May 6, 2003

ADVANCE COPY OF INTERNAL REVENUE BULLETIN ITEM

Attached is an advance copy of Revenue Ruling 2003-43, describing rules regarding the use of debit and credit cards to reimburse participants in self insured medical reimbursement plans.

It will appear in Internal Revenue Bulletin 2003-21, dated May 27, 2003.

You may release this rev. rul. immediately.

Communications Division

Part I

Section 105.- Amounts Received Under Accident and Health Plans (Also Section 106-Contributions by Employers to Accident and Health Plans and Section 125-Cafeteria Plans)

Rev. Rul. 2003-43

ISSUE

Whether, under the facts described, employer-provided expense reimbursements made through debit or credit cards and other electronic media are excludable from gross income under § 105 of the Internal Revenue Code.

FACTS

Situation 1.

Employer N sponsors one or more major medical plans for employees that provide coverage under accident and health insurance. Each plan has a fixed copayment amount (e.g., a $15 copayment for physician office visits). Employer N also sponsors both a health flexible spending arrangement (health FSA) and a health reimbursement arrangement (HRA). The health FSA and the HRA reimburse the uninsured medical care expenses of all participating employees and their spouses and dependents up to a maximum reimbursement amount that is fixed at the beginning of each year. The health FSA is paid pursuant to salary reduction elections under Employer N's § 125 cafeteria plan. The HRA is paid by Employer N and employees make no salary reduction election to pay for the HRA. The HRA plan document specifies that coverage under the HRA is available only after expenses exceeding the dollar amount elected under the § 125 health FSA have been paid from the health FSA. Both the health FSA and the HRA meet the nondiscrimination requirements of § 105(h).

In conjunction with the health FSA and the HRA, Employer N permits electronic reimbursement of medical expenses through the use of a debit card or stored-value card ("card"). Under the arrangement adopted by Employer N, each participating employee is issued a card and certifies upon enrollment in the health FSA and HRA and each plan year thereafter that the card will only be used for eligible medical care expenses, as defined in § 213(d), of the employee and the employee's spouse and dependents. The employee also certifies that any expense paid with the card has not been reimbursed and that the employee will not seek reimbursement under any other plan covering health benefits. An employee-cardholder understands that the certification, which is printed on the back of the card, is reaffirmed each time the card is

used. The cardholder also agrees to acquire and retain sufficient documentation for any expense paid with the card, including invoices and receipts where appropriate. The card is automatically cancelled at termination of employment.

The cardholder's use of the card is limited to the maximum dollar amount of coverage available in the cardholder's health FSA or HRA. As described below, the card is ineffective except at those merchants and service providers authorized by Employer N, so that the use of the card at other merchants or service providers would be rejected. Employer N limits the card's use to specified Merchant Codes relating to health care. Thus, the card's use is limited to physicians, pharmacies, dentists, vision care offices, hospitals, and other medical care providers. When a cardholder uses the card at the point-of-sale, the merchant or service provider is paid the full amount of the charge (assuming there is sufficient coverage available in the health FSA or HRA), and the cardholder's maximum available coverage remaining is reduced by that amount.

To provide assurance that only eligible medical expenses are reimbursed, Employer N has established, in the health FSA and HRA documents, the following procedures for substantiating claimed medical expenses after the use of the card.

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 major medical plan of the specific employee-cardholder, the charge is fully substantiated without the need for submission of a receipt or further review. For example, Employee A is enrolled in a major medical plan with a $15 physician's office visit copayment. When Employee A uses the card to satisfy the copayment requirement, the system matches the amount of the transaction, $15, with the copayment under Employee A's coverage and the fact that the transaction is at a physician's office.

Second, Employer N permits automatic reimbursement, without further review, of recurring expenses that match expenses previously approved as to amount, provider, and time period (e.g., for an employee who refills a prescription drug on a regular basis at the same provider for the same amount).

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 Employer N (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"). For example, Employee A fills a prescription at a pharmacy. The Pharmacy Benefit Manager under Employee A's major medical coverage provides information that $37.85 of the cost of the prescription is a medical expense that is not covered by the major medical coverage. Because the information about the medical expense, $37.85,

matches the amount of the transaction, the transaction is substantiated. The transaction would also be fully substantiated where, for example, treatment at a physician's office results in charges in addition to the copayment and, after obtaining authorization for the card, the provider is prompted to enter treatment codes and

charges. The additional third-party information regarding the type of care, date of service, and amount provides substantiation of the expense without the need for further review.

Employer N's procedures provide that all charges to the card, other than copayments, recurring expenses, and real-time substantiation as described above, are treated as conditional pending confirmation of the charge. Thus, Employer N requires 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.

An employee may also obtain benefits under the health FSA or HRA without the use of the card by submitting to Employer N either an Explanation of Benefits (EOB) received from a health insurance provider or a receipt from a merchant or service provider showing that funds are owed for an eligible medical expense (e.g., on a deductible). In this case, Employer N pays the merchant or service provider directly. Alternatively, an employee may pay the merchant or service provider directly and submit a claim for reimbursement, including third-party information supporting the claim.

Under Employer N's card arrangement, a few of the claims that have been reimbursed are subsequently identified as not qualifying for reimbursement. As a result, Employer N has adopted, in the health FSA and HRA plan documents, all of the following correction procedures with respect to the improper payments. First, upon identifying an improper payment, Employer N requires the employee to pay back to the plan an amount equal to the improper payment. Second, where this proves unsuccessful, Employer N has the amount of the improper payment withheld from the employee's wages or other compensation to the extent consistent with applicable law. Third, if the improper payment still remains outstanding, Employer N utilizes a claims substitution or offset approach to resolve improper claims. For example, if Employee A has received an improper reimbursement of $200 and subsequently submits a substantiated claim incurred during the same coverage period, no reimbursement is made until the improper payment is fully recouped. In addition to the above, Employer N takes other actions to ensure that further violations of the terms of the card do not occur, including denial of access to the card until the indebtedness is repaid by the employee.

If these correction efforts prove unsuccessful, or are otherwise unavailable, the employee remains indebted to Employer N for the amount of the improper payment. In that event and consistent with its business practices, Employer N treats the payment as it would any other business indebtedness.

Situation 2.

The facts are the same as Situation 1, except that Employer P's procedures utilize sampling techniques based on transaction amounts. For example, Employer P reviews 20% of dental office transactions paid with the card that have not been otherwise substantiated and are above $100 on the assumption that no dental cosmetic procedures are available for less than $100. Also, Employer P reviews a smaller percentage (e.g., 5%) of physician office transactions paid with the card that have not been otherwise substantiated and are below $150 on the assumption that almost all such charges are for eligible medical care. In addition, Employer P does not review any card transaction below a low dollar threshold (e.g., $25) or where the amount of the transaction is a multiple of a specified whole-dollar amount (e.g., $5, $10, $15, etc.) on the assumption that these latter amounts are copayments. Only those payments selected for review are required to be substantiated by submission of merchant or service provider receipts. Thus, Employer P does not substantiate all reimbursements made through the card.

Situation 3.

Employer R sponsors major medical plans, a health FSA, and an HRA for employees. The health FSA and the HRA meet the nondiscrimination requirements of § 105(h). In conjunction with the health FSA and the HRA, Employer R has entered into an agreement with a sponsoring bank to issue to each participating employee a credit card with individual limits equaling the coverage available in the health FSA or HRA. As in Situation 1, Employer R requires each employee to certify upon enrollment in the plans (which is reaffirmed upon each use of the credit card) that the card will only be used for eligible medical care expenses and that any medical expense paid with the card has not been reimbursed and the employee will not seek reimbursement under any other plan covering health benefits. In addition, as in Situation 1, the credit card is usable only at a merchant or service provider with a specified Merchant Code relating to health care. Pursuant to the agreement between Employer R and the sponsoring bank, Employer R agrees to be liable to the sponsoring bank for all charges made with the credit card against the line of credit. When the card is used at the point-of-sale, the merchant or service provider is paid the full amount of the charge by the sponsoring bank.

Employer R utilizes substantiation methods identical to those of Employer N in Situation 1, so that copayments, recurring expenses, and real-time substantiation need no further review. Employer R treats all other charges to the card as conditional pending confirmation of the medical expense. If the claim is approved, the employee's maximum available coverage in the health FSA or HRA is reduced by that amount and

Employer R repays the sponsoring bank. If the employee fails to provide substantiation of the medical expense or the claim is denied, Employer R repays the sponsoring bank and the employee becomes liable to Employer R for the charge. To recoup amounts that have been identified as improper payments, Employer R has adopted the same correction procedures as those utilized by Employer N in Situation 1. Also, as described in Situation 1, an employee may obtain benefits under the health FSA or HRA without the use of the credit card.

LAW AND ANALYSIS

Section 61(a)(1) and § 1.61-21(a)(3) of the Income Tax Regulations provide that, except as otherwise provided in subtitle A, gross income includes compensation for services, including fees, commissions, fringe benefits, and similar items.

Section 106 provides that "gross income of an employee does not include employer-provided coverage under an accident or health plan." Section 1.106-1 provides that the gross income of an employee does not include contributions which the employee's employer makes to an accident or health plan for compensation (through insurance or otherwise) for personal injuries or sickness to the employee or the employee's spouse or dependents (as defined in § 152).

Section 105(a) provides that "amounts received by an employee through accident or health insurance for personal injuries or sickness shall be included in gross income to the extent such amounts (1) are attributable to contributions by the employer which were not includible in the gross income of the employee, or (2) are paid by the employer."

Section 105(e) states that amounts received under an accident or health plan for employees are treated as amounts received through accident or health insurance for purposes of § 105. Section 1.105-5(a) provides that an accident or health plan is an arrangement for the payment of amounts to employees in the event of personal injuries or sickness. Thus, amounts that are paid to an employee regardless of whether the employee incurs expenses for medical care or suffers a personal injury or sickness are not received under an accident or health plan.

Section 105(b) states that, except in the case of amounts attributable to (and not in excess of) deductions allowed under § 213 (relating to medical expenses) for any prior taxable year, gross income does not include amounts referred to in § 105(a) if such amounts are paid, directly or indirectly, to the taxpayer to reimburse the taxpayer for expenses incurred by the taxpayer for the medical care (as defined in § 213(d)) of the taxpayer or the taxpayer's spouse or dependents (as defined in § 152).

Section 1.105-2 provides that only amounts that are paid specifically to reimburse the taxpayer for expenses incurred by the taxpayer for the prescribed medical care are excludable from gross income. Section 105(b) does not apply to amounts that the taxpayer would be entitled to receive irrespective of whether or not the taxpayer incurs expenses for medical care. Accordingly, if an employee is not paid specifically to reimburse medical care expenses but is entitled to receive the payment irrespective of whether any medical expenses have been incurred, none of those payments are excludable from gross income under § 105(b) whether or not the employee has incurred medical expenses during the year.

Under § 125, an employer may establish a cafeteria plan that permits an employee to choose among two or more benefits, consisting of cash (generally, salary) and qualified benefits, including accident or health coverage. Pursuant to § 125, the amount of an employee's salary reduction applied to purchase such coverage is not included in gross income, even though it is available to the employee and the employee could have chosen to receive cash instead. If an employee elects salary reduction pursuant to § 125, the accident and health coverage is excludable from gross income under § 106 as employer-provided accident or health coverage.

Q&A-7(a) of § 1.125-2 of the Proposed Income Tax Regulations states that health plans that are FSAs must conform to the generally applicable rules under §§ 105 and 106 in order for the coverage and reimbursements to qualify for tax-favored treatment. Thus, health FSAs must qualify as accident or health plans and reimbursements must be paid specifically to reimburse the participant for medical expenses incurred previously during the period of coverage.

Q&A-7(b)(5) of § 1.125-2 addresses claims substantiation for health FSAs and provides that a health FSA may reimburse a medical expense only if the participant provides a written statement from an independent third-party stating that the medical expense has been incurred and the amount of such expense and the participant also provides a written statement that the medical expense has not been reimbursed or is not reimbursable under any other health plan coverage.

Part 1 of Notice 2002-45, 2002-28 I.R.B. 93, describes an HRA as an arrangement that: (1) is paid for solely by the employer and not pursuant to salary reduction; (2) reimburses the employee for medical care expenses as defined in § 213(d); and (3) provides that any unused portion of the maximum dollar amount available during the coverage period is carried forward to subsequent coverage periods. Part 2 of the Notice provides that to qualify for the exclusion under §§ 106 and 105, an HRA may only provide benefits that reimburse § 213(d) medical expenses and that each medical expense submitted for reimbursement must be substantiated.

Rev. Rul. 2002-80, 2002-49 I.R.B. 925, describes plans in which amounts are automatically paid to an employee as “advance reimbursements” or “loans” of uninsured medical expenses. The employer treats the “advance reimbursements” or “loans” as an indebtedness that is forgiven by the end of the year or upon termination of employment. In addition, to the extent an employee does not have uninsured medical expenses equal to the “advance reimbursements” or “loans,” the excess payments to the employee are included in gross income. The ruling holds that the exclusion from gross income under § 105(b) does not apply to these plans because the “advance reimbursements” or “loans” are paid to the employee whether or not the employee incurs medical expenses. See § 1.105-2

Not all health-related expenses qualify for tax-free treatment under § 105(b). Only amounts that are paid specifically to reimburse eligible medical care expenses as defined in § 213(d) receive tax-favored treatment. Therefore, to provide certainty that a particular expense is for medical care within the meaning of § 213(d), all claims for expense reimbursements must be substantiated. However, § 105(b) does not specify the method of substantiation. The procedures adopted by Employer N in Situation 1 with respect to the electronic reimbursement of medical expenses meet the requirements of § 105(b). First, Employer N requires a certification upon enrollment and a reaffirmation upon each use of the card, as printed on the back, that the card will only be used for eligible medical care expenses. Second, reimbursements for medical expenses are processed only if they originate with certain vendors having health care related Merchant Codes. Third, Employer N’s procedures provide that every claim is reviewed and substantiated, either automatically without additional documentation or manually through the submission of merchant or service provider receipts. Fourth, Employer N has adopted meaningful correction procedures for claims that are subsequently identified as impermissible. These procedures meet the requirements of § 105(b) and the same conclusion applies to the procedures adopted by Employer R in Situation 3.

In contrast, the sampling techniques adopted by Employer P in Situation 2 do not provide that every claim is substantiated. Thus, because Employer P’s procedures, by plan design, do not specifically limit reimbursements or payments of claims to eligible medical expenses, the procedures do not meet the requirements of § 105(b).

HOLDING

Employer-provided expense reimbursements made through debit or credit cards and other electronic media, as described in Situation 1 and Situation 3, are excludable from gross income under § 105(b). Employer-provided expense reimbursements, as described in Situation 2, are not excludable from gross income under § 105(b) because the payments are made irrespective of whether any medical expenses have been incurred. Thus, in Situation 2, all payments made during the year, including amounts paid to reimburse medical expenses, are included in the gross income of the employee.

SCOPE

This ruling addresses only issues under §§ 106, 105, and 125. No inference is intended as to any other section of the Internal Revenue Code.

EFFECT ON OTHER REVENUE RULINGS

Rev. Rul. 2002-80 is distinguished because in that ruling, unlike Situations 1 and 3, a payment is made in advance and irrespective of the employee incurring a medical expense. In Situations 1 and 3, a payment is made concurrent with the employee incurring a medical expense that is substantiated. Final regulations under § 125 will reflect the modifications to the rules concerning claims substantiation of health FSA expenses as set forth in this revenue ruling.

FORM 1099 CONSIDERATION

Under the facts described, payments made to medical service providers through the use of debit, credit, and stored-value cards are reportable by the employer on Form 1099-MISC under § 6041. Section 6041 provides for information reporting by persons engaged in a trade or business who make payments of fixed or determinable income to another person in the course of such trade or business of $600 or more in a taxable year. The exceptions provided in § 1.6041-3 may apply to this requirement, such as the exception for payments to tax-exempt hospitals.

EFFECTIVE DATE

The holding in Situation 2 is effective for plan years beginning after December 31, 2003.

COMMENTS REQUESTED

The Service requests comments on sampling techniques or statistical approaches, other than those described in Situation 2, that may be used by employers in identifying types of transactions that should be deemed to be substantiated. The methodology proposed should demonstrate that the outcome of measures selected provide a high degree of certainty sufficient to constitute substantiation that the employee has incurred a medical expense. Send comments to: CC: PA: RU (Rev. Rul. 2003-43), Room 5226, Internal Revenue Service, POB 7604, Ben Franklin Station, Washington, DC 20044. Comments may be hand-delivered between the hours of 8 a.m. and 4 p.m. to: CC: PA: RU (Rev. Rul. 2003-43), Courier's Desk, Internal Revenue

Service, 1111 Constitution Avenue, NW, Washington, DC. In the alternative, taxpayers may submit comments electronically at: Notice.Comments@irscounsel.treas.gov. All comments will be available for public inspection.

DRAFTING INFORMATION

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