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RE: Discrimination Appraisal
Medical Reimbursement Plan(s)

Employer(s)____

Engager____

Eligible User________________________________**Test Year**_____

This Work-Product constitutes a Risk and Actuarial Opinion and serves as a Discrimination Appraisal of the subject Medical Reimbursement Plan(s) that have been tested and summarized in Part 4 herein. Such appraisal reflects the mandates of (a) Section 105(h) of the Internal Revenue Code and relevant Treasury Regulations, (b) civil rights and age discrimination laws, (c) HIPAA, (d) miscellaneous health-related federal mandates, (e) the Patient Protection and Affordable Health Act of 2010 and (d) basic principles and practices of Federal Trade and Commerce Laws and risk management This Certification is in six parts:

1. Narrative or Explanation
2. Statement of Actuarial Opinion
3. Submitted Data
4. Testing Results
5. Employer Options
6. Comments of the Actuary.

Sincerely,

____
Principal
Actuarial Work-Products, Inc.

PART 1

NARRATIVE OR EXPLANATION

In General

This Discrimination Appraisal has as it 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 defined by federal mandates (HIPAA, e.g.) and (d) violating the principles and practices of the Federal Trade and Commerce Laws which might include the presence of structural conflicted interests among it fiduciaries as an infraction.

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 based solely on submitted data and documentation and (c) considers primarily medical reimbursement plans but secondarily cafeteria, flexible spending accounts, premium only 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.

Favoring the Highly Compensated

The new Health Care Reform Act (PPACA) amended the Federal Public Health and Safety Act so a to require that fully insured medical reimbursement health care plan do not discriminate (i.e., violate the Benefits Test) in favor of the highly compensated individuals as described in IRC Section 105(h). Fully insured plans are not subject to the Eligibility Test as are self-funded plans. The penalty for this newly-defined violation is not a W-2 Statement to the Individual but rather a notable infraction of the law and consequential fines.

Self-funded medical reimbursement plans continue to be governed by IRC Section 105(h). This means that such plans must demonstrate that (a) the Benefits Test is met (i.e., no favoritism to the highly compensated as to (i) eligibility, (ii) benefits, (iii) contributions, (iv) tenure or (v) compensation) and (b) the Eligibility Test is also met. The penalty for an act of discrimination is the reversal of the statutory tax advantage that results in (a) a W-2 to the specific highly compensated individual if the Benefits Test fails or (b) a Form 1099 to the highly compensated individuals (as a group) if the Eligibility Test fails.

Disfavoring the Protected Class

Three major federal laws define what are commonly referred to as the protected class: (a) the Civil Rights Laws (race, sex, religion, national origin, e.g.), (b) ADEA (Age Discrimination in Employment Act), and (c) Equal Employment Opportunity Laws (handicapped or disabled worker, e.g.). The protected class must not be disfavored with respect to (a) eligibility, (b) benefits, (c) contributions, (d) tenure or (e) compensation. Plan-related discrimination infractions against the protected class will be subject to an EEOC enforcement action.

Misusing Health Status

A family of federal laws that directly impact medical reimbursement plan have the effect of making it an act of discrimination to be in violation thereof. The primary laws in this grouping are: (a) Mental Health Parity Acts, (b) Newborn and Mothers' Health Protection Act, (c) HIPAA, (d) Women's Health and Cancer Rights Act or (e) 2010 Patient Protection and Affordability Health Act (pre-existing condition, e.g).

Violating Federal Trade and Commerce Laws

The essence of our family of trade and commerce laws is this: (1) there shall be no (a) restraint of trade or stifling of competition, (b) price-fixing, (c) unfair price discrimination or activities that are anti-trust in design or result and (2) trade shall be conducted fairly. These Trade and Commerce Laws were enacted in the early decades of the twentieth century and had as their motivation the Commerce Clause of the U.S. Constitution. The Supreme Court, in 1942, held that insurance was interstate commerce (overturning a long precedence to the contrary); in direct response, Congress enacted the McCarran-Ferguson Act in 1945 which exempted insurance from compliance with the Trade and Commerce Laws. Congress at that time had confidence in the ability of the states to regulate insurance. The new Health Care Reform Act revoked the McCarran-Ferguson *free-pass* to insurers but restricted such revocation to health insurance. Self-funders will be unaffected by the revocation of such Law to health insurance since they had to conform thereto all the time. Fully insured health care plan must pay particular heed to any potential discrimination that might violate the Federal Trade and Commerce laws. Also, the Supreme Court held in *MetLife v. Glenn* that the presence of a conflicted interest with a plan fiduciary (even if only potential or structural) should result in the court, in its adjudication, holding a litigant, with such conflicted interest, to a higher standing than a litigant without such conflicted interest. The issue from a both a trade and commerce as well as a risk standpoint is this: Is it significant that the Employer could be disadvantaged should a plan-related legal issue arise solely because of its conflicted interest (even if potential or structural? For purposes of this Work-Product, the response to this question is affirmative,

PART 2

STATEMENT OF ACTUARIAL OPINION
DISCRIMINATION APPRAISAL
MEDICAL REIMBURSEMENT PLAN(S)

I am a principal of both Self-funding Actuarial Services, Inc. and Actuarial Work-Products, Inc. (affiliated Corporations); am a member of the Society of Actuaries and am a member of the American Academy of Actuaries. My firm has been retained by the Engager to provide calculations of certain actuarial items for the above-cited Health Care Plan. I relied upon the Engager shown herein as to the accuracy and completeness of the underlying information that was used in this Certification. In other aspects, my examination included (a) reviews of the actuarial assumptions, methods, submitted data and (b) tests of actuarial computations as I considered necessary under the circumstances.

Summary of the Discrimination Appraisal

Favoring the Highly Compensated

Benefits Test (All Plans)

Choice A
The Benefits Tests are summarized in Part 4 and show that all of the Plans meet such Tests.

Choice B
The Benefits Tests are summarized in Part 4 and show and that certain of the Plans fail to meet such Tests. When such Plan is self-funded, the penalty is for the affected highly compensated individual that benefits from such discrimination to be given a W-2 (Block 1 only) for the plan-provided benefits that are attributable to the miscreant provision(s). When such Plan is fully insured, discrimination in favor of the highly compensated constitutes an infraction of the new health care reform law and significant statutory civil penalties will be assessed against the employer; that is, fully insured plans do not have the privilege of the W-2 remediation. The recommended course of action with any such Benefit Test failure is to (a) eliminate any/all such discriminations and (b) obtain a new Discrimination Appraisal.

Eligibility Test (Self-Funded Plans Only)

Choice A
The Tests are summarized in Part 4 and show that all of Plans meet the Eligibility Tests.

Choice B
The Tests are summarized in Part 4 and show that certain of the Plans fail to meet the Eligibility Tests. Such tests are limited to self-funded plans. The penalty that results from a self-funded plan that discriminates by eligibility is for any highly compensated individual who is in such plan and who receives a benefit to be given a W-2 (Block 1 only) for a percentage determined by a statutory formula of such benefit. The protocol involved in assessing such penalty is complicated and involves, among other steps, the determination of all highly compensated individuals of the composite of all of the employers connected to the employer sponsoring the discriminating plan by ownership control, business activity, etc. The recommended course of action with any such Eligibility Test failure is to (a) eliminate such discrimination (b) obtain a new Discrimination Appraisal. In the event that such self-funded plan either (a) intends to be discriminatory by election or (b) must pay the penalty tax to the IRS as determined by the Work-Product titled Discrimination Testing (Medical Reimbursement Plan) available in the Menu of Work-Products should be used; in this Work-Product, the requisite and usually complicated enumeration of the highly compensated individuals is made.

Choice C
The Tests are summarized in Part 4 and show that what impact there would be on the eligibility results if some (or even all) of the subject plans were restructured' The Actuary believes it is both appropriate and sufficient to demonstrate such results without making them a part of the Opinion. Such restructuring involves two types of aggregations: (a) combining two benefits with an common eligible employee base (medical and dental plans, e.g.) or (b) combining two plans with an uncommon eligible employee base (hourly plan and salaried plan, e.g.).This Work-Product does not contemplate Plan dis-aggregations.

Choice D
The Tests are summarized in Part 4 and show that the census data needed to make the Eligibility Tests for some of the subject Plans are NA (not available). With this event, the User may respond in either of two ways: (a) make the effort to replace the NA or (b) use the Work-Product titled Discrimination Testing as the means to develop the requisite highly compensated database.

Disfavoring the Protected Class (All Plans)

Choice A
The Tests are summarized on Part 4 and show that the Plan does not discriminate against the Protected Class in violation of the (a) Civil Rights Laws (race, sex, religion, national origin), (b) ADEA (age discrimination in employment) or (c) equal opportunity in employment laws (disabled or handicapped workers, e.g.) with respect to (a) benefits, (b) eligibility, (c) contributions, (d) tenure or (e) compensation.

Choice B
The Tests are summarized in Part 4 and show that the Plan discriminates against the Protected Class in violation of the (a) Civil Rights Laws (race, sex, religion, national Origin), (b) the ADEA (Age Discrimination in Employment Act) or(c) equal employment in employment laws (disabled or handicapped workers, e.g.) with respect to (a) benefits, (b) eligibility, (c) contributions, (d) tenure or (e) compensation. The recommended course of action is to eliminate such discrimination because such constitutes a violation of the such federal (and even state) laws.

Health Status (All Plans)

Choice A
The Tests are summarized in Part 4 and show that the Plan does not discriminate against any covered person because of health status as required by (a) the Mental Health Parity Acts, (b) the Newborn and Mothers' Health Protection Act, (c) HIPAA, (d) the Women's Health and Cancer Rights Act or (e) the Americans with Disabilities Act.

Choice B
The Tests are summarized in Part 4 and show that the Plan does discriminate against one or more covered persons because of health status as prohibited by (a) the Mental Health Parity Acts, (b) the Newborn and Mothers' Protection Act, (c) HIPAA, (d) the Women's Health and Cancer Rights Act or (e) the Americans with Disabilities Act. The recommended course of action is to eliminate such discrimination because such constitutes a violation of the federal laws.

Patient Protection and Affordable Care Act (PPAGA)

Choice A
The Tests are summarized in Part 4 and show that the Plan might discriminate either for or against any of the three newly-added classes that might eventually be targeted for regulatory discrimination testing - providers, consumers or insurers.

Choice B
The Tests are summarized in Part 4 and show that the Plan most likely does not discriminate either for or against any of the three newly-added classes that might eventually be targeted for regulatory discrimination testing – providers, consumers, or insurers.

Federal Trade and Commerce Laws

The Submitted Data, as summarized in Part 4, indicate that the Plans, and their sponsors, are not involved with any practice that could possibly be questioned as violating any of the Federal Trade and Commerce Laws (antitrust, restraint of trade, price-fixing, anti-competition, unfair trade practices, e.g.). The Submitted Data, as summarized in Part 4, indicate that the Plans, and their fiduciaries, are not involved with any undisclosed structural conflicted interest(s) that could possibly be questioned as being contrary to the letter and the spirit of the Supreme Court decision (*MetLife v. Glenn).*

Audits

The Submitted Data, as summarized in Part 4, shows that certain audits have (or have not) been performed with respect to the discrimination and/or unfair trade practices of this Plan:

Internal Audits: Discrimination?_____ Unfair Trade Practices?_____ (Yes or No)

External Audits: Discrimination?_____ Unfair Trade Practices?_____ (Yes or No)

Other Statutory Discrimination Tests

Based upon the submitted data, the following benefit arrangements require a special discrimination test:

____Cafeteria Plan

_____Premium Only Plan

_____Flexible Spending Account

_____Dependent Child Assistance Plan.

Conditions and Terms of Opinion

1. That this Work-Product is an Actuarial Opinion as contemplated by the American Academy of Actuaries.
2. That I am qualified to offer such opinion by reason of my meeting the requisite examination, experience and continuing education requirements of the American Academy of Actuaries
3. That this Actuarial Work-Product is the result of a mathematical computer program processing inputted data and documentation by Actuarial Work-Products, Inc. as summarized herein.
4. That I am independent of and have no conflicted interest with any party with respects to this Work-Product.
5. That the Work-Product was prepared at the request of the Eligible User, who is identified herein, and who may or may not be the ultimate user of such Work-Product.
6. That I have been engaged, as contemplated by the relevant American Academy of Actuaries, by the Engager identified herein.
7. That I intend to be a fiduciary with respect to this Work-Product and will act accordingly, striving to meet any and all standards of conduct necessary to meet this end.
8. That the professional liability for this Work-Product is assumed by Self-Funding Actuarial Services, Inc. which has in place an appropriate professional liability insurance policy. A PDF of the summary page of this policy is available at: www.awpse.com/eando.pdf.

09/25/2008
Date

____
Principal
Actuarial Work-Products, Inc.

PART 3

SUBMITTED DATA

In General

The Discrimination Appraisal Questionnaire(s) constitute, in their entirety, the only Submitted Data to this Work-Product and are attached and made part thereof.

PART 4

TESTING RESULTS

PART 5

EMPLOYER OPTIONS

Commentary

When the Discrimination Appraisal indicates a violation of law, the only acceptable solution would appear to be the remediation of such violation irrespective of the Plan's funding method.

Employer options are available with self-funded medical reimbursement plans: (a) a benefit that fails the Benefit Test may be (i) changed or (ii) may be left unchanged and a W-2 (Block I only) provided to the affected highly compensated individual (of an unknown and possibly disastrous amount); (b) a failed Eligibility Test offers the Employer the choice of (i) correcting the infraction, (ii) accepting the infraction and making the computations needed for the W-2 Forms to the affected highly compensated individuals and (iii) seeking two other available sources of remediation (i.e., restructuring amendment or other tests).

Restructuring Amendment. This option is commonly referred to as a Wraparound (or wrap) Amendment. This Work-Product opines that such Amendment is a legal document notwithstanding that is sole purpose is to make a failed Eligibility Test a successful one. The Amendment will do either or both of the following: (a) aggregate (or disaggregate) different benefits (medical and dental, e.g.) with a common eligible employee base or (b) aggregate (or disaggregate) different eligibility groupings (hourly and salaried, e.g.). With the (a) Amendment, the census are not combined; with the (b) Amendment, the census are combined. The testing results in Part 4 show the results of such aggregating (but not disaggregating) that may be the basis for the requisite Wrap Amendment. This Risk/Actuarial Work-Product asserts that the Wrap Amendment is a legal matter to be handled accordingly.

Other Remedial Tests. There are two tests that may be used to meet the Eligibility Test: (a) the Classification Test and (b) the Fair Cross-Section Test. These Tests are not made part of this Work-Product because such tests are (a) very complex and (b) of dubious effectiveness. Depending on facts and circumstances, such tests may always be examined as an amendment to this Work-Product.

PART 6

COMMENTS OF THE ACTUARY

Elaborative or explanatory comments may be found in the appropriate Sub-Site under these headings: Description of Work-Product, Background Reading, Fees and Data Handling.

This Work-Product is the property of the Engager (shown on Page 1) who has the fee responsibility and is the party engaging the Actuary. The Eligible User is the person who actually enters the data and must be approved by Actuarial Work-Products, Inc.