

Benefit Insights

Methods of Substantiating FSA Card Transactions

Health Care Flexible Spending Accounts (FSAs) offer employees a cost-effective way to pay for health care expenses that are not covered by insurance. Participating employees elect a contribution amount for the plan year, contribute to the account on a pre-tax basis, and are reimbursed from this account for their out-of-pocket health care expenses.

The IRS requires substantiation of expenses submitted for reimbursement. Over the past few years, more and more employers have offered a type of debit, credit or stored value card linked to the FSA so that employees can immediately pay for qualified medical expenses using FSA funds, instead of having to pay out-of-pocket and then file a claim for reimbursement. For transactions conducted with these types of cards, IRS rules and notices define how the basic substantiation requirements can be met without the employee having to submit documentation after the fact.

The following IRS-approved methods alleviate the need for an employee to provide further substantiation of an FSA card transaction (the first three can only be used for transactions with health care service providers or merchants that have health care-related merchant category codes):

- **Co-payment method.** If the amount of the FSA card transaction equals the amount of the co-payment required under the employee's health care plan for the service being paid for with the card, or equals an exact multiple of not more than five times the amount of the co-payment for that service, the charge will be considered fully substantiated without the need for submission of further documentation or additional review. If the health care plan has more than one co-payment for the same type of service (such as would be case with a tiered pharmacy benefit), transactions of exact multiples of co-payments OR exact combinations of the different co-payments (up to five times the maximum co-payment) will also be considered

fully substantiated.

- **Recurring expense method.** If a transaction matches an expense with a previously approved amount, provider and time period (for example, an employee who refills a prescription on a regular basis at the same pharmacy and for the same amount), the charge will be considered fully substantiated without the need for submission of further documentation or additional review.
- **Real-time substantiation.** If at the point of sale the service provider, merchant or other third party provides information that verifies the charge is for a qualified medical expense, then the charge will be considered fully substantiated without the need for submission of further documentation or additional review. This verification may be provided through various means, including e-mail, Internet, intranet, phone or fax.
- **Inventory information approval system method.** This method relies on a system that collects inventory control information about the items purchased (SKUs) and compares these SKUs against a list of qualified medical expenses. At the time of the transaction, the system approves only the amount of the qualified medical expense for payment with the FSA card, and requires the card user to pay for any remaining portion of the purchase separately. Unlike the three previous expense substantiation methods, this method may be used with merchants that do not have health care-related merchant codes. For example, if an employee purchases over-the-counter (OTC) medications at a grocery store, along with a few food items, with the inventory information approval system method the FSA card transaction will be approved for the OTC medications without the need for further substantiation or review.

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The larger the Rx gap, the bigger the Rx savings. A recent research study examined patient cost share in prescription drugs and generic-fill rate (GFR). The study shows that the larger the differential between generic and preferred-brand copays, the more apt the patient is to fill their prescription in generic form. If you're thinking about redesigning your tiered copay prescription drug plan, please contact a Tobias Customer Service Agent today at 317-844-7759 for further discussion.

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Court Rules That Employers Can Run a Worker's Sick Leave Concurrently with Leave Provided by the Family and Medical Leave Act

In May 2006, the 8th U.S. Circuit Court of Appeals ruled that an employer is permitted to run a worker's sick leave concurrently with time off provided under the Family and Medical Leave Act (FMLA). In addition, the employer can limit the employee's time off to the maximum 12 weeks allotted under the FMLA even if the employee's benefit plan or bargaining agreement provides more sick days.



The landmark case, *Slentz vs. City of Republic*, involved a police officer, employed by the city of Republic, Missouri, who underwent surgery after injuring his shoulder in an accident that occurred while he was off duty. After his surgery, Officer Robert Slentz was notified by the city that it was designating his sick leave as FMLA time based on its personnel policy. Furthermore, the city also sent Slentz a letter stating that he must provide a "fitness-for-duty" certificate before returning to work. If he didn't provide it, he would have to resign when his FMLA leave expired.

The problem arose because Slentz's doctor refused to certify his fitness for duty upon the expiration of his FMLA leave, stating that Slentz needed several more weeks of recuperation time before he could be certified as fit for duty. When his leave ended, even though he had accrued more than 12 weeks sick time, Slentz submitted a resignation letter and then sued, alleging wrongful interference with his FMLA rights.

A district court granted the defendants a summary judgment in the case, ruling that it was permissible to run sick leave and FMLA leave concurrently, that Slentz was given proper notice, and that the defendants did not otherwise wrongfully interfere with Slentz's exercise of his FMLA leave. After the first decision, Slentz appealed based on the grounds that the city violated his FMLA rights by extending him only 12 weeks leave despite his having more than 12 weeks of accrued sick leave. However, the 8th U.S. Circuit Court of Appeals affirmed the lower court's granting of summary judgment. As part of its ruling, the court issued the following statement:

"In this case, the City elected to run Slentz's FMLA leave concurrently with his accrued sick leave as authorized under the FMLA. *Id.* A contrary result would unduly and unfairly burden employers." *Strickland*, 239 F.3d at 1206. "[T]he FMLA was intended only to be a statute that provided a minimum labor standard; an assurance that employers would provide employees with twelve weeks of leave every year." *Ragsdale v. Wolverine World Wide, Inc.*, 218 F.3d 933, 939 (8th Cir. 2000), *aff'd* 535 U.S. 81 (2002). "Under the FMLA, twelve weeks of leave is both the minimum the employer must provide and the maximum that the statute requires." *Ragsdale*, 218 F.3d at 938; accord *Strickland*, 239 F.3d at 1206 ("To balance the needs of employers and sick employees, Congress intended that the FMLA provide employees with a minimum entitlement of 12 weeks of leave, while protecting employers against employees tacking their FMLA entitlement on to any paid leave benefit offered by the employer."). Consequently, we affirm the district court and hold that there was no violation of Slentz's rights under the FMLA."

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If an FSA card transaction does not fall into one of these methods, it cannot be automatically substantiated just because the card was used. It must be treated as pending and subject to additional third party verification, such as a receipt or explanation of benefits (EOB) from the employee's health plan, which shows the date of service and the amount that the employee is responsible for paying.

FSA cards are a great convenience to employees, but expense substantiation remains a requirement, and non-substantiated expenses are taxable to the employee. These automatic substantiation methods provide a way to simplify plan administration while helping to avoid inadvertent approval of expenses that should not be covered by the plan.

Boosting HSA Participation Is Important to Consumer-Driven Health Plans

Participation in Health Savings Account (HSA)-qualified high deductible health plans tripled from March 2005 to January 2006, while the number of employers offering these plans is doubling annually, according to research from America's Health Insurance Plans. Yet, the Government Accounting Office estimates that only 50% to 60% of individuals with health coverage that would make them eligible to open an HSA—namely, a high deductible health plan—had actually opened the account.

Given that out-of-pocket costs can be sizable in a high deductible health plan, having access to HSA funds to cover these costs can be important to these plans being perceived as meeting a member's health care needs. What can sponsoring employers do to encourage eligible employees to participate?

Looking to lessons learned by 401(k) plan sponsors can provide some insight and useful ideas. For example, surveys have consistently shown that possibly the most important factor influencing 401(k) plan participation is the presence of an employer match. While employers cannot match HSA contributions, they can provide seed money so long as all eligible employees receive comparable contributions. Currently,

about 60% of employers provide funding to their employees' HSAs, according to data from UnitedHealth Group. This same study found that 90% of employees open an HSA if the employer offers to contribute funding to the account. Clearly, some amount of employer funding is a powerful draw.

Another factor shown to be effective in achieving high 401(k) plan participation rates is employee education (both about the plan and on surrounding issues). Consider that consumer-driven health care plans are still new, and are very different from traditional plans and the various forms of managed care that employees learned about over the past two decades. Further consider that they are another addition to the alphabet soup of health care accounts (HSA? HRA? FSA?). It should come as no surprise that education would be a critical component to achieving good participation rates. Employees are unlikely to commit money to an account that they have any uncertainties about. An especially important part of the HSA communication message should be distinguishing these accounts from health care flexible spending accounts, which many employees are wary of due to the "use-it-or-lose-it" rule.

Finally, consumer-driven health plans rely on informed decision-making employees to succeed, both at reining in health care costs and at ensuring quality care for members. Vendors of consumer driven plans tout the decision-making tools they offer as helping employees reach a higher level of health care awareness. And, according to a survey from Hewitt Associates, employees who use decision-support tools are more likely to enroll in consumer-driven plans. These tools might include health plan comparison charts, provider directories, personal summaries of members' health care claims and costs, and health care spending account estimators. As an employer, you can make sure employees are aware of the availability of any offered tools and alert them to the importance of using these tools.

Consumer-driven health plans hold great promise, but can't be as effective if employees aren't making optimal use of them, which includes participating in health savings accounts when eligible. Developing strategies to boost HSA participation among eligible employees can help consumer-driven plans become a winning health care offering for your workplace.



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providing—or commit to ensuring that the CDHP vendor provides—tools and information that enable employees to make smart health care decisions. Such a commitment includes ensuring that employees understand how CDHPs work; having plan provisions that encourage utilization of wellness programs and preventive care services; offering

easy-to-use tools that give employees useful, comprehensible information on health care issues, services and providers; and educating employees that how they manage their health and use health care services is a financial—as well as a personal—issue for them.

Higher Engagement, Lower Costs Characterize CDHP Enrollees

Participants in Consumer-Directed Health Plans (CDHPs) are more likely to make engaged, informed decisions about their health care, and more likely to use preventive health care services than non-CDHP participants, according to a study from UnitedHealth Group. The study covered three years of data from 40,000 CDHP participants and 15,000 individuals who were enrolled in preferred provider organizations (PPOs).

Other conclusions from the study include:

- In each of the three study years, up to 5% more CDHP members sought preventive care services than did PPO members.
- CDHP members reduced their hospital admissions by 22% and their emergency room visits by 14%, while the relative utilization of these services by PPO members increased. Importantly, this reduction in acute care services came without adverse health effects or outcomes for the CDHP members.
- Hospital admissions and emergency room visits by CDHP members with chronic conditions also decreased, by 8% for hospital admissions and by 12% for emergency room visits. Importantly, these enrollees continued to visit a primary care physician at the same rate as chronically ill PPO members.

- Health plan costs per plan member over the study period decreased for CDHP enrollees while increasing for PPO enrollees. After adjusting for demographics, health status, plan design impact and geography, costs per CDHP member decreased 3% to 5%, while increasing 8% to 10% for PPO enrollees.

This cost data is consistent with the results of a survey released earlier this year by Deloitte which, though reporting an increase in CDHP health plan costs from 2004 to 2005, found that this increase averaged only 2.8%, compared to increases of 8% for health maintenance organizations, 8.5% for point-of-service plans, 7.2% for PPOs, and 6.4% for indemnity plans.

Currently, a small but growing number of employers offer CDHPs to employees, according to a report from the General Accounting Office. Most do so in order to help control health care costs, through increasing employees' awareness of health care spending and by giving employees a more immediate financial stake in their health care decision-making.

According to UnitedHealth Group, health care spending and consumer behavior can be positively impacted, without adverse effects on members' health, when CDHP enrollees are given the necessary support. Thus, employers wishing to see the best that CDHPs can offer must commit to

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