GH FVCU Model Solutions
Fall 2020

1. Learning Objectives:

5. The candidate will understand how to evaluate the impact of regulation and taxation on companies and plan sponsors in the US.

Learning Outcomes:

(5a) Describe the regulatory and policy making process in the US.

(5b) Describe the major applicable laws and regulations and evaluate their impact.

(5c) Apply applicable standards of practice.

Sources:

Skwire, Group Insurance, Ch15 and Ch18
ASOP 8 and ASOP 26

Commentary on Question:

Candidate performance was generally mixed. While most received partial credit and did particularly well on the lists and identification, very few candidates provided enough detail as it related to connecting goals on insurance regulation and ACA components meant to address them.

Solution:

(a) Identify four potential problems that could exist in an unregulated insurance market.

Commentary on Question:

Most candidates received full or the majority of credit for adequately identifying potential problems under a lack of regulation in the insurance market. Other reasonable answers beyond the below were accepted.

1. Dishonest Company gains competitive advantage
2. Customer might purchase policy based on misinformation or fraudulent claims
3. Company may become insolvent with no warning leaving customer without insurance protection
4. Insurance policy may be more geared toward company profit rather than consumer value

1. Continued

(b)

(i) List the four goals of insurance regulation.

(ii) Identify and describe two relevant components of the Affordable Care Act (ACA) that help to achieve each of these goals.

Commentary on Question:
Most candidates received full or the majority of credit for listing goals of regulation in part i). Answers beyond those listed below were accepted if reasonable. For part ii), very few candidates provided sufficient responses to receive full credit. The question asked candidates to identify two ACA components relevant to each goal of insurance regulation; not two ACA components in total. Partial credit was given for providing a subset of the answers below or others assuming reasonable justification of a connection to goals of regulation.

(i)

1. Prevent problems for the consumer
2. Maintain fairness among competing companies
3. Raise tax revenue
4. Advance or promote social goals

(ii)

1. Prevent Problems for the Consumer:
    i. MLR Requirements – Ensure minimum portion of premium is spent on clinical services, quality, and other associated costs
    ii. Rate Review – Ensure consumer protection from unreasonable rate increases
    iii. Guaranteed Issue-Employers and individuals must be accepted for coverage and not denied due to pre-existing conditions or health status
2. Maintain Fairness among Competitors
    i. 3Rs/Premium Stabilization-Mitigate risk for carriers entering new markets and ensure balance among carriers
    ii. EHBs-Required package of benefits to be offered by all plans operating in ACA market
3. Raise Tax Revenue
    i. Individual and Employer Mandate-Penalties levied on individuals and employers lacking or refusing to offer coverage
    ii. HIF-ACA imposed tax on insurers
    iii. Cadillac tax-Tax imposed on policies offering high value and cost coverage above set thresholds

1. Continued

4. Promote Social Goals-
    i. Expansion of Dependent Coverage to Age 26-Coverage must be offered to dependents up to age 26
    ii. Preventative Care Coverage-Mandated coverage of services deemed preventative with no cost share imposed
    iii. Medicaid Expansion-Expand Medicaid availability to individuals below 133% of FPL

(c) List and describe two of the Actuarial Standards of Practice (ASOPs) relevant to actuaries preparing filings under the ACA.

Commentary on Question:
Performance was mixed based on candidate approach to the question. Some candidates took a broader interpretation of this question and referenced more general ASOPs like 23 (Data Quality) or 41 (Communications). Others listed more general health ASOPs like 50 (Determining AV/MV). Since this question focused on ASOP specific to ACA rate filings, these answers were not accepted.

1. ASOP 8 -Regulatory Filings for Health Plan Benefits
    a. Applies to actuaries when performing professional services with respect to preparing or reviewing health filings…made to state insurance departments, state health departments, the federal government (including those required by the Affordable Care Act), and other regulatory bodies.
2. ASOP 26-Compliance with Statutory and Regulatory Requirements for the Certification of Small Employer Health Benefit Plans
    a. Applies to actuarial certifications of compliance prescribed by regulatory requirements that a carrier's rating methods and other actuarial practices applicable to small employer health benefit plans comply with statutory and regulatory rating constraints.

2. Learning Objectives:

6. The candidate will understand how to evaluate retiree group and life benefits in the United States.

Learning Outcomes:

(6b) Determine appropriate baseline assumptions for benefits and population.

(6c) Determine employer liabilities for retiree benefits under US GAAP.

(6d) Describe funding alternatives for retiree benefits.

Sources:

Group Insurance – Skwire – Ch. 8: Retiree Group Benefits

GHFV-816-16: US Employers' Accounting of Postretirement Benefits Other Than Pensions Study Note

Commentary on Question:

This question tested the candidates on their knowledge of various aspects of group retiree benefits. Results were generally mixed, with most candidates receiving most of or full credits on some parts of the question, and partial to no credit on others.

Solution:

(a) Explain how long term assumptions factor into the development of retiree benefit obligations.

Commentary on Question:

Different long term assumptions were required in order to receive full credit. Partial credit was given for any answers given without any additional explanation.

1) Discount Rate: The rate used should reference market yields at the valuation date, and reflects the estimated timing of benefit payments.
2) Salary Escalation: Assumption should reflect employee's salary at retirement, accounting for inflation/merit increases over their career.
3) Mortality Decrement: Mortality decrements should be based on age and gender. Factors can be based on standard tables, or adjusted for the plan's own experience if it is credible.
4) Termination and Disability Rates: Adjustments for employees that exit the plan and may not be able to collect benefits. Factors can be based on standard tables, or adjusted for the plan's own experience if it is credible.
5) Retirement Rate: Assumptions should be based on age or service-basis when employees can collect benefits prior to normal retirement age.

2. Continued

(b) Explain factors that can increase and/or decrease health care trend rates.

Commentary on Question:
Full credit was only received if an explanation of how the factor impacted trend rates was given.

1) General Inflation: Increasing inflation can lead to a general increase in the cost of health care goods and services, and in turn increasing trends.
2) Utilization Changes: New health products and services can lead to higher levels of health care utilization, which will increase trend rates.
3) Behavioral Patterns: Behaviors in the general population and employee group can impact cost of care (ie, healthy lifestyles may reduce trends, while smoking can increase it).
4) The GDP: GDP fluctuations can impact government financing of healthcare, which will directly impact health care spend in the commercial market.
5) Benefit Types: Certain benefits, such as Rx, may have a different trend rate than medical coverage in general, which will have an impact on the overall healthcare trend (ie, faster growth in high cost drugs may result in higher Rx trend rates than medical trends, and result in higher overall healthcare trends).
6) Geographic Location: Health care spending patterns can differ by region.
7) Government Programs: New government programs and legislation can be passed that can lead to added medical costs (ie, mandated coverages) and thus higher trends, or vice versa.
8) Plan Provisions: Benefit designs can affect trend, as richer benefits may lead to higher spending, or less rich benefits, such as a high deductible, can reduce trends.

(c)

(i) Describe the components of the NPPBC.

(ii) Calculate the maximum impact of all known errors in the restatement of the Company X 2019 NPPBC. Show your work.

Commentary on Question:
Most candidates did well on part (i) of the question, but struggled on part (ii). As the question asked for the maximum liability, points were deducted if candidates assumed the errors in directions that would lessen the liability. Very few candidates received full credit, but most received at least partial credit.

(i)

NPPBC = Service Cost + Interest Cost + Return on Assets + Amortizations of Unrecognized Amounts

2. Continued

Service Cost = Active EPBO / (retirement age – current age)

Interest Cost = Discount Rate * (APBO + Service Cost – EBP/2)

Active EPBO = Number of Actives * Claims Cost * Annuity * Survival Factor * Trend Factor * Discount Factor

Active APBO = Active EPBO * Attribution Factor

(ii)

As we are given that both the return on assets and amortization of unrecognized amounts equal zero, then only the Service Cost and Interest Cost are impacted by the errors:

<u>Service Cost</u>
Original age impact: 1 / (65-45) = .05
Updated age impact: 1 / (65-46) = .05263
Age Adjustment: .05263 / .05 = 1.05263
We can ignore the possibility of age being off in the other direction, as that would reduce the liability

The EPBO is impacted by the annuity factor error, and must be increased by 1.007

The overall impact to Service Cost, therefore, is a product of multiplicative changes:

Age Adjustment * Annuity Adjustment = 1.05263 * 1.007 = 1.06

<u>Interest Cost</u>
Original discount rate: .05
Updated discount rate: .053
Interest Cost Adjustment = .053 / .05 = 1.06

As the adjustment is the same for both the Service Cost and the Interest Cost, the overall correction is 6%

Original 2019 NPPBC: $1,357,000
Maximum Error: 6%
Maximum NPPBC Liability: $1,357,000 * .06 = **$81,420**

2. Continued

(d) Identify characteristics of an ideal funding vehicle that specifically pertain to the Controller's concerns.

Commentary on Question:
The Controller was specifically concerned about tax concerns, so points were deducted for characteristics raised that did not address tax concerns specifically.

1. Company tax deductions for contributions that adequately fund retiree health benefits
2. A tax-free or tax-deferred savings mechanism for employees
3. Investment earnings that accumulate in a tax-sheltered environment
4. Tax-free benefits paid to employees

(e) Recommend a funding vehicle with the characteristics identified in (d) above. Justify your answer.

Commentary on Question:
For full credit, the candidate had to correctly identify a retirement vehicle that was tax advantaged, and explain the tax advantages to justify the answer. Several different retirement vehicles were acceptable.

I would recommend a VEBA, which would best address the Controller's concerns about tax implications. The money contributed by the employer is tax deductible, the funds grow tax-free, and the money can be taken out tax free as long as it is used for qualified medical expenses.

3. Learning Objectives:

4. The candidate will understand how to prepare and be able to interpret insurance company financial statements in accordance with U.S. statutory principles and GAAP.

Learning Outcomes:

(4b) Interpret the results of both statutory and GAAP statements from the viewpoint of various stakeholders, including regulators, senior management, investors.

(4c) Project financial outcomes and recommend a strategy.

(4d) Apply applicable standards of practice.

Sources:

GHFV-109-19: Health Insurance Accounting Basics for Actuaries (HIABA), Section 3.3 and 4.3

GHFV-818-18: AAA, Revised Actuarial Statement of Opinion Instructions for the NAIC Health Annual Statement Effective December 31, 2010

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) Identify the considerations in determining the need for a premium deficiency reserve.

Commentary on Question:

Candidates did poorly on this section. Most candidates struggled to list more than one relevant consideration.

Grouping considerations:

- All commercial combined or grouped based on how each block is regulated?
- Should ancillary be grouped with Medical?
- Should ACA block be separated from pre-ACA or Small Group or Medicaid?
- Should Medicare Advantage, Standalone Part D, and Med Supp be separate groupings?
- For Medicaid across several States, should each State be its own grouping?
- Is reinsured business grouped with business where the insurer is the primary carrier?

Timing considerations:

- What are the renewability characteristics of the underlying insurance contracts?

- Are there insurance contracts with future effective dates that need to be included in the PDR calculation?

3. Continued

(b) Justify whether you have sufficient information to calculate a premium deficiency reserve on this block of business as of 12/31/2019.

Commentary on Question:
Candidates did generally well on this section. Most candidates correctly identified that there was insufficient information to calculate PDR. Partial credits were given where justification was sound and demonstrated an understanding of the material.

I do not have sufficient information because,

- Information is needed at a more granular level, splitting out Medicare supplement business.
- For guaranteed renewable coverage, information regarding renewability and premium increase limitation are needed.
- Information may be needed that projects profit/loss beyond the next 12-month period.

(c) With regards to the requirements of VNC as regulated by the National Association of Insurance Commissioners (NAIC)

(i) Describe the publicly available statutory financial reports that VNC is required to submit to the NAIC.

(ii) Describe the confidential statutory financial reports that VNC is required to submit to the NAIC

Commentary on Question:
Candidates' performance was mixed in this section. Most candidates were able to identify all the required statutory financial reports but struggled to categorize them as public or confidential. Since the problem requested a description, credit was only given to candidates who provided an explanation of each item that demonstrated understanding of the item.

(i) Public available statutory financial reports include:

- Annual statement blank: an annual pre-formatted template consisting of core financial statements together with a wide variety of supplemental exhibits.
- Quarterly statement blank: a similar but less voluminous pre-formatted template submitted on a quarterly basis.
- Annual audited financial statement: presents the core financial information found in the annual statement blank in more condensed form, and includes an opinion statement from the audit firm.

3. Continued

- Annual actuarial opinion: a statement signed by the insurer's appointed actuary attesting to the adequacy of the actuarial liabilities & assets recorded by the insurer.

(ii) Confidential statutory financial reports include:

- Annual RBC report: a pre-formatted template that computes an insurer's minimum capital requirement under formulas adopted by the NAIC.
- Annual actuarial opinion memorandum: documents the appointed actuary's work supporting the conclusions expressed in the opinion.

(d) Create a Statement of Actuarial Opinion to comment on VNC's premium deficiency reserve.

Commentary on Question:
This question tests the rules established within GHFV-818-18 source material. Opinion can be anything (qualified, unqualified, etc.) as long as it is internally consistent. Most candidates were able to identify some or all sections of actuarial opinion and formed a relevant actuarial opinion. Candidates who only listed the sections without forming an opinion regarding PDR received partial credits.

Table of key indicators:

Opinion Type	Inconclusive
Identification Section	Prescribed Wording
Scope Section	Prescribed Wording
Reliance Section	Prescribed Wording
Opinion Section	Revised Wording
Relevant Comment	Revised Wording

I, *FSA Candidate*, am a member of the American Academy of Actuaries. I was appointed by VNC on 1/1/2020 in accordance with the requirements of the annual statement instructions. I meet the Academy qualification standards for rendering the opinion.

I have examined the assumptions and methods used in determining Premium Deficiency Reserve for VNC's Commercial, Medicare and Medicaid business, as shown in the annual statement of the organization as prepared for filing with state regulatory officials, as of December 31, 2019.

In forming my opinion on premium deficiency reserve, I relied upon financial pro-forma data prepared by VNC as certified in the attached statements. I evaluated that data for reasonableness and consistency.

3. Continued

I am issuing an **inconclusive** opinion regarding VNC's premium deficiency reserve due to inadequate data and information provided.

Additional information has been requested, including premium increase limitation for guaranteed renewable products, and future year financial projection. Another actuarial opinion will be issued once this information is provided.

4. Learning Objectives:

3. The candidate will understand how to describe and evaluate government programs providing health and disability benefits in the U.S.

5. The candidate will understand how to evaluate the impact of regulation and taxation on companies and plan sponsors in the US.

Learning Outcomes:

(3b) Describe Medicaid program structure and benefits and evaluate pricing and filing.

(5b) Describe the major applicable laws and regulations and evaluate their impact.

Sources:

KFF brief – August 2019 – Medicaid expansion effects

Commentary on Question:

Candidates generally were able to articulate and describe a few key concepts of the effects of Medicaid expansion. A common theme of the responses was not providing enough impacts for full credit on the question.

Solution:

(a) Describe key effects of Medicaid expansion under the Affordable Care Act as they pertain to:

Impact on coverage

- States expanding their Medicaid programs under the ACA have seen large increases in Medicaid enrollment overall
- Medicaid expansion states experienced large reductions in the uninsured rates that significantly exceed those in non-expansion states
- Specific vulnerable populations have seen coverage gains in expansion vs. non-expansion state, including young adults, prescription drug users, people with HIV, low-income adults who screened positive for depression Medicaid expansion has had a particularly large impact on coverage and uninsured rates in rural areas
- Larger coverage gains and reductions in uninsured rates in expansion states have occurred across most or all of the major racial/ethnic categories compared to non-expansion states
- Effects of expansion on private insurance coverage is mixed – some states saw no evidence of expansion substituting for private coverage, some saw declines in private coverage
- States implementing expansion through waivers have seen similar or larger gains in coverage than in states not using waivers
- Some provisions in waivers presented barriers to coverage (e.g., work requirements, monthly contribution requirements)

4. Continued

(b) Access to care and related measures

- Medicaid expansion improved access to care and increased utilization of health care services among the low income population
- These services include cancer diagnosis and treatment, transplants, smoking cessation, behavioral health and medication assisted treatment for opioid use disorder
- Improvements in access and utilization of care across SES categories (race/ethnicity, income, education levels, employment status)
- Some reductions in patterns of emergency department use
- Some waiver provisions intended to change utilization or improve health outcomes have been confusing for beneficiaries
- General improvements in quality of care have been observed
- Some quality improvements in hospital care and outcomes observed – lower LOS and increased discharges to rehab
- Improvements in measures of self-reported health following expansion (access to life-changing treatments previously unavailable, e.g. Hep C)
- Improvements in outcomes such as cardiovascular mortality rates, cardiac surgery outcomes, one-year mortality rates for ESRD patients
- Some association with reductions in infant mortality vs. non-expansion states, particularly in the African-American population
- Providers have expanded capacity or participation in Medicaid following expansion and are meeting increased demands for care (more PCP availability, new patient acceptance, etc.)
- Provider availability did not worsen in most expansion states despite increased demand for care
- A few instances of difficulty obtaining appointments with specialists
- Expansion improved affordability of health care and reduced patient medical debt
- Improvements in other broader measures of financial security (e.g., credit scores, levels of consumer debt, evictions, bankruptcy rates)

(c) Economic measures

- State budgets and economies – increased federal match rate, also large infusions into state economies and significant state savings (DSH payments)
- State savings in other areas such as behavioral health services, crime and the criminal justice system
- Medicaid spending per adult enrollee are lower in expansion population than in traditional adult Medicaid enrollees (aged, blind, disabled)
- Marketplace effects – expansion has helped lower premiums vs. non-expansion states

4. Continued

- Impacts on hospitals and other providers – reduced uninsured utilization and uncompensated care costs vs. non-expansion states (ED, SUD treatment, cardiac conditions)
- Expansion has improved hospital operating margins and financial performance
- Employment and labor market effects – significant job growth
- Some evidence of increased employment
- Some evidence of increased labor participation rates and volunteer work

5. Learning Objectives:

5. The candidate will understand how to evaluate the impact of regulation and taxation on companies and plan sponsors in the US.

Learning Outcomes:

(5a) Describe the regulatory and policy making process in the US.

(5b) Describe the major applicable laws and regulations and evaluate their impact.

(5c) Apply applicable standards of practice.

Sources:

ASOP 50 and GHFV 830-20

Commentary on Question:

Candidates generally performed fairly well on part (a) of the question. On part (b), about half of the candidates did well while many were only partially successful. The most common mistake on (b) was confusing the actuarial value with the anticipated loss ratio. On part (c), most candidates provided at least a partial answer but relatively few provided a complete answer. Candidates struggled with part (d). Many candidates determined that there was a difference in pmpm premiums based on the actual enrollment but few candidates matched up the difference in expenses with the difference in premiums and failed to recognize that profitability varies significantly by silver tier.

Solution:

(a) For each of the following terms in the ACA:

- Actuarial Value
- Minimum Value
- Essential Health Benefits
- Non-Standard Plan Designs

(i) Define the term

(ii) Explain the term's application to Company ABC

(a)(i) (Source: ASOP 50)

Actuarial Value is the percentage of total allowed costs that the plan is expected to pay in benefits.

Minimum Value is the minimum percentage of allowed costs that the plan is expected to pay to be an ACA approved employer plan.

Essential Health Benefits is the defined list of benefits that an ACA plan is required to provide in the individual and small group markets.

5. Continued

Non-Standard Plan Designs are plan designs that cannot be evaluated using the AV calculator or MV calculator.

(a)(ii) (Source: ASOP 50)

ABC must determine actuarial value for each of their plans and fit each into Bronze, Silver, Gold or Platinum designations.

Minimum value does not apply for ABC since they are only offering individual products.

ABC must include all essential health benefits in their plan design.

If ABC's plans have any non-standard plan designs, then ABC must use a supplemental calculation and make the appropriate disclosures.

(b) Calculate premium loadings necessary under each of the options below. Show your work.

(i) Option 1: Load Silver plans only

(ii) Option 2: Load all metal levels

(b)(i) (Source: GHFV 823-20)

First step is to calculate required premiums for each benefit plan as shown:

- Bronze=200
- Silver (70)=300
- Silver (73)=300*73/70=313
- Silver (87)=300*87/70=373
- Silver (94)=300*94/70=403
- Gold=360

Next step is to determine the average premium for the silver plans weighted by enrollment since all silver plans need to have the same rate.

- Average of silver plans=(300*0.1+313*0.2+373*0.25+403*0.25)/(0.1+0.2+0.25+0.25)=358

Final step is to determine the percentage load to the existing Silver premium.

- Load=358/300-1=19.3%

5. Continued

(b)(ii) (Source GHFV 823-20)

Using amounts calculated in the first step above, first step is to determine average required premium for all plans weighted by enrollment.

- Average required premium=200*0.15+300*0.1+313*0.2+373*0.25+403*0.25+360*0.05=335

Second step is to determine average premium based on existing premium and weighted by enrollment.

- Average premium=200*0.15+300*0.8+360*0.05=288

Final step is to determine the percentage load to be applied to all premiums.

- Load=335/288-1=16.3%

(c)

(i) Identify alternative options Company ABC can use aside from premium loading

(ii) Describe the pros and cons of each of the options in i).

(c)(i) (Source GHFV 823-20)

Options include:

- Sue the government
- Withdraw from exchanges and, therefore, not offer CSR plans
- Do nothing and have inadequate premium

(c)(ii) (Source GHFV 823-20)

Sue the government

- Pros: potential collection of loss of premium
- Cons: expensive and may not be successful

Withdraw from exchanges

- Pros: avoid subsidy of CSR plans
- Cons: loss of potential customers and associated profits

Do nothing

- Pros: maintain premium competitiveness; no additional filing; less disruptive to customers
- Cons: deterioration of profitability and potential insolvency

5. Continued

(d) Calculate the financial impact of the actual enrollment to Company ABC's profitability. Show your work.

(d) (Source GHFV 823-20)

First step is to determine planned profitability. Easiest method to calculate this is to take 2.5% of the average pmpm after loading.

- Planned profits=335*0.025=8.38

Next step is to determine profitability based on revised enrollment. This requires subtracting premiums based on revised enrollment from required premiums by tier based on revised enrollment (after adjusting out planned profit margin). The premiums based on revised enrollment is the average of the premiums developed in (b)(i) weighted by revised enrollment. The required premiums by tier based on revised enrollment is the required premiums developed in the first step of (b)(i) weighted by revised enrollment and adjusted for the planned profit margin.

- Average premium based on revised enrollment=200*0.18+358*(0.07+0.19+0.23+0.26)+360*0.07=329.70
- Required premiums based on revised enrollment adjusted for planned profit= (1-0.025)*(200*0.18+300*0.07+313*0.19+373*0.23+403*0.26+360*0.07)=323.8
- Actual profits=329.70-323.84=5.86

Revised enrollment caused profitability to reduce by 2.52 pmpm based on a combination of lower pmpm and richer average benefit plans.

6. Learning Objectives:

4. The candidate will understand how to prepare and be able to interpret insurance company financial statements in accordance with U.S. statutory principles and GAAP.

Learning Outcomes:

(4a) Prepare financial statement entries in accordance with generally accepted accounting principles.

(4b) Interpret the results of both statutory and GAAP statements from the viewpoint of various stakeholders, including regulators, senior management, investors.

(4c) Project financial outcomes and recommend a strategy.

(4d) Apply applicable standards of practice.

Sources:
GHFV-109-19: Health Insurance Accounting Basics for Actuaries

Commentary on Question:
Commentary listed underneath question component.

Solution:

(a) List the three main concepts that have influenced the development of NAIC Statutory Accounting Principles guidance.

Commentary on Question:
Since the question only asked candidates to list the items, full credit was given for listing the items from p. 117 of the study note.

- Conservatism
- Consistency
- Recognition

(b) Explain six distinct ways in which GAAP accounting differs from statutory accounting.

Commentary on Question:
Study notes pp. 120-124 listed 12 specific items related to NAIC SAP and US GAAP, one of which (unpaid claims liabilities) was noted as generally being the same under both. Full credit was given for identifying and explaining any six of the remaining 11 items.
Many candidates just noted general differences between the two (e.g., statutory accounting is more conservative). Partial credit was given if any of the general observations were linked to one of the specific items.

6. Continued

- Disabled life reserves – under GAAP, based on the ultimate cost of settling the claim; SAP prescribes minimum standards for methods and assumptions
- Policy reserves – similar to disabled life reserves in that SAP uses prescribed minimum standards; SAP reserves are implicitly "locked in"
- Deferred acquisition costs (DAC) – allowed under GAAP; does not exist under SAP (recognized as expenses when costs are incurred)
- Premium deficiency reserves (PDR) – under GAAP, if DAC exists, PDR may lead to partial write off of DAC; under SAP, no DAC allowed, so premium deficiency always results in PDR
- Additional actuarial reserves – under SAP, actuary may conclude need for additional reserves; no such requirement under GAAP
- Reinsurance – ceded reserves are an asset under GAAP; treated as a contra-liability under SAP
- Healthcare receivables – asset under GAAP; generally non-admitted asset under SAP unless there is specific guidance to the contrary
- Prepaid expenses – under GAAP, debit asset account and later recognize expenses and reduce asset; under SAP, assets are non-admitted
- ASO Fees – recognized as revenue under GAAP; treated as a contra-expense under SAP
- Cost containment expenses – no clear guidance under GAAP, may be included in claims expense; treated as an administrative expense under SAP
- Measurement attributes for invested assets – GAAP has different measurement guidelines for asset class; SAP also distinguished between Orange Blank and Blue Blank companies (with latter having special Asset Valuation Reserves and Interest Maintenance Reserves)

(c) Calculate ABC's claims expense for 2019 for annual GAAP reporting. Show your work.

Commentary on Question:
This was a straightforward calculation of claims incurred for the year plus change in reserves (p. 107 of the study note). Many candidates received full credit. The most common mistakes were miscalculating or ignoring the change in reserves or not including claims paid in the current year for prior years' services.

Claims expense = (Claims paid in current year for current year services + Claims paid in current year for prior years' services) + (Ending UCL for current year services + Ending UCL for prior years' services) – Beginning UCL

Claims expense (in $millions) = ($160.3 + $11.5) + ($15.2 + $0.3) - $13.8 = $173.5

6. Continued

(d) Justify whether a change in the following items would impact statutory income, statutory surplus, or both:

(i) Prepaid Expense Assets

(ii) Claims Overpayment Receivables

Commentary on Question:
To receive full credit, candidates must have understood admitted versus non-admitted assets (p. 118 of the study note), and how each of the items affects statutory income and surplus (pp. 122-123). Very few candidates demonstrated this correctly. Partial credit was given if the correct impacts were given, even if the reasoning was not fully demonstrated.

Statutory surplus is equal to admitted assets less liabilities, and therefore only admitted assets impact surplus. Statutory income may be impacted by both admitted assets and non-admitted assets.

(i) Prepaid expenses are non-admitted assets and therefore a change in their value would only impact statutory income.

(ii) Claims overpayment receivables are admitted assets to the extent that an insurer has sent an invoice to the provider; assets above that are non-admitted. A change in value of the admitted portion would impact both statutory surplus and statutory income, and a change in value of the non-admitted portion would only impact statutory income.

(e) Critique the strategy of using Fee-For-Service providers to enhance a capitated provider network.

Commentary on Question:
Candidates were expected to provide both strengths and weaknesses of this approach in their answer. Many candidates provided only weaknesses. Full credit was given if at least two strengths and two weaknesses were provided. (See discussion on pp. 57-63 of the study note. Examples for strengths and weaknesses below:

Strengths:

- Quick and easy to add new providers, since no need to negotiate a capitated rate
- FFS relatively easier to administer than capitated plans
- May result in increased quality of service as FFS providers are more incentivized to have repeat business than capitated providers

6. Continued

Weaknesses:

- FFS providers may be higher cost that capitated ones
- Difficult to control claims trend, since no incentive for FFS providers to keep utilization under control
- Current capitated providers may find out about FFS providers getting paid more for similar services, and may opt out of HMO network or demand higher reimbursements

(f) Recommend an alternative strategy that can help ABC expand rapidly into new geographic areas. Justify your answer.

Commentary on Question:
This was an open-ended question meant to draw on a candidate's ability to synthesize different risk sharing and provider contracting arrangements. To receive full credit, a candidate needed to identify and justify only one arrangement. Partial credit was given for solutions that were not necessarily "rapid" expansions as required by the questions (e.g., purchasing or merging with another insurer). Examples below:

- Create a new network product that is exclusively PPO (FFS), while gradually continuing to expand its HMO network in the new area as well, so eventually it can have a product in the new geography that carries the same value proposition (low cost) as the existing HMO.
- Allow PPO (FFS) providers to join the HMO network, but invest in a strong care management program and/or incentive/bonus program that ensures there is no excess utilization and claims costs are kept low.
- Establish a partnership with an HMO already operating in the geographic area, in order to leverage pre-existing provider relationship.

7. Learning Objectives:

3. The candidate will understand how to describe and evaluate government programs providing health and disability benefits in the U.S.

Learning Outcomes:

(3a) Describe Medicare benefits and evaluate pricing and filing.

(3b) Describe Medicaid program structure and benefits and evaluate pricing and filing.

Sources:

Health Watch February 2019

Commentary on Question:

Candidates did well identifying data quality issues related to data elements and completeness but often excluded issues related to benefit parameters and provider contracts. Common mistakes were mixing up internal vs external concerns and only including information from ASOP #23 Data Quality. Several candidates explained bid pricing considerations rather than concerns related to data quality.

Solution:

(a) Explain potential areas of concern related to data quality that are internal to your company's claims adjudication process.

Commentary on Question:

Candidates were given credit for explaining elements in any category. Most answers focused on required data elements.

Does the data contain the required elements?

- Missing information – certain benefits may not have claims data at a member level detail, or didn't track encounter data associated with capitated services
- Aggregate data – some claims data may lack sufficient detail to allocate to specific service categories as outlined in the BPT
- Integration of benefits – related to dual eligibles, need to be able to segregate the two benefits and use only the subset used by Medicare-Medicare vs. non-Medicare covered benefits – some service categories include services that are covered under traditional Medicare vs. only supplemental benefits
- Incomplete data – claims lags impact completion, also impact of vendor changes or contract changes
- Eligibility – member claim records need to have a consistent eligibility record; 2021 bids now allow for ESRD enrollment so corresponding data needs to be included
- Utilization considerations – verify that the correct unit definitions are being used to measure a particular service

7. Continued

- Paid amounts – ensure all the appropriate financial fields are being used
- BPT and PBP classification – ensure claims data correctly correspond to the appropriate BPT and PBP categories (e.g., crosswalk table)

Is claims experience consistent with benefit parameters and provider contracts?

- Capitated arrangements – need to validate that the vendor is receiving the correct PMPM amounts and they are covering services consistent with the PBP definition
- Member cost sharing – need to confirm that vendors and providers are charging cost sharing consistently with the PBP and CMS rules; need to ensure negotiated reimbursement rates are in compliance with CMS
- Benefit coverage – confirm and vendors are providing beneficiaries with the correct coverage for each of their plans and correctly adjudicated

Is claims experience reasonable compared to internal expectations?
Examples of actual-to-expected comparisons include:

- Financial results
- Adjudication or contracting issues
- Impact of care management
- Should monitor A/E throughout the year as well as at year end

(b) Explain potential areas of concern related to data quality that are <u>external</u> to your company's claims adjudication process.

Commentary on Question:
Candidates did well identifying concerns related to benchmarks and population risk.

Is the experience reasonable given external benchmarks?

- Need to compare claims experience to both the expected results and external benchmarks
- Elements include geographic area, covered benefits, risk scores and levels of utilization management

Is claims experience being prepared to comply with CMS requirements for bid pricing?

- Non-benefit expenses – need to be consistent with CMS guidance on what qualifies as medical claims expense vs. non-benefit expense
- Capitation encounters – encounter data needs to incorporated into the BPT; if accurate data is unavailable this needs to be disclosed as a deficiency and a develop corrective action plan
- Global payment allocation – related to capitation or risk-sharing arrangements. Need to allocate appropriately to the net cost of services on Worksheet 1