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Economic Effects of Medicaid Expansion in Montana: 2025 Update

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Summary

Four prior studies show that Montana's decision to expand Medicaid generated substantial benefits at minimal costs.[1] Specifically, these studies show that:

> "Medicaid expansion increases health insurance coverage and healthcare access, improving individuals' health and households' financial health while creating thousands of jobs and millions in income for Montanans throughout the economy. Medicaid expansion also reduces state spending and boosts state revenues. Combined, these savings and revenues likely more than offset the "sticker price" of expansion (10 percent of costs). As such, Medicaid expansion generates health, well-being, and economic opportunity for Montanans at minimal (or no) cost to the state budget."

This study revisits the prior reports and confirms that things have stayed the same. Specifically:

> Medicaid expansion still reduces un-insurance.
>
> Medicaid expansion still improves healthcare access and utilization.
>
> Medicaid expansion still allows beneficiaries to spend less on healthcare (and spend more on other goods and services).

These changes continue to generate benefits for recipients, the healthcare system, and the State. Specifically:

> Medicaid recipients enjoy better physical and financial health.
>
> Healthcare providers benefit from more robust demand.
>
> Medicaid expansion allows beneficiaries to spend less on healthcare (and spend more on other goods and services), creating 5,600-8,000 jobs and generating $350-$560 million in personal income throughout Montana's economy each year.

[1] Bryce Ward, Economic Effects of Medicaid Expansion in Montana: 2023 Update (Montana Healthcare Foundation, January 2023) https://mthf.org/wp-content/uploads/Medicaid-Expansion_2023-Update_FINAL.pdf; Bryce Ward, Economic Effects of Medicaid Expansion in Montana (ABMJ Consulting, January 2021), https://mthcf.org/wp-content/uploads/ABMJ-Medicaid-Report_2.2.21-FINAL-1.pdf; Bryce Ward and Brandon Bridge, The Economic Impact of Medicaid Expansion in Montana: Updated Findings (Bureau of Business and Economic Research, January 2019), https://mthcf.org/wpcontent/uploads/2019/01/Economic-Impact-of-MedEx-in-MT_1.28.19-FINAL.pdf; Bryce Ward and Brandon Bridge, The Economic Impact of Medicaid Expansion in Montana (Bureau of Business and Economic Research, April 2018), https://mthcf.org/wp-content/uploads/2018/04/BBER-MT-Medicaid-Expansion-Report_4.11.18.pdf.

The decision to expand Medicaid generates these benefits at no cost to the state. Specifically:

> Medicaid expansion does not reduce economic capacity by lowering labor force participation.
>
> Medicaid expansion does not impose a fiscal cost on the state. Savings generated by expansion coupled with increased revenues attributable to expansion more than offset the state's share of expansion costs.

Medicaid expansion benefits a wide range of people and places. Specifically, while it is hard to separate Medicaid expansion beneficiaries from other Medicaid beneficiaries in various survey-based data, excluding most adults who receive Medicaid via a disability pathway, Medicaid covers:

> 16 percent of Montana's post-secondary students (approx. 9,000 students);
> 13 percent of Montana's workers (approx. 62,000 workers);
> 10 percent of Montana's veterans (approx. 4,000 veterans);
> 20 percent of Montana's caregivers (people with children or disabled adults in their households) (approx. 55,000 caregivers);
> 31 percent of Montanan's report some form of disability or impairment (approx. 17,000 people with disabilities);
> 30 percent of Montana's American Indian population (approx. 19,000 American Indians).

Furthermore, nearly all adult Medicaid beneficiaries (over 80 percent) are (or were recently) in the labor force or attending school, and nearly all of those who are not in the labor force or attending school have potential caregiving responsibilities or report disabilities.

Medicaid expansion also touches all parts of the state. At least four percent of every county's population is typically enrolled in expansion, and expansion covers nearly 20 percent of the population in some counties. As such, the effects described throughout this report extend across the whole state.

In the remainder of this report, I briefly revisit the key findings in the prior reports; however, in a few cases, I present additional findings based on new analyses that augment or extend previous findings. Interested readers can find additional evidence and analytical detail in the prior reports, as well as in other literature reviews on the effects of Medicaid expansion.[2] Mostly, the results and analyses are unchanged; however, some of expansion's

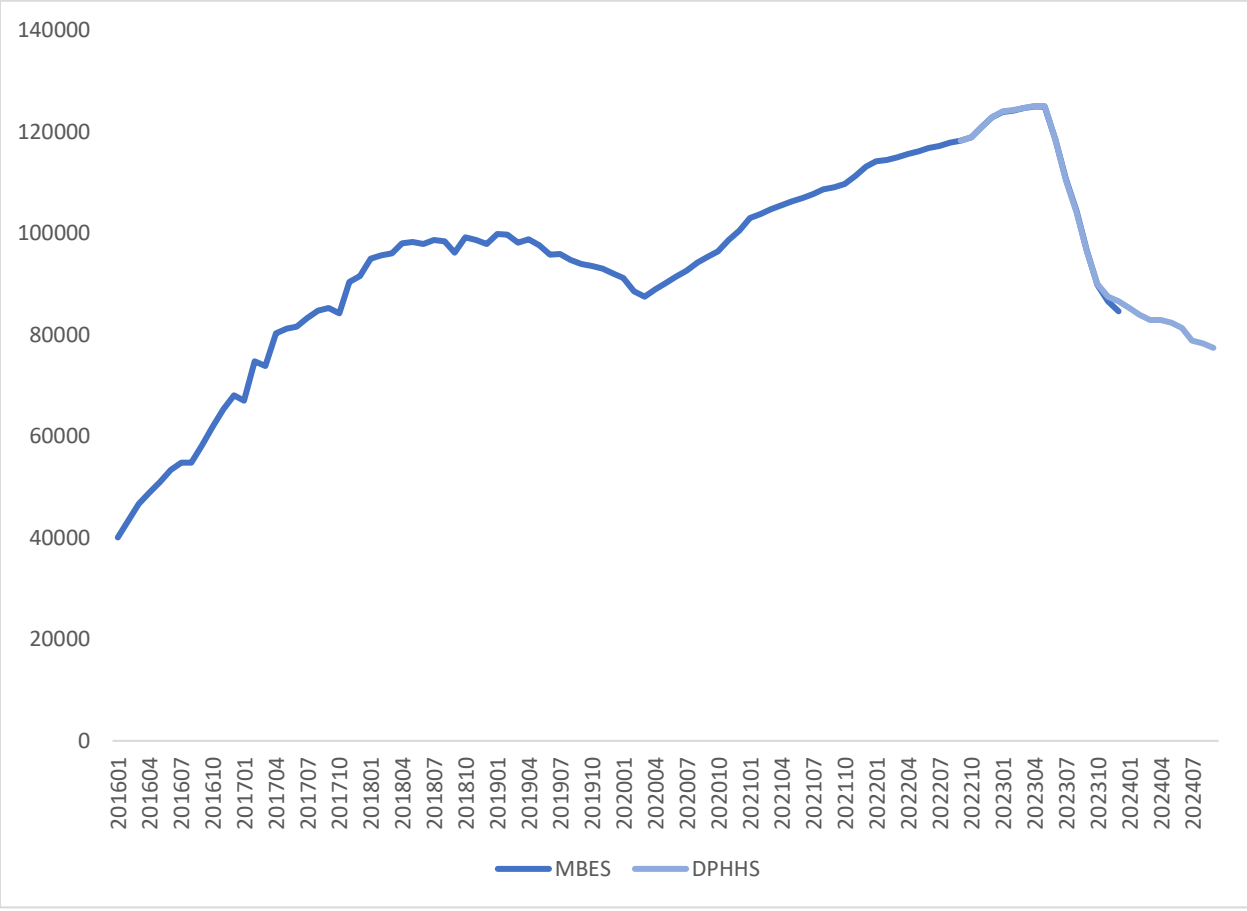
[2] E.g., Guth, M. and M. Ammula (2021). Building on the Evidence Base: Studies on the Effects of Medicaid Expansion, February 2020 to March 2021. https://www.kff.org/medicaid/report/building-on-the-evidence-base-studies-on-the-effects-of-medicaid-expansion-february-2020-to-march-2021/; M. Guth, R. Garfield, and R. Rudowitz (2020). The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020. https://www.kff.org/medicaid/report/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review/; The White House, Council of Economic Advisors (2021). "The Effects of

impact changed during the pandemic and public health emergency. Most of the changes from the past few years have reversed, so expansion's effects will likely return to their pre-pandemic trends/levels.

1. Medicaid expansion covers a large share (typically 12 to 15 percent) of Montana adults.

As shown in Figure 1, Medicaid expansion enrollment in Montana has changed over time. It ramped up for roughly two-and-a-half years, stabilized for a year, drifted down a little before the pandemic, rose substantially during the public health emergency, and fell dramatically once redetermination began in 2023. Setting aside the initial ramp-up and the spike during the public health emergency, Medicaid expansion has covered roughly 12-15 percent of Montana's adult population (ages 19-64); however, recent enrollment is at the low end of that range and is 20 percent below the average over the two years before the pandemic.

Figure 1: Montana Medicaid expansion enrollment over time



Notes: Data from Medicaid Budget and Expenditure System (MBES) through 2023, and DPHHS Medicaid Dashboard for 9/2022-9/2024.

Earlier Medicaid Expansions: A Literature Review." https://www.whitehouse.gov/cea/written-materials/2021/06/22/the-effects-of-earlier-medicaid-expansions-a-literature-review/

The fact that current enrollment is below the level reached in early 2017 (when enrollment was still ramping up) begs the question, "Why is enrollment this low?" There are two plausible explanations. First, income in Montana increased substantially over the past several years. As a result, the number of Montanans with income below 139 percent of the Federal Poverty Level declined by 11 percent between 2019 and 2023.[3] Income continued to rise in 2024, so it is possible that lower expansion enrollment simply reflects a decline in the number of people eligible. However, given the margin of error in income/poverty estimates and normal fluctuations in Medicaid take-up rates, it is unclear whether rising income explains all or only part of the enrollment decline.

Second, lower enrollment could reflect redetermination challenges. Anecdotally, many people struggled to remain enrolled during redetermination. As such, it is possible that redetermination depressed enrollment. Some data support this perspective. For instance, recent waves of the Census Bureau's Household Pulse Survey included a question about whether the respondent lost Medicaid coverage since January 1, 2023, and, if so, what was the reason. The second question included the option "I tried to stay in Medicaid, but I could not complete the renewal process." Montana ranks high in both the share of the population that reported losing Medicaid coverage (8.4 percent versus 6.1 percent in the median expansion state) and the share of those who lost coverage and couldn't complete the redetermination process (24.1 percent versus 15.5 percent in the median expansion state). Thus, two percent of Montana's population cited the inability to complete the redetermination process as the reason for losing Medicaid.

Also consistent with redetermination challenges, uninsurance increased after the end of the public health emergency. The share of adults reporting no insurance coverage in March 2024 was 3.2 percentage points (32 percent) higher than in March 2023 (and 3.4 percentage points higher than in March 2019).[4] Notably, uninsurance increased substantially among people who had Medicaid coverage at some point during 2023. Eight percent of adults with Medicaid coverage in 2023 were uninsured in March 2024. Typically, since expansion, only two percent of adults covered by Medicaid during the prior year are uninsured the following March.

As such, Medicaid enrollment may be artificially low due to redetermination challenges. However, the data are also insufficient to show how much redetermination challenges may have depressed Medicaid expansion enrollment.

Thus, it is unclear if Medicaid expansion enrollment is artificially low and will return to "normal" levels in the near future or if enrollment is consistent with current economic conditions and will remain at this level until economic conditions change.

In the remainder of this report, I build the analyses assuming enrollment ranges between the current levels to levels in more recent years (this higher level is consistent with the levels assumed in recent state budget forecasts).

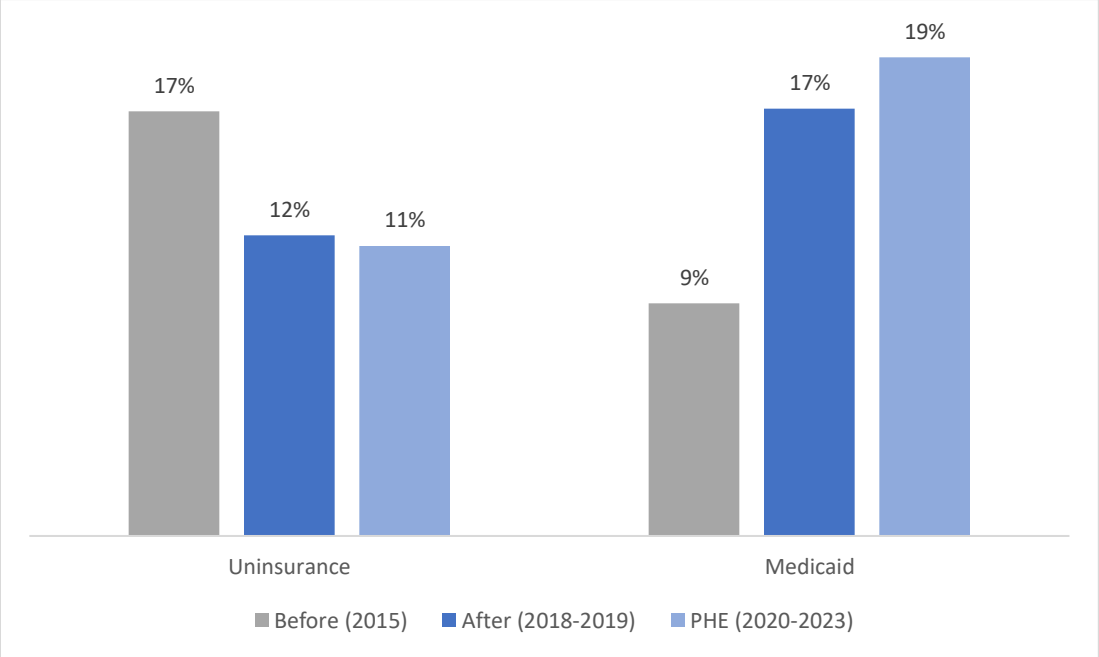
[3] Analysis of American Community Survey data obtained from IPUMS-USA.
[4] Analysis of Current Population Survey Annual Social and Economic Component data obtained from IPUMS-CPS.

2. Medicaid expansion reduces un-insurance.

In the absence of expansion, some expansion beneficiaries would have had private insurance, some would have enrolled in traditional Medicaid, but a significant proportion (approximately half) likely would have had no insurance.

Figure 2 shows the change in uninsurance and Medicaid coverage for Montana adults across three periods: before expansion (2015), after the initial expansion ramp-up but before the pandemic (2018-2019), and during the public health emergency (2020-2023). Following Medicaid expansion, the share of Montanans adults with Medicaid increased from nine percent to 17 percent, and the share uninsured declined (from 17 percent to 12 percent). Similar changes did not occur in non-expansion states during this period. During the public health emergency, when states were not removing people from Medicaid, the share of Montana adults with Medicaid increased further (to 19 percent), and the share uninsured fell further (to 11 percent). During this period, Medicaid coverage and uninsurance unsurprisingly changed in non-expansion states. However, these changes are the temporary byproduct of the PHE.[5]

Figure 2: Share of Montanans ages 19-64 with no health insurance or with Medicaid over time.



Notes: Analysis of American Community Survey microdata obtained from IPUMS-USA.

Medicaid expansion also has spillover effects on insurance coverage among groups not eligible for expansion (e.g., children or people aged 65 and over). For instance, when

[5] The ACS and CPS-ASEC suggest different impacts of expansion on uninsurance. In the ACS, adult uninsurance in Montana declines by 3-5pp relative to non-expansion states, but in CPS-ASEC the decline is 3-9pp. As such, the share of expansion enrollees who would be uninsured without expansion ranges from slightly less than half to somewhat more than half.

parents enroll in Medicaid expansion, they are more likely to enroll their eligible children.[6] As a result, Medicaid expansion increases in Medicaid coverage and a decreases uninsurance for children in Montana. The share of children covered by Medicaid increased by roughly four percentage points (10-15 percent), and uninsurance decreased by three percentage points (30-35 percent).[7]

3. Medicaid expansion improves healthcare access and increases utilization.

After expansion, the share of low-income Montanans who skipped needed healthcare because they could not afford it fell, and the share that had a routine checkup in the past year increased. Before expansion, 28 percent of low-income Montanans skipped care due to cost.[8] Since expansion, only 18 percent skipped care due to cost.[9] Before expansion, 52 percent of low-income Montanans had visited a physician for a routine checkup within the past year. Since expansion, this share has risen to 67 percent. Again, comparable changes did not occur in non-expansion states.

Also consistent with Medicaid expansion prompting large changes in healthcare access/use, Montana hospitals reported more discharges and hospital visits per capita following expansion. Respectively, relative to the 2014-15 average, these measures increased by 17 and 10 percent by 2018-2019. In contrast, these measures fell slightly in non-expansion states over this period.[10]

The broader literature on Medicaid expansion provides additional detail about the effects of Medicaid expansion on healthcare access. For instance, this literature finds that expansion increased the share of people with a personal doctor and regular source of care and increased treatment for chronic conditions, including treatment of substance use disorder.[11] In Montana, Manatt found that Medicaid beneficiaries' use of emergency

[6] Hudson, J. L., & Moriya, A. S. (2017). Medicaid expansion for adults had measurable 'welcome mat' effects on their children. *Health affairs*, *36*(9), 1643-1651.
[7] Analysis of ACS and CPS-ASEC data. Different data sets, assumptions, and periods analyzed suggest modestly different effect sizes.
[8] Analysis of 2014-2015 BRFSS data for Montanans 19-64 with imputed income less than 150 percent of FPL.
[9] Analysis of 2018-2023 BRFSS data for Montanans 19-64 with imputed income less than 150 percent of FPL. I exclude 2016-17 because these were transition years with substantially changing enrollment. I also exclude 2020 due to the pandemic.
[10] These results are based on an analysis of hospital utilization measures reported by providers to CMS as part of the Healthcare Cost Reporting Information System (HCRIS). These data are only updated through 2020 at this time. I restrict the analysis to pre-2020 to avoid any COVID impacts.
[11] See sources in footnote 2 and Sommers, B., M. Gunja, and K. Finegold. 2015. "Changes in Self-reported Insurance Coverage, Access to Care, and Health Under the Affordable Care Act," JAMA, 314, no. 4: 366–74; Simon, K., A. Soni, and J. Cawley. 2017. "The Impact of Health Insurance on Preventative Care and Health Behaviors: Evidence from the First Two Years of the ACA Medicaid Expansion." Journal of Policy Analysis and Management, 36, no. 2: 390–417; Ghosh, A., K. Simon, and B. Sommers. 2018. "The Effect of Health Insurance on Prescription Drug Use Among Low-Income Adults: Evidence from Recent Medicaid Expansions." Journal of Health Economics, 63: 64–80; Maclean, J. C., & B. Saloner. 2019. The effect of public insurance expansions on substance use disorder treatment: evidence from the Affordable Care Act. *Journal of Policy Analysis and Management*, *38*(2), 366-393.

departments falls with the number of years enrolled, which may result from greater access to preventative, outpatient, and specialist care.[12]

4. Medicaid expansion allows beneficiaries to spend less for healthcare and spend more on other goods and services.

Without Medicaid expansion, beneficiaries would have to pay for their healthcare out-of-pocket (if uninsured) via deductibles/premiums/out-of-pocket (if privately insured), or others would have paid their care via charity/uncompensated care. With expansion, Montanans can redirect this spending elsewhere in the economy. Ultimately, shifting who pays for this healthcare means Montana households have approximately $175-$300 million more to spend in other parts of Montana's economy.[13]

Beyond reducing healthcare spending, Medicaid expansion also changes the resources available to Montana families by changing enrollment in other income-based public assistance programs. However, effects vary across programs.

For some programs, Medicaid expansion increases awareness of program eligibility and willingness to enroll (e.g., SNAP). Before the pandemic, SNAP enrollment generally declined across all states; however, it fell more slowly in states that expanded Medicaid, particularly in states like Montana, where expansion greatly impacted insurance coverage. As a result, in 2019, the share of Montanans receiving SNAP benefits was 11-12 percent higher than if SNAP enrollment rates had followed the trend in non-expansion states, and Montana families benefited from an additional $15-$30 million in SNAP benefits.[14] The trend for other income transfers was similar, although less statistically certain.

During the pandemic/public health emergency, these effects disappeared in Montana (although they generally persisted in other expansion states). The pandemic era declines likely reflect temporary factors. For instance, the decline in SNAP enrollment may reflect administration difficulties (e.g., Montana struggling to process SNAP applications promptly).[15] Other income transfers also declined in Montana, in part due to Montana's decision not to participate in the P-EBT program. Given that these shocks are temporary (and other expansion states did not have similar changes), these effects may reverse going forward (e.g., SNAP enrollment rates may rise).

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[12] Manatt (2022) Medicaid in Montana. https://mthcf.org/wp-content/uploads/Medicaid-in-MT-2022_4.12.22-FINAL.pdf

[13] While precisely calculating this share is difficult, Ward (2021) argues that roughly 25-30 percent of total Medicaid spending shifts from other forms of healthcare spending.

[14] Analysis of SNAP enrollment data provided by USDA and compiled by the Kaiser Family Foundation, and total SNAP benefits included in BEA measures of state personal income. https://www.kff.org/other/state-indicator/avg-monthly-participation/?activeTab=graph&currentTimeframe=0&startTimeframe=21&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D; BEA table SAINC35 (Current Transfer Receipts).

[15] https://montanafreepress.org/2024/02/29/montana-under-corrective-plan-for-delayed-snap-applications/

Medicaid expansion is also associated with declining enrollment in disability-related programs, SSI and SSDI. Given the difficulty of applying for these programs and the restrictions on income and assets that may accompany these benefits, some people who may have applied for these programs without expansion choose to only enroll in expansion instead. Relative to the trend in non-expansion states, Montana's SSI enrollment rate and benefits were four-to five percent lower in 2019. The decline in SSI enrollment and benefits continued through the pandemic. In 2023, enrollment rates and benefits were approximately 10 percent below expected based on the trends in non-expansion states.

These changes led to a slight increase in net income transfers before the pandemic. During the pandemic, the effects were more erratic. However, assuming that pre-pandemic trends will reemerge the further one gets from the pandemic/public health emergency, Medicaid expansion may again increase program participation and modestly increase resources available to low-income Montanans.

5. Medicaid recipients enjoy better physical and financial health.

An extensive literature documents that Medicaid expansion improves health outcomes.[16] This literature finds that Medicaid expansion boosts self-reported physical and mental health and reduces mortality (by nearly 10 percent in one recent study).[17]

Expansion also improves financial health. The share of Montana households with medical debt fell from 17 percent in 2015 to four percent in 2023.[18] Less medical debt reduces other credit/loan delinquencies and improves credit scores.[19] Medicaid expansion also reduces Chapter 7 bankruptcy filings, boosts food and housing security, and increases the timeliness of child support payments.[20]

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[16] See citations in footnote 2.

[17] Borgschulte, M. and J. Vogler. 2020. "Did the ACA Medicaid Expansion Save Lives?" Journal of Health Economics, 72: 102333; Miller, S., N. Johnson, and L. Wherry. 2021. "Medicaid and Mortality: New Evidence from Linked Survey and Administrative Data." NBER Working Paper 26081. Cambridge, MA: National Bureau of Economic Research; Sommers, B., B. Maylone, R. Blendon, E.J. Orav, and A. Epstein. 2017. "Three-Year Impacts of the Affordable Care Act: Improved Medical Care and Health Among Low-Income Adults." Health Affairs, 36, no. 6: 1119–28; Winkleman, T and V. Chang. 2018. "Medicaid Expansion, Mental Health, and Access to Care Among Childless Adults with and without Chronic Conditions." Journal of General Internal Medicine, 33, no. 3: 376–83.

[18] https://apps.urban.org/features/medical-debt-over-time/?r0=30#chart-area

[19] Brevoort, K., D. Groadzicki, and M. Hackmann. 2020. "The Credit Consequences of Unpaid Medical Bills." Journal of Public Economics, 187: 104203.

[20] Kuroki, M. 2020. "The Effect of Health Insurance Coverage on Personal Bankruptcy: Evidence from the Medicaid Expansion." Review of Economics of the Household, 19: 429–51; Moellman, N. 2020. "Health care and Hunger: Effects of the ACA Medicaid Expansions on Food Insecurity in America." Applied Economic Perspectives and Policy, 42, no. 2: 168–86; Kuroki, M. and X. Liu. 2021. "The Effect of Health Insurance Coverage on Homeownership and Housing Prices: Evidence from the Medicaid Expansion." Social Science Quarterly, 102, no. 2: 633–48; Bullinger, L.R. 2020. "Child Support and the Affordable Care Act's Medicaid Expansions." Journal of Policy Analysis and Management, 40, no. 1: 42–77.

Improved physical and financial health may generate benefits for all Montanans. For instance, several papers document that increased access to Medicaid reduces crime, likely by improving access to mental healthcare.[21]

6. Medicaid expansion leads to more robust demand for healthcare which benefits providers.

Medicaid expansion strengthens the healthcare system. It improves provider financial health and supports investments in new capacity that benefit all Montanans (not just Medicaid beneficiaries).

For instance, Medicaid expansion reduced uncompensated care at Montana hospitals. Before expansion, uncompensated care in Montana was equal to five percent of operating expenses; however, it fell to two percent after expansion. In non-expansion states, uncompensated care remained constant.[22] Figure 3 shows the trend in uncompensated care at Montana hospitals compared to the level expected based on the trend in non-expansion states. By 2019, adopting Medicaid expansion had reduced uncompensated care at Montana hospitals by $225 million per year.

Beyond just reducing uncompensated care, expansion improves various provider performance measures. Multiple studies show that Medicaid expansion improves profit margins, decreases indicators of financial distress, and lowers the odds of hospital closures, particularly among small and rural hospitals.[23]

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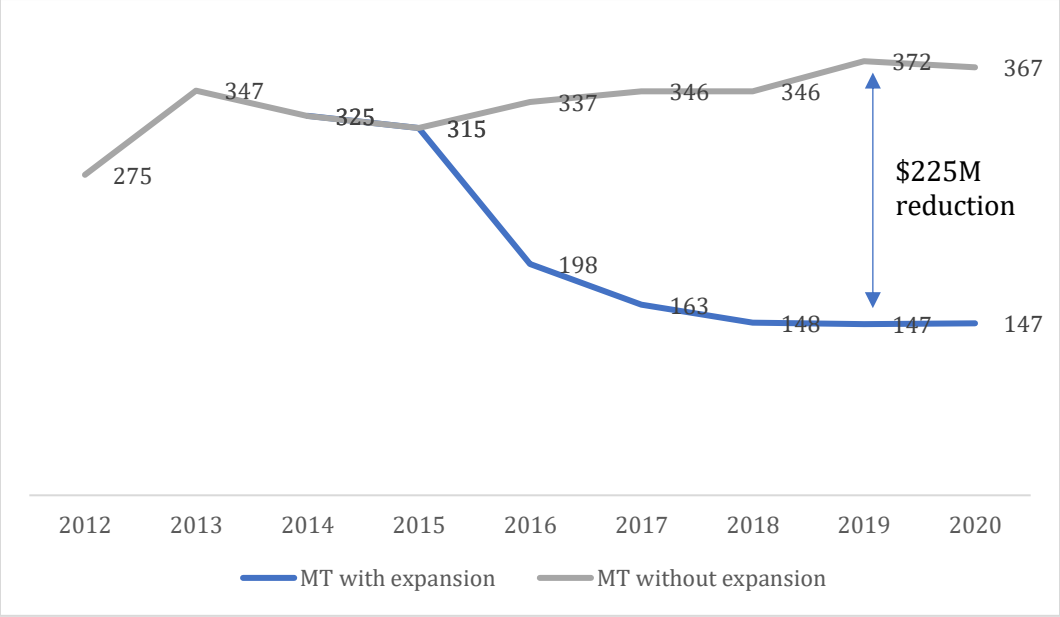
[21] Deza, M., Lu, T., Maclean, J. C., & Ortega, A. (2024). *Losing Medicaid and Crime* (No. w32227). National Bureau of Economic Research; He, Q. and Barkowski, S. (2020). The effect of health insurance on crime: Evidence from the Affordable Care Act Medicaid expansion. Health Economics, 29(3):261–277; Vogler, J. (2020). Access to healthcare and criminal behavior: Evidence from the ACA Medicaid expansions. Journal of Policy Analysis and Management, 39(4):1166–1213; Wen, H., Hockenberry, J. M., and Cummings, J. R. (2017). The effect of Medicaid expansion on crime reduction: Evidence from HIFA-waiver expansions. Journal of Public Economics, 154:67–94; Aslim, E. G., Mungan, M. C., Navarro, C. I., and Yu, H. (2022). The effect of public health insurance on criminal recidivism. Journal of Policy Analysis and Management, 41(1):45–91; Badaracco, N., Burns, M., and Dague, L. (2021). The effects of Medicaid coverage on post-incarceration employment and recidivism. Health Services Research, 56(52):2425; Arenberg, S., Neller, S., and Stripling, S. (2023). The impact of youth Medicaid eligibility on adult incarceration. American Economic Journal: Applied Economics; Gollu, G. and Zapryanova, M. (2022). The effect of Medicaid on recidivism: Evidence from Medicaid suspension and termination policies. Southern Economic Journal, 89(2):326–372; J´acome, E. (2023). Mental health and criminal involvement: Evidence from losing Medicaid eligibility. Job Market Paper, Princeton University.

[22] Analysis of HCRIS provider-level data. Providers with reporting periods longer than 370 days excluded. I also exclude providers with negative uncompensated care, negative operating expenses, or where uncompensated care exceeds 70% of operating expenses. Given different reporting years across hospitals, I allocate values in proportion to the share of the reporting year in each calendar year. However, this means that some post-expansion (2016) outcomes get applied to 2015, so I exclude 2015 from the pre period.

[23] Fredric Blavin and Christal Ramos, "Medicaid Expansion: Effects On Hospital Finances And Implications For Hospitals Facing COVID-19 Challenges," *Health Affairs* 40 no. 1 (January 2021): 82-90; Ali Moghtaderi, Jesse Pines, Mark Zocchi, and Bernard Black, "The Effect of Affordable Care Act Medicaid Expansion on Hospital Revenue," *Health Economics* 29 no. 12 (December 2020): 1682-1704; Tyler L. Malone, George H. Pink, and George M. Holmes, "Decline in Inpatient Volume at Rural Hospitals," *The Journal of Rural Health* Epub ahead of print (December 2020); David J. Wallace et al., "Association Between State Medicaid Expansion and

Figure 3: Uncompensated care at Montana hospitals relative to expectation without expansion (millions $2023)



Note: Analysis of HCRIS provider-level data. Providers with reporting periods longer than 370 days excluded. I also exclude providers with negative uncompensated care, negative operating expenses, or where uncompensated care exceeds 70% of operating expenses. Without expansion level projected based on average inflation-adjusted uncompensated care per capita in states that expanded Medicaid after 2020. Hospital reporting years often straddle calendar years. I allocate outcomes in proportion to share of fiscal year in each calendar year. As such, some expansion changes from 2016 get applied to 2015, so I project 2015 based on the non-expansion state trend.

With better financial health and more demand for care, providers invest in capacity. Montana's healthcare sector is much larger than it likely would be without expansion. In total, Medicaid expansion increased annual compensation for all healthcare workers in Montana by $200-$300 million. Included in this are additional providers. For instance, Montana has approximately 50 additional primary care physicians and 20 additional dentists due to Medicaid expansion.[24]

7. All Montanans benefit from increased economic activity/opportunity created by Medicaid expansion.

Roughly 75-80 percent of Medicaid expansion spending represents new spending in Montana's economy.[25] Without Medicaid expansion these dollars would not have been spent in Montana (they would have remained with the federal government).

Emergency Access to Acute Care Hospitals in the United States," *JAMA Network Open* 3 no. 11 (November 2020).

[24] Analysis of physicians and dentist based on data obtained from county health rankings. Values derived from comparing the change in providers per capita in Montana to changes in non-expansion states.

[25] Ward (2021) and Levy, H., Ayanian, J. Z., Buchmueller, T. C., Grimes, D. R., & Ehrlich, G. (2020). Macroeconomic feedback effects of Medicaid expansion: Evidence from Michigan. *Journal of Health Politics, Policy and Law*, *45*(1), 5-48.

When money enters an economy from the outside, economic activity increases. New money becomes revenue for Montana firms and additional wages for Montana workers. These firms and workers spend these earnings in other parts of the economy, which creates earnings for other firms and workers, and the cycle repeats. Multiple studies document that new spending introduced by Medicaid expansion supports thousands of jobs and millions in income throughout the economy.[26]

Given the uncertainty about the size of Medicaid expansion enrollment and associated spending, these effects are somewhat unclear. Current budget projections assume that spending in the next biennium will be roughly $1 billion per year, which aligns with recent spending levels. However, if recent enrollment declines persist, spending may end up 25-30 percent below this amount.

With a wide range of potential spending, economic impacts may fall within a wide range. For instance, if spending ranges between $750 million and $1 billion per year, Medicaid expansion in Montana supports between 5,600-8,000 jobs and approximately $350-$560 million in personal income.[27] While a margin of error certainly exists around any economic impact estimate, these results align with the prior studies, which find that Medicaid generates roughly 10 jobs and $625,000-$700,000 in personal income per million dollars added to Montanan's economy. Roughly half of these impacts are in the healthcare sector. The rest are distributed throughout the local sector of the economy (e.g., real estate, restaurants, retail).

In sum, Medicaid expansion generates a variety of positive impacts -- more health insurance coverage, access to more healthcare, better health, better financial health, a more robust healthcare sector, and more economic opportunity for Montanans throughout Montana's economy. However, when evaluating the effects of Medicaid expansion, one also wants to weigh these positive effects against the costs.

8. The decision to expand Medicaid generates these substantial benefits at no cost to the state.

[26] Ward and Bridge (2018); Ward and Bridge (2019); Ward (2021); Guth et al. (2020); Ayanian, J. Z., Ehrlich, G. M., Grimes, D. R., & Levy, H. (2017). Economic effects of Medicaid expansion in Michigan. *Obstetrical & Gynecological Survey*, *72*(6), 326-328; Levy, H., Ayanian, J. Z., Buchmueller, T. C., Grimes, D. R., & Ehrlich, G. (2020). Macroeconomic Feedback Effects of Medicaid Expansion: Evidence from Michigan. *Journal of health politics, policy and law*, *45*(1), 5-48; Richardson, J. A., Llorens, J. J., & Heidelberg, R. L. (2018). Medicaid Expansion and the Louisiana Economy. *Public Administration Institute at Louisiana State University, prepared for the Louisiana Department of Health*.

[27] Calculated using the IMPLAN model assuming 50 percent of total spending is new healthcare spending and 25 percent of total spending is transferred to households as reduced healthcare spending. Slightly different allocations or allocating slightly different proportions to different parts of the healthcare sector yields slightly different results.

Medicaid expansion is not free. The state must weigh the value of these effects against expansion's costs. The two most discussed potential costs of expanding Medicaid are (1) job loss (some people who would otherwise participate in the labor force drop out or work fewer hours once they qualify for Medicaid coverage) and (2) fiscal cost (states must pay 10 percent of expansion's costs which may require states to cut spending on other programs or raise taxes). However, the evidence suggests that these costs are minimal.

a. Medicaid expansion does not reduce economic capacity by reducing labor force participation.

Labor force participation among Montanans aged 19-64 increased slightly since expansion. During 2011-2015, 81 percent of Montanan's 19-64 participated in the labor force. During 2022-2023, 83 percent of Montanans 19-64 participated in the labor force. This change is nearly identical to the shift in non-expansion states.

I provide more information about employment among the adult Medicaid population in Section 13 below.

b. Medicaid expansion does not impose a fiscal cost on the state. In fact, it is likely a fiscal benefit.

By statute, the state must pay for 10 percent of expansion's costs; however, the actual share paid in Montana is only nine percent because the federal government pays for 100 percent of Medicaid expansion costs for care provided in or through Indian Health Service or tribal facilities. However, given the state must also pay for a share of expansion's administrative costs, total costs, including administration, equal approximately 10 percent.[28]

As discussed above, spending and enrollment in the near future are uncertain. Budget projections assume state spending of approximately $100 million per year based on recent spending levels; however, state spending may fall to $70-$75 million given lower enrollment (and thus likely lower spending).

However, this "sticker price" does not reflect the cost of Medicaid expansion to the state budget. To understand the effect of Medicaid expansion on the state budget, one needs to account for the impact of expansion on state spending outside expansion and its impact on state revenues. Medicaid expansion has significant effects on both. Medicaid expansion allows the state to cut spending in some areas, and increased economic activity attributable to Medicaid expansion boosts state revenues. These effects likely more than offset the state's share of expansion costs.[29]

[28] Analysis from a forthcoming report on Medicaid expansion's fiscal impacts.
[29] For a more detailed discussion of these effects, see Ward, B. (2020). The Impact of Medicaid Expansion on States' Budgets. https://www.commonwealthfund.org/sites/default/files/2020-05/Ward_impact_Medicaid_expansion_state_budgets_ib_final.pdf; Gruber, J., & Sommers, B. D. (2020). *Fiscal*

Medicaid expansion creates two types of state budget savings. First, it allows states to reduce spending in other parts of their Medicaid programs. Second, it lets states cut spending outside of Medicaid, particularly on state-funded health services for the uninsured.

Savings within Medicaid are substantial. In 2023, total (expansion plus traditional) inflation-adjusted state Medicaid spending per capita was *lower* than in 2015. Thus, although the state provided Medicaid to approximately 100,000 more adults (plus an additional 10,000 children and maybe 1,000 or 2,000 adults over age 64), state Medicaid costs fell. While some of the reductions reflect the enhanced FMAP provided during the public health emergency or improved economic conditions that may have depressed enrollment, a substantial proportion is attributable to Medicaid expansion. In 2019, before the change to the FMAP during the public health emergency, total inflation-adjusted state Medicaid spending per capita (not including administration) was only 2.9 percent (or approximately $14 million) higher than in 2015.

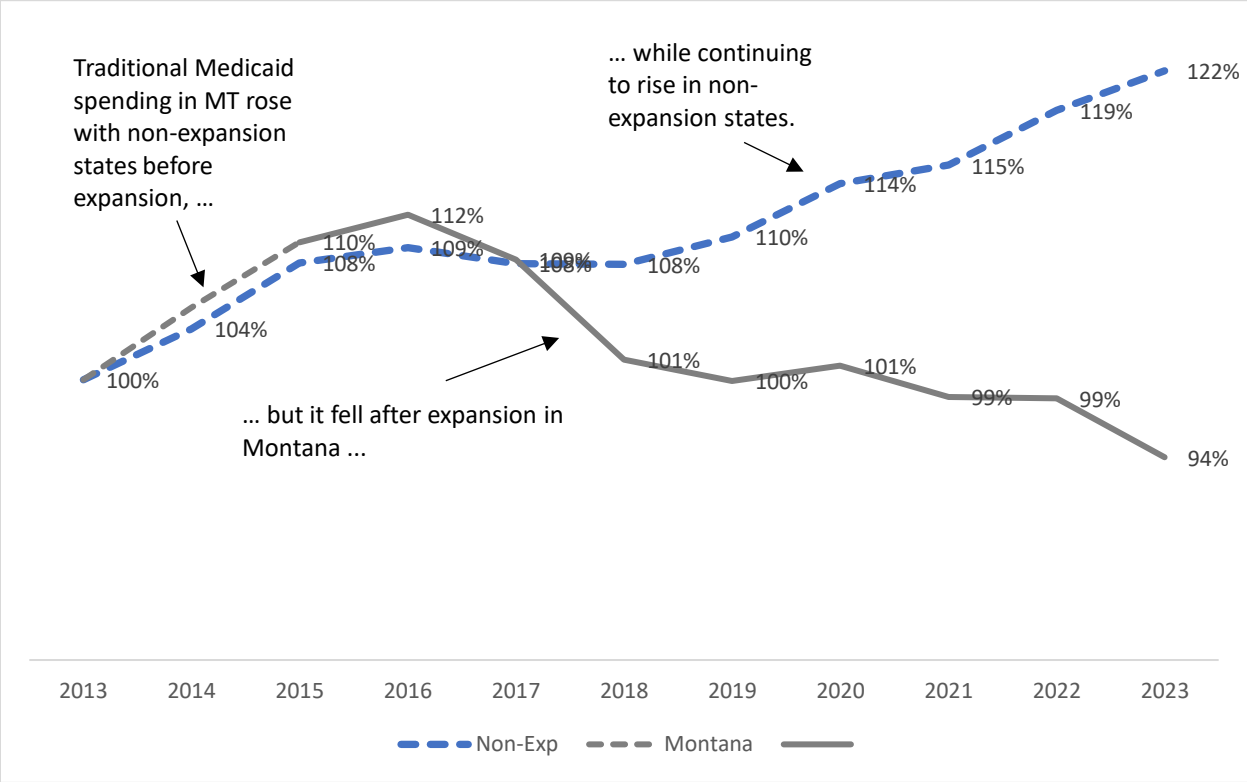
Figure 4 illustrates the impact of Medicaid expansion on traditional Medicaid spending. Prior to Medicaid expansion, total inflation-adjusted traditional Medicaid spending in Montana rose slightly faster than in non-expansion states. However, after expansion, it fell substantially even though traditional Medicaid spending in non-expansion states continued to increase (particularly during the public health emergency). In 2019, total traditional Medicaid spending in Montana was 10-12 percent below what it would have been had Montana continued to follow the trend in non-expansion states, and it was nearly 30 percent below the expected level in 2022. This means that by 2019, state spending on traditional Medicaid was $50 million below expected based on the trend in non-expansion states, and by 2022, it was $75 million below expected. The reduction in spending in these years was sufficient to offset 74 percent of state expansion costs in 2019 and 72 percent of state costs in 2022. While precise estimates change year-to-year, and traditional Medicaid spending in Montana may not have precisely followed the trend in non-expansion states without expansion, these data strongly suggest that savings within traditional Medicaid offset a substantial proportion of the state's share of expansion costs. The savings observed in Montana are not unusual; states that expand Medicaid typically experience similar declines in traditional Medicaid costs.

These estimates suggest more savings than found by the Legislative Fiscal Division estimates of expansion's fiscal impact. Based on an analysis by DPHHS that estimates how many expansion enrollees would enroll in traditional Medicaid without expansion and the increase in the state share of costs associated with this shift (from 10 percent to 38 percent), LFD estimates that Medicaid expansion has effectively zero impact on the state

federalism and the budget impacts of the Affordable Care Act's Medicaid expansion (No. w26862). National Bureau of Economic Research.

general fund.[30] Since general fund spending comprises only 36 percent of state Medicaid spending in their analysis, they estimate lower savings as a share of expansion costs; however, their analysis does not capture all of expansion's potential impacts described below.

Figure 4: Inflation-adjusted traditional Medicaid spending per capita trends in Montana and non-expansion states (2013=100).



Note: Analysis of traditional Medicaid spending (total minus expansion) obtained from CMS Financial Management Reports. Note, Montana data contain errors in FY2016 and FY2017. In FY2016, all Medicaid expansion spending in Montana was recorded as going to those not newly eligible. This error was reversed in FY17.

Medicaid expansion reduces traditional Medicaid spending via three main pathways. First, expansion diverts some people who would have enrolled in traditional Medicaid to expansion. Diversion occurs when someone who, at some point, would have qualified and enrolled in traditional Medicaid does not enroll because they already qualified for expansion. The key force allowing diversion is that Medicaid eligibility is not continuously redetermined. Medicaid beneficiaries are classified into expansion or traditional Medicaid based on their characteristics at the time of application, and they are not reassessed until their next formal redetermination process (often a year after enrollment). If, at some point during their enrollment, an expansion beneficiary's conditions change such that they would

[30] https://archive.legmt.gov/content/Publications/fiscal/2027-Biennium/Budget-and-Revenue/Budget-Analysis/Section-B/Section-B-BA-Full-Report-27Bi.pdf

qualify for traditional Medicaid, they do not immediately move to traditional Medicaid. They remain in expansion until their next formal redetermination process. However, without expansion, they likely would have enrolled in traditional Medicaid when they became eligible. As such, some people who would have enrolled in traditional Medicaid without expansion never apply or enroll because they already have Medicaid coverage via expansion.[31]

Second, expansion may reduce the number of people who qualify (and therefore enroll) in traditional Medicaid. Medicaid expansion can shrink the number of people eligible via behavioral change or policy change. Behavioral changes shrink the number of people eligible when people who would have maintained an income below traditional Medicaid thresholds or pursued a disability designation that allowed them access to Medicaid no longer make these choices once expansion is available. Policy changes shrink the number of people eligible for traditional Medicaid when states change or eliminate various Medicaid programs, particularly limited-benefit programs, following expansion.

Third, expansion may make it easier to make other cuts to Medicaid. While Medicaid requires certain benefits, states have a great deal of flexibility over how they implement Medicaid. They can choose to include certain benefits; they can decide how much to reimburse providers, etc. The substantial resources provided by Medicaid expansion may change the political consequences that follow attempts to cut various parts of a state's Medicaid program.

In addition to savings within traditional Medicaid, expansion allows the state to reduce spending elsewhere. For instance, Medicaid expansion directly affects correctional healthcare spending. Before Medicaid expansion, most inmates were not eligible for coverage. However, with expansion, most inmates are eligible for Medicaid. While federal rules historically precluded states from using Medicaid funds to cover healthcare provided at correctional health facilities, Medicaid funds can be used for care provided at offsite facilities.

Medicaid has also recently approved several waivers allowing states to offer Medicaid benefits to individuals 30-90 days before release. Montana was one of the first states to receive such a waiver. As such, the set of inmate healthcare costs states can shift from corrections to Medicaid is expanding. Furthermore, one of the goals of these waivers is to

[31] To further understand this process, consider a person (X) whose income falls over time. At time one, X's income falls below 139 percent of FPL, and the person enrolls in Medicaid expansion. Later, at time two, X's income falls below the 2009 traditional Medicaid eligibility standard at time two. Without expansion, the person would have enrolled in traditional Medicaid at this point. However, since they are already enrolled in expansion, they do not apply for traditional Medicaid. They are not moved to traditional Medicaid because Medicaid eligibility is not continuously redetermined. Thus, in the absence of expansion, person X would have enrolled in traditional Medicaid; however, with expansion, they do not. As a result, the state avoids paying the full traditional Medicaid share for care received by person X during this period.

improve access to healthcare among the formerly incarcerated and reduce recidivism (which, if successful, would further lower state costs).

While the waiver's impacts on state spending are not yet known, the savings from shifting the cost of inmate hospitalizations are substantial and likely offset four to six percent of state expansion costs. These savings align with those observed in other expansion states.[32]

Given the time that has passed since expansion, other savings attributable to expansion are hard to assess. Around the time of expansion, Montana reduced state support for some substance abuse and mental health programs (which offset an additional five to ten percent of costs); however, for these types of discretionary savings, the key question is, "What programs would the state spend more on over the long-run without expansion?" These are hard to determine until various interest groups argue that spending on X needs to increase. However, given how many people have benefited from expansion, it seems likely that many groups would lobby for increased state spending to partially offset any losses from removing expansion.

While there are other potential ripple effects of Medicaid expansion on state spending (e.g., potential increases in SNAP administration costs and decreases in spending on disability programs, including SSI), the net impact of these changes is likely relatively small.

As such, spending reductions attributable to expansion offset roughly 50-90 percent of the state's share expansion costs.

Revenue increases attributable to expansion offset any remaining portion of Montana's expansion costs. Most directly, in 2019, Montana created a state special revenue fund to help offset the cost of expansion as part of the reauthorization of Medicaid expansion under HB 658. This fund is mostly supported by hospital utilization fees ($75 per inpatient day and 0.9 percent of outpatient revenues). In FY2024, this fund covered $57.1 million (or 64 percent) of the state's share of expansion costs.[33]

This is an example of Medicaid expansion changing the political climate and policy choices. Groups that may have lobbied against an increase in hospital fees in the absence of Medicaid expansion accepted the increase in exchange for preserving Medicaid expansion. In this case, these fees were directly negotiated between hospitals and the state to preserve Medicaid expansion. Further consistent with the view that Medicaid expansion changes the political viability of certain taxes or fees, 18 states increased Medicaid spending from similar special taxes or fees by more than 50 percent after expanding Medicaid.

[32] Ward (2020).
[33] https://archive.legmt.gov/content/Publications/fiscal/2027-Biennium/Budget-and-Revenue/Budget-Analysis/Section-B/Section-B-BA-Full-Report-27Bi.pdf

How much of the revenues collected under HB 658 one should attribute to Medicaid expansion depends on what one assumes would have happened without expansion. Ultimately, one needs to answer the question, "Would the state have created this fund and raised this amount of revenues without expansion?" If the answer to this question is "no" or the answer is "it would have created the fund but raised less revenue," then Medicaid expansion is responsible for an increase in state revenues, potentially large enough to fully offset the state's share of expansion costs (regardless of any other savings or revenue impacts).

Beyond the impact on HB 658 revenues, Medicaid expansion may change revenues from other activities directly impacted by expansion. The specific taxes most commonly affected by Medicaid expansion are insurance premium taxes and healthcare utilization fees. All else equal, Medicaid expansion may reduce insurance premium taxes (by reducing premiums paid to private health insurers) but increase healthcare utilization fees (by increasing healthcare use). However, in Montana, insurance premium tax collections did not fall, and, as discussed above, healthcare user fees increased (in large part due to increased rates).

More significantly, as discussed above, Medicaid expansion increases total economic activity. Before large shifts from pandemic-era programs, Medicaid expansion increased inflation-adjusted federal spending in Montana by approximately $500-$750 per person. As discussed above, uncertainty about future spending levels creates uncertainty about the magnitude of these effects going forward; however, as mentioned above, Medicaid expansion likely supports roughly $350-$560 million in personal income. In recent years, Montana's own-source revenues average over 12 percent of personal income, and total taxes equal nearly nine percent of personal income.[34] As such, the increase in income due to expansion may yield $42 to $67 million in additional revenues. Thus, if marginal income attributable to expansion generates state revenues at the average rate, the total increase in own-source revenue combined with the savings and revenue effects outlined above is more than sufficient to cover the state share of expansion's costs.

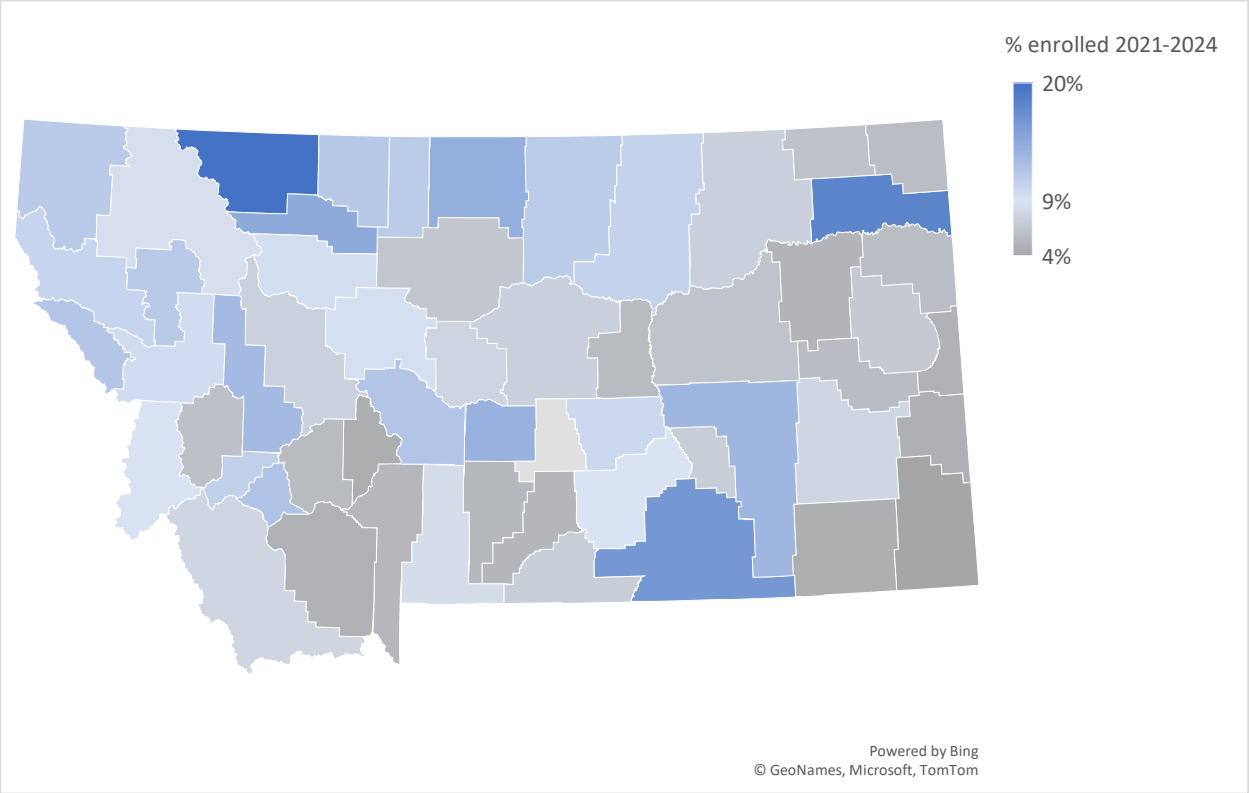
Ultimately, tracking expansion's effects through the state budget is difficult. While some savings and revenue effects can be calculated with reasonable precision, some are more difficult to quantify. However, the information available suggests that Medicaid expansion generates budget savings and increased revenues sufficient to offset the state's share of expansion costs. Consistent with this conclusion, a recent study of the fiscal effects of expansion found that total state spending does not significantly increase in response to expansion, and spending in other areas of the budget (e.g., transportation, education) does not fall.[35] This is what we would expect if Medicaid expansion does not require states to raise taxes or cut spending to afford expansion.

[34] Rates from 2019, 2021 obtained from: US Census Bureau Annual Survey of State and Local Government Finances, 1977-2021 (compiled by the Urban Institute via State and Local Finance Data: Exploring the Census of Governments; accessed 7-Dec-2024), https://state-local-finance-data.taxpolicycenter.org.
[35] Gruber and Sommers (2020).

9. Medicaid expansion's effects extend across the state.

Medicaid expansion enrollment is not uniformly distributed across the state. Figure 5 shows the share of county population enrolled in Medicaid expansion.[36] Darker gray counties are well below the statewide share. Lighter counties are close to the statewide share. Darker blue counties are well above the statewide share. At the high end, Medicaid expansion covers 20 percent of the total county population, but at the low end, expansion covers only four percent of county population.

Figure 5: Average share of total population covered by Medicaid expansion during October 2021-August 2024



Notes: Medicaid expansion enrollment during October 2021-August 2024. Total county population as of July 1 in 2021, 2022, and 2023. Population for 2024 assumed equal to 2023.

With changing insurance coverage and declining un-insurance, the same sequence of events described above is unleashed at the local level. Residents consume more healthcare. Households have more money to spend. This creates more jobs, particularly in the local healthcare sector, but also elsewhere in the economy. While results are not exactly proportional to enrollment due to the fact healthcare provider availability is not uniformly distributed across counties. Impacts are largest in Montana's healthcare centers; however,

[36] Enrollment data from Sept. 2022 was obtained from DPHHS's Medicaid Expansion Enrollment Dashboard. County population obtained from Census population estimates for July 1, 2021.

many counties have some healthcare providers and a significant portion of Medicaid spending remains in these counties.

10. Medicaid expansion affects a wide variety of Montanans.

The discussion above describes the impacts of Medicaid expansion, but it includes relatively little information about the primary beneficiaries of Medicaid expansion—enrollees. Medicaid expansion provides health insurance coverage to many different types of Montanans. While data sources do not separate people enrolled in expansion from those enrolled in traditional Medicaid, among Montanans ages 19-64 who report no SSI or SSDI income (and thus those who are unlikely to receive Medicaid via a disability pathway), Medicaid provides health insurance to:

- 16 percent of Montana's post-secondary students (approx. 9,000 students);
- 13 percent of Montana's workers (approx. 62,000 workers);
- 10 percent of Montana's veterans (approx. 4,000 veterans);
- 20 percent of Montana's caregivers (people with children or disabled adults in their households) (approx. 55,000 caregivers);
- 31 percent of Montanan's report some form of disability or impairment (approx. 17,000 people with disabilities);
- 30 percent of Montana's American Indian population (approx. 19,000 American Indians).

11. Most Medicaid expansion beneficiaries work, and those who do not have caregiving responsibilities or disabilities.

Figure 6 describes the allocation of Montana's adult Medicaid beneficiaries (excluding those residing in institutions, those who report SSI income, and those who report both Social Security and Medicare) across several key categories.[37] Averaging across 2019-2023 (but excluding 2020 because of its short-lived impacts on employment), 72 percent of this population was in the labor force when they completed the survey (the blue rectangles). Forty percent worked full-time. Eighteen percent worked part-time, and 6.5 percent actively look for work (unemployed). Seven percent were students.

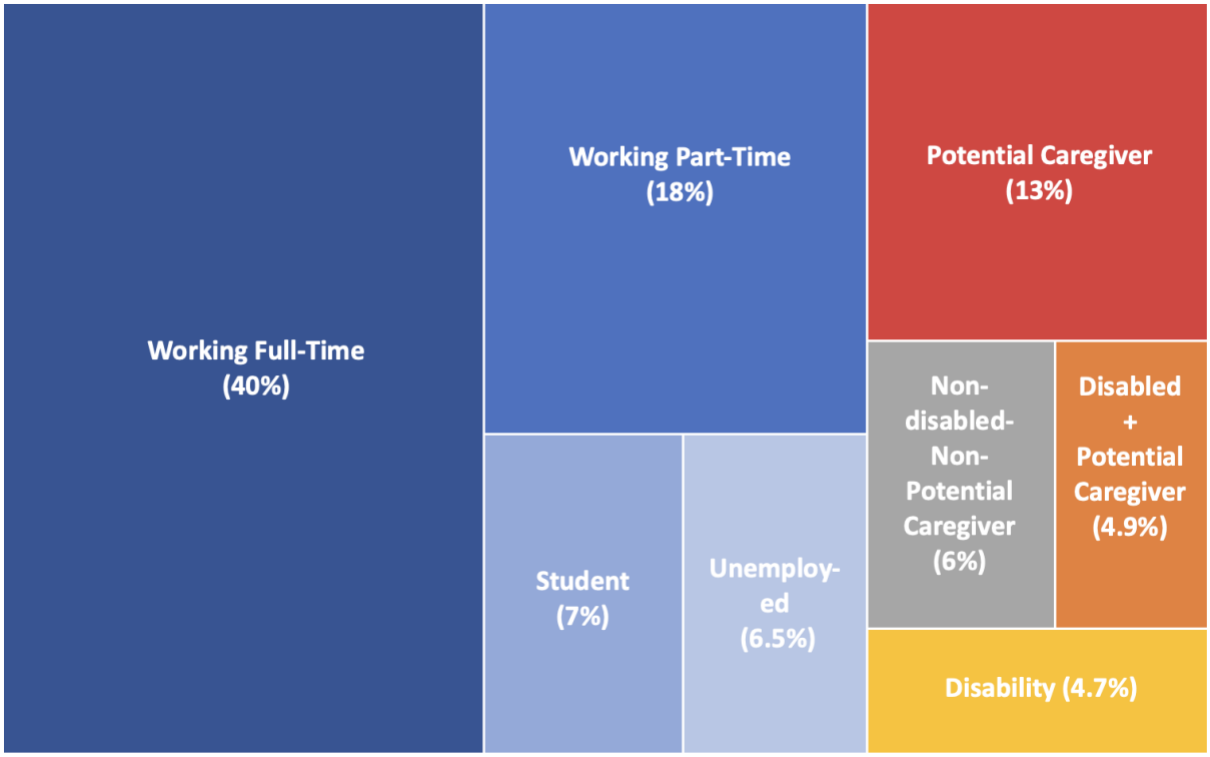
Among those not working, most (79 percent) report some degree of disability or some type of potential caregiving responsibility (e.g., they live with someone under 18 or with an adult who reports some degree of disability). Thus, only six percent are not in the labor force, disabled, or potential caregivers.

The findings above slightly understate labor force attachment for potential Medicaid expansion beneficiaries. First, among those not currently in the labor force, 20 percent had worked within the last year. As such, 77 percent of the included Medicaid beneficiaries

[37] While those institutionalized (e.g., prison inmates) may qualify for Medicaid expansion, their employment outcomes are not relevant for understanding the relationships between Medicaid and work.

were in the labor force or had worked at some point within the previous year. Furthermore, if one uses some simple assumptions to adjust for the downward bias from including non-Medicaid expansion beneficiaries in this analysis, 81 percent of likely expansion beneficiaries were currently in the labor force or had worked at some point within the last year.[38]

Figure 6: Employment, caregiving, and disability among Montana adult Medicaid beneficiaries



Notes: Analysis of American Community Survey microdata obtained from IPUMS-USA. Population includes all Montana adults (19-64) with Medicaid coverage who are non-institutionalized and who do not report SSI income or SS income and Medicare coverage from year 2019, 2021-2023.

12. Most working adult Medicaid beneficiaries are disproportionately concentrated in a certain occupations and industries. These occupation and industries tend to have low wages, irregular (or limited) hours, and a high degree of seasonality.

While adult Medicaid beneficiaries can be found across occupations and industries, they are disproportionately concentrated in a few. Table 1 shows the industries with the highest concentration of adult Medicaid beneficiaries. The first column shows the share of all

[38] Roughly 30 percent of the included population may have qualified for traditional Medicaid without expansion (although there's an additional degree of complexity created by the fact that some people who would have enrolled in traditional Medicaid without expansion enroll in expansion instead, so the line between these populations is not always clear). This population has much lower labor force participation, etc. Given that the combined adult Medicaid outcome is a weighted average of this population and the expansion population, I infer expansion outcomes by removing the portion of the weighted average in the traditional population, assuming outcomes remained at their pre-expansion level.

included adult Medicaid beneficiaries in each industry. E.g., 16.8 percent of non-institutionalized, non-SSI/SSDI labor force participants ages 19-64 who report Medicaid coverage are employed the arts, entertainment, and recreation industry. The second column shows that share of all adult labor force participants in each industry (e.g., 7.8 percent of adults work in arts, entertainment, and recreation). The third column is the ratio of the first two columns. A number higher than one means that Medicaid beneficiaries are more concentrated in this industry. The table includes all industries where the ratio is greater than one. Finally, the fourth column shows the percent of all adults in the industry who report Medicaid. E.g., 25 percent of the included adults who work in arts, entertainment, or recreation report Medicaid coverage. The final two columns show average annual hours worked and median weekly wages for all workers in each industry.

Importantly, these industries include five of the eight industries with the fewest average hours worked among all adult workers and six of the eight industries with the lowest average weekly wages.

Table 1: Industries with disproportionately high shares of workers covered by Medicaid

	Percent of adult Medicaid beneficiaries in industry	Percent of all adults in industry	Ratio	Percent of industry adults with Medicaid	Average hours worked per year for all adults	Median weekly wage
Arts, Entertainment, Recreation	17%	8%	2.14	25%	1,561	$523
Accommodation and Food Service	4%	3%	1.47	18%	1,659	$454
Admin Support and Waste Mgt	5%	3%	1.42	17%	1,733	$1033
Ag, Forestry, Fishing	6%	5%	1.39	16%	2,375	$918
Retail Trade	13%	11%	1.26	15%	1,792	$775
Other Services	5%	5%	1.08	13%	1,875	$812

Notes: Columns 1-5 based on analysis of ACS data for 2016-2023. All analyses include adults 19-64 who do not report SSI or SS + Medicare and who are non-institutionalized. The final column is based on 2024q2 QCEW data.

Table 2 presents the same information for high-level occupation categories. Again, Medicaid receipt is disproportionately concentrated in occupations where all workers (regardless of Medicaid receipt) tend to work fewer hours per year and earn lower wages.

Table 2: Occupation categories with disproportionately high shares of workers covered by Medicaid

	Percent of adult Medicaid beneficiaries in occ.	Percent of all adults in occ.	Ratio	Percent of all adults in occ. with Medicaid	Average hours worked per year by all adults in occ.	Median hourly wage for occ.
Food Prep and Serving	13%	6%	2.15	26%	1,448	13.59
Personal Care and Service	6%	3%	1.88	22%	1,536	14.98
Farming, Fishing, and Forestry	3%	2%	1.87	22%	2,205	19.46
Healthcare Support	5%	3%	1.82	22%	1,627	17.51
Building and Grounds Maintenance	6%	4%	1.65	20%	1,573	17.25
Transportation and Material Moving	8%	6%	1.21	14%	1,896	20.31
Sales and Related	10%	9%	1.08	13%	1,909	17.56
Production	4%	4%	1.03	12%	1,990	21.5

Notes: Columns 1-5 based on analysis of ACS data for 2016-2023. All analyses include adults 19-64 who do not report SSI or SS + Medicare and who are non-institutionalized. The final column is based on 2023 OEWS.

Moving to more specific occupations, most adult Medicaid beneficiaries work in only a small number of specific occupations. The top 20 occupations listed in Table 3 comprise 43 percent of all included working adult Medicaid beneficiaries, and substantial minorities of the adults working these occupations report Medicaid coverage. For instance, cooks comprise 4.3 percent of working adult Medicaid beneficiaries, and 32 percent of all adult cooks in Montana report Medicaid coverage. Median hourly wages in these occupations are relatively low. Among those with available data, nearly half have median hourly wages below $15/hour (in 2023). Similarly, average annual hours worked among all adult workers reporting these occupations were also low (with most working less than full-time, full-year (2000+ hours) on average).

Table 3: 20 occupations comprising the largest shares of adult Medicaid beneficiaries

	Percent of adult Medicaid beneficiaries in occupation	Percent of all adults in occupation	Average annual hours	Median hourly wage
Cooks	4.3%	32%	1,463	
Cashiers	3.7%	31%	1,301	14.12
Waiters and Waitresses	3.1%	26%	1,047	10.99
Retail Salespersons	2.6%	17%	1,533	16.18
Maids and Housekeepers	2.6%	32%	1,184	15.65
Laborers (freight and stock movers)	2.4%	23%	1,515	18.02
Misc. Ag. Workers	2.3%	25%	2,018	
Construction laborers	2.3%	20%	1,642	22.88
Janitors and Building Cleaners	2.2%	18%	1,415	17.55
Personal Care Aides	2.1%	39%	1,384	14.78
Farmers, Ranchers, and Other Ag. Managers	1.9%	14%	2,572	
Driver/Sales Workers and Truck Drivers	1.8%	11%	1,965	13.19
Nursing Assistants	1.7%	28%	1,405	18.25
Food Preparation Workers	1.6%	32%	976	14.21
Customer Service Representatives	1.6%	14%	1,522	18.99
Childcare Workers	1.5%	25%	1,028	13.99
Carpenters	1.3%	15%	1,858	24.2
Other Managers	1.3%	9%	1,952	
Dishwashers	1.3%	43%	766	12.63
Stockers and Order Fillers	1.3%	24%	1,364	17.9

Notes: Columns 1-3 based on analysis of ACS data for 2016-2023. All analyses include adults 19-64 who do not report SSI or SS + Medicare and who are non-institutionalized. The final column is based on 2023 OEWS.

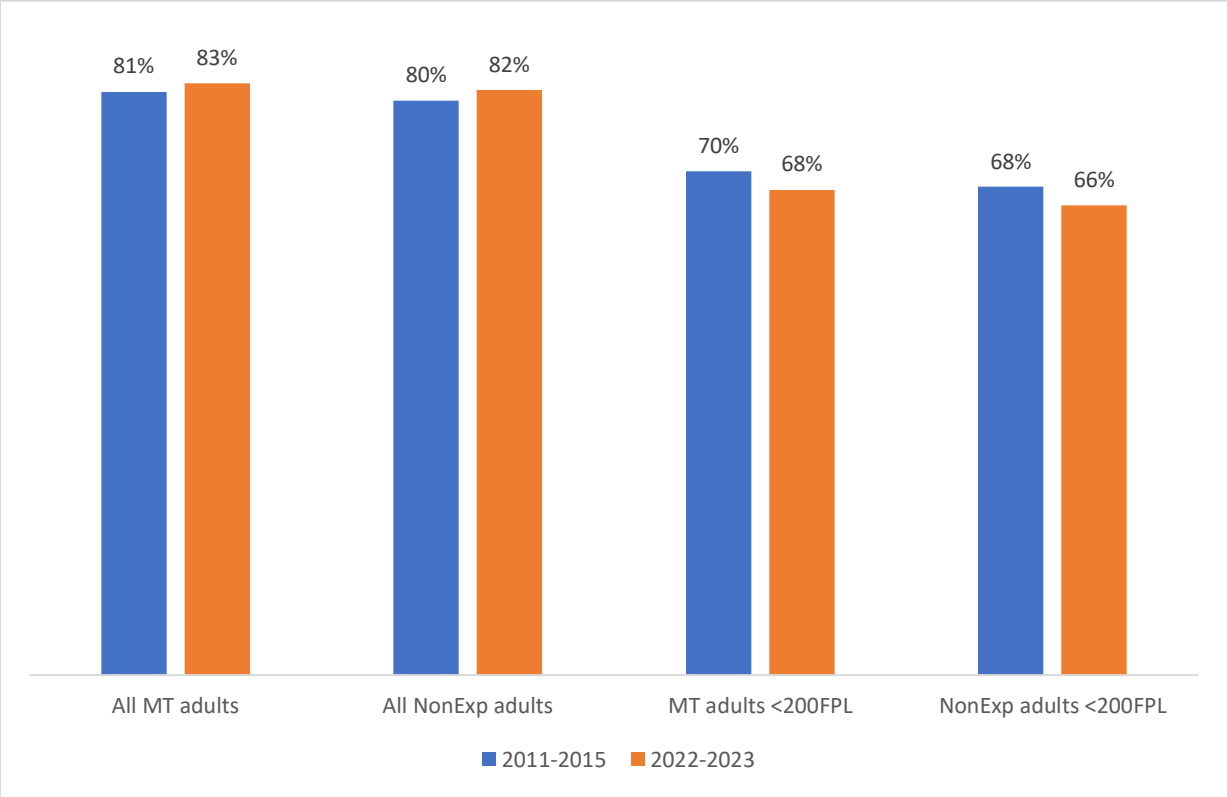
These results help answer a natural question often asked of public assistance recipients, "How do adults end up with income low enough to qualify for Medicaid coverage?" Generally, they have impediments to work like caregiving responsibilities or physical

impairments, or they work in jobs that offer fairly low wages or irregular (often seasonal) hours.[39]

13. Medicaid expansion has not reduced adult labor force participation in Montana.

Since expanding Medicaid, overall adult labor force participation increased in Montana, and the change is almost exactly aligned with the change observed in non-expansion states. This is not consistent with what one would expect if Medicaid expansion was adversely affecting labor force participation.

Figure 7: Labor force participation in Montana and non-expansion states before and after expansion



Notes: Analysis of American Community Survey microdata obtained from IPUMS-USA for 2011-2023. All analyses include adults 19-64 who do not report SSI or SS + Medicare and who are non-institutionalized.

While low-income labor force participation fell in Montana, it also fell in non-expansion states at basically the same rate. The decline in low-income labor force participation is the counter-intuitive result of rising income. When income rises, fewer people are low income (have income less than 200 percent of FPL). Those remaining in the low-income group are

[39] Additional information about how people end qualifying for income-based public assistance, including Medicaid in Montana see Bryce Ward (2024). Supporting our Neighbors: Understanding Who Receives Public Assistance in Montana, For How Long, and Why? *Headwaters Foundation.*

those with more barriers to employment, so labor force participation among the low-income falls as incomes rise.

Conclusion

In sum, Medicaid expansion continues to generate significant benefits for Montana and Montana's economy at minimal marginal cost to the state. Medicaid expansion boosts healthcare access, health outcomes, and household financial health, creates a more robust healthcare sector in Montana and supports thousands of jobs and millions in income across the state without depressing labor force participation or burdening the state budget. These benefits are spread around the state, although the uneven distributions of enrollment and healthcare provision mean these impacts are unevenly distributed. The benefits of Medicaid expansion also accrue to a wide variety of different types of households. Medicaid beneficiaries are not drawn from a narrow swath of the population. Most beneficiaries work, but many face various impediments to greater earnings.