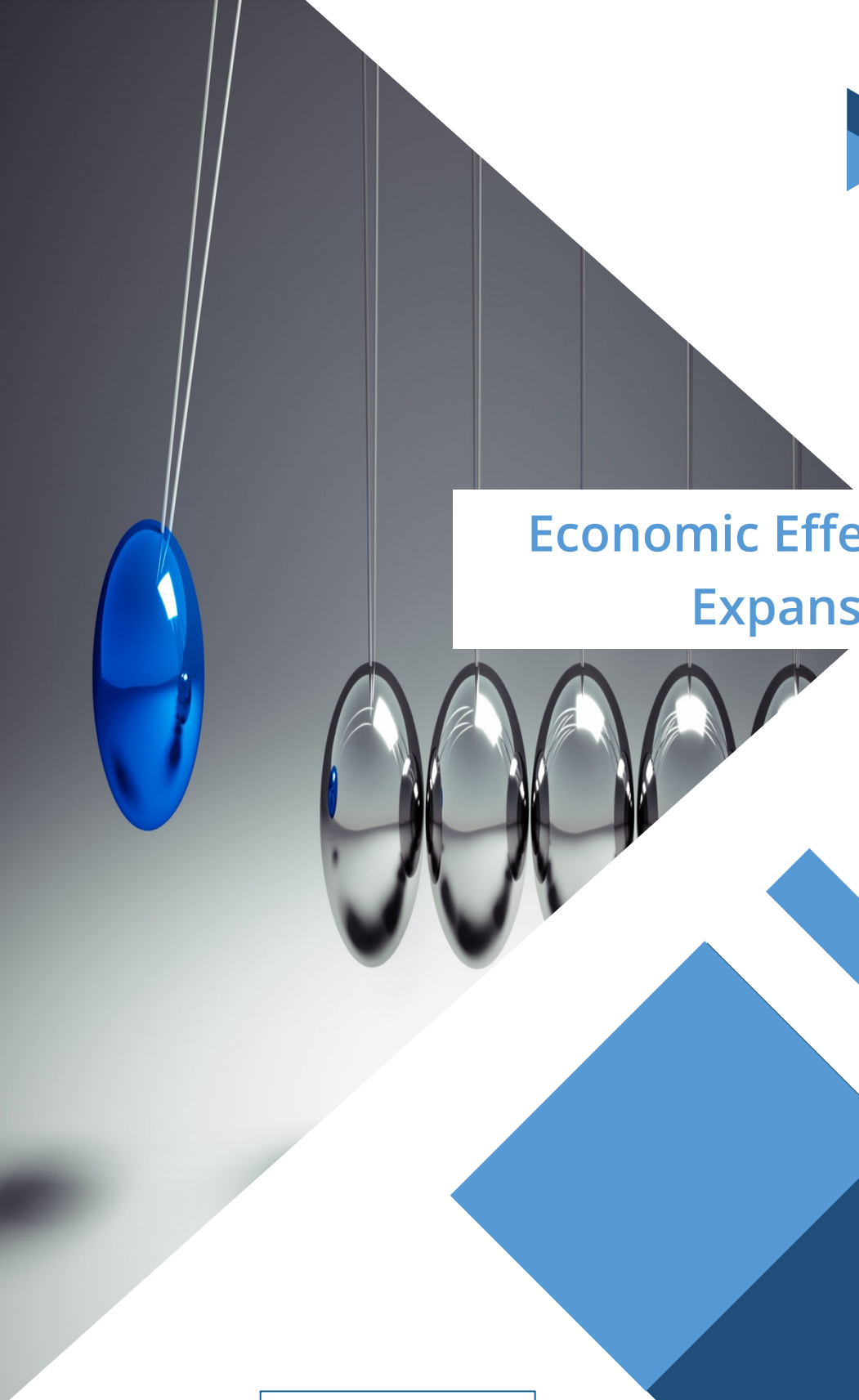

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Economic Effects of Medicaid Expansion in Montana

2023 Update

AβMJ

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I. Summary

Three 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 beneficiaries, 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 over 7,500 jobs and generating $475 million in personal income throughout Montana's economy each year.

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

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[1] 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.

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.

In addition to revisiting the prior reports, this report includes two new analyses. First, it examines the impacts of expansion across Montana's counties. Second, it includes a deeper look at employment and barriers to employment among Medicaid beneficiaries.

The analysis of county-level impacts describes enrollment, the change in un-insurance, and the local economic impacts. It shows that:

- Medicaid expansion enrollment as a share of total county population ranges from a low of four percent to a high of 20 percent;
- The decline in un-insurance between 2011-2015 and 2017-2021 also varies widely across counties from effectively no change to over 70 percent;
- Economic impacts vary with enrollment and the share of Medicaid expansion spending captured by local providers. However, the total jobs supported by Medicaid expansion are equal to 0.7 percent of total county employment in the median county and are approximately 1.3 percent in healthcare centers like Missoula and Yellowstone County.

The analysis of employment and barriers to employment among Medicaid beneficiaries focuses on Montana adults ages 19-64 who report Medicaid coverage. Since survey data do not distinguish Medicaid expansion from traditional Medicaid, I exclude people who report Supplemental Security Income (SSI) (who receive Medicaid regardless of expansion) to reduce the number of traditional Medicaid recipients included. This analysis shows that:

- 60 percent of Montana's Medicaid beneficiaries aged 19-64 work full time, want to work full time (i.e., they work part-time for economic reasons), or attend school;
- Nearly all of the remaining 40 percent work part-time or report a plausible impediment to full-time work (e.g., some level of disability/impairment or caregiving responsibilities);
- Only four percent of Montana's adult Medicaid beneficiaries report no impediments and no work.
- People move into and out of Medicaid. As such, the population covered by Medicaid at some point over prolonged periods is much larger than the currently covered population. Over four years, 25 percent of adults ages 19-64 (not receiving SSI) report Medicaid coverage at some point (nearly double the rate in a single year, 14 percent). Only 36 percent of those ever-covered report coverage in all four years, and those who report more persistent coverage report more impediments to work (e.g., disability).

II. Summarizing/updating the findings of the previous reports

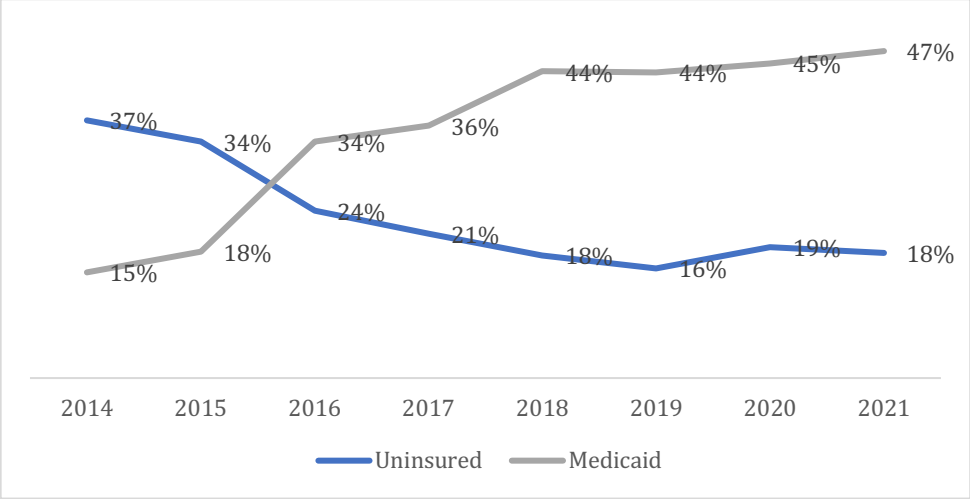
In this section, I briefly revisit the key findings in the prior reports. Interested readers can find additional evidence and analytical detail in those prior reports, as well as in other literature reviews on the effects of Medicaid expansion.[2]

A. Medicaid expansion reduces un-insurance.

In recent years, Medicaid expansion provided insurance to over 100,000 Montanans. In the absence of expansion, some expansion beneficiaries would have had private insurance, some would have enrolled in traditional Medicaid, but a significant proportion (slightly less than half) likely would have had no insurance.

Figure 1 shows the decline in uninsurance among Montanans aged 19-64 with income below 139 percent of the federal poverty level (FPL), excluding people who receive SSI (who already received Medicaid before expansion). Following Medicaid expansion in 2016, the share of low-income Montanans with Medicaid increased substantially, and the share uninsured declined substantially (from over 30 percent to less than 20 percent). However, similar changes did not occur in states that did not expand Medicaid.

Figure 1: Share of low-income (<139% FPL) Montanans ages 19-64 with no SSI income with no health insurance or with Medicaid, 2014-2021.



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

[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 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/

B. Medicaid expansion improves healthcare access and utilization.

After expansion, the share of low-income Montanans that 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.[3] Since expansion, only 19 percent of low-income Montanans skipped care due to cost.[4] Before expansion, 52 percent of low-income Montanans had visited a physician for a routine checkup within the past year. After expansion, this share rose to 64 percent. Again, comparable changes did not occur in non-expansion states.

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.[5] In Montana, Manatt found that Medicaid beneficiaries' use of emergency departments falls with the number of years enrolled, which may result from greater access to preventative, outpatient, and specialist care.[6]

C. 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 their care would have been paid by others via charity/uncompensated care. With expansion, this spending is free to be spent elsewhere in the economy. Ultimately, shifting who pays for this healthcare means Montana households have approximately $250-$300 million more to spend in other parts of Montana's economy.[7]

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[3] Analysis of 2014-2015 BRFSS data for Montanans with imputed income less than 150 percent of FPL.
[4] Analysis of 2017-2021 BRFSS data for Montanans with imputed income less than 150 percent of FPL. I exclude 2016 because it was a transition year with substantially changing enrollment.
[5] 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.
[6] Manatt (2022) Medicaid in Montana. https://mthcf.org/wp-content/uploads/Medicaid-in-MT-2022_4.12.22-FINAL.pdf
[7] 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. Recent expansion spending of roughly $1 billion translates into $250-$300 million in new spending elsewhere in Montana's economy.

Combined, more health insurance, more healthcare, and more money to spend on other things generate substantial benefits for the beneficiaries, for the healthcare system, and for the State.

D. Medicaid recipients enjoy better physical and financial health.

An extensive literature documents that Medicaid expansion improves health outcomes.[8] This literature finds that Medicaid expansion boosts self-reported physical and mental health and reduces mortality (by nearly 10 percent in one recent study).[9]

Expansion also improves financial health. Medicaid expansion reduces Chapter 7 bankruptcy filings.[10] It reduces medical debt, which, in turn, reduces other credit/loan delinquencies and improves credit scores.[11] Medicaid expansion is also associated with increased food and housing security and increased timeliness of child support payments.[12]

E. Healthcare providers benefit from more robust demand and better financial health.

More than 50 percent of total Medicaid expansion spending represents new healthcare spending.[13] Given recent spending levels, this suggests that Medicaid expansion increased total healthcare spending in Montana by over $500 million per year.[14]

More healthcare spending also leads to jobs and investment in the healthcare sector. Montana's total healthcare earnings spiked with Medicaid expansion and remain elevated.

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[8] See citations in footnote 2.

[9] 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.

[10] 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.

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

[12] 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.

[13] Ward (2021).

[14] Montana's total spending on Medicaid expansion in FY2022 was slightly more than $1 billion. https://leg.mt.gov/content/Publications/fiscal/leg_reference/Brochures/Medicaid-Expansion-Brochure-2022-Final.pdf

Medicaid expansion likely boosts total healthcare earnings by $260-$310 million per year.[15]

Higher healthcare revenues also boost the financial health of healthcare providers. 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.[16]

F. Montanans benefit from a more robust healthcare system and from increased economic activity/opportunity.

Roughly 75-80 percent of Medicaid expansion spending ($750-$800 million) represents new spending in Montana's economy.[17] Without Medicaid expansion these dollars would not have been spent in Montana (they would have remained with the federal government). This amount equals more than one percent of Montana's total economy.[18]

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.[19]

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[15] This range comes from the economic impact analysis discussed below. New healthcare spending generates $260 million in direct employee compensation and proprietor income. Adding indirect and induced impacts increases this value to $310 million. The empirical estimate of the change in healthcare earnings in Ward (2021) was $255 million, which is in line with these estimates once inflation and increased Medicaid spending are taken into account.

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

[17] 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.

[18] Montana's total GDP in 2021 was $58.7 billion. New spending attributable to Medicaid expansion in FY2022 was approximately $750-$800 million. This is equal to 1.3-1.4 percent of 2021 GDP.

[19] 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*.

At current levels, Medicaid expansion in Montana supports roughly 7,500 jobs and approximately $475 million in personal income.[20] 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. Slightly more than 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.

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

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.

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

Labor force participation among Montanans aged 19-64 increased slightly since expansion (and marginally more than in non-expansion states). During 2011-2015, 80.8 percent of Montanan's 19-64 participated in the labor force. During 2017-2021, 82.1 percent of Montanans 19-64 participated in the labor force. This 1.3 percentage point increase is larger than the 0.5 percent increase in non-expansion states.

Describing changes in labor force participation among low-income Montanans is more complicated—the set of people who are low-income changes over time. In particular, the share of Montanans aged 19-64 whose incomes fall below 139 percent of FPL shrank since expansion (from 24 percent in 2015 to 19 percent in 2021). As incomes rise, the composition of the low-income population changes. In particular, those who face the most significant barriers to higher earnings are the most likely to remain low-income as the share of low-income people falls. As such, low-income labor force participation falls as the

[20] 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.

share of low-income people falls. Between 2011-2015, 57.7 percent of low-income Montanans 19-64 participated in the labor force. During 2017-2021, this fell to 55.3. However, the modest decline in Montana's low-income labor force participation was smaller than in non-expansion states (4.2 percentage points). As such, this decline likely reflects forces unrelated to Medicaid expansion.

I provide more information about employment among the adult Medicaid population in section IV below.

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

The state must pay for ten percent of expansion's costs. At recent spending levels, this amounts to approximately $100 million per year in Montana.[21] 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.[22]

Medicaid expansion creates two types of state budget savings. First, expansion 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.

The savings within Medicaid are substantial. Medicaid expansion offers states a much better deal than traditional Medicaid. While typically, Montana must pay 35 percent of the cost of traditional Medicaid, it only has to pay 10 percent of the cost of expansion.[23] As

[21] Ten percent of the FY2022 costs of expansion amount to $101.85 million. However, the actual cost may differ slightly from this amount due to various program details (e.g., administration costs, twelve-month eligibility, etc.). Actual state costs in FY2022 equaled 9.1 percent of total expansion expenditures (https://leg.mt.gov/content/Publications/fiscal/leg_reference/Brochures/Medicaid-Expansion-Brochure-2022-Final.pdf). However, historically, the state share of expansion spending was very close to the stated FMAP. As such, I use the stated FMAP as the benchmark in this analysis.
https://leg.mt.gov/content/Publications/fiscal/leg_reference/Brochures/Medicaid-Expansion-Brochure-2022-Final.pdf

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

[23] Due to the Public Health Emergency, the FMAP on traditional Medicaid is currently 71 percent; however, I focus on the "normal" FMAP for this analysis.

such, Montana saves 25 cents on every dollar of care that moves from traditional Medicaid to expansion.

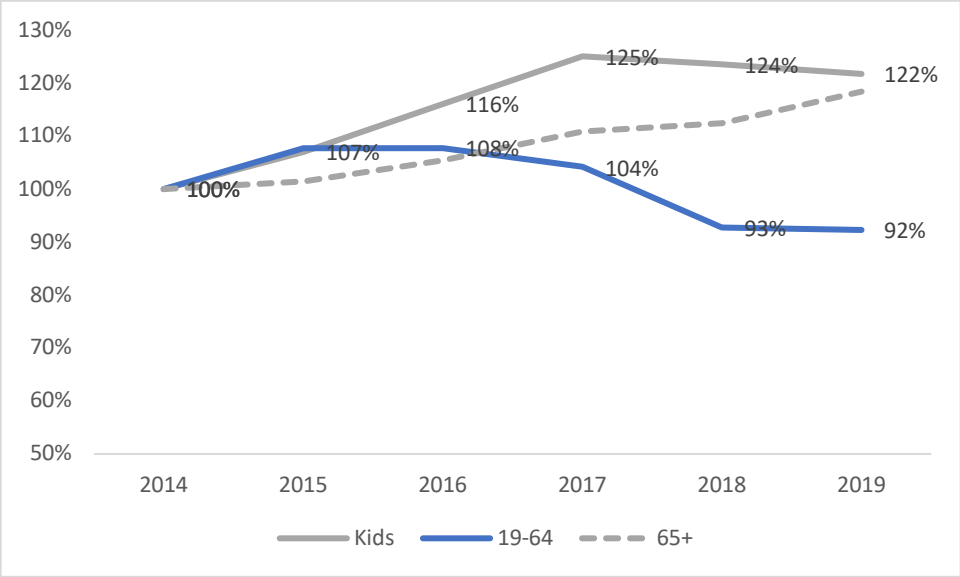
In the earlier reports on the impacts of Medicaid expansion, the size of the savings within Medicaid was uncertain, so the reports included a wide range for these savings. Manatt had calculated the savings from the specific programs that the ACA allowed to shift from traditional Medicaid to expansion (e.g., Section 1115 waivers, the Breast and Cervical Treatment Program). However, the Manatt estimate did not include people who changed their behavior in response to expansion. i.e., people who would have made choices to ensure they qualified for traditional Medicaid (e.g., they reduced their income or pursued disability designations) now simply enroll in the expansion. The size of this second group was harder to estimate. However, an analysis of changes in Montana's traditional Medicaid spending relative to changes in non-expansion state spending suggested that total spending on traditional Medicaid in Montana had fallen by $127-$197 million in FY2019.[24] Assuming all this spending transferred to Medicaid expansion and that the state saves 25 percent on each dollar shifted, the savings within traditional Medicaid amounted to $32-49 million. Given state expansion spending of 723 million in FY2019, these savings amounted to 44-68 percent of the state's share of expansion spending (assuming a 10 percent FMAP on expansion spending).

Data on spending by age in Montana's traditional Medicaid program released in a 2021 DPHHS report provide additional support for this estimate.[25] As shown in Figure 2, before Medicaid expansion, traditional Medicaid spending for adults 19-64 rose at the same rate as children; however, after expansion, spending on adults fell while spending on kids (and people over age 64) continued to rise. If one assumes that total spending on adults would have risen at the same rate as spending on kids, traditional Medicaid spending would have been $144 million higher in FY2019, a value within the range identified in the 2021 report. Again, assuming all of this reduction transferred to expansion, this approach estimates savings within traditional Medicaid equal to 50 percent of the state's expansion costs.

In addition to savings within traditional Medicaid, expansion allows the state to reduce spending elsewhere. For instance, Medicaid expansion allowed the state to reduce spending on substance abuse and mental health programs. Expansion also allowed the state to shift the cost of inmate hospitalizations to Medicaid. Combined, these savings amount to $13.8 million in SFY2021, or roughly 15 percent of the state's share of expansion costs.[26]

[24] Ward (2021)
[25] DPHHS (2021) Medicaid in Montana. https://dphhs.mt.gov/assets/2021biennialreports/MedicaidinMontana2021.pdf
[26] Manatt (2022). Medicaid in Montana. https://mthcf.org/wp-content/uploads/Medicaid-in-MT-2022_4.12.22-FINAL.pdf

Figure 2: Traditional Medicaid spending as % of 2014 level by age group



Notes: Data from DPHHS (2021). Medicaid in Montana 2021.

As such, without even accounting for additional ripple effects from Medicaid expansion on the state budget (like a reduction in SSI enrollment attributable to Medicaid expansion reducing Montana's supplemental payments to SSI beneficiaries), budget savings attributable to expansion offset roughly 59-83 percent of the state's share expansion's costs.

Revenue increases attributable to expansion offset the 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. In FY2022, this fund covered $53.4 million (or 58 percent) of the state's share of expansion costs.[27]

One can take one of three approaches to evaluate Medicaid expansion's impact on the revenues generated by HB 658:

(1) Include all of the revenues generated under HB 658. The approach assumes that the state would not have raised any of these revenues had it not expanded Medicaid. Given that only 50 percent of the revenues generated go toward Medicaid expansion, the figure above suggests that increased revenues directly attributable to Medicaid expansion approximately offset the entire state share of expansion.[28]

[27] https://leg.mt.gov/content/Publications/fiscal/leg_reference/Brochures/Medicaid-Expansion-Brochure-2022-Final.pdf
[28] https://leg.mt.gov/bills/2019/FNPDF/HB0658_1.pdf

(2) Include all of the revenues generated under HB 658 expressly designated for Medicaid expansion. This approach assumes that, but for expansion, the State would not have raised the revenues raised under HB 658 dedicated to Medicaid expansion. Under this approach, the revenues directly attributable to Medicaid expansion equal the amount discussed above (58 percent of expansion's costs).
(3) Include only the portion of the revenues generated by HB 658 attributable to increased healthcare utilization due to Medicaid expansion. This approach assumes that the state would have raised these fees regardless of expansion; however, these fees would have generated less revenue without expansion. Under this approach, the revenues directly attributable to Medicaid expansion stem from the roughly six percent increase in total healthcare spending attributable to expansion. Assuming that the revenue bases under HB 658 rise in the same proportion, this suggests that these revenues offset approximately six percent of the state's share of expansion cost.

If one assumes that the first approach is correct, these revenues offset the state's share of expansion costs alone. If one assumes that the second approach is correct, these revenues plus the savings discussed above more than offset the state's share of expansion costs. If one assumes that the third approach is correct, these revenues plus the above savings offset nearly all the state's share of expansion costs.

Any remaining costs not covered by the savings and HB 658 revenues are dwarfed by the increase in state revenues on the increased economic activity attributable to expansion. As discussed above, Medicaid expansion supports roughly $475 million in personal income. In recent years, Montana's own-source revenues average 11.3 percent of personal income.[29] As such, the increase in income due to expansion may yield $51 million in additional revenues (or 51 percent of the state share of expansion costs).[30] 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

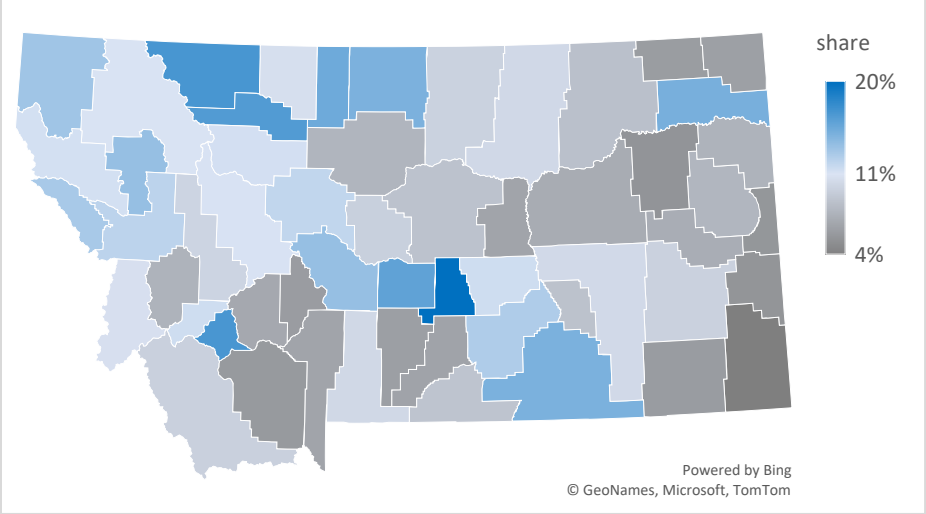
[29] Average of rates from 2016-2020 obtained from: US Census Bureau Annual Survey of State and Local Government Finances, 1977-2017 (compiled by the Urban Institute via State and Local Finance Data: Exploring the Census of Governments; accessed 7-Dec-2022), https://state-local-finance-data.taxpolicycenter.org.
[30] If I use general own-source revenue instead of all own-source revenue, the recent average was 7.5 percent. This amounts to $34 million. This is roughly comparable to IMPLAN's estimate for state tax revenues collected on the economic impacts, $31 million.

expansion, and spending in other areas of the budget (e.g., transportation, education) does not fall.[31] This is what we would expect if Medicaid expansion does not require states to raise taxes or cut spending to afford expansion.

III. Geographic distribution

Medicaid expansion enrollment is not uniformly distributed across the state. 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 3 shows the share of county population enrolled in Medicaid expansion.[32] 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.

Figure 3: Share of total population covered by Medicaid expansion, 2022



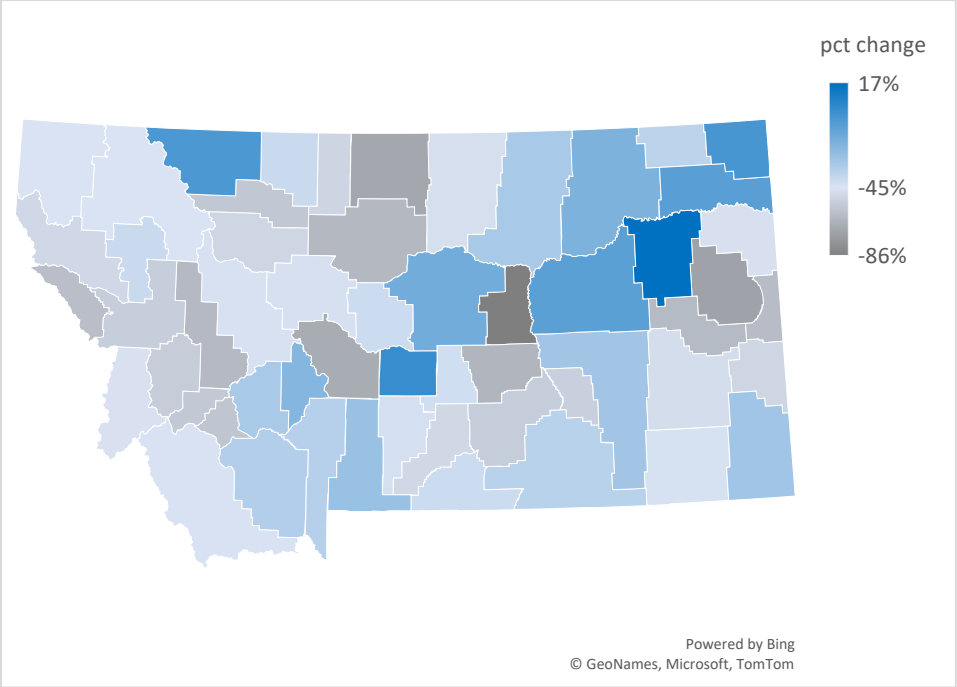
Notes: Medicaid expansion enrollment as of September 2022. Total county population as of July 1, 2021.

Figure 4 provides a different view of the impacts of Medicaid expansion. It shows the percent change in un-insurance among 19-64-year-olds between 2011-2015 and 2017-2021. While the total change in un-insurance over this period may reflect changes other than Medicaid expansion, Medicaid expansion is the primary source of these changes. It is not a coincidence that Figure 4 is opposite Figure 3. Places with higher Medicaid expansion enrollment also tend to show larger declines in uninsurance.

Statewide, uninsurance among this age group fell by 45 percent over this period, but there is a wide range around this level. At the high end, uninsurance fell by over 70 percent. At the low end, it fell by less than 10 percent. Some of this dispersion may reflect noise in the data for counties with small populations (and small sample sizes).

[31] Gruber and Sommers (2020).
[32] 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.

Figure 4: % change in uninsurance among 19-64-year-olds, pre- and post-expansion



Notes: American Community Survey

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. The key question for this section is what share of the statewide economic impacts described above occur in each county?

This is a difficult question to answer well. A very accurate, reliable estimate is likely impossible, particularly for Montana's smaller counties. At best, one can pursue a set of thought exercises that provide a general order of magnitude for Medicaid expansion's expected local economic impacts.

The key challenge for computing local economic impacts is allocating Medicaid expansion spending to healthcare providers and households across the state. I am not aware of publicly available data that describe Medicaid expansion spending by the location of both the patient and the provider. As such, expansion spending must be allocated across places using some other assumptions. For many Montanans, the goods and services they consume (both in healthcare and in other sectors) are not available in their communities. They must obtain them from elsewhere in Montana. As such, to understand local impacts, one needs to geographically track Medicaid expansion related spending as it flows around the state.

Ultimately, to calculate local impacts, I allocate new healthcare spending and shifted healthcare spending using the following steps:

(1) Allocate Medicaid expansion spending to each county in proportion to Medicaid expansion enrollment. E.g., if a county is home to three percent of Medicaid expansion enrollees, I assume that three percent of all expansion spending originates with people living in that county.[33]

(2) Allocate value of healthcare spending that would have occurred regardless of expansion to households. As discussed above, 25 percent of Medicaid expansion spending would have occurred regardless of expansion and would have come from local households. I allocate the 25 percent value calculated in (1) to local households.

(3) Allocate new healthcare spending by likely industry and provider location. As discussed above, 50 percent of Medicaid expansion spending represents spending that would not have occurred without expansion. To calculate the economic impacts of this spending, one needs to allocate spending across industries and by provider location. Both of these allocations pose significant challenges.

a. Industry: Data on healthcare spending is typically organized by service, but economic impact models are organized by industry. Unfortunately, there is not a clear concordance between services and industries because many services can be provided by providers in different industries. Furthermore, the same service could be provided in different industries in different counties. I allocate spending to industries using the same proportion as the statewide calculation. However, I note this may introduce error, particularly in smaller counties.

b. Provider location: Unfortunately, given the uneven provision of healthcare services across Montana, a significant proportion of care is provided outside the beneficiaries' county of residence. I allocate healthcare to counties based on the concentration of healthcare output in the county. Specifically, I calculate the county share of statewide output for each healthcare sector and divide this value by the county's share of statewide population.

   In places where concentration is close to or greater than one (suggesting the output is at the expected level given population), I assume all spending by residents stays in the county.

   In places where concentration is significantly less than one (suggesting the counties produce less than expected), I assume the county retains its concentration share of each industry. E.g., if a county produces 35 percent of

[33] Effectively, this means I am assuming that spending per beneficiary is constant across counties. This is unlikely to be true. Spending per beneficiary varies across counties for both idiosyncratic reasons (a beneficiary in county X had very expensive needs this year) and systematic reasons (beneficiaries in county X are consistently sicker than others). I do not have reliable data that allows me to (a) measure spending by county and (b) separate idiosyncratic factors from systematic ones. As such, I rely on the simple assumption that spending is allocated in proportion to enrollment.

the expected amount of a service, I allocate 35 percent of its expansion spending to the county. The remaining 65 percent is allocated to other counties where concentration is greater than one. To allocate this "remainder", I calculate the total output in excess of the expected amount in counties with concentration greater than one, then I divide each counties' excess output by this total. Finally, I multiply the total "remainder" by this share and allocate this amount to the high concentration county.

(4) Finally, these direct effects are entered into the IMPLAN model for each county and the total economic impacts obtained.[34]

Table 1 describes these impacts along with some key contextual parameters like enrollment and the share of statewide healthcare output in the county. Unsurprisingly, the economic impacts of Medicaid expansion vary widely across the state.[35]

In counties where the concentration of enrollment or healthcare output are high, impacts are relatively large. For instance, Medicaid expansion covers 1.9 percent of Hill County's population. Healthcare providers in Hill County generate output equal to 1.1 percent of statewide output, so much of local Medicaid expansion spending remains in the county (and it attracts some from other places). Combined, Medicaid expansion supports 121 jobs and over $6 million in labor income in Hill County. These impacts represent approximately 1.2 percent of county employment and income.

In smaller counties, particularly those where the share of enrollment and healthcare output are low, economic impacts are relatively small. However, even in counties with limited economic impacts, residents still benefit from greater access to health insurance.

[34] Each county model is a multi-region input-ouput model (MRIO) that includes the county as well as the other 55 Montana counties. This approach captures impacts that spill from the examined county into other Montana counties (e.g., shopping trips from residents of Lake County into Missoula County) and helps ensure that the separate county models yield a value closer to the comparable statewide model.

[35] In 2019, Navigant also produced county-level estimates for the economic impact of Medicaid expansion (https://mtha.org/wp-content/uploads/2021/03/2019_Navigant_Analysis-of-Impact-of-Medicaid-Expansion-on-Montana.pdf). While the estimates in Table 1 are similar to Navigant's estimates for some counties, they are different for others. These differences reflect several differences between the analyses. First, Navigant assumes that 90 percent of expansion spending reflects new money in Montana's economy. I assume only 75 percent represent new spending. Second, Navigant allocates all new spending to the healthcare sector. I assume that 50 percent of expansion spending represents new healthcare spending, and 25 percent effectively represents an increase in household incomes. Economic impact multiplers for higher household income are smaller than for increased healthcare output. Third, the allocation of expansion dollars across the state may differ due to both changes in enrollment patterns and due to different assumptions about how to allocate spending, in particular how to allocate spending by residents of one county at providers in a different county. Fourth, the Navigant analysis uses the RIMSII model, but I use IMPLAN.

Table 1: County-level data and impacts

						Economic impacts from Medicaid expansion			
County	Exp. Enroll	Enr. as share of cnty. pop.	Pp chg. in share unins	Cnty. share of total enr.	Cnty. share of health-care output	Total Jobs	Total labor income (000s)	Total output (000s)	Jobs as % of cnty. total
Beaverhead	922	10%	-7.2	0.8%	0.6%	39.7	2,105	5,839	0.7%
Big Horn	1,918	15%	-18.6	1.6%	0.4%	45.8	2,438	6,917	0.9%
Blaine	683	10%	-19	0.6%	0.1%	10.9	420	1,361	0.4%
Broadwater	421	6%	-4.2	0.3%	0.2%	7.8	365	1,211	0.3%
Carbon	953	9%	-8	0.8%	0.3%	21.6	1,020	2,892	0.4%
Carter	51	4%	-7.8	0.0%	0.0%	0.7	18	77	0.1%
Cascade	10,209	12%	-9.4	8.3%	10.0%	696.3	44,758	107,544	1.4%
Chouteau	453	8%	-18.4	0.4%	0.1%	7.8	334	1,145	0.3%
Custer	1,163	10%	-7.9	0.9%	1.1%	65.0	3,717	9,257	0.8%
Daniels	98	6%	-4.4	0.1%	0.2%	8.0	406	1,245	0.7%
Dawson	690	8%	-11.8	0.6%	0.6%	30.3	1,578	4,163	0.6%
Deer Lodge	1,098	12%	-11.1	0.9%	1.1%	54.8	3,762	8,598	1.2%
Fallon	157	5%	-8.9	0.1%	0.2%	6.3	314	941	0.3%
Fergus	1,004	9%	-3.1	0.8%	0.8%	51.0	2,818	7,493	0.7%
Flathead	12,075	11%	-10.8	9.8%	11.7%	799.6	52,767	124,939	1.2%
Gallatin	7,842	6%	-5.1	6.4%	9.0%	469.6	30,044	69,979	0.5%
Garfield	84	7%	-2.2	0.1%	0.0%	0.8	22	95	0.1%
Glacier	2,314	17%	-2.1	1.9%	0.3%	52.6	2,807	7,704	0.9%
Golden Valley	163	20%	-11.4	0.1%	0.0%	1.8	49	191	0.4%
Granite	250	7%	-13	0.2%	0.0%	1.8	44	258	0.1%
Hill	2,390	15%	-16.6	1.9%	1.1%	122.1	6,051	17,106	1.2%
Jefferson	835	7%	-4.2	0.7%	0.2%	13.3	527	1,547	0.3%
Judith Basin	197	10%	-9	0.2%	0.0%	2.0	72	269	0.2%
Lake	4,399	14%	-14.1	3.6%	1.6%	167.4	8,512	23,055	1.1%
Lewis and Clark	8,082	11%	-6.3	6.6%	7.4%	487.8	29,584	71,795	1.0%
Liberty	298	15%	-10.8	0.2%	0.3%	7.4	361	1,146	0.7%
Lincoln	2,739	13%	-13.5	2.2%	1.0%	113.4	5,191	13,962	1.2%
Madison	498	6%	-7.4	0.4%	0.4%	14.0	814	2,262	0.2%
McCone	89	5%	1.7	0.1%	0.2%	3.8	169	571	0.3%
Meagher	270	14%	-16.2	0.2%	0.2%	9.0	449	1,388	0.8%
Mineral	634	13%	-20.6	0.5%	0.3%	23.6	1,149	3,395	1.2%
Missoula	14,682	12%	-10.6	12.0%	14.2%	1205.2	80,707	183,560	1.4%
Musselshell	567	12%	-13.3	0.5%	0.2%	16.3	759	2,334	0.7%
Park	1,796	10%	-5.9	1.5%	1.1%	42.9	1,769	4,761	0.4%
Petroleum	33	6%	-36.2	0.0%	0.0%	0.4	7	32	0.1%
Phillips	431	10%	-7.6	0.4%	0.2%	17.4	754	2,405	0.7%
Pondera	984	16%	-14.4	0.8%	0.3%	30.2	1,901	4,655	1.1%
Powder River	98	6%	-10.8	0.1%	0.0%	0.7	20	89	0.1%
Powell	698	10%	-13.9	0.6%	0.3%	32.8	1,726	5,079	0.8%
Prairie	77	7%	-15.4	0.1%	0.0%	1.0	19	99	0.2%
Ravalli	4,972	11%	-12.5	4.1%	2.3%	196.3	10,865	27,724	0.9%

						Economic impacts from Medicaid expansion			
County	Exp. Enroll	Enr. as share of cnty. pop.	Pp chg. in share unins	Cnty. share of total enr.	Cnty. share of health-care output	Total Jobs	County	Exp. Enroll	Enr. as share of cnty. pop.
Richland	846	7%	-9.2	0.7%	0.8%	33.2	2,067	5,249	0.4%
Roosevelt	1,614	15%	-3.1	1.3%	0.6%	64.4	3,775	10,558	1.3%
Rosebud	842	10%	-8.5	0.7%	0.6%	44.6	2,589	6,619	0.9%
Sanders	1,472	11%	-16	1.2%	0.6%	53.0	2,479	7,224	0.9%
Sheridan	214	6%	-0.4	0.2%	0.2%	9.5	519	1,492	0.4%
Silver Bow	5,943	17%	-13.1	4.8%	3.0%	317.0	19,377	46,300	1.4%
Stillwater	569	6%	-7.8	0.5%	0.5%	17.4	1,137	2,911	0.3%
Sweet Grass	222	6%	-7.9	0.2%	0.9%	9.9	687	1,736	0.3%
Teton	713	11%	-11.8	0.6%	0.2%	16.9	678	2,051	0.5%
Toole	539	11%	-11.9	0.4%	0.3%	21.6	1,289	3,229	0.8%
Treasure	66	9%	-7.3	0.1%	0.0%	0.6	17	67	0.2%
Valley	640	8%	-3.2	0.5%	0.8%	36.7	2,014	4,960	0.8%
Wheatland	327	16%	0.4	0.3%	0.2%	11.5	508	1,603	1.2%
Wibaux	50	5%	-16	0.0%	0.0%	0.5	21	67	0.1%
Yellowstone	21,378	13%	-10.3	17.4%	23.1%	1583.0	113,652	262,532	1.4%

Notes: Medicaid expansion enrollment from Sept. 2022. County population totals from Census estimates for July 1, 2021. Percentage point change in uninsurance from American Community Survey data for residents ages 19-64 between 2011-2015 and 2017-2021. Healthcare output share equal total output for relevant industries weighted by share of assumed expansion spending obtained from IMPLAN data.

IV. Key facts about Montana's adult Medicaid population

The discussion above describes the impacts of Medicaid expansion, but it includes relatively little information about the primary beneficiaries of Medicaid expansion—enrollees. In this section, I provide additional detail about Montana's adult Medicaid population. Basic demographic information about this population is easily obtained from DPHHS's Medicaid expansion dashboard. Here, I focus on outcomes not available on the dashboard, namely potential impediments to employment (like disability). I also use data that track the same people over time to provide a broader view of the Medicaid population, including those enrolled over several years, not just those enrolled at a single point in time.

I use data from the Current Population Survey Annual Social and Economic Component (CPS-ASEC) and the Survey of Income and Program Participation (SIPP) for these analyses.[36] Unfortunately, these surveys do not distinguish Medicaid expansion enrollees from traditional Medicaid enrollees. However, I restrict the analysis to include people ages

[36] For the CPS, I use data from 2012-2022 obtained from Sarah Flood, Miriam King, Renae Rodgers, Steven Ruggles, J. Robert Warren and Michael Westberry. Integrated Public Use Microdata Series, Current Population Survey: Version 10.0 [dataset]. Minneapolis, MN: IPUMS, 2022. https://doi.org/10.18128/D030.V10.0. For the SIPP, I use the 2018 panel (which surveyed individuals during 2017-2020) obtained from https://www.census.gov/programs-surveys/sipp/data.html.

19-64 who do not receive Supplemental Security Income (SSI). By excluding SSI recipients, I (approximately) exclude the blind/disabled portion of traditional Medicaid. This restricts the analysis to the adult Medicaid population. Medicaid expansion covers over 80% of this population.

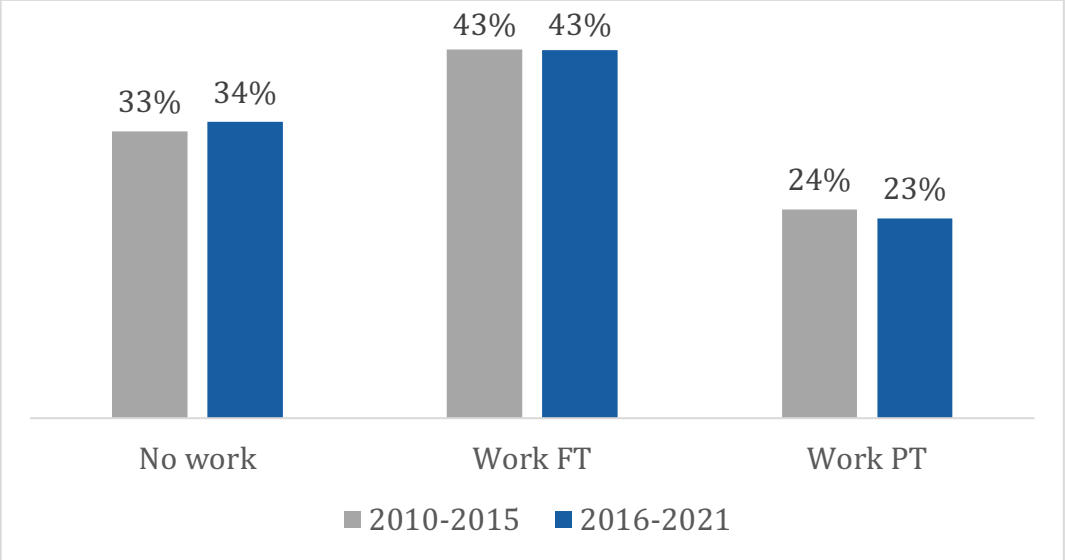
Finding #1: 71% of MT's adult Medicaid recipients worked during a year they receive Medicaid.

Among the Montanans 19-64 covered by Medicaid at any point in the prior year who do not report any SSI income, 71 percent worked during the prior year (45 percent worked full-time, 26 percent worked part-time), and 29 percent did not work.

Finding #2 Medicaid expansion did not change the propensity for low-income Montanans to work.

In the five years before expansion (2011-2015), 67 percent of Montanans with income less than 200 percent of FPL worked.[37] In the past five years (2017-2021), 66 percent of Montanans with income less than 200 percent of FPL worked. The small one percentage point change is not statistically significant, occurred even in non-expansion states, and may reflect the changes in the composition of the low-income population discussed in section II.G.1.

Figure 5: Work status last year among lower-income (<200% FPL) Montanans, pre- and post-expansion



Notes: Analysis of CPS-ASEC.

[37] The CPS-ASEC is collected in March each year; however, the relevant questions for this analysis cover "last year." As such, data from the 2022 ASEC describe outcomes for 2021.

Finding #3: Most employed adult Medicaid recipients work in a relatively small number of jobs.

Working Montanans aged 19-64 who receive Medicaid work in a small number of jobs. Among adult Medicaid recipients who work, nearly fifty percent work in the 20 occupations listed in the table below. For instance, 4.6 percent of all adult Medicaid recipients work as personal care aides, and 26.3 percent of all 19-64-year-olds who work as personal care aides receive Medicaid. In addition, among all workers ages 19-64 in these occupations, Medicaid covers more than 20% in 11 of these occupations, and more than 30% of Montana's maids, child care workers, food preparation workers, cooks, and bakers.

Table 2: Working adult Medicaid recipients by occupation

	Occupation	% of occ.	% of adult Medicaid
1	Personal Care Aides	26.3%	4.6%
2	Cooks	30.5%	4.4%
3	Cashiers	26.4%	4.1%
4	Retail Salespersons	15.9%	3.4%
5	Waiters and Waitresses	23.1%	3.2%
6	Maids and Housekeepers	34.0%	3.0%
7	Laborers and Freight, Stock, and Material Movers, Hand	21.3%	2.8%
8	Janitors and Building Cleaners	16.4%	2.7%
9	Food Preparation Workers	31.5%	2.5%
10	Childcare Workers	31.8%	2.2%
11	Misc. Ag. Workers	17.4%	1.9%
12	Driver/Sales Workers and Truck Drivers	7.3%	1.7%
13	Grounds Maintenance Workers	23.3%	1.6%
14	Construction Laborers	11.9%	1.5%
15	Customer Service Representatives	8.7%	1.4%
16	Carpenters	12.3%	1.4%
17	Farmers, Ranchers, and Other Ag. Managers	8.0%	1.4%
18	Bakers	66.8%	1.3%
19	First-Line Supervisors of Retail Sales Workers	5.1%	1.2%
20	Food Service Managers	19.9%	1.2%

Notes: Analysis of American Community Survey microdata obtained from IPUMS-USA. I switch from the CPS-ASEC to the ACS for this analysis to increase the sample size and obtain more reliable estimates. Analysis of CPS data yields similar results.

Finding #4: Montana's adult Medicaid population differs from the non-Medicaid population.

As shown in Table 3, the composition of Montana's adult Medicaid population is very different from Montana's adult non-Medicaid population. Specifically, the Medicaid population has much higher shares of people who:

- Work part-time for economic reasons[38];
- Attend school[39];
- Report some form of impairment/disability[40];
- Have children or other reported care responsibilities[41];
- Are single parents.

For instance, 27 percent of Montana's adult Medicaid population reports some form of impairment/disability, but only 11 percent of Montana's adult non-Medicaid population reports an impairment/disability.

Table 3: Composition of adult Medicaid and non-Medicaid population

	Share of Adult Medicaid	Share of Adult Non-Medicaid
Working part time for economic reasons	11.7%	5.6%
Attending school	14.0%	8.0%
With some reported disability	26.9%	11.2%
With children in family (or other reported care responsibilities)	54.1%	40.2%
Single adult with child	7.8%	2.3%
Female	54.5%	48.4%
Living outside of metro area	62.2%	61.9%

Notes: Analysis of 2018-2022 CPS-ASEC data.

[38] I code an individual as working part-time for economic reasons if the worker worked part-time last year because they couldn't find a full-time job or they faced slack work.

[39] I code an individual as attending school if they currently attend school or college or the reported reason for not working last year or only working part-year last year was school attendance.

[40] I code an individual as having disability/impairment if respondent reported that they had "a health problem or a disability which prevents him/her from working or which limits the kind or amount of work" at any point in the prior year or the reason reported for not working last year or the reason for only working part-year last year was "illness/disability" or the respondent reported that they:

- Were deaf or had serious difficulty hearing;
- Were blind or had serious difficulty seeing even with corrective lenses;
- Had cognitive difficulties (such as remembering, concentrating, or making decisions) because of a physical, mental, or emotional condition;
- Had serious difficulty walking or climbing stairs;
- Had any physical, mental, or emotional condition that makes it difficult or impossible to perform basic activities outside the home alone;
- Had have any physical or mental health condition that makes it difficult for them to take care of their own personal needs, such as bathing, dressing, or getting around inside the home.

[41] I code an individual as having children/care responsibilities if the number of children in the supplemental poverty measure family unit is greater than zero or the reason listed for not working last year or only working part-year last year was taking care of home/family.

Finding #5: Ninety-six percent of Montana's adult Medicaid population works or reports at least one plausible impediment to work.

Table 4 shows the allocation of Montana's adult Medicaid population across nine categories that combine the various attributes in Table 3. As discussed above, 44 percent of Montana's adult Medicaid population works full-time. Another 10 percent do not work full-time, but attend school. An additional six percent work part-time but indicate that they prefer to work full-time. As such, 60 percent of Montana's adult Medicaid population works full time, wants to work full time, or attends school.

Among the remaining adult Medicaid population, 40 percent work part-time, and 80 percent report some form of disability or have caregiving responsibilities. Only nine percent of Montana's adult Medicaid population works less than full-time and report no disability or caregiving responsibility, and only four percent report no work and no disability or caregiving.

Table 4: Composition of adult Medicaid population by employment, disability, caregiving

Cumulative share	Share	
44%	44%	Working full-time regardless of potential impediment (e.g., this share includes the 3.6% of adult Medicaid beneficiaries who work full-time and attend school and the 7% who work full-time and report some form of disability).
55%	10%	Not working full-time, but attending school (regardless of other potential impediment).
60%	6%	Not working full-time (or attending school), but working part-time for economic reasons (e.g., would like a FT job) (regardless of other impediment)
64%	4%	Working part-time (for non-economic reasons) and report some form of disability or impairment (regardless of other impediment)
71%	7%	Working part-time (for non-economic reasons), no reported disability, but child in family (or other reported care responsibility)
76%	5%	Working part-time with no reported potential impediments
88%	13%	Not working, but reported some form of disability/impairment
96%	8%	Not working, no reported some form of disability/impairment, but child in family (or other reported care responsibility)
100%	4%	Not working and no reported potential impediments

Notes: Analysis of 2018-2022 CPS-ACES data.

While these data do not perfectly describe barriers to work (e.g., someone with a disability could work more and someone with no reported impairment may be unable to work),

these data suggest that nearly all adult Medicaid beneficiaries face plausible impediments to work/higher earnings that contribute to their Medicaid eligibility.

Finding #6: Over the course of four years 25 percent of adults are covered by Medicaid at some point.

People move into and out of Medicaid. As such, across a multi-year period, the size of the population ever covered by Medicaid exceeds the size of the currently covered population. For example, during 2017-2021, 14 percent of Montanans 19-64 with no SSI income reported Medicaid coverage in a given year, but 20 percent reported Medicaid coverage at any point during two consecutive years. In a national dataset, 25 percent of adults 19-64 (with no SSI income) in expansion states report Medicaid coverage at some point over four years.[42] Among those covered by Medicaid at any point during the four years, 36 percent reported coverage in all four years, and roughly half reported coverage for less than two years.

Finding #7: People who persist on Medicaid differ from those covered for shorter periods.

Those more persistently covered differ from those covered for shorter periods. In particular, individuals with disabilities are significantly more likely to be covered for longer periods. Over the course of four years, 53 percent of people with some level of disability report Medicaid coverage at some point, and 28 percent of people with some disability report coverage in three-four years. Twenty-eight percent is three times the share of the whole 19-64 population that report coverage in three-four years.

Table 5: Experience and duration of Medicaid among adult population

	All	Any disability	Child present
Share of adult population with …			
Any coverage over four years	25%	53%	30%
Coverage in 1 year or less	7%	7%	8%
Coverage in 1 to 2 years	4%	8%	5%
Coverage in 2 to 3 years	4%	9%	5%
Coverage in 3 to 4 years	9%	28%	11%
Share of beneficiaries with coverage in all 4 years	36%	53%	37%

Notes: Analysis of SIPP 2018 panel.

[42] Montana's annual share of adults with Medicaid coverage equals the national Medicaid expansion share.

V. 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.