

IRS Provides Additional Debit Card Guidance

On July 11, 2006, the Internal Revenue Service (IRS) issued Notice 2006-69, which expands the acceptable methods for electronic payment card substantiation for a Flexible Savings Arrangement (FSA), Health Reimbursement Arrangement (HRA) and Dependent Care Assistance Program (DCAP). With one exception, the Notice takes effect immediately, and employers and administrators may rely on the Notice in making any necessary changes to substantiation procedures.

Previously, Revenue Ruling 2003-43 set out three safe harbors for auto-substantiation of medical expenses (i.e., approval of medical claims without a receipt or further review): the expense matches a copayment for that service; the expense is of a recurring nature and matches a previous claim as to amount, provider, and time period; and the expense is substantiated in real time at the point-of-sale.

Notice 2006-69 clarifies auto-substantiation rules in five major areas:

Copayment Multiples - Matches of copayment multiples are acceptable for up to five times the copayment amount for that particular service or benefit. For example, a transaction for three physician visits of \$10 each can be auto-substantiated in a single \$30 transaction. This marks a change from previous informal guidance from IRS that Revenue Ruling 2003-43 did not explicitly permit copayment multiples.

Also, a plan with multiple copayments for the same benefit may auto-substantiate any combination of the copayments up to five times the maximum copayment amount. For example, consider a plan with a \$5 generic/\$10 non-generic prescription drug copayment structure. A purchase of seven generic drugs and one non-generic drug could be auto-substantiated because the transaction amount ($\$5 \times 7 + \$10 = \$45$) is less than five times the maximum copayment amount ($\$10 \times 5 = \50).

On the other hand, auto-substantiation is not available if an expense matching the copayment is combined with one that does not. For example, for a \$15.25 purchase that includes a prescription drug expense of \$10 (matching the co-payment) combined with \$5.25 for cough medicine, the participant would need to submit a receipt to substantiate this transaction.

Inventory Information Approval System (IIAS) - The IRS validated an increasingly common practice whereby medical purchases are auto-substantiated at the point of sale based on a distinctive number (such as a stock-keeping unit [SKU]) assigned to the purchased item that identifies it as a legitimate medical expense. This practice is referred to by merchants as an Inventory Information Approval System (IIAS). Previously this system had only been used in places that had specific 4-digit Merchant Category Codes, such as doctor's and dentist offices, pharmacies, vision care offices, hospitals and other medical care providers. However, in the new guidance the IRS broadened this auto-substantiation method to include merchants that do not have healthcare related merchant category codes as long as they are using a merchant category code where legitimate medical purchases are coded with a numbering system (such as SKU's). Effective for plan years beginning on January 1, 2007, and thereafter, merchants/employers using an IIAS are responsible for ensuring that it complies with IRS recordkeeping requirements.

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321 North Clark Street
Chicago, Illinois 60610
312-595-6200

610 Central Avenue, Suite 200
Highland Park, Illinois 60035
847-681-2300

One Oakbrook Terrace
Oakbrook Terrace, Illinois 60181
630-705-2000

www.mesirowfinancial.com

Explanation of Benefits (EOBs) - Another common practice is for plans to auto-substantiate expenses via EOBs and other documents sent (often electronically) from the carrier to the plan. IRS endorsed this practice both for card and non-card transactions. The EOB must contain the required information: description of the expense, the date it was incurred and the amount.

No Self-Certification - IRS clarified that all medical expenses reimbursed from an FSA, HRA or DCAP must be substantiated, either through one of the approved auto-substantiation methods or via submission of a claim form and receipt. Participants may not satisfy the requirement without verification from a third party. We are aware that some FSA/HRA administrators promote a “paperless” card that requires no receipts. The IRS position is now very clear that this is an impermissible practice if the expense does not fall into one of the three auto-substantiation safe harbors described in Notice 2003-43: copayment matching, recurring claims, and real-time substantiation.

(DCAPs) - Revenue Ruling 2003-43 made no mention of DCAPs; thus, use of a debit card for dependent care was a risky proposition. Notice 2006-69 confirms the general rule that reimbursement may not occur until services have been provided. Only when a dependent care provider is willing to wait until after services have been provided may the participant use a debit card. Thereafter, future card transactions could be auto-substantiated if they are for the same time frame, provider and the same or lesser amount.

For example, consider an employer with a weekly payroll and a DCAP. A participant elects the full \$5,000 of coverage (\$96.15 per week). For the first week of the plan year, the dependent care expense is \$250. If the provider accepts payment at the end of the week, the participant can use the debit card to pay for \$96.15 and pay for the balance (\$153.85) by other means. Subsequent transactions could be auto-substantiated if they met the requirements described above.

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