

GH CORU Model Solutions

Spring 2014

1. Learning Objectives:

4. The candidate will understand how to describe Government Programs providing Health and Disability Benefits in the U.S.
6. Evaluate the impact of regulation and taxation on companies and plan sponsors in the U.S.

Learning Outcomes:

- (4a) Describe benefits and eligibility requirements for:
 - (i) Medicare, including Part D
 - (ii) Social Security, including disability income
 - (iii) Medicaid
- (6a) Describe the regulatory and policy making process in the U.S.
- (6b) Describe the major applicable laws and regulations and evaluate their impact.

Sources:

The syllabus material included Bluhm, chapters 15 and 17.

Commentary on Question:

The question tested the candidate's ability to evaluate the impact of regulation on insurance companies and plan sponsors inside the U.S. The candidate was required to show a basic understanding of some of the historical laws as well as recent laws which are impacting the current environment. The candidate was also required to have an understanding of how these laws challenge the federal and state regulators and the decisions each must make.

Solution:

- (a) Outline each of the following acts and comment on how each one impacted the balance of regulatory power over health insurance in the United States.
 - (i) McCarran-Ferguson Act of 1945
 - (ii) Federal HMO Act of 1973
 - (iii) Employee Retirement Income Security Act of 1974
 - (iv) Health Insurance Portability & Accountability Act of 1996

1. Continued

Commentary on Question:

1.(a) To receive full credit, candidates needed to demonstrate a basic knowledge of the applicable Acts AND describe how each affected the balance of regulator power between federal and state governments. Candidates didn't receive full credit if they only listed what each Act covered and did not show an understanding of how the Acts impacted the balance of power.

- (i) This Act overturned the Supreme Court ruling that had previously given the federal government regulatory authority over interstate insurance transactions. It was significant in that it put virtually all health insurance regulation in the hands of the states.
 - (ii) This Act was created to promote the growth of HMO's. Federally qualified HMO's were exempt from state laws that prevented them from acting as an HMO. This Act shifted regulatory power away from the states and back to the federal government.
 - (iii) This Act imposed reporting and disclosure requirements (ex. Form 5500) on employers who sponsor welfare benefit plans. Other requirements include a plan fiduciary and Summary Plan Description. This Act shifted more regulatory power back to the federal government.
 - (iv) This Act focused on three areas: 1) Insurance Portability and Availability, 2) Health Insurance Fraud and Abuse, and 3) Administrative Simplification. This Act allows federal regulations to govern when no state laws are present.
- (b) Identify decisions that states must make with respect to ACA-required exchanges, and explain which three are the most important. Justify your answer.

Commentary on Question:

Most candidates identified the decisions a state must make. There was no right or wrong answer in picking the three most important as long as the candidate provided justification for their decision as it relates to the HBE.

- 1) Should the State Establish an HBE?
- 2) How will the State Govern the HBE?
- 3) Should the State Require Carrier Participation in the HBE?
- 4) How will the State Control Antiselection?
- 5) Should the State Offer a Basic Health Plan?

1. Continued

Most Important:

- 1) If a state chooses not to establish and HBE the federal government is required to set one up for them. A federal program may not meet the needs of the residents of the particular state. This could have political consequences.
 - 2) Antiselection: If the HBE enrolls participants who are less healthy than those who do not participate in the HBE, premium rates within the HBE will eventually increase to a point where they are not competitive. This will eventually lead to the destruction of the HBE.
 - 3) BHP: A state may wish to offer a separate health plan for residents who fall below 200% of FPL. This might provide this class with a richer benefit or lower premiums but it would remove a significant population from the HBE which could diminish the success of the HBE.
- (c) Compare and contrast federal and state opportunities to mitigate anti-selection on health benefit exchanges.

Commentary on Question:

Many candidates listed one or two federal and state opportunities. Candidates who received full credit listed three or four opportunities for each and distinguished between the overall goals at the state and federal levels.

- Federal – focuses on max enrollment and consistency between plans:
 1. Individual Mandate – requiring all people to be covered
 2. Premium Subsidies / Cost Sharing for low income individuals helps increase the size of the HBE
 3. Establishing plan and pricing rules for plans inside and outside the HBE
 4. Risk Adjustment – plans with healthier participants subsidize plans with less healthy participants
- State – focuses on carrier participation, benefit offerings, and pricing:
 1. Focus on maximizing carrier participation in the HBE
 2. Can prohibit a carrier from re-entering the HBE for a period of time if the carrier drops out of the HBE
 3. Restrict benefit plans offered outside the HBE
 4. Ensure consistency of rates inside and outside the HBE

2. 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:

Chapter 3, Bluhm – Group Insurance

Commentary on Question:

The purpose of this question was to test candidates' understanding how ACA impacts insurers, specifically as it relates to added costs (taxes, fees and assessments).

Solution:

Describe the ACA-related items you need to include in your retention load, including their purpose, and their applicability to each product.

Commentary on Question:

Most candidates only gave one or two of the fees/taxes/assessments that are related to ACA instead of the entire array. Many did not elaborate on the purpose of the fees and the impact/applicability to each of the products. Also, many candidates included non-ACA related item, which is not relevant to this question.

- Health Insurer Tax
 - new tax of \$8 billion in 2014 (\$8 billion in 2014, increasing to \$14.3 in 2018 and indexed thereafter) to be used to fund various ACA provisions
 - not-for-profits pay 50% of the assessment and certain plans pay 0% so we pay 100%
 - assessed across all health insurance sector but not assessed on ASO products so applies to individual and small group insured but not on large group ASO
- Excise Tax for High Cost Health Plans
 - New tax on rich plans equal to 40% of the excess costs over \$10,200 single (\$27,500 family)
 - Tax is to discourage overly rich coverage (as well as just a source of funds for other ACA provisions)
 - Tax doesn't apply until 1/1/2018 so not applicable for any of the coverage for 2014 pricing
- Reinsurer Fee
 - Used to pay for high risk members in the individual products but funded assessed across all products, including ASO.
 - Covers 80% of the expense between \$60K and \$250K
 - So, all three products need to include an estimate of this fee in their retention but you should also factor in any expected recoveries on the individual product claims projections

2. Continued

- Patient Centered Outcomes Research Institute Assessment
 - Fee paid to cover the cost of this new not-for-profit institute on the clinical effectiveness of medical treatments
 - Assessed on health plans and employers so should be included in retention for all three products
- Health Benefit Exchange Fee
 - Amount paid to exchange for its services (marketing, enrollment, subsidy checking, etc.)
 - Since offering individual and small group products off and on the exchange, need to estimate % that will be sold on the exchange so that you can calculate the average amount to include in retention
 - Do not need to include in large group ASO retention since it is not sold on the exchange
- Underwriting assessments / requirements (**Many candidates included the below information and were awarded partial points**)
 - ACA now requires insurers to only underwrite based on age (3:1); tobacco usage (1.5:1), geography and family tier
 - Eligibility rule changes – must offer coverage to children up to age 26; guarantee issue and renewability
 - Plan design restrictions: no pre-existing conditions, no lifetime maximums, preventive care at 100%, cover essential health benefits. Exchanges plans follow metallic plans (platinum, gold, silver, bronze)
 - Rebates to plans if MLR are not met; Individual / Small Group = 80% MLR; Large Group = 85% MLR

3. Learning Objectives:

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

Learning Outcomes:

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

Sources:

Payment Reform Under the Medicare-Medicaid Financial Alignment Demonstrations, Health Watch, May 2013

Bluhm Chapter 13 – Group Insurance

Commentary on Question:

Candidate should recognize the question was asking for responses from an insurance company point of view.

Solution:

- (a) Prepare a brief memo for Golden Boomers' management that describes the differences between a dual-eligible SNP plan and a Medicare-Medicaid Financial Alignment Demonstration.

Commentary on Question:

Candidate should describe the two programs and note the fundamental differences; focusing on populations and services covered, role of managed care, payment mechanism, and purpose of the program.

- D-SNPs
 - Provide coordinated provider network and schedule of benefits across Medicare and Medicaid to dual eligibles
 - But level of integration varies across states
 - Federal contract for Medicare benefits
 - Health plan may or may not be at risk for Medicaid-covered services under separate contract with the state
 - Medicare and Medicaid revenue streams are kept separate
 - Prospective payments based on plan's bid
- Medicare Financial Alignment plans
 - Fully coordinated care for dual eligibles
 - Medicare and Medicaid revenues are combined and savings are shared between state and federal government
 - Capitated model – three way contract between plan, state, and CMS; prospective payments that anticipate savings; health plan is fully responsible for providing integrated Medicare and Medicaid benefits;

3. Continued

plans receive separate caps for Medicare A/B, Medicaid, and Medicare Part D, quality withhold on Medicare A/B and Medicaid pieces

- Managed FFS Model – state is responsible for establishing program to coordinate care for duals; in return state will be eligible for share of savings based on retrospective measurement as long as quality thresholds are met

- (b) Identify sources of potential savings from Medicare-Medicaid Financial Alignment Demonstrations.

Commentary on Question:

Candidate should focus on the benefits being coordinated and how managed care organizations will help reduce costs in those areas. Important to list each area of savings and what savings mechanism will generate savings.

Savings sources

- Acute
 - Coordinate treatment of multiple chronic conditions
 - Provide care in most appropriate setting, emphasizing community-based care
 - Reduce or eliminate unnecessary tests or procedures
 - Better manage ambulatory sensitive admissions to reduce avoidable emergency room visits and inpatient admissions or readmissions
- Behavioral Health
 - Improve coordination between Medicare and Medicaid with emphasis on community-based care
- Long-term care
 - Delay members entry in to nursing homes by use of HCBS waiver services
 - Discourage unnecessary hospital admissions from nursing homes
- Admin
 - Increase enrollment in order to help spread fixed costs
 - Reduce marketing costs
 - Integrate Medicare and Medicaid appeals process

- (c) State reasons why savings may vary from state to state under a Medicare-Medicaid Financial Alignment Demonstration Plan.

Commentary on Question:

Candidate should focus on population and services being represented under the Demonstration and how differences in State Medicaid programs may attribute to variations in savings.

3. Continued

Reasons for variations in savings

- Populations included under the demonstration may vary
- Services covered under the demonstration may vary
- Penetration of managed care prior to implementation of demo varies
- Historical acute care and long-term care utilization pattern of the targeted population
- Other State Medicaid program structure differences not listed above

(d) Explain how the following laws have impacted the payments made by the Centers for Medicare and Medicaid Services (CMS) to Medicare Advantage plans.

- (i) The Tax Equity and Fiscal Responsibility Act of 1984 (TEFRA)
- (ii) The Balanced Budget Act of 1997 (BBA)
- (iii) Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA)
- (iv) Affordable Care Act (ACA)

Commentary on Question:

Question is looking at these laws from the point of view of a managed care organization called Golden Boomers. So the candidate should focus on how these laws impacted managed care organizations, not employers or providers.

- (i) TEFRA
 - introduced concept of risk contracting with managed care organizations
 - set payment at 95% of FFS costs
- (ii) Balanced Budget Act of 1997
 - created Medicare + choices program and reduced payments to private health plans in attempt to address issue that HMOs had been overpaid due to favorable selection
 - added risk adjustment (first PIP-DCG, later CMS-HCCs)
- (iii) Medicare Prescription Drug, Improvement and Modernization Act of 2013
 - created Medicare Part D which expands the revenue (and the costs too)
 - increase MA payments rates in certain parts of country, and required payment rates to keep pace with FFS Medicare
 - added bidding approach introduced with 75% of savings kept by plan

3. Continued

- (iv) Accountable Care Act
 - new blended benchmarks that are included bonus and savings percentages that are impacted by quality ratings (stars)
 - added 85% MLR requirement as of 2014
- (e) Calculate the projected 2014 capitation payment, net of withholds, for Bloom County under a Medicare-Medicaid Financial Alignment Demonstration using the following assumptions provided by CMS and the state's actuary.

Commentary on Question:

Candidate should understand the different rate components and how to calculate each.

- Develop baseline costs
 - Medicare A/B – projected costs will reflect expected mix of FFS and MA members enrolling and the appropriate expected costs (FFS costs versus plan specific MA quality-adjusted benchmark)
 - Medicaid – projected costs for Medicaid in absence of demonstration (managed care capitation or trend FFS costs); likely to provide a financial incentive to provide HCBS services in lieu of institutional placement – couple of approaches
 - Medicare Part D – national average bid; special treatment to allow MMP plans to reduce cost sharing for LI without forfeiting LICS subsidies
- Apply savings percentages to Medicare A/B and Medicaid
- Apply withhold percentages to Medicare A/B and Medicaid
- Apply any prospective risk adjustment mechanism (e.g., HCC or RxHCC Medicare risk adjustment)

Projected Capitation = Medicare a/B Capitation + Medicare Part D Capitation + Medicaid Capitation

Medicare Capitation = $(1.1 \times \$1,000 \times 10\% + 1.1 \times (1 - 4.91\%) \times \$920 \times (1 - 10\%)) \times 98\% \times 95\%$

Medicare Part D Capitation = $\$78 \times 1.2$

Medicaid Capitation = $\$500 \times 98\% \times 95\%$

4. Learning Objectives:

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

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

Learning Outcomes:

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

Sources:

Group Insurance

- Chapter 25: Cafeteria Plan Design and Administration
- Chapter 17: Health Benefit Exchanges and Connectors (page 264-265)
- Chapter 20: Federal Regulation and Taxation of Employer-Sponsored Group Insurance Benefits

GHC801-13: US Health Insurance Taxation

Commentary on Question:

Candidates generally met expectations when responding to parts (b) through (e) but struggled to compare and contrast differences in part (a). Discussion of both types of plans in part (a), identification of applicable options under parts (b) through (d), and a reasonable description of how the laws apply to John's family received maximum points.

Solution:

- (a) Describe differences between “simple cafeteria plans” and traditional cafeteria plans.

Commentary on Question:

Many candidates stated facts about simple cafeteria plans and traditional cafeteria plans, but didn't always describe the differences between the two.

4. Continued

Item	Simple	Traditional
Established	By ACA for plan years after 12/31/2010	By Revenue Act of 1978
Applies to	Can be set up by employers with 100 or fewer employees during the preceding two years (or, if the employer has not been in existence for two years), based on average number of employees it reasonably expects to employ in the current year- must terminate when average number of employees equals or exceeds 200	Can be set up by any size employer except for self-employed individuals described in Section 401(c), including sole proprietors, partners in a partnership, and 2 percent or greater shareholders in an S-corporation
Eligibility	All employees who were credited with at least 1,000 hours of service for the preceding year	<ul style="list-style-type: none"> • Present or former employees' include common, law employees, leased employees, and fulltime life insurance salesmen • Retirees are not permitted to pay for medical coverage on a pre-tax basis through a cafeteria plan using qualified retirement plan contributions • No outside directors and no employees of marketing partners or any other company not within the controlled group can participate unless the cafeteria plan is structured as a multiple employer welfare plan
Exclusions	Can exclude certain classes of employees (e.g., those under age 21 before the close the plan year, those who are covered under a collective bargaining agreement, nonresident aliens working outside the US)	<ul style="list-style-type: none"> • Can exclude employees who have not completed three years of employment and may be excluded as long as participation begins no later than the first day of the first plan year beginning after the three-year requirement has been satisfied. • Can exclude other categories of employees, as long as it does not discriminate in favor of a prohibited group of employees that includes owners and highly paid individuals.
Exclusion Application	Applied throughout the plan year	Met before initial plan year of participation
Employer Contribution	Required whether or not the participant enters in to a salary deferral election	Not required
Contribution Minimum	Percentage $\geq 2\%$ of each qualified employee's compensation or Amount equal to lesser of 6% of qualified employee's salary or twice the salary-reduction contribution of each qualified employee	No minimum required

4. Continued

Discrimination Testing	If passes the eligibility and contribution requirements, there is a safe harbor and doesn't have to do Section 125 eligibility, contribution, benefits, and key employee contribution tests; also means satisfies Section 79 group term life insurance, Section 105 self-insured medical expense reimbursement plan and dependent care assistance requirements	<ul style="list-style-type: none"> • An eligibility test, including a classification test, a length of services test, a participation test, a facts and circumstances determination – cannot discriminate in favor of highly compensated in terms of eligibility • A contributions and benefits test – cannot discriminate in favor of highly compensated in terms of availability and utilization • The key employee concentration test – cannot provide benefits to key employees that are worth more than 25% of the aggregate benefits provided all employees.
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- (b) Describe the options and calculate costs for medical coverage available on January 2, 2014 to:
- (i) Mary,
 - (ii) Barry,
 - (iii) Mary, if John had died on December 1, 2013.

Commentary on Question:

Most candidates were successful in identifying the options available for Mary and Barry in each scenario. In addition to the options below, opting out of the Health Exchange Plan was also considered an acceptable response. Most were also successful in calculating the costs associated with each. Candidates who were not successful generally did not discuss the age restrictions which excluded Mary and Barry from coverage with TGIFJ and OGC, respectively.

	TGIFJ Employer Plan	John's OGC Plan	Health Exchange Plan
Mary	(Option) – Mary cannot enroll in her employer's plan since she is under 21. (Cost) – N/A	(Option) – She can enroll in John's plan since she is under age 26. (Cost) – \$0 since John is already paying for family coverage.	(Option) – She can enroll in an individual plan via the Exchange. (Cost) – \$2,900 since she earns more than 400% of the FPL and is not eligible for premium subsidies.

4. Continued

Barry	(Option) – Barry can enroll in his employer’s plan since he is over 21. (Cost) – The employer pays $2\% \times \$60,000 = \$1,200$ towards medical coverage; he pays the remaining \$1,800.	(Option) – He cannot enroll in John’s plan since he is over age 26. (Cost) – N/A	(Option) – He can enroll in an individual plan via the Exchange. (Cost) – \$2,900 since she earns more than 400% of the FPL and is not eligible for premium subsidies.
Mary, if John had died on December 1, 2013	(Option) – Mary cannot enroll in her employer’s plan since she is under 21. (Cost) – N/A	(Option) – She cannot stay on John’s plan at \$0 since he is no longer alive. She can sign up for COBRA on John’s plan. (Cost) – She will pay 102% of the cost of single coverage ($1.02 \times \$2,600$) = \$2,652	(Option) – She can enroll in an individual plan via the Exchange. (Cost) – \$2,900 since she earns more than 400% of the FPL and is not eligible for premium subsidies.

- (c) Identify the lowest cost option in (b)(i), (b)(ii), and (b)(iii).

Commentary on Question:

Most candidates were successful in identifying the lowest cost option in each of the three parts from part b. A common mistake made by candidates was choosing a singular subsection from part b as the lowest cost option rather than identifying the lowest cost option for each subsection.

- (i) Staying on John’s plan as a dependent is the least expensive option for Mary (\$0) and will be until she turns 27.
 - (ii) Enrolling in his employer plan is the least expensive option for Barry (\$1,800 per year).
 - (iii) Signing up for COBRA will be the cheapest option for Mary (\$2,652 per year).
- (d) Describe the changes John may make during 2014 to his cafeteria plan benefits if, instead of John dying on December 1, 2013, John learned on February 14, 2014 that his wife Jane is pregnant with a due date of October 1, 2014.

Commentary on Question:

Many candidates were able to describe applicable benefit changes. Those who didn’t focused on describing a time table for making changes in lieu of describing specific benefits changes.

4. Continued

Once the baby is born, John can change his elections related to:

- Accident and health coverage (medical, dental, short-term disability, long-term disability)
- Dependent care expenses
- Group term life insurance
- Adoption assistance

(e) Describe how the following laws may apply to John's family assuming his wife is pregnant with a due date of October 1, 2014.

- (i) The Family And Medical Leave Act of 1993
- (ii) The Newborns' and Mothers' Health Protection Act of 1996
- (iii) Michelle's Law
- (iv) Mental Health Parity Act of 1996

Commentary on Question:

Most candidates who knew the laws were successful in describing them, but didn't always describe how they may apply to John's family.

- (i) John can take up to 12 weeks of unpaid time off to care for the new baby. His employer would have to continue to pay for its portion of his health insurance during that time.
- (ii) His wife will be able to stay 48 hours after a vaginal delivery and 96 hours after a C-section.
- (iii) If Mary had become ill with a serious condition and lost student status before graduating, she would be able to continue as a dependent on John's plan.
- (iv) If John or anyone in his family needs mental health treatment, such as his wife for post-partum depression, the cost sharing for mental health treatment is no different than for other services, with no annual max.

5. Learning Objectives:

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

Learning Outcomes:

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

Sources:

Kongstvedt, Essentials of Managed Health Care Ch. 25: Medicaid Managed Health Care

Commentary on Question:

Commentary listed underneath question component.

Solution:

- (a)
 - (i) List examples of services covered under a Section 1915(c) Home and Community-Based Services Waiver, and
 - (ii) List federal requirements for states choosing to implement the waiver.

Commentary on Question:

This asks about HCBS waiver coverage and not what is covered under a Medicaid as a whole.

The candidate did not need to remember the whole list to receive full credit.

- (i) Adult Day Care
Respite Care
Personal Care
Training of a Caregiver
 - (ii) Waiver is no more costly than FFS.
The program ensures that measures are taken to protect the health and welfare of consumers
- (b) Describe elements of effective managed Long-Term Care models.

Commentary on Question:

Note the verb describe. Simply listing elements without descriptions was not sufficient – particularly for an element such as “rates”.

5. Continued

Population – cover as broad a population as possible

Benefits – cover all of Medicare and Medicaid at least.

Program design – the program should demonstrate savings.

Rates – Design reimbursement rates to encourage care in a community setting and to discourage use of more expensive institutional care.

Authority – The waiver should have the authority to ensure adequate access to cost effective waiver services

Identification and Stratification. – Members are interviewed early in the process and are identified as high risk in order to make sure they are in a program that meets their needs.

Transition Care – There is a care team to make sure that transitions from care settings are smooth and the member can stay in the community.

Care Management – a team of providers makes a coordinated care plan that includes many types of providers and is culturally sensitive.

Comprehensive Care management – The care plan should go beyond regular medical benefits.

- (c) Recommend changes to the current program in order to reduce the overall cost to Untitled State. Justify your answer and show your work.

Commentary on Question:

To receive full credit, candidates needed to recognize that Speedy Recoveries controls placement of patients. A common mistake was to assert that Untitled State should simply move patients out of nursing homes to HCBS. An alternative series of recommendations could be more programmatic than the one shown here, with a focus on coordinated care and broad community based programs to support members so that they could stay at home.

Untitled State needs to encourage more utilization of HCBS. Untitled State currently reimburses Speedy in a way that incentivizes placement in nursing homes (Speedy makes a \$50 margin on nursing homes but only \$25 on HCBS). Raising HCBS placement reimbursement by \$25 and lowering nursing home placement reimbursement by \$25 will reverse this incentive.

Current costs to Untitled State are $9500(\$350) + 500(\$150) = \$3,400,000$.

By changing reimbursement schedule, new costs will be $9500(\$325) + 500(\$175) = \$3,175,000$. Savings = \$225,000

Further savings may be achieved if all available waiver slots are used. Currently only 500 of 1,000 slots are being used. Since up to 3,000 could receive HCBS, even greater savings could be achieved if the number of slots were increased to at least 3,000. The new incentive structure would encourage placement to those additional slots as well.

6. 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:

Academy Issue Brief “Risk adjustment and other risk sharing provisions of the ACA”
Bluhm 33

Commentary on Question:

Commentary listed underneath question component.

Solution:

- (a) Describe the following three provisions of the Affordable Care Act, including the markets and timeframes in which they apply:
 - Risk Sharing
 - Reinsurance
 - Risk Corridor

Commentary on Question:

This was a straightforward definition question. Define each program, the timeframes and if it applied to Small Group, Individual or both. Risk adjustment isn't the government paying for high risk members; it is a pool where insurance companies with lower than average risk contribute and insurance companies with higher than average risk withdraw. Reinsurance is related to specific claims not to high risk individuals.

- Risk adjustment:
 - A tool used to redistribute total payments across health plans to account for the relative risk of plan participants
 - Mitigate anti-selection among insurers; help ensure plans are appropriately compensated for risks they enroll
 - Applies to non-grandfathered small group and individual, on and off exchange
 - Permanent beginning in 2014
- Reinsurance:
 - Protect individual market plans against financial losses from individuals with unusually high claims
 - Funds for those payments will be collected from all individual and group plans, including grandfathered plans and self-funded plans
 - Applies to non-grandfathered individual market plans, on and off exchange
 - Applies 2014 – 2016

6. Continued

- Risk Corridor:
 - Temporary program to limit gains and losses for insurers
 - Applies to individual and small group plans on exchanges
 - Applies 2014 - 2016
- (b) Determine the reinsurance benefit for the block of business under the Reinsurance provision of the ACA. Show your work.

Commentary on Question:

Most candidates understood how the reinsurance should apply, but had trouble working with the probability distribution table. Reinsurance does apply to claims over \$250,000.

Step 1: determine excess above \$60,000

Accumulated cost above \$60,000 = \$1,300, frequency above \$60,000 = .95%

Excess cost = $\$1,300 - 60,000 \times .95\% = \730

Step 2: determine excess above \$250,000

Accumulated cost above \$250,000 = \$175, frequency above \$250,000 = .05%

Excess cost = $\$175 - \$250,000 \times .05\% = \$50$

Step 3: determine value of claims in reinsurance range

Value between \$60,000 and \$250,000 = $\$730 - \$50 = \$680$

Step 4: Reinsurance pays 80% of claims between \$60,000 and \$250,000

So pays $80\% \times \$680 = \544 per member

Total reinsurance payment is $10,000 \times \$544 = \$5,440,000$

- (c) Calculate the amount due to IPRIC under the ACA Risk Corridor provision. Show your work.

Commentary on Question:

Risk corridor compares a target claim amount to net claims. It is not based on loss ratios.

Step 1 Determine Target

Target = Premiums – Administrative cost = $\$69,000,000 - \$12,000,000 = \$57,000,000$

Step 2: Determine net claims

Total claims = premium \times unadjusted loss ratio = $\$69,000,000 \times 105\% = \$72,450,000$

6. Continued

Net claims = total claims – reinsurance payment - risk adjustment received =
 $\$72,450,000 - \$5,440,000 - \$3,000,000 = \$64,010,000$

Step 3: Determine ratio of net claims to target

$112.3\% = \$64,010,000 / \$57,000,000$ 1.122982456

Step 4 (4 points): Determine payment

Gov't pays 50% of loss from 103% - 108%, 80% of loss above 108%

$50\% \times [108\% - 103\%] \times \$57,000,000 = \$1,425,000$

$80\% \times [112.3\% - 108\%] \times \$57,000,000 = \$1,959,888$

Total Risk Corridor: Gov't pays \$3,384,888

7. Learning Objectives:

7. The candidate will understand and evaluate Retiree Group and Life Benefits in the United States.

Learning Outcomes:

- (7b) Determine appropriate baseline assumptions for benefits and population
- (7c) Determine employer liabilities for retiree benefits under various accounting standards

Sources:

Yamamoto Ch. 9, ASB 6000

Towers Watson IAS vs. FAS summary, IAS 19, Yamamoto CH. 7

Overview of Post Retirement Benefit Calculations

Commentary on Question:

The question is testing candidates' understanding of developing reasonable key assumptions for retiree group benefits plan valuation as well as the accounting knowledge for the calculation accrued benefit obligations, and the treatment actuarial gains and losses and plan amendments.

Solution:

- (a) Explain how you would validate each of your manager's assumptions and the sources you would reference.

Commentary on Question:

Candidates were required to provide a description of at least one way to validate the assumption as opposed to simply listing the assumptions.

1. Discount rate: rate is based on high quality fixed income investments that are currently available in the market so I would compare the assumption to benchmark indices and also use the rule of thumb that these often fall 2% to 4% above inflation
2. Trend rate: I would compare this against recent claims experience trends and long term expectations relative to the inflation rate and the long term expectation of GDP growth.
3. Claims cost: I would collect the claims data for the current retiree population and compare the per capita cost for versus the assumption provided.
4. Termination rates: I would collect what data was available for the group in terms of historical turnover and compare that to the annualized assumption provided.

7. Continued

5. Retirement age: I would collect actual retirement data to validate the average retirement age for employees and compare that against the assumption.
6. Age 65 annuity: Effectively this assumption is using the provided trend and discount rate and simplifying the mortality component. I would convert the rate to a life expectancy and compare that against various mortality tables available from SOA studies.

(b) Calculate the Accrued Benefit Obligation. Show your work.

Commentary on Question:

Candidates were required to show work to receive full credit.

Group	Number	Per Capita Present Value from 65	Per Capita EBO at Valuation	Total EBO at Valuation
A	B	C	D	E
Active	500	6,000	2,966	1,483,000
Retiree	200	6,000	6,000	1,200,000
Group	Hire Age	Total Service at Retirement	ABO Factor	Total ABO at Valuation
A	F	G	H	I
Active	40	25	0.2	296,600
Retiree	n/a	n/a	1.0	1,200,000
Total				1,496,600

$$C = \text{claims cost} \times \text{annuity factor} = 500 \times 12$$

$$D = C \times \left\{ \left[\frac{1+\text{trend}}{1+\text{discount}} \right]^{\text{years to 65}} \times (1-\text{termination rate})^{\text{years to 65}} \right\}$$

For retirees no adjustment required as “years” = 0

$$\text{For actives} = 6,000 \times [1.045/1.05]^{20} \times .97^{20} = 2,966$$

$$E = B \times D$$

$$F = \text{current age} - \text{current service} = 45 - 5$$

$$G = \text{retirement age} - \text{hire age} = 65 - 40$$

H = current service / service at retirement for actives and fully attributed for retirees

$$I = \text{EBO at valuation} \times \text{ABO factor}$$

7. Continued

- (c) An assumption change has increased the annual claims cost per capita to \$600. Calculate the annual accounting expense under both IAS 19 (2008) and FAS 106 assuming the minimum amortization allowed by each accounting standard. State all assumptions and show your work.

The minimum amortization amount under both accounting standards is the same. The approach used is the 10% corridor approach. Therefore the total accounting expense is equal under both approaches.

Due to the increase in claims cost an actuarial loss arises equal to the percentage change in claims cost $(600/500 - 1) = 20\%$

$$\text{Loss} = 0.20 \times 1,496,600 = 299,320$$

$$\text{New ABO} = 1,795,920$$

Service cost = EBO / average years of service at retirement for actives and zero for retirees

$$\text{New Service cost} = 1,483,000 \times 1.2 / 25 = 71,184$$

$$\text{New Expected Benefit Payments} = \text{retirees} \times \text{claims cost} = 200 \times 600 = 120,000$$

Interest cost = discount rate \times (ABO + Service Cost – Expected Benefit Payments/2)

$$\text{Interest cost} = .05 \times (1,795,920 + 71,184 - 120,000/2) = 90,355$$

Minimum amortization = (Loss – 10% \times New ABO) / expected average remaining service lifetime = $(299,320 - 0.10 \times 1,795,920) / 20 = 5,986$

$$\text{Accounting expense} = \text{service cost} + \text{interest cost} + \text{amortization} = 167,525$$

- (d) A plan design change has increased the annual claims cost per capita to \$600. Calculate the new annual accounting expense under IAS 19 (2008) and FAS 106. State all assumptions and show your work.

The annual expense will differ for FAS versus IAS 19 (2008) as the treatment of plan amendments is handled differently. The service cost and interest cost will be equal to those calculated in part D given the change to claims cost is the same.

$$\text{Service cost} = 71,184$$

$$\text{Interest cost} = 90,355$$

FAS amortizes prior service cost over the expected average remaining service life of the active participants. In this case it is from 45 to 65 or 20 years. The actuarial loss as calculated in part D was 299,320

$$\text{Amortization FAS} = 299,320 / 20 = 14,966$$

7. Continued

IAS (2008) amortizes prior service cost for fully vested members immediately and non-vested benefits over the average remaining service lifetime of the population. In this case the retirees are fully vested and the actives are not fully vested.

Retiree ABO change = $0.20 \times 1,200,000 = 240,000$
Active ABO change = $0.20 \times 296,600 = 59,320$
Amortization IAS = $240,000 + 59,320/20 = 242,966$

Expense FAS = 176,505
Expense IAS = 404,505

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

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:

- (1d) Evaluate the potential financial, legal and moral risks associated with each coverage.

- (5b) Prepare a financial statement in accordance with generally accepted accounting principles.

Sources:

Herget Chapter 12

Commentary on Question:

Candidates did not receive points for distinguishing whether or not an item was important in GAAP vs. STAT reporting. Instead, they were required to mention what these items would be categorized as in a GAAP Balance Sheet (e.g. Asset or Liability) Some candidates confused Unearned Premiums with Unpaid Premiums. This was common to both parts.

It seems some candidates cited concepts from other materials, such as FAS60, rather than intended source material. Some credit was given where concepts cited aligned. For instance, some candidates described PDR per FAS60 for short-term and long-term contracts (even though group insurance is generally short-term).

Solution:

- (a) Describe the following balance sheet items as they relate to GAAP reporting for group insurance, and explain their purpose.
 - (i) Unearned premium reserve (UPR)

 - (ii) Deferred policy acquisition costs (DPAC)

 - (iii) Premium deficiency reserve (PDR)

8. Continued

Commentary on Question:

a (i) Most candidates failed to appreciate the fact that group contracts are generally short duration and that straight-line depreciation can be used to calculate the outstanding UPR balance. Candidates did receive points if they used an example that indirectly illustrated this point. Candidates did not receive points for simply defining UPR as "A reserve for premiums that have not yet been earned".

a (ii) Candidates should appreciate that DPAC is not necessarily amortized over the life of the contract, but rather it is matched with the recognition of unearned premiums.

Very few candidates mentioned that DPAC can only be held to the point of recoverability and how recoverability is demonstrated. Some candidates delved into extraneous information, such as defining what acquisition expenses were. No points were given for these examples.

a (iii) Not many candidates appreciated that PDR is held for the entire premium guarantee period, not just the existing contract year.

Candidates failed to mention that investment income may be used in the recoverability test. Candidates were awarded points if they indirectly referenced the recoverability test in other words, such as $PV(\text{Premiums}) < PV(\text{Claims}) + PV(\text{Maintenance Expenses})$

(i) Unearned premium reserve (UPR)

- UPR is a reserve held for premiums in advance of their due date.
- It is treated as a LIABILITY equal to the premiums received, but not recognized.
- Since group contracts are generally short in duration, straight-line depreciation is used in calculated UPR.

(ii) Deferred policy acquisition costs (DPAC)

- DPAC is an ASSET that is equal associated with unearned premiums.
- It should be recognized/timed similarly to that unearned premium.
- DPAC is generally relatively low for group coverage.
- It should only be held up to the point of RECOVERABILITY.
- RECOVERABILITY is demonstrated when:
 $(\text{Loss Ratio}) + (\text{Total Expense Ratio}) \leq 100\%$

(iii) Premium deficiency reserve (PDR)

- PDR is a reserve held if a loss is projected in advance.
- It can be established if:
 $(\text{Loss Ratio}) + (\text{Maintenance Expense}) > 100\%$
- It applies to the entire premium guarantee period, even if the period extends beyond the current contract year.
- Investment income may be used to determine recoverability

8. Continued

- (b) Calculate the UPR, DPAC, and PDR as of March 31. Show your work.

Commentary on Question:

Some candidates were confused by the timing of premiums and incorrectly wrote down \$2.5M as the UPR instead of \$1.25M.

Full points were awarded for DPAC calculations if the candidate calculated the wrong UPR, but based the DPAC on their UPR value from earlier.

Candidates were not awarded full points if they calculated the correct pre-write-down DPAC, but failed to explicitly mention that the asset must be written down from 12% to 4% after recoverability testing.

Candidates were awarded full points for PDR if they did not explicitly calculate the PDR in the absence of DPAC, but simply recognized that PDR is not needed since DPAC is still > 0 after recoverability testing.

UPR

Semi-annually means 6 months per period

$$\begin{aligned} \Rightarrow \text{Premium received at Jan 1} &= (6 / 12) \times \text{Annual Premium} = (6 / 12) \times \\ &\$5,000,000 = \\ &\$2,500,000 \end{aligned}$$

March 31 -> 3 months left in current period

$$\Rightarrow \text{UPR} = (3 / 6) \times \$2,500,000 = \$1,250,000$$

DPAC

First test recoverability.

$$\begin{aligned} (\text{Expected Loss Ratio}) + (\text{Acquisition Expense}) + (\text{Maintenance Expense}) &= \\ 86\% + 12\% + 10\% &= 108\% \end{aligned}$$

Since 108% > 100%, will need to write down Acquisition Expense to get to 100%.

$$\Rightarrow \text{"New Acquisition Expense"} = 12\% - (108\% - 100\%) = 4\%$$

$$\begin{aligned} \Rightarrow \text{DPAC} &= (\text{New Acquisition Expense}) \times \text{Unearned Premium} = 4\% \times \$1,250,000 \\ &= \$50,000 \end{aligned}$$

PDR

Premium Deficiency Reserve is only needed if:

- 1) Recoverability is not demonstrated.

AND

- 2) $(\text{Expected Loss Ratio}) + (\text{Maintenance Expense}) > 100\%$, after writing down Acquisition Expense to 0%.

In this case:

- 1) Recoverability is not demonstrated.

BUT

- 2) Acquisition Expense was only written down to 4% to achieve Recoverability, and $(\text{Expected Loss Ratio}) + (\text{Maintenance Expense}) = 98\% < 100\%$.

Therefore PDR is not needed.

9. Learning Objectives:

- (5h) Construct basic financial statements and its actuarial entries for an L&H insurance company.

Learning Outcomes:

- (5a) Interpret insurer financial statements from the viewpoint of various stakeholders.
- (5b) Evaluate a key financial performance measures used by L&H insurers for both short and long-term products.
- (5c) Project financial outcomes and recommend strategy to senior management to achieve financial goals.
- (5d) Describe the planning process of L&H insurance company (strategic, operational, and budgeting).
- (5e) Compare key differences and similarities in measures by accounting basis.
- (5f) Describe how to compute the taxable income of an L&H insurance company.
- (5g) Explain fair value accounting principles and describe International Accounting Standards (IAS).
- (5h) Construct basic financial statements and its actuarial entries for an L&H insurance company.

Sources:

Group Insurance, 6th Edition, Bluhm Chapter 21 and 45

Commentary on Question:

Commentary listed underneath question component.

Solution:

- (a) Describe the major modifications that must be made when converting from US Statutory reporting for group health insurers to US GAAP.
- Removal of some of the conservatism in reserving assumptions
 - Full recognition of deferred taxes
 - Recognition of the market value of most assets
 - Recognition of lapses in reserves
 - Capitalization of deferred acquisition costs
 - Recognition of all receivables and allowances
 - Removal of the AVR and IMR

9. Continued

- (b) Explain the key conceptual differences between U.S. Statutory reporting and U.S. GAAP reporting for group health insurers.

Commentary on Question:

A number of candidates either provided an answer that was too brief or vague, resulting in partial credits only.

- GAAP reporting attempts to match the incidence of revenue and expenses, while statutory reporting tends to accelerate recognition of expenses and defer recognition of revenue
- Statutory reporting attempts to determine the value of the insurance company if it were to liquidate, while GAAP looks at the insurance company as a going concern
- Many of the conservative assumptions required for statutory reporting can be replaced by a much less conservative margin for adverse deviation in GAAP

- (c) Define and explain the three financial measures provided by Oingo.

Commentary on Question:

Full credits cannot be received without both the formula and the description of what the formula is illustrating.

Total Asset Turnover = Revenues/Total Assets

- Represents the total investments required to meet the demands of the business

Net Profit Margin = Net Income/Revenue

- Represents what portion of total sales results in profit and measures the profitability of the company

Total Leverage Ratio = Total Assets/Shareholder Equity

- Represents how much creditors' money can be magnified to improve the return on assets for the shareholders

- (d) Recommend whether MonCo should invest in Oingo based on MonCo's return on equity requirements. Justify your answer.

Commentary on Question:

In order to receive full credit, the formula for ROE must be specified and explicit recommendation relevant to MonCo's ROE requirement must be made.

9. Continued

Return on Equity = Total Asset Turnover x Net Profit Margin x Total Leverage Ratio

Oingo Return on Equity = 70.0% x 3.5% x 150% = 3.7%

Since MonCo's ROE requirement is 5%, but Oingo ROE is 3.7%, therefore MonCo should not to invest in Oingo.

10. Learning Objectives:

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

Learning Outcomes:

- (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:

The Handbook of Employee Benefits, Rosenbloom, Chapters 27 & 32

Commentary on Question:

Commentary listed underneath question component.

Solution:

- (a) Describe challenges small companies face when offering group medical insurance.

Commentary on Question:

Candidates tended to score well on this section. At times the candidates would mention items that would actually be favorable to buying insurance, such as the small group's lack of credibility.

- Because they are most often fully insured, they are subject to state-mandated plan design options
 - Because the employees of most small companies are in a relatively small geographic area, the plans must be designed using options available in that area.
 - Small companies in general, and start-up companies in particular, may have to provide additional documentation not required for larger companies in order to put a new plan in place so that insurance carriers can verify the existence of an actual company, and not just banding together of people solely for the purpose of obtaining insurance.
 - Most states do not allow companies and organizations to join forces to form larger purchasing pools in order to get group discounts.
- (b) Small companies want to attract top talent and have considered not requiring employee contributions for medical care insurance. Describe why small companies should require employee contributions.

Commentary on Question:

Section B was the most correctly answered by the candidates.

10. Continued

- Most employees are accustomed to paying some level of contribution
 - Requiring a contribution usually motivates or forces employees who have coverage, or the option to get coverage elsewhere to decline the coverage under their small employer's plan.
 - It is much easier to set policy and precedent, and plan for future growth, by introducing the concept of contributions at the inception of the plan when there are only a few employees
 - Having a contribution also can help to avoid potential legal problems.
- (c) Describe reasons why insuring an STD plan may be more efficient than small companies self-insuring the risk.

Commentary on Question:

A majority of candidates obtained partial credit on this question, with few receiving full credit. Some candidates listed out the attributes of STD, which will be present whether it is fully insured or self-insured.

- The cost is not expensive when intelligently designed
 - It takes the employer out of the role of having to deal with privacy issues and claim adjudication
 - Just one claim per year could pay for the cost of the annual premium
- (d) Describe the communication process you would use when educating various types of employees on their benefits:
- (i) New Employees
 - (ii) Annual Open Enrollment
 - (iii) Communications through the year
 - (iv) Retirees

Commentary on Question:

The majority of candidates did not fully answer this question. Candidates typically listed the materials to be given out and how these materials would be delivered. Most candidates did not describe why the process is important or important pitfalls to avoid. Almost no candidate received full credit on this part of problem.

10. Continued

- (i) New Employees
 - HR departments have developed communication tools that incorporate notification and disclosure requirements and present their benefits program with the most advantageous aspects.
 - Common problems that can arise are misunderstandings about actual benefits offered, missing applications, vendor enrollment delays, and employee challenges to mandatory benefits.

- (ii) Annual Open Enrollment Process
 - Open enrollment communication process requires a major commitment of HR resources. Much effort is devoted to updating and revising personal data reports, printed materials, and Web-application programs.
 - Best practices entail a communication campaign that motivates employees to take the time to understand the plan changes and their impact, get their questions answered, and make informed decisions on next year's choices.

- (iii) Communications through the year
 - Using the life-events approach, the plan sponsor extracts from each its benefits plans applicable information for a specific event and then in one place the sponsor communicates step by step the option available and action required to make benefit changes as a result of the particular life-event.
 - An employee who has access to a fully interactive HR Web site that uses a life-event approach is an empowered individual.

- (iv) Communications to Retirees
 - The mode of communication for the retiree group has been traditionally predominantly printed materials. However, the use of Web-based programs is gaining ground with newly retired works and older retirees having greater access to computers and more familiarity with the e-world.
 - Communication to retirees should state clearly what has not changed, be very specific of how a change

11. 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:

- (1c) Describe each of the coverages listed above
- (2c) Calculate and recommend assumptions

Sources:

Group Insurance, 6th Edition, Bluhm, Chapter 33, pages 541 - 543.

Group Insurance, 6th Edition, Bluhm, Chapter 38, pages 632 - 638.

Commentary on Question:

Candidates tended to do fairly well, overall, on this question. The overall goal was to show understanding of calculating claims costs based on specific utilization and cost assumptions, and ultimately use this information to calculate an expected premium. Although some candidates may have differed from the model solution, stating your assumption (with it being a reasonable assumption) could still result in receiving full credit. Additionally, candidates needed to remember to fully describe an answer when it was asked, instead of just listing individual bullet points.

Solution:

- (a) Calculate the 2014 PMPM total gross and net cost assuming no change in benefits. Show your work.

Commentary on Question:

Candidates generally did well on the calculations in this section. To earn full credit, candidates needed to calculate the 2014 gross and net PMPMs and show their work. The given cost and utilization figures needed to be trended for two years in the calculation. Some candidates only applied one year of trend, so partial credit was given. Some candidates were not sure which annual trend value to apply to certain services, but as long as the candidate stated their assumption, full credit was granted. Lastly, a few candidates correctly calculated the gross PMPM cost, but did not account for the copay correctly when calculating the net cost. Partial credit was given in these situations.

11. Continued

The relevant numbers are shown in the table below, followed by the formulas used.

Services	2012 Services per 1,000	2012 Cost per Service	2012 to 2014 Cost Trend	2012 to 2014 Util. Trend	2014 Annual Services per 1,000 Members	2014 Avg Cost per Service
Hospital IP						
Medical	120	\$5,000	6.09%	8.16%	129.79	\$5,304.50
Surgical	100	\$9,500	6.09%	8.16%	108.16	\$10,078.55
Hospital OP						
ER	175	\$1,300	4.04%	6.09%	185.66	\$1,353
Radiology	310	\$700	4.04%	6.09%	328.88	\$728
Surgery	125	\$3,400	4.04%	6.09%	132.61	\$3,537
Professional						
Office Visits	5,000	\$120	2.01%	6.09%	5,304.50	\$122
IP Surgery	50	\$3,000	2.01%	6.09%	53.05	\$3,060
OP Surgery	600	\$600	2.01%	6.09%	636.54	\$612
Outpatient MH	600	\$150	2.01%	6.09%	636.54	\$153

For each category, the 2012 services per 1,000 members and average cost per service was given.

The utilization and cost trends are calculated as: $(1 + \text{Annual Trend})^2 - 1$

2014 Annual Services per 1,000 Members = (2012 Annual Services per 1,000 Members) x (1 + 2012 to 2014 Util Trend)

2014 Avg Cost per Service = 2012 Avg Cost per Service x (1 + 2012 to 2014 Cost Trend)

With these pieces of information, the PMPMs can be calculated below.

11. Continued

Services	2014 Annual Services per 1,000 Members	2014 Avg Cost per Service	2014 Gross Cost PMPM	2014 Value of Copay PMPM	2014 Net Cost PMPM
Hospital IP					
Medical	129.79	\$5,304.50	\$57.37	\$2.70	\$54.67
Surgical	108.16	\$10,078.55	\$90.84	\$2.25	\$88.59
Hospital OP					
ER	185.66	\$1,353	\$20.93	\$1.55	\$19.38
Radiology	328.88	\$728	\$19.96	\$0.69	\$19.27
Surgery	132.61	\$3,537	<u>\$39.09</u>	\$1.11	<u>\$37.99</u>
Hospital Subtotal			\$228.19		\$219.90
Professional					
Office Visits	5,304.50	\$122	\$54.11	\$11.05	\$43.06
IP Surgery	53.05	\$3,060	\$13.53	\$0.00	\$13.53
OP Surgery	636.54	\$612	\$32.47	\$0.00	\$32.47
Outpatient MH	636.54	\$153	\$8.12	\$0.00	\$8.12
		Total	\$336.41	\$19.35	\$317.07

2014 Gross Costs PMPM =

$(2014 \text{ Annual Services per } 1,000 \text{ Members} \times 2014 \text{ Avg Cost per Service}) / (12 \times 1000)$

2014 Value of Copay PMPM = $(2012 \text{ Copay} \times 2014 \text{ Annual Services per } 1,000 \text{ Members}) / (12 \times 1000)$

2014 Net Cost PMPM = 2014 Gross Costs PMPM - 2014 Value of Copay PMPM

The total gross cost PMPM for all services in 2014 is \$336.41.

The total net cost PMPM for all services in 2014 is \$317.07.

11. Continued

- (b)
- (i) Describe the components of medical trend.
 - (ii) Calculate the gross cost annual trend of Gross Cost from 2012 to 2014 for each of hospital, physician, and all services. Show your work.

Commentary on Question:

The first part of this question asked candidates to describe the components of medical trend. As such, a description was needed for the drivers of trend that the candidate identified. Candidates who just wrote a bulleted list of items with no explanation did not receive credit since they did not describe as the question required. A variety of answers was acceptable, as long as a reasonable description was given.

In the second part of the question, candidates had to calculate the annual gross cost trend for hospital, physician, and all services, with most candidates performing well. Two common mistakes were forgetting to take the square root to get to an annual trend number and forgetting to subtotal the hospital services. Partial credit was given to candidates who made these mistakes but otherwise had the calculation correct.

General Macroeconomic Force of Trend – general aging causes an increase in medical trend, as does inflation (price of goods/services). The supply of doctors and their specialty also impacts the costs of medical services since typically as supply decreases, prices increase.

Changes to provider reimbursements - changing to HMO managed care products with greater control of costs vs. using general fee for service reimbursement model can cause a decrease in medical trend.

Changes in covered populations – increasing the number of older members that are covered could cause overall claims costs to increase.

Changes in covered services/benefits – By adding or changing benefits, such as reducing a physician copay, you could increase utilization of that service, and increase overall medical costs

Other random fluctuations – such as an unexpected expensive flu season could increase claims costs.

Effects of benefit leveraging - leaving copays the same can have a different impact on allowed vs net trends

Company initiatives to control costs like prior authorizations

11. Continued

Gross PMPM = (Services per 1,000 x Cost per service) / (12 x 1,000)

Services	2012 Services per 1,000	2012 Cost per Service	2012 Gross PMPM Benefit Costs
Hospital IP			
Medical	120	\$5,000	\$50.00
Surgical	100	\$9,500	\$79.17
Hospital OP			
ER	175	\$1,300	\$18.96
Radiology	310	\$700	\$18.08
Surgery	125	\$3,400	<u>\$35.42</u>
Hospital Subtotal			\$201.63
Professional			
Office Visits	5,000	\$120	\$50.00
IP Surgery	50	\$3,000	\$12.50
OP Surgery	600	\$600	\$30.00
Outpatient MH	600	\$150	\$7.50
Grand Total			\$301.63

The 2014 gross costs were found in part A.

Annual 2012 to 2014 Hospital gross cost trend = $(\$228.19 / \$201.63)^{0.5} - 1 = 6.4\%$

Annual 2012 to 2014 Physician gross cost trend = $(\$108.22 / \$100.00)^{0.5} - 1 = 4.0\%$

- Note that physician is assumed to include office visits, IP surgery, OP Surgery, and Outpatient MH in the chart above, so these services have all been summed.

11. Continued

Annual 2012 to 2014 Hospital gross cost trend = $(\$336.41 / \$301.63) ^{0.5} - 1 = 5.6\%$

- (c) Calculate the required increase in hospital inpatient copay to reduce 2014 net cost PMPM by \$10, assuming the following. Show your work.

Commentary on Question:

Most candidates had difficulty with the calculations in this part. Some received partial credit for showing the reduction in utilization but could not correctly translate that into the impact on the copay.

From part a, the 2014 gross and net costs are \$148.21 and \$143.26 respectively for hospital inpatient services.

Revised 2014 Hospital IP utilization after the 5% reduction =
Medical = $120 \times 1.0816 \times (1 - 5\%) = 123.30$
Surgical = $100 \times 1.0816 \times (1 - 5\%) = 102.75$

The 2014 net cost needs to be \$10 less, so $\$143.26 - \$10 = \$133.26$.

Revised 2014 Gross Cost PMPMs:
Medical = $123.30 \times 5,304.50 / 12,000 = \54.50
Surgical = $102.75 \times 10,078.55 / 12,000 = \86.30
Total = \$140.80

Thus, the value of the 2014 cost sharing needs to be $\$140.80 - \$133.26 = \$7.54$

To solve for the copay: $\$7.54 = 226.05 \times Z / 12,000 \Rightarrow Z = \400

Since the copay is \$250 in 2012, the required increase is \$150.

- (d) Describe the different retentions on net premium used to calculate gross premiums.

Commentary on Question:

This part again asked candidates to describe, so no credit was given for writing a list of bullet points with no explanations. Candidates needed to identify some of the common retention items used to convert net costs into gross premiums. Candidates who included at least 4 of these items and described them received full credit.

Gross premiums, the premiums actually charged, must account for expected claims as well as a number of other items, generally called “retentions.” Some of the most common retention items are the following:

11. Continued

- Expense Loadings: This is usually the largest part of retention, and is generally included as a number of separate charges. These would include salaries, administrative expenses, rent, taxes, etc.
- Pooling Charges: This spreads the cost of any pooled claims over all policy holders. May be included in retention or elsewhere in pricing.
- Profit Charge or Contribution to Free Reserves: This is the profit that the insurer chooses to include in its pricing formula. Non-profit insurers call this “contributions to free reserves.” Profit charges may be embedded in other assumptions, so it may or may not be an explicit retention loading.
- Investment Income: Some insurers provide for the crediting of investment income on reserves or other money held, and treats this income as an offset to other retention items.
- Explicit Margin: An insurer may include a specific margin in the retention calculation to reduce the insurer’s risk and increase the confidence in the pricing assumptions built into the rates.
- Deficit Recovery Charge: If a policyholder has caused incurred losses by the insurer in prior years, and those losses have not yet been recovered, the insurer may build in a deficit recovery charge intended to recoup past losses within a reasonable period of time.
- Termination Risk Charge: Occasionally, a policyholder in a deficit position will terminate its contract, leaving the insurer who has chosen a deficit recovery charge philosophy no means to recover the losses from that policyholder. A risk charge may therefore be made in advance on all policyholders in order to finance this business risk.

- (e) Calculate the required 2014 premium PMPM based on the new hospital inpatient copayment. Show your work.

Commentary on Question:

Candidates did very well on this section. Full credit was given as long as the candidate used their 2014 net cost from part A (even if it was incorrect), subtracted the \$10 as indicated in part c, added on for the pooling charge, and divided by (1 – retention).

$$\text{Revised 2014 Net PMPM} = \$317.07 - \$10 = \$307.07$$

This is the 2014 Net PMPM from part a, minus the \$10 from part c

$$\text{Adjusted 2014 Total Benefit Cost PMPM} = \$307.07 + \$50 \text{ pooling charge} = \$357.07$$

$$\text{Retention items} = 15\%$$

$$\text{2014 Premium PMPM} = \$357.07 / (1 - 15\%) = \$420.08$$

12. 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:

- (1a) Describe typical organizations offering these coverages including the historical context.
- (1c) Describe each of the coverages listed above.

Sources:

Kongstvedt, Chapter 2

Commentary on Question:

This question was intended to test a student's knowledge of the plans on the healthcare continuum, and an understanding of ACOs and PCMHs.

Solution:

- (a) Describe the managed care continuum and the makeup of existing plans from low to high.

Commentary on Question:

Students did well on listing and describing the plan types in the appropriate order. To get full marks a description of the continuum was also required, something missed by most students.

Plans on the continuum start with low complexity, administrative cost, cost and quality control and these elements increase as they move further up the continuum.

- Managed Indemnity – indemnity plans with UM overlay
- PPO – contract with network of providers, in and out of network coverage
- EPO – like PPO but no out of network
- POS – HMO with high cost share indemnity for out of network
- HMO – in network only, gatekeeper approach
 - Open – contract with private physicians
 - Closed – single medical group employed by HMO

12. Continued

- (b) Between puffs from his cigar, your uncle expresses interest in hearing more about ACOs.
- (i) Describe an ACO.
- (ii) Describe the structural requirements of an ACO.

Commentary on Question:

In general, students did well on this part of the question. To get full points more depth was needed in describing the ACO than many students provided.

- (i) ACO stands for Accountable Care Organization
- Shared savings program using performance measures
 - Written into ACA
 - Approach to achieve more integrated and efficient care
 - Local organizational accountability for quality and costs
- (ii) Structural requirements:
- Can be formed by
 - Group practices
 - Network of individual practices
 - Hospitals
 - Rural health clinics
 - Federally qualified health centers
 - Legal entity authorized to conduct business in each state it operates
 - Formed for the purpose of:
 - Receiving and distributing shared savings
 - Repaying shared losses
 - Establishing, enforcing healthcare quality criteria
 - Governing body
 - 75% board members must be participants
 - Management structure similar to non-profit
 - Demonstration of ability to repay losses
 - Purchase of reinsurance
 - Establish line of credit
 - Place funds in escrow
- (c) Your uncle has heard about Patient-Centered Medical Homes (PCMH) from a business associate but doesn't fully understand how they work.
- (i) List the key characteristics of PCMHs.
- (ii) Explain the similarities and differences to HMOs.

12. Continued

Commentary on Question:

Many students did well on the first part of the question, capturing the majority of the key characteristics of a PCMH. The second part of the question required more thought since it required knowledge utilization. Most students did not capture the key similarities and differences between PCMHs and HMOs in their answer.

- (i) Key Characteristics
 - Ongoing relationship with personal physician
 - Personal physician responsible for coordinating care
 - Patients receive care from a team
 - Patient care integrated across all elements of continuum
 - Quality and safety important
 - Enhanced access to care
 - Payment recognizes added value

- (ii) Similarities
 - Recognizes team of physicians, medical assistants, RNs, etc. aligned around a PCP
 - Enhanced focus on quality monitoring and improvement (NCQA)Differences
 - Value of patient engagement in decision making
 - Role of patient not always clear under gatekeeper/closed panel HMO
 - PCMH mechanism for patients to be more engaged in how/when treated

13. Learning Objectives:

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

Learning Outcomes:

- (2a) Identify and evaluate sources of data needed pricing, including the quality, appropriateness and limitations of each data source

Sources:

Bluhm, Group Insurance, Chapters 31&36

Commentary on Question:

Commentary listed underneath question component.

Solution:

- (a) List and describe the components of gross premiums.

Commentary on Question:

Some candidates supplied an expense formula and received less credit.

- Expected Claim Costs
 - Claims that will be charged to the plan during the contract period
 - Determined using manual or experience rates, with credibility adjustments
- Administrative Expenses
- Commissions and other sales expenses
 - Generally marketed by agents or brokers compensated on a commission basis
 - In addition to commissions, may have other expenses related to sale of product
 - Allocation of expenses attributable to promotion of product, such as advertising to promote brand recognition
 - Generally a % of premiums
- Premium taxes
 - Vary by state, generally 1-3%
 - Assumption for larger groups reflects distribution by state
- Other taxes and fees
 - Federal and state income taxes
 - State sponsored high-risk pool
 - Federal assessment on health coverage under ACA totaling \$8 billion in 2014, increasing to \$14.3 billion by 2018
 - Small comparative effectiveness research assessment required by ACA
- Contributions to surplus / Risk and Profit Charges
 - Reflect degree of risk involved, the amount of company capital allocated to support the coverage, and return expected on the capital

13. Continued

- Risk varies by group size, benefits provided, funding vehicle, degree of resources required to administer
 - Risk often pooled for smaller groups
 - Larger groups may have financial arrangements other than full assumption of risk by carrier (ASO, etc)
 - Credit for investment income on assets and cash flow
 - Typically thought of assets related to medical reserves and on cash flows
 - Rate of return is generally based on portfolio rate of return
 - Can be reflected as
 - Explicit rate component
 - Offset to expenses
 - Offset to the provision for risk or profit
- (b) Outline considerations in developing and allocating administrative expenses.

Commentary on Question:

Many candidates hit the essential points on this section.

- How are expenses allocated to the product?
 - Activity-based allocation
 - Allocates expenses according to some measure or estimate of use for products or functions
 - Example of activity based allocation (postage costs, transfer charges, etc)
 - Functional Expense Allocation
 - Determine how total expenses for an organization are split by major and minor activity categories, line of business, and new and renewal business
 - Survey employees how much time they spend on each category
 - Multiple Allocation Methods
 - A financial report may include both activity and functional expense allocation
- How should administrative expenses be allocated to groups?
 - Primary objective is to achieve equity among group customers without unduly complicating process
 - Sometimes this is secondary to overriding company strategy
 - Expressed on one or more of following bases
 - Percent of premium
 - Percent of claims
 - Per policy
 - Per employee
 - Per claim administered
 - Some particularly demanding customers may have specific charges to provide services (i.e. reporting requirements)

13. Continued

- Generally preferable to use basis that reflects activities that generate expense
 - What does the competition include as expenses in pricing?
 - Adjustments may be necessary to accommodate to marketplace
 - Sources of data
 - May be internal or external
 - Internal sources: generally accounting systems (salary, bonuses, rent, postage, travel, etc)
 - External sources: studies by industry associations, published expense data from annual statements, competitive feedback, special surveys
- (c) List common rating characteristics and group specific adjustments used in determining and using manual rates for group insurance.

Commentary on Question:

Most candidates received full credit on this section.

- Age
- Gender (often restricted in many products and states)
- Health status (risk adjustment scores)
- Rating tiers/Family Tier
- Geographic factors
- Industry codes
- Group Size
- Length of premium period
- Marketing, competitive, and regulatory issues
- Value of benefits (“Actuarial value”)

Rating Characteristics Override/Additional Points

- Group specific adjustments
 - New business discounts
 - Past or estimated claims experience
- (d) Describe the three characteristics which set pricing GLTC apart from other group product pricing.

Commentary on Question:

Candidates struggled to distinguish answers to section d from section e. Full credit was given for viable answers to either section.

- Issue age rated
- Offered as optional coverage
- Unique set of eligible insureds
- Additional credit was given for

13. Continued

- married persons claims lower with built-in caregiver
 - shared pool of benefits available for spousal coverage
 - restoration of benefits option
 - non-forfeiture or contingent non-forfeiture
 - voluntary lapses lower than other coverages
- (e) Describe key pricing considerations for group long term care which aren't considered in other group pricing.

Commentary on Question:

Candidates struggled to distinguish answers to section d from section e. Full credit was given for viable answers to either section.

- Certification for initial rate filings
 - Rate schedule is sufficient to cover anticipated cost under moderately adverse experience
 - Statement that policy design and coverage have been taken into consideration
 - Statement that underwriting and claims adjudication have been reviewed and taken into consideration
 - A complete description of basis for contract reserves
- Long-term care policies are typically in effect for much longer than other group coverages, with longer payment patterns
- There is much lower participation in GLTC than other products. 5-10% is considered high participation.
- Claims costs often have a very steep slope, requiring pricing projections that last a long time
- LTC is a young industry with long payment periods, so emerging experience is often not fully credible
- Morbidity shifts over time, including morbidity improvement, have been more pronounced in LTC products
- GLTC often has higher start-up expenses as compared to other group coverages

14. Learning Objectives:

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

Learning Outcomes:

- (3b) Evaluate the elements of cafeteria plan design, pricing and management
- (3c) Recommend an employee benefit strategy in light of an employer's objectives

Sources:

Canadian Handbook of Flexible Benefits, McKay, Ch. 7; The Handbook of Employee Benefits, Rosenbloom Ch. 7

Commentary on Question:

Generally, candidates did well on this question.

Solution:

- (a) Describe the similarities and differences between Health Savings Accounts and Health Spending Accounts.

Commentary on Question:

Most candidates performed well in this section. If mistakes were made, they were usually misstatements of some features of either a Health Savings Account or a Health Spending Account.

Similarities

- Both can be used for eligible medical expenses
- Both have tax advantages such as tax free distribution for qualified expenses, as well as tax penalties for misuse
- Both have states/provinces that dictate tax treatments of accounts

Differences

- Spending accounts do not need to be tied to a High Deductible Health Plan
- Eligible expenses broader for Spending Accounts than Savings Accounts
- Spending accounts have only one annual election unless life event. Savings accounts can change elections throughout the year.
- Spending accounts have time-limiting rollover/forfeiture characteristics. Savings accounts do not have limits.
- Savings accounts are owned by the employee (portable), whereas Spending accounts are not.

- (b) Calculate the remaining balances after Years 1-3 in your Health Spending Account using the Roll over unused balance approach and then Roll over unpaid claims approach.

14. Continued

Commentary on Question:

In general, candidates did very well on this section. Of mistakes made, a typical one was not to carryover the balance from year 2 to 3 in the rollover unused balance method.

year	Amount	roll over	roll over
		<u>unused balance</u>	<u>unpaid claims</u>
1	\$2,000	\$2,000	\$2,000
	(\$600)	\$1,400	\$1,400
	(\$100)	\$1,300	\$1,300
	(\$350)	\$950	\$950
	(\$100)	\$850	\$850
year-end balance		\$850	\$0
2	\$1,500	\$2,350	\$1,500
	(\$150)	\$2,200	\$1,350
	(\$450)	\$1,750	\$900
	(\$950)	\$800	(\$50)
	year-end balance	\$800	\$0
3	\$1,000	\$1,800	\$950
	(\$200)	\$1,600	\$750
	(\$400)	\$1,200	\$350
	(\$300)	\$900	\$50
	year-end balance	\$900	\$0

Please note the following in regard to the calculations above:

- For the rollover unused balance method, there was no forfeiture of the year one rollover amount since over \$850 of expenses occurred in year 2; thus, full \$800 carries from year 2 to year 3
- For the rollover unpaid claims method, all \$850 at the end of year one is forfeited, along with the \$50 at the end of year 3.
- For the rollover unpaid claims method, -\$50 in claims is carried over from the end of year 2 into the beginning of year 3.

- (c) Describe the tax issues of a personal account.

Commentary on Question:

Of the three sections in this question, this one was where candidates did not perform as well.

14. Continued

- Personal accounts can cover many items, ranging from health-related items such as gym memberships to personal items such as gas or vacations.
- Reimbursed items generally count as taxable income to the employee
- Employers tax the account based on the allocations rather than the reimbursements
- Balance remaining in account at year end can be rolled over indefinitely