

Long-Awaited Electronic Benefit Card Guidance Includes Many Surprises
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The IRS has issued its much anticipated follow up to its original electronic payment card guidance. Notice 2006-69 (the “Notice”) clarifies the parameters established in its original 2003 guidance (Notice 2003-43). In addition, the Notice clarifies and expands the substantiation requirements generally (whether a debit card is used or not). Plan sponsors and administrators should undertake a careful review of their current systems now, as many common industry practices may be adversely affected by the Notice. What follows are our very preliminary observations with regard to this Notice.

In a nutshell, the Notice provides the following clarifications and expansions:

- **Co-pay Match Expanded to Allow Certain Multiples of Co-pays:** Transactions equal to multiples of a co-pay or combinations of co-pays for a particular benefit require no additional substantiation provided that the employer has certified the co-pay amounts for that covered individual.
- **Point of Sale Merchant Based Adjudication Confirmed (Provided Certain Recordkeeping Requirements Are Satisfied) And Allowed Even for Non-Health Care Merchants.** Merchant-based adjudication by health care providers was specifically allowed under Notice 2003-43. The Notice confirms that no additional substantiation is required for transactions that are approved at the point of sale by merchants through an inventory information approval (e.g., SKU) system that matches items to a list of eligible expenses. However, strict recordkeeping requirements must be satisfied whereby the employer (or TPA) has access to claims-level detail (i.e. certain recordkeeping requirements must be satisfied so that the IRS has sufficient information to examine payments on audit). In an expansion from the 2003 guidance, cards may be used at merchants who do not have a medical merchant category code if the merchant utilizes the inventory information approval process addressed in the Notice.
- **Electronic Card Substantiation Allowed For Certain Dependent Care FSA Expenses.** The Notice clarifies that debit cards may be used to pay for Dependent Care FSA expenses, but that funds can only be released for expenses that have already been incurred. Advance reimbursement/payment through the card is not permitted.
- **Clarification Provided With Regard to EOB Rollover Adjudication.** The Notice clarifies that direct substantiation from a third party requires no additional review from the administrator and no certification from the employee contemporaneous with the reimbursement (e.g. an EOB from the health insurance carrier or administrator).
- **Claims Cannot Be Self-Certified.** Self-certification of expenses is strictly prohibited (in other words, if the transaction does not fit within one of the auto

adjudication categories identified in Notice 2003-43 and Notice 2006-69, third party substantiation is required).

The Notice provides significant expansions to the auto adjudication rules established by Notice 2003-43; however, the IRS clarified certain aspects of Notice 2003-43 that many plan sponsors and administrators may find disappointing. The following is a more detailed analysis of the guidance provided by the Notice and a roadmap for plan sponsors and administrators.

Reiteration of the Original Guidance

At the outset, the Notice reiterates the parameters established in Notice 2003-43. In particular, the Notice reiterates the following:

- The employee must provide certification at enrollment and each time he/she swipes the card that the card will only be used for medical expenses;
- With the exception of the newly created merchant-based adjudication category (described below), the card may only be used at merchants with health care merchant category codes;
- All transactions require additional substantiation and certification except in the case of transactions that fall into one of the following categories:
 - Transactions *at health care providers* that match co-pays under the employer's health plan covering the specific employee-cardholder (i.e., co-pay match).
 - Transactions that match a previously approved expense as to amount, duration and provider (i.e. recurring expenses).
 - Verification is provided by a merchant or other third party at the time of the transaction (or shortly thereafter) that the expense is an eligible medical expense (i.e., real-time adjudication).

The Notice does not revise these rules but instead clarifies their application and (e.g., in the case of merchant-based adjudication at non health care providers) expands on them.

Clarification and Expansion of Auto-Adjudication Parameters

Expansion of Co Pay Match Auto Adjudication to Address Multiples of Co-Pays

The Notice expands the original co-pay match auto adjudication category to allow auto adjudication in two additional situations:

- Single co-pay for a specific benefit. If the transaction equals a *multiple* of a specific co-pay applicable to the employee under the employer's 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.

- Different 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 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 Notice 2003-43 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 employee's (or dependent's) specific co-pay under the employer's plan. It is not sufficient if the transaction amount matches a co-pay under any health plan option provided by the employer; it must equal a multiple of the specific co-pay applicable to the employee or dependent. 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.

Merchant Based Adjudication Based on Inventory Information Approval System

No additional substantiation is required if a 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; the Notice simply confirms that this approach is permissible, and opens

the door for its use 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 regarding the process.

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. The Notice forecloses the possibility of using the card at non-health care provider merchants under other circumstances. This may require procedure changes for both administrators and merchants that have established other means of auto substantiating medical expenses – e.g., such as co-pay match or real time adjudication at merchants without health care MCCs.

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.

Electronic Card Substantiation for Dependent Care FSAs

The Notice clarifies that an electronic payment card may be used to pay Dependent Care FSA expenses, but only for expenses already incurred. The card may *not* be used to pay for day care expenses in advance of the services actually being rendered. However, the Notice does outline a procedure for reimbursing the participant with the card as services are rendered for advance payments made by the participant.

The Notice indicates that employees required to pay a day care expense in advance may pay the expense out of pocket and submit the appropriate substantiation to the administrator. The substantiation that is initially provided must identify the provider, time period that the coverage will be provided, and the amount. The amount allocated to the card will be increased at the end of the time period identified in the substantiation (i.e. after the expense has been incurred) by an amount equal to lesser of the original expense or the account balance at that time. The employee may then use the card to pay the next day care installment without providing additional substantiation. The card amount will continue to be increased at the end of each previously identified time period by the lesser of the original expense amount and the account balance. Subsequent payments with the card of equal or lesser value to the same provider may be paid with the card without providing additional substantiation. The employee must immediately report to the administrator any changes in the amount, time period, or provider and provide additional substantiation as necessary.

Clarification and Expansion of Substantiation Requirements Generally

Direct Substantiation from Third Party

The Notice clarifies that no additional substantiation is required if the plan sponsor or administrator receives substantiation directly from a third party that verifies the date of the expense and the employee's responsibility for such expense. This opens the door for Health FSAs and HRAs to automatically reimburse participants for health plan expenditures based on an EOB submitted directly to the Health FSA or HRA administrator from the health plan insurance carrier or administrator. Essentially, it eliminates the requirement in this limited circumstance for the employee to provide contemporaneous certification that the expense has not been reimbursed from any other source and that the participant will seek reimbursement from another source.

Self-certification

The Notice confirms that self-certification of expenses is strictly prohibited. This further supports the proposition that only those card transactions that fit within the auto

adjudication parameters established in Notice 2003-43 and 2006-69 can be used to release funds prior to additional substantiation.

What Now?

Technically, the Notice is an expansion of the parameters established in Notice 2003-43 and the substantiation requirements set forth in Prop. Treas. Reg. 1.125-2 Q-7. Practically, many plan sponsors and administrators may find the Notice a disappointment for the following reasons:

- The record keeping requirements associated with the merchant based inventory information approval approach will be considered by some to be burdensome.
- The Notice clarifies that cards may not be used at merchants that do not have a medical merchant category unless the inventory information approval approach is utilized.
- Co-pay matches at merchants that do not have a health care merchant category code are apparently not permitted.

Plan sponsors and administrators must take a serious look at their current electronic payment card adjudication procedures. Failure to comply with these rules can result in disqualification of the entire plan, which results in taxation of all reimbursements, even if the reimbursement was for an otherwise eligible expense.