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Sociodemographic and Health Status Characteristics of Maine's Newly Eligible Medicaid Beneficiaries

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INTRODUCTION

Maine's recently approved Medicaid expansion is projected to provide health coverage to approximately 80,000 adults with low-income and no dependent children¹ (referred to as "low-income childless adults" throughout this brief). However, little is known about the sociodemographic characteristics and health care needs of these newly eligible adults. The limited research to date suggests that low-income uninsured residents of Maine are more likely to go without needed care due to cost, leading to undiagnosed and unmanaged illness and placing them at greater risk of poor health.² Research on Maine's prior Medicaid expansion to low-income childless adults (that expired in December 2013) found that this population faces multiple health issues including mental health conditions, substance use and tobacco use disorders, and chronic conditions including high blood pressure, high cholesterol, diabetes, and heart disease.³

To implement Maine's Medicaid expansion most effectively, providers, policymakers, and other stakeholders require more complete and up-to-date information on the characteristics of potential enrollees. This brief reports on data from the 2011-2016 Maine Behavioral Risk Factor Surveillance System (BRFSS) to describe sociodemographic characteristics, health status, and access to care for Maine's low-income childless adult population—the target of expanded Medicaid.* (See Methods Note at the end of the document for a more detailed description of the BRFSS and our definitions). We also offer practical recommendations to policymakers, providers, and other stakeholders

KEY FINDINGS

Maine's low-income childless adults are more likely than other nonelderly adults to:

- Live in remote rural areas of the state
- Experience poor health and chronic illness
- Face barriers to accessing health care services

currently working to implement Medicaid expansion and address the health needs of potential enrollees.

FINDINGS

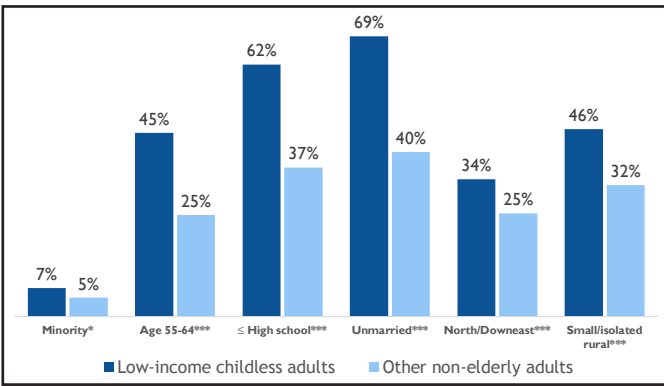
Low-Income Childless Adults Have Lower Education and Live in More Remote Areas

Compared to other adults aged 18-64, Maine's low-income childless adults are more likely to identify as a racial or ethnic minority (Figure 1).** While both groups have equal distributions of females and males (data not shown), low-income childless adults are almost twice as likely to be aged 55-64 (45% vs. 25%), and to have a high school diploma or less (62% vs. 37%). Only 11% have completed a bachelor's degree or higher compared with 31% of other nonelderly adults (data not shown). Low-income childless adults are also more likely to be unmarried (69% vs. 40%) and more likely to live in the North or Downeast region of the state and, consequently, in small or isolated rural areas (46% vs. 32%).

* For this study, low-income refers to households of one or two adults aged 18-64 that are income eligible for expanded Medicaid (approximately \$16,000 annually for individuals and \$22,000 for a family of two), and we define adults as childless if they report zero children younger than 18 living in the household.

** Given the small number of respondents in our sample who identified as a member of a racial or ethnic minority group, we combined multiple groups into a single category, which limited our ability to explore potential differences in health status, access barriers, and resources among these groups.

Figure 1. Sociodemographic Characteristics

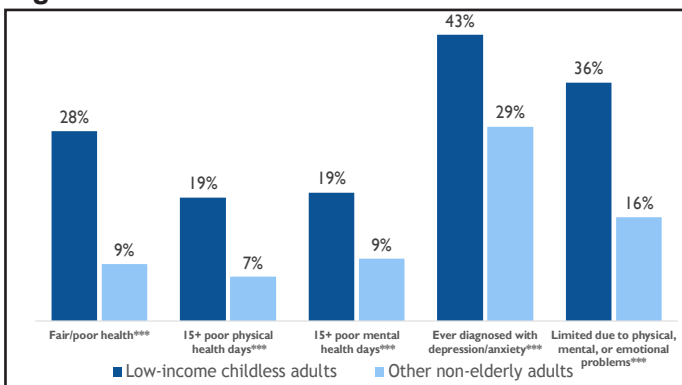


Source: Maine Behavioral Risk Factor Surveillance System, 2011-2016
Differences significant at $p \leq .05^*$, $p \leq .01^{**}$, and $p \leq .001^{***}$

LOW-INCOME CHILDLESS ADULTS EXPERIENCE GENERALLY POORER HEALTH AND MORE CHRONIC ILLNESS

Low-income childless adults are in substantially poorer health than other non-elderly adults (see Figure 2). They are more than three times as likely to describe their health as fair or poor (28% vs. 9%) and almost half as likely to report excellent or very good overall health (38% vs. 63%, data not shown). Compared to other Maine adults, more low-income childless adults experience 15 or more days of poor physical health (19% vs. 7%) and mental health (19% vs. 9%) per month. They are also more than twice as likely to report being limited in their activities due to physical, mental, or emotional problems (36% vs. 16%). Additionally, low-income childless adults are more likely to have ever been diagnosed with anxiety or depression (43% vs. 29%), and are more likely to report current feelings of depression (17% vs. 6%, data not shown).

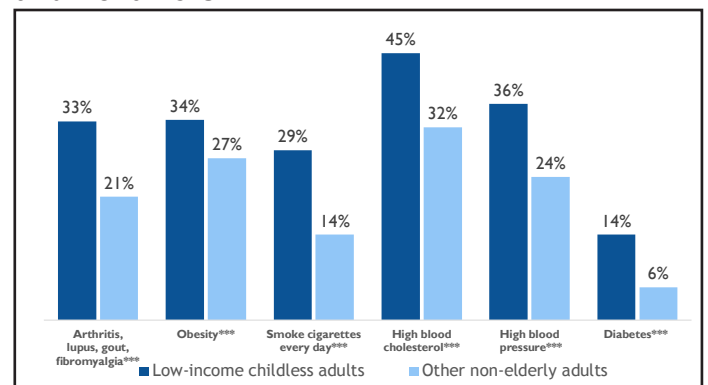
Figure 2. General Health Status



Source: Maine Behavioral Risk Factor Surveillance System, 2011-2016
Differences significant at $p \leq .05^*$, $p \leq .01^{**}$, and $p \leq .001^{***}$

Low-income childless adults are also more likely to be obese and to have been diagnosed with arthritis or other joint problems, high cholesterol, high blood pressure, and diabetes (Figure 3). Among those who have ever been diagnosed with arthritis or other joint problems, low-income childless adults are more likely to report that their symptoms affect the type or amount of work that they do (55% vs. 30%; data not shown). Low-income childless adults are also more likely than other nonelderly adults to have prediabetes, chronic obstructive pulmonary disorder (COPD), heart disease, stroke, kidney disease, and cancer (excluding melanoma; data not shown). Low-income childless adults are no more likely than other nonelderly adults to be at risk for heavy drinking or to misuse prescription drugs (data not shown). However, they are more likely to currently smoke cigarettes every day (29% vs. 14%) and on some days (9% vs. 4%; data not shown). Although low-income childless adults were also statistically no more likely than other nonelderly adults to report ever being diagnosed with asthma, they were somewhat more likely to report having asthma at the time of the survey (79% vs. 68%; data not shown).

Figure 3. Prevalence of Select Health Conditions and Behaviors

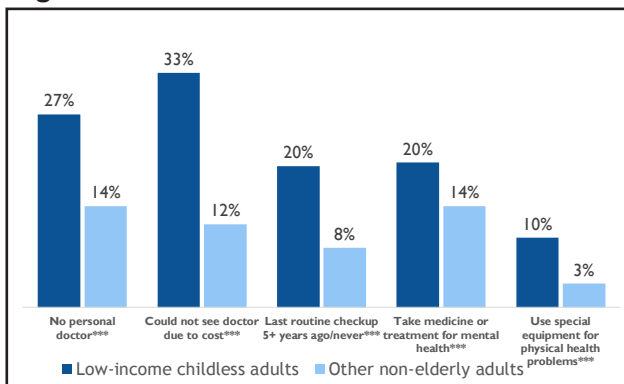


Source: Maine Behavioral Risk Factor Surveillance System, 2011-2016
Differences significant at $p \leq .05^*$, $p \leq .01^{**}$, and $p \leq .001^{***}$

LOW-INCOME CHILDLESS ADULTS HAVE POORER ACCESS TO HEALTH CARE SERVICES DESPITE POORER HEALTH

Reflecting their poorer health status, Maine’s low-income childless adults are more likely than other nonelderly adults to take medicine or receive other treatment for mental health or emotional problems (20% vs. 14%) and to use special equipment due

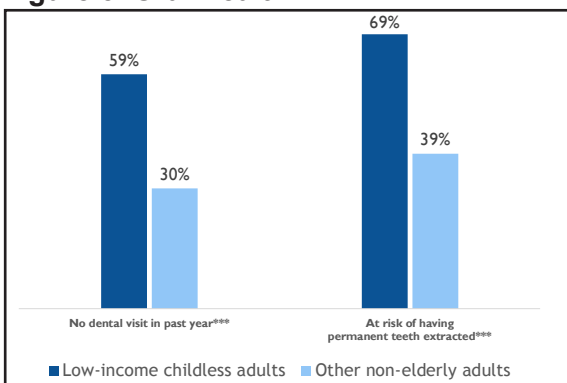
Figure 4. Health Care Access and Service Use



Source: Maine Behavioral Risk Factor Surveillance System, 2011-2016
Differences significant at $p \leq .05^*$, $p \leq .01^{**}$, and $p \leq .001^{***}$

to physical health problems (10% vs. 3%) (Figure 4). However, they are also more likely to report barriers to accessing health care services. For example, they are more likely than other nonelderly adults to not have a personal doctor (27% vs. 14%), to have not seen a doctor in the past year due to cost (33% vs. 12%), and to have had their last routine checkup 5 or more years ago or to have never had a routine checkup (20% vs. 8%). Finally, with regard to oral health, low-income childless adults are significantly more likely to have had no dental visit in the past year (59% vs. 30%) and to be at risk of having their permanent teeth extracted (69% vs. 39%) (Figure 5).

Figure 5. Oral Health



Source: Maine Behavioral Risk Factor Surveillance System, 2011-2016
Differences significant at $p \leq .05^*$, $p \leq .01^{**}$, and $p \leq .001^{***}$

CONCLUSION AND POLICY CONSIDERATIONS

Maine’s low-income childless adults are in significantly poorer health than much of Maine’s other nonelderly adult population aged 18-64. Indeed, 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 (data not shown); and mental health conditions including anxiety and depression. Low-income childless adults also experience multiple access barriers: 33% have not seen a doctor in the past year due to cost, 27% do not have a personal doctor or other health care provider, and 20% received their last routine checkup 5 or more years ago. These findings suggest there may be substantial unmet need for health care services among low-income childless adults, and providers should anticipate a possible influx of new patients who can benefit from chronic disease management and other needed services. The results of this study suggest that the low-income childless adult population may particularly benefit from behavioral health services, tobacco treatment, and dietary and exercise counseling to improve cardiovascular health.

To address the physical and behavioral health needs of newly enrolled low-income childless adult Medicaid beneficiaries, providers and policymakers should seek to draw upon MaineCare’s existing primary care and disease management infrastructure such as Accountable Communities, Health Home primary care practices, and Behavioral Health Homes.⁴ Importantly, these models integrate behavioral health and primary care service delivery to better meet patients’ needs and reimburse providers for the types of chronic disease management and preventive services that newly enrolled adults will require. Meeting the health needs of new Medicaid enrollees will be most challenging in rural parts of the state, where a greater proportion of low-income childless adults live and shortages of primary care and mental health providers persist.⁵ As a result, stakeholders including state and federal policymakers, health care providers, academic medical centers, nonprofit organizations, and philanthropies should strengthen existing efforts to encourage rural medical practice and expand the rural health care workforce. Evidence-based approaches to rural workforce expansion include rural education tracks,⁶ student loan forgiveness and scholarship programs,⁷ and rural nurse training programs.⁸ By preserving

Maine's generally progressive scope of practice laws, policymakers can ensure that advanced practice providers can help address the unmet needs of rural low-income childless adults, and all residents, throughout the state. Finally, coverage and access to health care services are more successful when paired with efforts that help individuals navigate through the health care system (such as deployment of community health workers) and interventions that improve the social determinants of health.⁹ Long-term lack of coverage and utilization of primary care may require significant outreach and encouragement to build effective clinical relationships to address long-term chronic conditions.

METHODS NOTE

This brief uses data from the 2011-2016 Maine Behavioral Risk Factor Surveillance System (BRFSS), an annual telephone survey that tracks health conditions, behaviors, and health care use among Maine adults. Given the small number of low-income childless adults surveyed each year, we pooled these years to ensure sufficient sample size to conduct our analysis.

For the purpose of this study, low-income refers to households of one or two adults aged 18-64 that we estimate may be income eligible for expanded Medicaid (annual income of approximately \$16,000 for individuals and \$22,000 for a family of two). Because BRFSS collects household income in \$5,000 increments, we categorized individuals with income between \$15,000 and \$19,999, and two-adult households with income between \$20,000 and \$24,999, as having low income. We define adults as childless if they live alone or with one other adult and report zero children younger than 18 years of age living in the household. We limited our analyses to adults aged 18-64 because adults aged 65 and older are not eligible for Medicaid under the ACA expansion. We also excluded adults under age 65 with Medicare coverage and individuals already enrolled in Medicaid. All analyses compare low-income childless adults (n = 1,543) to other nonelderly Maine adults aged 18-64 that do not have Medicare or Medicaid (n = 20,926).

Because the BRFSS uses a complex sampling strategy, all analyses for this brief use sample weights to correct for stratification. The statistical testing produced by these analyses account for the complex sample design of the BRFSS. Statistical significance p-values appear below figures.

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