ 1,189	$ 814	68.5%		$ 2,788	$ 2,506	*29.2%*	*32.5%*	$ 1,309
VA	7,883	1,039	$ 5,693	$ 3,431	60.3%		$ 28,559	$ 16,608	12.0%	20.7%	$ 435
WA	6,664	1,159	$ 6,555	$ 4,038	61.6%		$ 23,392	$ 16,408	17.3%	24.6%	$ 606
WV	1,820	417	$ 2,421	$ 1,963	81.1%		$ 16,493	$ 4,787	11.9%	<u>41.0%</u>	$ 1,079
WI*	NA	NA	NA	NA	NA		$ 28,733	$ 14,447	NA	NA	NA
WY	544	82	$ 519	$ 299	57.7%		$ 5,214	$ 2,764	5.7%	10.8%	$ 549
USA	307,007	64,525	$ 360,316	$ 238,887	66.3%		$ 1,059,508	$ 715,496	22.5%	<u>33.4%</u>	$ 778

All figures are for Fiscal Year 2009. See *supra* at 6 n.2 for source information.

* Some 2009 data for Massachusetts, Utah, and Wisconsin not available.
** States for which federal Medicaid expenditure was equivalent to more than half of that state's total spending or tax collections in **bold**.
States for which federal Medicaid expenditure was equivalent to more than one-third but less than half of that state's total spending or tax collections <u>underlined</u>.
States for which federal Medicaid expenditure was equivalent to more than one-quarter but less than one-third of that state's total spending or tax collections in *italics* .