Internal Revenue Bulletin: 2006-31
July 31, 2006

Notice 2006-69

Debit Cards Used to Reimburse Participants in Self-Insured Medical Reimbursement Plans and Dependent Care Assistance Programs

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I. PURPOSE

This notice provides further guidance on the use of debit cards, credit cards, and stored value cards (cards) to reimburse participants in self-insured medical reimbursement plans, such as health flexible spending arrangements (health FSAs) and health reimbursement arrangements (HRAs). See Rev. Rul. 2003-43, 2003-1 C.B. 935. This notice also clarifies certain substantiation methods and requirements that apply to all medical reimbursement plans whether or not a card is used. Finally, the notice provides guidance on the use of cards to reimburse participants in dependent care assistance programs (DCAPs), including dependent care flexible spending arrangements (dependent care FSAs).

II. BACKGROUND

Rev. Rul 2003-43 addresses the use of cards to reimburse participants in health FSAs and HRAs. The ruling describes three situations in which employers adopt electronic reimbursement systems in connection with health FSAs and HRAs. In each of the three situations, employees who participate in the health FSA or HRA are issued cards.

Each participating employee certifies upon enrollment and for each plan year thereafter that the card will only be used for eligible medical care expenses of the employee, the employee's spouse and dependents. The employee also certifies that any expense paid with the card has not been reimbursed and that the employees will not seek reimbursement under any other plan covering health benefits. The certification is printed on the back of the card and the employee-cardholder understands the certification is reaffirmed each time the card is used. The use of the card is limited to the maximum dollar amount of coverage available in the employee's health FSA or HRA. The card can only be used at merchants and service providers that have merchant category codes related to health care, such as physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers.

In Situation 1 of the ruling, the employer establishes the following procedures for substantiating claimed medical expenses after the card is used. First, if the dollar amount of the transaction at a health care provider equals the dollar amount of the copayment for that service under the accident or health plan (*i.e.*, the major medical plan, health maintenance organization, etc.) covering the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review (*i.e.*, copayment match). Second, the employer permits automatic reimbursement without further review of recurring expenses that match expenses previously approved as to amount, provider, and time period (*i.e.*, recurring expenses). Third, if the merchant, service-provider, or other independent third-party (*e.g.*, Pharmacy Benefit Manager), at the time and point-of-sale, provides information to verify to the employer (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated without the need for submission of a receipt or further review (*i.e.*, real-time substantiation).

All other charges to the card are treated as conditional pending confirmation of the charge by the submission of additional third-party information, such as a receipt. Claims that are identified as not qualifying for reimbursement because of lack of additional information or otherwise, are subject to certain correction procedures.

Rev. Rul. 2003-43 concludes that the procedures adopted by the employer in Situation 1 meet the requirements of § 105(b) because all claims for medical expenses are substantiated, either automatically or by the submission of additional information. Card systems that do not meet the requirements of § 105(b) result in all payments provided by the cards being included in the participant's income.

III. ADDITIONAL USE OF CARDS TO SUBSTANTIATE HEALTH FSA AND HRA MEDICAL EXPENSES

In addition to the substantiation methods approved in Rev. Rul. 2003-43, as described below, an employer may adopt additional methods for substantiating claimed medical expenses. Employers that adopt these methods must also comply with requirements of Treas. Reg. § 1.105-2, Prop. Treas. Reg. § 1.125-2, Q & A-7, Notice 2002-45, 2002-2 C.B. 93, and Rev. Rul. 2003-43, including, but not limited to, employee certifications and adoption of meaningful correction procedures for amounts that are not automatically substantiated at the point-of-sale or within a reasonable time after the transaction.

A. *Copayment Amounts*

As described in Rev. Rul. 2003-43, the copayment match substantiation method is only permissible at merchants or service-providers that have health care related merchant category codes. Consistent with this approach, this notice expands the copayment match substantiation method to include as automatic substantiations certain matches of multiple copayments. Under this method, if the employer's accident or health plan has copayments in specific dollar amounts, and the dollar amount of the transaction at a health care provider (as identified by its merchant category code) equals an exact multiple of not more than five times the dollar amount of the copayment for the specific service (*i.e.*, pharmacy benefit copayment, copayment for a physician's office visit, etc.) under the accident or health plan (*i.e.*, the major medical plan, health maintenance organization, etc.) covering the specific employee-cardholder, then the charge is fully substantiated without the need for submission of a receipt or further review. In addition, if a health plan has multiple copayments for the same benefit, (*e.g.*, tiered copayments for a pharmacy benefit), exact matches of multiples or combinations of the copayments (but not more than the exact multiple of five times the maximum copayment) will similarly be fully substantiated without the need for submission of a receipt or further review.

If the dollar amount of the transaction at a health care provider exceeds a multiple of five or more times the dollar amount of the copayment for the specific service, the transaction must be treated as conditional pending confirmation of the charge by the submission of additional third-party information. In the case of a plan with multiple copayments for the same benefit, if the dollar amount of the transaction exceeds five or more times the maximum copayment for the benefit, the transaction must also be treated as conditional pending confirmation of the charge by the submission of additional third-party information. Similarly, if the dollar amount of the transaction is not an exact multiple of the copayment (or an exact match of a multiple or combination of different copayments for a benefit in the case of multiple copayments for the same benefit), the transaction must be treated as conditional pending confirmation of the charge, even if the amount is less than five times the copayment. In these cases, the employer must require that additional third-party information, such as merchant or service provider receipts, describing (1) the service or product, (2) the date of the service or sale and, (3) the amount, be submitted for review and substantiation.

The copayment schedule required under the accident or health plan must be independently verified by the employer (*i.e.*, the copayment amount must be substantiated by a third-party; statements or other representations by the employee are not sufficient).

Example 1. Employer W reimburses health FSA claims through debit cards, as described in Situation 1 of Rev. Rul. 2003-43. Employee A and Employee B are participants in the health FSA and are enrolled in W's medical plan. The plan has a $5 copayment for generic prescriptions and a $10 copayment for all other prescriptions.

A uses the card at a pharmacy to purchase five non-generic prescriptions, for a total card transaction of $50. W's system matches the amount of the transaction, $50, with the $10 copayment for non-generic prescriptions under A's coverage and the fact that the transaction is at a pharmacy. Because the amount of the transaction is an exact multiple not in excess of five times the maximum copayment for prescriptions under A's medical coverage and the transaction is at a pharmacy, the transaction is substantiated without further review or documentation.

B uses the card at a pharmacy to purchase three generic prescriptions and three non-generic prescriptions for a total card transaction of $45. Because the transaction is at a pharmacy and the amount of the transaction is an exact match of a combination of the copayments and does not exceed fives times the maximum copayment for prescriptions under B's medical coverage, the transaction is substantiated without further review or documentation.

Example 2. The facts are the same as *Example 1* except that A uses the card at a pharmacy to purchase six non-generic prescriptions for a total charge of $60. Because the amount of the transaction exceeds five times the maximum copayment for prescriptions under A's medical coverage, the entire transaction must be further substantiated through the submission of a receipt indicating that A purchased prescription drugs, the date of the purchase, and the amount of the purchase.

Example 3. The facts are the same as *Example 1*, except that A uses the card at a pharmacy to purchase two non-generic prescriptions and a nonprescription medication. The amount of the transaction is $27. Because the amount of the transaction is not an exact match of a multiple or combination of the copayments for generic and non-generic prescriptions under A's medical coverage, the transaction must be further substantiated through the submission of a receipt indicating that A incurred a medical expense (the prescription drugs and nonprescription medication), the date of the purchase and the amount of the purchase.

B. *Inventory Information Approval System*

An employer may adopt the method described below for approving reimbursements made through a payment card in conjunction with a health FSA or an HRA. Under this method, the payment card processor provides a system for approving and rejecting card transactions using inventory control information (*e.g.*, stock keeping units (SKUs)) with merchants who need not be health care providers as described in Rev. Rul. 2003-43. Card transactions using this method are fully substantiated without the need for submission of a receipt by the employee or further review.

Under this method, when an employee uses the card, the merchant's system collects information about the items purchased using the inventory control information (*e.g.*, SKUs). The system compares the inventory control information for the items purchased against a list of items, the purchase of which qualifies as expenses for medical care under § 213(d) (including nonprescription medications as described in Rev. Rul. 2003-102, 2003-2 C.B. 559). The § 213(d) medical expenses are totaled and the merchant's or payment card processor's system approves the use of the card only for the amount of the §213(d) medical expenses subject to coverage under the health FSA (taking into consideration the uniform coverage rule) or HRA. If the transaction is only partially approved, the employee is required to tender additional amounts, resulting in a split-tender transaction.

As described in Rev. Rul. 2003-43, if the merchant, service provider, or other independent third-party at the time and point-of-sale provides information to verify to the employer (including electronically by e-mail, the internet, intranet, or telephone) that the charge is for a medical expense, the charge is fully substantiated, without the need for submission of a receipt for further review (*i.e.*, real-time substantiation). Similarly, the inventory information approval system satisfies the substantiation requirements for purposes of reimbursing an employee's § 213(d) medical expenses without further review. However, an employer that adopts this system is nonetheless responsible for complying with all requirements in this notice, including recordkeeping requirements. Under this notice, the information required to be retained may be provided at the time of the transaction, or after the transaction (*e.g.*, upon an examination of the employer by Internal Revenue Service). Rev. Proc. 98-25, 1998-1 C.B. 689, which sets out requirements where a taxpayer's records are maintained within an automatic data processing system, also applies to the inventory information approval system.

An employer using this system may expand card use to merchants or service-providers that do not have health care related merchant category codes, provided that the only non-health care related merchants or service-providers where the card can be used are those that use the system (*i.e.*, participating merchants or participating service-providers). Under the inventory information approval system, attempts to use the card at non-participating merchants or service-providers would be rejected.

For example, if, after matching inventory information, it is determined that all items purchased are § 213(d) medical expenses, the entire transaction is approved, subject to the coverage limitations of the health FSA or HRA. If, after matching inventory information, it is determined that only some of the items purchased are § 213(d) medical expenses, the transaction is approved only as to the § 213(d) medical expenses. In this case, the merchant or service-provider would request additional payments from the employee for the items that do not satisfy the definition of medical care under § 213(d). The merchant or service-provider would also request additional payments from the employee if the employee does not have sufficient health FSA or HRA coverage to purchase the § 213(d) medical items.

Example. Employer Y reimburses health FSA claims through debit cards, as described in Situation 1 of Rev. Rul. 2003-43. Y has adopted the inventory information approval system. Several stores that do not have health care related merchant category codes participate in the system (*i.e.*, participating merchants). These participating merchants sell nonprescription medications. The use of the card has been expanded to include the participating merchants.

Employee C is a participant in the health FSA sponsored by Employer Y and has $100 of health FSA coverage. Y's health FSA covers nonprescription medications. C purchases aspirin, antacid, and cold medication for C and C's spouse and dependents at one of the participating merchants. The total amount for these medical expenses is $20.75. At the same time, C also purchases $50.00 of items that do not qualify as medical expenses under § 213(d), for a total purchase amount of $70.75. The store's system compares the SKUs from all of the items against the SKUs from a list of items that

qualify as medical expenses under § 213(d). The charge for the medical expenses totaling $20.75 is authorized and the remaining $50.00 is rejected. Employee C is asked for additional payment to purchase the remaining non-medical items.

IV. OTHER SUBSTANTIATION ISSUES

A. *Direct Third-Party Substantiation*

If the employer is provided with information from an independent third-party (such as an explanation of benefits from an insurance company (EOB)) 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.

B. *Prohibition Against Self-Certification*

Section 105 and § 125 require the substantiation of all medical expenses as a precondition of payment or reimbursement (including the automatic substantiation methods described in Rev. Rul. 2003-43 and this notice). "Self-substantiation" or "self-certification" of an expense by an employee-participant does not constitute the required substantiation.

For example, a health FSA or an HRA does not satisfy the requirements of § 105(b) if it reimburses participants for expenses where the participants only submit information (including via internet, intranet, facsimile or other electronic means) describing medical expenses, the amount of the expenses, and the date of the expenses, but does not provide a statement from an independent third-party (either automatically or subsequent to the transaction) verifying the expenses. Under § 1.105-2 of the regulations, all amounts paid under a plan that permits "self-substantiation" or "self-certification" are included in gross income, including amounts reimbursed for medical expenses whether or not substantiated. *See* Rev. Rul. 2002-80, 2002-2 C.B. 925, and Rev. Rul. 2003-43. Similarly, "self-substantiation" or "self-certification" of an employee's copayment in connection with copayment matching procedures through payment cards or otherwise does not constitute substantiation. If a plan's copayment matching system relies on an employee to provide a copayment amount without independent verification of the amount, claims have not been substantiated, and all amounts paid from the plan are included in gross income, including amounts paid for medical care whether or not substantiated.

V. USE OF CARDS FOR DEPENDENT CARE ASSISTANCE PROGRAMS

An employer may use a payment card program to provide benefits under its DCAP, including a dependent care FSA. However, dependent care expenses may not be reimbursed before the expenses are incurred. For this purpose, dependent care expenses are treated as having been incurred when the dependent care services are provided, not when the expenses are formally billed, charged for, or paid by the participant. Prop. Treas. Reg. § 1.125-1, Q & A-18. Thus, if a dependent care provider requires payment before the dependent care services are provided, those expenses cannot be reimbursed at the time of payment, even through the use of a payment card program.

An employer offering a DCAP or dependent care FSA may nevertheless adopt the following method to provide reimbursements for dependent care expenses through a payment card program. At the beginning of the plan year or upon enrollment in the DCAP, the employee pays initial expenses to the dependent care provider and substantiates the initial expenses by submitting to the employer or plan administrator a statement from the dependent care provider substantiating the dates and amounts for the services. After the employer or plan administrator receives the substantiation, but not before the date the services are provided as indicated by the statement from the dependent care provider, the plan makes available through the payment card an amount equal to the lesser of: (1) the previously incurred and substantiated expense, or (2) the employee's total salary reduction amount to date. See Prop. Treas. Reg. § 1.125-2, Q & A-7(b)(8). The amount available through the card may be increased in the amount of any additional dependent care expenses only after the additional expenses have been incurred. The amount on the card may then be used to pay for later dependent care expenses.

Later card transactions that have been previously approved as to the dependent care provider and time period may be treated as substantiated without further review if the later card transactions are for an amount equal to or less than the previously substantiated amount. If there is an increase to the previously substantiated amount or a change in the

dependent care provider, the employee must submit a statement or receipt from the dependent care provider substantiating the new claimed expense before amounts relating to the increased amount or new provider may be added to the card.

Example. Employer Z sponsors a dependent care FSA that is offered through its cafeteria plan. Salary reduction amounts for participating employees are made on a weekly payroll basis, which are available for dependent care coverage on a weekly basis. As a result, the amount of available dependent care coverage equals the employee's salary reduction amount minus claims previously paid from the plan. Z has adopted a payment card program for its dependent care FSA. Employee F is a participant in the dependent care FSA and has elected $5,000 of dependent care coverage. Z reduces F's salary by $96.15 on a weekly basis to pay for coverage under the dependent care FSA.

At the beginning of the plan year, F is issued a debit card with a balance of zero. F's childcare provider, ABC Daycare Center, requires a $250 advance payment at the beginning of the week for dependent care services that will be provided during the week. The dependent care services provided for F by ABC qualify for reimbursement under § 129. However, because the services have not yet been provided as of the beginning of the plan year, F cannot be reimbursed for any of the amounts until the end of the first week after the services have been provided. F submits a claim for reimbursement that includes a statement from ABC with a description of the services, the amount of the services, and the dates of the services. Z increases the balance of F's payment card to $96.15 after the services have been provided (*i.e.*, the lesser of F's salary reduction to date or the incurred dependent care expenses). F uses the card to pay ABC $96.15 on the first day of the next week and pays ABC the remaining balance due for the week ($153.85) by check.

To the extent that this card transaction and each subsequent transaction is with ABC and is for an amount equal to or less than the previously substantiated amount, the charges are fully substantiated without the need for the submission by F of a statement from the provider or further review by the employer. However, the subsequent amount may not be made available on the card until the end of the week when the services have been provided.

EFFECTIVE DATE

With respect to the Inventory Information Approval System, as described in section III B of this notice, the requirement that an employer that uses this system is responsible for ensuring that the system complies with the recordkeeping requirements of this notice (including Rev. Proc. 98-25) is effective for plan years beginning after December 31, 2006.

EFFECT ON OTHER DOCUMENTS

Rev. Rul. 2003-43, 2003-1 C.B. 935, is amplified.

DRAFTING INFORMATION

The principal author of this notice is Barbara Pie of the Office of Division Counsel/Associate Chief Counsel (Tax Exempt and Government Entities). For further information regarding this notice, contact Mireille T. Khoury at (202) 622-6080 (not a toll-free call).