OVERVIEW OF ELECTRONIC PAYMENT CARD ADJUDICATION AND SUBSTANTIATION REQUIREMENTS

What every employer/plan sponsor should know about electronic payment card claims processing!!!

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Employer/plan sponsors who allow reimbursement plan (e.g. Health FSA, Dependent Care FSA, and/or HRA) participants to pay for eligible expenses with an electronic payment card at the point of service are faced with a fundamental question—what are the substantiation requirements associated with electronic payment card payments? Current trends in the industry have made this a difficult question to answer. The applicable Internal Revenue Code ("Code") sections, regulations and other guidance applicable to health and dependent care reimbursement arrangements mandate that each and every request for reimbursement under the applicable plan be adjudicated by a third party and supported by appropriate substantiation. The IRS has also issued clear guidance that each and every electronic payment card ("Card") payment must be adjudicated and properly substantiated and that only those transactions that fit squarely into very limited "auto adjudication" categories need no additional paper substantiation because they are self-substantiating by their very nature. Despite the clear language in the applicable guidance, the benefits community continues to allow participants to self-certify the eligibility of Card transactions that fall outside the scope of the Auto Adjudication categories set forth in the applicable guidance. Many in the benefits community argue that the applicable guidance establishes a mere safe harbor and that other approaches not set forth in the guidance or that the other restrictions placed on the use of Cards (e.g. use only merchants with a health care related merchant category code) effectively preclude the use of such Cards for anything other than eligible medical expenses—thus, no substantiation is required. From a business viewpoint, these types of administrative policies are attractive for plan sponsors because the claims processing is easier for everyone involved, which results in lower administrative costs for the employer/plan sponsor and fewer complaints from the participants.

Despite the attractiveness of such administrative policies, the applicable guidance is very clear that only those specific adjudication and substantiation approaches identified in the guidance are permissible and that guidance requires after the fact adjudication/substantiation in every instance except in certain very narrow and limited situations strictly defined by the guidance. The failure to properly adjudicate and substantiate reimbursements under a reimbursement plan in accordance with the guidance can result in rather severe tax consequences for both the participants and the employer/plan sponsor. For example, failure to require appropriate substantiation can result in disqualification of the reimbursement plan, which will result in all reimbursements under the plan, even those for otherwise eligible expenses, being included in the participant's income and subject to withholding by the employer/plan sponsor.

The purpose of this "white paper" is two-fold:

1) Identify the applicable parameters for Card use, including but not limited to the adjudication and substantiation requirements and the merchant category code restrictions.
2) Identify various electronic payment card administrative policies that are similar to those currently being utilized in the industry that we do not believe comply with the applicable substantiation requirements.

We hope that this “white paper” will be enlightening and that it will provide valuable assistance in your decision to adopt an administrative approach that is consistent with the applicable guidance. In addition, this white paper should shed light on the reasons we will not conduct Card administration that is inconsistent with the adjudication and substantiation requirements set forth in the applicable guidance

If you have any questions, please feel free to contact Steve Honig at (609) 514-0777 ext. 10 or shonig@oca125.com. You should note this white paper was prepared by OCA, in conjunction with its outside counsel, Alston & Bird, LLP for the benefit of its business associates/partners and clients. This white paper is intended to be educational in nature and is not intended to be nor should it be construed or relied upon as legal advice. We strongly encourage you to contact qualified tax and/or legal counsel to discuss the issues addressed herein as they impact the tax liability of the employer plan sponsor and could result in liability for those who market to employer/plan sponsors any schemes or arrangements that do not comply with the applicable rules and guidance regarding substantiation.

I. What are the applicable adjudication and substantiation requirements for health and dependent care reimbursement arrangements?

In the beginning. . . .

It is important to begin this section of the white paper with a reiteration of the fundamental rule regarding exclusion of health and dependent care reimbursements from income.

Generally speaking, reimbursements under a health expense reimbursement arrangement must be limited to “medical care” as defined in Code Section 213(d) (see Code Section 105(b); see also Treas. Reg. 1.105-2). The regulations elaborate that the exclusion under Code Section 105(b) applies only to amounts “which are paid specifically to reimburse the taxpayer [either directly or indirectly] for expenses incurred by him for the prescribed medical care” (see Treas. Reg. 1.105-2). Thus, there is no income exclusion under Code Section 105 (or any other section of the Code) for amounts that a participant is entitled to receive under a medical reimbursement plan, even if such amounts are attributable to medical care, if the participant can receive such amounts without regard to whether the amounts are attributable medical care (see Treas. Reg. 1.105-2). While Section 105 does not specifically prescribe a substantiation process, a substantiation process is nonetheless implicitly required.[1]

Also, implicit in the Code Section 105 rules is that the substantiation must be received and the claim must be adjudicated *before* the reimbursement/payment is made.

[1] Readers of Treas. Reg. 1.105-2 should not be mislead by another provision in 1.105-2 that states “If the amounts are paid to the taxpayer solely to reimburse him for expenses which he incurred for the prescribed medical care, section 105(b) is applicable even though such amounts are paid to the taxpayer without proof of the actual expenses incurred by the taxpayer, but section 105(b) is not applicable to the extent that such amounts exceed the amount of the actual expenses for such medical care”. Treas. Reg. 1.105-2 is not advocating a reimbursement system without substantiation. In fact, the entire statement is conditioned on a reimbursement system that pays amounts “solely to reimburse him for [medical care]”, which references a system that takes steps to ensure the amounts are indeed for medical care. Instead, this section makes way for indemnity payments to be made without disqualifying the plan, so long as the payments are triggered by a medical event (e.g. sickness).

Since the issuance of Code Section 105, the IRS has clarified in subsequent guidance relating to various types of reimbursement arrangements that a substantiation process is indeed required. For example, the IRS noted in Notice 2002-45 that "each medical care expense submitted for reimbursement {under an HRA} must be substantiated". Also, the Treasury Regulations indicate that an FSA may reimburse an expense "only if the participant provides a written statement from an independent third party stating that the expense has been incurred and the amount of such expense and the participant provides a statement that the expense has not been reimbursed or is not reimbursable under any other health plan coverage."[2]

It must also be pointed out that the reimbursement may only be made if the substantiation is provided; therefore, it is clear that substantiation must occur *before* reimbursement is made.[3]

As you can see, the IRS and Treasury have made it clear that in order for health or dependent care reimbursements to be excluded from income, the arrangements must ensure that reimbursements are made ONLY for eligible expenses.

And then came the electronic payment card . . . .

Obviously, the Card has become an integral part of FSA and HRA administration. Cards are desired because they facilitate payment before submission of the claim and thus reduce out of pocket expenditures. However, payments through a Card arrangement are inevitably made *prior to proper substantiation being provide*, which does not fit neatly into the legal concepts identified above---that substantiation is required before reimbursement can be made.

Nevertheless, the IRS has issued guidance permitting plan participants to use a Card to pay for eligible expenses at the point of service provided certain strict requirements are satisfied. In June 2003, the IRS issued Rev. Rul. 2003-43 (the "Ruling"), which establishes the fundamental parameters for Card use, including but not limited to the "Auto Adjudication" categories, and the safeguards to prevent inappropriate card use. In July of 2006, the IRS issued Notice 2006-69, which clarifies the parameters set forth in the Ruling. In December of 2006, the IRS issued Notice 2007-02, which provides very limited transition relief from certain requirements set forth in the Ruling and Notice 2006-69 and establishes new requirements for pharmacies beginning January 1, 2009. Last, the guidance issued between 2003 and 2006 was incorporated into the proposed regulations issued under Code Section 125 in August of 2007. The guidance to date has struck a careful balance between the need for efficiency with regard to reimbursements and certainty that the expense is an "eligible" expense by requiring employer/plan sponsors to implement very strict safeguards to ensure that Card purchases are restricted to eligible expenses, including but not limited to, restricting use of the card to merchants with health care related merchant category codes and suspension of card privileges when participants misuse the card. Unfortunately, members of the benefit community have misconstrued the IRS' guidance, especially the Auto

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[2] See Prop. Treas. Reg. 1.125-2, Q/A-7(b)(5). For Dependent Care FSAs, Code Section 129 specifically limits the exclusion to "employment related expenses" as defined in Code Section 21 (see Code Section 129(a)(1), (d)(1), and (e)(1)). Moreover, the same cafeteria plan regulations that establish a substantiation requirement for Health FSAs apply equally to Dependent Care FSAs offered under a cafeteria plan (see Prop. Treas. Reg. 1.125-2, Q/A-7(b)(8), which incorporates Treas. Reg. 1.125-2, Q/A-7(b)(5)).

[3] See also Rev. Rul. 2002-80. 2002-80 holds that the exclusion from gross income under § 105(b) does not apply to plans that provide "advance reimbursements" or "loans" because the "advance reimbursements" or "loans" are paid to the employee whether or not the employee incurs medical expenses.

Adjudication guidance, to mean that substantiation is never required when a Card is used. The Ruling does not eliminate the substantiation requirement. Quite the contrary!!!! The guidance specifically requires that plan sponsors adjudicate 100% of all Card transactions, even the transactions that fit within the Auto Adjudication categories (the nature of these expenses are such that they are adjudicated based only on the transaction information but they are adjudicated nonetheless).[4]

What the Guidance Says

Auto Adjudication

The current guidance establishes the following four auto adjudication categories (and only these four):

- *Co-Payment match claims.* If the claim for a particular service matches a co-payment imposed for that service under your health plan in which the participant or dependent is participating, no substantiation other than the information in the electronic swipe is needed. For example, if your health plan in which the participant or dependent participate imposes a $15 co-pay for all physician office visits and there is a $15 payment to a physician, the plan may assume that such payment is for the co-payment under the health plan and thus no additional substantiation is required. The rule applies equally to pharmacy co-payments imposed by the plan.[5]

Originally, the Ruling did not address situations where the participant was required to pay multiple co-pays in a single visit (e.g. where participant and three children all visit the doctor at the same time). Under the Ruling, the participant would have to swipe the card multiple times. Notice 2006-69 expanded the original co-pay match auto adjudication category to allow auto adjudication in two additional situations:

- Multiples of Co-Pays for a Specific Benefit. If the transaction equals a *multiple* of a specific co-pay applicable to the participant or dependent under your plan, then no additional substantiation is required; however, the transaction will fall outside of this auto adjudication category if the transaction amount exceeds five (5) times the applicable co-pay amount. For example, assume Plan A imposes a $20 co-pay for each doctor visit. Bob is covered under Plan A. Bob uses his card to pay $80 at the doctor's office for services provided to himself, his spouse and two children. No additional substantiation is required because the $80 transaction occurred at a health care provider and is a multiple of Bob's applicable physician co-pay that does not exceed five (5) times the applicable co-pay amount.

- Multiples of Variable Co-Pays for a Specific Benefit. If the transaction equals a multiple of a co-pay for a particular benefit or a combination of the co-pays for a

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[4] In the Ruling, the IRS approved Situation 1, in part, because "Employer N's procedures provide that every claim is reviewed and substantiated, either automatically without additional documentation or manually through the submission of merchant or service provider receipts." Notice 2006-69 also indicates that a plan that permits self certification may be disqualified.

[5] The Rev. Rul. relies on the fact that health plans will not cover cosmetic and other expenses not otherwise considered "medical care" but that might be provided by a physician.

particular benefit, then no additional substantiation is required; however, this transaction will fall outside of the auto adjudication category if the transaction amount exceeds five (5) times the maximum co-pay for a particular benefit. For example, assume Plan A imposes a $5 co pay for generic drugs and $15 co pay for brand name drugs. Bob uses his card at the pharmacy to purchase three (3) generic drugs and two (2) brand name drugs for himself and his family (assume it is flu season) for a total of $45. No additional substantiation is required because the $45 is a multiple of a combination of the co-pays for the particular benefit.

This is a significant expansion of the parameters established in the Ruling but plan sponsors and administrators should also consider the following clarifications:

- ➢ If the transaction amount exceeds the maximum transaction amount (i.e. 5 times the maximum co-pay for that type of benefit) or it is not a multiple of the co pay or combination of co-pays for a benefit, *additional substantiation is required for the entire transaction.* Assume that Bob uses his card to purchase 2 brand name drugs ($30) and other over the counter drugs/products totaling $7.00. The $37 transaction does not exceed the maximum transaction amount but it is not a multiple of the combination of Bob's prescription drug co-pays. Therefore, the plan sponsor or administrator must request substantiation for the entire $37. Administrators should resist the temptation to ask for substantiation for only the $7 over the counter drugs.

- ➢ The co-pay must match the participant (or dependent's) specific co-pay under YOUR plan. It is not sufficient if the transaction amount matches a co-pay under any health plan option provided by you; it must equal a multiple of the specific co-pay applicable to the participant or dependent under your Plan. In addition, it would appear that auto adjudication is not permitted for a co-pay match under a dependent's employer's health plan.

- ➢ The administrator must receive certification from the employer regarding the co-pay applicable to participants in the plan. Self-certification is not sufficient.

- *Recurring previously approved claims.* In situations where a claim has been previously approved, a subsequent electronic claim that is the same as the previously approved claim as to a) amount, b) provider, and c) time period (e.g., for prescription drug refills that occur on a regular basis at the same provider for the same amount) will not require additional substantiation. A recurring claim must be accompanied with paper substantiation if the subsequent claim is different as to any of the elements, e.g. provider. Practically speaking, very few claims will satisfy this auto-adjudication parameter. Typically, such recurring claims must arise from an original paper claim or claim paid via the electronic payment card that is adjudicated with paper substantiation. Presumably, recurring claims will typically be in the form of prescription drug claims where the administrator knows the amount of the claim, the number and frequency of refills and the pharmacy; however, other recurring claims such as physical therapy may also fall into this category. Needless to say, this is a somewhat limited category in operation.

- *Real time verified claims.* In situations where an electronic payment is accompanied at

the time and point of sale with verifying information that the claim is for an eligible medical expense, which may be sent either electronically (e.g. internet, intranet, email, telephone) or by paper, no additional substantiation is needed. The verifying information may be in the form of a note from an administrator, e.g. a Pharmacy Benefit Manager, or treatment codes entered by the provider. For example, if a claim is paid at the physician's office for an amount over and above the co-payment, no additional substantiation would be needed if a pre-approved treatment code is also entered or called in. Currently, few claims (other than perhaps claims monitored by the PBM) fall into this category. However, new technological developments and approaches may soon open this category to claims for other types of expenses.

- *Merchant Based Adjudication Based on Inventory Information Approval System.* This Inventory Information Approval System ("IIAS") System was added by Notice 2006-69. Under the IIAS, no additional substantiation is required if the retail merchant compares the item or items to a pre-determined list of covered expenses and restricts use of the card only to those items that fall on that list. Many plan sponsors and administrators are already using health care vendors to verify the transaction at the point of sale by comparing the item(s) to a pre-determined list; Notice 2006-69 simply confirms that this approach is permissible, and opens the door for use of the Card at non-health care merchants. However, as noted below, the employer (or its TPA) must have access to claims level detail.

  The IRS made three clarifications regarding this process that many plan sponsors, administrators, and merchants, will find very interesting.

  - First, unlike the real time verification parameters established in Notice 2003-43, contemporaneous information need not be sent to the plan sponsor or administrator at the time of the transaction. However, the employer is responsible for ensuring that sufficient claims level detail of each transaction is maintained in accordance with Rev. Proc. 98-25 so that the plan sponsor can appropriately respond to examinations by the IRS. Generally, every taxpayer (including the employer) must maintain sufficient records and books to establish the amount of gross income, deductions, etc. required to be shown by a taxpayer on the tax return. Rev. Proc. 98-25 establishes rules for maintaining machine sensible records and information and clarifies that such data must be maintained as long as the information is material to administration of an IRS law (generally, the applicable statute of limitations on IRS assessments). Essentially, the records maintained as part of this inventory information approval system must be able to identify the following:

    - Name of individual
    - Transaction amount
    - Date expense incurred
    - Nature of the expense

    Plan sponsors and/or administrators must negotiate agreements with merchants for the merchant to maintain the information and make it accessible upon request or, alternatively, send the information at the time of the transaction to the employer, administrator, or other entity that can warehouse the data for the plan. Of course, where such information includes protected health information (PHI),

HIPAA's requirements apply as well. The recordkeeping requirement associated with the inventory information approval approach applies for plan years beginning after December 31, 2006.

- Second, this process opens up card use to merchants with non-health care merchant category codes (e.g. grocery stores and discount stores that sell medical items such as OTCs, but do not have a health care merchant category code) but only if this process is utilized. Notice 2006-69 forecloses any possibility of using the card at non-health care provider merchants under other circumstances.

- Third, merchant may permit split transactions. If the employee attempts to purchase $20 of eligible expenses and $40 of non-eligible expenses, the card may be used for the $20 of eligible expenses; however, the merchant must ask for some other form of payment for the other $40. The Notice confirms that the merchant need not reject the entire transaction. On the other hand, the Notice does not appear to prohibit merchants from rejecting the entire card transaction if both eligible and non-eligible items are purchased.

Pay and Chase

If a claim does not fall into one of the four auto adjudication categories listed above, the plan must obtain the appropriate substantiation. Notice 2006-69 confirms that self-certification of expenses is strictly prohibited and plans that permit self-certification risk disqualification. If proper substantiation is not subsequently provided, the plan must follow the procedures below to recoup the money from the participant.

- The Plan must require the participant to repay the bad claim. The Ruling does not identify the specific steps that must be taken; however, a letter (or electronic communication) to the participant should be sent identifying the amount, the reasons for repayment and the time frame in which the repayment must be made.
- If the repayment request is unsuccessful, an amount equal to the bad claim must be withheld from the individual's pay (to the extent consistent with applicable law). Employers should check with legal counsel to determine whether state law permits such a process. Also, appropriate authorization for withholding should be included as part of the plan and card enrollment materials.
- If the bad claim is still outstanding and amounts are not available to be withheld, then the plan should utilize a substitution or offset approach to offset subsequent valid claims against the amount of the bad claim.

If the three "pay and chase" methods identified above prove unsuccessful, the Ruling indicates that the participant remains indebted to the employer and the employer may treat the payment as it does any other business indebtedness. Comments from the IRS indicate that the employer may include the bad claim amount in the income of the employee (e.g., an adjustment to the employee's Form W-2), but only as a last resort. In addition to the above, other actions must be taken to ensure that no further violations occur, including denial of access to the card until the amount is repaid.

More importantly, Notice 2006-69 confirms that self-certification of expenses is strictly prohibited.

Consequences of failing to comply with the adjudication and substantiation requirements set forth above

Code Section 105 makes it rather clear that failing to take steps to ensure that payments are made solely for medical care expenses can result in the taxation of all payments made under the arrangement, including those payments actually made for medical care expenses (see Treas. Reg. 1.105-2). As noted above, Notice 2006-69 confirms that plans that permit self-certification risk disqualification (i.e. even the reimbursements for eligible expenses would be included in income).

Although amounts paid under a health care reimbursement arrangement that are actually for medical care expenses are not typically treated as "wages" subject to employment tax withholding[6], even if later included in gross income (e.g. where the plan is discriminatory), it appears that payments under a reimbursement arrangement that are included in gross income because no substantiation is required would be "wages" subject to employment tax withholding (see Rev. Rul. 2002-80).

If employment taxes are not properly collected and deposited, the IRS may impose penalties and interest. The particular penalty and interest provisions that apply depend on the factual situation and reasons for failure to deposit the correct amount.

[6] See Treas. Reg. 31.3401(a)(19)-1; Code Section 3121(a)(2); Code Section (b)(2).