ALSTON+BIRD LLP

EMPLOYEE BENEFITS AND
EXECUTIVE COMPENSATION ADVISORY

July 9, 2007

Health Benefit Cards: New Rules for 2008 and Beyond

The IRS recently issued two pieces of much anticipated follow-up guidance to its original electronic payment card ("Card") guidance for health benefit cards. This guidance will substantially impact how health benefit cards are administered in 2008 and beyond to access funds in a flexible spending arrangement (FSA) or health reimbursement arrangement (HRA). [Distributions from health savings accounts (HSAs) are not subject to the substantiation and other requirements discussed herein; so HSA benefit cards need not follow these rules.] Indeed, the IRS guidance shifts the paradigm from TPA-based adjudication to merchant-administered adjudication with the IRS' approval of a merchant-based inventory information approval system (or "IIAS"). This advisory tracks through the IRS guidance and describes what's permissible (and what's not) under the new guidance.

In July 2006, IRS issued Notice 2006-69 (the "2006 Notice"), which clarifies the parameters established in the original 2003 IRS Card guidance (Rev. Rul. 2003-43, hereafter the "Ruling"). The 2006 Notice confirmed that the original Ruling was restricted to merchants that have a health care merchant category code (or "MCC"), but allowed for merchant based IIAS adjudication for other merchants. Then, in Notice 2007-02 (the "2007 Notice") the IRS provided a limited transition period (calendar year 2007) during which certain merchants that do not have a health MCC (i.e., supermarkets, grocery stores, discount stores and certain Web-based and mail-order stores that sell prescriptions) can be treated as if they have a health care MCC under the Ruling.

Taken together, the 2006 and 2007 Notices provide the following clarifications and expansions to the 2003 Ruling:

- **Co-pay Match for Merchants With a Health Care MCC Expanded to Allow Certain Multiples of Co-pays:** Card transactions equal to multiples of a co-pay or combinations of co-pays for a particular benefit (not to exceed five times the co-pay amount generally) require no additional substantiation provided that the employer or plan has certified the co-pay amounts for that covered individual.
- **Point of Sale Merchant Based Adjudication Allowed Even for Merchants Without a Health Care MCC.** The 2006 Notice confirms that no additional substantiation is required for Card transactions that are approved at the point of sale by merchants through an inventory information approval (e.g., SKU) system that matches items sold by the merchant to a list maintained by the merchant of eligible expenses. However, strict recordkeeping requirements must be satisfied so that the plan sponsor (or TPA) has access to claims-level detail (i.e., information related to the products that were actually purchased) necessary to satisfy future requests for information by the IRS during an audit of plan reimbursement. In an expansion from the 2003 Ruling, Cards may be used at merchants who do not have a health care related MCC if the merchant utilizes the inventory information approval described in the 2006 Notice.

- **Electronic Card Substantiation Allowed For Certain Dependent Care FSA Expenses.** The 2006 Notice clarifies that Cards may be used to pay for dependent care FSA expenses in accordance with special rules established in the 2006 Notice; however, 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 2006 Notice clarifies that direct substantiation from a third party (e.g., an explanation of benefits (EOB) from the health insurance carrier or administrator) requires no additional review from the administrator and no certification from the employee contemporaneous with the reimbursement. This applies whether the Card is used for payment or not.

- **Claims Cannot Be Self-Certified.** Self-certification of expenses (paid with the Card or otherwise) is strictly prohibited. In other words, if the transaction does not fit within those allowed under the Ruling and Notice, third party substantiation is required *before funds are released* from the FSA or HRA. Also, if funds are released under the Ruling, but the transaction is outside an auto-adjudication category, the plan sponsor (or its TPA) must substantiate the claim or take certain correction procedures set forth in the Ruling.

- **Under the 2007 Notice, Certain Merchants Treated as if Having a Health Care MCC for 2007:** The IRS issued transition relief treating certain merchants (all supermarkets, grocery stores, discount stores and wholesale clubs, as well as certain mail-order and Web-based retailers that sell prescription drugs) as merchants with a health care related merchant category code for 2007. The normal electronic card substantiation rules (including "pay and chase" substantiation described below) apply during this time. Beginning January 1, 2008, the Card may only be used at merchants that actually have a health care related MCC or at merchants that use an IIAS system as described in the 2006 Notice.

- **After December 31, 2008, Card use at Pharmacy and Drug Stores Limited to IIAS.** After December 31, 2008, all merchants that have a pharmacy or drug store MCC must use IIAS unless, on a location-by-location basis, they sell 90 percent by gross receipts medical qualifying items.

This advisory integrates existing IRS guidance in one source. Plan sponsors, third-party administrators, Card issuers, and Card processors should undertake a careful review of their current systems now, as many common industry practices may be adversely affected by the 2006 and 2007 Notices.

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

Electronic payment cards can come in the form of a debit card, stored value card,[1] or credit card. 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 generally limited to use solely at merchants that have implemented an IIAS system or that have a health care related MCC (e.g., physicians, hospitals, pharmacies). The electronic payment card can reduce paper administration for the administrator and plan sponsor since certain claims are "auto-adjudicated" by the swipe of the Card. However, as discussed below, even with auto-adjudication, the arrangement can never really be "paperless."

[1] A debit card typically has an "account" balance available to the account holder. A stored value card has no real account attached to it, but operates from an available balance with a particular merchant, similar to a credit card.

In light of the Ruling and Notices, how do I set up an electronic payment system for a health FSA or HRA?

The original IRS Ruling addressed three factual situations involving Card systems, two of which the IRS approved. The following is a summary of the required elements of a compliant Card system.

1. The system may utilize either a debit card, stored value 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 enters into an arrangement with a sponsoring bank to issue each participating employee a credit card with individual limits equaling the coverage available under the health FSA and/or 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 situations described in the Ruling, the Card is turned off upon termination of employment. 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). However, turning off a Card would prohibit use by a retiree as well as a COBRA qualified beneficiary.

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.[2]

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 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, on at least one occasion, an IRS official informally indicated that the preference is to

[2] IRS has informally indicated that the same certification requirements apply equally to traditional requests for reimbursements.

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).[3]

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

Under the Ruling, the FSA/HRA plan must require each person that pays a claim with a 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 documentation (even for auto-adjudicated claims) should be kept by participants for at least a year. [4] Note that the retention period for the Plan is even longer (see discussion below).

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 or the available benefit under an HRA plan. In addition, except for an IIAS option (discussed below), the Card must be limited to merchants and service providers that have a merchant category code related to health care. The Ruling identifies merchants with a health care related merchant category code as physicians, dentists, hospitals, vision care service centers, pharmacies, and "other medical providers." This created confusion for some in the industry because the Ruling does not specifically indicate whether multi-use merchants that do not have a health care related MCC but that provide a wide variety of products and services in addition to pharmaceutical and/or vision care (e.g., groceries, cosmetics, clothes) such as Target, Safeway, Kroger, would be acceptable. The 2006 Notice clarified that merchants would not qualify where they do not have a health care related MCC (even though they sell health care items). As discussed below, the 2007 Notice clarified that certain multi-use merchants (i.e., all supermarkets, grocery stores, discount stores, and wholesale clubs, as well as certain mail-order and Web-based retailers that sell prescription drugs) would be treated as merchants with health care MCCs until January 1, 2008. Also, as discussed below, under the 2006 Notice, an IIAS system can be used by all merchants, even those that do not have a health care related merchant category code, that have the appropriate infrastructure in place.

7. All claims must be adjudicated.

In terms of adjudication, 100 percent of all claims must be adjudicated, which is consistent with pre-Ruling IRS FSA rules. The position remains unchanged by the Ruling. 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 and also provides an after-the-fact adjudication (real-time data supplemented with additional substantiating data at a later time) for claims that are incurred at certain merchants (i.e., those with a health related MCC) and 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. As discussed below, the 2006 Notice also allows for auto adjudication by an IIAS-based system.

---

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

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

a) **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.

b) **Auto-adjudication (via Card swipe) is permitted in three instances.** The Ruling allows for auto adjudication via Card swipe for claims that fall into one of the following three categories:

(i) Co-Payment match. 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 in which the Card holder is covered 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 Card 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.

The 2006 Notice expands the original co-pay match auto-adjudication category for merchants with a health-related MCC 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 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 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 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 generic drugs and two 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 Card issuers, Card processors, and plan sponsors and administrators should also consider the following clarifications:

- If the transaction amount exceeds the maximum transaction amount (i.e., five 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 two 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 of co-pay amounts by participants is not sufficient.

(ii) 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 (1) amount, (2) provider, and (3) 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.

(iii) 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 (PBM), 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.

c) After-the fact adjudication for certain merchants with health related MCCs. If a claim is paid (e.g., because there is a valid health care related MCC) but does not fall into one of the above auto-adjudication categories, then additional substantiation must be provided.[5] 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.

[5] 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 check writing process.

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

When a "bad" claim is paid, i.e., a Card swipe occurs (as allowed by the Ruling) at a merchant with a health care MCC, but the claim 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 likely be an "adverse benefit determination" under ERISA's final claims procedure regulations. Consequently, the notice requesting repayment should 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. Although not addressed in the Ruling, IRS officials have expressed skepticism as to whether claims can be offset against good claims in a subsequent plan year.

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. Informal comments from the IRS indicate that the employer may include the bad claim amount in the income of the employee (e.g., most likely an adjustment to the employee's Form W-2), but only as a last resort.[6]

9. Merchant based adjudication based on inventory information approval system.

The 2006 Notice allows for auto adjudication for an additional category of claims under the merchant based inventory information approval system. As described below, under such an arrangement, a real-time determination is made by the merchant at the point of sale of the amount of eligible medical expenses by comparing the selected items to a pre-approved list. An amount corresponding to the charges allocable to permissible medical expenses is then paid under arrangement. No additional substantiation is required if a merchant compares the item or items to a pre-determined list maintained by the merchant of items sold by the merchant that constitute Code Section 213(d) expenses and restricts use of the Card only to those items that fall on that list. However, as noted below, the employer (or its TPA) must have access to claims level detail provided at the time of the transaction or a later date.

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

The IIAS system approves the use of the Card only for eligible medical care expenses; when a transaction is not approved in full, the employee must pay the additional amounts, resulting in a split-tender transaction. For example, 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. 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 maintained by the merchant; the 2006 Notice simply confirms that this approach is permissible (provided auditable records are retained), and opens the door for Card use at non-health care MCCs.

In the 2006 Notice, plans using the merchant based IIAS system are required to maintain records including transaction-level detail sufficient to satisfy the recordkeeping requirements established by Rev. Proc. 98-25 for machine-sensible data. IRS officials have informally indicated that this recordkeeping requirement applies to all Card-based transactions, including transactions that would otherwise qualify for auto adjudication under the Ruling. According to the IRS, this recordkeeping requirement is not new, but rather is statutorily imposed by Section 6001 of the IRC.

Thus, to recap the IIAS approach, several requirements must be satisfied prior to implementation of the IIAS:

(i) The Approved List: The merchant must establish and maintain a list of items that it sells that qualify as Section 213(d) medical expenses.

(ii) Inventory Flagging: The merchant must have the system capability to apply the list to items attempted to be purchased by the cardholder in real time to ensure that SKU numbers (or other inventory tracking criteria) are flagged to indicate status as an eligible medical expense.

(iii) The Electronic Card System Requirements: The merchant must ensure that its electronic card system can identify cards that are restricted to medical expenses, and that "split-tender" transactions can be correctly handled.

(iv) Recordkeeping: The plan must ensure that claims-level records are maintained to satisfy the recordkeeping requirements specified in Rev. Proc. 98-25.

10. Exactly what information must be retained to satisfy Rev. Proc 98-25?

As noted above, the IRS takes the position that Section 6001 imposes the Rev. Proc 98-25 recordkeeping requirement on all auto-adjudication categories. Section 6001 requires that every taxpayer (including plan sponsors) maintain sufficient records and books to establish the amount of gross income, deductions, etc., required to be shown on their 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, up to four years after the transaction has occurred). Thus, adequate transaction-level information must be retained to establish that the requirements of the appropriate auto-adjudication category were satisfied. However, the nature of the records required to be retained may vary, depending on which category is relied upon.

For example, under the co-pay match category (discussed above), it would seem that the records required to be kept include information relating to the participant's specific co-pay amount(s), that transactions were incurred at merchants that had a health care related MCC, and that the transaction

amount matched an appropriate multiple of the appropriate co-pay. However, information as to the specific items purchased may not necessarily need to be retained. Likewise, under the recurring transaction category, information must apparently be retained with regard to the original (e.g., paper) processed transaction amount, the provider, and appropriate time period.

Under the merchant based IIAS category, the recordkeeping requirement seems to be more onerous, requiring transaction-level detail as to the specific underlying claims that were approved. It appears that the records required to be maintained as part of the IIAS system must be able to identify:

- the name of the individual (e.g., perhaps with a truncated card number and transaction reference);
- the transaction amount;
- the date the expense was incurred; and
- adequate information as to what was purchased to confirm that the expense was an eligible 213(d) expense.

While not specifically addressed, it would seem that the actual eligible medical expense list against which the claim was adjudicated need not be maintained since the IRS can establish whether a particular claim was valid by looking at the retained claims level detail.

Plan sponsors and/or administrators must negotiate agreements with merchants (and/or Card processors) to maintain the information and make it accessible upon request or, alternatively, send the information 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. Under the 2006 Notice, the recordkeeping requirement associated with the IIAS approach applies for plan years beginning after December 31, 2006.

11. Transition relief for certain merchants under Notice 2007-02.

The IRS issued transition relief treating certain merchants (all supermarkets, grocery stores, discount stores, and wholesale clubs, as well as certain mail-order and Web-based retailers that sell prescription drugs) as merchants with a health care related merchant category code for calendar year 2007. The normal electronic Card substantiation rules (including pay and chase) apply during this time. Then, beginning January 1, 2008, these merchants will need to have a health care MCC or use an IIAS system as described in the 2006 Notice. Also after December 31, 2008, all merchants that have a pharmacy or drug store MCC must use an IIAS unless, on a location-by-location basis, they sell 90% by gross receipts of medical qualifying items.

12. Recap Chart

The following chart recaps which IRS-approved claims substantiation techniques are permitted with respect to merchants that have (and do not have) MCCs related to health care.

	Health Related MCC	**Non-Health Related MCC**	**Merchants With Transition Relief in 2007-02** (i.e., all supermarkets, grocery stores, discount stores, and wholesale clubs, as well as certain mail-order and Web-based retailers that sell prescriptions)	**Merchants with a Pharmacy or Drug Store MCC**
Co-Pay Match	Permitted	Not permitted (but see transition relief provided by 2007 Notice)	Permitted prior to January 1, 2008	Permitted only until January 1, 2009 (unless 90% gross receipts on a store-by-store basis are qualifying medical items)
Recurring Expense	Permitted	Not permitted (but see transition relief provided by 2007 Notice)	Permitted prior to January 1, 2008	Permitted only until January 1, 2009 (unless 90% gross receipts on a store-by-store basis are qualifying medical items)
Real Time Substantiation	Permitted	Not permitted (unless IIAS) (but see transition relief provided by 2007 Notice)	Permitted prior to January 1, 2008; thereafter, only if IIAS	Permitted only until January 1, 2009 (unless 90% gross receipts on a store-by-store basis are qualifying medical items)
Pay and Chase (i.e., substantiate after claim is paid)	Permitted	Not permitted (but see transition relief provided by 2007 Notice)	Permitted prior to January 1, 2008	Permitted only until January 1, 2009 (unless 90% gross receipts are qualifying medical items)
Merchant Based Adjudication Under IIAS	Permitted	Permitted	Permitted	Permitted

How can electronic payment cards be used for dependent care expenses?

The 2003 Ruling did not provide for Card use for dependent care expenses. The 2006 Notice provided that Cards 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.

The 2006 Notice indicates that employees using a Card to pay a day care expense must first 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.

What about EOB "Rollover" arrangements?

The 2006 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. Simply stated, the requirements of this "Third Party Substantiation Rule" are that the plan be provided with information from an independent third party that indicates the date that an eligible health care expense has been incurred and the amount of the expense that has not been reimbursed.

More specifically, Section IV.A. of the 2006 Notice provides as follows:

> If the employer is provided with information from an independent third party (such as an explanation of benefits from an insurance company) indicating the date of the § 213(d) service and the employee's responsibility for payment for that service (i.e., coinsurance payments and amounts below the plan's deductible), the claim is fully substantiated without the need for submission of a receipt by the employee or further review.
>
> ***Example.*** Employee D is a participant in the health FSA sponsored by Employer X and is enrolled in X's medical plan. D visits a physician's office for medical care as defined in § 213(d). The cost of the services provided by the physician is $150.00. Under the medical plan, D is responsible for 20% of the services provided by the physician. X has coordinated with the medical plan and X or its agent is automatically provided with an EOB from the plan indicating that D is responsible for payment of 20% of the $150 (i.e., $30) charged by the physician. Because X has received a statement from an independent third party that D has incurred a medical expense, the date the expense was incurred, and the amount of the expense, the claim is substantiated without the need for D to submit additional information regarding the expense. D has sufficient FSA coverage for the claim, which was incurred during the coverage period. X's FSA reimburses D the $30 medical expense without requiring D to submit a receipt or a statement from the physician.

According to the Notice, this Third Party Substantiation Rule applies "whether or not a Card is used".

Impact of Ruling and Notice on self-certification

The 2006 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 the 2003 Ruling and 2006 Notice can be used to release funds prior to additional substantiation.

Does an employer need to consider ERISA plan asset and trust requirements?

With the exception of church and government sponsored plans, health FSAs and HRAs are subject to ERISA's requirements including the plan asset/trust and claims procedure requirements. Plan sponsors that utilize Card mechanisms must ensure that the accelerated payment procedure does not run afoul of these requirements.

According to the Department of Labor (DOL), health FSA salary reductions are ERISA plan assets. Under ERISA, such amounts must generally be kept in a trust account unless the requirements of ERISA Technical Release 92-1 (Tech Rel. 92-1) are satisfied. One of the requirements of Tech Rel. 92-1 is that salary reduction amounts must be maintained as part of the general assets of the plan sponsor until used to fund benefits. If salary reductions are sent to an intermediary account *other than an account that is part of the plan sponsor's general assets* Tech Rel. 92-1 does not apply and the FSA plan would be considered a "funded" plan under ERISA. Where the plan is considered to be a "funded plan" ERISA's trust and Form 5500 (including audited financials) requirements apply regardless of the number of participants.

Many electronic card payment mechanisms require pre-funding to ensure that adequate funds are available to satisfy electronic payment requests. Such arrangements could cause an otherwise "unfunded" plan (under Tech Rel. 92-1) to be considered to be "funded" *if* salary reduction amounts are considered to be maintained outside of the general assets of the plan sponsor (e.g., in a TPA or other intermediary conduit account). Given the fact that money is fungible, an issue may arise as to whether funds in the intermediary's hands are plan assets (comprised in part of salary reductions) or employer funds that are not subject to ERISA's requirements. There is some risk that an arrangement may be considered to be "funded" even where a zero-balance "conduit" account is utilized. Moreover, amounts recovered under the "pay and chase" process could cause an otherwise unfunded plan to be considered funded for ERISA purposes. This issue should be addressed with legal counsel prior to implementing an electronic payment card arrangement that utilizes a funding account that is separate from the employer's general assets.

Some electronic card payment mechanisms fund benefit claims in arrears (i.e., by reimbursing the payment intermediary) or otherwise utilize a "credit mechanism" to fund claims. Under such an arrangement, health FSA plan benefits may be paid by the plan sponsor or a third party and then *subsequently* reimbursed (in arrears) by the FSA plan. Such a construct (in and of itself) should not cause the plan to be funded. However, care should be taken to ensure that the "credit" mechanism does not violate ERISA's prohibited transaction requirements (i.e., a loan between the plan and plan sponsor would be a prohibited transaction under ERISA). In this regard, it is worth noting that DOL has issued a class exemption allowing certain unsecured "interest-free" loans between a plan and plan sponsor to be established to fund plan benefits.[7] Presumably an electronic payment card mechanism (with benefits funded in arrears) could be structured to satisfy the requirements of the class exemption. Once again, legal counsel should evaluate the ERISA compliance aspects of any electronic payment mechanism.

HRAs (unlike their traditional health FSA counterparts) are required to be funded exclusively with employer funds. Thus, ERISA plan asset issues should not arise unless a separate plan owned account or trust account is established to pay claims. As a result, an employer's provision of general assets to a third party to pre-fund electronic payment requests should not (without more) cause the plan to be a funded plan.

[7] PTE 80-26.

Compliance test for plan sponsors considering electronic payment cards

A careful evaluation of any Card system should be undertaken with the assistance of benefits counsel. The following questions should help spot critical compliance-related issues. Any "no" answer should raise concern in the eyes of the plan sponsor or administrator evaluating a proposed system.

1. Does the system provide for adequate participant certification?

IRS guidance requires that participants certify during enrollment that the Card will only be used for eligible medical expenses and that certain statements as to claims eligibility be included on the back of the Card (and perhaps in the cardholder agreement) so that certification provided at enrollment is re-affirmed whenever the Card is swiped. Is the necessary language included and adequate?

2. Is the Card limited to IIAS and otherwise by merchant category code to eligible health care providers?

As a general rule, the Card must be limited to specific merchant codes relating to health care – e.g., physicians, pharmacies, dentists, vision care. The IRS issued transition relief in the 2007 Notice treating certain merchants (all supermarkets, grocery stores, discount stores, and wholesale clubs, as well as certain mail-order and Web-based retailers that sell prescription drugs) as merchants with a health care related merchant category code for 2007. Is the Card usable at a merchant that does not have a health care related merchant category code? If yes, the Card must be restricted to IIAS merchants; or for 2007 only, merchants that are supermarkets, grocery stores, wholesale clubs, discount stores and each Web-based and/or mail order retailer that sell prescription drugs. What steps will be taken to turn off non-health care MCC merchants prior to January 1, 2008? Under the 2006 Notice the Card can also be utilized at additional merchants that have a compliant IIAS system.

3. Does the system adjudicate every claim?

The IRS Ruling specifically requires adjudication of each and every claim. While a swipe may be adjudication in certain cases, auto-adjudication is limited to claims that fit the three auto-adjudication parameters (co-pay, recurring expenses, and real-time substantiation) or the IIAS arrangement described above. Systems that utilize a "sampling" technique do not fall within the safe harbor established by the IRS Ruling.

4. Does the system provide adequate flagging of claims that do NOT fit the auto-adjudication parameters?

Claims that are not auto-adjudicated can be paid at merchants with a health related MCC, but must be substantiated the traditional way – e.g., by reviewing paper receipts, invoices. Does the plan have an adequate after-the-fact mechanism for identifying and reviewing "fall-out" claims? Is the necessary information provided for the claims administrator or employer to proceed with "pay and chase"?

5. Can the system "turn-off" Cards for terminated employees and/or individuals who submit bad claims?

Under the Ruling, the Card must be turned off in certain cases (e.g., termination, failure to substantiate). Can the system accommodate this?

6. Does the system comply with ERISA's trust and plan asset requirements?

As noted above, ERISA issues will arise if plan assets are segregated from the employer's general assets and retained in a non-trust account. Care should be taken so that Card funding liquidity requirements do not result in plan asset violations. Steps should be taken to ensure that salary reductions are kept as part of an employer's general assets or that plan assets fund claims in arrears (i.e., after the expense has been reimbursed).

This advisory was written by John R. Hickman and Ashley Gillihan.

If you have any questions or would like additional information, please contact your Alston & Bird health benefit attorney:

Health Benefit Attorneys

Ashley Gillihan
404.881.7390
ashley.gillihan@alston.com

John Hickman
404.881.7885
john.hickman@alston.com

Amy Heppner
404.881.7272
amy.heppner@alston.com

Laurie Kirkwood
404.881.7832
laurie.kirkwood@alston.com

Johann Lee
202.756.5574
johann.lee@alston.com

or you may contact any of the other members of the Employee Benefits & Executive Compensation Group

Bob Bauman
202.756.3366
bob.bauman@alston.com

David Kaleda
202.756.3329
david.kaleda@alston.com

Tom Schendt
202.756.3330
thomas.schendt@alston.com

Kathie Bekkers
404.881.7525
kathie.bekkers@alston.com

Blake MacKay
404.881.4982
blake.mackay@alston.com

John Shannon
404.881.7466
john.shannon@alston.com

Saul Ben-Meyer
212.210.9545
saul.ben-meyer@alston.com

Emily Mao
202.756.3374
emily.mao@alston.com

Michael Stevens
404.881.7970
mike.stevens@alston.com

Philip C. Cook
404.881.7491
philip.cook@alston.com

Sean McMahan
404.881.4250
sean.mcmahan@alston.com

Laura Thatcher
404.881.7546
laura.thatcher@alston.com

Pat DiCarlo
404.881.4512
pat.dicarlo@alston.com

Michael Monnolly
404.881.7816
mike.monnolly@alston.com

Kerry Tynan
404.881.4983
kerry.tynan@alston.com

David Godofsky
202.756.3392
david.godofsky@alston.com

Craig Pett
404.881.7469
craig.pett@alston.com

Peter Varney
404.881.7856
peter.varney@alston.com

Doug Hinson
404.881.7590
doug.hinson@alston.com

Kimberly Knight Phillips
404.881.7593
kimberly.phillips@alston.com

Jamie Hutchinson
202.756.3359
jamie.hutchinson@alston.com

Nancy Pridgen
404.881.7884
nancy.pridgen@alston.com

If you would like to receive future Employee Benefits and Executive Compensation Advisories electronically, please forward your contact information including e-mail address to ***employeebenefits.advisory@alston.com****. Be sure to put "****subscribe****" in the subject line.*

ALSTON+BIRD LLP

www.alston.com

ATLANTA
One Atlantic Center
1201 West Peachtree Street
Atlanta, GA 30309-3424
404.881.7000

CHARLOTTE
Bank of America Plaza
101 South Tryon Street
Suite 4000
Charlotte, NC 28280-4000
704.444.1000

NEW YORK
90 Park Avenue
New York, NY 10016-1387
212.210.9400

RESEARCH TRIANGLE
3201 Beechleaf Court
Suite 600
Raleigh, NC 27604-1062
919.862.2200

WASHINGTON, DC
The Atlantic Building
950 F Street, NW
Washington, DC 20004-1404
202.756.3300

www.alston.com