GH 201-U Model Solutions
March 2026

1.

Learning Objectives:

1. The candidate will understand how to apply valuation principles for group and health insurance contracts.

Learning Outcomes:

(1a) Describe the types of claim reserves.

(1b) Explain the limitations and biases of the traditional valuation methods.

(1c) Calculate appropriate claim reserves given data.

(1g) Apply applicable best practices related to reserving.

Sources:

GH201-100-25: Health Reserves

ASOP 5

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) Describe four methods for estimating claim reserves.

Commentary on Question:
Most candidates received full credit by providing adequate descriptions to at least 4 methods. Credit was not awarded for the "Stochastic Method", as stochastic techniques are modifications to other methods, not a distinct method themselves. Candidates earned credit for other methods than those referenced below.

Case reserves (examiner's method)

This method develops reserves by estimating the ultimate claims amount for each reported claim and then subtracting the amount already paid against the claims.

This method is most often employed to develop claims estimate for large catastrophic medical claims or for liabilities associated with litigated claims.
Projection methods

1. Continued

Projection methods estimate incurred claims by developing an historical claim rate as a function of membership or other measures of exposures or liabilities. Reserves are estimated by:

1. Developing a projected incurred claims cost per unit of exposure
2. Multiplying this value times the exposure base for each period being estimated
3. Subtraction of known paid claims

Loss ratio methods
This is a form of projection method in which the estimate is based on anticipated loss ratios. The reserves are estimated by:

1. Developing a projected loss ratio based on historical ratios of incurred claims to earned premium or on anticipated loss ratio from pricing or other analysis
2. Multiplying the loss ratio times exposed earned premium for the projected months
3. Subtraction of known paid claims

Tabular methods

- Tabular methods are commonly used to develop the present value of amounts not yet due by applying a continuance table deemed to be predictive of future claims liabilities. This approach is useful for claims such as disability or long-term care for which a claims event triggers a sequence of payments.

Average size claim method

Under this method, the claim reserve for reported claims is estimated by reviewing claim sizes for previously closed claims. The total reported reserves is then calculated as the estimated average size multiplied by the number of reported claims, less any payments made on these claims prior to the valuation date.

(b) Calculate the dental IBNR as of August 31, 20X3. State any assumptions and show your work.

Commentary on Question:
Most candidates were able to set up an incurred/paid claims triangle, calculate completion factors, and produce an IBNR estimate. Many candidates received partial credit by using the age-to-age development method instead of the age-to-ultimate the question prescribed.

1. Continued

Answer:

- The model solution for this part is in the Excel spreadsheet.

(c)

(i) Explain reasons for adding a provision for adverse deviation.

(ii) Recommend a provision for adverse deviation that should be recorded as of August 31, 20X3. Justify your response.

Commentary on Question:
Most candidates were able to provide reasonable explanations for adding a provision for adverse deviation (PAD) as well as recommend an appropriate PAD amount. The highest-performing candidates provided justification for their recommended PAD amount. Below is a sample response that received full credit.

(i) A provision for adverse deviation is added because the IBNR estimate is uncertain and actual future emergence may be less favorable than indicated by historical development. A PAD provides conservatism to protect against random fluctuation, possible changes in claim payment patterns, data limitations, and the risk that recent lag factors are not fully credible or stable. This helps reduce the risk that the recorded reserve is inadequate.

(ii) I recorded a small explicit PAD of 5% of the calculated IBNR. This is appropriate because dental claims are generally short-tailed and do not usually have the same severity volatility as major medical, so a very large PAD is not necessary. A modest explicit margin recognizes uncertainty without overstating the liability.

(d) List and describe considerations for estimating incurred claims based on ASOP 5.

Commentary on Question:
Candidates that performed well on this question were able to list and describe most considerations contained in ASOP 5. Partial credit was awarded to candidates who provided only a few considerations or provided a list without description.

In an external user report, the actuary should:

- Benefit plan provisions and business practices: *special group contract holder requirements and provider arrangements which, in the actuary's judgement, may materially affect the cost, frequency, and severity of claims. This would include elimination periods, deductibles, preexisting condition limitations, maximum allowances, and managed-care restrictions.*

1. Continued

- Economic and other external influences: *Other items such as changes in price levels, unemployment levels, medical practice, managed care contracts, cost shifting, provider fee schedule changes, medical procedures, epidemics or catastrophic events, and elective claims processes in recessionary periods or prior to contract termination.*

- Behavior of claimants: *reasonably available information regarding claimant behavior, such as pent-up demand for new benefits, or impending benefit changes.*

- Organizational claims administration: *factors that may affect claims admin practices such as staffing levels, variable claim processing and investigation time, computer system changes, seasonal backlogs of claims submitted, increased electronic submission, governmental influences and cash flow considerations.*

- Claim seasonality: *seasonality may impact the estimate of incurred claims and appropriate adjustments may be needed. Claim seasonality may be exhibited in the patterns of claims incurral and submission, or in the manner that costs actually emerge within the health plan provisions (such as high-deductible plans).*

- Credibility: *the credibility of the data affects the development of incurred claim estimates, including guidance provided in ASOP 25*

- Risk Characteristics and organizational practices by block of business: *marketing, underwriting and other business practices can influence the types of risks accepted, and how the pattern of growth or contractions and relative maturity of a block of business can influence incurred claims.*

- Legislative requirements: *relevant legislative and regulatory changes as they pertain to determining incurred costs, including government mandates on the provision of new benefits.*

- Carve-outs: *the pertinent benefits, payment arrangements, and separate reporting of these benefits subject to carve-outs in incurred claims estimates.*

- Specialist considerations for long-term products: *consider variety of benefits available in these plans, such as lump-sum, fixed, or variable payments for services; provisions such as cost of living adjustments and inflation projection; payment differences based on institutional or home health care; social insurance integration; and the criteria for benefit eligibility.*

2. Learning Objectives:

1. The candidate will understand how to apply valuation principles for group and health insurance contracts.

5. The candidate will understand how to describe the flow of funds in the health care system and the role of providers in the system.

Learning Outcomes:

(1f) Describe, calculate, and evaluate non-IBNR types of reserves and explain when each is required.

(1g) Apply applicable best practices related to reserving.

(5b) Describe the role physicians play and their influence on the flow of funds.

(5c) Describe the market power of hospitals and how provider systems compete for patients, physicians, and contracts.

Sources:
GH201-100-25: Health Reserves

ASOP 42: Health and Disability Actuarial Assets and Liabilities Other than Liabilities for Incurred Claims

GH201-102-25: Flow of Funds in Healthcare System and the Role of Providers

GH201-103-25: Health Economics and Financing, Getzen, Thomas and Kobernick, Michael, 6th Edition, 2022

Commentary on Question:
Commentary listed underneath question component.

Solution:

(a) List and describe provider liabilities for which payers establish a reserve.

Commentary on Question:
This question was answered well in general.

- Capitation Payments owed, but not paid as of the valuation date
- Withholds or bonus payments subject to defined experience outcomes. If these are to be paid in the future, they must be assessed currently and reserved for if a payment is likely.
- Bundled Payments - more services are at risk than normally be the liability of a given FFS event

2. Continued

- Settlements under stop-loss contracts.
- Reserves for provider insolvency. Payers may need to reserve for more volatile FFS events when capitated provider groups fail.

(b)

(i) Calculate the expected total payments to Elena Physicians under each of the following reimbursement arrangements. Show your work.

- A capitation agreement of $125 per member per year (PMPY)
- A fee-for-service (FFS) scheme paid at 125% of the Medicare rate
- A bundled payment of $175 per office visit
- A bonus structure where Elena Physicians is paid FFS at the current contracted unit cost and receives a 20% bonus if the cost is less than $190 PMPY
- A capitation and withhold structure where 5% of a $150 PMPY cost is withheld and returned if costs are below $140 PMPY

(ii) Describe the advantages and disadvantages of the bonus structure to both parties.

Commentary on Question:
This question was answered well in general. Most candidates received full credit for part (b)(i).

The model solution for part (b)(i) is in the Excel spreadsheet.

Solution for part (b)(ii):
Elena Physicians

- Advantages
  Still get paid an FFS scheme which means they get more money the more services they perform. Even if they perform less services, the bonus could still make up for it.
- Disadvantages
  If their practice cannot find enough patients, they could potentially lose money against their overhead.

Avalor Health

- Advantages
  Gives an incentive for Elena to keep costs down since they would receive a bonus

2. Continued

- Disadvantages
  The bonus structure is purely based on services performed. There is no incentive for quality which could further improve the costs and health of their members.

(c) List and describe ways Elena Physicians can increase their revenue or decrease their exposure to risk.

Commentary on Question:
This question was not answered well in general. Successful candidates recommended approaches that increase provider revenue while maintaining public health. Proposals aimed solely at increasing revenues through higher FFS or Cap rates did not receive credit. Other reasonable responses beyond those listed below also earned credit.

Elena Physicians can purchase stoploss contracts. These plans could pay out when Elena is liable for payment in at-risk provider contracts. These plans could also cover when payments are not enough to cover complex services like transplants.

Elena Physicians could grow their practice and take advantage of economies of scale.

Elena Physicians could hire more doctors to increase their marginal revenue as overhead (like buildings, office staff, and equipment) remain constant.

Growing the practice also increases risk sharing. The revenue stream in larger practices is smoothed out and more certain.

(d) Identify considerations when estimating provider related liabilities according to ASOP 42.

Commentary on Question:
This question was not answered well in general. Many candidates incorrectly listed other considerations from ASOP 42, rather than the specific considerations relating to provider liabilities.

The actuary should evaluate provider contracts to determine if a liability is necessary.

Also need to determine if liability is necessary given the valuation date, financial status of the provider, collectability, and whether these liabilities could be offset.

2. Continued

If the provider accepts some risk either through capitation or another risk-sharing arrangement, the provider's financial condition needs to be considered when setting the liability.

If there is a penalty or incentive for providers when certain conditions are met, the actuary needs to determine if a liability or asset is necessary.

(e) Identify whether each of the following statements is true or false. Justify your answer.

- Economic problems of medical care can be explained as uncertainties in disease incidence and treatment outcome leading a patient to seek transfer of their financial risk and agency.
- Regardless of the severity of a medical condition, consumers can shop around for the best price.
- Medical costs tend to be elastic.
- A US major medical plan covers substantially more services than a Canadian Medicare plan.
- The increase in supply of physicians is not instantaneous.
- Most hospitals compete over patients rather than physicians.

Commentary on Question:
This question was answered well in general. Successful candidates evaluated the statements as either true or false correctly and provided clear justification. No credit for wrong or ambiguous evaluation was given.

(i) This is true. The number and severity of medical treatments is random to a person. Risk pooling via insurance transfers financial risk from the patient to the insurance company, and agency transfers medical decision making from the patient to the physician.

(ii) This is false. The pain price dictates the ability for a member to shop around. For low severity cases the member has the ability to shop around. In a heart attack, the member lacks the ability to shop around.

(iii) This is false. Medical costs tend to be inelastic. The vast majority of costs are paid by insurance. So a person's tendency to get medical is unaffected by price. Physicians also tend to look at medical needs and ignore price.

(iv) This is true. US plans cover smaller ancillary services than Canadian Medicare plans do not cover like Psychologists, Optometrists, and DME. In Canada, a supplemental health plan is needed to cover these extra benefits.

2. Continued

(v) This is true. Even if you increase the number of students in medical schools, it takes time for them to complete medical school and residency. Simultaneously, the supply of physicians is reduced by retirement.

(vi) This is false. For most, the care decision regarding hospitalization is made by physicians. Generally, hospitals compete for the contracting party that has the power to make revenues come to them, which is often the physician due to the agency relationship between a patient and their physician.

3. Learning Objectives:

2. The candidate will understand how to prepare and interpret insurance company financial statements in accordance with Statutory Accounting Standards and GAAP.

Learning Outcomes:

(2a) Prepare a financial statement in accordance with Generally Accepted Accounting Principles (GAAP).

(2c) Project financial outcomes and recommend strategy.

(2d) Apply applicable best practices related to financial statements.

Sources:
ASOP21; GH201-400-25

Commentary on Question:
Commentary listed underneath question component.

Solution:

(a) Describe the primary differences in the actuarial items between the SAP basis financial statements and the GAAP basis financial statements.

Commentary on Question:
Candidates were asked specifically about actuarial items. Those candidates that gave examples outside actuarial items, such as treatment of ASO fees, received no credit. Generic response on the difference between SAP and GAAP (such as purpose, audience, solvency, etc.) without relating that to specific actuarial items also received no credit. Candidates that described actuarial items such as the types and treatment of reserves, liabilities, loss recognition and asset valuation received credit. Several examples of responses that received credit are listed below:

- Policy reserves – For NAIC SAP, these will be based on minimum standards with an implicit locked in reserve. For GAAP, these are based on explicit original assumptions and a provision for adverse deviation.
- Disabled life reserves – for NAIC SAP these are based on minimum standards while for GAAP these use ultimate expected costs.
- Additional actuarial liabilities – because NAIC SAP requires an actuarial opinion and asset adequacy, the opining actuary may require additional reserves to be held to feel comfortable signing the actuarial opinion. This asset adequacy analysis does not exist for US GAAP and additional reserves will not be held.

3. Continued

- Policy acquisition cost – This must be expensed when it occurs for NAIC SAP which can lead to a loss in the short term known as statutory strain. Under GAAP, this can be held in an asset account and amortized known as deferred acquisition cost.
- Premium deficiency reserves – because there is no DAC for NAIC SAP, the PDR may be larger. For US GAAP, it can be offset by the DAC and may be smaller or unnecessary.
- Reinsurance ceded liabilities are a contra-liability for NAIC SAP for asset for GAAP
- Health care receivables are a contra-liability for GAAP but asset for SAP after offsetting any unpaid claims
- Asset valuation reserves and interest maintenance valuation reserves must be held for blue blank companies under NAIC SAP but not GAAP

(b) Describe the obligations you (the reviewing actuary) have to the responding actuary who prepared the HMO’s financial statement information.

Commentary on Question:
Candidate performed well on question (b). Credit was given to candidates who addressed the timing and scope of procedures, describing the type of information to be requested and cooperating in the compilation of information needed.

In accordance with ASOP #21, I must:

- Communicate with the responding actuary regarding the expected timing, nature of responses, and scope of the audit.
- Cooperate with the responding actuary when gathering information for the audit.
- Request information for the audit, preferably in writing and in what time frame.
- Disclose to the auditor if I have any relationship with the company being audited or their affiliate.
- Document the information requested and any findings of the audit.

(c) List items the responding actuary should be prepared to discuss with the reviewing actuary.

Commentary on Question:
Candidates were allocated time to make a list of items on (c). To receive full credit, candidates were expected to list 10 or more items, though many only recorded 2 or 3. Candidates that only restated their answer from part (b) on the obligations of the reviewing actuary instead of the responding actuary received no credit.

3. Continued

- The responding actuary should be prepared to discuss the actuarial elements underlying any items on the financial statements. This includes but is not limited to:
    - Data, Assumptions, and Methods Used
    - Assumptions that were not set by the Responding Actuary, and who set them
    - Any risks to the company
    - Any supporting work to support the items on the financial statement
    - The effectiveness and design of controls around policies, procedures, models
- The responding actuary should discuss any items that may have had (or may have) an impact on the financial statements, in the responding actuary's professional judgment (e.g. changing conditions). This includes but is not limited to:
    - Changes in operating environment
    - Changes in products
    - Changes in plan mix
    - Changes due to complying with new laws/regulations
    - Changes from prior valuation methodology
    - Changes in experience trends

(d) Calculate the loss ratios for 20X1 based on the "accounting view" and the "actuarial view". Show your work.

Commentary on Question:
Many candidates were able to correctly calculate both claim numbers for both the accounting view and the actuarial view. Fewer candidates were able to correctly calculate the premiums, sometimes making multiple logical errors.

Actuarial view: looks at expenses for valuation year; carves out prior period development that occurs in the current year; updates results based on most current information

Accounting view: incorporates all expenses and premiums that are paid/received in a given accounting year

3. Continued

20X1 Incurred Claims (paid through 20X2)	$239,437,500.00
20X1 Premiums Paid	$315,000,000
less 20X0 Paid premiums	-$15,000,000
plus remaining D&U	$3,000,000
plus change in UEP	$100,000
less risk equalization payment	-$6,000,000
Total Actuarial Premium	$297,100,000
Actuarial MLR	**80.6%**

Accounting View	
Claims Paid in 20X1	$226,687,500.00
Change in UPL	$7,500,000.00
Claims	$234,187,500.00
Premium paid in 20X1	$300,000,000
less risk equalization payments	-$7,000,000
plus change in D&U reserves	$3,000,000
less UEP Change	$100,000
less RE Payable Change	$4,000,000
Total Accounting Premium	$300,100,000
Accounting MLR	**78.0%**

(e) Construct a response that describes key components that support your calculation.

Commentary on Question:
The slightly more open-ended nature of question (e) yielded a variety of responses which were all considered in context and evaluated for the candidate's ability to communicate their understanding of the responding actuary's limited response with respect to the analysis the candidate performed in part (d). Stronger responses provided a complete answer that provided perspective on differences between what was expected and what the responding actuary provided. Weaker responses gave an explanation that was missing a key component in its defense or simply provided a description of their calculation in part (d). Below is an example of an average response that would have received full credit.

3. Continued

While the analysis indicates the loss ratios are both close to 80% for both the accounting and the actuarial view, the two measures are still inherently different. The is because the accounting view & actuarial view are meant to measure different things. As mentioned in part (d), the accounting view is not adjusted retroactively, so while it accounts for changes in reserves, if there is a miss on the reserving side –which there was—the accounting view will remain different from actuarial. The actuarial review is adjusted retrospectively once actual completed experience data is available.

4. **Learning Objectives:**

2. The candidate will understand how to prepare and interpret insurance company financial statements in accordance with Statutory Accounting Standards and GAAP.

Learning Outcomes:

(2c) Project financial outcomes and recommend strategy.

(2d) Apply applicable best practices related to financial statements.

Sources:

GH201-400-25 Health Insurance Accounting Basics for Actuaries

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) Contrast an experience-rated refund with a premium stabilization reserve.

Commentary on Question:
Candidates who were able to explain the differences between Experience-rated Refunds and Premium Stabilization Reserves received full credit. Many candidates did not explain the premium stabilization reserve or its use.

Experience Rated Refunds are estimated amounts for unsettled years for a specific period.

Premium Stabilization Reserves are from previously unsettled years. The insurer may use these reserves to offset losses or premium increases.

(b) Describe the two main methods used to account for experience-rated refund contracts during the middle of the contract period.

Commentary on Question:
Several candidates did not explain that the YTD method was based solely on actual experience year-to-date. Candidates receiving full credit were able to describe both methods accurately.

The two main methods are Year-to-date (YTD) and Prorated Ultimate.

YTD Method: The insurer records a liability based solely on actual year-to-date experience under the contract, as if the contract were to terminate as of the financial statement date.

4. Continued

Prorated Ultimate Method: The insurer computes the amount that it now expects to owe to the employer for the full contract period, based on both actual experience for the partial contract period and projected experience for the remainder of the contract period; then, the insurer prorates that amount.

(c) Calculate the experience-rated refund balance for all four quarters of the prior year using both methods in part (b). Show your work.

Commentary on Question:
The question asks to calculate the experience-rated refund balance for all four quarters. Many candidates performed the calculation for only one quarter or as of year-end.

See Excel.

(d) Recommend which method to use. Justify your response.

Commentary on Question:
Candidates generally did well on this part if they provided a recommendation with logical support based on their answers to the rest of the question. The top candidates were able to explain the implications of their recommendation to the financial statement. Below is a sample response that received full credit.

Recommend the Year-to-date method since it will smooth the financials throughout the year as it matches actual claims experience with the experience rated refund.

5. Learning Objectives:

3. The candidate will understand how to evaluate the impact of regulation on insurance companies and plan sponsors in the United States.

Learning Outcomes:

(3a) Describe the regulatory and policy making process in United Sates.

(3b) Describe the major applicable laws and regulations and evaluate their impact.

Sources:

Federal Regulation of Prescription Drugs in the United States, The Actuary, Feb 2021
Group Insurance, Skwire, Daniel D. Chapter 17: Federal Regulation in the United States

Commentary on Question:

The goal of this question is to test the student's ability to identify the applicability of various federal laws and agencies, including the target audience and protections each law provides. Performance on this question overall was mixed, a few strong responses received full credit, but the majority only received partial credit. Performance in part b was slightly stronger than performance in part a.

Solution:

(a)

(i) State the protected population for each listed law or regulation.

(ii) Describe the purpose for each listed law or regulation.

Provide your answer in table format below.

Commentary on Question:

Performance on this part was mixed. Candidates who performed well in part (i) generally performed well in part (ii) and vice versa. To receive full credit, the candidate must correctly state the protected population and correctly describe the purpose for at least 7 laws/regulations. Responses must be specific enough to demonstrate knowledge of the law/regulation, for example, simply stating women as the protected population of the Women's Health and Cancer Rights of 1998 was not sufficient. Similarly, stating the purpose of Patients' Right to Know Drug Prices Act of 2018 as improve price transparency was not sufficient, the response must mention banning pharmacist gag clauses in some form to receive credit.

5. Continued

Law/Regulation	Protected Population	Purpose
Newborns' & Mothers' Health Protection Act	Mothers & Children	Health plans must cover hospitalization of at least 48 hours for normal delivery and 96 hours aver a c-section
The Family Medical Leave Act (FMLA)	Employees at employers > 50 employees with more than 12 months of employment	Employees may take unpaid leave of up to 12 weeks during a 12 month period for specific family & personal situations
Womens' Health and Cancer Rights of 1998	Women with mastectomies/breast cancer	Health plans must cover reconstructive surgery
Michelle's Law	Students	Full time students who take medical leave from school must continue to be covered
Genetic Information Nondiscrimination Act (GINA) of 2008	Groups purchasing fully insured health plans, employees	Health plans may not set group premium or contribution amounts based on genetic information of employees. Employees may not be asked to undergo or requiring a genetic test for UW purposes.
Patients' Right to Know Drug Prices Act of 2018	Pharmacists and Prescription Drug Purchasers	Insurers, HMOs, Health Plans, and Pharmacy Benefit Managers may NOT restrict pharmacists from providing pricing information to enrollees.
Transparency in Coverage Rule	Consumers of Healthcare, everyone	Self-Insured Health plans, insurers, and HMOs must provide real time, online access to cost sharing & price of covered health care items and services. Hospitals, Health Plans, Insurers, and HMOs must publicly disclose online their negotiated rates with network providers and allowed amounts paid to Out of Network providers.
The Coronavirus Aid, Relief and Economic Security (CARES) Act	Families and Hospitals, everyone	Insurers, HMOs, and Health Plans must: Provide access to COVID-19 testing at no cost sharing Allowed Over the counter drugs to be reimbursed under HSAs, HRAs, and FSAs

		Created a tele-health cost sharing safe harbor for high deductible health plans

(b)

(i) Define each aspect of the healthcare system as it pertains to prescription drugs.

(ii) Construct an example on how each federal agency listed below regulates each aspect as it pertains to prescription drugs.

Provide your answer in table format below.

Commentary on Question:
Performance on this part was mixed. In order to receive full credit, the candidate must correctly define all 3 aspects and give at least 5 separate examples. In part (i), many candidates listed goals such as improving access and lowering cost with no definition provided or used the term itself in the definition (using quality to define quality), these responses did not receive full credit. In part (ii), examples that received credit were not limited to ones listed above, reasonable examples were given credit.

5. Continued

Aspect	Definition	Food and Drug Administration (FDA)	Centers for Medicare & Medicaid Services (CMS)
Access	Can an individual obtain a drug, and what limits/barriers are in place.	Expediting and/or approving drugs, with a focus on safety and clinical efficacy	Formulary oversight and approval for Part D to enforce minimum requirements and protected classes or Approves utilization management practices or Network adherence standards based on member distance to Pharmacies
Quality	The clinical efficacy and safety of a drug	Overseeing the drug supply chain manufactured in or imported into the United States	Providing guidance on high-risk medications or The use of safety edits in the Formulary Reference File – lists all drugs covered
Cost	How much any purchaser must pay to obtain the drug	Federal government does not regulate prices but does encourage the development of generic drugs	Through the regulation of formularies, CMS indirectly affects both member cost and rebate levels

6. Learning Objectives:

4. The candidate will understand how to describe government programs providing health benefits in the United States.

Learning Outcomes:

(4a) Describe Medicare benefits and evaluate pricing and filing requirements.

Sources:

Group Insurance, Skwire, 8th Edition, 2021, Ch. 9: Government Health Plans in the United States, pp. 134-138, 141-143

GH201-404-25: Medicare Advantage: Eight Critical Considerations for Every Organization as ESRD Eligibility Expands in 2021

GH201-403-25: Medicare Part D Prescription Drug Benefits

GH201-400-25: Health Insurance Accounting Basics for Actuaries, pp. 69-70

Commentary on Question:

Overall candidate scores on this question were mixed; few candidates earned full credit across all subparts. Candidates generally performed well on (b), (c), and (e). Alternative responses to parts (a), (b), and (e) were considered and received credit if appropriate.

This question tested the candidate's ability to recall and differentiate key Medicare programs and their regulatory environments, apply pricing principles and regulatory requirements to real-world scenarios, and evaluate risk in the context of policy-driven decision-making.

Solution:

(a)

(i) Contrast the pricing considerations under Medicare Part C and Part D by completing the following table:

	Part C	Part D
Risk Management		
Eligibility		
Benefit Structure		

(ii) Contrast the regulatory considerations under Medicare Part C and Part D by completing the following table:

	Part C	Part D
Risk Management		
Eligibility		
Benefit Structure		

6. **Continued**

Commentary on Question:
Candidates generally received partial credit for this question. Many candidates listed features of each Part C and Part D but did not contrast. Alternate responses were considered valid if they were appropriately categorized (e.g. a valid Risk Management item appearing in the Benefit Structure row did not receive credit).

Pricing Considerations

	Part C	Part D
Risk Management	CMS pays MAOs a capitated amount adjusted for risk using CMS-HCC model. Prospective risk scores are based on diagnoses and demographics, as well as other status indicators (e.g. dual enrollment in Medicaid, disability status).	CMS reimburses MAOs via Risk Adjustment (RxHCC model) and Reinsurance for high-cost enrollees; CMS uses Risk Corridors to share in gains / losses when experience significantly deviates from projections.
Eligibility	Enrollees must be eligible for both Part A and Part B in order to be eligible for Part C; enrollment in both is required.	Enrollees must be enrolled in either Part A or Part B; enrollment in both is not required.
Benefit Structure	Part C plans cover all Part A and Part B services and typically include Part D; additional services are often included (e.g. dental, vision).	Part D plans cover only outpatient prescription drugs. Member cost sharing must follow either the Standard Benefit or a design that is actuarially equivalent; can offer enhanced plans.

Regulatory Considerations

	Part C	Part D
Risk Management	Benchmark and bid-based reimbursement structure; quality ratings impact revenue through capitation rebate percentages and bonus payments.	Standardized cost sharing tiers (deductible, coverage gap, catastrophic) limit adverse selection among issuers. Risk sharing mechanisms protect against extreme losses.
Eligibility	Subject to CMS rules on plan availability by region. Enrollment windows and disenrollment periods	Follows a national enrollment period. Plans must follow CMS rules on marketing to eligible enrollees. Late enrollment

	follow Original Medicare rules.	penalty for enrollees who defer enrollment after eligibility without credible coverage.
Benefit Structure	Plans must cover at least what Original Medicare covers. Plans must meet network adequacy requirements and offer MOOP protection. Plans may not offer supplemental benefits that are solely inducements to enroll.	Formularies must meet CMS guidelines. Plans must offer defined standard benefit design or one that is actuarially equivalent; plans can offer enhanced plans if the benefit design is actuarially equivalent or better relative to the standard benefit.

(b) Describe two risk-sharing mechanisms that influence premium setting for Part D prescription drug plans.

Commentary on Question:
Candidates generally did well on this question. In addition to correctly describing Reinsurance and Risk Corridors, responses that appropriately described the Coverage Gap Discount Program or its post-2025 replacement (Manufacturer Discount Program), or appropriately described Part D Risk Adjustment under the RxHCC model also received credit.

Federal Reinsurance: CMS reimburses plan sponsors for a share of drug costs above the catastrophic threshold, typically 80% of drug costs beyond a defined threshold. Reinsurance is paid prospectively based on bid estimates and reconciled to actual costs after year-end. Because it offsets a specified share of high-cost claims, it reduces the insurer's exposure to catastrophic claims and therefore must be factored into the pricing assumptions.

Risk Corridors: CMS compares each plan's actual allowable risk corridor costs to a target amount derived from its risk-adjusted bid. If costs fall within 5% of target, no adjustment is made. Between 5% and 10% above/below target, CMS and the plan share the difference at 50% each. Beyond 10% of target, CMS absorbs or recoups 80% and the plan retains 20%.

Both of these mechanisms limit the risk taken on by the plan and allow for premiums to not need to build in additional margin and contingency for this risk.

(c) Calculate the insurer's total drug cost liability under the defined standard benefit for all member groups. Show your work.

6. Continued

Commentary on Question:
Candidates generally performed well on this calculation. Full credit was awarded for correctly calculating total expected drug liability for all three member groups and the total. Partial credit was awarded for calculating one or two of the member group totals correctly, or for responses that included administrative costs in the calculation.

Solution for this part is in the Excel file.

(d) Calculate the percentage change in the insurer's Part D margin after the Part D risk corridor. Show your work.

Commentary on Question:
Candidates were inadvertently not given actual claims and therefore any assumption for actual claims was accepted. Despite this, some candidates still received full credit for this question. Many candidates conflated expected costs from (c) with actual costs. Several candidates also sought to apply Risk Corridors to each individual member group rather than the issuer's holistic margin. Candidates earned partial credit progressively by calculating a premium, assuming actual claims, correctly calculating Risk Corridor risk sharing amounts, and illustrating a change in margin because of the Risk Corridor payment.

Solution for this part is in the Excel file

(e) Recommend an adjustment to the pricing or benefit design to mitigate the insurer's financial risk. Justify your response.

Commentary on Question:
A variety of recommendations were accepted, provided they were permissible under the defined standard benefit. Candidates who recommended a pricing or benefit-related adjustment received credit. Recommendations involving increased cost sharing or formulary adjustments received credit provided the candidate acknowledged CMS limitations. Full credit required an accompanying justification.

Recommendation: Implement step therapy or prior authorization protocols for high-cost tiers. This reduces plan liability by steering utilization toward lower-cost therapeutic alternatives before approving higher-cost drugs, lowering expected issuer liability.