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PRELIMINARY Racial Impact Statement for LD 372, *An Act To Provide Maine Children Access to Affordable Health Care*

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Summary of Key Points

- LD 372 expands Maine's Cub Care program for persons under the age of 21 by expanding the poverty eligibility threshold to 300% of federal policy level, covering non-citizen under age 21, removing barriers to enrollment, and eliminating premiums.
- Disaggregated data regarding applications and enrollment in the Cub Care program are not publicly available and could not be accessed for this pilot.
- Data from the US Census is limited when generating disaggregated counts by multiple demographic characteristics due to small numbers and undercounts.
- **Using publicly available Census, it appears that roughly 2,000 BIPOC children under the age of 21 and 420 persons under the age of 21 who are non-citizens could be newly eligible for the Cub Care program.**

Background

In Maine, as of 2019, 5.7% of children under the age of 18 in Maine lacked access to health care (approximately 14,500), and this number has been growing since 2016.¹ Access to affordable and quality health care, has major impacts on individual health and well-being. In particular, access to health care for children affects their healthy growth and development over their lifespan. According to Maine Kids Count 2021,

“Access to quality, affordable health care is critical for child health and well-being. When children have insurance, they can get the preventive care they need to grow and develop and are more likely to have positive, long-term health outcomes. Research shows that children without health insurance are more likely to have significant trouble accessing care when they need it.”

LD 372 proposes to make changes to Maine's Cub Care program that expand access to the services contained therein. The proposed policy changes that are under examination within this research memo are as follows:

1. changes the maximum eligibility level for family income from 200% of the federal poverty level to 300% of the federal poverty level;
2. removes the 3-month waiting period for enrollment in the Cub Care program following the loss of health insurance or coverage under an employer-based plan;
3. establishes that eligibility is not subject to an asset test;
4. provides coverage to persons 19 and 20 years of age and to noncitizens under 21 years of age; and

¹ https://mainechildrensalliance.org/site/assets/files/1825/2021_kidscount_db_final.pdf

5. repeals the provisions regarding premium payments for the Cub Care program.

In addition, it directs the Maine Department of Health and Human Services (ME DHHS) to submit to the US Department of Health and Human Services, Centers for Medicare and Medicaid Services, waivers and/or state plan amendments to accomplish the goals of the legislation, with items 2 and 5 above being contingent upon approval. It further directs ME DHHS to use state funds to fund item 4 but stipulates that ME DHHS may apply for waivers or state plan amendments from US DHHS.

Methods and Limitations

This analysis explores the potential racial impact of LS 372 using data from the US Census to estimate how many children live within the expanded eligibility range (200% - 300%), by race. We were also able to use data from the US Census to estimate the impact of expanding coverage to those who are 19 and 20 years of age, by race, as well as non-citizens under 21. The data were access using the IPUMS Abacus which we used to generate 5-year rolling estimates (2015-2019).²

There are multiple challenges with using US Census data. First, when we start looking into intersecting demographics (e.g., age and race and income) the total number of people who provided information diminishes. This can make the estimates less precise and, in some instances, unavailable due to privacy and confidentiality concerns. Thus, we could only report two racial categories: White and Black, Indigenous, and people of color (BIPOC). Second, the US Census undercounts many groups, and that this is more likely for children, persons of color, and non-citizens.^{3,4} For example, the Urban Institute recently estimated that the 2020 US Census likely undercounted Black and Hispanic/Latinx people by a factor of 2.45% and 2.17% respectively, and that young children under the age of five were also likely undercounted by a factor of 4.86%; households with a non-citizen were likely undercounted by a factor of 3.36%.⁵

We must also note that US Census categories for federal poverty levels (FPL) are limited to the range of 200-300% which does not fully align with the existing eligibility guidelines (208% FPL)⁶ although the ranges do align with the proposed legislation.

A final limitation of this impact statement is that we were unable to access detailed data from Maine DHHS about program applications and enrollment due to shortness of time available for this study. Those data could help us to determine the potential racial impacts of removing the waiting period, asset test, and premium payments.

² <https://usa.ipums.org/usa/abacus.shtml>

³ <https://www.census.gov/programs-surveys/decennial-census/decade/2020/planning-management/plan/undercount-of-young-children.html>

⁴ https://www.census.gov/library/working-papers/2021/acs/2021_Rothbaum_01.html

⁵ <https://www.urban.org/research/publication/simulating-2020-census-miscounts-and-fairness-outcomes>

⁶ <https://www.nashp.org/maine-chip-fact-sheet/>

Estimated Populations of Impact

1. *Change the maximum eligibility level for family income from 200% of the federal poverty level to 300% of the federal poverty level*
2. *Provide coverage to persons 19 and 20 years of age and to noncitizens under 21 years of age*

Nationally, data show that children of color are less likely to have access to health insurance and more likely to experience a gap in coverage. For example, the Georgetown Health Policy Institute shows that 13.9% of Hispanic children, 11.7% of Black children and 10.3% of other children of color were uninsured for all or part of a year.⁷ That same study also showed that children under 250% of the federal policy level were more likely to be uninsured compared to those over 250% of the FPL (12.9% compared with 7.0%). Similarly, they estimated that in 2018 Medicaid and CHIP provided health insurance to more than half of children of color in America (57.1% of Black children, 56.1% of American Indian/Alaska Native children, and 54.7% of Latino children).⁸

In Maine, a five-year rolling estimate of US Census ACS data indicates that approximately **2,706 BIPOC persons under the age of 21 live within 200% and 300% of poverty in Maine and lack health insurance**, compared with 13,303 White persons under the age of 21 who live within that poverty range and lack health insurance (IPUMS, ACS 2015-2019). In 2019, Kids Count similarly estimated that 15,500 children lacked health insurance in Maine, approximately 2,000 of whom were BIPOC.⁹ When examined as a percentage, these estimates suggest that **43.7% of all BIPOC children living within 200% and 300% of poverty are uninsured** (compared with a rate of 23.5% uninsured among White children who live within 200% and 300% FPL).

The proposed legislation would also expand coverage to non-citizens under the age of 21, although lawfully residing children are already eligible. National research shows that children who lack citizenship status are more likely to be uninsured (42% compared with 12%) and experience delays in needed care (7% compared with 3%).¹⁰ Our 5-year ACS estimate suggests that as many as **420 noncitizens under the age of 21 in Maine** (IPUMS, ACS 2015-2019) do not have health insurance.

⁷ <https://ccf.georgetown.edu/2021/11/22/gaps-in-coverage-a-look-at-child-health-insurance-trends/>

⁸ <https://ccf.georgetown.edu/2020/07/27/medicaid-and-chip-provide-health-coverage-to-more-than-half-of-children-of-color/>

⁹ <https://datacenter.kidscount.org/data/tables/10196-children-without-health-insurance-by-race-and-ethnicity?loc=21&loc=2#detailed/2/21/false/1729,37,871/10,11,9,12,1,185,13/19728,19729>

¹⁰ Jewers M, Ku L. Noncitizen Children Face Higher Health Harms Compared With Their Siblings Who Have US Citizen Status. *Health Aff (Millwood)*. 2021 Jul;40(7):1084-1089

3. *Remove the 3-month waiting period for enrollment in the Cub Care program following the loss of health insurance or coverage under an employer-based plan*
4. *Establish that eligibility is not subject to an asset test*
5. *Repeal the provisions regarding premium payments for the Cub Care program*

The impact of these policy changes on racial disparity could not be estimated at this time due the lack of access to application and enrollment data and the time needed to generate a reliable method of estimating the impact. A potential approach to analyzing the impacts of these policy changes would be to know the number of child applicants, by race, who apply to the Cub Care program. Even more precise estimates of impact could be determined by knowing who did not ultimately enroll, who stopped participating in the program, and the reasons why. While monthly snapshots of enrollment for Maine are available from the federal Centers for Medicare and Medicaid Studies,¹¹ aggregate application and enrollment statistics by race for CHIP/Cub Care are not publicly available through DHHS. Because the data are considered protected health information they are subject to rigorous privacy protections and would require assistance and authorization from Maine DHHS to access.

Conclusion and Other Considerations

Using publicly available data, it appears that roughly 2,000 BIPOC children who live within 200% and 300% FPL could be newly eligible for the Cub Care program. It is more difficult to determine the extent to which LD 372 would have a notable impact on racial disparities in Maine in terms of enrollment. While the research team was able to estimate the populations potentially impacted by the policy change, we were unable to determine whether the reasons those children lack coverage are addressed by this bill. However, national research suggests the proposed policy changes will have a positive effect on access overall, as well as expand access for historically marginalized groups.

The research was hindered by the issue of “low numbers” within the US Census (meaning, too few cases exist in a sample to report results, or from which to draw strong conclusions) which limited our ability to pinpoint the impact on specific populations or groups. Furthermore, disaggregated Medicaid/Cub Care application and enrollment data by race are not readily available and require authorized access from ME DHHS. Lastly, when it comes to exploring the barriers and challenges to accessing health insurance coverage by race, it is important to consider rigorous qualitative data collection approaches (e.g., interviews, focus groups) which can focus on experiences rather than prevalence; such activities require a skilled qualitative researcher, and substantially more time and resources to complete.

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¹¹ <https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html>