Notice 2015-16

AMERICAN SPEECH-LANGUAGE-HEARING ASSOCIATION

Submitted via e-mail to: Notice.comments@irscounsel.treas.gov

May 13, 2015

Karen Levin
Office of Associate Chief Counsel (Tax Exempt and Government Entities)
Internal Revenue Service
Room 5203
Ben Franklin Station
Washington, DC 20044

RE: Section 4980I—Excise Tax on High Cost Employer-Sponsored Health Coverage (Notice 2015-16)

Dear Ms. Levin:

The American Speech-Language-Hearing Association (ASHA) is the national professional, scientific, and credentialing association for more than 182,000 audiologists, speech-language pathologists, speech, language, and hearing scientists, audiology and speech-language pathology support personnel, and students. ASHA has carefully reviewed Section 4980I—Excise Tax on High Cost Employer-Sponsored Health Coverage notice and provides the following comments for consideration.

Though ASHA appreciates the Internal Revenue Service's deliberate and measured approach to changing this section of the Code, we anticipate that the proposed changes could have significant implications for our members and employees. We appreciate the IRS' decision to seek comments well before the implementation of any such tax as ASHA, like many employers, has already begun to make decisions about our group health plans in anticipation of the proposed effective date.

One of the major goals of the excise or "Cadillac tax" was designed to help finance health reform, especially the Affordable Care Act's coverage provisions. The excise tax was promoted as affecting a small number of employer plans that provide their employees with the most generous level of health benefits with low, if any, deductibles and little cost sharing. The original Senate proposal would have hit 19% of all large employers. However, more recent data show that approximately 33% of employers will be adversely affected by 2018 and 60% by 2022. Many of the benefits (e.g. flexible spending accounts) that are considered "applicable coverage" in the statute are actually routine benefits offered by more employers to help employees defray their medical costs and access medical services they otherwise couldn't afford.

Currently, nearly half of Americans get health insurance through their employers. The unintended consequences of implementing the excise tax as proposed in 2018 will prove deleterious for employer-sponsored health insurance. For instance, to avoid paying the tax employers may scale back coverage, pass the cost on to employees in the form of both higher premiums and more cost sharing and/or require higher deductibles and copays to keep the health plan costs as they are. This trend can undoubtedly fuel a major and troubling increase in personal debt for employees, many of whom will simply be unable to absorb the rising costs of both higher copays and higher deductibles. Not to mention, higher cost sharing could lead some employees to forgo needed care, which is especially unfair for people with chronic or costly medical conditions (e.g., stroke, traumatic brain injury, Parkinson's disease) and runs counter to the legislative intent of the statute.

Nearly 50 million Americans have a speech, language or hearing disorder. The ability to communicate is essential to learning, working, social well-being and living independently. When communication is impaired, it affects every aspect of a person's life, including interactions in the workplace. Two out of every 10 children have some type of speech, language or hearing disorder. Although educational systems provide speech, language, and hearing services, they are available only to children who qualify under a very rigid set of federal regulations and state education laws. In addition, caseloads in the schools are high, so many children access services covered by their health plan. Most health plans do not cover developmental speech services or only offer the services through providers who are outside the network and whose services are subject to deductibles and coinsurance. This can be a big expense for parents, but many are able to pay for at least some portion of the necessary care by using money they have saved pretax in Flexible Spending Accounts (FSA) or Health Savings Accounts (HSA). Unfortunately, these are likely to be some of the first benefits employers eliminate to avoid exceeding the threshold and triggering the tax if the proposed definition of "Applicable Coverage" does not change.

Approximately 30 million Americans have a hearing loss and half of them are under age 50, so many of them are in the workplace. Today's digital hearing aid prices range from approximately $1,000 to $3,500 per hearing aid and hearing aids are often not covered by insurance. Many employees save money for hearing aids in their Flexible Spending Accounts and Health Savings Accounts and will likely be similarly affected.

To preserve employees' access to affordable and comprehensive health care ASHA offers the following comments:

- With respect to the types of coverage that are included in applicable coverage, the calculation of health savings accounts and flexible spending accounts (HSA/FSA) should only be applied to employer contributions, if any. We further suggest that the weight of these contributions to determine the applicable dollar limit be reduced so that employees' access to these invaluable health care resources is maintained. In addition, any carry over amounts should also be clearly excluded. FSA contributions are used by employees to pay for much needed services, such as audiology and/or speech-language pathology services, if their primary health insurance does not provide adequate coverage.

  In ASHA's modeling of the expected impact of the Cadillac tax, it is the catch-up contributions allowed to Health Savings Accounts for those over 55 years old in current regulation that would first cause us to trigger the tax. Therefore; the tax could cause unintended negative consequences for people over 55. Clearly the IRS already recognizes that the cost of coverage is higher for older workers since age and gender adjustments were proposed. We would like to see this implemented in a way that does not increase the complexity and administrative burden of performing the calculations.

- With respect to the types of coverage excluded from applicable coverage, ASHA strongly supports the Treasury's and IRS' proposal to qualify Employee Assistance Programs as an excepted benefit pursuant to recently issued regulations under §9831. Treating plans that offer direct counseling and treatment, even if only for very short-term needs, differently than plans that don't under ERISA already creates confusion in the current W-2 reporting. We support excluding all limited scope dental and vision benefits as suggested in Section III.G of

the Notice as well. We also recommend that the 2% administrative fee—a fee that is often added to the medical premium for the calculation of the COBRA rate—be excluded from applicable coverage.

- With respect to dollar limit adjustments for the two baseline per-employee dollar limits for 2018 ($10,200 for self-only coverage and $27,500 for other-than-self-only coverage), ASHA suggests that the IRS and Treasury also allow a geographic adjustment based on bona fide geographic distinctions (i.e., an employee's residence in or business' location in different states or metropolitan areas). According to the Kaiser Family Foundation, the Average Single Premium per Enrolled Employee For Employer-Based Health Insurance in 2013 varied from $7,369 in Alaska to $4,536 in Arkansas. Without an adjustment, employers in Alaska and other states above the national average will pay much more in taxes than employers located in states like Arkansas for providing similar coverage to their employees. State mandates impact the cost of coverage with heavily regulated states like Massachusetts and Maryland above the average. This will magnify the impact of the tax further for employers in these states. This recommended adjustment would be in addition to the current adjustments in statute for health cost adjustment percentage (in 2018), cost-of-living adjustment (in 2019), qualified retirees, high-risk professions as well as age and gender. We note that the IRS and Treasury are already considering steps to allow disaggregation of similarly situated individuals in a single benefit package based on geographic distinctions in determining the cost of coverage.
- Finally, we believe that it is unusual for benefit costs to change monthly. For this reason, we recommend that the calculation only be performed once per year after the end of the calendar year, and that payment of the excise tax be required only once per year. Group medical cost is relatively easy to determine, either by looking at the monthly invoice from the carrier for a fully insured plan or by calculating the COBRA rate for a self-insured plan. Limiting the calculations required to determine "Applicable Coverage" to this plus any employer contributions to an HSA or HRA would greatly ease the administrative burden on employers and increase the accuracy of the calculations.

ASHA appreciates the opportunity to provide comments on Notice 2015-16. Please contact Janet McNichol, ASHA's human resources director at jmcnichol@asha.org, if you require additional information or clarification.

Sincerely,

Judith L. Page

Judith L. Page, PhD, CCC-SLP
2015 ASHA President