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SUMMARY OF IRS ELECTRONIC PAYMENT CARD RULING

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The IRS has finally issued its long-awaited electronic payment card (aka debit card) guidance in the form of Revenue Ruling 2003-43. The guidance resolves many claims substantiation issues associated with electronic payment card systems by providing helpful auto-adjudication safe harbors. However, the guidance raises a caution flag with regard to Form 1099 reporting obligations for plan sponsors and administrators that use electronic payment cards whereby funds are transferred to the provider from an employer or plan (we call this the "direct pay approach" below). The following is an overview of what the IRS has to say about electronic payment cards in the guidance.

Q ***What is an electronic payment card and what value does it provide to Health FSA and/or HRA administration?***

A Electronic payment cards can come in the form of a debit card, a stored value card, or credit card. While the cards look alike, the differences in legal compliance may be significant. These cards enable a Health FSA/HRA participant to pay a medical care expense at the time a service or treatment is provided by swiping the card (much like you would swipe your Visa or MasterCard for groceries or clothes). However, the cards are limited to use solely at merchants that are health care providers (e.g., physicians, hospitals, pharmacies). Claims are adjudicated by after the fact substantiation of paper receipts. Historically Health FSA participants have paid for eligible expenses out of pocket and then waited while their claim form was processed before they were reimbursed for the out of pocket expense. The electronic payment card eliminates the cash flow burden created by the out of pocket expenditure arising under the historical method.

The IRS Ruling addresses three fact situations involving electronic payment card systems, two of which the IRS approves. The following is a summary of the required elements of a compliant electronic payment card system in light of the recent Ruling.

1. The system may utilize either a debit card or a credit card.

The fact situations in the IRS ruling involve the use of both a debit card or "stored value card" and a credit card. In one of the fact patterns, an employer issues each participating employee a credit card with individual limits equaling the coverage available under the Health Care Flexible Spending Account (HCSA) and/or Health Reimbursement Arrangement (HRA). The employer negotiates with the bank and uses a single line of credit, indicating a type of corporate expense account credit card.

2. The card must be turned off upon termination of employment.

In the fact patterns in the Ruling, the card is turned off upon termination of employment. Thus, the literal language of the Ruling would seem to prohibit use of the card by a retiree as well as a COBRA qualified beneficiary. Once an employee terminates, it may be administratively impossible for a plan to effectively implement "pay and chase" procedures (see discussion below addressing collection for a "bad" claim). Turning off a card would prohibit use by a retiree as well as a COBRA qualified beneficiary. However, it appears that COBRA's rules and regulations may provide that use of the card by a Qualified Beneficiary is required. We understand that IRS may be rethinking this position, and additional guidance is needed with respect to use of the card following termination of employment.

3. Each employee issued a card must provide a special certification at the time of enrollment in the plan and each year thereafter.

Each employee who is issued a card must certify at the time of enrollment and each year thereafter (e.g. annual enrollment) the following:

- The card will only be used for eligible medical expenses
- Claims paid with the card have not been reimbursed and the employee will not seek reimbursement from any other plan covering health benefits.

Plan sponsors should add language to new hire and annual enrollment forms that sets out this certification.

4. Employees must re-affirm special certification each time the card is used and the cardholder agreement itself must contain certification language.

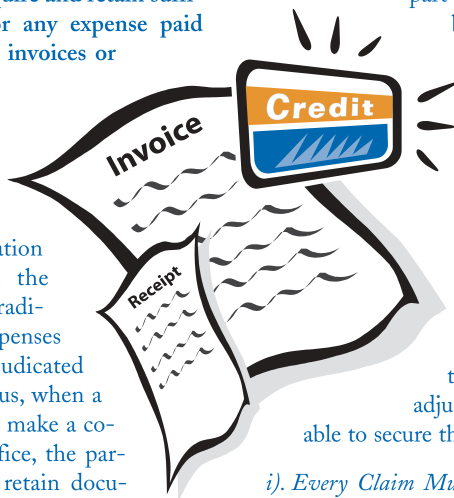
The same language (or perhaps an abbreviated version) included on the enrollment form must be printed on the back of the card. Employee-cardholders should be aware that each time the card is used, the special certification that the the expense is an eligible expense and will not be reimbursed by any other source is reaffirmed. This is consistent with the traditional Health

FSA requirement that participant certification be provided before or at the same time as the payment.

Furthermore, such language should be included in a cardholder agreement as well. While the Ruling literally requires that the participant certification be "printed on the back of the card", most electronic payment cards incorporate the terms of a cardholder agreement by reference. Presumably, such incorporation would have the same legal effect as verbatim inclusion of such language on the card. Nevertheless, IRS officials have informally indicated that their preference is to include language on the back of the card to the effect that: i) the swipe is for a valid medical expense; ii) the expense will not be submitted for reimbursement elsewhere; and iii) the swipe of the card is a recertification as to i) and ii).[1]

5. The cardholder must acquire and retain sufficient documentation for any expense paid with the card, including invoices or receipts.

Under the Ruling, the plan must require each person that pays a claim with the card to obtain and retain the documentation necessary to substantiate the claim in accordance with traditional rules, even those expenses that are automatically adjudicated (see discussion below). Thus, when a participant uses the card to make a co-payment at the doctor's office, the participant must ask for and retain documentation that shows the amount, date of service, and nature of the expense. IRS officials have commented that the underlying substantiation (even for auto-adjudicated claims) should be kept at least a year.[2] Unfortunately, the IRS has not commented on whether a failure to retain adequate documentation would jeopardize the qualified status of an FSA or HRA arrangement.



6. The card must be limited both as to amount and provider.

The card must be limited to the amount elected by the employee (reduced by prior reimbursements) under the FSA plan. In addition, the card must be limited to merchants and service providers that provide health care. The Ruling identifies appropriate merchants and services providers as physicians, dentists, hospitals, vision care service centers and *pharmacies*. The Ruling does not specifically indicate whether merchants that provide a wide variety of products and services in addition to pharmaceutical and/or vision care (e.g. groceries, cosmetics, clothes, etc.) such as Wal-Mart, Kmart, etc. would be acceptable "merchants or service providers." If the merchant category code is the same as an acceptable health care provider, it would appear that a multi-use merchant (e.g., a merchant that sells both eligible and ineligible services and products) would qualify.

7. All claims must be adjudicated.

In terms of adjudication, 100% of all claims must be adjudicated, which is consistent with current IRS FSA rules. The position remains unchanged by the Ruling. Indeed, the Ruling details two appropriate fact patterns within which 100% of all claims paid are adjudicated. What has changed in the IRS position is the acknowledgement that certain auto-adjudication techniques are valid. The Ruling provides a three-part auto-adjudication safe harbor for certain claims supplemented by after-the-fact adjudication (real-time data supplemented with additional substantiating data at a later time) for claims that are paid, but do not meet the safe harbor criteria. Note, while we describe these requirements as a "safe harbor", they are the only permissible auto-adjudication techniques allowable to secure the protection of the Ruling.

i). Every Claim Must be Adjudicated: Sampling Not Permitted.

The Ruling addresses and rejects a fact pattern where the hypothetical plan adjudicates only certain claims using sampling techniques based on transaction amounts. Under the Ruling, the following "sampling" technique was deemed to be inadequate:

- 20% of unsubstantiated dental claims in excess of $100 on the assumption that no cosmetic dental claims are available for less than $100.

- 5% of physician office transaction below $150 on the assumption that almost all such charges are for medical expenses.

- Amounts below a low dollar threshold on the assumption that such amounts are for eligible medical care, or

- Amounts that are multiples of a whole dollar amount on the assumption that these are for co-payments.

The IRS has requested comments regarding other sampling techniques, which could mean that the door is not closed on sampling. Nevertheless, until additional guidance is issued, plan sponsors should adjudicate all claims (via manual review or an acceptable auto adjudication technique) and should not rely on sampling techniques regardless of the integrity of the "filters" included in the electronic procedures.

ii). Auto-adjudication (via card swipe) is permitted in three instances.

The ruling allows for auto adjudication via swipe for claims that fall into one of the following three categories:

Co-Payment match claims. If the claim for a particular service matches a co-payment imposed for that service, no substantiation other than the information in the electronic feed is needed. For example, if the plan 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 was for the co-payment and no additional substantiation is required. The rule applies equally to pharmacy co-payments imposed by the plan. Interestingly, as long as the swipe amount matches a co-pay, payments could presumably be made under this approach for items and/or services that are not medical care without adverse consequences to the plan. Of course, as discussed above, the participant must certify both during enrollment and when he or she swipes the card that the expense is for an eligible medical care expense. Additionally, the participant is required to keep the receipts for all medical expenses paid for with the card. Although it might be difficult to catch, a participant who uses a card in this way is defrauding the plan, if not the IRS. Amounts paid would be considered income, not payments for medical expense.

However, this auto-adjudication parameter is not as broad as it may initially seem. This is because the Electronic Card Ruling contemplates a participant/plan level review of the co-pay amounts ("the transaction of a health care provider equals the dollar amount of the co-payment for that service under the major medical plan of the specific employee-cardholder"). Thus, the electronic card vendors must be able to set the co-pay level by MCC and plan category (e.g., $5, $10, $15 option). Moreover, IRS officials have informally indicated that multiples of a "matched" co-pay amount cannot be auto adjudicated under this option.[2] Thus, where multiple prescriptions are picked up or multiple charges incurred (e.g., for siblings) separate charges must apparently be made for each co-pay.

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 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 (and later adjudicated through traditional means) that is adjudicated with paper substantiation, but the Ruling safe harbor may not apply as electronic data will not generally provide data necessary to establish the required "time period" information. 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, it is a somewhat limited category.

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) will fall into this category due to technology limitations. However, when and if treatment codes can be associated with each eligible expense, this category will provide the basis for completely paperless administration.

iii). After-the Fact Adjudication

If a claim is paid (e.g., because there is a valid MCC) but does not fall into one of the above auto adjudication categories, then additional substantiation must be provided.[3] As indicated above, the participant should be directed by the Plan to obtain and retain all necessary documentation to substantiate the claim at the time a transaction is completed. If inadequate substantiation is provided, then the employer must have procedures to "pay and chase" (see below) the previously paid claim.

8. Plan must have certain procedures to recollect a "bad" claim ("pay and chase").

When a "bad" claim is paid, i.e. a claim that does not fall into one of the three auto adjudication categories listed above, and proper substantiation is not subsequently provided, the plan must follow the procedures below to recoup the money from the participant.

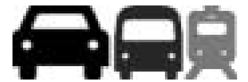
- First, the Plan must require the participant to repay the bad claim. The Ruling does not identify the specific steps that must be taken; however, a letter to the participant should be sent identifying the amount, the reasons for repayment and the time frame in which the repayment must be made. NOTE: such a notice will constitute an "adverse benefit determination" under ERISA's final claims procedure regulations. Consequently, the notice requesting repayment must contain the elements that ERISA requires to be in a denial notice.

- 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 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.

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. Other employers may wish to permanently deactivate the card once a bad claim is identified as incentive for participants to limit use only for eligible medical expenses.

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.[4]



Q ***Does the ruling apply to dependent care spending accounts or any other types of arrangements such as transportation fringe benefit programs?***

A The ruling is specifically limited to HCSAs and HRAs. IRS officials have been careful to say that the Electronic Card Ruling does not, by its express terms, apply to such arrangements.[5] That being said, dependent care spending accounts (DCSAs) are subject to many of the same adjudication and substantiation rules as HCSAs. By analogy, a good argument can be made that a card that satisfies the same requirements described in the Electronic Card Ruling with respect to dependent care plans should be permissible. However, some of the important distinctions to consider for DCSAs are that: i) under the FSA rules, claims can only be reimbursed after expenses are incurred — pre-payment, which often occurs for dependent care, is not permitted; and ii) unlike HCSAs, dependent care benefits are not subject to the uniform coverage requirement – and thus the cards may need to be refreshed/recharged as salary reduction funding occurs. Similar concepts may also apply to transportation expenses. However, with respect to transit expenses, formal clarification that the electronic payment card is considered a "voucher" as defined in the regulations under Code Section 132 would be welcome. Hopefully, additional guidance officially paving the way for use of electronic payment cards with DCSAs and/or transportation fringe benefit plans will be issued in the near future.

***Q** What are the 1099 requirements and how do they affect electronic HCSA and/or HRA administration?*

A A critical issue that should not be overlooked in evaluating any electronic payment card system is what (if any) reporting obligations may arise in connection with the electronic payments that are made. Depending on how the arrangement is structured (e.g., reimbursement or direct pay as discussed herein) and whether the electronic system can capture taxpayer identification numbers (TINs) of health care providers, the Form 1099-MISC reporting requirement may be the proverbial "fly in the ointment" of the IRS guidance.

a. A Little Background on Form 1099 Reporting

Under Code Section 6041, all persons engaged in a trade or business who make payment in the course of their trade or business to another person of $600 or more in a taxable year are required to file returns (a Form 1099-MISC) with the IRS supplying the amount of the payments and the names and addresses of the recipients. In addition, anyone required to file Form 1099-MISC must provide a statement to the recipient. Failure to file and issue Form 1099s may result in significant IRS penalties.

Payments made to physicians or other suppliers or providers of medical or health care services are specifically subject to the Form 1099-MISC reporting requirement. [6] The exemption from issuing Form 1099-MISC to a corporation does not apply to payments for medical or health care services provided by corporations, including professional corporations. However, there is no reporting requirement if the payment is made to a tax-exempt hospital or to a hospital owned and operated by the United States. And there is no need to report payments to pharmacies for prescription drugs. [7]

b. Two Types of Payments: Participant Reimbursements and Direct Payments

Under traditional HCSA arrangements (e.g., where reimbursements are sent directly to the plan participant via check or electronically via automated clearinghouse (ACH) transfer to the participant's account), HCSAs and their third-party administrators (TPAs) are not obligated to report the payments on a Form 1099-MISC. This is because the payments are structured as reimbursements to plan participants and not as payments to providers of medical services. Generally, no payment is ever made directly to the medical provider by an entity that may have a reporting obligation (e.g., the plan, the employer, or third party administrator). (We call this approach the "reimbursement approach").

In contrast to the traditional HCSA, the Form 1099-MISC requirement may arise when payments are made directly to medical providers by an employer, an employer's health plan, or someone acting on behalf of the employer or the employer's plan (e.g., a TPA) who exercises discretion in connection with the payment. (We call this the "direct pay approach" since payments are made directly to the medical vendor by an entity that must report).

Under IRS regulations, a person making a payment on behalf of another person is obligated to file information returns under Code Section 6041 if the payor either (a) performs management or oversight functions in connection with the payment (this excludes a person performing mere administrative or ministerial functions such as writing checks at another's direction); or (b) has a significant economic interest in the payment. [8] Examples in the regulations highlight discretion as the hallmark of management. One example discusses a medical insurer that administers a self-funded health care program pursuant to a contract with a state. [9] Because the insurer reviews claims to determine eligibility and determines the amount of the payments (based on program parameters established by the state), the insurer is deemed to perform management or oversight functions and must report payments on Form 1099-MISC.

c. What the Guidance Provides

The IRS Ruling clearly imposes a Form 1099-MISC reporting requirement on the employer sponsoring the arrangement. Citing section 6041, the guidance provides that payments of $600 or more (in a taxable year) made to medical service providers through the use of debit, credit and stored-value cards must be reported by the employer on Form 1099-MISC. Certain exceptions (e.g., payments to tax-exempt hospitals and to pharmacies) may apply to this requirement.

Assuming a Form 1099 is required, the real difficulty surrounding distribution of the 1099 is not the ability (or lack thereof) to actually distribute the 1099; it is the ability (or lack thereof) to obtain the information necessary to complete and distribute the 1099, specifically the taxpayer identification number (TIN) of the health care provider. If the employer and/or administrator were able to match up the payment with the TIN for the provider, the 1099 issue would not be as onerous as it currently appears to be; however, current debit-card technology does not easily facilitate the TIN process.

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[1] Informal comments from Harry Beker on ECFC teleconference May 28, 2003.

[2] Informal comments from Harry Beker on ECFC teleconference May 28, 2003.

[3] Some streamlining occurs by having certain data (e.g., date of claim, amount, participant's name and service provider's name) automatically pre-entered into the computer for later claims adjudication. Also, for plans that write hard copy reimbursement checks, streamlining and cost savings will be realized by eliminating the checkwriting process.

[4] Informal comments from Harry Beker on ECFC teleconference May 28, 2003.

[5] Informal comments from Harry Beker on ECFC teleconference May 28, 2003.

[6] 2002 Instructions for Form 1099-MISC, Specific Instructions (Box 6). The exemption from issuing Form 1099-MISC to a corporation does not apply to payments for medical or health care services provided by corporations, including professional corporations.

[7] 2002 Instructions for Form 1099-MISC, Specific Instructions (Box 6).

[8] Treas. Reg.§ 1.6041-1(e).

[9] Treas. Reg. § 1.6041-1(e), Example 9.