



Discussion of the IRS's Guidelines Regarding Receipt Submission for Health FSAs - "ADEQUATE CLAIMS SUBSTANTIATION MUST BE RECEIVED FROM THE PARTICIPANT AND AN INDEPENDENT THIRD PARTY."

Health FSA claims are required to be substantiated with two items:

- ✚ A written or electronic document from an independent third party showing the amount of the expense and that the medical expense has already been incurred; and
- ✚ A written or electronic document from the participant stating that the medical expense has never been reimbursed and that the participant will not try to obtain reimbursement for the expense under any other health plan coverage.

Furthermore, the IRS proposed regulations expect claims adjudication to be done by an entity other than the plan participant such as the employer or a third party administrator. (See 3rd requirement, below).

These three requirements are established to ensure that the health FSA operates like traditional health or accident insurance and pays only legitimate health claims. It is very important to understand that if the substantiation requirements are not satisfied, the IRS could consider all other health FSA reimbursements as taxable, whether or not they are properly substantiated.

1. 1st REQUIREMENT - THIRD-PARTY STATEMENT

A written statement from an independent third party such as a provider's receipt or bill is required to substantiate Health FSA claims, indicating that the medical expense has been incurred and indicating the amount of the expense. This requirement also ensures that a health FSA does not make reimbursements in advance of future or projected expenses. Legible originals, copies, faxes, or scanned copies will most likely satisfy this requirement. Credit card receipts or canceled checks usually do not satisfy the third-party statement requirement.

In similar manner substantiation of this sort is also required for taxpayers claiming a medical expense deduction under Code 213 as quoted below:

In connection with claims for deductions under section 213, the taxpayer shall furnish the name and address of each person to whom payment for medical expenses was made and the amount and date of the payment thereof in each case. If payment was made in kind, such fact shall be so reflected. Claims for deductions must be substantiated, when requested by the district director, by a statement or itemized invoice from the individual or entity to which payment for medical expenses was made showing the nature of the service

rendered, and to or for whom rendered; the nature of any other item of expense and for whom incurred and for what specific purpose, the amount paid therefore and the date of the payment thereof; and by such other information as the district director may deem necessary.

IRS Notice 2006-69 confirms that Third Party Administrators cannot accept a participant's "self-substantiation" or "self-certification" as a substitute for all or part of the information in a third-party statement. This clarifies that Code 105 (HRAs) and Code 125 (FSAs) "require the substantiation of all medical expenses as a precondition of payment or reimbursement: and that a participant's self-substantiation or self-certification of an expense "does not constitute the required substantiation." For example, a health FSA may not reimburse expenses based solely on a participant's email, fax, or other statement describing the expense, its amount and its date. Plans that do so face stiff penalties: IRS Notice 2006-69 states that "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."

Dual-Purpose Items Require Higher Levels of Substantiation - The IRS has indicated that it will more closely review claims for dual-purpose items (i.e. those that could be for personal as well as medical reasons, such as nutritional supplements) than claims that are obviously only for medical reasons (such as a prescription for treating diabetes). For dual-purpose items, adequate substantiation generally requires a qualified medical practitioner's diagnosis of a medical condition and recommendation of the item to treat the diagnosed condition. In some cases, however, a plan administration might be able to rely on other evidence that the item treats the condition (e.g., because that information is general knowledge or appears in a professional publication). When in doubt, Administrators should favor the side of obtaining more substantiation regarding the medical condition and the expense.

2. 2nd REQUIREMENT - PARTICIPANT STATEMENT

The proposed regulations require that Health FSA claims must also be accompanied by a participant statement "that the medical expense has not been reimbursed or is not reimbursable under any other health plan coverage." However, a more normal language certification that the expense "has not been reimbursed and that the employee will not seek reimbursement under any other plan covering health benefits" has been approved more recently by the IRS. Plan sponsors and administrators should make sure to update their plans' administrative forms to reflect the change.

Given the "has not been reimbursed" language, the participant statement must be obtained at or after the time that the expense is incurred. The same is also true for the self-insured medical reimbursement plan rule providing that a participant may not claim a tax deduction for any expense reimbursed under a health FSA. Sample certification language that should meet both the participant statement requirement and the tax deduction requirement follows (as suggested by the Employee Benefits Institute of America):

I certify that these expenses have not been reimbursed and I will not seek reimbursement for them under a major medical plan or another health plan, such as an individual policy or my spouse's or dependent's health plan. I understand that the expense for which I am reimbursed may not be used to claim any federal income tax deduction or credit.

The participant statement should also provide that the expense was incurred for the participant, the participant's spouse, or an eligible dependent, and either the participant statement (such as the claim form) or the third-party statement (such as the receipts or other documentation) should identify the individual for whom the expense was incurred. If the health FSA were administered like a traditional major medical plan, the health FSA administrator would check to see if the individual was on a list of eligible individuals before reimbursing the claim. In practice, however, few health FSA administrators maintain lists of covered dependents. If an administrator does not maintain such a list, then the participant statement will be the sole basis for determining that the expense is for an eligible individual.

3. 3rd REQUIREMENT - INDEPENDENT ADJUDICATION

According to the introduction to Prop. Treas. Reg. 1.125-2 the purpose of the claims substantiation requirements is to “protect the integrity of the distinction between the taxable treatment of personal medical expenses [which are subject to a 7.5% deduction threshold under Code 213] and the more favorable tax treatment of employer-provided health plan coverage and benefits under Code 106 or 105.” The introduction further provides that the substantiation requirements were needed “because there is no party directly involved in an FSA with an interest in assuring [sic] that claims are bona fide.” These statements clearly intend claims adjudication by an entity other than the plan participant (e.g., the employer or a third-party claims administrator). This independent adjudication requirement is in stark contrast to the self-adjudication of claims allowed under HSAs and Archer MSAs.

To obtain independent adjudication, the participant generally must provide the two written statements (see Requirements #1 and #2, discussed above) to the health FSA administrator after the expense is incurred and before it is reimbursed.

Furthermore, and of major importance, IRS guidance regarding electronic debit cards makes it clear that every claim must be reviewed and substantiated. Consequently, previous adjudication methods such as using sampling techniques are not permitted, whether under electronic debit card programs or for paper reimbursement requests. For example, plans cannot automatically approve claims below a certain dollar threshold—all claims are subject to the claims substantiation requirements, regardless of amount.

4. IRS CONCERNS RAISED BY USING EXPEDITED CLAIM SUBSTANTIATION TECHNIQUES

The claims substantiation requirements in the most recent proposed regulations may result in processing delays and cash flow hardships for participants. Therefore, many plan sponsors have considered techniques to expedite the claim substantiation process, such as electronic debit card programs and reimbursing claims based upon pre-submitted participant affidavits. Below are several expedited claim techniques and whether they satisfy the claim substantiation requirements.

a. Electronic Debit Card Programs (allowed)

Electronic debit card programs allow health FSA participants to access funds to pay providers at the point of service. IRS guidance regarding such programs allows electronic debit cards to be used for certain types of transactions.

b. Reimbursing Claims Based Solely on an EOB (allowed)

Many health FSAs reimburse co-payments and deductibles under a health plan (e.g., a major medical plan covering the participant) based on an explanation of benefits (EOB) statement from the health plan. Some health FSAs use a procedure (sometimes referred to as an “EOB rollover”) under which EOBs for claims that have been processed under the major medical plan are sent directly to the health FSA administrator, which reimburses the amount that the major medical plan did not pay or pays this amount to the provider.

The IRS has approved of the use of an EOB submitted with the claim to satisfy the requirement of a third-party statement. IRS guidance issued in 2006 further provides that if the employer or administrator receives an EOB from an independent third party that indicates “the date of the [Code] 213(d) service and the employee’s responsibility for payment for the service (i.e., coinsurance payments and amounts below the plan’s deductible),” then the claim submitted by the employee is fully substantiated, with no need for the submission of a receipt or further review. Thus, EOB rollover claims can be considered fully substantiated without a receipt from the participant.

Example: EOB Rollover. Bill is a participant in ABC Company’s health FSA and insured major medical plan. He visits his doctor, who charges \$200 for the visit. ABC Company’s major medical plan requires a 20% co-payment for doctors’ services, so James must pay a \$40 co-payment for the visit. Under EOB rollover procedures put in place by ABC Company, the major medical insurer sends the EOB for the visit to ABC Company’s health FSA claims administrator, showing that James must pay \$40 for the visit. His health FSA reimbursement claim for \$40 is substantiated by the EOB and there is no need for him to submit a bill or other third-party statement.

IRS Notice 2006-69 says nothing about whether a participant statement (indicating that the expense has not been reimbursed and that reimbursement will not be sought elsewhere) is still required before an EOB rollover claim is reimbursed.

However, IRS officials have informally indicated that no participant statement is needed, thereby opening the door for health FSAs to reimburse EOB rollover claims based only on the EOB. Nevertheless, participants in health FSAs that use the EOB rollover procedures should certify at open enrollment (on their enrollment forms) that they will not seek reimbursement elsewhere for expenses that the health FSA reimburses.

c. Annual Affidavit or Pre Submitted Form From Participant (not allowed)

Some plan sponsors have been known to provide for automatic reimbursement of health FSA expenses based on an annual affidavit or form from the participant, stating that all receipts submitted will be for expenses that are eligible for reimbursement under the plan. This practice violates the substantiation and expense-incurred requirements contained in the proposed regulations. Under the regulations, participants must submit a written statement after each expense is incurred, stating that the expense has not been reimbursed and that reimbursement will not be sought under any other plan covering health benefits. And reimbursing expenses without an independent third-party statement that meets the requirements of the regulations constitutes prohibited self-substantiation.

d. Reimbursing Claims Based Only on Participant Statement (not allowed)

Reimbursing claims based solely on a participant's statement describing the type of expense, the amount, and the date (i.e., without appropriate third-party substantiation) is prohibited under IRS Notice 2006-69. This is the case even if reimbursement is made with the understanding that third-party substantiation will be provided later, as IRS Notice 2006-69 makes appropriate substantiation a "precondition of payment of reimbursement."

e. Reimbursing Claims Based Only on Canceled Checks or Charge Card Receipts (almost never allowed)

Canceled Checks and charge card receipts will seldom satisfy the third-party statement requirement applicable to health FSAs.

Some plan sponsors seek to avoid obtaining a signed participant statement by including a statement such as the following on the back of the reimbursement check:

By endorsing this check, the plan participant confirms that the health FSA expenses for which the check is issued have been incurred, they are for the participant or an eligible dependent, and they have not been reimbursed and reimbursement will not be sought for them under any other health plan.

Such a certification, combined with a third-party statement containing sufficient detail (e.g., a provider's bill showing the nature and date of the expense and who

incurred it), looks like it would provide a reasonable argument that the claims substantiation requirements have been satisfied, so long as the reimbursement is provided after the services have been rendered and independent adjudication occurs. However, this approach will not work if reimbursements are made by direct deposit to a participant's checking account, making a separate participant statement necessary. Thus, trying to administer both cases becomes error-prone.

f. Receipts From Health Care Providers, but Without Details (depends upon circumstances)

IRS guidance regarding electronic payment cards allows auto-adjudication of certain card transactions that match the participant's co-payments or are for recurring expenses. It is unclear whether similar concepts would apply to health FSAs that do not use electronic payment cards -i.e., whether a plan might be able to reimburse a traditional paper claim based on a receipt from a pharmacy or doctor's office with only the date, amount, and name of the provider, if the amount matches the participant's co-payment or if the amount and the service provider are identical to a previously approved claim. Further guidance on this issue from the IRS is needed.

g. Post-Reimbursement Adjudication (not allowed)

It is obvious that claims cannot be reimbursed prior to the date that expenses are incurred, because of the prohibition on advance reimbursements. In IRS Notice 2006-69, the IRS clarified that substantiation is a precondition to payment or reimbursement. Except as permitted under IRS guidance regarding electronic debit cards (i.e., "pay and chase" for merchants with health care-related MCCs) adjudication must occur before funds are released.

For example, claims cannot be reimbursed based only on a participant's email or phone certification and a promise to follow up with receipts within 15 days. This is because the administrator would not have any independent assurance at the time of reimbursement that the expense was for medical care. (Contrast the pay-and-chase exception for electronic payment card programs, where the administrator at least knows that the card was used at a merchant with a health care-related MCC.)