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CC:PA:LPD:PR (Notice 2015-52)
Room 5203
Internal Revenue Service
P.O. Box 7604
Ben Franklin Station
Washington, DC 20044

Re: Notice 2015-52 (Section 4980I – Excise Tax on High Cost Employer-Sponsored Health Coverage)

Dear Sir or Madam:

Teachers Insurance and Annuity Association – College Retirement Equities Fund (“TIAA-CREF”) is pleased to submit this comment letter to assist the Internal Revenue Service (“Service”) and the Department of the Treasury (“Treasury”) as they prepare proposed regulations implementing Internal Revenue Code (“Code”) section 4980I, which provides for an excise tax on high cost employer sponsored health coverage.

I. Introduction and Background

TIAA-CREF is the leading provider of financial services in the higher education and not-for-profit markets and a global asset manager with more than \$869 billion in assets under management.¹ Although TIAA-CREF is well-known as a retirement plan provider and for its annuities and mutual funds, the subject of this letter is our valuable retiree health savings programs that complement our retirement plan products and services.

The TIAA-CREF Retirement Healthcare Program (“RHP”) provides a defined contribution retiree health plan for employers to help employees prepare for, and manage, health care costs during retirement. In addition, TIAA-CREF offers this product in collaboration with Emeriti Retirement Health Solutions. Under the RHP, assets are generally contributed during an employee’s working career and set aside in either a Voluntary Employees’ Beneficiary Association (VEBA) trust or a governmental (Code

¹ As of June 30, 2015.

section 115) trust. TIAA-CREF Trust Company, FSB can act as the trustee or custodian and provides investment options. Furthermore, TIAA-CREF delegates the claim reimbursement process to a third party, ConnectYourCare LLC.

The RHP is attractive for employers because it addresses challenges associated with traditional defined benefit retiree health care promises, which are often unfunded, and has a transparent cost structure with significant flexibility and scalability. For state and local governmental entities, it lowers the volatility and burden² of public funding for retiree health care expenses, while providing employees with a mechanism to fill gaps in health care coverage during retirement, both before and after eligibility for Medicare.

Under the RHP, employers make contributions to the VEBA or Code section 115 trust based on the eligibility conditions specified in the plan. If permitted under the employer's plan, participants can make employee contributions on an after-tax basis only. An individual's account in RHP may reimburse eligible medical expenses described in Code section 213(d) for the participant, spouse or dependents, per the terms of the employer's plan. The account is generally only available for reimbursement after an employee has retired or otherwise separated from service. Therefore, RHP qualifies as a "retiree-only" plan for purposes of the Patient Protection and Affordable Care Act ("ACA"). Once an individual retires, (s)he may use his or her RHP account balance for eligible medical expenses until the account is exhausted.

The RHP functions similarly to a retiree-only Health Reimbursement Arrangement ("HRA"), although it is generally funded through a trust during the participant's working career. Therefore, many questions raised by Treasury and the Service in Notices 2015-16 and 2015-52 regarding HRAs also apply to RHP. Accordingly, in this letter, we often refer to HRAs. RHP is not, however, identical to all HRAs. Rather, RHP is a *funded* arrangement, with contributions held in the underlying VEBA or Code section 115 trust with benefit levels represented by notional account balances. These unallocated amounts grow over time based on the investments selected for a participant's account. Further, as noted above, the RHP allows for after-tax employee contributions (a feature we discuss further in section V, below).

The RHP and similar retiree-only defined contribution health savings vehicles blend well with the ACA because they bridge the gap in coverage that often occurs for workers who retire before eligibility for Medicare – a problem the ACA also addresses by making coverage available through the exchanges. These retiree health savings programs also support the long-term nature of funding benefits above and beyond Medicare, especially during a period in which employer-provided retiree medical benefits are being curtailed or, worse, eliminated. Thus, it is critical that Treasury's and the Service's implementation of Code section 4980I does not discourage employers from adopting retiree health savings

² By one estimate, "total unfunded accrued liability of state and local governments for the provision of retiree health care exceeds \$1 trillion, or about 1/3 of total state and local government revenue." Lutz and Sheiner, *The Fiscal Stress Arising from State and Local Retiree Health Obligations* (NBER Working Paper Jan. 2014), available at <http://www.nber.org/papers/w19779>.

programs like RHP. Our comments below address a range of issues raised by Treasury and the Service in Notices 2015-16 and 2015-52.

II. Pre-Funded Retiree Health Coverage Should Receive Special Consideration

TIAA-CREF encourages Treasury and the Service to adopt regulations that do not discourage employers from adopting pre-funded retiree health savings programs like RHP. Over the last few decades, many employers have moved away from providing retiree health coverage, while many other employers only offer unfunded retiree health coverage. The RHP is a fully funded alternative to these legacy benefits, and employers should not be dissuaded from offering these benefits for long-service workers. The RHP and similar pre-funded retiree health programs provide a viable solution to these problems. First, these programs allow employers to pre-fund retiree health coverage in a way that safeguards against unpredictable health care liabilities. Second, such programs benefit employees by increasing their ability to pay for health care costs in retirement. These benefits are even more critical because the American workforce is aging and, in the near future, fewer workers will be funding Medicare in proportion to the number of Medicare beneficiaries.

In light of these concerns, Treasury and the Service should adopt regulations that encourage, rather than discourage, using defined contribution retiree health coverage. The RHP and similar programs serve as a critical way to ease the burden on the federal government to fund Medicare. Congress designed section 4980I with different health arrangements in mind, and it is up to Treasury and the Service to ensure that the rules recognize the unique and valuable role pre-funded retiree defined contribution arrangements can play in preparing for, and managing, retiree health care costs.

For example, we encourage Treasury and the Service to provide “grandfathering” relief for amounts set aside or contributed to a retiree-only HRA prior to 2018. It would not be fair for employers to owe significant excise tax payments for amounts contributed to a VEBA or Code section 115 trust for retiree medical expenses prior to the effective date of Code section 4980I. Because such amounts are already set aside in a trust and the notional benefit is already determined, an excise tax on the contribution or eventual payment of benefits has no ability to influence an employer’s health expenditures with respect to amounts contributed prior to 2018. As a further example, we discuss below in further detail the need to provide employers flexibility when determining the cost of coverage attributable to pre-funded defined contribution retiree health coverage.

III. Determining the Cost of Applicable Coverage

Although Code section 4980I does not expressly include special rules for determining the cost of applicable coverage under an HRA, Notice 2015-16 indicates that Treasury and the Service are considering two possible HRA-specific valuation methods for determining the cost of applicable coverage. Under the first method, the cost of applicable coverage attributable to an HRA would be “based on amounts made newly available to participants each year.” Under the second method, the cost of applicable coverage attributable to an

HRA would be determined “by adding together all claims and administrative expenses attributable to HRAs for a particular period . . . and dividing that sum by the number of employees covered for that period.” Notice 2015-16 also indicates that an actuarial basis method is also being considered for determining the cost of coverage under an HRA. We appreciate Treasury and the Service recognizing the difficulty created when applying the general valuation principles of Code section 4980I to an HRA, but we are concerned that the HRA valuation methods proposed in Notice 2015-16 create unique challenges for employers who adopt the RHP or similar programs.

A. Overvaluation

Notice 2015-16 indicates that Treasury and the Service are concerned that an HRA valuation approach “based on amounts made newly available to participants each year” could overvalue an HRA when contributions go unused in a given year. We agree. This approach could cause significant overvaluation because *all* amounts accrued over an employee’s career could be considered newly made available to each participant upon retirement or other separation from service. Such a result would disproportionately account for the RHP benefit during one singular point in time, despite the fact that contributions were made over the employee’s career and medical expense reimbursements are available throughout retirement.

In other words, we are concerned that taking RHP benefits into account “based on amounts made newly available to participants each year” could create a “balloon” effect in which an entire RHP account accumulated over several years is suddenly taken into account in a single month, making it very likely that the Code section 4980I tax will be triggered. This result seems inappropriate when compared to other account-based health arrangements, like HSAs, which would not be subject to equally severe penalties because they are valued when the employer makes contributions. Moreover, this concern will only become more problematic as millions of “baby-boomers” exit the workforce and become eligible to receive benefits accrued in a pre-funded HRA. If our overvaluation concerns are not addressed, this would likely create severe excise tax liability for employers who provide retiree health benefits to this population.

We are also concerned that this “balloon” effect could occur when employers convert unfunded promises provided under a defined benefit retiree health plan into a pre-funded defined contribution health plan, like RHP. For many employers, such a conversion avoids the risk of unpredictable health costs, while ensuring the continued provision of retiree health benefits for current and future retirees. We are concerned that an HRA valuation method “based on amounts made newly available” would effectively prohibit such a conversion because the conversion of unfunded promises to a funded benefit could be considered “amounts made newly available” for retired employees who would be eligible to receive benefits. Such a result would likely generate prohibitively severe excise tax penalties for the employer, which means an employer will be forced to simply discontinue retiree health coverage rather than converting to a defined contribution arrangement. Therefore, we encourage the adoption of final rules that do not limit HRA valuation to “amounts made

newly available to a participant each year” and provide employers the flexibility to choose among multiple HRA valuation methods, as discussed in more detail in the next section.

B. Provide employers the flexibility to choose among alternative HRA valuation methods.

Based on the concerns outlined above, we discourage adoption of a regulation making Notice 2015-16’s first proposed HRA valuation method the exclusive valuation method for HRAs and encourage Treasury and the Service to allow employers to select from multiple HRA valuation methods. We suggest three possible approaches, and recommend that an employer be allowed to choose which method to use (subject to a reasonable anti-abuse requirement that the method chosen be used consistently for a specified period).

Approach 1: Retiree-only HRA coverage is included in the cost of applicable coverage when contributions are set aside or credited to participants. Under this method, pre-funded HRA coverage is valued when contributions are set aside in a VEBA or other trust or otherwise credited to a participant’s notional account. Such an approach would avoid the overvaluation concerns discussed above and the cost of applicable coverage would more closely reflect health expenditures when they are actually made by an employer. This approach also parallels the statutorily prescribed valuation methods for other account-based health arrangements, like HSAs, Archer MSAs, and FSAs.³

For example, Code section 4980I(d)(2)(C) provides that the cost of applicable coverage attributable to an HSA equals the amount of employer contributions made during a given period. This approach focuses on employer contributions, not the availability or receipt of benefits by an employee. Similar to HSAs, pre-funded HRAs permit contributions to be carried over from year to year and allow reimbursement of eligible medical expenses during a given year up to the value of the participant’s account. Accordingly, we believe that an HRA valuation approach for a pre-funded HRA based on employer contributions is one appropriate approach for determining the cost of applicable coverage.

Approach 2: Retiree-only HRA coverage is included in the cost of applicable coverage during retirement on an actuarial-basis method. Another alternative method could allow an employer to include retiree-only HRA coverage in the cost of applicable coverage when the benefit is made available to participants, by using an actuarial-basis method, under which the cost is equal to a reasonable estimate of the cost of providing coverage for similarly situated participants determined on an actuarial basis. With pre-funded retiree-only health coverage, this approach must also account for the fact that each participant’s account balance will not be the same.

For example, assume a participant accumulates, over her working career, an RHP balance of \$10,000. Under the employer’s plan, the balance may be used beginning at retirement or separation from employment for eligible medical expenses during the

³ We note that the pro rata allocation discussion in Part V.E. of Notice 2015-52 seems to assume that the cost of applicable coverage for an HRA might be determined based on employer contributions made during a given period, which is entirely consistent with an approach based on employer contributions.

individual's life. Using reasonable actuarial assumptions, the employer would estimate the "cost" of providing such a benefit each month. (The calculation could take into account the life expectancy of the participant if that would be consistent with reasonable actuarial assumptions.) The actuarial cost probably would not be \$10,000 in the first month (or likely even the first year), because the participant is unlikely to use the entire account in the first month or year unless unique circumstances arise.

Approach 3: Retiree-only HRA coverage is included in the cost of applicable coverage during retirement based on a weighted average of HRA reimbursements made during the coverage period. Notice 2015-16 also describes a possible approach under which employers could determine the cost of coverage by adding together all claims and administrative expenses attributable to HRAs for a particular period and dividing that sum by the number of participants covered for that period. Such a method may work for some HRAs. We note, however, that this method anticipates there are fairly stable "levels" of HRA coverage that could be banded together. In theory, such a method could work for a pre-funded HRA if each account's reimbursement average is weighted based on the account value. Put another way, the employer could determine that, on average, for each \$1 in any retiree's HRA account, there is \$0.08 cents of reimbursement during the year, and then determine the cost for any particular participant accordingly.

Advantages and Disadvantages. TIAA-CREF recognizes that none of the methods described above are perfect. Each approach creates its own set of benefits and challenges for employers sponsoring pre-funded retiree health coverage. For example, a valuation method based on employer contributions (Approach #1) will likely increase the cost of coverage for employers when the relevant employee is also likely receiving other employer-sponsored coverage. This fact makes it more likely the total health care coverage expense will exceed the excise tax threshold. On the other hand, Approach #1 is much more stable and predictable, and contributions can be calibrated to avoid the tax. An approach based on valuing the coverage, rather than contributions (i.e. Approach #2 and #3), will likely carry significant administrative burdens and costs for employers. Approach #3 has additional challenges, because claims during the year could fluctuate, and it may be difficult to know the total claims until the year has ended. But Approaches #2 and #3 have the advantage of making it less likely that an employer will exceed the limit in Code section 4980I, particularly if this is the only health coverage that is provided by the employer to retirees.

Because each approach generates unique advantages and disadvantages for the employer, it is critical for the final regulations to provide employers the flexibility to choose among multiple HRA valuation methods. Limiting the valuation methods exclusively to one of the methods proposed in Notice 2015-16 threatens the availability of pre-funded retiree health accounts, which it is worth repeating, address an important public policy need.

IV. Allocation of Contributions to HRAs

Although Code section 4980I(b)(3)(C) defines the excise tax's applicable dollar limit on an annual basis, "excess benefits" are effectively calculated on a month-by-month basis

under Code section 4980I(b)(2). Notice 2015-52 correctly notes that the month-by-month determination can have unintended consequences for account-based health coverage, including HSAs, Archer MSAs, FSAs, and HRAs, and explains that Treasury and the Service “are considering an approach under which contributions to account-based plans would be allocated on a pro-rata basis over the period to which the contributions relate (generally, the plan year), regardless of the timing of the contributions during that period.”

TIAA-CREF encourages Treasury and the Service to adopt a pro rata allocation rule for account based health plans under the approach described in Notice 2015-52. A pro rata rule would be appropriate for any of the valuation methods described above in section III.B. Otherwise, employers making annual or semi-annual contributions would unfairly incur a significant excise tax penalty by creating an “excess benefit” during the month contributions are made, even though the cost of applicable coverage would satisfy the annual dollar amount threshold. Similarly, if the cost of coverage is based on the value of the account in retirement (Approaches #2 and #3 above), then it is critical that the cost of applicable coverage be determined on a pro rata basis.

V. After-Tax Contributions

Some employers who adopt the RHP allow participants to make after-tax contributions, which are subsequently invested while held in the VEBA or Code section 115 trust and made available for the reimbursement of qualified medical expenses. The regulations implementing Code section 4980I will need to address these contributions.

Notice 2015-16 states, without any explanation, that “coverage that otherwise meets the definition of applicable coverage is applicable coverage without regard to whether the employer provides the coverage (and thus the coverage is excludable from the employee’s gross income) or the employee pays for the coverage with after-tax dollars.” We urge the Service to reconsider this position in the context of after-tax contributions to pre-funded retiree health accounts. These after-tax contributions are functionally equivalent to employee after-tax contributions made to HSAs and Archer MSAs, which are excluded from the cost of applicable coverage according to Notice 2015-16 Section III.D. Moreover, a rule including after-tax contributions to a pre-funded retiree health account would discourage employers from making such features available to employees based on the risk of excise tax liability. This would create an unfortunate result for many employees who would significantly benefit from such coverage, especially when employer provided retiree health coverage is becoming more rare.

If the Service concludes, however, that the value of the RHP account that is attributable to after-tax contributions should be considered applicable coverage, then only the *earnings* on the after-tax contributions should be taken into account, not the after-tax contributions themselves. This is, at most, the “coverage” that is subject to exclusion under Code section 106, and the only lost tax revenue that Code section 4980I is trying to limit.

VI. Person Liable for the Excise Tax

Code section 4980I(c)(1) provides that the “coverage provider” is liable for the payment of its share of the excise tax. The statute further provides:

- For insured health plans, the “coverage provider” is the health insurance issuer under Code section 4980I(c)(2)(A).
- For employer contributions to HSAs and Archer MSAs, the “coverage provider” is the employer under Code section 4980I(c)(2)(B).
- For all other types of health coverage, the “coverage provider” is the “person that administers the plan benefits” under Code section 4980I(c)(2)(C).

Code section 4980I(f)(6) states that the “person that administers the plan benefits” shall “include the plan sponsor if the plan sponsor administers the benefits under the plan.”

Notice 2015-52 indicates that Treasury and the Service are considering two approaches for determining the “person that administers the plan benefits.” Under the first approach, the “coverage provider” is “the person responsible for performing the day-to-day functions that constitute the administration of plan benefits, such as receiving and processing claims for benefits, responding to inquiries, or providing a technology platform for benefits information.” Notice 2015-52 indicates that this person would generally be the third-party administrator. Under the second approach, the “person that administers the plan benefits” would be the person that has ultimate authority or responsibility under the plan or arrangement with respect to the administration of the plan benefits (including final decisions on administrative matters), regardless of whether the person routinely exercises the authority or responsibility.” Usually, this would be the employer, who is the “plan sponsor” mentioned in Code section 4980I(f)(6) and generally has ultimate authority or responsibility under the plan.

TIAA-CREF encourages Treasury and the Service to adopt the second approach – making the employer, which has ultimate authority or responsibility over the plan, liable for the excise tax. The second approach is the better approach because:

- The employer is the person actually able to control employer health expenditures included in the cost of applicable coverage through the contribution design.⁴
- The employer is the more easily identifiable person.
- It avoids administrative complexity resulting from service providers passing their excise tax liability back to the sponsoring employer.
- The party responsible for the plan, typically the employer, should bear responsibility for the tax. While the employer may delegate responsibility for administration to a third party, the employer is ultimately responsible for the plan.

⁴ Thus, this second approach is aligned with the statute’s approach to HSAs and Archer MSAs, which looks to the employer.

Unlike insured health plans, where employer expenditures are determined based on the actuarial assumptions of a third-party insurance company, employer expenditures for self-insured health plans are typically controlled by employers. This is particularly true with respect to a funded retiree-only defined contribution health arrangement, where the employer determines the contribution structure. Accordingly, it would not make sense for non-discretionary third-party administrators and service providers to be liable for an excise tax on health expenditures which they cannot control.⁵

The person with ultimate authority or responsibility over the plan is also more easily identifiable than the person responsible for performing the day-to-day administration of plan benefits; this person is likely identified in the controlling plan documents or in the contract for administrative services. In contrast, it could be difficult to identify definitively *one* person responsible for performing the day-to-day administration of plan benefits. Sometimes this responsibility could be shared across multiple parties, including, but not limited to, the employer, claims administrator, record keeper, custodian, and investment platform provider. For example, under the RHP, TIAA-CREF provides investment management, recordkeeping, and other administrative services, but uses a third party to process reimbursement claims. Not only would this person be difficult to identify, it also would be difficult to coordinate the apportionment of each service provider's share of the excise tax if multiple service providers make available separate products triggering the tax.

Finally, placing excise tax liability on the person with ultimate authority or responsibility over the plan avoids the complex administrative issues (e.g., calculating the proportionate share of "excess benefits" attributable to a separate service provider or billing employers for excise tax payments) created when third party coverage providers liable for the excise tax pass the excise tax cost back to the employer.⁶ Because this approach would typically make the employer liable for making the excise tax payments, there would be no need for service providers to pass through the cost of paying the excise tax back to the sponsoring employer. This approach also would help relieve the administrative complexity of having to coordinate the calculation and payment of excise tax liability within a short time following the end of the taxable period. Besides the excise tax itself, the administrative cost and burden associated with charging the excise tax back to employers might increase the cost of the arrangement for employers.

VII. Excise Tax "Pass Through"

Although we believe that the coverage provider liable for payment of the excise tax should generally be the person with ultimate authority and responsibility over a self-insured health plan (typically the employer), if a person other than the employer is the coverage provider liable for the excise tax, a "pass through" problem is created, as discussed in Notice 2015-52. We agree with the assumption made in Notice 2015-52 that, if a person other than

⁵ The second approach is more closely aligned with other statutorily defined "coverage providers."

⁶ See Notice 2015-52, § V.C-D (discussing the consequences for coverage providers who are liable for the excise tax and likely to pass through the cost of excise tax back to the employer plan sponsor).

the employer is the coverage provider liable for the excise tax, that provider will pass through all or part of the excise tax to the employer.

Notice 2015-52 indicates that Treasury and the Service anticipate that coverage providers would be permitted to exclude any excise tax reimbursement or income tax reimbursement if it is separately billed to the employer and identified as attributable to the cost of the excise tax. TIAA-CREF encourages Treasury and the Service to adopt regulations that would allow coverage providers to exclude any excise tax reimbursement or income tax reimbursement from the coverage provider's income, if the coverage provider for self-insured health plans administered by a third party is not the employer.

VIII. Conclusion

For many retirees, health care coverage is critical to a successful, timely, and prosperous retirement. Unfortunately, many workers are facing reduced access to employer provided health coverage in retirement due to the elimination or freezing of unsustainable defined benefit retiree health plans. Moreover, government funded coverage through Medicare faces significant threats created by an aging American workforce that has already begun entering retirement. TIAA-CREF shares the goal of making the Code section 4980I rules workable while avoiding an unintended consequence – discouraging employers from sponsoring defined contribution retiree health plans to help provide for health care benefits in retirement. As employers move away from defined benefit health plans, defined contribution health plans (like RHP) help provide health coverage for workers in retirement when coverage is needed the most. We encourage Treasury and the Service to support these efforts and implement regulations that consider the unique needs of pre-funded retiree health plans and do not discourage their use. We strongly urge Treasury and the Service to give special consideration to RHP and similar retiree health savings programs in formulating the rules under Code section 4980I. We also would be pleased to discuss our program and our recommendations with you.

Sincerely,

A handwritten signature in cursive script, reading "Timothy E. Lane".

Timothy Lane