GH CORU Model Solutions
Fall 2013

1. **Learning Objectives:**

6. Evaluate the impact of regulation and taxation on companies and plan sponsors in the U.S.

Learning Outcomes:

(6b) Describe the major applicable laws and regulations and evaluate their impact.

Sources:

Group Insurance, Bluhm, 6th Edition

- Chapter 17 Health Exchanges and Connectors

GHC-803-13: Brief for the AAA as Amicus Curiae Supporting Respondents on the Severability Issue to the Supreme Court

GHC-804-13: Letter to NAIC on White Paper on Adverse Selection and Exchanges

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) Provide an example of how benefit plan offerings can create anti-selection in the post Affordable Care Act (ACA) world from the perspective of a carrier on the Exchange who:

(i) has one competitor only on the Exchange

(ii) has one competitor only off the Exchange

Commentary on Question:

The majority of candidates understood that anti-selection involved getting more unfavorable risk but not many were able to provide clear examples. Most candidates struggled to provide a different example or explanation of why anti-selection would be different off and on the exchange

(i) If a competitor on the exchange offers gold, silver and bronze options and you offer only silver and gold; the bronze plan – which will be priced lower and have less benefit coverage – will attract younger and healthier insureds because they don't anticipate needing healthcare and want to pay as little as possible for insurance.

1. Continued

(ii) Situations where the insurer on the exchange may get more unfavorable risk. If a large carrier that mostly underwrote before ACA still only offers products off the exchange, their starting pool (assuming they maintain most of their pre-ACA enrollees) may be healthier to begin with since they were originally underwritten. Subsidies on exchange business may cause anti-selection since people with subsidies generally less healthy, because low income is positively correlated to poor health. Uninsureds who can now buy healthcare on the exchange with subsidies may have more health need. Also, high risk employers may choose to purchase through the exchange because it would be cheaper.

(b) Describe ACA provisions that help control anti-selection against the Exchange.

Commentary on Question:
Most candidates missed the meaning of anti-selection for the Exchange

Describe features that encourage as much enrollment on the exchange as possible.

- Individual mandate requires individuals to purchase healthcare insurance or pay a penalty.
- Premium subsidies, cost sharing subsidies, tax credits for lower income individuals make insurance more affordable and those are only available on the exchange.

Describe features that level the playing field on and off the exchange:

- Must cover essential health benefits both on and off
  Must be one of the metal plans or a catastrophic plan
- Single risk pool on and off exchange
- Pre-existing exclusions, no lifetime/annual maximums, rating restrictions same on and off exchange

(c) Describe ACA provisions that help control anti-selection among carriers on the Exchange.

Commentary on Question:
Most candidates did well on this section. Some misinterpreted anti-selection among carriers on the exchange determined by ACA (Federal law) with part (d) which asks about what individual states can do to further control anti-selection

- Risk corridor – a temporary program from 2014-2016. Federal government shares the risk for loss ratio variances. Variances between 3-8% share 50% of gain/loss and 8%+ government covers 80% of gain/loss
- Reinsurance also a temporary program from 2014-2016. All fully insured and self-funded plans pay into a reinsurance pool to pay for individual claims on the exchange exceeding a prescribed threshold.

1. Continued

- Risk adjustment is a permanent program where carriers will make or receive payments based on the risk profile of their members. Applies to both individual and small group risk pools. It is a zero sum program. Credit was also given for mentioning that the same rules apply on and off the exchange.

(d) Describe state provisions that can help mitigate the risk of anti-selection.

Commentary on Question:
See the commentary on part (c) above.

The question asked for specific actions states can do on their own outside of federal regulation to mitigate anti-selection in the market. Some examples are:

- Allow every carrier that applies to be on the exchange to participate
- Require all carriers to be on the exchange
- Require all carriers to offer the same plans on and off the exchange
- Require all carriers to offer all 4 plans (or specified plans)
- Place additional restrictions on plans offered outside the exchange
- Actively managed the rate review process
- Don't let carriers in/out of the exchange at will – i.e. must stay out of exchange for *x* years if they leave; or accept new carriers every other year
- Ensure risk adjustment is effective and timely, or administer own risk adjustment
- Provide additional tax credits/subsidies
- Continue reinsurance beyond 2016 or set up additional reinsurance
- Expand Medicaid – reduces anti-selection on the individual market
- Choose not to establish basic health care plan to increase exchange participation
- Combine individual and small group on the exchange
- Expand definition of large group to 100

(e) Identify consumer protection features added by ACA.

Commentary on Question:
Most candidates did very well on this part.

- Guarantee issue/renewability
- No rating on health status
- Dependent coverage to 26
- No rescissions
- No pre-existing conditions for kids beginning in 2010 or 2011 and for adults beginning in 2014
- Preventive care at 0% cost share
- No annual maximums/no lifetime maximum

1. **Continued**

- Essential health benefits package
- OOP Limits Capped at HSA limits
- Waiting periods cannot be more than 90 days
- Standardized disclosure documentations
- Rating restrictions
- MLR requirements
- Premium rate increase reviews
- Cost sharing subsidies

2. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   a. Group and individual medical, dental and pharmacy plans
   b. Group and individual long-term disability plans
   c. Group short-term disability plans
   d. Supplementary plans, like Medicare Supplement
   e. Group and Individual Long Term Care Insurance

2. The candidate will understand and recommend a manual rate for each of the coverages described in Learning Objective 1.

4. The candidate will understand how to describe Government Programs providing Health and Disability Benefits in the U.S.

Learning Outcomes:

(2b) Develop an experience analysis.

(4a) Describe benefits and eligibility requirements for:
   (i) Medicare, including Part D
   (ii) Social Security, including disability income
   (iii) Medicaid

Sources:

Group Insurance, Bluhm, 6th Edition

- Chapter 25 Filings and Certifications for Medicare-Related Group Coverages: pages 403 - 405
- Chapter 38 Medical Claims Costs Trends Analysis: pages 642 - 644

Commentary on Question:

This question tested a candidate's ability to calculate and apply gross and net value tests for determining an employer group's eligibility for a Medicare Part D subsidy. It also tested the candidate's knowledge of retiree prescription drug benefit options in addition to an understanding of trend analytics.

Solution:

(a) Describe the requirements for offering prescription drug benefits to retirees via:

   (i) an employer group waiver plan, and

   (ii) a retiree drug subsidy.

   Commentary on Question:
   This section required candidates to cite two basic lists of prescriptions drug benefit requirements. The candidates generally did very well on this section and many got the full points.

2. Continued

(i)
- Group-specific benefits must be on average at least as rich as Part D
- Plan deductible no greater than Part D deductible
- Catastrophic coverage at least as rich as Part D catastrophic coverage

(ii)
- Apply for retiree drug subsidy and report actual experience to CMS
- Pass gross value test, which tests that coverage on average as rich as Part D coverage
- Pass net value test, which tests whether portion of plan covered by subsidy is at least as rich as that offered by Part D

(b) Determine whether Suspenders' retiree drug plan is eligible for the retiree drug subsidy next year using the prior year claims data. Show your work.

Commentary on Question:
The question provided the prior year data with a claim table with prior year Gross Values by tier. The question asked the candidate to evaluate the current year plan design to determine whether it is was eligible for the Retiree Drug Subsidy. Since the table had prior year values, the candidate is required to calculate the current year Gross Values. It is important to show the equations and to describe what the Gross Value and Net Value tests. Successful candidates demonstrated knowledge of the Gross Value test and the Net Value test, even if the plan failed the former.

Part D Gross Value Test
- Tests that, across whole plan, value offered under plan is better than standard Part D
- In order to do this must evaluate claim costs across all members under both plans

Need to calculate the Gross Values by Tier, candidates also received points for writing down basic equation:
- **$0 - $300 Tier:**
  - **Part D Plan Value** = $0 because deductible
  - **Employer Plan Value** = $0 because of deductible
- **$300 - $500 Tier:**
  - **Part D Plan Value** = (Claims Costs in Tier – Deductible) x (Plan Responsibility in Tier) x Number of Members/Total Pop to get Aggregate PMPY = ($450 - $300) x (1 – 25%) x 30/215 = $15.70 PMPY
  - **Employer Plan Value** = $0 because of deductible

2. Continued

- **$1,000 - $3,000 Tier:**
  - **Part D Plan Value** = ($1,750 - $300) x (1 – 25%) x 70/215 = $354.07 PMPY
  - **Employer Plan Value** = ($1,750 - $500) x (1 – 7%) x 70/215 = $378.49 PMPY
- **$3,000 - $6,000 Tier:**
  - **Part D Plan Value** = [($3,000 - $300) x (1 – 25%) + ($4,210 - $3,000) x (1 – 70%)] x 55/215 = $610.88 PMPY
  - **Employer Plan Value** = ($4,210 - $500) x (1 – 7%) x 55/215 = $882.63 PMPY
- **$6,000+ Tier:**
  - **Part D Plan Value** = [($3,000 - $300) x (1 – 25%) + ($6,000 - $3,000) x (1 – 70%) + ($7,100 - $6,000) x (1 – 5%)] x 20/215 = $369.30 PMPY
  - **Employer Plan Value** = [($6,000 - $500) x (1 – 7%) + (7,100 - $6,000) x (1 – 5%)] x 20/215 = $573.02 PMPY

To determine Plan Gross Value for Each Plan, sum together calculated PMPYs:

- **Part D Plan Gross Value** = $0 + $15.70 + $354.07 + $610.88 + $369.30 = $1,349.95 PMPY
- **Employer Plan Gross Value** = $0 + $0 + $378.49 + $882.63 + $573.02 = $1,834.15 PMPY

The plan passes the gross value test because $1,834.15 > $1,349.95

<u>Part D Net Value Test</u>

The Part D Net Value Test simply values the gross value minus plan premium

- **Part D Plan Value** = $1,349.95 - $75 x 12 = $449.95 PMPY
- **Employer Plan Gross Value** = $1,834.15 - $0 = $1,834.15 PMPY

The plan passes the net value test because $1,834.15 > $449.95

(c) A colleague comments to you that your initial analysis of Suspenders' eligibility for the retiree drug subsidy may be flawed because it doesn't include the impact of trend. Respond to your colleague's criticism, and list any key items omitted from your initial analysis.

Commentary on Question:

This section required candidates to determine whether trend would impact the net and gross value tests, justify their response and list omitted items from the trend analysis. A candidate could receive credit for either supporting or refuting the colleague's criticism. A majority of candidates cited deductible leveraging. Some candidates did not cite omitted items listed below and only provided a list of trend considerations.

2. Continued

[*Note: Candidates could receive credit for agreeing or disagreeing with the colleague if they provided a reasonable justification.]*

I agree with my colleague. Due to deductible leveraging, trend could have an impact of on the results, as the deductibles and coverage limits are different between the employer plan and the Part D plan.

Key items omitted from initial analysis:

- Available experience data
- Other data sources
- Expected cost trends
- Expected rebates
- Formularies
- The cost of drugs not covered by Part D
- Anticipated population characteristics

(d) Describe common challenges in trend analysis.

Commentary on Question:
This section required candidates to recite a basic list of trend analysis challenges. A majority were able to get most, if not all of the items on this list.

- Seasonality – trends may need to be adjusted to a 12-month annual basis to dampen impact
- One-time events, such as a severe flu season, can cause a spike in monthly trends
- Margin – may need to assume higher than best estimate for certain purposes
- Changes in prior period estimates – include restatements in correct period to produce most accurate trends
- Legislative changes – can cause impacts that change prospective trends

(e) Determine Suspenders' plan eligibility for the retiree drug subsidy next year assuming:

- A 5% total two year trend,
- All Defined Standard Part D and Suspenders' Retiree Plan benefit parameters remain the same.

Briefly comment on how these results compare to the determination in part (b) above. Show your work.

2. Continued

Commentary on Question:
Assume all plan criteria are the same, but trend all claims amounts forward by 5% since no leveraging is assumed. Successful candidates demonstrated knowledge of the Gross Value test and the Net Value test, even if the plan failed the former. Remember to add commentary about how the result compares to the result in part(b).

Aggregate Claims Tier	# of Members	Average Claims Cost PMPY of Members in Tier
$0 – $300	40	$221
$300 – 500	30	$473
$1,000 – $3,000	70	$1,838
$3,000 – $6,000	55	$4,421
$6,000 +	20	$7,455

Need to calculate the Gross Values by Tier**:**

- **$0 - $300 Tier:**
  - **Part D Plan Value** = $0 because of deductible
  - **Employer Plan Value** = $0 because of deductible

- **$300 - $500 Tier:**
  - **Part D Plan Value** = ($473 - $300) x (1 – 25%) x 30/215 = $18.05 PMPY
  - **Employer Plan Value** = $0 because of deductible

- **$1,000 - $3,000 Tier:**
  - **Part D Plan Value** = ($1,838 - $300) x (1 – 25%) x 70/215 = $375.44 PMPY
  - **Employer Plan Value** = ($1,838 - $500) x (1 – 7%) x 70/215 = $404.98 PMPY

- **$3,000 - $6,000 Tier:**
  - **Part D Plan Value** = [($3,000 - $300) x (1 – 25%) + ($4,421 - $3,000) x (1 – 70%)] x 55/215 = $627.04 PMPY
  - **Employer Plan Value** = ($4,421 - $500) x (1 – 7%) x 55/215 = $932.71 PMPY

- **$6,000+ Tier:**
  - **Part D Plan Value** = [($3,000 - $300) x (1 – 25%) + ($6,000 - $3,000) x (1 – 70%) + ($7,455 - $6,000) x (1 – 5%)] x 20/215 = $400.67 PMPY
  - **Employer Plan Value** = [($6,000 - $500) x (1 – 7%) + (7,455 - $6,000) x (1 – 5%)] x 20/215 = $604.40 PMPY

2. Continued

To Get Plan Gross Value for Each Plan, sum together calculated PMPYs:

- **Part D Plan Gross Value** = $0 + $18.05 + $375.44 + $627.04 + $400.67 = $1,421.20 PMPY
- **Employer Plan Gross Value** = $0 + $0 + $404.98 + $932.71 + $604.40 = $1,942.09 PMPY

The plan passes the gross value test because $1,942.09 > $1,421.20

Part D Net Value Test

- **Part D Plan Value** = $1,421.20 - $75 x 12 = $521.20 PMPY
- **Employer Plan Gross Value** = $1,942.09 - $0 = $1,942.09 PMPY

The plan passes the net value test because $1,942.09 > $521.20

Commentary: The results of the test didn't change, which is expected given that the plan passed the first time, and the employer plan is richer in the later tiers (that have most of the claims) vs. part (d), which should exacerbate the spread between them.

3. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   a. Group and individual medical, dental and pharmacy plans
   b. Group and individual long-term disability plans
   c. Group short-term disability plans
   d. Supplementary plans, like Medicare Supplement
   e. Group and Individual Long Term Care Insurance

3. The candidate will understand how to recommend an employee benefit strategy.

Learning Outcomes:

(1c) Describe each of the coverages listed above.

(3a) Describe employer's rationale and strategies for offering employee benefit plans.

(3c) Recommend an employee benefit strategy in light of an employer's objectives.

Sources:

Group Insurance, Bluhm, 6th Edition

- Chapter 13 Government Health Care Plans in the US
- Chapter 19 Retiree Group Benefits

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) State reasons employers offer retiree group benefits.

Commentary on Question:

Graders gave marks for other reasonable benefits that did not appear on the list in Group Insurance. Most candidates stated sufficient reasons to receive full marks on this portion of the question.

Key reasons that employers offer retiree group benefits include:

- Retiree group benefits are a tax-effective means of providing retirement financial security.
- It is a valuable benefit for those currently receiving the coverage or who are soon to retire.
- The benefits can support workforce planning and growth opportunities for employees.
- Providing ongoing health care coverage is a social responsibility of the employer.
- Providing retiree health care benefits helps provide a competitive package of total compensation.

3. Continued

- The current cash costs are nominal relative to the total spending on benefits.
- Retiree benefits are often at the top of the list of union demands.

(b) Identify the key types of services provided by Medicare Parts A and B.

Commentary on Question:
Most candidates knew enough components of Part A and Part B services to receive full marks on this portion of the question (if not necessarily all parts of the lists in Group Insurance.

Although it was implied in the question, the question does not stipulate that Part A benefits be listed separately from Part B benefits. Most candidates answered in the way that the question implied.

Medicare Part A provides Hospital Insurance, including:

- Inpatient hospital coverage
- Skilled nursing facility benefits
- Home health agency / skilled nursing facility benefits
- Hospice care for terminally ill patients

Medicare Part B provides Supplementary Medical Insurance, including:

- Outpatient hospital benefits (including emergency room and outpatient surgery)
- Medical care (services provided by physicians, diagnostic tests, supplies, durable medical equipment, prosthetic devices, and ambulatory surgical center care)
- A one-time initial wellness physical within six months of enrollment
- Ambulance
- Clinical laboratory and radiology
- Physical and occupational therapy
- Speech pathology
- Outpatient rehabilitation including partial hospitalization
- Radiation therapy
- Transplants
- Dialysis
- Home health care (beyond what is covered in Medicare Part A)
- Certain drugs and biologicals (primarily those that cannot be self-administered)
- Certain preventive services

3. Continued

(c) Determine which plan option will result in the lowest total out-of-pocket cost for the CEO's aunt in the next calendar year based on her expected expenses. Show your work.

Commentary on Question:
Many students knew the formula for the standard COB method, but incorrectly applied it at the aggregate level rather than at the service level (totaling all costs, all employer plan cost sharing, and all Medicare benefits, and then applying the formula).

Some students correctly calculated the aunt's medical liability under the arrangements, but did not include her premium as a liability.

Employer-Customized Benefit:

Greenstone's customized benefit pays secondary to fee-for-service Medicare, using the standard COB method.

Under the standard COB method, the benefit paid by the Greenstone plan is the lesser of (C × %) and (C-M), where:

- C = Actual incurred costs of the insured
- % = Greenstone plan cost sharing
- M = Benefit paid under traditional Medicare FFS

Inpatient Stay:
The aunt expects to incur one admission of 3 days, totaling $25,000:

- C = $25,000
- C × % = $24,500 ($25,000 less $500 cost sharing)
- M = $23,800 ($1,200 part A deductible)
- C-M = $1,200
- min(C × %,C-M) = min($24,500, $1,200) = $1,200

Therefore, for the inpatient stay:

- Medicare pays $23,800
- The employer plan pays $1,200
- The aunt pays $0

Skilled Nursing Facility Stay:
The aunt expects four days of SNF coverage, totaling $1,600 (after the inpatient stay has occurred).

- C = $1,600
- C × % = $1,480 ($1,600 less $120 cost sharing equal to $30/day times 4 days)

3. Continued

- M = $1,600 (Part A deductible was met during the IP stay, therefore $0 cost share for days 1-4)
- C-M = $0
- min(C × %,C-M) = min($1,480, $0) = $0

Therefore, for the SNF stay:

- Medicare pays $1,600
- The employer plan pays $0
- The aunt pays $0

Primary Care Physician Visits:

The aunt expects three PCP visits, totaling $450.

- C = $450
- C × % = $435 ($450 less $15 cost sharing equal to $5/visit times 3 visits)
- M = $450 - $210 = $240 (cost sharing equal to $150 Part B deductible plus 20% of the remaining $300)
- C-M = $210
- min(C × %,C-M) = min($435, $210) = $210

Therefore, for the PCP visits:

- Medicare pays $240
- The employer plan pays $210
- The aunt pays $0

Specialty Physician Visits:

The aunt expects four specialty physician visits, totaling $1,000

- C = $1,000
- C × % = $920 ($1,000 less $80 cost sharing equal to $20/visit times 4 visits)
- M = $1,000 - $200 = $800 (cost sharing equal to 20% of the $1,000, since the Part B deductible was applied above)
- C-M = $200
- min(C × %,C-M) = min($920, $200) = $200

Therefore, for the specialty physician visits:

- Medicare pays $800
- The employer plan pays $200
- The aunt pays $0

(Note that the Part B deductible was applied to the PCP visits and not the specialty visits here. If we apply the deductible to the specialty visits instead, then the service level allocation between the PCP visits and specialty visits will be different between Medicare and the employer plan, but will be the same in total).

3. Continued

Therefore, under the aunt's expected costs next year, and the employer-customized benefit, the expected costs to each party are as follows:

- Medicare: $23,800 + $1,600 + $240 + $800 = $26,440
- Employer plan: $1,200 + $0 + $210 + $200 = $1,610
- Aunt: $0 + $0 + $0 + $0 = $0

In addition, the aunt needs to pay premiums equal to $120 per month, or $1,440 in total. **Therefore, under the employer-customized benefit, the aunt's total expected expenses are $1,440.**

Standardized Medicare Supplement Plan K Benefit:

Under the standard Medicare Supplement Plan K plan design:

- 50% of the Part A deductible is covered.
- The Part B deductible is not covered.
- 100% of Part A coinsurance is covered (beyond the deductible)
- 50% of Part B coinsurance is covered (beyond the deductible)
- The out-of-pocket limit for Plan K is $4,640.

Inpatient Stay:
The aunt expects to incur one admission of 3 days, totaling $25,000:

- C = $25,000
- M = $23,800
- Remaining aunt costs are $1,200 (Part A deductible).
- Plan K covers 50% of the deductible ($600)

Therefore, for the inpatient stay:

- Medicare pays $23,800
- Plan K pays $600
- The aunt pays $600

Skilled Nursing Facility Stay:
The aunt expects four days of SNF coverage, totaling $1,600 (after the inpatient stay has occurred).

- C = $1,600
- M = $1,600 (Part A deductible was met during the IP stay, therefore $0 cost share for days 1-4)

Therefore, for the SNF stay:

- Medicare pays $1,600
- Plan K pays $0
- The aunt pays $0

3. Continued

Primary Care Physician Visits:
The aunt expects three PCP visits, totaling $450.

- C = $450
- M = $450 - $210 = $240 (cost sharing equal to $150 Part B deductible plus 20% of the remaining $300)
- Remaining aunt costs are $150 Part B deductible and $60 coinsurance
- Plan K does not cover the deductible, but covers half of the coinsurance, or $30

Therefore, for the PCP visits:

- Medicare pays $240
- Plan K pays $30
- The aunt pays $180

Specialty Physician Visits:
The aunt expects four specialty physician visits, totaling $1,000

- C = $1,000
- M = $1,000 - $200 = $800 (cost sharing equal to 20% of the $1,000, since the Part B deductible was applied above)
- Remaining aunt costs are $200 coinsurance.
- Plan K covers half of the coinsurance, or $100

Therefore, for the specialty physician visits:

- Medicare pays $800
- Plan K pays $100
- The aunt pays $100

(Note that the Part B deductible was applied to the PCP visits and not the specialty visits here. If we apply the deductible to the specialty visits instead, then the service level allocation between the PCP visits and specialty visits will be different between Medicare and the employer plan, but will be the same in total).

Therefore, under the aunt's expected costs next year, and the employer-customized benefit, the expected costs to each party are as follows:

- Medicare: $23,800 + $1,600 + $240 + $800 = $26,440
- Plan K: $600 + $0 + $30 + 100 = $730
- Aunt: $600 + $0 + $180 + $100 = $880

In addition, the aunt needs to pay premiums equal to $50 per month, or $600 in total. **Therefore, under the Medicare Supplement Plan K benefit, the aunt's total expected expenses are $1,480.**

3. Continued

In total, the aunt would expect to pay $1,440 under the employer-customized benefit, and $1,480 under the Medicare Supplement Plan K benefit. Therefore, under these assumptions, the employer-customized benefit is a better option.

(d) The CEO is interested in understanding the value of other coordination of benefit methods with FFS Medicare for the customized plan option. Using the aunt's expected expenses as an example, calculate the change in the plan's costs from switching to the other methods. Show your work.

Commentary on Question:
Many students had trouble with how the "standard coordination of benefits" question was asked in part (c), but correctly worked out the plan's liability under standard COB in part (d). In that case, candidates received credit for relevant work done in part (c).

For the employer-customized benefit, under standard coordination of benefits, the total cost to the plan is $1,610 (from work above in part (c)).

Two other coordination of benefits methods are the Exclusion method and the Carveout method.

In the Exclusion method, the plan's cost sharing is applied to the costs that remain after Medicare: (C-M) × %

Using work from part (c) above:

Inpatient Stay:
- C-M = $1,200
- Employer Benefit Cost Sharing = $500
- (C-M) × % = $1,200 - $500 = $700

Skilled Nursing Facility Stay:
- C-M = $0
- (C-M) × % = $0

Primary Care Physician Visits:
- C-M = $210
- Employer Benefit Cost Sharing = $15
- (C-M) × % = $210 - $15 = $195

3. Continued

Specialty Physician Visits:

- C-M = $200
- Employer Benefit Cost Sharing = $80
- (C-M) × % = $200 - $80 = $120

In total, under the Exclusion method for coordination of benefits, the total cost to the plan is $700 + $0 + $195 + $120 = $1,015.

In the Carveout method, the plan's cost sharing is applied to the total costs, then Medicare benefits apply to the remainder: C × % - M.

Using work from part (c) above:

Inpatient Stay:

- C × % = $24,500
- M = $23,800
- C × % - M = $24,500 - $23,800 = $700

Skilled Nursing Facility Stay:

- C × % = $1,480
- M = $1,600
- C × % - M = $1,480 - $1,600 < $0, so $0

Primary Care Physician Visits:

- C × % = $435
- M = $240
- C × % - M = $435 - $240 = $195

Specialty Physician Visits:

- C × % = $920
- M = $800
- C × % - M = $920 - $800 = $120

In total, under the Carveout method for coordination of benefits, the total cost to the plan is $700 + $0 + $195 + $120 = $1,015.

The total cost to the plan under Standard coordination of benefits is $1,610; therefore, the plan would expect to save $595 in costs by switching to either the Exclusion or the Carveout method.

4. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   a. Group and individual medical, dental and pharmacy plans
   b. Group and individual long-term disability plans
   c. Group short-term disability plans
   d. Supplementary plans, like Medicare Supplement
   e. Group and Individual Long Term Care Insurance

6. Evaluate the impact of regulation and taxation on companies and plan sponsors in the U.S.

Learning Outcomes:

(1b) Understand the historical context for each coverage.

(1c) Describe each of the coverages listed above.

(6b) Describe the major applicable laws and regulations and evaluate their impact.

Sources:

Group Insurance, Bluhm, 6th Edition

- Chapter 20 Federal Regulation and Taxation of Employer-Sponsored group Insurance Benefits

Commentary on Question:

Section (a) related to COBRA and HIPAA, and now PPACA, and their impact on employees continuation/conversion of coverage. Most candidates understood this section, but many didn't provide sufficient detail of each regulation in order to get full credit.

Section (b) related to how pre-existing exclusions apply in the current environment (2013) vs. new environment (2014 and beyond). Almost all candidates understood that PPACA removes all pre-existing condition exclusions. Candidates also recognized that pre-ex applies in 2013, but many didn't understand the "how and why" of its application.

Section (c) was intended to test the candidate's knowledge around an individual's taxation of medical expenses. Many candidates added the medical expenses and the premium together in their answer, meaning employee would have to pay for both. However, the medical premium paid for the coverage of the medical expenses. If they had no coverage, they would either buy new insurance OR pay 100% of medical expenses, not both. If the member pays for entire medical expenses, most candidates didn't even consider that a portion of the medical expenses may be tax deductible. Since the question specifically asked about tax implications, this was a key part of the answer.

4. Continued

While the question assumed that the employer would not be expected to provide the employee with remuneration for any penalties resulting from the employee's non-compliance with the ACA requirement to have insurance, candidates also received credit if they considered that if the member did not buy new insurance, they would be subject to 1% tax penalty or $95, whichever is greater.

Solution:

(a) Describe the portability provisions of the two major U.S. regulations affecting group health plan portability.

COBRA

- Allows continuation of group coverage after a qualifying event, such as termination of employment, divorce, child aging out
- Coverage can continue for up to 18 months (36 months in certain cases)
- Members pay the full premium plus up to a 2% administrative fee

HIPAA

- Limits a group's ability to impose pre-existing condition exclusions
- Allows conversion to a guarantee issue individual policy once COBRA coverage is exhausted
- Does not allow plan eligibility or premium payment to vary based on health status
- Requires special enrollment periods in the middle of the plan year under certain circumstances

(b) Explain whether the newly-hired employee under Scenario 1 above would be subject to a pre-existing condition exclusion for his surgery citing specific laws and regulations, assuming:

(i) the year of hire is 2013

The employee has been without coverage for 5 months. Under HIPAA, pre-existing condition exclusions can apply when the gap in coverage exceeds 63 days. Therefore the member is subject to the pre-existing condition exclusion period. The surgery would not be covered.

(ii) the year of hire is 2014

In 2014, the ACA is in effect. The ACA eliminated all pre-existing condition exclusion periods. The surgery would be covered.

(c) Calculate the annual salary adjustment necessary under Scenario 2 to give the employee equal compensation, net of medical expenses and applicable tax impacts, if this employee is no longer offered health insurance in 2014. Show your work.

4. Continued

The benefit offered by Spirit was worth $8,000, the exact amount of medical expenses since it was first dollar coverage and all premium was paid by Spirit.

Assume the employee does not buy other coverage, medical expenses stay at $8,000, and the employee now has to pay for all medical expenses.

Tax Implications:

- In 2014, only medical expenses above 10% of gross income are tax deductible.
- If employee does not buy other coverage, he is subject to tax penalty of 1% or $95, whichever is greater.

Calculation:

- Current compensation net of taxes and medical expense is $90,000 × (1-15%) = $76,500. Employee currently pays no premium and has no cost sharing.
- In 2014, employee must pay the entire $8,000 in medical expense.
- $8,000 is less than 10% of $90,000, so there will be no tax deductible medical expenses
- Revised post tax income required is $76,500 + $8,000 = $84,500
- Pre-tax salary required is $84,500 / (1 – 0.15) = $99,412.
  Note: $100,595 was also accepted ($84,500 / (1 – 0.15 – 0.01)) if the candidate considered the 1% penalty.
- Employee must be paid $9,412 more ($99,412 - $90,000) to be fully compensated for not being offered health insurance. As mentioned, $10,595 ($100,595 - $90,000) was also accepted if the candidate considered the 1% penalty.

5. Learning Objectives:

5. The candidate will understand how to prepare and interpret insurance company financial statements in accordance with U.S. Statutory Principles and GAAP.

Learning Outcomes:

(5c) Interpret the results of both statutory and GAAP statements from the viewpoint of various stakeholders, including regulators, senior management, investors.

Sources:

Group Insurance, Bluhm 6th Edition

- Chapter 21 Group Insurance Financial Reporting: U.S. & Canada

Analysis for Financial Management, Higgins, 10th Edition

- Chapter 3 Financial Forecasting
- Chapter 4 Managing Growth

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) Describe how statutory reporting differs from GAAP in the U.S. and Canada.

Commentary on Question:

Few candidates commented on Canadian GAAP vs. statutory reporting.
Very few identified that the focus on statutory is the balance sheet, while GAAP focus is the income statement.

US Statutory vs. GAAP

US Statutory requires filing in the NAIC statement

- Statutory emphasizes solvency (hence more conservative valuation of assets and liabilities) and the balance sheet
- GAAP emphasis the income statement

Where Statutory differs from GAAP:

- Statutory has more conservative reserving assumptions.
  - Statutory sets limits on interest rates, mortality and morbidity
  - GAAP has provisions for adverse deviation and allows lapses
- Statutory sets the method for asset values and what counts as admitted assets; GAAP uses market values
- Statutory doesn't allow DAC
- Statutory only partially recognizes deferred taxes
- Statutory requires AVR and IMR, which serve as cushions

Canada: Statutory = GAAP

5. Continued

(b) Compare the sustainable and actual growth rates for each of 2011, 2012 and 2013F, including an explanation of each component of sustainable growth and its impact on overall growth during the 3-year period. Show your work.

Commentary on Question:
Most candidates identified the key components (profit margin, retention, asset turnover, financial leverage). Only a few knew the translation between other financial measure (ROE, ROA), and identified the correct points in time. The majority of candidates confused sustainable growth with (revenue) growth. Very few commented on the components of sustainable growth and the interaction with overall (revenue) growth.

P = profit margin = net income / revenue (or premium)
R = retention ratio = (1 - dividend %); assume 100%
A = asset turnover = revenue (or premium) / assets EOY
T = leverage = assets EOY / equity BOY

BOY = beginning of the year
EOY = end of the year

OR, you can use ROE (BOY) × retention
OR, you can use ROA (BOY) × leverage × retention
OR, you can show ratio of retained earnings between 2 years

Calculate for each year 2011, 2012 and 2013, respectively, the sustainable growth, using the PRAT formula (show the numerator and denominator)

- Profit margin:
  - 2011: 11.5% ($115,000/$1,000,000)
  - 2012: 6.3% ($75,000/$1,200,000)
  - 2013: 5.7% ($85,000/$1,500,000)
- Retention: 100% both years
- Asset turnover:
  - 2011: 0.62 ($1,000,000/$1,615,000)
  - 2012: 0.46 ($1,200,000/$2,590,000)
  - 2013: 0.43 ($1,500,00/$3,475,000)
- Leverage:
  - 2011: 2.02 ($1,615,000/$800,000)
  - 2012: 2.83 ($2,590,000/$915,000)
  - 2013: 3.51 ($3,475,000/$990,000)
- Sustainable growth (product):
  - 2011: 14.4% (11.5% × 0.62 × 2.02)
  - 2012: 8.2% (6.3% × 0.46 × 2.83)
  - 2013: 8.6% (5.7% × 0.43 × 3.51)

5. Continued

- Actual growth (change in revenue or premium): 20% ($1,200,000/$1,000,000 - 1), 25% ($1,500,000/$1,200,000 - 1)

Therefore, actual growth > sustainable growth

At a minimum state that that over the 3-year period:
- Profit margin decreased significantly
- Asset turnover decreased (growth in premium is slower than asset growth)
- Leverage increased, but there's a limit to the amount of debt that a company can bear

(c) Describe strategies for Brother John to address differences between sustainable and actual growth.

Commentary on Question:
Strategies described should agree with the response in previous sub-question (b). Some candidates who were not able to arrive at a conclusion in (b) responded both ways (sustainable > actual growth, and sustainable < actual growth).

Because actual growth > sustainable growth, recommended strategies to slow down the actual growth include:
- Sell new equity (sell shares); this is difficult for companies to do
- Increase financial leverage (borrow); there's a limit to debt financing
- Lower dividends (currently 0%)
- Prune (sell) marginal activities (this lower sales)
- Outsource (higher asset turnover)
- Raise prices (premiums) to improve profit margins
- Merge with cash cow

(d) Critique the forecast provided by the company in light of the results of the last three years and prepare a list of questions for management to justify the forecast.

Commentary on Question:
Very few candidates showed calculations in 2014 and 2015. Other than profit margins and claim reserves, the majority of candidates did not comment on the patterns of the key financial measures (asset turnover, leverage; or the translated equivalents of ROA/ROE). Most interchanged sustainable and actual growth measures.

Many simply took ratios (loss ratios, expense ratios, tax ratios) and based their comments on these measures.

5. Continued

Calculate for each year 2014 and 2015, the PRAT (using the same basis as part c; show the numerator and denominator)

- Profit margin:
  - 2014F: 4.5% ($90,000/$2,000,000)
  - 2015F: 3.7% ($100,000/$2,700,000)
- Retention: 100% both years
- Asset turnover:
  - 2014F: 0.42 ($2,000,000/$4,765,000)
  - 2015F: 0.40 ($2,700,000/$6,765,000)
- Leverage:
  - 2014F: 4.4 ($4,765,000/$1,075,000)
  - 2015F: 5.8 ($6,765,000/$1,165,000)
- Sustainable growth (product):
  - 2014F: 8.4%
  - 2015F: 8.6%
- Actual growth forecasted: 33% ($2,000,000/$1,500,000 - 1), 35% ($2,700,000/$2,000,000 - 1)

Patterns

- Sustainable growth rates are similar/consistent in actual % as past 2 years (but are lower than actual growth)
- Actual growth rates are higher than past 2 years
- Profit margins continue to decrease
- Financial leverage (debt) continues to increase

Questions for management:

- Why is growth expected to increase/accelerate?
- How does one close the gap between actual and sustainable growth?
- Why does the profit margin continue to decrease?
- Why are claims and reserves both increasing? What assumptions were used?

6. Learning Objectives:

5. The candidate will understand how to prepare and interpret insurance company financial statements in accordance with U.S. Statutory Principles and GAAP.

Learning Outcomes:

Sources:
US GAAP for Life Insurers, Herget, 2nd Edition

- Chapter 10 Individual Life Insurance
- Chapter 12 Group Insurance, Large Case Pension Liabilities and Related Liabilities

Statement of Financial Accounting Standards No. 60 (excl. Appendix B)

Commentary on Question:
Commentary listed underneath question component.

Solution:

(a) Briefly describe the meaning of these terms in the context of GAAP financial reporting for your company with regard to A&H products:

(i) Long-duration contract

(ii) Short-duration contract

(iii) Long-term benefits

(iv) Short-term benefits

Commentary on Question:
Few candidates provided the definition of contract length based on financial reporting. Most candidates correctly defined long and short-term benefits.

(i) A long-duration contract's premium is recognized when due from policyholders; Liability recognized as present value of future expense minus present value of future premium.

(ii) A short-duration contract's premium is recognized in proportion to protection provided; Liability recognized as incurred, including estimates for IBNR.

(iii) Long term benefits may provide benefits to the policy holder over many years, like a long-term disability plan.

(iv) Short-term benefits provide benefits for a short period of time or an acute episode, like a major medical or dental plan.

6. Continued

(b) For each contract type, identify two A&H or group life products that have:

(i) Long-term benefits

(ii) Short-term benefits

Commentary on Question:
Most candidates only listed products specified by the length of the benefits but did not specify the length of the contract type when listing examples.

The following table provides an example (not comprehensive) of A&H or group life products for each type of contract and benefit type:

Contract Type	Benefit Type	
	Long-term	Short-term
Long-Duration	• Individual Long-Term Disability • Individual Long-Term Care	• Individual Major Medical • Individual Cancer (or other dread disease policy)
Short-Duration	• Group Long-Term Disability • Group Life Waiver of Premium	• Group Major Medical • Group Short-Term Disability

7. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   a. Group and individual medical, dental and pharmacy plans
   b. Group and individual long-term disability plans
   c. Group short-term disability plans
   d. Supplementary plans, like Medicare Supplement
   e. Group and Individual Long Term Care Insurance

2. The candidate will understand and recommend a manual rate for each of the coverages described in Learning Objective 1.

Learning Outcomes:

Sources:
Group Insurance, Bluhm, 6th Edition

- Chapter 9 Prescription Drug Benefits in the US
- Chapter 33 Estimating Medical Claims Costs

Commentary on Question:
Commentary listed underneath question component.

Solution:
(a) Explain how PBMs add value.

Commentary on Question:
Most candidates did well on listing the ways that PBMs can provide values. Credit was given for a variety of responses if the candidate explained how various items added value rather than just listing functions that PBMs perform.

PBMs provide value by:

- Negotiating contracts and developing pharmacy networks
- Negotiating better AWP discounts
- Giving advice on formulary design
- Providing MAC lists for generics

(b) Identify the main drivers of growth in pharmacy costs.

Commentary on Question:
Candidates performed well on this section in identifying drivers of the increase in Rx costs.

7. Continued

The growth in Rx costs has been driven by:

- New drug pipeline: Drugs continue to be developed at a rapid pace and are pharmaceutical companies are eager to recoup the Research & Development costs
- Biologics: Very expensive specialty/ injectable drugs
- Patents: These protect brand name drugs and can preventer cheaper, generic alternatives from being able to enter the market.
- Direct-to-consumer advertising increase the public's awareness and knowledge of drugs available
- Manufacturing cost-sharing offsets in the form of rebates make it easier for consumers to purchase pharmaceutical drugs
- Faster approval process by the FDA
- Aging population

(c) Explain reasons why pharmacy cost growth has slowed in recent years.

Commentary on Question:
Many candidates were able to identify reasons that Rx cost increase has started to slow. Others seemed to contradict what they had listed in part b, or listed their personal/general ideas and theories.

Rx cost increase has slowed in recent years because of:

- Wave of patent expirations: Additional generics have been able to come on the market as patents have expired on brand drugs
- Economy: Economic recession has led to decreased spending in several areas, including pharmaceuticals
- Lower overall spending in important therapeutic classes, such as Lipitor, and increased use of generics

(d) Recommend strategies, other than increasing co-payments or switching to coinsurance, your company could use to control increasing pharmacy benefit costs.

Commentary on Question:
Candidates recommended a variety of plan design, utilization control, and negotiation strategies to control Rx costs. We have included a sample of these actions in the model solution, but credit was given to other proposals as long as the candidate explained how this would mitigate cost increase.

7. Continued

Possible actions that could help control Rx cost increase are:

- Formularies
- Tiered benefit designs
- Value-based plan designs
- Limits on usage, which could include step therapy, and other utilization control mechanisms

(e) Construct a table with the projected unit cost and utilization levels for each of brand and generic drugs in 2013 and 2014. Show your work.

Commentary on Question:
Most candidates did well on the calculations in this section. This part of the question asked candidates to create a table (or two tables). Candidates who included the relevant formulas and numbers but did not create a table did not earn full credit. Some candidates missed the inclusion of the dispensing fee when calculating unit cost, earning only partial credit.

UNIT COST	2013	2014
Brand	\$80*0.85+\$1 = \$69.00	\$80*0.85*1.11 +\$1 = \$76.48
Generic	\$10*0.50+\$1.50 = \$6.50	\$10*0.50*1.02+\$1.50 = \$6.60

UTILIZATION	2013	2014
Brand	25.0*26% = 6.5	27.0*25% = 6.75
Generic	25.0*74% = 18.5	27.0*75% = 20.25

(f) Calculate the overall PMPM trend for 2014 with the existing PBM. Show your work.

Commentary on Question:
This section relied on the information calculated in the prior section. For those who correctly computed the numbers in part e, full credit was often earned here. For candidates who made a mistake in part e but still correctly applied the PMPM and trend formulas in this section, credit was still given as long as work was shown. Candidates who did not divide by 12 to get a PMPM did not receive full credit since the question specifically asked for the PMPMs.

The first step is to calculate the PMPM in 2013 and 2014 based on the information in the table above.

7. Continued

PMPM = (Unit Cost * Annual Utilization) / 12

2013 PMPM = ($69.00*6.5+$6.50*18.5) / 12 = $47.40

2014 PMPM = ($76.48*6.75+$6.60*20.25) / 12 = $54.16

Trend = $54.16 / $47.40 – 1 = 14.3%

(g) Evaluate whether switching PBMs would generate savings. Show your work and explain your conclusion.

Commentary on Question:
This section asked candidates to evaluate if switching PBMs would generate savings. Some candidates computed the new cost but did not assess how this compared to the PMPM calculated in part f. To receive full credit, candidates needed to show their new calculations and explain that this PBM would cost more than the current PBM. Full credit was given to candidates who identified that the reason for this was the decreased brand discount and the heavy weighting given to brand drugs.

First, calculate revised unit cost for 2014 under the new PBM:

UNIT COST	2014
Brand	$80*0.90*1.11 +$1+$1 = $81.92
Generic	$10*0.35*1.02+$1.50+$1 = $6.07

Revised 2014 PMPM = ($81.92*6.75 + $6.07*20.25) / 12 = $56.32

You should not switch PBMs because it results in a higher PMPM and switching will not generate savings.

Although the new PBM has deeper generic discounts, the brand discount is worse. Brand drugs have a much higher unit cost so, in total, they make up a greater portion of the overall PMPM which makes the overall cost with the new PBM not as good as with the current PBM.

8. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   a. Group and individual medical, dental and pharmacy plans
   b. Group and individual long-term disability plans
   c. Group short-term disability plans
   d. Supplementary plans, like Medicare Supplement
   e. Group and Individual Long Term Care Insurance

Learning Outcomes:

Sources:
Group Insurance, Bluhm, 6th Edition
- Chapter 4 Group Life Insurance

Commentary on Question:
Question tested basic understanding of plan provisions and tax considerations, both written calculations.

Solution:
(a) For group basic and group supplemental term life:

(i) Outline provisions common to both

Eligibility
- Full-time working minimum number of hours
- Actively at work
- Waiting period from hire date

Continuity of coverage
- Ability for insured to covert the group term insurance coverage to an individual life insurance policy upon termination of employment

Disability
- Waiver of premium for disability
- Total and permanent disability
- Extended death benefit

Benefit payment provisions
- Accelerated benefits
- Beneficiary
- Minimum participation

8. Continued

(ii) Compare the tax treatment applicable to Lovestar and its employees

First $50k of ER paid group term coverage is tax free
Amounts above $50k results in imputed income for EE
Premiums paid by employer are generally deductible on employers income tax return
Death benefits payable are excludable from a beneficiary's gross income

Group supplemental

- Generally EE pay all avoiding imputed income (if premium step rates are all at or below the Table I premium step rates or all at or above Table I premium step rates)
- Advantageous for basic and supplemental group life to be treated as separate plans

(b) Calculate the basic life renewal premium charged to Lovestar, assuming an administration and profit load equal to 20% of premium and a January 1 renewal date. Show your work.

Industry Adj applied at member level

Name	Salary		1,000		12		Manual Claims Rate		Industry Adj		Central Date Adj		Annual Claims	Name	Monthly Claims
Marie	$60,000	/	1,000	x	12	x	$0.05	x	1.05	x	1.00	=	$37.80	Marie	$3.15
Joel	$42,000	/	1,000	x	12	x	$0.12	x	1.05	x	1.00	=	$63.50	Joel	$5.29
Elise	$125,000	/	1,000	x	12	x	$0.15	x	1.05	x	1.00	=	$236.25	Elise	$19.69
Jenny	$70,000	/	1,000	x	12	x	$0.08	x	1.05	x	1.00	=	$70.56	Jenny	$5.88
Mike	$31,000	/	1,000	x	12	x	$0.64	x	1.05	x	1.00	=	$249.98	Mike	$20.83
													$658.09	Total Claims	$54.84
													20%	Retention/Load	
													$822.61	**Total Premium**	**$68.55**
													$0.2090	Monthly premium per $1,000 covered	

(c) Compare the annual imputed income for Marie and Joel. Show your work.

Marie = $0.06 x ($60 - $50) x 12 = $7.20 annual imputed income
Joel = no imputed income, coverage less than $50K

9. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   a. Group and individual medical, dental and pharmacy plans
   b. Group and individual long-term disability plans
   c. Group short-term disability plans
   d. Supplementary plans, like Medicare Supplement
   e. Group and Individual Long Term Care Insurance

Learning Outcomes:

(1c) Describe each of the coverages listed above.

(1e) Describe various markets for these products.

Sources:

Group Insurance, Bluhm, 6th Edition

- Chapter 5 Group Disability Benefits
- Chapter 10 Group Long Term Care Insurance

Commentary on Question:

In general, candidates performed better on sections (b) and (c) than on section (a).

Solution:

(a) Compare the U.S. group LTC market to the U.S. individual and Canadian LTC markets.

Commentary on Question:

In general, candidates had trouble with this section because they compared plan benefit differences rather than describing the various markets themselves.

- Market for LTC insurance in the U.S. is much more developed than the Canadian market because Canadian Medicare covers some long term care expenses
- The group LTC market in the U.S. is much smaller than the individual LTC market
- However, the group LTC insurance market has been growing at a rapid pace

(b) Describe plan provisions common to both LTC and LTD.

Commentary on Question:

This section is specifically asking for only plan provisions which are common between both coverages. Thus, candidates who supplied two separate lists with no commentary on the connection between the two, or candidates who listed plan provisions which are not common between the two coverages did not score as well as those who listed only common provisions.

9. Continued

- Both LTD and LTC have benefit triggers
  i. LTD: inability to perform material and substantial occupation duties
  ii. LTC: inability to perform ADLs
- Both have elimination periods
  i. Typical LTD elimination period is 3 or 6 months
  ii. Typical LTC is usually expressed in days and varies from zero to 365 days. The most common waiting periods are 30, 60, 90, and 100 days.
- Both have optional inflation protection
- Both have spousal benefits
- Both have death benefits
- Both have exclusions/limitations

(c) Critique the position of the executive team.

Commentary on Question:
In general, candidates performed well in this section.

- While LTC and LTD may have some similar plan provisions, they insure against very different events.
- Long term care insurance prefunds future expenses for skilled or custodial care and services—which may be due to accident or illness, but is commonly just from aging—when they cannot perform basic activities of daily living (ADLs).
- Disability insurance replaces lost income during working years (pre-65) when the member has had a serious accident or sickness.
- The LTC coverage to be offered will be voluntary, so other than administrative burden, there won't be any cost to Loony Lakes.

10. Learning Objectives:

2. The candidate will understand and recommend a manual rate for each of the coverages described in Learning Objective 1.

Learning Outcomes:

Sources:
GHC-102-13: Loss Ratios and Health Coverages, American Academy of Actuaries' Loss ratio Work Group

GHC-103-13: The Challenges of Pricing Health Insurance for the 2013 Exchanges

Commentary on Question:
This question was testing the candidate's understanding of the pricing of health insurance due to ACA, as well as how the newly promulgated Minimum Loss Ratio standards are used by different entities.

Solution:

(a) Summarize the changes created by the ACA and the associated pricing challenges in these markets.

Commentary on Question:
Many candidates did well on listing the changes created by ACA but did not note challenges, or when challenges were noted they were they were not challenges but instead descriptions of the rule or a reference that they were challenging.

Change #1: Expands private insurance coverage by

- Requiring guaranteed issue
- Mandating coverage
- Making premium subsidies available to lower-income people

Pricing Challenges: Predicting who will enter the exchange for various reasons: flux of previously uninsured, young/healthy may elect to pay the penalty, % of employers electing to stop providing coverage, etc.

Change #2: Requires new benefit designs to be offered

- Including four "metal levels" corresponding to different levels of actuarial value for a benchmark package of essential health benefits

Pricing Challenges: Benchmark plans are left to the states so there is uncertainty as to what the benefits will be; the potential for "rate shock" as the benefits will be richer for many as a result.

Change #3: Eliminates premium differentials by health status and gender and restricts age variation to a 3-to-1 ratio.
Pricing Challenges: Adverse selection may result when younger people see rates go up and older find coverage more affordable; Rules vary by state so selection effects are complicated.

10. Continued

Change #4: Contains three risk mitigation strategies
- Temporary reinsurance
- Risk corridors
- Risk adjustment program

Pricing Challenges: Full design parameters of these programs are unknown; limited data for actuaries to use to model expected impact.

Change #5: Adherance to Minimum Loss Ratio
- >80% SG and Individual

Pricing Challenges: Maintain admin and profitability while maintaining MLR. Additional administrative costs related to tracking MLR and paying rebates as necessary.

(b) Describe ways company management uses medical loss ratio information.

Measuring the financial performance of products
- By subgroup – individual vs. group, etc.
- Used to manage care provider groups

Preparing business plans that project earnings
- Can be used for applications for license for a new company or expansion to operate in a new jurisdiction
- Support filings for new or renewal rates and policy forms

Reporting information concerning results to policyholders such as employer groups
- Used by them for budgeting purposes, monitoring experience, and/or understanding rate increases

Setting incentive target earnings for management, employee, and provider compensation
- Agents and brokers may be compensated based on loss ratios
- Loss ratios may trigger payments to providers subject to profit sharing arrangements

(c) Describe considerations Derby*Health* should take into account when performing the loss ratio comparison.

- Plans/products, geographical footprint, and benefit designs
- Financial arrangements such as non-refunding and refunding as their loss ratios can present very different results
- How expenses are treated; for example, managed care organizations and commercial insurer treatment of medical care expenses as claims
- The effect of combining/pooling 'cells' in order to achieve credibility
- Reinsurance transactions

10. Continued

- The presence of conservatism in pricing and IBNR, particularly for new business or markets

(d) List ways regulators might use this information.

- Prospective rate reviews - determining if premiums are reasonable in relation to claims
- Retrospective rate reviews – e.g. refund calculations
- As an indicator of the insurer profitability
- As an indicator of insurer solvency

(e) Canetuckee's commissioner has questioned the proposed rate increases. Justify the 2014 rate increase for each line of business.

Commentary on Question:
Many candidates did well on this question. A relatively common oversight was not noting the lack of credibility for the small group line of business.

Individual
- The 9% increase is equal to the projected medical trend and expected to maintain an 80% loss ratio.
- Since this is at the ACA minimum, it's considered reasonable in relation to the benefits provided.

Small Group
- With 100 members, the block is not credible.
- MLR is higher than the ACA standard, but this may be due to a large claimant (or duration of existing membership, etc.)

11. Learning Objectives:

3. The candidate will understand how to recommend an employee benefit strategy.

Learning Outcomes:

Sources:
The Handbook of Employee Benefits, 7th Edition, Rosenbloom

- Chapter 24 Strategic Benefit Plan Management
- Chapter 25 Cafeteria Plan Design and Management, pages 671 - 699

Commentary on Question:
In the first part of the question, candidates were required to identify errors, applying knowledge of the rules surrounding cafeteria plans. In the second and third portions, the candidate was asked to "describe" considerations, requiring them to supply some demonstration of understanding rather than simply listing them from memory.

Solution:

(a) Identify and explain the conflicts and errors in Wally's email.

Commentary on Question:
This portion of the question required the highest level of thinking skills, and the scores reflected it. Responses clearly showed that candidates understood what was being asked, but the majority failed to score most of the available points for this section.

Errors and inconsistencies:

- LTC cannot be offered in a cafeteria plan
- Employees must be able to choose cash or a benefit
- Life insurance above $50,000 is taxable to employee
- Identity theft protection on FSA debit card is not optional
- FSA only for qualified medical expenses, not for paying medical premiums
- Welfare benefits (medical, etc.) still subject to ERISA, even though the cafeteria plan itself is not

(b) List the disadvantages of offering a cafeteria plan from an employer's perspective.

Commentary on Question:
Scores were fairly high on this portion of the test. Then again, it was the simplest to answer as it required little more than the regurgitation of a list.

Disadvantages to an employer:

- Costly to set up and administer
- More adverse selection likely
- For an FSA, the funds must be available any time during the year
- Must test for non-discrimination of benefits to get tax-free status

11. Continued

(c) Wally's brother, a part owner, questions your company's ability to administer benefits properly. Describe competencies in which a benefits director must be proficient.

Commentary on Question:
The vast majority of candidates successfully provided approximately half of the entries from the required list (9 items). However, approximately half of the candidates failed to provide relevant supporting details for more than two or three of these items.

Competencies:

- Benefits plan design – Help employers choose those that meet their objectives
- Communication – New employee orientation, special circumstances, etc
- Technology – Employee self-service site, etc
- Regulations – must stay up to date, including tax codes
- Reports to management, including measuring of achievement of HR objectives
- Monitor the external environment – including competitor trends, new technology

12. Learning Objectives:

2. The candidate will understand and recommend a manual rate for each of the coverages described in Learning Objective 1.

Learning Outcomes:

Sources:
GHC-101-13: Group Disability Insurance (Sections 4 & 7)

Commentary on Question:
Commentary listed underneath question component.

Solution:

(a) Describe sources of data your firm could use to develop independent premium rates.

Commentary on Question:
Most candidates listed general sources of data instead of describing sources specific to LTD pricing.

Sources of data your firm could use to develop independent premium rates include:

Insurer studies

- Use company's own LTD claims experience to conduct loss ratio studies and actual-to-expected incidence and termination rate studies

TSA Reports – 1984 Reports

- Containing annual claim incidence rates per 1,000 by age group, gender and elimination period and ratios of actual to tabular incidence rates

SOA 2000 Basic Experience Table

- Intercompany studies performed by the SOA Disability Experience committee

1987 Commissioners Group Disability Table

- Includes rates that vary by gender and elimination period

(b) Identify plan design features for which you would adjust the manual rates.

Commentary on Question:
Most candidates did well on this part of the question and identified enough plan features to receive full credit. Rating factors, instead of plan features, received no credit (e.g. geography, age, gender, etc.)

12. Continued

Plan design features for which you would adjust the manual rates could include:

- Benefit Percentage
- Maximum Benefit
- Minimum Benefit
- Elimination Period
- Benefit Period
- Definition of Disability
- Offsets from various sources
- Limits on Mental Health and Drug and Alcoholism
- Optional Features (pension, survivor, COLA)
- Underwriting Variations

(c) Calculate the monthly premium for $5,000 of monthly benefit based on the above information. Show your work.

Commentary on Question:
Some candidates calculated an annual premium instead of monthly. To receive full credit, the calculation of a monthly premium needed to be shown.

Given information:

- Reserve at time 0 is $50
- Incidence rate is 0.004

Monthly Premium
= \$5,000 * Base Rate$_{35, m, 90, 65}$ / 12
= \$5,000 * $I_{35,m,90}$ * Reserve$_{35, m, 90, 0}$ / 12
= \$5,000 * 0.0040 * \$50 / 12
= \$83.33