

Medicaid Expansion in Maine Significantly Reduced Uncompensated Care Costs during the COVID-19 Pandemic

by Jordan H. Rhodes

Abstract

This study examines the impact of Maine's 2019 Medicaid expansion through the Affordable Care Act on hospitals' uncompensated care costs. I find that this expansion reduced uncompensated care costs by an average of 26 percent per year, leading to a \$126 million reduction in uncompensated care costs during the first two years of the COVID-19 pandemic. The most pronounced reduction in costs occurred across larger, general acute care hospitals. When comparing bad debt vs charity care, I find that the reduction in uncompensated care costs is driven by a steep decline in reported charity care costs. This decline offsets increases in bad debt expenses in 2020 across smaller, critical access hospitals. The results highlight Medicaid expansion's effectiveness in lowering uncompensated care costs during the first two years of the COVID-19 pandemic in Maine.

Although other research shows a strong relationship between Medicaid expansion and reductions in uncompensated care costs, these studies have focused largely on states that expanded coverage around the time when states were first given the option to do so (January 1, 2014).² A more recent study by Callison et al. (2021) examines the impact of Louisiana's Medicaid expansion in 2016 and shows a significant decline in uncompensated care costs. This look at Medicaid expansion in Maine assesses the extent to which the impact of expansion persists five years after most states first expanded coverage and more than two years after the most

recent analysis of an expansion state.

INTRODUCTION

In January 2019, Maine expanded Medicaid coverage to all adults with incomes up to 138 percent of the federal poverty level through the Patient Protection and Affordable Care Act (ACA). By December 2021, nearly 90,000 Mainers were enrolled in Medicaid through the expansion program.¹ The growth in Medicaid enrollment from 2019 to 2021 coincided with a significant reduction in Maine's overall rate of uninsured, which dropped from 8 percent to under 6 percent. This drop was the largest percentage decline across all states during this period (Conway and Branch 2022). The first three years of Medicaid expansion in Maine also overlapped substantially with the COVID-19 pandemic and a period of monumental change and stress on the US healthcare system.

This study examines the impact of Maine's Medicaid expansion on uncompensated care costs across Maine's hospitals. The analysis contributes to a growing body of literature examining the impact of Medicaid expansion through the ACA on hospitals' financial outcomes.

This study is also the first causal analysis of the impact of Medicaid expansion on hospitals' financial outcomes during the COVID-19 pandemic. Although Maine did experience a significant decline in uninsured rates after Medicaid expansion, this decline does not necessarily translate into reduced levels of uncompensated care costs because of the overlap with pandemic-related disruptions. To control for the impact of the pandemic and other factors, I compare Maine hospitals before and after expansion to hospitals in 12 states that have not expanded Medicaid. I apply a robust set of empirical tools and sensitivity analyses to ensure that the findings capture a causal effect of expansion that is not confounded by factors related to the pandemic. Furthermore, this study differs from other studies by examining the changes in the components of uncompensated care costs—bad debt and charity care—following Medicaid expansion in Maine. Arranging the analysis by these outcomes offers further insight into how Medicaid expansion interacts with overall uncompensated care costs and how this dynamic may have shifted during the COVID-19 pandemic.

DATA AND METHODS

Data

To examine the impact of Medicaid expansion in Maine on uncompensated care costs, I use publicly available hospital cost report data for 2011 through 2021 from the Centers for Medicare and Medicaid Services.³ All hospitals that receive payments from the Medicare program must submit cost report data annually, so the cost report data contain financial information on nearly all US hospitals. I limit the sample to general acute care hospitals and critical access hospitals (and exclude children’s hospitals and psychiatric hospitals) because these facilities are most likely to have been directly affected by Medicaid expansion.

I obtained information on hospitals’ uncompensated care costs from worksheet S100 of the cost report data. A hospital’s uncompensated care costs are calculated as the sum of charity care costs plus the cost of non-Medicare and nonreimbursable Medicare bad debt. Bad debt is costs for which a hospital expected but did not receive payment. Hospitals do not seek reimbursement for charity care, and they may offer charity care to both uninsured and insured patients. Charity care for uninsured patients is generally a full or partial discount of medical bills, while charity care for insured patients may involve write-offs for deductibles or coinsurances. Other studies have also used this definition of uncompensated care costs (excluding payment shortfalls tied to public health insurance programs and other state or local government indigent care programs) (Callison et al. 2021; Rhodes et al. 2020).

Although the cost report data is generally regarded as the best resource for examining financial outcomes across hospitals over time, these data have several well-known limitations including inaccurate and incomplete submissions. I employed extensive data-cleaning techniques to address these issues (Rhodes et al. 2020, 2023a, 2023b). The data-cleaning efforts included aggregating uncompensated care costs when a hospital submitted multiple (nonoverlapping) cost reports within the same fiscal year; removing missing and negative uncompensated care cost submissions; and scrutinizing geographic fields, including hospitals’ state and county submissions.

I also linked other fields to the cost report data to supplement the analysis. The added data included county economic and demographic characteristics and communal exposure to the COVID-19 pandemic. More detail on the

data fields and their respective sources is available in the supplemental [appendix](#).⁴

Methods

To assess the impact of Maine’s Medicaid expansion on hospitals’ uncompensated care costs, I examined the change in these costs across Maine hospitals from before and after expansion went into effect on January 10, 2019.⁵ I then compared the changes in uncompensated care costs from Maine hospitals to hospitals located in nonexpansion states to account for other factors that may have contributed to changes in these costs during this time. For more details on this methodology, termed a “difference-in-differences” analysis, see the [appendix](#).

Along with examining the impact of Medicaid expansion across all hospitals, I examined the impact across three categories of hospitals: general acute care hospitals, critical access hospitals, and hospitals with the highest levels of uncompensated care costs before expansion. I compared Maine’s general acute care hospitals and Maine’s critical access hospitals to test for differences in the effect of expansion by hospital size and organizational structure. I examined the impact of Medicaid expansion across Maine hospitals with the highest baseline levels of uncompensated care costs because these facilities should benefit most from expanded coverage. I identified these hospitals by putting all US hospitals into three tiers based on the ratio of uncompensated care costs and operating expenses in 2018. I then flagged Maine hospitals and hospitals in nonexpansion states that fell within the highest tier.

RESULTS

Baseline Hospital Characteristics

Table 1 presents baseline hospital, county, and state characteristics for the sample of hospitals. The statistics in [Table 1](#) come from cost report submissions for the fiscal year that ended in 2018, the year before Medicaid expansion in Maine. Compared to hospitals in nonexpansion states, Maine hospitals are more likely to be private nonprofit entities and smaller critical access hospitals. On average, Maine hospitals had lower uncompensated care costs in 2018, both in absolute terms and as a percentage of operating expenses. Only 37 percent of Maine hospitals fell in the highest third of uncompensated care costs as a percentage of 2018 operating expenses, while nearly 65 percent of hospitals in nonexpansion states met this criterion. Of the hospitals in Maine in the highest third of

TABLE 1: **Baseline (2018) Hospital Characteristics across Maine Hospitals and Hospitals in Nonexpansion States**

	Maine	Nonexpansion states
Hospital characteristics		
Ownership		
Private nonprofit	93.9%	43.1%
For profit	0.0%	28.6%
Public	6.1%	28.4%
Critical access hospital	48.5%	27.5%
Teaching hospital	18.2%	19.8%
Average number of beds	81	146
Financial outcomes		
Uncompensated care (\$ millions)	\$7.29	\$13.75
Operating expenses (\$ millions)	\$197.33	\$187.57
Uncompensated care/operating expenses	4.7%	7.5%
Highest third of uncompensated care/operating expenses	36.4%	64.6%
Hospital county characteristics		
Median household income	\$50,760	\$53,400
Rural county	9.1%	9.2%
Unemployment rate	3.5%	3.9%
Poverty rate	13.3%	15.5%
Female	50.9%	50.5%
Ages 65 and older	21.8%	17.5%
Hispanic	1.6%	16.3%
Black	1.3%	15.9%
Hospital state characteristics		
Average number of hospitals	33	120

Financial outcomes appear in 2021 dollars.
Sources: CMS Cost Report Data, <https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports>; US Census Bureau, Population and Housing Unit Estimates Datasets, <https://www.census.gov/programs-surveys/popest/data/data-sets.html>; Small Area Income and Poverty Estimates (SAIPE) Program, <https://www.census.gov/programs-surveys/saie.html>; Small Area Health Insurance Estimates (SAHIE) Program, <https://www.census.gov/programs-surveys/sahie.html>; Bureau of Labor Statistics, Local Area Unemployment Statistics (LAUS) Program, <https://www.bls.gov/lau/>; USDA Rural-Urban Continuum Codes (RUCC), <https://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx>.

uncompensated care costs, 83 percent (10 out of 12) are critical access hospitals. Conversely, only 24 percent (223 out of 930) of hospitals with the highest baseline levels of uncompensated care costs in nonexpansion states are critical access hospitals.

There are several notable differences in county characteristics between Maine hospitals and hospitals in nonexpansion states. Compared to their nonexpansion counterparts, on average, Maine hospitals are in counties with lower poverty rates, lower median incomes, older

populations, and significantly smaller shares of Black and Hispanic individuals. These differences do not violate or confound the assumptions underlying the methodology, and they had no impact on the study findings (see the appendix).

Changes in Uninsured Rates and Uncompensated Care Costs

Figure 1 presents average uninsured rates and uncompensated care costs across Maine hospitals and hospitals in

nonexpansion states during the sample period. The uninsured rates correspond to the population of individuals most likely to have been directly affected by Medicaid expansion: individuals between the ages of 18 and 64 with incomes up to 138 percent of the federal poverty level.

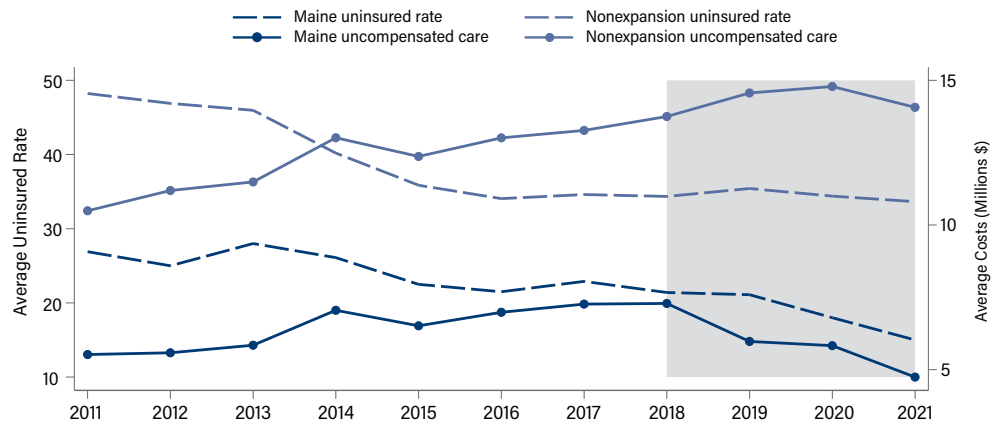
Two notable patterns appear in Figure 1 related to uninsured rates, uncompensated care costs, and the interaction between these two outcomes. First, the uninsured rate

in Maine is consistently lower than the average uninsured rate across nonexpansion states. This difference becomes more pronounced in the period following Medicaid expansion in Maine; the uninsured rate declines from 21 percent in 2018 to 15 percent in 2021, a 6-percentage point reduction. The average uninsured rate across nonexpansion states is relatively flat during this period, dropping less than a percentage point from an average of 34 percent in 2018. Second, the gap in average uncompensated care costs between Maine hospitals and hospitals in nonexpansion states widens following Medicaid expansion in Maine in 2019. Between 2018 and 2021, average uncompensated care costs decline by 35 percent across Maine hospitals, dropping from an average of \$7 million per hospital to under \$5 million. Hospitals in nonexpansion states, however, see an average increase in uncompensated care costs of 2 percent during this time, growing by roughly \$300,000 from a baseline of just under \$14 million.

Impact of Expansion on Uncompensated Care Costs

Table 2 presents the results from the analysis comparing the experiences of Maine hospitals and nonexpansion state hospitals before and after expansion. The first four columns in Table 2 compare the simple average of uncompensated care costs from 2011 to 2018 (pre-expansion) and from 2019 to 2021 (post-expansion) across Maine hospitals and hospitals in nonexpansion states. The

FIGURE 1: Average Uninsured Rates and Average Uncompensated Care Costs across Maine and Nonexpansion States, 2011–2021



Note: Figure contains average uninsured rates (18–64 at or below 138% FPL) and average levels of uncompensated care. Uninsured rates align with the calendar year; uncompensated care costs align with hospitals' reporting period end date. Gray-shaded area represents post-Maine-Care expansion period. Uncompensated care costs are in 2021 dollars.

Sources: 2011–2021 Census SAHIE data and 2011–2021 CMS Cost Report Data.

final column shows the estimates from a regression framework, which accounts for variation in hospital reporting periods, the share of a hospital's fiscal year exposed to the post-expansion period, and a range of hospital and county characteristics.⁶ The estimates in the last column are interpreted in approximate percentage terms. More details on the regression method and the interpretation of the estimates are available in the [appendix](#).

For Maine hospitals, uncompensated care costs were reduced by nearly \$1 million per year following expansion, while hospitals in nonexpansion states saw an average annual increase of over \$2 million during this time. This reduction can be seen as a \$3 million causal reduction in uncompensated care costs across Maine hospitals following expansion, or a 48 percent decline from the pre-expansion average of \$6.5 million. The estimate in the last column implies an average annual decline in uncompensated care costs of 26 percent⁷ across Maine hospitals following expansion.

Although there is a substantial decline in uncompensated care costs for Maine hospitals following expansion, this finding is not consistent across different types of hospitals. While general acute care hospitals in Maine experienced an average annual reduction in uncompensated care costs of nearly \$2 million, their counterparts in nonexpansion states had an average annual increase of more than \$3 million dollars. Combined, this total equals

TABLE 2: **Impact of Medicaid Expansion in Maine on Hospitals' Uncompensated Care Costs**

	2011–2018 (\$ millions)	2019–2021 (\$ millions)	Change (\$ millions)	Percentage change	Regression estimate
All hospitals					
Maine (n = 369)	6.49	5.52	-0.97	-47.9%	-0.302***
Nonexpansion (n = 15,707)	12.33	14.47	2.14		(-0.054)
Baseline difference-in-differences			-3.11		
General acute care hospitals					
Maine (n = 194)	9.85	8.00	-1.84	-50.7%	-0.41***
Nonexpansion (n = 11,507)	16.24	19.38	3.15		(-0.0802)
Baseline difference-in-differences			-4.99		
Critical access hospitals					
Maine (n = 175)	2.71	2.87	0.16	-7.0%	-0.18***
Nonexpansion (n = 4,200)	1.42	1.77	0.35		(-0.0402)
Baseline difference-in-differences			-0.19		
Highest third uncompensated care cost hospitals					
Maine (n = 132)	4.05	4.13	0.07	-57.0%	-0.29***
Nonexpansion (n = 9,706)	16.35	18.73	2.38		(-0.047)
Baseline difference-in-differences			-2.31		

The estimates in the last column are the difference-in-differences estimates corresponding to Equation 1 in the appendix. These models control for hospital fixed effects, year fixed effects, and time-varying hospital and county characteristics. The dependent variable in these models is the log of uncompensated care costs. Uncompensated care costs are in 2021 dollars. Standard errors are clustered at the state level and appear in parentheses below the estimates.

*** denotes statistically significant at the 1% level.

Sources: CMS Cost Report Data, <https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports>; US Census Bureau, Population and Housing Unit Estimates Datasets, <https://www.census.gov/programs-surveys/popest/data/data-sets.html>; Small Area Income and Poverty Estimates (SAIPE) Program, <https://www.census.gov/programs-surveys/saie.html>; Small Area Health Insurance Estimates (SAHIE) Program, <https://www.census.gov/programs-surveys/sahie.html>; Bureau of Labor Statistics, Local Area Unemployment Statistics (LAUS) Program, <https://www.bls.gov/lau/>; USDA Rural-Urban Continuum Codes (RUCC), <https://www.ers.usda.gov/data-products/rural-urban-continuum-codes.aspx>, and COVID-19 Pandemic Vulnerability Index Dashboard, <https://github.com/COVID19PVI/data/tree/master/Model11.21>.

a \$5 million causal reduction in uncompensated care costs across Maine’s general acute care hospitals, or a 50 percent reduction from the pre-expansion average. Both critical access hospitals in Maine and Maine hospitals with the highest levels of uncompensated care costs in 2018 experienced a small increase in average uncompensated care costs in the years following expansion. Their counterparts in nonexpansion states, however, experienced relatively larger increases during this time, which again means there was a causal decline across Maine hospitals.

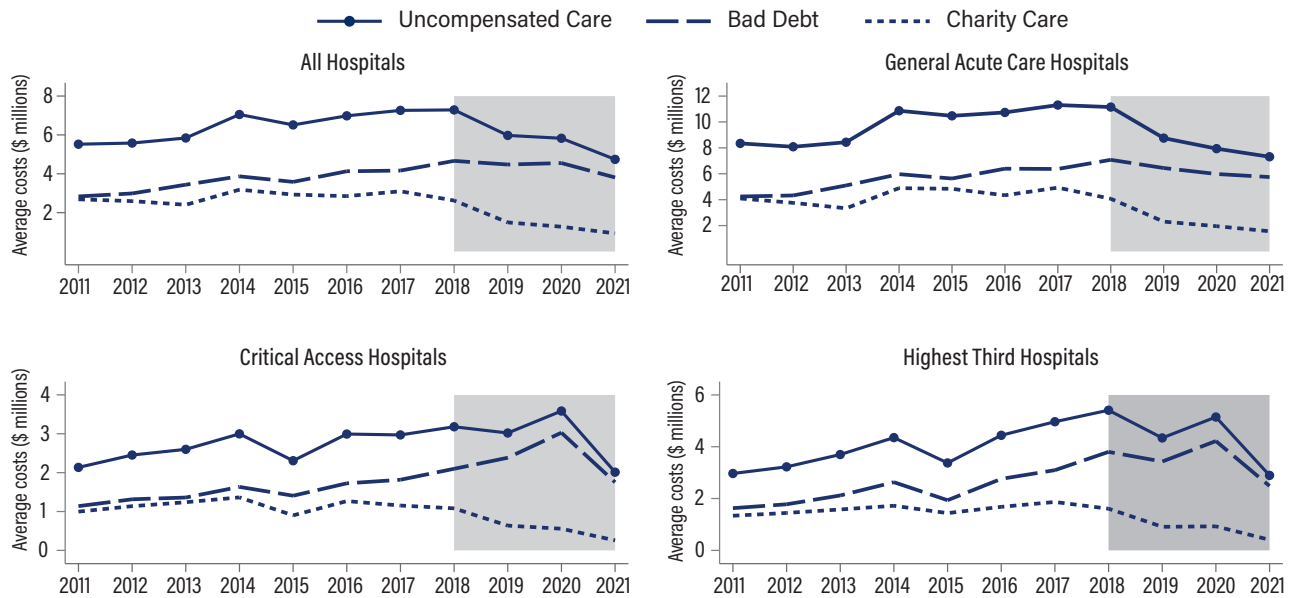
Changes in the Components of Uncompensated Care Costs

Figures 2 and 3 highlight the changes in the components of uncompensated care costs across Maine hospitals (Figure 2) and hospitals in nonexpansion states (Figure 3). The difference between average charity care costs and bad

debt costs across Maine hospitals grew in the years leading up to expansion, exceeding \$2 million by 2018. Following expansion in 2019, average charity care costs decline significantly across Maine hospitals. When looking at these numbers by hospital categories, we can see a significant reduction in average charity care costs across all three hospital types in Maine. While average bad debt costs are generally stable across Maine’s general acute care hospitals, Maine’s critical access hospitals and hospitals with the highest baseline levels of uncompensated care costs saw an increase in average bad debt costs in 2020.

Compared to Maine hospitals, hospitals in nonexpansion states have substantially different levels of charity care costs and bad debt expenses during the sample period. In nonexpansion states, average charity care costs exceed bad debt costs throughout the sample period. These costs increase after 2018 for both general acute care

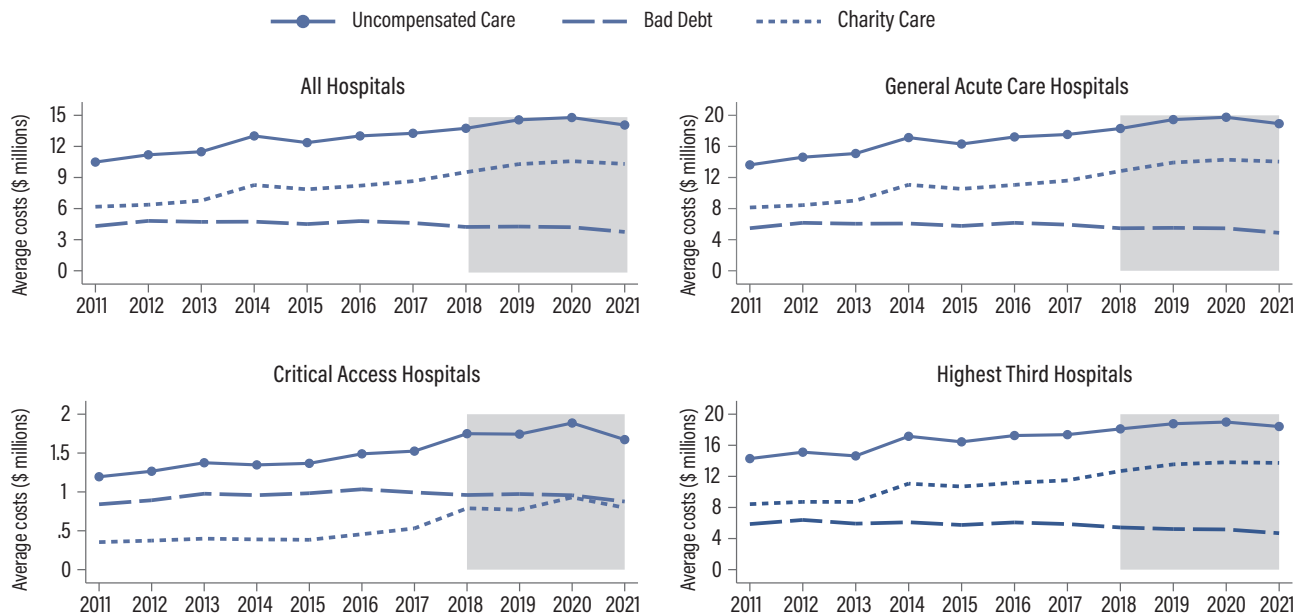
FIGURE 2: Breakdown of Uncompensated Care Costs by Hospital Type, Maine



Note: Figure contains average levels of uncompensated care, broken down by bad debt and charity care. All outcomes are in 2021 dollars. Gray-shaded area represents post-expansion period.

Source: 2011–2021 CMS Cost Report Data.

FIGURE 3: Breakdown of Uncompensated Care Costs by Hospital Type, Nonexpansion States



Note: Figure contains average levels of uncompensated care, broken down by bad debt and charity care. All outcomes are in 2021 dollars. Gray-shaded area represents post-expansion period.

Source: 2011–2021 CMS Cost Report Data.

hospitals and hospitals with the highest baseline levels of uncompensated care costs. While average bad debt costs exceed charity care costs for critical access hospitals in nonexpansion states for much of the period, average charity care costs increase for these hospitals beginning in 2018.

Table 3 shows the changes in charity care costs and bad debt costs from 2018 to 2021. The top part of Table 3 shows the changes in outcomes in dollar form, and the bottom section presents the changes in costs as a percentage of hospitals’ operating expenses, to account for hospital size. From 2018 to 2021, average charity care costs across Maine hospitals declined by 65 percent, dropping from \$2.6 million to under \$1 million. The decline in charity care costs is most pronounced for Maine’s critical access hospitals (76 percent) and hospitals with the highest baseline levels of uncompensated care costs (75 percent). Conversely, average charity care

costs increased across hospitals in nonexpansion states from 2018 to 2021. Both Maine hospitals and hospitals in nonexpansion states experienced a reduction in bad debt costs from 2018 to 2021.

DISCUSSION

This study adds to a growing body of literature that examines the impact of Medicaid expansion through the ACA on hospitals’ uncompensated care costs. The study documents a significant reduction in hospitals’ uncompensated care costs following Medicaid expansion in Maine, ranging from 25 percent to 50 percent per year, depending on the empirical methodology and primary outcome of analysis. A back-of-the-envelope calculation using the most conservative estimate indicates that Medicaid expansion in Maine lowered uncompensated care costs by \$63 million per year from 2018 levels

TABLE 3: Changes in Hospitals’ Charity Care Costs and Bad Debt Costs from 2018 to 2021

	Charity care costs			Bad debt costs		
	2018	2021	% change	2018	2021	% change
Panel A: Change in average outcomes in dollar amounts (\$ millions)						
Maine hospitals (all)	\$2.62	\$0.93	-64.50%	\$4.66	\$3.81	-18.24%
General acute care hospitals	\$4.08	\$1.57	-61.52%	\$7.08	\$5.75	-18.79%
Critical access hospitals	\$1.08	\$0.26	-75.93%	\$2.10	\$1.75	-16.67%
Highest third uncompensated care costs	\$1.61	\$0.41	-74.53%	\$3.80	\$2.49	-34.47%
Nonexpansion state hospitals (all)	\$9.52	\$10.31	8.30%	\$4.23	\$3.75	-11.35%
General acute care hospitals	\$12.83	\$14.05	9.51%	\$5.47	\$4.88	-10.79%
Critical access hospitals	\$0.79	\$0.79	0.00%	\$0.96	\$0.88	-8.33%
Highest third uncompensated care costs	\$12.68	\$13.73	8.28%	\$5.43	\$4.69	-13.63%
Panel B: Change in average outcomes as a percentage of operating expenses						
Maine hospitals (all)	1.58%	0.44%	-72.15%	3.07%	2.59%	-15.64%
General acute care hospitals	1.29%	0.44%	-65.89%	2.49%	2.22%	-10.84%
Critical access hospitals	1.87%	0.45%	-75.94%	3.69%	2.98%	-19.24%
Highest third uncompensated care costs	1.95%	0.44%	-77.44%	4.47%	3.08%	-31.10%
Nonexpansion state hospitals (all)	4.24%	4.31%	1.65%	3.30%	2.85%	-13.64%
General acute care hospitals	4.46%	4.56%	2.24%	2.89%	2.45%	-15.22%
Critical access hospitals	3.66%	3.62%	-1.09%	4.40%	3.86%	-12.27%
Highest third uncompensated care costs	5.89%	5.84%	-0.85%	4.32%	3.30%	-23.61%

Financial outcomes are in 2021 dollars.
Source: CMS Cost Report Data, <https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports>.

($0.26 \times \$7.29 \times 33$), a \$126 million reduction during the first two years of the COVID-19 pandemic. This estimate exceeds the two-year post-expansion estimate of \$84 million from the governor's office (Office of Governor 2022). The discrepancy between these findings is likely rooted in the methodological framework. In addition to examining the change in uncompensated care costs across Maine hospitals following expansion, this analysis controls for what would have occurred in Maine without Medicaid expansion. The experiences of nonexpansion state hospitals during this period indicate that Maine hospitals would have likely seen an increase in uncompensated care costs during the COVID-19 pandemic had the state not expanded coverage.

To assess the impact of Medicaid expansion in Maine, I conducted a range of sensitivity analyses to ensure that the findings are not confounded by the overlap in Maine's post-expansion period and the COVID-19 pandemic. In addition to the COVID-19 pandemic, Maine's post-expansion period overlaps with policies that tried to preserve health insurance coverage for individuals during the pandemic, including the continuous coverage provision. The overlap between Maine's post-expansion period and the continuous coverage provision does not bias the use of hospitals in nonexpansion states as a control in the empirical analysis because hospitals in these states continue to capture what would have occurred with uncompensated care costs for Maine hospitals had the state not expanded coverage. However, this policy likely influences the size of the study findings. As a result, I recommend using caution when applying findings from this analysis to the potential impact of expansion on hospitals in any nonexpansion states that elect to expand coverage because the continuous coverage provision will no longer apply. As more recent data become available, future research should evaluate the impact of the unwinding of the continuous coverage provision on uncompensated care costs across Maine hospitals.

This study finds differences in the effect of expansion across different categories of Maine hospitals. While larger, general acute care hospitals in Maine had a more significant decline in uncompensated care costs, both in absolute and percentage terms, hospitals with the highest baseline levels of uncompensated care, many of which are smaller critical access facilities, had a less pronounced decline in uncompensated care costs. Although surprising

on the surface, as it was expected that these facilities would be most affected by expansion, this finding appears to be driven by an increase in bad debt costs in 2020. Conversely, average charity care costs across these hospitals declined by 75 percent from 2018 to 2021. This finding suggests that Medicaid expansion in Maine offset increases in bad debt expenses across smaller, more financially vulnerable hospitals during the height of the COVID-19 pandemic.

The finding that charity care costs decline substantially across Maine hospitals following expansion aligns with state requirements for hospitals' nonprofit status. To keep their tax-exempt status, Maine's nonprofit hospitals must provide free, medically necessary care to individuals with incomes up to 150 percent of the federal poverty level. Because Medicaid expansion through the ACA expanded eligibility to individuals with incomes up to 138 percent of the federal poverty level, many Mainers previously eligible for charity care at Maine's nonprofit hospitals became eligible for MaineCare coverage. The findings from this analysis suggest there was a significant transfer of hospitals' charity care costs to reimbursement through the MaineCare program. This shift appears to have occurred at a crucial time, during the height of the COVID-19 pandemic, when average charity care costs increased across hospitals in nonexpansion states. Future research should examine if Maine's nonprofit hospitals have shifted resources towards providing other community benefits following this steep reduction in charity care costs. An analysis that compares the level of community benefits provided by Maine's nonprofit hospitals against the value of their tax exemptions, and whether this relationship shifted after expansion went into effect, would be of particular use in understanding this dynamic.

This study finds that Medicaid expansion through the ACA significantly reduced uncompensated care costs across Maine hospitals in the first three years following expansion, two of which overlapped with the COVID-19 pandemic. While uncompensated care costs are an important social safety net indicator and hospital financial outcome, this analysis does not capture the full impact of expansion on Maine's healthcare ecosystem. More research is needed to assess the effect of expansion on Maine hospitals' finances more broadly, as well as the impact of expansion on access to care and use outcomes among Mainers who gained coverage.

ACKNOWLEDGMENTS

The analysis and conclusions set forth are those of the author. The Maine Department of Health and Human Services has not reviewed the analysis or endorsed the conclusions.

NOTES

- 1 "MaineCare Expansion—Expansion Snapshot." October 1, 2023. <https://www.maine.gov/dhhs/data-reports/mainecare-expansion>
- 2 See Blavin (2016), Camilleri (2018), Dranove et al. (2016), Nikpay et al. (2015), Rhodes et al. (2020)
- 3 <https://www.cms.gov/research-statistics-data-and-systems/downloadable-public-use-files/cost-reports>
- 4 <https://digitalcommons.library.umaine.edu/mpr/vol33/iss1/5>
- 5 Although Medicaid expansion in Maine took effect on January 10, 2019, the state extended retroactive coverage to individuals who had applied for coverage as far back as July 2, 2018. Defining the post-expansion period as January 10, 2019, and later, yields a conservative estimate of the impact of expansion on uncompensated care costs.
- 6 The outcome in the regression model is the log of uncompensated care costs.
- 7 $(\exp(-0.302)-1)$

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