

# GH 101 Model Solutions

## March 2026

### 1. Learning Objectives:

3. The candidate will understand how to apply principles of pricing, risk assessment, and funding to an underwriting situation.
4. The candidate will understand how to evaluate and recommend an employee benefit strategy.

### Learning Outcomes:

- (3c) Recommend strategies for appropriately pricing, underwriting, and funding case-specific risks.
- (4b) Recommend an employee benefit strategy in light of an employer's objectives.

### Sources:

GH101-104-25: Recommend an Employer Benefit Strategy; Group Insurance, Skywire - Ch. 30: Managing Selection in a Multi-Choice Environment

### Commentary on Question:

*Candidates generally performed well on the qualitative parts of this question. The strongest candidates explicitly tied their responses in parts (c) and (d) back to specific numerical drivers from part (b) rather than providing generic rationale. Candidates had trouble with part (b) and most did not consider the financial impact of the transition for the existing Behemoth population. Further commentary listed under each question component.*

### Solution:

- (a) Describe the various parties and external considerations when designing an employee benefits strategy.

### Commentary on Question:

*Commentary on part (a), if appropriate. Candidates generally performed well on question (a). Full credit required candidates to describe parties and considerations specific to the design of an employee benefits strategy. Candidates who described parties and considerations to employee benefits plans more generally received partial credit.*

## 1. Continued

- Senior Leadership - Guiding Philosophy and principles to understand goals and overall benefits philosophy.
- Director of Benefits - to understand the 'guard rails' for making decisions on individual plan designs.
- Financial and Regulatory Limits - Senior Leadership Philosophy will be constrained by financial and regulatory constraints.

- (b) Calculate the annual difference in costs to Behemoth for transitioning Start-Up employees to Behemoth's benefit package compared to allowing them to continue on their current package. Show your work.

### **Commentary on Question:**

*Commentary on part (b), if appropriate. Candidates performed poorly on question (b). Most candidates did not consider the need to reprice premiums for the whole population. Responses that included only Start Up current costs and costs under Behemoth's plan calculated using Behemoth's current premiums and subsidies received minimal credit. Well-rounded responses included steps to adjust Start-Up current claims to Behemoth's plan and combine the two groups' experience in developing new premium rates. Responses where employer cost was calculated based on a self-insured model (in which employer net cost = total plan expense - employee contribution) were also acceptable. Some candidates incorrectly calculated employer cost by adding additional components (e.g. claims, admin expense) to premium.*

See Excel file.

- (c) Evaluate the drivers of the difference in costs between the two options in part (b).

### **Commentary on Question:**

*Commentary on part (c), if appropriate. Candidates performed well on question (c) and most were able to at least identify increased subsidy as the primary driver. Candidates who were able to evaluate increased subsidy as the primary driver and at least one offsetting driver (lower actuarial value or network savings) received full credit. Candidates who evaluated other viable drivers that were consistent with their responses in part (b) received partial credit.*

Moving Start-Up members to Behemoth has favorable impact on premium, as Behemoth's package has lower actuarial values and a 3% claims reduction is expected from provider contracting. However, transitioning Start-Up members to the Behemoth package increases employer cost, as the previous Start-Up reimbursement was significantly lower than Behemoth. This differential, leading to higher employer subsidies in the Behemoth package, more than offsets cost savings from Behemoth's leaner benefits & provider contracting.

## 1. Continued

- (d) Recommend to the benefits manager whether she should continue operating Start-Up's previous benefit package or enroll the Start-Up employees in Behemoth's benefit package. Justify your answer.

**Commentary on Question:**

*Commentary on part (d), if appropriate. Candidates performed well on question (d). Candidates who provided strong support for their recommendation, whether to continue the current package or transition to Behemoth's package, received full credit. Recommendations based solely on cost without other considerations received partial credit.*

I would recommend the benefits manager to continue to operate Start-Up's current benefit package given the significant additional cost expected with the transition, as well as potentially creating abrasion with Start-Up employees.

*OR*

I would recommend transitioning Start-Up employees to Behemoth's benefit package despite the increase in cost. Having one benefit package will simplify benefits administration and help integrate Start-Up employees into Behemoth's culture.

## 2. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under short duration contracts (medical, dental, vision, prescription drug, group life).

### Learning Outcomes:

- (1b) Describe each of the contracts listed above.
- (1c) Evaluate the potential moral hazard and financial and legal risks associated with each type of contract.

### Sources:

Group Insurance, Skwire, Daniel D., 8th Edition, 2021; Ch. 5: Medical Benefits in the United States

### Commentary on Question:

*Commentary listed underneath question component.*

### Solution:

- (a)
  - (i) Describe the three dimensions in defining a medical plan.
  - (ii) List two examples of each dimension.

### Commentary on Question:

*Candidates performed well on question (a). Full credits were awarded to candidates listing and describing the three dimensions in (i), while candidates listing less than 2 distinct examples per dimension only received partial credits in (ii).*

**Dimension 1:** Definition of services covered and conditions under which they are covered.

- Description : defines which types of benefits will be covered, who has access to those benefits, and any provisions along with those benefits that may need to be considered
- Examples:
  1. covered facilities,
  2. covered services,
  3. benefit eligibility,
  4. limitations,
  5. exclusions

## 2. Continued

**Dimension 2:** Degree in which the insured shares in the cost of medical services.

- Description: how the member will share cost with the insurer, which includes for example deductibles, coinsurance, and OOP maximum that define how much each member pays to receive services
- Examples:
  1. premiums,
  2. deductibles,
  3. copays,
  4. coinsurance,
  5. Out of pocket maximum

**Dimension 3:** The degree to which service providers participate in the cost of services risk, and the breadth of the service network.

- Description: defines provider reimbursement model, how risk is shared between the plan and the relationship between the provider and the health plan.
- Examples:
  1. breadth of provider network,
  2. degree to which provider participates in the cost

- (b) Compare and contrast the impact to utilization of service and cost control for each of an HMO and a PPO.

### **Commentary on Question:**

*Candidates performed well on this question and demonstrated a strong understanding. Candidates who received full credits successfully compared/contrasted the 4 items presented in the question. Candidates who did not perform well failed to apply the methodology presented in section 5.3.3 of a Guide to actuarial exams – Verb list.*

### Guide to SOA exams - Section 5.3.3: Verb List:

- Compare / Contrast – There must be at least two items being considered. Both similarities and differences are to be articulated, but no conclusion is expected.

### **Similarities**

#### HMO and PPO – Utilization management

Both HMOs and PPOs apply utilization control mechanisms such as prior authorization, medical review, and clinical guidelines to limit inappropriate or unnecessary use of services.

## 2. Continued

### HMO and PPO – Cost control through networks

Both models rely on contracted provider networks where in-network providers agree to discounted reimbursement rates, helping reduce overall healthcare costs compared to non-contracted providers.

### HMO and PPO – Quality and utilization control

Both require provider credentialing and quality assurance processes, which support appropriate service utilization and help prevent costly complications or repeat services.

### HMO and PPO – Member cost incentives

Both plans use cost-sharing structures to encourage members to seek care within the network, reinforcing both utilization oversight and cost containment.

## Differences

### HMO vs PPO – Utilization control through access

HMOs use a gatekeeper model requiring members to select a primary care physician (PCP) who coordinates care and issues specialist referrals, tightly controlling utilization, whereas PPOs allow direct access to specialists without referrals, resulting in higher service utilization.

### HMO vs PPO – Provider network scope and utilization

HMOs generally operate with narrow provider networks that limit where members can receive care, reducing utilization flexibility, while PPOs offer broader networks and allow out-of-network access, increasing utilization options.

### HMO vs PPO – Cost control mechanisms

HMOs rely on network restrictions and managed access to control costs, whereas PPOs achieve cost control primarily through differential cost sharing, with lower deductibles and coinsurance for in-network care and higher costs for out-of-network services.

### HMO vs PPO – Provider incentives and utilization

HMO providers are often paid through capitation, bearing greater financial risk and thus having strong incentives to manage utilization efficiently; PPO providers are typically paid on a discounted fee-for-service basis, bearing less risk and facing weaker incentives to limit utilization.

## 2. Continued

### HMO vs PPO – Cost sharing and preventive care

HMOs usually feature minimal cost sharing, which encourages preventive care while still controlling utilization through access restrictions, whereas PPOs place more cost responsibility on members but allow greater freedom of choice.

- (c) Identify and describe two differences between the current PPO plan and the proposed CDHP that could impact employee behavior and plan costs.

### **Commentary on Question:**

*The majority of candidates successfully identified at least 2 distinct differences between the plans. Candidates who did not describe the impacts only received partial credits.*

### Difference #1: Cost-Sharing Structure

The PPO has a lower deductible with coinsurance up to an out-of-pocket maximum, resulting in lower upfront costs and more predictable expenses for employees. The CDHP has a higher deductible with 100% coverage afterward, shifting more initial costs to employees. This increased cost sharing may reduce discretionary utilization and lower plan costs.

### Difference #2: Health Savings Account (HSA)

The CDHP includes a Health Savings Account (HSA), often with employer contributions, while the PPO typically does not. The HSA encourages employees to be more cost-conscious and save for future healthcare expenses through tax-advantaged contributions, which may help offset the higher deductible and reduce employer plan costs over time.

### Difference #3: Utilization of Healthcare Services

Lower cost sharing under the PPO may lead to higher utilization of services. Under the CDHP, greater financial responsibility may encourage employees to shop for care, choose lower-cost options, or delay non-urgent services, contributing to reduced utilization and lower overall plan costs.

- (d) Explain risks the employer may face in transitioning to the CDHP.

### **Commentary on Question:**

*Many candidates struggled on this question. Full credits were awarded to candidates identifying and explaining 2 distinct risks in sufficient detail to demonstrate understanding.*

## 2. Continued

### Guide to SOA exams - Section 5.3.3: Verb List:

- Explain – This calls for even more information than describe, showing that you can convey “why” or “how.” A connection is expected between the items and something else. Could be at the next level, depending on the complexity of the situation

#### 1. Communication and Education Risk

Transitioning to a CDHP requires significant communication efforts to educate employees on how to use a Health Savings Account (HSA) and how to navigate a high-deductible plan. Inadequate education may lead to confusion or poor plan use.

#### 2. Employee Resistance

Higher deductibles may be perceived as a reduction in benefits, leading to employee dissatisfaction. Some employees may not fully understand or value the HSA, increasing resistance to the new plan design.

#### 3. Employee Health Outcomes

Employees with lower incomes or chronic conditions may delay or avoid necessary care due to higher upfront costs. This could negatively affect employee health and potentially increase long-term medical costs for the employer.

- (e) Propose two strategies management can implement to improve the transition. Justify your response.

### **Commentary on Question:**

*The majority of candidates successfully proposed 2 distinct strategies with solid justifications. Candidates who presented less than 2 distinct strategies were only awarded partial credit.*

### Guide to SOA exams - Section 5.3.3: Verb List:

- Propose/Recommend – You are to make a decision regarding what to do about a situation. Note that there may be more than one reasonable choice and your grade will depend on the support you provide for your choice

### **Strategies to Improve the Transition to a CDHP**

#### 1. Offer Both Plans During the Transition Period:

Management can offer the PPO and CDHP simultaneously and monitor employee take-up of the CDHP. This approach allows employees time to understand the new plan design, reduces resistance to change, and provides management with data on employee preferences and behavior.

## 2. Continued

### 2. Set HSA Contributions to Achieve Actuarial Equivalence:

Management can structure employer HSA contributions so that the CDHP is actuarially equivalent to the PPO. This helps ensure that, on average, employees are no worse off financially under the CDHP, improving acceptance and reducing concerns that the change represents a benefit reduction.

### 3. Implement a Strong Communication and Education Program:

Management can provide targeted education sessions, decision-support tools, and clear communications explaining how the CDHP and HSA work. Improving employee understanding reduces confusion, increases confidence in using the plan, and supports informed enrollment decisions.

### 4. Provide Targeted Support for High-Risk or Low-Income Employees:

Management can offer enhanced employer HSA contributions, care navigation support, or exemptions for preventive care to protect vulnerable employees. This reduces the risk that employees delay necessary care due to cost concerns and helps maintain overall workforce health during the transition.

### 3. Learning Objectives:

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

#### Learning Outcomes:

- (2d) Calculate and recommend a manual rate (includes developing a base rate and applying a rating manual).

#### Sources:

Group Insurance Chapter 21: Estimating Medical Claim Costs

#### Commentary on Question:

*The intent of this question is to evaluate the candidate's understanding of normalization factors and how to apply them when estimating claim costs along with how to value a copay when determining the net benefit. Candidates generally performed very well on this question, though minor calculation errors were relatively common.*

*As noted in a communication to candidates, the solutions for part b) to d) were inadvertently included in the Excel file. Candidates were awarded full credit for these items. The exam chair & committee considered this item and situation when setting the pass mark for the exam. In particular, we evaluated candidate performance on the entire exam, the exam without #3, and several other additional performance metrics. When setting the pass mark, we came down on the side of being more generous so as to reflect the fact that not all candidates were testing under the same circumstances. Senior SOA staff were included in the evaluation of candidate performance to ensure a fair and equitable exam grade for every candidate.*

#### Solution:

- (a) For each rating variable:
  - (i) Explain why the variables need to be normalized when analyzing historical data for prospective pricing.
  - (ii) Identify and describe a scenario when normalizing the rating variable would have a material impact on pricing.

#### Commentary on Question:

*Most candidates understood what was being asked and performed well on this part of the question. Candidates were expected to both explain why the two provided variables need to be normalized and provide a specific scenario for each given variable that would have a material impact on pricing. Answers related to other group characteristics outside of industry and group size were also accepted for full credit.*

### 3. Continued

Provider Reimbursement Arrangements: Historical data needs to be normalized for provider reimbursement arrangements if there is a change in the arrangement between the historical and current timeframe as this may lead to different utilization or cost patterns. An example would be if a provider was switched from a fee for service to a capitation-based contract. The capitation would likely cause a reduction in utilization that would need to be captured through normalization.

Group Characteristics: Group characteristics such as industry need to be normalized because some industries can have different utilization patterns that would need to be adjusted for. Group size is another significant rating variable because as the size of the group decreases, the influence of high-cost claimants is magnified. There is also some tendency for small employers to provide medical insurance in a way that selects against insurers since these employers may be more aware of the specific health needs of their employees and choose the plan most beneficial to them. An example would be if a group expanded into a new sector with an older, relatively less healthy population, healthcare utilization would be expected to increase compared to the group's past experience and need to be normalized.

- (b) Calculate ABC's 2026 allowed claim cost for Group A. Show your work.

**Commentary on Question:**

*Candidates had the most trouble on this part, though still generally did well overall. Some candidates struggled to correctly normalize the manual and historical experience factors given the data tables provided. A common issue was directly applying the given manual Geographic Area Factor instead of normalizing it based on the 2026 projected Geographic Area Factor. Other common issues were trending the manual experience incorrectly and not providing the expected 2026 allowed claim cost as a PMPM since the expected membership for 2026 was not given.*

*As noted above, although all candidate papers were graded rigorously following the March 2026 sitting, all candidates were ultimately given full credit for part (b).*

See Excel for full solution. General Outline of steps:

1. Using Table 1, calculate the PMPM Cost for each of the three data sources. The PMPM Cost = Allowed Charges / Member Months.
2. Using Table 2, calculate the Geographic Area pricing adjustment needed to normalize the three data sources to 2026.
  1. The first step is to calculate the composite Geographic Area Factor for all four data sources (including 2026). The composite Geographic Area Factor = Sumproduct (Area Factor, Distribution of Members) for 2023 Experience, 2024 Experience, and 2026 Projection. Note: The manual composite Geographic Area factor is provided as 0.958 in the question.

### 3. Continued

2. The second step is to normalize the 2023 Experience, 2024 Experience, and Manual Geographic Area factor to the 2026 Projected. Pricing Adjustment to 2026 = 2026 Projection Composite Area Factor / Data Source Area Factor (e.g. 2023 Experience)
3. Similarly, using Table 3, calculate the Age-Gender pricing adjustment needed to normalize the three data sources to 2026.
  1. The first step is to calculate the Composite Age-Gender factor for all four data sources (including 2026). The Composite Age-Gender factor = Sumproduct (Age-Gender Factor, Distribution of Members) for 2023 Experience, 2024 Experience, Manual and 2026 Projection.
  2. The second step is to normalize the 2023 Experience, 2024 Experience, and Manual Age-Gender factor to the 2026 Projected. Pricing Adjustment to 2026 = 2026 Projection Composite Age-Gender Factor / Data Source Age-Gender Factor (e.g. 2023 Experience)
4. The final factor needed is the Trend factor. The annual trend is given in the problem as 6.5%. The Trend Factor =  $(1+6.5\%)^{[\text{Months of Trend} / 12]}$  The 2023 Experience is trended forward 36 months (3 years \* 12 months in a year) while the 2024 Experience and Manual is trended forward 24 months. The problem states that the Manual is using 2024 experience.
5. To calculate the 2026 Projected Allowed PMPM for each separate data source, take the product of the four values calculated above. 2026 Projected Allowed PMPM = Allowed PMPM Cost \* Geographic Area Factor \* Age-Gender Factor \* Trend Factor
6. The final answer is the blended average of the 2023 Experience, 2024 Experience, and Manual using a weighting of 25%, 25%, and 50% respectively.

Final answer = \$755.56

- (c) Calculate the current Net Benefit PMPM. Show your work.

#### **Commentary on Question:**

*Candidates generally did very well on this part. The most common issue was not realizing that the provided table was already normalized to per 1,000 members so utilization did not need to be scaled to expected membership figures given in Table 1. Another common mistake was missing the net benefit from skilled nursing as it did not have the same copay as the other inpatient hospital services. Partial credit was given if the response was not scaled properly to a PMPM value.*

*As noted above, although all candidate papers were graded rigorously following the March 2026 sitting, all candidates were ultimately given full credit for part (b).*

### 3. Continued

See Excel for full solution. General outline of steps:

1. Calculate Gross PMPM Benefit Cost = (Annual Services per 1000 Members / 1000) \* (Average Cost per Service / 12) across all services.
2. Calculate the Value of Current Copay Amount = (Annual Services per 1000 Members / 1000) \* (Current Copay / 12) across all services.
3. Calculate the Current Net Benefit Cost = Gross PMPM Benefit Cost – Value of Current Copay Amount.

Final Answer = \$517.97

- (d) Calculate the new net benefit PMPM after the copay updates. Show your work.

**Commentary on Question:**

*Candidates that did well on part C generally also did very well on part D. Common mistakes include misapplying the new copay amounts to the correct services and dropping off unchanged copay amounts from part C. Partial credit was given if the response was not properly scaled to a PMPM value. Alternative solutions were also accepted for full credit if the final answer was correct.*

*As noted above, although all candidate papers were graded rigorously following the March 2026 sitting, all candidates were ultimately given full credit for part (b).*

See Excel for full solution. General outline of steps:

1. Repeat Step 2 from Part C with the New Copay Amount. Value of New Copay Amount = (Annual Services per 1000 Members / 1000) \* (New Copay / 12) across all services.
2. Calculate the New Net Benefit Cost = Gross PMPM Benefit Cost – Value of New Copay Amount

Final Answer = \$508.45

#### 4. Learning Objectives:

3. The candidate will understand how to apply principles of pricing, risk assessment, and funding to an underwriting situation.

#### Learning Outcomes:

- (3a) Understand the risks and opportunities associated with a given contract, eligibility requirement, or funding mechanism
- (3c) Recommend strategies for appropriately pricing, underwriting, and funding case-specific risks.

#### Sources:

Group Insurance, Skwire, 8th Edition, Ch. 29; Ch. 30

#### Commentary on Question:

*Commentary listed underneath question component.*

#### Solution:

- (a) Calculate the estimated morbidity of the new enrollees in year 2, under Proposal 1, given the break-even selection load for ABC of 10%. Show your work.

#### Commentary on Question:

*Most candidates used goal seek to solve for the morbidity. Although this was not the only way to solve the problem, full credit was given for getting the correct answer whether the candidate used goal seek or not, as long as sufficient work was shown. Common mistakes included not mapping year 2 plans correctly, not trending the premium in year 2, and not using the correct calculation for the selection load required to solve for the unknown morbidity.*

See Excel file.

- (b) Calculate the selection load needed in year 2 for ABC to break even under Proposal 2. Show your work.

#### Commentary on Question:

*Candidates typically did well on this part if they did well on part (a). Full credit was given for calculating the selection load correctly, even if the morbidity used from part (a) was not correct. Common mistakes were similar to those in part (a).*

See Excel file.

## 4. Continued

- (c) Contrast this funding arrangement with a Traditional Fully Insured plan.

**Commentary on Question:**

*This question was testing the candidate's ability to differentiate features of an ASO (self-funded) plan versus a fully insured plan, including the mechanics of stop loss coverage. For full credit, four differences needed to be accurately described between ASO and fully insured.*

ASO (self-insured) plans differ from traditional fully insured plans in the following ways:

- In an ASO plan, the plan sponsor assumes the financial risk, litigation risk, reputational risk, and operational risk. In a fully insured plan, these risks are transferred to the insurer.
- ASO plans provide increased plan flexibility for the plan sponsor as they are governed by ERISA and not subject to state mandated benefits. Traditional fully insured plans are less flexible and are governed by states, so they have less flexibility in plan design and require certain benefits to be covered.
- Under the fully insured arrangement, XYZ will pay premium tax to the insurer for its premium, as well as the health insurer fee and other risk charges. In an ASO plan this would only apply to the stop loss portion of the premium.
- The fully insured plan has fixed monthly premium requirements, whereas the ASO plan is subject to monthly volatility in cash flows for XYZ.
- An ASO plan allows XYZ to benefit if their actual experience is better than expected. If there is good experience in a fully insured plan, the insurer keeps any surplus as additional profit.
- With stop loss, XYZ limits some of the risk of an ASO plan by protecting against individuals with high claims expense (SSL) and high total claims expense (ASL).

## 5. Learning Objectives:

3. The candidate will understand how to apply principles of pricing, risk assessment, and funding to an underwriting situation.
4. The candidate will understand how to evaluate and recommend an employee benefit strategy.

### Learning Outcomes:

- (3a) Understand the risks and opportunities associated with a given contract, eligibility requirement, or funding mechanism.
- (3c) Recommend strategies for appropriately pricing, underwriting, and funding case-specific risks.

### Sources:

Level Funding. An Alternative to ACA for Small Groups; Group Insurance Ch 26

### Commentary on Question:

*Generally students performed well on this question.*

### Solution:

- (a) Describe advantages and disadvantages of self-insurance, including how a level-funded product addresses a disadvantage, mitigates an advantage, or has no impact, by completing the grid in Excel.

### Commentary on Question:

*Most candidates did well on filling out this chart. To receive full credit the candidates needed to supply 3 advantages and 3 disadvantages and then properly link it to the implications for level funding.*

See Excel

- (b)
  - (i) Calculate the cash flows by month for each of the three funding arrangements by using the table and chart in Excel. Show your work.
  - (ii) Explain how the level funded plan generates the cash flow illustrated in part (i).
  - (iii) Interpret the chart.

## 5. Continued

### **Commentary on Question:**

*Majority of candidates received full credit for fully-insured and self-funded. Candidates struggled with the level-funded calculation.*

*To be awarded full credit in part ii, candidates' had to mention level-funded premiums were the same per month. To be awarded with full credits in part iii, candidates needed to mention impact of three funding arrangements on cash flow.*

See Excel

- (c)
- (i) Calculate how the claims liability for Company ABC changes as the annual claims increase. Use the table and chart in Excel. Show your work.
  - (ii) Explain how the level funded plan generates the claims liability illustrated in part (i).
  - (iii) Interpret the chart.

### **Commentary on Question:**

*Candidates struggled more with part C than other parts of the question. Common errors in part i included: non-zero claim liability for the fully insured plan, not applying the maximum liability (stop loss attachment) to the level funded plan, and including non-claim expenses.*

*Candidates typically did well in part ii when their answer to part i was correct or very close. To earn full credit, the candidate must have accurately described the impact of level funding on claims liability before and after the aggregate stop loss attachment point. Partial credit was awarded if the candidate accurately described an incorrect graph.*

*Similar to part ii, candidates struggled in part iii when the graph they were interpreting had errors. To earn full credit, the candidate must have accurately described the impact of all three funding arrangements on claims liability and compared and contrasted them. Partial credit was awarded if the candidate accurately described an incorrect graph.*

See Excel

## 5. Continued

- (d) Recommend a funding arrangement to the CFO. Justify your response.

**Commentary on Question:**

*Candidate performance was mixed for question (d). Candidates who provided a recommendation that included a strong explanation of the chosen funding arrangement and who used results from parts b/c received full credit. Candidates received partial credit for providing a recommendation, but who failed to bring in the results from prior parts. A recommendation without justification received minimal credit.*

See Excel

## 6. Learning Objectives:

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

### Learning Outcomes:

(2b) Develop a medical cost trend experience analysis.

(2c) Calculate and recommend assumptions.

### Sources:

Group Insurance CH 35 - Medical Cost Trend

### Commentary on Question:

*Commentary listed underneath question component.*

### Solution:

- (a) Describe the phases of the technology curve following the introduction of new technology.

#### Commentary on Question:

*Candidates performed generally well here. Full credit was given to solutions with the list of phrases in the technology curve with a basic level of explanation of each.*

1. Start-up: slow increase in utilization as people become aware of the technology (small increase in trend)
2. Catch-up: focus on existing members who can benefit from the technology (large increase in trend)
3. Steady-state: focus on new members who can benefit from the technology (decrease in trend because it is growing slower)
4. Transition stage: new technology is introduced, or lower cost versions of the technology are available (trends revert back to levels from before the technology)

- (b) Calculate the following. Show your work.

- Unit Cost Trend
- Change in Severity
- Core Unit Cost Trend

#### Commentary on Question:

*This was a straightforward calculation with data provided. Calculation provided in Excel*

## 6. Continued

Unit cost	15.18%
Severity	17.03%
Core cost trend	34.80%

- (c) Recommend a projected 20X5 Net Paid Trend. Justify your assumptions and show your work.

### **Commentary on Question:**

*This question provides several assumptions to be included in the calculation, but also asks for the candidate to provide an additional adjustment to trend (basically any negative number would suffice), and it seems like it was not entirely clear to many candidates that they were being asked to add their own arbitrary recommendation to the mix. Many candidates either omitted that part of the answer, or tried to derive something from what was given elsewhere in the question.*

*Top scores were given when candidates applied the given copay to calculate a paid trend, incorporated the given 3% core utilization trend, and introduced a one-time negative change representing the shift to the steady-state phase of the technology curve.*

*Calculation provided in Excel*

Core cost trend	37.96%	
core util trend	3%	
one time change	-0.05	
Net paid trend with one time change trend added		35.00%

**7. Learning Objectives:**

4. The candidate will understand how to evaluate and recommend an employee benefit strategy.

**Learning Outcomes:**

- (4a) Describe the structure of employee benefit plans and products offered, and the rationale for offering these structures.

**Commentary on Question:**

*Commentary listed underneath question component.*

**Solution:**

- (a) Compare the features of a Health Savings Account (HSA), Health Reimbursement Account (HRA) and Flexible Spending Account (FSA) by completing the table below in Excel.

<b>Feature</b>	<b>HSA</b>	<b>HRA</b>	<b>FSA</b>
Who owns the account?			
Who can contribute?			
Are contributions tax-deductible?			
Can the funds roll over to the next year?			
What distributions are tax-free?			
What distributions are not eligible?			
Is an HDHP required?			

**Commentary on Question:**

*Candidates performed well on this part of the question and were able to correctly populate most of the entries in the table. The question regarding the distribution that are tax-free and the distributions that are not eligible are the more challenging parts of this question; candidates who did not receive full credit typically missed this part of the question.*

7. Continued

Feature	HSA	HRA	FSA
Who owns the account?	Employee	Employer	Employer
Who can contribute?	Employer/ Employee	Employer	Employer/ Employee
Are contributions tax-deductible?	Yes	Yes	Yes, except LTC ER contributions
Can the funds roll over to the next year?	Yes	Yes, up to the employer	Yes, up to the employer
What distributions are tax-free?	Med, Rx, dental, vision, LTC prem, Medicare prem	Med, Rx, dental, vision, HI prems, LTC prems, expenses	Med, Rx, dental, vision
What distributions are not eligible?	Amounts covered under another health plan	Amounts covered under another health plan	HI prems, LTC prems or expenses, amounts under another health plan
Is an HDHP required?	Yes	No	No

- (b)
- (i) Calculate the expected cost sharing difference between Plan A and Plan B. Show your work.
  - (ii) Describe additional considerations, beyond anticipated cost sharing, for choosing between Plan A and Plan B.

**Commentary on Question:**

*Candidates that correctly calculated the cost share and the difference in cost share between Plan A and Plan B received full credit. In general, candidates performed well and received full credit or partial credit for minor calculation errors.*

## 7. Continued

*Most candidates received only partial credit regarding additional considerations for choosing between Plan A and Plan B. Candidates who only listed considerations without explanation received partial credit. Below is a list of considerations that are correct responses; other responses are also acceptable. The candidate does not need to list all the considerations below to receive full credit.*

### Cost Share Calculations

	Plan A	Plan B	Comment
Claim #1	\$1,200	\$1,020	Deductible for Plan A; Ded & Coins for Plan B
Claim #2	\$1,450	\$500	Ded & Coins. for Plan A; Coins. For Plan B
Claim #3	\$150	\$75	Coins. Only
<b>Total</b>	<b>\$2,800</b>	<b>\$1,595</b>	
<b>Difference</b>	<b>\$0</b>	<b>(\$1,205)</b>	Lower OOP for Plan B

#### Claim #1

Plan A = entire \$1,200 subject to deductible

Plan B = \$1,000 (deductible) + 20% \* (\$1,200 - \$1,000) = \$1,020

#### Claim #2

Plan A = \$1,000 (deductible) + (\$2,500 - \$1,000) \* 30% = \$1,450

Plan B = \$2,500 \* 20% = \$500

#### Claim #3

Plan A = \$750 \* 20% = \$150

Plan B = \$750 \* 10% = \$75

### Considerations

- Cost sharing in the HDHP can be paid for with tax-deductible HSA funds associated with the plan. This could include contributions to the HSA made by the employer outside of employee contributions
- Employer may charge higher premiums for the major medical HMO
- Higher cost sharing under the HDHP may deter employee from obtaining needed services

## 7. Continued

- Major medical HMO could have restrictions such as requiring PCP referrals for specialty services in Claim #3
  - HMO does not cover out-of-network claims except for emergencies
- (c) Explain how allowing HSAs to be utilized for the following differs from current regulation:
- Health care premiums
  - Over-the-counter health supplies
  - Pre-funding long-term care needs

### **Commentary on Question:**

*Most candidates received partial credit only for this part of the question. Candidates that explained the difference between current regulation and the proposed regulation received full credit. Candidates that cited current regulation per the source material included in the syllabus OR the current regulation based on recent legislation received credit.*

#### Health Care Premiums

- Under current regulation, HSA funds cannot be used for the employer plan premiums. However, they can be used for premiums for other plans (e.g. Medicare, LTC).
- Allowing the use of HSA for health insurance premiums could result in increased uptake with marketplace plans.

#### OTC Health Supplies

- The Affordable Care Act prohibited the usage of HSA funds for OTC health supplies, which include needed items that health plans don't cover. This could discourage employees from self-treating minor issues, and instead, seeking medical attention.
- Allowing the use of HSA for OTC health supplies can relieve the financial strain on members to manage their health. This can potentially avoid more costly medical care.

#### Pre-funding long-term care needs

- Under current regulation, HSA funds cannot be used for long-term care services. Not funding for long-term care services is a current crisis as it puts individuals at significant financial risk and instability in that financial market.
- Changing this regulation could be a solution to this pressing problem; broader use of HSA for LTC-related care