

American Academy
of Pediatrics



DEDICATED TO THE HEALTH OF ALL CHILDREN™

May 29, 2013

Testimony of
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On behalf of the
American Academy of Pediatrics

Before the
U.S. Internal Revenue Service

My name is Lynda Young and I join you today on behalf of the 60,000 primary care pediatricians, pediatric subspecialists and pediatric surgical specialists of the American Academy of Pediatrics. I am a practicing pediatrician from the state of Massachusetts. Let me begin by thanking you for the opportunity you've afforded the AAP to respond to the shared responsibility payment for not maintaining minimum essential coverage notice of proposed rulemaking – which I will call the NPRM.

I hope to touch on three issues regarding children in my testimony: the so-called “family glitch,” the importance of Medicaid “wrap-around” coverage, and the needs of children whose parents claim a religious exemption.

First, children’s advocates would urge the IRS to reconsider its ruling on the affordability test of employer-sponsored family coverage, which creates a problem that has become known as the kid, or family, glitch. The current IRS interpretation will cut off access to quality health insurance for close to half a million children according to a June 2012 Government Accountability Office report.

It shouldn’t have to be stated, but children need quality health insurance. While pediatricians are not tax lawyers, we are clinicians who see the impact of inadequate insurance on our patients and their families every day. Most insurance products are designed for adults and treat children as little versions of the adult population. From a clinical perspective – and even from the perspective of insurance design – this creates big problems for pediatricians and other clinicians whose job it is to help children develop to their full potential.

Caring for children is simply different than caring for adults. For instance, the number one cause of death in children is not heart disease, cancer, or chronic disease, but injury. As a result, pediatricians provide anticipatory guidance during well baby and well child visits regarding prevention, urging the use proper of car seats, gun safety, and for adolescents, healthy body image, physical activity and healthy eating. Children are also different because they are dependent upon caregivers for the vast majority of their interactions with the medical system. A six month old cannot advocate for herself with respect to her medical needs. Children are continuously developing so that environmental and pathological exposures often have disproportionate effects on them that require specific attention to generating, maintaining, and restoring age appropriate functioning. A hearing aid for an infant serves a significantly different function than a hearing aid for an octogenarian. The child population also has a different ethnic, racial and economic profile than the adult population and is therefore subject to more prevalent health disparities. Twenty-two percent of children in this country live in poverty compared with 13.7 percent of those aged 18-64 and 8.7 percent of those over 65. For African-American children, the poverty rate was 37.4 percent in 2011. The rate for Hispanic children was 34.1 percent.

The goal of the medical home is to address these challenges by coordinating care for a population of children to promote health across their lifespan. It is very challenging to do that

when their insurance is inadequate. Quality health insurance for these families is essential to ensure that children grow into health adults.

The family glitch is important because it will impact millions of children. The Urban Institute reports that if federal funding for CHIP is not extended beyond 2015 and the single-only affordability test is maintained, some 6.3 million children would be in families that would have to pay more than 9.5 percent of their income for family coverage. A significant share of these, 1.7 million, are currently uninsured and are among those who may remain that way under reform. As a result, IRS's interpretation could unravel much of the progress that has been made in covering children in recent years.

And this progress has been impressive. InsureKidsNow.gov reports that fewer than 8% of children are uninsured for the first time ever. This is a result both of CHIPRA (the CHIP Reauthorization Act) and the economic downturn in which parents lost jobs – and thus their employer-sponsored insurance which was replaced by Medicaid and CHIP coverage. Taking a step back from the goal of covering all children in the United States because of one interpretation of tax law is a tragic misstep for our shared future.

The **second** pediatric issue I'd like to note today is the importance to children with special health care needs of Medicaid "wrap-around coverage." The NPRM proposes two bright line pathways for coverage: coverage in the Exchange defrayed by a tax credit for those below 400% of the FPL, or coverage through an insurance affordability program. The Academy strongly believes that children with disabilities should not lose access to their premium tax credit when their families rely on Medicaid to secure supplemental wrap-around benefits as a payer of last resort.

Medicaid fills in the gaps of private insurance or provides insurance coverage for about 40% of children with special health care needs. This happens because of the pediatric-appropriate benefit package at the heart of Medicaid known as the Early and Periodic Screening, Diagnosis and Treatment or EPSDT benefit. EPSDT allows for coverage of all medically-necessary treatments and thus supports age-appropriate coverage for a large portion of the US pediatric population.

Some children are eligible for Medicaid based on disability through Medicaid state options and waiver programs, even though their families' incomes would not otherwise qualify them for Medicaid. These are very vulnerable children who may have private insurance, but require extensive and expensive health care services and supports not covered by their private insurance plan (e.g., private-duty nursing, certain medical equipment, extensive therapy). States offer Medicaid wrap-around coverage to fill gaps in private insurance for these children and prevent families from seeking care for their children in more costly institutional settings and/or "spending down" to qualify for traditional Medicaid. Many families would not be able to afford the needed services for their child without this supplemental Medicaid coverage.

The availability of Medicaid wrap-around coverage varies state by state, and states may offer multiple avenues for children with disabilities to access Medicaid coverage. These avenues to

Medicaid are based on disability and can occur through a Tax Equity and Fiscal Responsibility Act (TEFRA) state plan option, a Katie Beckett waiver, home and community based services waivers, or Medicaid buy-in coverage, including through the Family Opportunity Act of 2005. While these programs allow children to access supplemental Medicaid coverage, federal and state policies require families to keep children with disabilities enrolled in private coverage to prevent “crowd-out” and limit costs to the Medicaid program. Under these circumstances, Medicaid is the payer of last resort and supplements the child’s private insurance plan, covering co-pays, deductibles, and health care services that private insurance will not defray.

Plans offered in the Exchanges are not likely to offer robust pediatric benefits to meet the needs of children with disabilities, meaning that Medicaid wrap coverage will still be important in the new marketplace. Families who would otherwise be eligible for premium subsidies should not have to choose between ensuring that their disabled child has access to the full range of medically necessary services and affording private coverage that does not meet their needs. Inclusion of Medicaid wrap coverage for children with disabilities as minimum essential coverage will force many families to make that choice.

We would urge IRS not to bar families who receive tax credits to defray the cost of health insurance listed in an Exchange from accessing supplemental Medicaid coverage.

Third, the Academy hopes to encourage IRS to consider the impact on children if their parents claim an exemption under the NPRM due to a claim of religious conscience or their membership in a health care sharing ministry. Pediatricians see children whose medical needs are neglected due to one or more of a variety of factors, such as poverty, economic hardship, lack of access to care, family chaos, lack of awareness, lack of trust in health care professionals, impairment of caregivers, and/or belief systems of caregivers. Each year, some parents’ religious views lead them to forgo appropriate medical care for their children, resulting in substantial harm, suffering, or death due to treatable conditions such as meningitis, bowel obstruction, diabetes mellitus, or pneumonia. The AAP’s policy reflects pediatricians’ deep concern about children being denied necessary medical care. We urge that regulations consider the impacts on children of parents’ exemption for “religious conscience” and not allow children to be exempted.

In summary, the Academy appreciates the opportunity to testify before you today. As noted, we have strong concerns regarding the impact of the family glitch, the availability of Medicaid wrap-around services, the need for a pregnancy-related services safe harbor, and the impact of religious exemptions on children. The AAP urges the IRS to address these issues with what is otherwise an excellent regulation that should work well for children in the United States.