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### Health Status and Access to Care among Maine's Low-Income Childless Adults: Implications for State Medicaid Expansion

Zach Croll

*University of Southern Maine, Muskie School, Maine Rural Health Research Center,*  
[zachariah.croll@maine.edu](mailto:zachariah.croll@maine.edu)

Erika C. Ziller PhD

*University of Southern Maine, Muskie School of Public Service, Maine Rural Health Research Center,*  
[erika.ziller@maine.edu](mailto:erika.ziller@maine.edu)

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# Health Status and Access to Care among Maine's Low-Income Childless Adults:

## Implications for State Medicaid Expansion

by Zachariah Croll and Erika Ziller

### Abstract

The Affordable Care Act allows states to expand Medicaid coverage to low-income childless adults with income at or below 138 percent of the federal poverty level. Following a 2017 statewide referendum, Maine began enrolling eligible residents in expanded Medicaid in January 2019. While prior research suggests that Maine's low-income childless adults may face health problems and barriers to accessing services, their health status has not been well documented. The rollout and ongoing implementation of Maine's Medicaid expansion may be hampered by incomplete information on the characteristics and health status of the low-income childless adult population. This study examines demographic characteristics, health status, and access to care among Maine's low-income childless adults and offers recommendations to policymakers, providers, and other stakeholders working to implement Medicaid expansion and address the health needs of this vulnerable population.

maintain budget neutrality, Maine implemented its low-income childless (or noncategorical) adult waiver by funding a limited Medicaid benefits package for up to 20,000 individuals aged 21 to 64 who earned up to 100 percent of the federal poverty level (FPL). The waiver was implemented on October 1, 2002; however, citing state budget shortfalls, the state allowed it to expire on December 31, 2013 (Scott 2014).

As originally enacted, the ACA required states to expand Medicaid coverage to residents with income at or below 138 percent of the FPL based on income alone. The US

Supreme Court subsequently ruled in *National Federation of Independent Business (NFIB) v. Sebelius* that this provision of the ACA was unconstitutionally coercive and that states could therefore opt out of expansion (Musumeci 2012; Swendiman and Baumrucker 2012). Without expansion, low-income childless adults risk falling into a coverage gap as a result of having incomes above Medicaid-eligibility limits but below eligibility limits for ACA Marketplace premium tax credits (Garfield, Damico, and Orgera 2018). States that choose to expand Medicaid receive increased federal funding to support expansion and are required to provide benefits to new enrollees that include, at a minimum, the 10 categories of essential health benefits specified in the ACA (Musumeci 2012).

At the time of this writing, 37 states including D.C. have adopted the Medicaid expansion through either a state plan amendment (SPA) or waiver, and 14 states have not expanded Medicaid coverage (KFF 2019). Research on the politics of state Medicaid expansion has found that key predictors of expansion include the distribution of partisan power, state Medicaid policy

### BACKGROUND

Medicaid is a jointly funded and administered federal and state program established in 1965 to provide health insurance coverage to low-income families with dependent children as well as the elderly, blind, and disabled (Brown and Sparer 2003; Moore and Smith 2005). Since the program's inception, state administrators have retained wide discretion in determining eligibility, benefits, provider payments, and the organization of care (Brown and Sparer 2003; Musumeci 2012). Federal law prior to the Patient Protection and Affordable Care Act (ACA) of 2010 excluded nondisabled, nonpregnant adults without dependent children from the program although states could seek waivers from the federal government to add additional eligibility and benefit categories. Prior to the ACA, eight states (including Maine) obtained waivers to expand full Medicaid coverage to low-income childless adults; however, these states established very low income thresholds for eligibility and/or capped the number of adults who could enroll (Musumeci 2012). To

legacy, the influence of provider groups, and the levels of conservative ideology and racial resentment among members of the public (Lanford and Quadagno 2018). Despite years of categorical expansion, increased enrollment, and general destigmatization of the program, Medicaid has frequently been subject to partisan politics and targeted for retrenchment by Republican officials (Grogan and Park 2017). Republican opposition to the program is perhaps most evident in the party's repeated efforts at the federal level to reduce funding (Grogan and Park 2017) and by states' reactions to Medicaid expansion, with 13 of the 14 nonexpansion states controlled by Republican trifecta before the 2018 elections ([https://ballotpedia.org/State\\_government\\_trifectas](https://ballotpedia.org/State_government_trifectas)). Indeed, following the Supreme Court's ruling that states could opt out of the Medicaid expansion, blocking expansion became the primary vehicle that opponents of the ACA have used to delay implementation (Lanford and Quadagno 2018).

In Maine, as elsewhere in the United States, partisanship has played a key role in shaping the discourse around, and eventual implementation of, the ACA's Medicaid expansion. Between 2013 and 2016, the Maine Legislature voted five times to approve Medicaid expansion, but each bill was ultimately vetoed by Governor Paul LePage (R) (Shepard 2018). In November 2017, Maine became the first state to approve expansion by referendum when 59 percent of Maine voters approved a ballot initiative expanding Medicaid for qualified adults under age 65 with incomes at or below 138 percent of the FPL (Bloch and Lee 2017).

The LePage administration, however, delayed implementation throughout 2018, the remainder of his term. The administration and other opponents had long argued that wait-lists and access to care for disabled and elderly beneficiaries would only worsen if Maine chose to expand access to care for the ostensibly younger and able-bodied childless adults targeted by Medicaid expansion. However, on January 3, 2019, newly elected Governor Janet Mills (D) signed an executive order securing approval for expansion retroactive to July 2, 2018.<sup>1</sup>

Maine's Medicaid expansion is projected to provide health coverage to 80,000 low-income Mainers (Kilbreth 2017). While opponents of expansion have characterized the target population as able bodied, their actual health status has not been well established empirically. Similarly, proponents of expansion have lacked a robust understanding of who exactly the newly eligible adults are in

terms of their demographic characteristics and health-care needs. The limited research to date exploring the characteristics and health status of Maine's low-income childless adults suggests that they contend with multiple health issues and barriers to obtaining needed care, as evidenced in part by the rapid uptake and long wait-list for the now expired noncategorical adult waiver program (MEJP 2012). According to the waiver's year 7 annual report, the most frequent and costly diagnoses among waiver members included nondependent tobacco-use disorder, mental health and substance-use disorders, and chronic conditions including high blood pressure, high cholesterol, diabetes, and heart disease (Anderson and Gressani 2010). Interestingly, a majority of waiver members incurred relatively few expenses while the top 5 percent to 10 percent accounted for a majority of costs (Anderson and Gressani 2010). Other research has shown that low-income Mainers without health insurance are less likely than their insured counterparts to have a usual source of care, get timely appointments with healthcare providers, and receive regular checkups (Ziller, Burgess, and Leonard 2018). They are also more likely to have difficulty paying medical bills and to delay or go without needed healthcare services because of cost, potentially leading to undiagnosed and unmanaged illness and placing them at greater risk of poor health (Ziller, Burgess, and Leonard 2018).

## Maine's Medicaid expansion is projected to provide health coverage to 80,000 low-income Mainers....

In addition to being limited, the prior studies are somewhat dated (Anderson and Gressani 2010) or did not specifically examine the health status of the low-income childless adult population (Ziller, Burgess, and Leonard 2018). To effectively implement Medicaid expansion, providers, policymakers, and other stakeholders require more complete information on the characteristics of potential enrollees. The goal of this study is to address these gaps by providing empirical evidence on demographic characteristics, health status, and access to care for Maine's low-income childless

adult population, and to offer recommendations to policymakers, providers, and other stakeholders working to implement Medicaid expansion and address the health needs of this vulnerable population.

## METHODS

This study uses data from the 2011–2016 Maine Behavioral Risk Factor Surveillance System (BRFSS), an annual telephone survey tracking health conditions and risk behaviors, as a way to address the following research questions:

- What are the demographic characteristics of Maine's low-income childless adults?
- What are the rates of chronic health conditions and access to care among Maine's low-income childless adults?
- How does the health status and access to care of low-income childless adults compare to other nonelderly adults in the state?

...low-income childless adults are more likely to live in the northern/Downeast region [and]... in small or isolated rural areas.

For purposes of this study, *low-income* refers to households of one or two adults that report earning an annual income of 138 percent of the FPL or less. In 2016, 138 percent of the FPL was \$16,394 for individuals and \$22,135 for a family of two. *Childless adults* includes all respondents aged 18 to 64, living alone or with one other adult, who report zero children less than 18 years of age living in the household. BRFSS respondents with private insurance are included in our sample population and comparison group because research shows that individuals with low incomes, and rural adults in particular, often experience shifts in their work, family, and other life circumstances (including income fluctuations) that lead to changes in eligibility for health insurance (Rosenbaum et al. 2014; Sommers et al. 2016; Ziller, Thayer, and Lenardson 2018).

Individuals who reported coverage through the military, Tricare (formerly CHAMPUS), the US Department of Veterans Affairs (VA), and the Indian Health Service (IHS) are also included in this study because Medicaid may act as a wraparound or alternative source of coverage for low-income veterans (TCHS 2019; Zelaya and Nugent 2018) and Native Americans (Artiga, Ubri, and Foutz 2017). Respondents over the age of 65 and younger adults with Medicare coverage were excluded from this study because they are ineligible for expanded Medicaid. Finally, current Medicaid enrollees were also excluded because they will not gain coverage under the expansion.

We analyzed our data using the survey procedures in SAS statistical software, version 9.4. We compare the demographic characteristics, self-reported health status, and prevalence of chronic health conditions, substance-use behaviors, and access to care among low-income childless adults to other nonelderly adults in Maine (ages 18–64) using chi square tests of independence. Unless noted otherwise, all reported findings are statistically significant at the  $p < 0.05$  threshold. Our use of the 2011–2016 Maine BRFSS data was approved by the Maine Center for Disease Control and Prevention, and the project was approved by the University of Southern Maine Institutional Review Board.

## RESULTS

### *Demographic Characteristics*

As shown in Table 1, low-income childless adults in Maine are more likely than other nonelderly adults to identify as a racial or ethnic minority, be aged 55–64, and be uninsured. Low-income childless adults are also less likely to have private health insurance coverage, but more likely to be covered by Tricare, the VA, or the IHS. Additionally, low-income childless adults are more likely to have a high school diploma or less and are less likely to have completed a bachelor's degree or higher. A smaller proportion of low-income childless adults than other nonelderly adults are employed for wages, and they are more likely to be out of work for more than one year and less than one year. Low-income childless adults are also more likely to report being unable to work than are other non-elderly adults. Finally, low-income childless adults are more likely to live in the northern/Downeast region of the state and, as would be expected given the regional distribution, in small or isolated rural areas.

TABLE 1: **Demographic Characteristics of Low-Income Childless Adults (LICA)**

Measure	LICA (%) (n = 1,563) <sup>1</sup>	Non-LICA (%) (n = 20,926) <sup>1</sup>	p-value
Gender (% female)	49.6	48.9	0.708
Race (% racial/ ethnic minority <sup>2</sup> )*	7.0	4.6	0.0142
<b>Age***</b>			
18–24	6.6	12.7	<0.0001
25–34	12.2	17.9	
35–44	8.7	19.5	
45–54	27.7	25.0	
55–64	44.9	24.8	
<b>Insurance status***</b>			
Uninsured	52.7	15.3	<0.0001
Private coverage	34.8	77.4	
Tricare/VA/IHS	12.6	7.3	
<b>Education***</b>			
Less than high school	12.7	5.5	<0.0001
High school diploma/GED	49.0	31.0	
Some college	27.0	32.9	
Bachelor's degree or higher	11.3	30.7	

Measure	LICA (%) (n = 1,563) <sup>1</sup>	Non-LICA (%) (n = 20,926) <sup>1</sup>	p-value
<b>Employment status***</b>			
Employed for wages	34.9	64.7	<0.0001
Self-employed	15.5	13.0	
Out of work more than 1 year	12.0	2.0	
Out of work less than 1 year	9.2	3.5	
Unable to work	13.3	2.7	
Homemaker/ Student/Retired	15.1	14.1	
Veteran status (% Yes)	10.5	9.8	0.4483
<b>Region<sup>3</sup>,***</b>			
Northern/ Downeast	33.6	25.3	<0.0001
Central/Western	36.8	35.8	
Southern	29.6	38.9	
<b>Place of residence***</b>			
Metro	20.1	29.2	<0.0001
Large rural	34.0	38.7	
Small rural	33.4	24.8	
Isolated rural	12.4	7.3	

Source: Maine Behavioral Risk Factor Surveillance System, 2011–2016

Differences significant at  $p \leq 0.05^*$ ,  $p \leq 0.01^{**}$ , and  $p \leq 0.001^{***}$

1. Unweighted.
2. Racial/ethnic minority includes Black or African American, American Indian or Alaskan Native, Asian, Native Hawaiian or other Pacific Islander, Multiracial, and Other race.
3. Northern/Downeast region includes Aroostook, Hancock, Penobscot, Piscataquis, and Washington Counties; Central/Western region includes Androscoggin, Franklin, Kennebec, Knox, Oxford, Somerset, and Waldo Counties; Southern region includes Cumberland, Lincoln, Sagadahoc, and York Counties.

### Health Status

With regard to health status, Maine’s low-income childless adults experience a substantially higher burden of ill health and chronic disease than other nonelderly adults (Table 2). They are less likely to report excellent or very good overall health and are more likely to report fair or poor health. Low-income childless adults are also more likely to have 15 or more days per month of poor physical health and mental health. They are also more

likely to report that their daily activity is limited in some way by physical, mental, or emotional problems. Among respondents who have ever been diagnosed with arthritis or other joint problems, low-income childless adults are more likely to report that their symptoms affect whether they work or the type or amount of work that they do. Low-income childless adults are also more likely to be obese and to have been diagnosed with high blood cholesterol, high blood pressure, prediabetes, diabetes,

TABLE 2: **Health Status of Low-Income Childless Adults (LICA)**

Measure	LICA (%) (n = 1,563) <sup>1</sup>	Non-LICA (%) (n = 20,926) <sup>1</sup>	p-value
<b>Overall health status***</b>			
Excellent/very good	37.7	62.9	<0.0001
Good	33.9	28.6	
Fair/poor	28.4	8.5	
<b>Bad physical health days (past month)***</b>			
None	53.2	66.9	<0.0001
1 to 14	28.4	26.5	
15 or more	18.5	6.6	
<b>Bad mental health days (past month)***</b>			
None	54.7	64.1	<0.0001
1 to 14	26.1	26.6	
15 or more	19.2	9.3	
<b>Body mass index**</b>			
Underweight	1.4	1.2	0.0011
Normal weight	31.7	34.8	
Overweight	33.3	36.9	
Obese	33.6	27.1	
Limited in any way, in any activities, due to physical, mental, or emotional problems***	35.7	15.5	<0.0001
Arthritis/lupus/gout/fibromyalgia***	33.3	20.7	<0.0001

  

Measure	LICA (%) (n = 1,563) <sup>1</sup>	Non-LICA (%) (n = 20,926) <sup>1</sup>	p-value
Symptoms affect ability to work <sup>2</sup> ,***	54.9	29.7	<0.0001
Ever diagnosed with depression/anxiety***	42.9	29.1	<0.0001
Current depression <sup>3</sup> ,***	17.1	6.4	<0.0001
Ever diagnosed with asthma	16.2	15.1	0.4655
Current asthma <sup>4</sup> ,*	79.1	68.4	0.0175
High blood cholesterol***	44.7	32.3	<0.0001
High blood pressure***	36.2	24.0	<0.0001
Diabetes***	14.3	5.5	<0.0001
COPD***	10.3	3.6	<0.0001
Prediabetes***	10.2	6.0	0.0002
Cancer (excluding melanoma)*	5.9	4.2	0.0106
Heart attack/myocardial infarction***	5.2	1.9	<0.0001
Angina/coronary heart disease***	4.6	1.9	<0.0001
Skin cancer	4.1	3.4	0.2551
Kidney disease***	3.4	1.2	<0.0001
Stroke***	3.3	0.9	<0.0001

Source: Maine Behavioral Risk Factor Surveillance System, 2011–2016

Differences significant at  $p \leq 0.05^*$ ,  $p \leq 0.01^{**}$ , and  $p \leq 0.001^{***}$

1. Unweighted.
2. Proportion of respondents ever diagnosed with arthritis or joint problems (unweighted n = 3,095) who indicated it affects their ability to work.
3. Indicator of current depression at time of the survey using two items from the PHQ-2 depression screener.
4. Proportion of respondents ever diagnosed with asthma (unweighted n = 3,043) who still have asthma.

arthritis and other joint problems, chronic obstructive pulmonary disorder (COPD), heart attack or myocardial infarction, angina or coronary artery disease, stroke, kidney disease, and cancer (excluding melanoma) (Table 2). Notably, low-income childless adults are more likely

to have ever been diagnosed with anxiety or depression and are more likely to currently be feeling depressed. Among respondents who reported ever being diagnosed with asthma, a greater proportion of low-income childless adults still had asthma at the time of the survey.



**TABLE 3: Substance Use among Low-Income Childless Adults (LICA)**

Measure	LICA (%) (n = 1,563) <sup>1</sup>	Non-LICA (%) (n = 20,926) <sup>1</sup>	p-value
<b>Cigarettes***</b>			
Never smoked	34.3	54.9	<0.0001
Former smoker	28.5	26.5	
Currently smoke every day	28.5	14.3	
Currently smoke some days	8.7	4.4	
<b>Alcohol use</b>			
At risk for heavy drinking <sup>2</sup>	8.6	8.3	0.8516
<b>Binge drinking in past month<sup>3</sup></b>			
None	65.1	68.3	0.0738
1 to 14 times	30.8	29.4	
15 or more times	4.1	2.3	
Misuse prescription drugs to get high	5.3	3.9	0.2955

Source: Maine Behavioral Risk Factor Surveillance System, 2011–2016  
Differences significant at  $p \leq 0.05^*$ ,  $p \leq 0.01^{**}$ , and  $p \leq 0.001^{***}$

1. Unweighted.
2. More than two drinks per day for men and more than one drink per day for women.
3. Number of times respondent had five or more drinks for men and four or more drinks for women.

### *Substance-Use Behaviors*

With regard to substance-use behaviors, low-income childless adults are no more likely than other nonelderly adults in Maine to be at risk for heavy drinking or to have engaged in binge drinking during the past month. Low-income childless adults are also no more likely to misuse prescription drugs to get high. However, they are more likely to currently smoke cigarettes every day or on some days (Table 3).

### *Access to Care*

As shown in Table 4, Maine's low-income childless adults experience a number of barriers to accessing healthcare services. For example, they are less likely to have a personal doctor and to have had a routine

checkup within the past year. They are much more likely to not see a doctor due to cost and to have had their last routine checkup five or more years ago or never. Low-income childless adults are also more likely to take medicine or receive treatment for mental health or emotional problems and to use special equipment due to physical health problems.

In terms of use of preventive services, low-income childless adults are less likely to have received a flu shot within the past year or to have ever received a sigmoidoscopy/colonoscopy or prostate-specific antigen test. However, low-income childless adults are more likely to receive pneumonia vaccines and mammograms. To better understand these unexpected differences in the rate of pneumonia vaccination and mammography, we conducted additional bivariate analyses that showed that, among those aged 45 to 64, low-income childless adults received these services at a rate equal to or lower than the non-low-income childless adult group. Thus, the observed rate differences for pneumonia vaccination and mammography may be partly explained by the higher average age of low-income childless adults in our sample. Additionally, mammograms are obtainable for free through the Maine Center for Disease Control & Prevention's Breast and Cervical Health Program, increasing access among low-income residents.<sup>2</sup>

### **LIMITATIONS**

This study has several potential limitations. First, the indicators used to measure health conditions and substance use in our analyses are self-reported by survey respondents and, as a result, may be underestimated due to response bias (Lavrakas 2008). There is no reason to suspect, however, that low-income childless adults would be any more likely than other nonelderly adults to misrepresent their responses. Additionally, because self-reported health conditions are contingent upon diagnosis by a provider and (as this study shows) many low-income childless adults face barriers to accessing care, our point estimates may underestimate the true prevalence of disease in the study population. Moreover, although we were able to examine a range of indicators for low-income childless adults, the BRFSS does not include data on specific unmet needs that could further help tailor Medicaid programming and expansion implementation. Also, we combined multiple racial and ethnic minority groups into one category given their small numbers in

**TABLE 4: Access to Care among Low-Income Childless Adults (LICA)**

Measure	LICA (%) (n = 1,563) <sup>1</sup>	Non-LICA (%) (n = 20,926) <sup>1</sup>	p-value
<b>Has a personal doctor***</b>			
Yes	67.6	81.8	<0.0001
More than 1	5.4	4.0	
No	26.9	14.1	
<b>Last routine checkup***</b>			
Past Year	55.0	66.5	<0.0001
1–2 years	13.9	15.4	
2–5 years	11.5	9.7	
5+years/Never	19.7	8.3	
Could not see doctor due to cost (past 12 months)***	32.7	11.6	<0.0001
Take medicine or receive treatment for mental health or emotional problems***	20.2	14.1	<0.0001
Use special equipment due to health problems (e.g., a cane, wheelchair, special bed, or special telephone)***	9.7	3.3	<0.0001
Flu vaccine (past 12 months)***	29.6	36.2	0.0002
Pneumonia vaccine**	26.7	21.7	0.0017
Mammogram <sup>2</sup> ,***	82.6	62.4	<0.0001
Sigmoidoscopy/colonoscopy <sup>3</sup> ,***	58.2	73.9	<0.0001
Blood stool test <sup>4</sup>	31.8	27.4	0.0934
PSA test <sup>5</sup> ,**	28.4	39.4	0.0079

Source: Maine Behavioral Risk Factor Surveillance System, 2011–2016

Differences significant at  $p \leq 0.05^*$ ,  $p \leq 0.01^{**}$ , and  $p \leq 0.001^{***}$

1. Unweighted.
2. The mammogram question was only asked of female respondents (n = 5,191).
3. The sigmoidoscopy/colonoscopy question was only asked of respondents age 50 or older (n = 5,091).
4. The blood stool test question was only asked of respondents age 50 or older (n = 5,078).
5. The PSA test question was only asked of male respondents age 40 or older (n = 2,826).

our sample, but this limited our ability to explore any differences across these groups. Additionally, because the household income variable in BRFSS uses \$5,000 increments, we were unable to define our sample as precisely as we would have liked, i.e., by including only respondents who make exactly 138 percent of the FPL or less (\$16,394 for individuals and \$22,135 for a family of two in 2016). As a result, individuals with income between \$15,000 and \$19,999, and households with two adults and income between \$20,000 and \$24,999 were included in our sample of low-income childless adults. However, the overinclusion of individuals in these income brackets is defensible given the considerable body of research showing that low-income adults are at greater risk of income fluctuations that result in churning among different sources of coverage and/or becoming uninsured (Rosenbaum et al. 2014; Sommers and Rosenbaum 2011; Sommers et al. 2016; Ziller, Thayer, and Lenardson 2018). Indeed, Maine's now-expired waiver program for noncategorical adults experienced considerable turnover among members, with nearly half enrolled for less than one year and three-quarters enrolled for less than two years (Anderson and Gressani 2010). Finally, there is no way to determine who will actually enroll in expanded Medicaid across the included insurance statuses (i.e., uninsured, private coverage, and Tricare/VA/IHS).

## DISCUSSION AND POLICY IMPLICATIONS

This study shows that Maine's low-income childless adult population is in generally poorer health than much of Maine's adult population aged 18 to 64. Compared to other nonelderly adults, low-income childless adults face a higher prevalence of chronic health conditions including high blood pressure, high cholesterol, cardiovascular disease, arthritis, obesity, and diabetes; higher rates of smoking; and higher rates of mental health conditions including anxiety and depression. Low-income childless adults also experience multiple access barriers: 33 percent have not seen a doctor in the past 12 months due to cost, 27 percent do not have a personal doctor or healthcare provider, and 20 percent report that their last routine checkup was five or more years



ago. These findings suggest that there may be substantial unmet need for healthcare services among low-income childless adults, and providers should anticipate a potential influx of new patients who can benefit from chronic disease management and other services. Based on our results, the low-income childless adult population may particularly benefit from behavioral health services, tobacco treatment services, and efforts to improve cardiovascular health through dietary and exercise counseling.

To address the full scope of physical and behavioral health needs among newly enrolled low-income childless adult beneficiaries, providers and policymakers will be able to draw upon MaineCare's existing infrastructure for primary care and disease management and the innovative value-based purchasing strategies currently used by accountable care communities, health home primary care practices, community care teams, and behavioral health homes. Health homes and community care teams receive a per member, per month payment to provide care coordination, case management, individual and family support, chronic disease self-management, and health promotion and education services to MaineCare members who have two chronic conditions or one chronic condition and are at risk for another. Similarly, accountable care communities are groups of providers who work together to reduce costs while improving the quality of care and patient health outcomes, primarily through care coordination and chronic disease management; if participating providers are able to reduce costs while continuing to meet quality benchmarks, they earn a portion of the shared savings. Importantly, both models integrate the delivery of behavioral health and primary care services to better meet the needs of patients and reimburse providers for the chronic disease management and preventive services that newly enrolled low-income childless adults will need.<sup>3</sup>

Meeting the health needs of these newly enrolled adults will be particularly challenging in rural parts of the state, where the greatest proportion of low-income childless adults live and where there are chronic shortages of primary care and mental health providers. As a result, state and federal policymakers, healthcare providers, academic medical centers, nonprofits, and philanthropies should strengthen existing efforts to expand Maine's rural healthcare workforce. For example, stakeholders can continue to encourage rural medical practice among newly trained physicians and advanced practice providers through rural education tracks such as

the highly successful Maine Track program offered by Tufts University School of Medicine and Maine Medical Center or Central Maine Medical Center's rural training track program that includes rural obstetrics. Notably, 64 percent of the first graduating class of the Maine Track program now practices in Maine, and 50 percent of its graduates have pursued a primary care-related specialty. Stakeholders should also seek to increase awareness of programs like the Finance Authority of Maine's student loan forgiveness program for the health professions and the Doctors for Maine's Future scholarship program. Finally, the recently passed University of Maine System bond package offers a unique opportunity to expand Maine's overall nursing workforce and to produce more nurses for rural areas by doubling the size of the University of Southern Maine's nursing simulation center to enable higher enrollment and by increasing educational opportunities in rural areas such as Aroostook County.<sup>4</sup>

## Meeting the health needs of these newly enrolled adults will be particularly challenging in rural parts of the state....

Policymakers and other stakeholders can further support the provision of care in rural areas by ensuring the maintenance of Maine's generally permissive scope of practice laws, which currently designate nurse practitioners (NPs) as primary care providers and allow physician assistants (PAs) to provide delegated medical services under the supervision of a licensed physician (<http://scopeofpracticepolicy.org/states/me/>). By enabling advanced practice providers to perform at the fullest scope of their licensure, NPs, PAs, certified registered nurse anesthetists, clinical nurse specialists, and certified nurse midwives can each play a valuable role in addressing the healthcare needs of rural low-income childless adults and all residents throughout the state.

States that have already expanded Medicaid have achieved coverage gains without diversion of coverage from traditional groups; improved self-reported health status among enrollees; and increased access to care, use

of services, quality of care, affordability of care, and financial security among low-income residents (Antonisse et al. 2018; ASPE 2015; Kilbreth 2017; Mazurenko et al. 2018; Rudowitz and Antonisse 2018; Sommers et al. 2015). Moreover, some expansion states have realized net savings by accessing enhanced federal matching funds for individuals who were previously covered under waivers or specialized categories of Medicaid eligibility and through reductions in state spending on programs for the uninsured (Bachrach et al. 2016). As provider and managed care plan revenues have increased under expansion, state and local governments have also been able to raise additional revenue through existing provider and health plan assessments and fees (ASPE 2015; Bachrach et al. 2016; Cross-Call 2018). Finally, according to FamiliesUSA expansion has also been associated with job growth in the health sector (<https://familiesusa.org/blog/2015/03>) and improved financial performance of hospitals by reducing uninsured visits and uncompensated care, particularly in rural markets and in counties with large numbers of uninsured, low-income childless adults (Lindrooth et al. 2018). In addition to these potential economic benefits to Maine, effective implementation of Medicaid expansion will improve the financial security, access to care, and chronic disease management of Maine's low-income childless adults, who are among the most vulnerable members of our communities. 🐟

## ENDNOTES

1. See testimony by Mary C. Mayhew, commissioner of Maine Department of Health and Human Services ("In Opposition to LD 1578, An Act to Increase Health Security by Expanding Federally Funded Health Care for Maine People: Hearing Before the Joint Standing Committee of Health and Human Service") on January 15, 2013, and Joel Allumbaugh, director of the Center for Health Reform Initiatives, Maine Heritage Policy Center ("In Opposition to LD 1066, An Act To Increase Access to Health Coverage and Qualify Maine for Federal Funding: Hearing Before the Joint Standing Committee of Health and Human Services") on April 2, 2013. More about Governor Mill's executive order may be found here: <https://www.maine.gov/tools/whatsnew/index.php?topic=DHHS-MAINECARE-UPDATES&id=990301&v=article>.
2. Maine CDC Breast and Cervical Health Program (MBCHP): <https://www.maine.gov/dhhs/mecdc/population-health/bcp/services.htm>.
3. More information on Maine's value-based purchasing strategy and reform efforts is available on the MaineCare Services website: <https://www.maine.gov/dhhs/oms/vbp/index.html>.
4. The Maine Center for Disease Control and Prevention's Rural Health and Primary Care division provides maps of areas in Maine with a shortage of health professionals (<https://www.maine.gov/dhhs/mecdc/public-health-systems/rhpc/hpsa.shtml>). More information about the programs is available on the following websites: Maine Track (<https://medicine.tufts.edu/education/MD-maine-track/>); CMMC rural training track (<https://www.cmhc.org/health-professionals/academic-programs/residency-programs-and-fellowship/swift-river-rural-training/>); FAME's loan program ([https://www.famemaine.com/maine\\_grants\\_loans/maine-health-professions-loan-program/](https://www.famemaine.com/maine_grants_loans/maine-health-professions-loan-program/)) and scholarship program ([https://www.famemaine.com/maine\\_grants\\_loans/doctors-for-maine-future-scholarship/](https://www.famemaine.com/maine_grants_loans/doctors-for-maine-future-scholarship/)); UMS's plan to strengthen nursing education (<http://www.maine.edu/about-the-system/system-office/governmental-affairs/invest/>).

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**Zachariah Croll** is a research analyst with the Maine Rural Health Research Center at the University of Southern Maine. His research emphasizes population health and access to healthcare services among rural residents. He has contributed to numerous studies examining rural health

insurance coverage, rural health clinic financial performance and practice transformation, hospital community benefit and population health improvement activity, and rural long-term services and supports.



**Erika Ziller** is an assistant professor and chair of public health at the University of Southern Maine (USM) Muskie School of Public Service. Ziller also directs USM's Maine Rural Health Research Center, which is funded under a federal cooperative agreement to conduct applied

health policy research of relevance to rural people and health systems. Her research emphasizes healthcare access among rural populations, including uninsured and low-income families.