Economic Effects of Medicaid Expansion on Montana's Native Americans and Tribal Communities

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Acknowledgements

This research was supported by the Montana Healthcare Foundation. ABMJ Consulting is solely responsible for the statements and conclusions in this report.

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Summary

Medicaid expansion significantly impacts Montana's Native American population and its tribal communities. Without Medicaid expansion, nearly half of Montana's Native American adult population (ages 19-64) would be uninsured. While many uninsured Native Americans can access some healthcare via the Indian Health Service (IHS) or other tribal healthcare providers, budget constraints, eligibility rules, and distance limit access to care. With Medicaid expansion, uninsurance rates are cut in half and access to care improves throughout tribal communities because fewer people are uninsured, IHS/tribal healthcare budgets stretch further, and providers expand service offerings.

With better insurance and better access to care, Native American outcomes have improved. Since expansion, more Montana Native Americans report being in good health, more Native American adults are employed, and the share of households with medical debt in majority Native zip codes fell substantially.

Medicaid expansion also adds millions of dollars to tribal communities. For some tribal communities the additional resources are equal to several percent of county GDP. Adding money to an economy increases economic activity, creating opportunities for all residents. Consistent with Medicaid expansion generating substantial economic impacts, unemployment rates in reservation counties have plummeted since expansion (by 3.1 percentage points on average).

Importantly, providing Medicaid expansion (and its associated benefits) to Native Americans imposes no cost on the state budget. Approximately half of Native Medicaid expansion spending is provided at or through IHS or other tribal facilities. The federal government provides 100 percent reimbursement for these costs. While the state must pay 10 percent of the costs for the remaining half, spending reductions or revenue increases attributable to Medicaid expansion more than offset these costs.

The rest of this report describes these findings in more detail. A companion report describes the economic effects of Medicaid expansion on Montana more generally.[1]

1. Medicaid expansion substantially reduces uninsurance for Montana's Native Americans.

To understand Medicaid expansion's effects, one must understand what would exist without it. Medicaid expansion fundamentally changes insurance coverage. How much expansion will change healthcare use, physical health, household financial health, the healthcare system, state budgets, etc., depends on how it changes health insurance. For expansion beneficiaries who would be uninsured without expansion, expansion will significantly impact healthcare use, household financial health, the healthcare sector, etc.

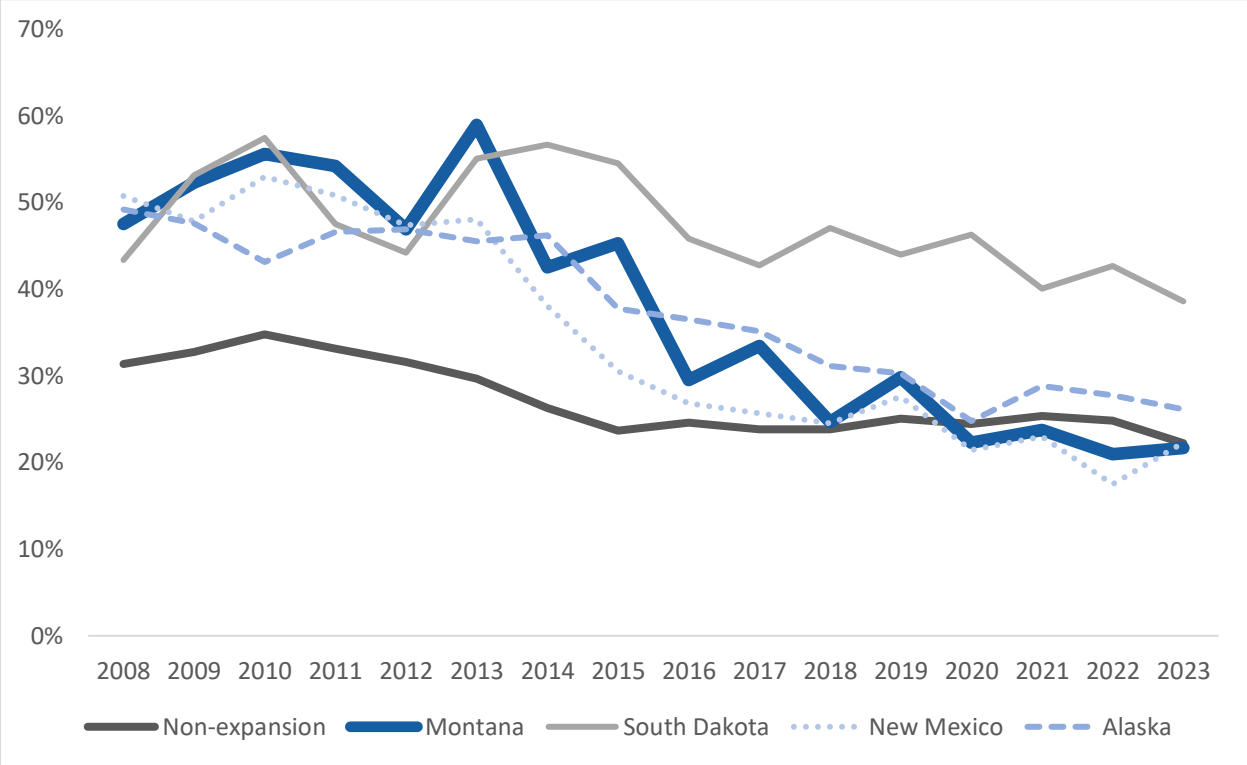
[1] Ward, B. (2025). Economic Effects of Medicaid Expansion in Montana: 2025 Update. https://mthf.org/wp-content/uploads/2025-MedEx-Economic-Impacts_FINAL.pdf

However, for expansion beneficiaries who would have enrolled in traditional Medicaid without expansion, expansion's impacts will be much smaller (although the effect of expansion on the state budget will be large because the state pays a much lower share of expansion costs). The impacts for people who would enroll in private health insurance without expansion likely fall somewhere in between (modest impacts on healthcare use, but costs shift from private payors to the government).

Thus, understanding the impact of Medicaid expansion on Montana's Native Americans starts by understanding what types of insurance this population would have without expansion.

Figure 1 shows the uninsurance rate for Montana's Native American adults (ages 19-64). Before Medicaid expansion, nearly half of Montana's Native American adults (19-64) were uninsured. After expansion, uninsurance rates declined to a bit above 20 percent (dark blue line). For context, the uninsurance rate for non-Native American Montana adults pre-expansion was only 20 percent (and declined to roughly 10 percent after expansion).

Figure 1: Share of Native American adults (19-64) uninsured, 2008-2023



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

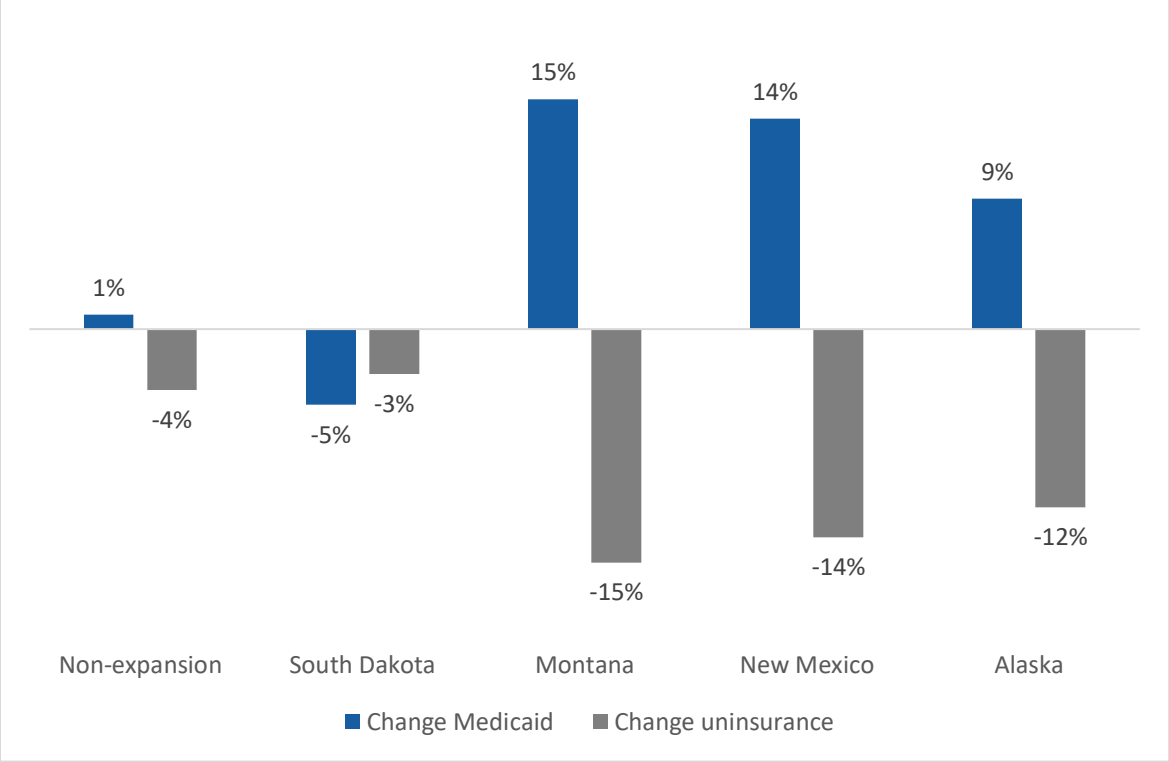
A natural question is whether Medicaid expansion caused this decline. Figure 1 includes other lines to help show that expansion caused most of these changes. First, the light blue lines show the trend in two other expansion states with large American Indian/Alaska Native (AIAN) concentrations and pre-Affordable Care Act (ACA) uninsurance rates comparable to Montana (Alaska and New Mexico). Like in Montana, uninsurance in these

states fell substantially after expansion. Second, the gray lines show the trend in uninsurance for Native Americans in all non-expansion states and a particular non-expansion state, South Dakota (which also had a high AIAN concentration and a high Native American uninsurance rate pre-ACA). While uninsurance rates fall slightly in the non-expansion states, the declines are much smaller than in the expansion states. If one assumes that the trends in the non-expansion states describe what would have happened in Montana without expansion, then most of the decline in Native American adult uninsurance in Montana is attributable to Medicaid expansion.

Medicaid expansion in Montana led to almost no change in private health insurance coverage among Native Americans. As such, without Medicaid expansion, most Native Americans enrolled in Medicaid expansion would be uninsured, although small portion likely would have enrolled in Medicaid via a traditional pathway.

It is important to note that Medicaid expansion has spillover effects on insurance coverage for other Native Americans. In particular, Medicaid expansion reduces uninsurance among Native American children. Figure 2 shows the change in Medicaid enrollment and uninsurance for Native American children in the same states as Figure 1. In the expansion states, uninsurance declined, and Medicaid coverage rose. Similar changes did not occur in the non-expansion states. These changes likely reflect the fact that adults who enroll in Medicaid are more likely to enroll their eligible children.

Figure 2: Change in Medicaid coverage and uninsurance among Native American kids pre- and post-Medicaid Expansion



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

While enrollment levels change over time, the analyses above suggest that approximately 13,000-18,000 Montana Native American adults and children would be uninsured without Medicaid expansion. As such, the main effects of Medicaid expansion on Montana's Native Americans and its tribal communities stem from providing Medicaid to people who would otherwise be uninsured.

2. Providing Medicaid to otherwise uninsured Native Americans significantly changes healthcare access and the source of healthcare spending.

To comprehend Medicaid expansion's potential effects on healthcare access, healthcare use, health outcomes, etc., one needs to understand uninsured Native Americans access to care without it. Without expansion, uninsured Native Americans still need healthcare. When they need care, they have a few options. First, some are eligible for care provided through the federal government's IHS or by a tribal government provider. Eligibility may be restricted to enrolled tribal members living on or near tribal land (although there are various exceptions). If eligible, an uninsured Native American may access care through these providers if:

- The service is provided via direct care at the IHS or tribal facility;
- The service is available via direct care within a reasonable period (i.e., the wait time is not too long);
- The service is available via an offsite provider through the IHS' Purchase/Referred Care budget (or a similar tribal program), and the funds are available to pay for it (which was often not the case prior to Medicaid expansion);
- The person can travel to the site where they are eligible to receive care.
- The person can afford any co-pay or deductible (including for any associated prescriptions).

If any of these conditions are not met or if the person is not eligible for IHS (or healthcare provided by the tribe), then they can only access care to the extent they can pay out-of-pocket or access some other program to help offset the cost of care.

With Medicaid expansion, healthcare access becomes much easier. The person only needs to travel to a provider with appointments available to people on Medicaid.

Thus, providing insurance to the otherwise uninsured via Medicaid expansion has two main effects. First, people substantially increase healthcare use. Second, those who paid for the cost of the care received without Medicaid expansion can devote those resources to other uses. These changes have important impacts for the whole community, not only those enrolled in Medicaid.

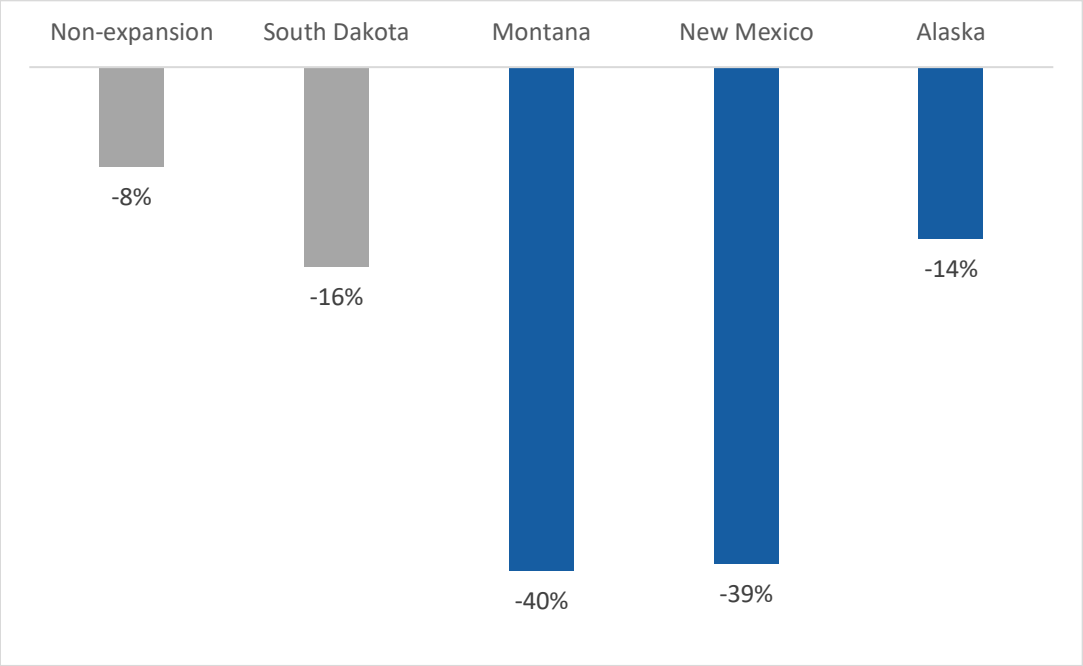
a. Shifting uninsured Native Americans to Medicaid leads to substantial increases in healthcare use.

While I do not have Montana-specific data that tracks healthcare use for the same people as they change health insurance coverage, the Medical Expenditure Panel Survey (MEPS) provides this information for a nationally representative sample.[2] In these data, moving someone from uninsured to Medicaid is associated with a 50 percent increase in office visits or prescriptions filled and 10-20 percent increases in outpatient visits, dental visits, or hospital discharges. In total, reported healthcare expenditures roughly triple when someone moves from uninsured to Medicaid.[3]

While the MEPS includes only a small sample of Native Americans who move from uninsured to Medicaid, the data suggest that Medicaid coverage has even larger impacts on healthcare use for Native Americans (office visits double, hospitalizations increase by 25-30 percent, expenditures quadruple).

Consistent with these national patterns, the share of Montana's Native Americans who report skipping care due to cost fell by 40 percent after Medicaid expansion. The change in the same measure in non-expansion states was much smaller. Also, consistent with the findings based on the MEPS data, Medicaid expansion increased total healthcare use in Montana. For instance, total hospital visits and discharges in Montana increased by 10-15 percent more than in non-expansion states.

Figure 3: Percent change in share of low-income Native American adults reporting they skipped care due to cost after expansion



Notes: Analysis of Behavior Risk Factor Surveillance System (BRFSS).

[2] Data obtained from *Lynn A. Blewett, Julia A. Rivera Drew, Daniel Backman, Annie Chen, Grace Cooper, Megan Schouweiler, and Stephanie Richards. IPUMS Health Surveys: Medical Expenditure Panel Survey, Version 2.4 [dataset]. Minneapolis, MN: IPUMS, 2024. https://doi.org/10.18128/D071.V2.4*

[3] Results from regression analyses with individual fixed effects for adults aged 19-64, excluding potential disabled, who are uninsured or on Medicaid, with controls for health status and income relative to poverty.

In interviews with tribal health leaders, they also confirmed that Medicaid expansion transformed Native Americans' access to healthcare. Across these interviews, leaders consistently noted substantial changes in access to:

- Specialty care that was previously unavailable due to budget constraints;
- Mental health and substance use disorder treatment;
- Prescription medications (they reported that many Natives would not refill prescriptions due to cost sharing requirements); and
- Dental care.

b. Shifting uninsured Native Americans to Medicaid gives them more money to spend on other priorities. It also allows the Indian Health Service to provide more comprehensive care to other IHS-eligible Native Americans.

Montana's Native Americans who would be uninsured without expansion still would have used some healthcare. They (or other entities) would have absorbed the cost of this care. With expansion, these funds are free to support other priorities.

Table 1 breaks down the sources of payment for care provided to people without insurance using the MEPS data. One column shows payment sources for uninsured Native Americans. The other shows payment sources for low-income Americans. Among uninsured Native Americans, approximately half of health care expenses are paid out-of-pocket or by "other federal programs" (which is mainly IHS). Many other listed sources are state and local programs (e.g., indigent care programs) that do not exist in Montana at the levels typical in other states. As such, self-pay and IHS likely comprise a larger share of uninsured Native American medical spending in Montana.

Table 1: Share of total health expenditures by source for uninsured adults (19-64) in US.

	Native Americans	All low-income
Other Federal Program (includes IHS)	31%	2%
Public insurance	22%	10%
Self	19%	30%
Unclassified	18%	28%
VA	4%	4%
Private insurance	3%	13%
Other State/Local Program	2%	12%
Workers Comp	1%	2%

Note: Analysis of MEPS data. Total expenditures do not include uncompensated care. Native Americans includes 2012-2022. All low-income includes 2014-2022

Shifting people from uninsured to Medicaid means these various entities have more resources to devote to other priorities. Specifically, for Montana's Native Americans, this

means families and IHS (and other tribal providers) have more money to spend on other needs.

Allowing IHS and tribal providers to stretch their budgets further has important spillover effects on Native Americans access to healthcare. These providers face budget constraints. Usually, IHS-eligible Native Americans need more care than the IHS budget can support. As such, before Medicaid expansion, IHS had to ration care.

For instance, IHS care delivered outside an IHS facility is known as "purchase/referred care" (PRC). Before expansion, PRC was only available for level I (life and limb) care, and even then, people needing this level of care may not have received it because funds may run out before the end of the year. However, since expansion, PRC has typically been available for care levels I through IV (emergencies, preventative care, treatment of prevalent conditions, and elective procedures). As such, Medicaid expansion directly improves healthcare access for Native Americans not enrolled in Medicaid.[4]

Table 2: Indian Health Service PRC Level Referral Priorities

	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024
Blackfeet	I	III	III	IV	IV	IV	IV	IV	IV	IV
Crow	I	III	IV	IV	IV	IV	IV	II	IV	II
Fort Belknap	I	III	III	IV	IV	IV	IV	IV	IV	III
Fort Peck	I	III	III	IV	IV	IV	IV	IV	IV	IV
Northern Cheyenne	I	IV	IV	IV	IV	IV	IV	IV	IV	III
Little Shell						III	III	III	III	IV

3. Better access to healthcare may have improved Native American health outcomes in Montana.

Assessing the impact of Medicaid expansion on Native American health outcomes in Montana is tricky. Montana's entire Native American population is relatively small (130,000 people). As such, survey-based estimates for Native American outcomes in Montana have large margins of error which makes it hard to reliably detect changes caused by expansion.

Furthermore, Medicaid expansion only changed healthcare access for a portion of Montana's Native American population. As such, if one examines aggregate measures for Native American outcomes, it is hard to detect expansion's effects because they are diluted

[4] The most recent Medicaid in Montana report includes additional information about Medicaid expansions impact on PRC and Native Americans' access to healthcare on pp. 35-38. https://mthf.org/wp-content/uploads/2025-Medicaid-in-Montana-Annual-Report_FINAL.pdf

(changes from expansion are mixed with changes (or the lack thereof) in the rest of the population).

However, despite these limitations, some evidence suggests that Medicaid expansion may have improved health outcomes among Montana's Native Americans. For instance, Table 3 shows the change in the share of Native Americans who describe their overall health as fair or poor. Before Medicaid expansion in Montana, nearly 28 percent of Native Americans reported only fair or poor health. After expansion, this fell to slightly less than 26 percent.[5] In other states with high concentrations of Native Americans that had not expanded Medicaid before 2020 (South Dakota and Oklahoma), health status worsened slightly.

Table 3: Share of Native Americans who describe their health as only fair/poor

	2011-2015	2016-2019	Change
MT	27.9%	25.8%	-2.1%
SD/OK	22.8%	26.5%	3.8%
Other non-expansion	29.0%	28.4%	-0.6%

Note: Analysis of BRFSS data.

Native American mortality rates also improved in counties where Native Americans comprise at least 20 percent of the population.[6] Relative to 2015, in 2019, the age-standardized mortality rate for AIAN in Montana's high AIAN counties fell by 1.4 percent on average. In contrast, mortality rates in high AIAN counties in non-expansion states (almost all of which are in South Dakota or Oklahoma) increased slightly on average.

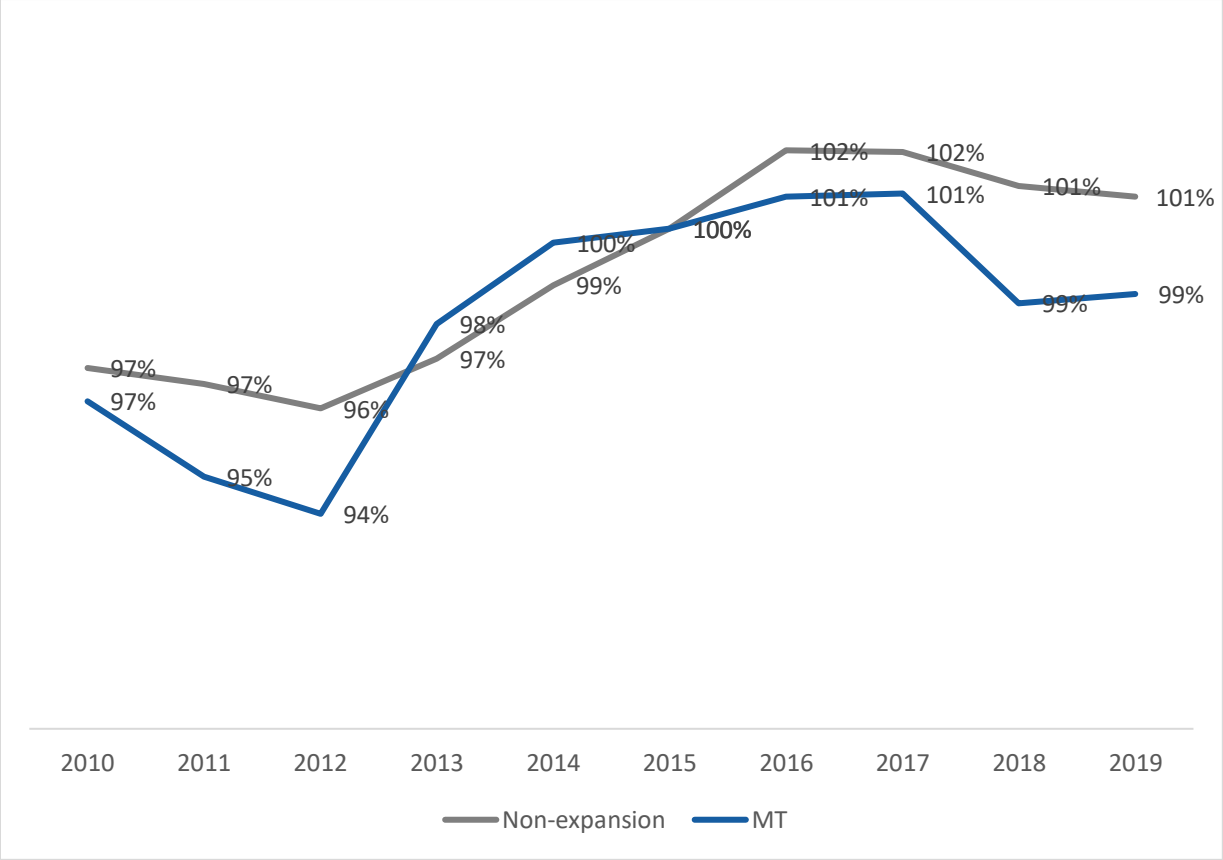
These changes are small, and it is possible Montana outcomes would not have followed the trend in South Dakota, Oklahoma, or other non-expansion areas without expansion. However, these changes are consistent with what one might expect from increased healthcare access and use, and they are consistent with other research into the effects of Medicaid expansion.[7]

[5] I restrict the analysis to the pre-pandemic period to avoid confounding effects caused by the pandemic and public health emergency.

[6] In Montana, these counties include Big Horn, Blaine, Glacier, Hill, Lake, Roosevelt, and Rosebud.

[7] 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.

Figure 4: Age-standardized mortality rate for AIAN as % of 2015 level in counties where >20% of population is AIAN

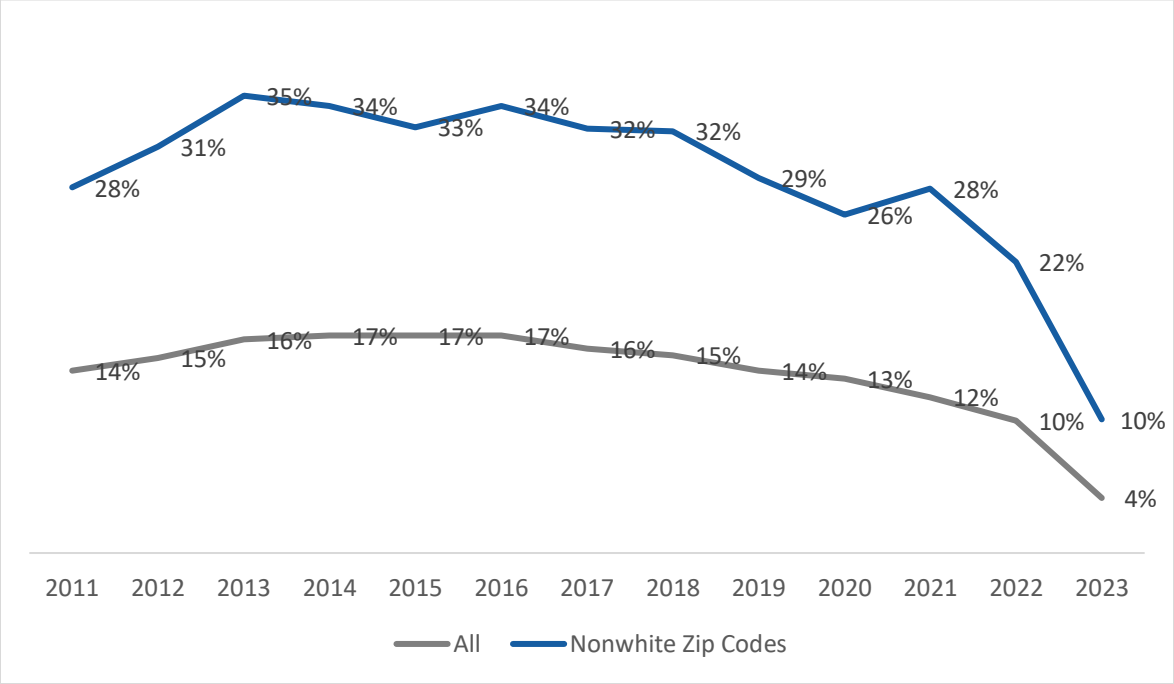


Note: Analysis of age-standardized AIAN mortality rates obtained from Institute for Health Metrics and Evaluation (IHME). United States Mortality Rates and Life Expectancy by County, Race, and Ethnicity 2000-2019. Seattle, United States of America: Institute for Health Metrics and Evaluation (IHME), 2022.

4. Shifting the cost of healthcare improves household financial health by reducing medical debt.

Beyond physical health, Medicaid expansion also affects household financial health. Without expansion, uninsured Native Americans may pay out-of-pocket for the care they receive. Often, these medical expenses lead to significant medical debt. Before Medicaid expansion, approximately one-third of Montana households in zip codes where the majority of the population was non-white (nearly all of which are Native American communities in Montana) had medical debt. After expansion but before the pandemic, this share fell by eight percentage points (or more than 25 percent); during the public health emergency, this share fell another 16 percentage points. In 2023, only 10 percent of households in Montana's majority non-white zip codes reported medical debt.

Figure 5: Share of Montana households with medical debt, 2011-2023



Note: Urban Institute (2024). The Changing Medical Debt Landscape in the United States. https://apps.urban.org/features/medical-debt-over-time/?r0=30#chart-area

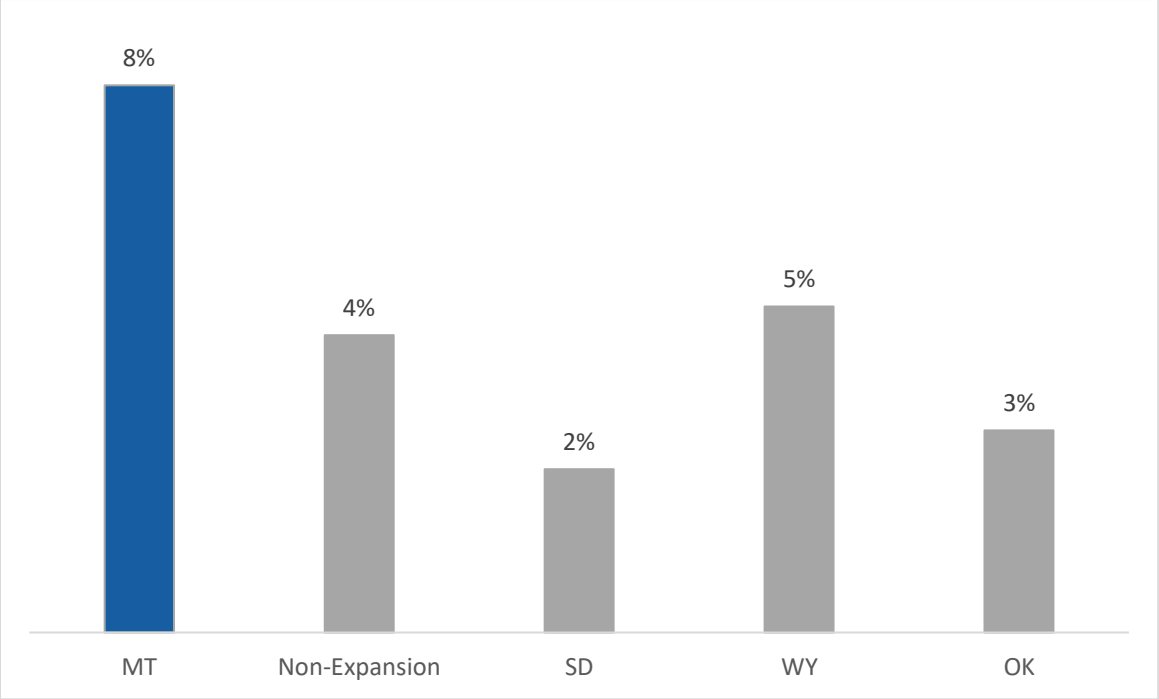
Spending less out-of-pocket for care and avoiding medical debt has important effects. Credit scores rise (allowing people to access debt with lower interest rates). Bankruptcies fall. Families have more resources to spend on other priorities like food, housing, and their children. Research finds that Medicaid expansion is associated with reduced food and housing insecurity and more timely child support payments.[8]

5. Montana's Medicaid expansion also may improve Native Americans' financial health by increasing employment and education.

Since Medicaid expansion, Native American employment in Montana surged. In 2018-2019 (after expansion ramp-up but before confounding pandemic effects), Native American employment rates were eight percentage points (16 percent) higher than in 2011-2015. This was substantially higher than the changes observed in non-expansion states, particularly those with high concentrations of Native Americans.

[8] 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.

Figure 6: Change in share of 19-64-year-old Native Americans employed, 2011-2015 v. 2018-2019



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

Medicaid expansion also makes it easier for Native Americans to pursue education. Nearly 40 percent of Montana's Native Americans aged 18-30 enrolled in school report Medicaid coverage.[9] This is more than double the share pre-expansion. As such, Medicaid expansion provides additional financial support to many of Montana's Native American post-secondary students.

6. Medicaid expansion provides significant additional resources to the healthcare system, increasing its capacity to serve everyone.

Given that most Native Americans enrolled in Medicaid expansion would be uninsured without it and given the large increase in care use associated with moving from uninsured to Medicaid, Medicaid expansion increases demand for healthcare. Furthermore, much of the care provided to Medicaid expansion beneficiaries without expansion was uncompensated. With expansion, providers are paid for this care. As a result of Medicaid expansion, Montana hospitals report approximately $225 million less uncompensated care each year.[10] As such, providers enjoy substantial additional resources due to Medicaid expansion.

While total spending associated with Medicaid expansion varies with enrollment, total Medicaid spending in Montana exceeded one billion dollars in recent years. It will likely

[9] Analysis of American Community Survey public-use microdata obtained from IPUMS-USA.
[10] Ward (2025).

continue to exceed $700 million in the near future. Given that Native Americans consistently comprise 16-17 percent of Medicaid expansion enrollment, annual Medicaid expansion spending on Native American care is likely $125-$175 million. Roughly half of this amount is provided at or through the IHS or other tribal health facilities. In addition to additional resources from expansion beneficiaries, local healthcare systems also benefit from increased Medicaid coverage for children attributable to expansion.

Rising demand prompts more supply. Effects vary over time, but total healthcare compensation in Montana is roughly four percent higher due to Medicaid expansion.[11] Consistent with the increase in compensation, expansion also increased the number of primary care physicians practicing in Montana by approximately five percent (or 50 physicians) and the number of dentists by three percent (20 dentists). Thus, healthcare capacity rose to satisfy the increased demand from Medicaid expansion.

During interviews with tribal health leaders, they stressed that Medicaid expansion allowed them to hire more providers and provide additional services. The additional resources provided by Medicaid expansion allowed them to add providers and extend hours of operation, which decreased wait times. Several leaders also emphasized that Medicaid expansion allowed them to offer more behavioral health services and more dental care, which increased treatment rates for substance use disorders and helped address an enormous backlog of needed dental care.

Importantly, increased capacity benefits everyone, not only Medicaid expansion beneficiaries. This is particularly important in Montana's rural areas. Many healthcare services require scale. Without sufficient demand, certain services are not viable. Medicaid expansion may increase demand to the point it is viable to provide services in an area where they were otherwise unavailable. Everyone in the region benefits from any increase in service availability (i.e., they no longer have to travel to more distant providers or skip care altogether because the distance is too far).

These effects are particularly important in Montana's tribal communities, most of which are distant from other healthcare providers. Due to expansion, many tribal healthcare providers have increased capacity.

7. Medicaid expansion increases economic activity in tribal communities and across the state.

Without Medicaid expansion, the $125-$175 million spent on Native American medical benefits largely disappears from Montana's economy. If the state hadn't expanded Medicaid, the federal government would not have provided those funds to Montana's Native American communities in some other form. As such, Medicaid expansion represents new spending in Montana and its tribal communities. New spending supports additional economic activity and opportunities for everyone.

[11] Ward (2025).

New spending attributable to Medicaid expansion supports the increase in healthcare compensation and employment referenced above, but it also ripples throughout the community as healthcare workers spend more at stores, restaurants, and other local service providers.

Unfortunately, no data precisely tracks Medicaid expansion spending as it ripples across the economy. As such, one cannot precisely quantify the number of jobs or the amount of income attributable to Medicaid expansion in each place. However, some data help clarify the basic order of magnitude.

Table 4 shows the share of total Medicaid expansion enrollment in each of the primary reservation county. It also shows the AIAN share of expansion enrollment in each of these counties. If one assumes expansion spending at recent levels (roughly $1 billion per year) and that expansion spending is proportional to enrollment, expected Medicaid expansion spending by county residents ranges between $7.6 million (Blaine County) and $36.3 million (Lake County), and spending by AIAN residents in these counties ranges between $5 million and $19.5 million. To help put these values in context, total expansion spending is equal to a significant portion of county GDP, ranging from 1.0 percent in Rosebud County to 3.8 percent in Glacier County. Statewide, expansion spending is equivalent to 1.3 percent of GDP. As such, expansion has a disproportionate impact in most of these counties.

Table 4: Medicaid spending in primary reservation counties

	Percent of total expansion enrollment in county	Percent of county expansion enrollment AIAN	Total est. expansion spending by county residents ($millions)	Total est. expansion spending by AIAN county residents ($millions)	Total expansion spending as % of county GDP
Big Horn	2.0%	82%	19.8	16.2	1.7%
Roosevelt	1.8%	81%	18.2	14.7	3.3%
Glacier	2.6%	76%	25.7	19.5	3.8%
Rosebud	1.0%	71%	10.4	7.4	1.0%
Blaine	0.8%	66%	7.6	5.0	2.9%
Hill	2.2%	50%	21.9	10.9	2.2%
Lake	3.6%	47%	36.3	17.1	3.2%

Notes: County enrollment rates averaged during 2021-2024 based on DPHHS Medicaid dashboard data. Spending estimates based on enrollment shares (i.e., assume spending is proportional to enrollment) and assumed total Medicaid expansion spending of $1B, consistent with recent levels. Table does not include additional spending impacts from increased Medicaid enrollment among children or expansions impacts on other income-based public support programs (e.g., SNAP). County-level GDP for 2023, obtained from BEA.gov.

To more precisely understand expansion's impact on these local economies, one must account for two things. First, not all resident spending remains in these counties. Given the availability of healthcare locally, providers in other counties provide some of the care received by resident beneficiaries. As such, some portion of Medicaid spending by residents

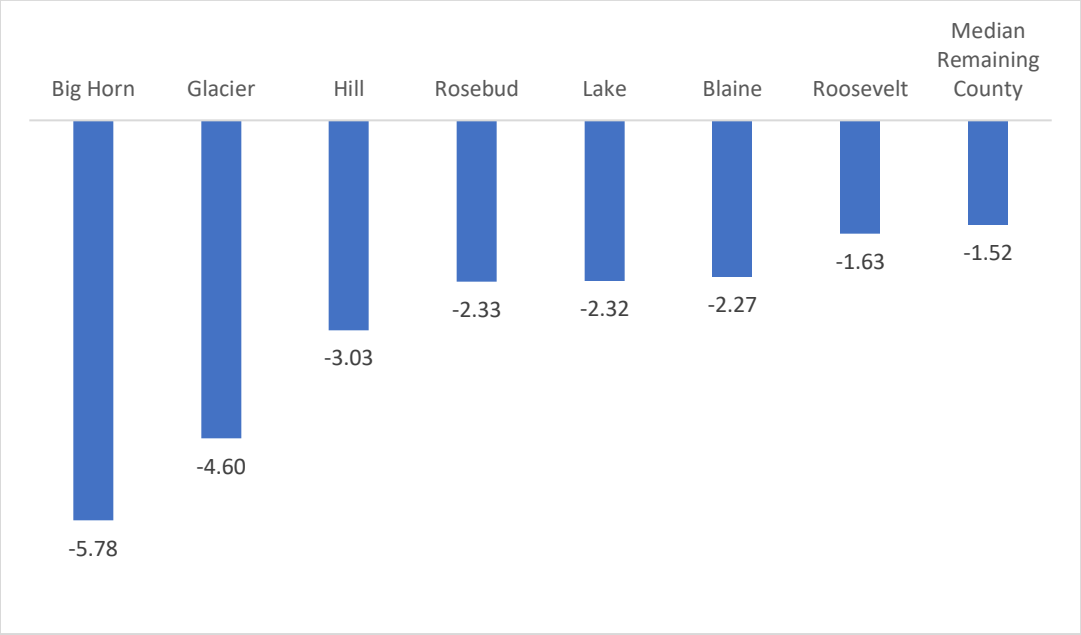
of these counties supports jobs and incomes in other counties. The precise share is hard to determine and differs across counties. In most of these counties, it is reasonable to assume that approximately half of spending remains within county and half is spent in counties with larger healthcare sectors.

Second, one needs to account for the fact that not all Medicaid expansion spending is new spending. Some would have occurred without expansion (e.g., via IHS); however, given that IHS funding that may have been spent providing care to expansion beneficiaries is used to provide care to others in the same locations, nearly all expansion spending in these areas is "new money" in these economies.

While the precise change in economic circumstances attributable to expansion is unknown (and changes overtime), expansion provides a significant boost to the economies in tribal communities by adding millions of dollars that would otherwise not circulate in these economies, supporting dozens (and in some cases potentially hundreds) of jobs.

Consistent with expansion generating significant economic impacts in tribal communities (and with the rise in Native American employment rates discussed above), the unemployment rate in Montana's counties with the highest Native American population shares (i.e., the counties with the main portions of Montana's Indian reservations) plummeted after expansion. Relative to the three years before expansion (2013-2015), on average, unemployment fell by 3.1 percentage points (or 46 percent) in these counties by 2022-2023. This decline was above the median non-reservation Montana county in all seven counties.

Figure 7: Percentage point change in unemployment rate pre-expansion (2013-2015) – post-expansion (2022-2023)



Notes: Analysis of annual average county unemployment rates obtained from Bureau of Labor Statistics Local Area Unemployment Series (LAUS).

8. Providing Medicaid expansion to Montana's Native American population costs the state little or nothing.

In general, Montana must pay 10 percent of the cost of Medicaid expansion (the federal government pays the other 90 percent); however, this calculation differs for Native American populations. The federal government pays for 100 percent of Medicaid costs provided at or through IHS or tribal health facilities. Given that roughly half of the costs for Native American Medicaid expansion benefits flow through such facilities, Montana pays only approximately five percent of the cost associated with offering Medicaid expansion to its Native American population. This also means that, unlike other expansion states, Medicaid expansion statewide costs less in Montana than in most other states. While other states pay ten percent of expansion costs, Montana pays only nine percent.

Furthermore, Medicaid expansion allows the state to cut other spending, and it generates additional revenues. As such, the net impact of expansion on the overall state budget is minimal. For instance, with Medicaid expansion some people who would have enrolled in traditional Medicaid (where the state pays 38 percent of the cost) enroll in expansion instead (where the state pays only 10 percent). Medicaid expansion also allows the state to shift some costs for inmate healthcare (where the state pays 100 percent of the cost) to Medicaid expansion (where the state pays only 10 percent of the cost). I describe Medicaid expansion's larger fiscal effects in various other reports.

Conclusion

In sum, Medicaid expansion moves a substantial portion of Montana's Native American population from uninsured to Medicaid. This allows them to access more healthcare, become healthier, and improve their financial health. It also provides ample resources to Montana's tribal healthcare providers and tribal communities. These resources allow non-Medicaid beneficiaries to enjoy better access to healthcare and a more robust economy.