November 17, 2011

Testimony of  
David Isaac Bromberg, MD, FAAP

On behalf of the  
American Academy of Pediatrics

Before the  
U.S. Internal Revenue Service
My name is David Bromberg 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 Maryland. Let me begin by thanking you for the opportunity you’ve afforded the AAP to respond to the health insurance premium tax credit notice of proposed rulemaking – which I will call the NPRM. I understand we have been asked to be brief and I intend to respect that request by restricting my remarks to ten minutes. The essential message that I would ask the committee to take away from my testimony is: the American Academy of Pediatrics (the AAP or the Academy) is deeply concerned that the IRS has decided to interpret the Affordable Care Act (ACA) in a way that would cut off access to quality health insurance for millions of children unless these families find coverage for their children in the Children’s Health Insurance Program, also known as CHIP.

CHIP is a good program, but it is not fully funded after 2014. And while pediatricians are not tax lawyers, we are clinicians who see the impact of inadequate insurance on our patients every day. Insurance is designed for adults and often children are treated as little versions of the adult population. From a clinical perspective – and even from the perspective of insurance design – this creates large problems for pediatricians and other clinicians who try to help children develop into their full potential. For instance, the number one cause of death in children is not heart disease, cancer, or chronic disease, but injury. Insurance plans that offer children coverage for prostate tests and mammograms are nevertheless legion. Additionally, the cost of addressing children’s health needs is quite low in comparison with the adult population. The main government insurance program for children – Medicaid – spends just $2,422 per year, on average, for each Medicaid-eligible child compared to the average costs per adult Medicaid enrollee of $7,683. In private insurance, it is common knowledge that risk pools hope to attract younger and healthier populations. And most plans charge a family the same premium if the family size is four or ten. Finally, the outcomes of pediatric clinical interventions, due to their preventive nature, do not provide savings immediately. The goal of the medical home I have established for my patients is to coordinate care for a population of children to establish health across their lifespan. It is very challenging to do that when their insurance is inadequate. Quality health insurance for these families is essential in helping me do my job.

The “Family Penalty”
The AAP has adopted Access Principles that have as their core the goal of providing quality health insurance for infants, children, adolescents, and young adults, and eventually everyone. The Academy’s Principles also conclude that access to quality health care is a right. The interpretation that the IRS has adopted essentially bases the right to health insurance for millions of children on further funding of the CHIP block grant, which as I have stated is not included in current law.

An Urban Institute report notes that the stakes for children of the single-only test are particularly high and intersect with the fate of CHIP coverage for children. Urban reports that if federal funding for CHIP is not extended beyond 2015 and the single-only test prevails, 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
would likely 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 10% 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. Medicaid and CHIP did their jobs in catching children whose families also lost Employer-Sponsored Insurance. Taking a step back from the goal of covering all children in the United States because of one interpretation of tax law would be a tragic misstep for our shared future.

**Impact on Families and Uninsured Children**

As I have noted, if the IRS chooses to stand by its interpretation of the Single Only test as set forth in the NPRM, many children and other family members of working Americans who are not now enrolled in quality health insurance are likely to remain uninsured. The Kaiser Family Foundation estimates that there are 3.9 million children and other dependents who do not live in families where coverage is under 9.5% of family income for the worker but not for other family members. There are likely even more people in families where both spouses are working, but only one has an offer of employer-sponsored coverage and that offer is over 9.5% of family income for family coverage. Many of the children, spouses and other dependents of these individuals will be left without access to affordable coverage in 2014, and as a result, even with the passage of the ACA, some will remain uninsured.

More uninsured children and other individuals means continued stress on the US healthcare system and pediatric practices to provide charity care. Uninsured children will continue to need health care, but many families will be unable to pay for that care. The result will be continued uncompensated care, and state and local governments will continue to need to provide funding to help pay for the costs of uninsured children. Insurance premium rates will continue to be higher in order to cover costs of care to the uninsured that are not compensated elsewhere. As uninsured children and other Americans become disabled due to lack of access to healthcare, there will be continued pressure on Medicaid to pick up the costs of serious health conditions that could have been prevented if the individuals had access to health care. For children in particular, strong scientific evidence exists to show that adult disease begins in childhood, and that the antecedents of cancer, diabetes, and other highly expensive and debilitating adult illnesses have their roots in inadequate health care for children.

In light of these serious issues, the Academy urges the IRS to use the discretion it has under the ACA to adopt an alternative interpretation of the affordability test; one that is family-based and includes the cost of dependent coverage. Specifically, we urge IRS to revise sec. 1.36B-2(c)(3)(v) to make it clear that a family will be potentially eligible for subsidized Exchange coverage if the cost of family coverage – not just single-only coverage – exceeds 9.5 percent of household income.
“Premium Stacking” for Families with CHIP-Eligible Children

Another issue is that the Health Insurance Premium Tax Credit Rule as proposed will also leave many families with children facing a “double premium” if the family happens to have a child eligible for CHIP (or Medicaid, in some limited circumstances where premiums apply). The issue (sometimes known as the “premium stacking issue”) arises from the statutory formula used to calculate the advance premium tax credit, which establishes a specific dollar amount that families are expected to contribute to their Exchange coverage without any variation allowed even if a family also must pay CHIP premiums. Unfortunately, the number of families subject to this type of “double premium” is likely to be significant. Estimates from the Urban Institute indicate that three out of four (75%) parents who are eligible for the Exchange will have one or more children who are eligible for CHIP or Medicaid and must enroll in these programs.

It is unknown how many of these families must pay premiums to enroll their children in public coverage, but 30 states charge a premium or annual enrollment fee to children in CHIP, so this is a serious concern. While the fundamental issue arises from the statute, the NPRM does not acknowledge the problem, nor does it provide states with any options or advice for addressing it. If the IRS chooses to maintain its current definition, the practical effect of using the affordability test as proposed in the NPRM means that families will be forced to either: 1) pay a larger part of their income for coverage than similarly-situated families without an employer offer; or 2) leave children without coverage. Such a choice should not be a consequence of the Affordable Care Act, the clear intent of which is to provide affordable coverage to nearly everyone in the United States. A more comprehensive and accurate assessment of a family’s premium obligations is consistent with the intent of the Affordable Care Act; would lead to more children having health coverage; and would be less disruptive to the employer-sponsored insurance market. Other solutions to lessen the burden of multiple premium costs on families should also be explored in the final rule; such as counting CHIP premiums in the tax credit calculation or modifying CHIP rules in some way to not penalize families with children in CHIP.

In summary, the Academy appreciates the opportunity to testify before you today. As noted, we have strong concerns regarding the impact of the family penalty and premium stacking and urge that you solve those problems with what is otherwise an excellent regulation that should work well for children in the United States.