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September 15, 2022

# Montana's Fiscal Gains From Medicaid Expansion Are a Model for Wyoming

By Gideon Lukens

Most states that have not expanded Medicaid are in the South, but one state in the West — Wyoming — is among the exceptions. The experience of other states, including its neighbor Montana, shows that if Wyoming expands Medicaid, it will dramatically increase coverage while providing the state with fiscal savings for many years to come.

Numerous studies have documented the benefits of Medicaid expansion to people who gain coverage. These include increased access to care, improvements in cancer diagnosis rates, and reductions in deaths — overall, from conditions such as cardiovascular disease, and among infants.[1] Medicaid expansion also improves financial security. It lowers medical debt, the most common form of debt, held by 100 million people in the U.S.[2] It also reduces catastrophic medical costs,[3] evictions, and bankruptcies while improving credit scores.[4]

But studies show that Medicaid expansion also has fiscal benefits, making it a great deal for state governments and taxpayers and often producing net fiscal gains. These studies do not include the American Rescue Plan's federal match rate incentive, which alone would provide enough federal

[1] Madeline Guth, Rachel Garfield, and Robin Rudowitz, "The Effects of Medicaid Expansion under the ACA: Studies from January 2014 to January 2020," Kaiser Family Foundation, March 17, 2020, https://www.kff.org/report-section/the-effects-of-medicaid-expansion-under-the-aca-updated-findings-from-a-literature-review-report/; Inna Rubin, Jesse Cross-Call, and Gideon Lukens, "Medicaid Expansion: Frequently Asked Questions," CBPP, June 16, 2021, https://www.cbpp.org/research/health/medicaid-expansion-frequently-asked-questions.

[2] Noam N. Levey, "100 Million People in America Are Saddled With Health Care Debt," Kaiser Health News, June 16, 2022, https://khn.org/news/article/diagnosis-debt-investigation-100-million-americans-hidden-medical-debt/.

[3] Katherine Baicker *et al.,* "The Oregon Experiment — Effects of Medicaid on Clinical Outcomes," *New England Journal of Medicine,* Vol. 368, May 2, 2013, https://www.nejm.org/doi/pdf/10.1056/NEJMsa1212321.

[4] See Heidi L. Allen *et al.,* "Can Medicaid Expansion Prevent Housing Evictions?" *Health Affairs,* Vol. 38, No. 9, 2019, https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2018.05071; Sarah Miller *et al.,* "The ACA Medicaid Expansion in Michigan and Financial Health," National Bureau of Economic Research Working Paper 25053, revised March 2020, http://www.nber.org/papers/w25053; Kenneth Brevoort, Daniel Grodzicki, and Martin B. Hackmann, "Medicaid and Financial Health," National Bureau of Economic Research Working Paper 24002, November 2017, https://www.nber.org/papers/w24002.

funding to fully offset non-federal expansion costs for between 3.1 and 6.5 years among the 12 non-expansion states, depending on the state.[5]

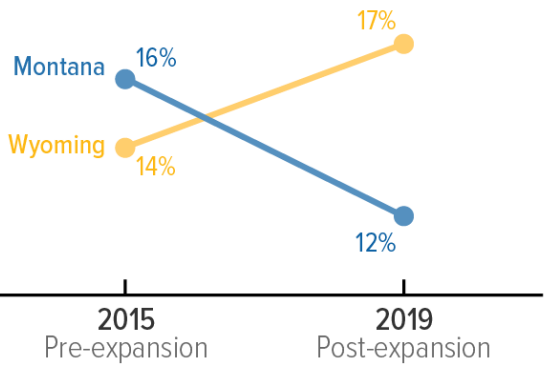
Montana's experience highlights the fiscal benefits that Wyoming could expect if it expands Medicaid. Like Wyoming, Montana is a Western state that is less densely populated than most other states. The two states have similar per-capita rates of total state expenditures and tax collections and share demographic similarities. In addition, Montana's expansion, which was implemented on January 1, 2016, was long enough ago to provide ample post-expansion data and to allow comprehensive studies of fiscal impacts, unlike some Western states that expanded more recently (for example, Idaho and Utah).

## Rapid Drop in Uninsured With No Decline in Employer Coverage

When states expand Medicaid, they experience steep reductions in the number of uninsured people, which drives many of the fiscal benefits to states. After Montana implemented its expansion on January 1, 2016, the uninsured rate fell steeply while Medicaid enrollment increased roughly 50 percent in only two years.[6] This result is unsurprising, as numerous studies have demonstrated large coverage gains for uninsured people in states that expanded Medicaid.[7]

FIGURE 1

**Montana Saw Large Drop in Uninsured Rate After Expansion**




Note: Uninsured rates for non-institutionalized population aged 19-64. Montana implemented Medicaid expansion on January 1, 2016.

Source: CBPP analysis of American Community Survey, 2015 and 2019

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A simple comparison of uninsured rates in Wyoming and Montana before and after Montana's expansion illustrates the impact of Montana's expansion on the uninsured rate. During the first year of the expansion, the uninsured rate among non-elderly adults dropped by one-quarter, from 16 percent in 2015 to 12 percent in 2016.[8] In contrast, Wyoming's uninsured rate rose from 14 to 15 percent during that period. By 2019, Montana's uninsured rate was still 12 percent while Wyoming's had further increased to 17 percent. (See Figure 1.)

[5] Manatt Health, "Assessing the Fiscal Impact of Medicaid Expansion Following the Enactment of the American Rescue Plan Act of 2021," April 2021, https://www.manatt.com/Manatt/media/Documents/Articles/ARP-Medicaid-Expansion.pdf.

[6] Centers for Medicare & Medicaid Services, Monthly Medicaid & CHIP Application, Eligibility Determination, and Enrollment Reports & Data: December 2015 – December 2017, https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-chip-enrollment-data/monthly-medicaid-chip-application-eligibility-determination-and-enrollment-reports-data/index.html.

[7] Guth, Garfield, and Rudowitz, *op. cit.*

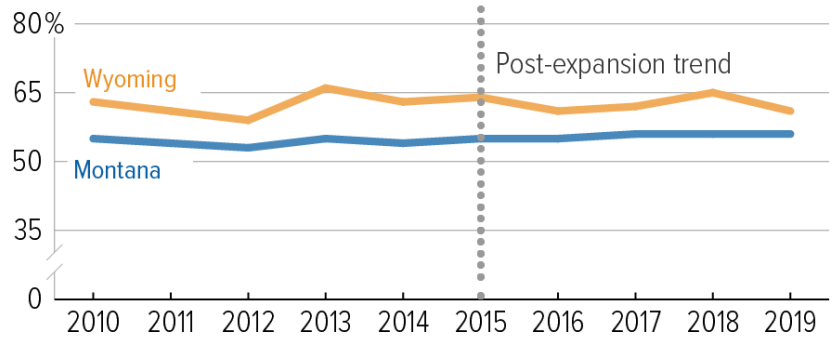
[8] This age group is the most impacted by Medicaid expansion because children who might otherwise be impacted are typically already eligible for the Children's Health Insurance Program (CHIP), while elderly people are eligible for Medicare. Montana implemented expansion on January 1, 2016.

The change between the two states' uninsured rates is revealing. Prior to 2016, Montana's uninsured rate was consistently higher than Wyoming, with the gap between the rates averaging about 4 percentage points from 2010 to 2015. Following expansion (2016 to 2019), the gap in uninsured rates still averaged about 4 percentage points, but the relationship was reversed: Montana's uninsured rate was consistently *lower* than Wyoming's. A recent report by the Urban Institute estimated that if Wyoming were to expand Medicaid, the number of uninsured people would decline by one-quarter in 2023, equivalent to 20,000 additional people with coverage.[9] That translates to a 3.8 percentage point decline in the uninsured rate in Wyoming, putting it more in line with Montana's uninsured rate.

While some critics have warned that Medicaid expansion causes significant numbers of people to shift from employer-based coverage to Medicaid, empirical research has demonstrated small or no impacts on employer coverage.[10] The lack of any obvious decline in employer coverage is evident in a comparison of trends in Wyoming and Montana. (See Figure 2.) The rate of employer coverage for non-elderly adults showed no signs of decline in Montana, averaging 55 percent in the three years prior to expansion and 56 percent in the three years after expansion. In Wyoming during the same period, employer coverage rates also do not trend significantly in either direction, averaging 64 percent from 2013 to 2015 (prior to Montana's expansion) and 63 percent from 2016 to 2018 (after Montana's expansion).

FIGURE 2

**Montana's Expansion Had No Obvious Impact on Employer-Based Coverage**




Note: Employer coverage rates for the non-institutionalized population aged 19-64. People with more than one type of coverage are assigned one type based on a hierarchy in the following order: Medicaid, Medicare, Employer, Military, Non-group. Montana implemented Medicaid expansion on January 1, 2016. Because the data are annual, trends after 2015 capture Montana's post-expansion period.

Source: CBPP analysis of American Community Survey, 2010-2019

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[9] Matthew Buettgens and Urmi Ramchandani, "3.7 Million People Would Gain Health Coverage in 2023 If the Remaining 12 States Were to Expand Medicaid Eligibility," July 2022, https://www.urban.org/research/publication/3-7-million-people-would-gain-health-coverage-2023-if-remaining-12-states-were.

[10] Molly Frean, Jonathan Gruber, and Benjamin Sommers, "Premium subsidies, the mandate, and Medicaid expansion: Coverage effects of the Affordable Care Act," *Journal of Health Economics*, Vol. 53, May 2017, https://www.sciencedirect.com/science/article/abs/pii/S0167629616302272. Michael Dworsky and Christine Eibner, "The Effect of the 2014 Medicaid Expansion on Insurance Coverage for Newly Eligible Childless Adults," Rand Corporation, 2016, https://www.rand.org/pubs/research_reports/RR1736.html.

## Net Budgetary Savings Would Last Many Years, If Not Indefinitely

The federal government pays 90 percent of the cost of Medicaid for expansion enrollees (leaving 10 percent for the states). That is far larger than the 60 percent federal contribution for traditional Medicaid enrollment groups in the median state and the 50 percent paid for Wyoming enrollees.[11] Due to offsetting savings and revenue increases, the net cost to states is even smaller than this modest 10 percent share. Studies of over a dozen states have consistently demonstrated substantial fiscal savings when states expand Medicaid, and most states with comprehensive analyses found that expansion would lead to net fiscal gains — savings and revenue increases that more than fully offset the state share of the costs of coverage.[12] Moreover, these studies were conducted before the Rescue Plan's large financial incentive for states that expand Medicaid.

A comparison of Medicaid spending trends in Montana and Wyoming do not show an obvious impact of Montana's expansion on state Medicaid spending.[13] In Montana, Medicaid expansion precipitated a dramatic increase in federal Medicaid spending with little change in the growth rate of state Medicaid spending. Annual growth in state Medicaid spending from 2015 (just prior to Montana's expansion) to 2019 averaged 3.2 percent, lower than the 4.2 percent annual average in the three years leading up to expansion. (See Figure 3.)[14] Meanwhile, federal Medicaid spending increased by an annual average of 18.3 percent from 2015 to 2019, up from 3.6 percent during the three years prior to expansion. By 2019, state Medicaid spending was 13 percent higher than it was in 2015, prior to expansion, while federal Medicaid spending had risen 87 percent. In contrast to the dramatic shift in federal Medicaid spending in Montana, the growth rates in Wyoming's state and federal portions of Medicaid spending were similar to one another over this period.

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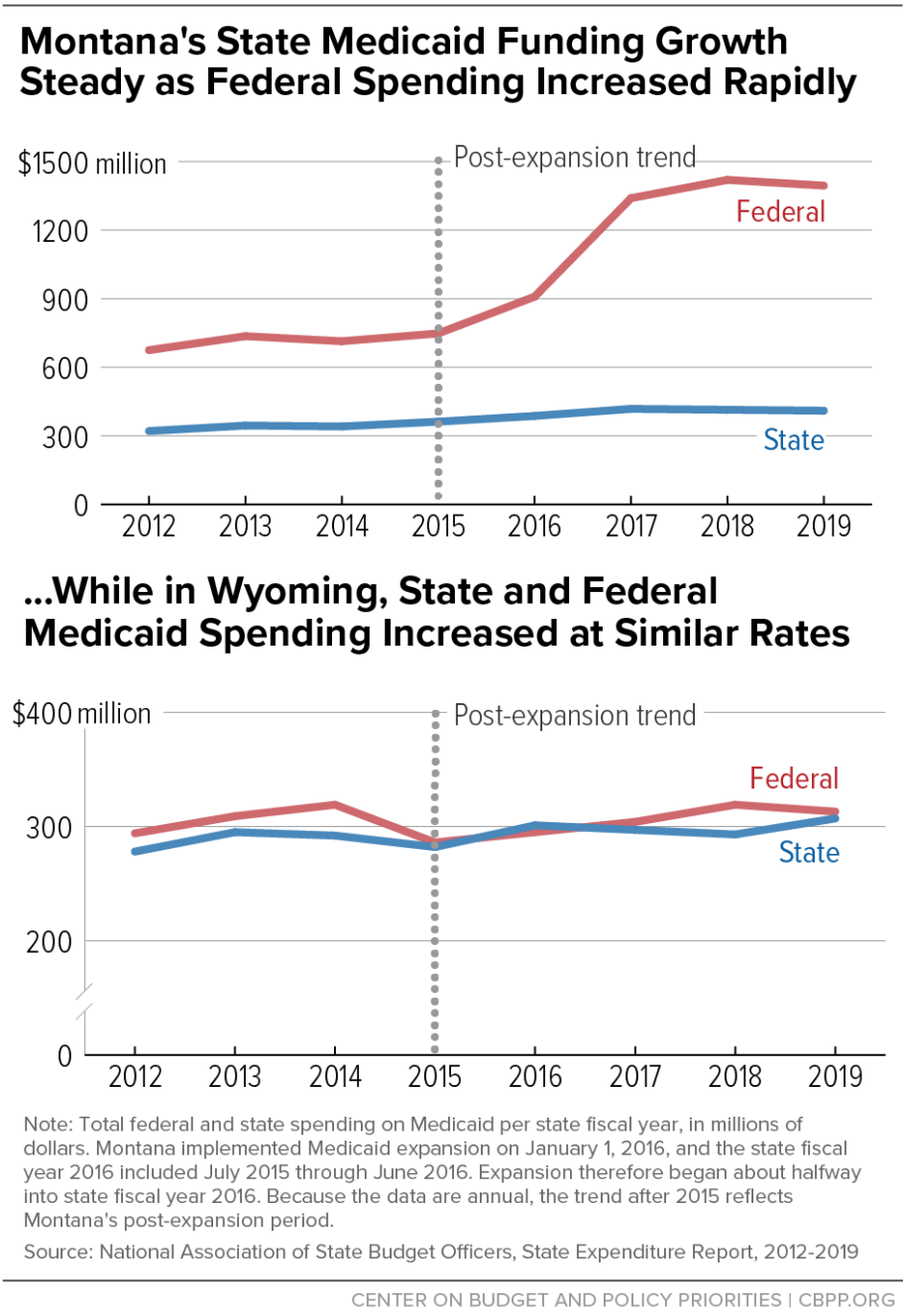
[11] Kaiser Family Foundation, Federal Medical Assistance Percentage (FMAP) for Medicaid and Multiplier, https://www.kff.org/medicaid/state-indicator/federal-matching-rate-and-multiplier. Federal match rates cited here are for 2023. The federal match is calculated by a formula such that the match is higher for states with relatively lower per-capita income. The minimum federal match is set to 50 percent, and Wyoming receives this minimum because it has high per-capita income relative to most other states. As part of pandemic relief legislation, all states receive a temporary 6.2 percentage point increase in their federal match rate, which brings the median state's match rate up to 66.2 percent and Wyoming's match rate up to 56.2 percent. This increase is temporary and will expire when the public health emergency ends.

[12] Bryce Ward, "The Impact of Medicaid Expansion on States' Budgets," Commonwealth Fund, May 5, 2020, https://www.commonwealthfund.org/publications/issue-briefs/2020/may/impact-medicaid-expansion-states-budgets. Buettgens and Ramchandani, *op. cit.* For a cross-state comparison study, see Benjamin Sommers and Jonathan Gruber, "Federal Funding Insulated State Budgets from Increased Spending Related to Medicaid Expansion," *Health Affairs*, Vol. 36, No. 5, May 2017, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1666.

[13] Calculations in this paragraph and the accompanying figure reflect nominal dollars, that is, they are not adjusted for inflation.

[14] Under the ACA, the federal match rate for the expansion group was 100 percent until 2017, when it fell to 95 percent and gradually phased down to 90 percent for 2020 and thereafter. Despite the declining federal match — and rising state share — for the expansion group that began in 2017, Montana's state Medicaid spending grew at a *lower* average annual rate from 2016-2019 than during any other three-year period since at least 2010.

FIGURE 3




Note: Total federal and state spending on Medicaid per state fiscal year, in millions of dollars. Montana implemented Medicaid expansion on January 1, 2016, and the state fiscal year 2016 included July 2015 through June 2016. Expansion therefore began about halfway into state fiscal year 2016. Because the data are annual, the trend after 2015 reflects Montana's post-expansion period.

Source: National Association of State Budget Officers, State Expenditure Report, 2012-2019

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### Savings Within Medicaid

Across studies of ten states, Medicaid expansion resulted in savings in other parts of the Medicaid program that are enough to finance 7 to 85 percent (50 percent on average) of state expansion costs.[15]

[15] Ward, *op. cit.* Estimates vary depending on the methodology used as well as the characteristics of the Medicaid program and federal match rates in the state that is being studied.

When states expand Medicaid, many enrollees who would otherwise be eligible through existing Medicaid groups — some of which offer only limited or temporary coverage — are instead classified as expansion group enrollees. For example, women who enroll in the expansion group and become pregnant may still be considered part of the expansion group instead of being classified as part of the pregnancy group.[16] Other eligibility pathways in which some enrollees could be categorized as part of the expansion group include those related to disability, breast and cervical cancer treatment, family planning, and limited coverage programs for low-income adults under waivers.

This creates offsetting savings in those existing Medicaid groups and produces overall net savings within Medicaid, because the federal government finances 90 percent of the cost of expansion group coverage but typically far less (60 percent in the median state, and 50 percent in Wyoming) for most other eligibility groups.

Studies of Montana's expansion estimate that it recouped enough savings within Medicaid to cover between 23 and 68 percent of the state cost of expansion in 2019.[17] The low estimate comes from a study that tallies categories of cost savings. This study was able to include separate estimates of savings within Medicaid because a portion of enrollees who would have been categorized among those with limited coverage under a waiver, pregnant women, those in the "medically needy" category, and those with breast and cervical cancer were instead categorized as part of the Medicaid expansion group. As such, some expenditures under these existing categories were subject to the 90 percent expansion group federal match rate instead of the lower traditional match rate.[18]

The study that produced the high estimate of offsetting savings within Medicaid in Montana (68 percent) used a common econometric technique that is likely to capture cost savings more comprehensively but does not provide separate estimates of each category.[19] This methodological approach is more likely to capture complex spillover impacts of Medicaid expansion than the approach used in the low estimate, but is unable to identify which parts of Medicaid produce the savings.[20]

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[16] Stan Dorn *et al.*, "The Effects of the Medicaid Expansion on State Budgets: An Early Look in Select States," Kaiser Family Foundation, March 2015, https://www.kff.org/report-section/the-effects-of-the-medicaid-expansion-on-state-budgets-an-early-look-in-select-states-issue-brief/.

[17] 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. Manatt Health, "Medicaid in Montana: How Medicaid Affects Montana's State Budget, Economy, and Health," February 2021, https://mthcf.org/resource/medicaid-in-montana-how-medicaid-affects-montanas-state-budget-economy-and-health/. Cost savings and revenue calculations assume Montana pays 10 percent of expansion costs as required currently and in future years. Pre-pandemic estimates and data are used to avoid the impact of the COVID-19 pandemic and temporary policy changes that altered enrollment and expenditures patterns.

[18] Manatt Health, February 2021, *op. cit.*

[19] Ward, 2021, *op cit.* This method of estimation, known as difference-in-differences, was also used by Sommers and Gruber (2017), cited above, in their cross-state study of the fiscal impacts of Medicaid expansion.

[20] One study found that Medicaid expansion led to fewer people enrolling in the Supplemental Security Income (SSI) program. SSI participation typically qualifies non-elderly adults for Medicaid but imposes income and asset limits; when states expand, low-income childless adults can qualify for Medicaid without SSI, giving them the freedom to increase their earning and assets beyond the SSI limits without losing Medicaid coverage. As a result, some people who otherwise would choose to qualify for Medicaid based on SSI instead opt for enrollment in the expansion group. See Aparna Soni *et al.*, "Medicaid Expansion and State Trends in Supplemental Security Income Program Participation," *Health Affairs*, February 2018, https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.1632.

Wyoming would save roughly 50 percent more than Montana for each enrollee that shifts from an existing group to the expansion group, because Wyoming receives the lowest allowable federal matching rate of 50 percent for most Medicaid enrollment groups, far lower than Montana's 64 percent federal match rate. For each enrollee whose federal match rate is 90 percent (due to being part of the expansion group) instead of Wyoming's usual 50 percent federal match, Wyoming would save 40 cents on the dollar (90 percent minus 50 percent), far more than Montana's 26 cents on the dollar (90 percent match minus 64 percent match).

## Savings in Other Programs

In addition to savings within Medicaid, states save in other programs when they expand Medicaid, especially state-funded programs that serve uninsured populations who under Medicaid expansion receive increased support through Medicaid.[21] These programs include treatment of mental health conditions and substance use disorders, health care for people who are incarcerated, and other programs for vulnerable populations.[22] Estimates of savings outside of Medicaid vary among studies in terms of which programs are included, complicating comparisons. Looking at estimates that include just two common categories of savings — mental health and substance use, and corrections — estimates for Arkansas are at the lower end of savings (6 percent of state expansion costs) while estimates for Michigan are at the upper end (41 percent of state expansion costs).[23]

In Montana, savings outside the Medicaid program have been estimated to equal 17 percent of expansion costs.[24] These savings accrue via Montana's mental health and services program, substance use disorder treatment, and reimbursement for inmate hospitalizations. Adding the 17 percent savings from programs outside of Medicaid to the range of savings estimated within Medicaid discussed above, total estimated cost savings for Montana range from 40 to 85 percent of the state's share of expansion costs, depending on whether we use the lower or upper bound estimate of Montana's within-Medicaid savings.

## Revenue Increases

When more people are covered by insurance due to Medicaid expansion, states gain additional revenue through provider taxes and fees, which are in place in all states except for Alaska and are commonly used by states to partly finance their Medicaid costs.[25] Wyoming has maintained a hospital provider tax since 2017 and a nursing facility provider tax since 2011.[26]

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[21] Whether states use these savings to reduce expenditures in these programs or instead to reach more people in need may depend on the programs and state policy decisions.

[22] Dorn *et al.*, *op. cit.* Medicaid does not cover care for services provided in prisons or jails, but it can cover inpatient care outside of the prison or jail, for example, when an incarcerated person requires inpatient hospitalization.

[23] Ward, 2020, *op. cit.*

[24] Manatt Health, February 2021, *op. cit.* Ward, 2021, *op. cit.*

[25] Kathleen Gifford *et al.*, "State Medicaid Programs Respond to Meet COVID-19 Challenges: Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2020 and 2021," Kaiser Family Foundation, October 2020, https://www.kff.org/medicaid/report/state-medicaid-programs-respond-to-meet-covid-19-challenges/.

[26] Kaiser Family Foundation Annual Medicaid Budget surveys, States With a Hospital Provider Tax in Place, https://www.kff.org/medicaid/state-indicator/states-with-a-hospital-provider-tax-in-place/, and States With a Nursing Facility Provider Tax in Place, https://www.kff.org/medicaid/state-indicator/states-with-a-nursing-facility-provider-tax-in-place/.

Some states newly implemented fees or changed existing fees to pay for some or all of Medicaid expansion, while other states gained additional revenue through existing taxes or fees without policy changes. Likewise, some states dedicate the additional revenues to Medicaid expansion while other states use it to finance other spending. State estimates of these revenue increases range from a premium tax that is enough to cover 13 percent of state expansion costs in Arkansas to a provider fee in Virginia that covers 100 percent of the state cost of expansion.[27] In Montana, one study estimated that Medicaid expansion, by increasing health care consumption, generated additional revenues through its hospital utilization fee that were enough to cover 18 percent of expansion costs.[28]

Many studies have also estimated large indirect impacts on state revenues, as the influx of federal funds following expansion can potentially spur increased economic activity and additional sales and other tax revenues. These impacts are uncertain and depend on future economic conditions and state tax regimes.

## Uncompensated Care Costs

States that expand Medicaid see substantial reductions in uncompensated care costs — the cost of providing health care that goes unpaid by patients or insurers. Uncompensated care costs mostly consist of charity care and debt expenses for uninsured people, and a large body of research shows that these costs fall precipitously for states that expand.[29] Between 2013 and 2015, when most states expanded Medicaid, hospitals' uncompensated care costs fell by $8.6 billion (23 percent), with states that expanded experiencing declines several times larger than those that did not.[30] When uncompensated care costs drop, savings accrue to a combination of the federal government, state and local governments, and health care providers. How these savings are ultimately distributed varies considerably among states depending on how their uncompensated care costs are financed. But a recent study estimated that if the 12 remaining non-expansion states expanded, the reduction in uncompensated care costs alone would offset more than 60 percent of new state Medicaid spending.[31]

The impact of Medicaid expansion on uncompensated care costs, as well as evidence that expansion improves the financial performance of hospitals and other providers,[32] could be part of

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[27] Ward, 2020, *op. cit.*

[28] Ward, 2021, *op. cit.* This estimate uses fiscal year 2020 data to capture the increase in Montana's hospital utilization fee in 2019, in part to help finance expansion.

[29] Gideon Lukens, "Medicaid Expansion Cuts Hospitals' Uncompensated Care Costs," CBPP, April 20, 2021, https://www.cbpp.org/blog/medicaid-expansion-cuts-hospitals-uncompensated-care-costs.

[30] Medicaid and CHIP Payment and Access Commission, "March 2018 Report to Congress on Medicaid and CHIP," March 2018, https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/.

[31] Buettgens and Ramchandani, *op. cit.*

[32] Guth, Garfield, and Rudowitz, *op. cit.*

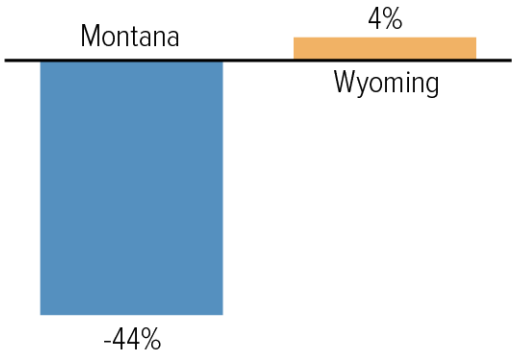
the reason the Wyoming Hospital Association and Wyoming Medical Society support expansion.[33] The Montana Hospital Association has also long championed Medicaid expansion.[34]

A comparison between Montana and Wyoming illustrates the dramatic impact of Medicaid expansion on uncompensated care costs and serves as a useful guide for Wyoming. (See Figure 4.) Uncompensated care in Montana dropped from $143 million in 2015, prior to expansion, to $89 million in 2019. This equates to a 44 percent decline in uncompensated care costs as a share of hospital operating expenses. In contrast, Wyoming's uncompensated care costs increased from $96 million to $106 million over the same period. By 2019, Wyoming's uncompensated care costs were almost three times Montana's as a share of hospital operating expenses.[35]

FIGURE 4

**Uncompensated Care Cut Nearly in Half in Montana After Expansion, Rose in Wyoming**

Percent change in uncompensated care costs as a share of hospital operating expenses, 2015 to 2019




Source: Medicaid and CHIP Payment and Access Commission, Report to Congress on Medicaid and CHIP, 2015 and 2019

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### Rescue Plan Federal Match Rate Incentive

While it is difficult to combine cost savings and revenue increases from separate studies, the estimates cited above indicate that Montana offsets at least the large majority, if not over 100 percent, of its expansion costs through cost savings and revenue increases. That does not factor in any indirect state revenue impacts from increases in economic activity or state savings resulting from uncompensated care reductions. And crucially, it does not include the American Rescue Plan's large financial incentive for states that expand Medicaid.

That incentive would provide Wyoming with a two-year, 5 percentage point increase in the share of Medicaid costs that the federal government pays for *non-expansion* enrollees, who account for most of a state's enrollees and costs. According to separate estimates from the Kaiser Family Foundation and Manatt Health, the incentive would provide Wyoming with $70 to $81 million in additional federal dollars during the first two years of expansion, enough to cover 3.8 years of the state share of

[33] See Wyoming Medical Society's position statement at https://www.wyomed.org/wyoming-medicaid/, and "Medicaid expansion revived despite flood of misinformation," *Oil City News*, May 15, 2021, https://oilcity.news/wyoming/legislature/2021/05/15/medicaid-expansion-revived-despite-flood-of-misinformation/.

[34] Montana Hospital Association President and CEO Rich Rasmussen's Weekly Update, April 22, 2022, https://mtha.org/mha-president-ceo-rich-rasmussens-weekly-update-04-22-22/.

[35] Medicaid and CHIP Payment and Access Commission, "March 2022 Report to Congress on Medicaid and CHIP," March 2022, https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/. Medicaid and CHIP Payment and Access Commission, "March 2018 Report to Congress on Medicaid and CHIP," March 2018, https://www.macpac.gov/publication/march-2018-report-to-congress-on-medicaid-and-chip/.

Medicaid expansion costs even before consideration of any of the cost savings and revenue increases discussed above.[36]

If we assume that Wyoming experiences the same lower bound estimate of offsetting savings and additional revenues as a share of Medicaid expansion costs as Montana, and we add in the estimated 3.8 years of expansion that the Rescue Plan federal match rate incentive would cover, Wyoming's expansion would be funded for about a decade at no net cost to the state. Assuming the upper bound estimate of Montana's offsetting cost savings and revenue increases as a share of expansion costs would produce a financial windfall for Wyoming, that would more than pay for the costs of Medicaid expansion indefinitely.[37]

These calculations are rough and do not factor in any potential revenue increases due to expansion's impact on the state economy or state savings due to reduced uncompensated care costs, which would likely lead to even more savings. And importantly, they do not consider the benefits to the people of Wyoming in increased financial security, reduced medical debt, better health outcomes and saved lives, which are social benefits that far outweigh the fiscal costs of expansion.

The evidence from Montana makes it clear that Medicaid expansion would not only provide tens of thousands of uninsured people in Wyoming with critical health coverage, but it would also be the fiscally sensible choice.

[36] Robin Rudowitz, Bradley Corallo, and Rachel Garfield, "New Incentive for States to Adopt the ACA Medicaid Expansion: Implications for State Spending," February 2021, https://www.kff.org/medicaid/issue-brief/new-incentive-for-states-to-adopt-the-aca-medicaid-expansion-implications-for-state-spending/. Manatt Health, April 2021, *op. cit.*

[37] These calculations do not constitute an estimate of the fiscal impact of Medicaid expansion on Wyoming, but rather are a way to consolidate the estimates for Montana and understand what they would mean for Wyoming if its fiscal impacts were similar.