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Testimony in <u>Support</u> of LD 372, An Act To Provide Maine Children Access to Affordable Health Care

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Good afternoon Senator Claxton, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services, my name is Kathy Kilrain del Rio and I am a policy analyst at Maine Equal Justice. Maine Equal Justice is a nonprofit legal aid provider working to increase economic security, opportunity, and equity for people in Maine. I am speaking today in support of LD 372, An Act To Provide Maine Children Access to Affordable Health Care.

We can all agree that ensuring Maine children—our state's future—have adequate access to affordable and comprehensive health care is an important policy goal. We know that good health impacts school attendance, academic success, and whether students ultimately graduate or drop out. Studies have found that children with public health insurance through Medicaid or CHIP have greater success in school than those who are uninsured.[i] And our school experiences have a major effect on our entire lives, including what we do for work, whether we struggle with poverty, and even whether or not we experience incarceration.

While children age twelve or younger are often healthy, they are at risk of common conditions that can affect them throughout their lives. The Healthy People project through the Office of Disease Prevention and Health Promotion names the following conditions as particular concerns for children in early (birth to age 8) and middle (ages 6 to 12) childhood: developmental and behavioral disorders, child maltreatment, asthma and other chronic conditions, obesity, dental caries, and unintentional injuries.[ii] These conditions can affect children in many ways, impacting their education, how they grow, their play, how they relate to others, and their health for the rest of their lives.[iii] One way we can prevent or mitigate problems associated with these conditions and many others that are less common is to ensure children have access to high-quality health care.

As children grow into adolescents, health care needs change but do not diminish. The US CDC notes that primary care visits are an important opportunity to provide education, preventive screenings, and treatment. These are key because most adolescent health issues are preventable, and this is a period when young people are making more of their own decisions

that can impact their health. However, data shows that "fewer than half of adolescents have an annual well-care visit, with noted disparities attributable to insurance coverage, income, race/ethnicity, and sex."[iv] While 43 percent of all adolescents had a preventive health visit in 2011, just 25 percent of adolescents without health insurance attended a preventive health care visit.[v]

Good health and well-being requires a strong start and we should do all we can to reduce the number of uninsured children in Maine. According to the 2018 Kids Count report, approximately 14,500 Maine children (approximately 6%) were uninsured. More than half of the children in Maine receive health care coverage through their parents' employers. The volatility of the past year has demonstrated how fragile access to employer health care coverage can be. This bill would help remove barriers to coverage by increasing eligibility to CHIP for families up to 300% FPL. It would also expand coverage to 19- and 20-year old's, close coverage gaps for Maine children who are immigrants, and would eliminate both the 3 month waiting period and family premiums. I want to take a moment to specifically address the importance of closing gaps for *all* Maine children, regardless of their immigration status. The pandemic has demonstrated just how dependent our collective health is on the health of each of us. When family, friends, neighbors, or classmates lack access to health care, it makes them more vulnerable to COVID-19. It is imperative that we ensure access for *all* our children so that they can thrive and for our collective public health.

Many Maine families with lower incomes move in and out of poverty based on job and economic conditions beyond their control. Increasing eligibility beyond 200 percent of the federal poverty level will help families who are at risk of financial hardship if they face an unexpected bill—something that can easily happen due to an unforeseen illness, accident, or medical condition. Today there are 19 states that cover children with incomes at or above 300 percent of the federal poverty level.[vi]

Similarly, eliminating premiums, the asset test, and wait times will lift a significant barrier to care off parents' shoulders for currently enrolled children in addition to those who would be newly covered under this bill. Wait times, that is requiring a child that has been covered by a private plan that may be unaffordable for the family to go without coverage for a period before entering CHIP, have been eliminated in over two-thirds of the states. This has been recognized as a barrier to affordable coverage for many. Endangering children's health by leaving them without coverage for any time is an unacceptable risk. For similar reasons many states have now abandoned charging premiums to CHIP children while Maine's premiums today are among the highest in New England.[vii] Eliminating premiums and wait times would be a positive step forward for the families with whom we work.

While some may be concerned that increasing eligibility for higher-income children and eliminating premiums or wait periods may result in more children leaving private insurance for this public option, a review of the data indicates that most children from families with higher incomes who enroll in public health care do so because they lack private insurance.[viii] It is also worth noting that some private insurance options are not affordable for families nor do they all provide the same level of access to key health care services such as Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefits available through CHIP, which can be a critical tool in identifying potential problems for children early so that appropriate interventions can be put in place to support them in their development. Access to dental care is another area of health care that can be inadequate for some families utilizing private insurance. Dental care is health care and all children and adolescents need access to it for their well-being. CHIP provides that critical care.

Medicaid and CHIP help reduce disparities for children more at risk of falling through cracks in our health care system. Currently these programs nationally cover half of all children with special health care needs. CHIP or Medicaid cover 47 percent of children living in rural areas across our country. And CHIP and Medicaid together help reduce health disparities for children of color who are more likely to live in families with lower incomes due to systemic inequities that result in higher levels of poverty and greater discrimination for people of color—especially Black and Latinx people. States, such as our neighbor to the south, Massachusetts, can choose to use state funds to cover children who are here without documentation. No matter where a child was born or what their immigration status may be, if Maine is their home, they should have access to quality, affordable health care. This bill helps this the reality for all Maine children.

Healthy people are necessary for healthy communities, healthy schools, healthy workplaces, and a healthy state. LD 372 would improve access to health care for Maine children so that they have the best start to a healthy and successful life that they can get. For all these reasons, we urge you to support LD 372. I'm happy to try to answer any questions you may have.

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[i] https://familiesusa.org/product/children-health-insurance-program-chip
[ii] https://www.healthypeople.gov/2020/topics-objectives/topic/early-and-middle-childhood
[iii] Ibid.
[iv] https://www.cdc.gov/mmwr/volumes/65/wr/mm6530a2.htm
[v] Ibid.
[vi] Ibid.
[vii] http://files.kff.org/attachment/Report-Medicaid-and-CHIP-Eligibility-as-of-Jan-2019-Table-15
[viii] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3983728/