

Chapter 7

Discrimination Appraisal

Introduction

This is a Work-Product designed to be (a) both risk and actuarial in nature as well as to be (b) generated through www.awpse.com

The purposes of the Work-Product are these; (a) obtain a one-stop critique of how all of the discrimination disciplines might impact its health care plans, (b) be able to use such one-stop critique as a decision-model by which management decisions might be made with respect to plan changes (if any) so to as to achieve discrimination-free plan(s). It is intended to be as user-friendly as possible with due regard to the complexity of the topics.

This Discrimination Appraisal may be of use and value by offering these unique features: (a) brings into focus all of the discrimination classes (prohibited, protected, Federal Trade and Commerce, new ACA classes); (b) by collecting data through the Questionnaire permits the results of plan aggregation (or restructuring) to be determined.

This Discrimination Appraisal has as its primary goal the determination of whether or not the health care plan(s) of the employer (and its affiliates, subsidiaries, and similar) discriminate in any of the following ways: (a) favoring the highly compensated, (b) disfavoring the protected class (sex, race, age, disabled, handicapped, e.g.), (c) improper use of or reliance on health status as described by federal mandates (HIPAA, e.g.), (d) violating the principles and practices of our Federal Trade and Commerce laws and, in a limited way, (e) permitting structural conflicted interests with the plan fiduciaries.

This Appraisal (a) avoids offering advice or consultation, (b) limits its scope to the determination of infractions and the measure of their potential economic consequences and (c) considers primarily medical reimbursement plans but secondarily cafeteria, flexible spending accounts, premium option plans or dependent child assistance arrangements. Employer organizations for purpose of this Appraisal include such structures as partnerships, government entities; not-for-profit companies, churches and sole proprietorships.

The typical use of this Work-Product is to provide a checklist by which the user (a) may review at a single time/place all of the discrimination challenges to be possibly faced and (b) using such Work-Product as a decision model make the requisite changes to gain a clear discrimination bill of health.

Depending on the results of the Appraisal, it is possible, given some failure results, that the Work-Product designed for the Discrimination Testing of Medical Reimbursement Plans might not be needed. This would be the case were the plan's Eligibility Test to fail and the fraction to determine the taxable value of benefits for the HCI to be required. Also, regardless of the Appraisal results, special discrimination tests are needed for these four benefits arrangements: cafeteria plan, premium only plan, flexible benefit plan and dependent child reimbursement plan.

There are three sections to this chapter: (a) Discussion of the Questionnaire (Appendix F); (b) discussion of the Data Entry to www.awpse.com (Appendix F). (c) Discussion of the Work-Product Risk/Actuarial Opinion) (Appendix F). It is in these discussions where the Reader/User will discern the need that this Work-Product is to fill.

Section One-Discussion of the Questionnaire

Introduction

A Questionnaire should be completed for each medical reimbursement plan sponsored by any Employer in the Control Group. With respect to medical reimbursement plans, each plan should have a unique DOL number. Such Questionnaires is appropriate for cafeteria, premium only, flexible spending or child assistance care plans.

The type of organization is significant in (a) doing the tests; (b) elimination any discrimination (if possible) and (c) identifying other types of discrimination.

The plan name and designation (typically the DOL Number) is needful as well as the plan's finding and administration methods.

Miscellaneous Organizations

There are several of such miscellaneous organizations that must be considered: (a) church, (b) state and local government entities and (c) not-for-profit entities. These lack the usual stock ownership features and/or are not entrepreneurial in nature. However, the employees who are indistinguishable for tax purposes from those employees of the traditional corporate organizations. These organizations do not escape the discrimination requirements with respect to the health care plans. Some practical considerations with miscellaneous organizations are these: (a) because they have no measurable ownership component, they escape the discrimination ownership tests and (b) the officer portion of the HCI does not exist.

Benefits Test

All plans must be able to show that there are no instances where the HCI is treated more favorably than the rank and file with respect to (a) benefits, (b) eligibility (c) contributions, (d) tenure or (e) compensation. This Benefits Test is entirely different from and independent of the Eligibility (or percentage) Test.

Risk Management Test

The basis of the Risk Management Test rest on four questions: (a) is the Protected Class discriminated against? (a) From all federally mandated benefits met? (c) Are any of the Federal Trade and Commerce Laws (included unfair trade practices) violated and (d) Have there been any audits made of either discrimination or unfair trade practices?

Eligibility Tests

The Eligibility Test applies only to plans that are self-funded. For analysis purposes, the benefits and eligibility provisions of each plan should be entered. The census consists of several census counts.

The number of employees in the defined population includes all common law employees and all self-employed (i.e., non-common law employees who are plan participants as a contractual matter such as an independent contractor). The Number of Excludible Employees includes all common law employees who are not Plan Participants and who are in any of these six groupings: (a) part-time, (b) temporary, (c) under age 25, (d) less than three years of service, (e) working under a collective bargaining agreement or (f) nonresident alien working with no U.S. income. The Participants (d) include all of the Plan Participants.

Other Statutory Discriminations Tests

If any of these are checked, a special discrimination test must be made. Such test is independent of medical reimbursement test that may be included from the Appraisal.

Execution Section

The person and firm actually submitting the Questionnaire should be entered (TPA, broker, consultant, e.g.).

Section Two – Discussion of www.awspe.com

In process of preparation

Section Three – Work-Product

Introduction

The Work-Product is both risk and actuarial in nature. To add the degree of discipline such work-product deserves, it is made a work-product deserving of a risk and actuarial certification.

The User is expected to read and understand the Narrative and Explanations, the Statement of Actuarial Opinion, the Submitted Data and Employer Options.

The Testing Results desire some comments: (a) the Benefits Test results merely summarize the submitted Questionnaires and (b) the Eligibility Test Results do likewise except the process of aggregating (i.e., restructuring) occurs as a computer – prepared computation.

Aggregation (or Restructuring) Amendments

The regulations permit medical care plans to be aggregated or the structured (i.e., merged or combined) or disaggregated (i.e., divided) solely for purposes of meeting the Eligibility Tests so long as such actions are supported by a plan amendment. It should be noted that aggregation is mandatory with DCAP. The affected employers must be controlled and the affected plans must primarily provide medical benefits. Two types of restructuring will be found: (a) the benefits are combined with the eligible employees remaining the same (e.g., the merger of a medical plan and a dental plan into one that offers both benefits albeit on a pick-choose basis) and (b) the plans are combined with the eligible employees increasing significantly (e.g., the merger of the medical-plan of Divisions A with the Medical Plan of Divisions B).

Miscellaneous Considerations

Checklist of Discrimination Critical Questions

1. Are the employer entities properly identified with respect to control, etc.
2. Are the plans subject to discrimination properly identified with respect to type of plan (medical reimbursement, cafeteria, etc.
3. Are the individuals properly identified with respect to type of individual (officer, shareholder, leased, excludible, etc.)
4. Are the practical problems properly identified such as (a) timing of tests, (b) accepting test failures, (c) plan restructuring, (d) related aspects of testing (regulatory requirements, e.g).

Grandfathering of Fully Insured Plans

Grandfathered insured plans will not be subject to the nondiscrimination rules of Internal Revenue Code Sections 105(h). Section 105(h) prohibits a covered health plan from discriminating in favor of highly compensated employees as to eligibility to participate or benefits provided. Previously, Code Section 105(h) applied only to self-funded health plans. PPACA expands the application of these rules (effective for plan years beginning after March 23, 2010) to include all insured plans that are not grandfathered. Avoiding the application of Code Section 105(h) will be critical issue for many employers who sponsor insured plans that provide different levels of benefits to different workforces or groups.

Timing the Discrimination Testing

There is little guidance provided by the Regulators that is helpful in setting the timing of the discrimination tests. Ideally, timing of such test should be as follows: (a) prior to the beginning of the plan year; (b) then a few months prior to the close of such plan year and finally (c) after the close of such plan year. The maximizes the control of such activity by the employer. The usual wisdom is that connection during the plan year and acceptable; after the close of the plan year such are too late.