GH RM Model Solutions
Spring 2024

1. Learning Objectives:

4. The candidate will understand how to apply risk adjustment in actuarial work.

Learning Outcomes:

(4a) Apply risk adjustment to underwriting, pricing, claims and care management situations.

Sources:

GHRM-112-23: HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper, Ch. 4

Commentary on Question:

This question was testing understanding of how to evaluate hybrid Risk Adjustment Models.

Solution:

(a) CMS uses five criteria for evaluating hybrid Risk Adjustment Models, which use both diagnosis and prescription drugs.

List the five criteria.

Commentary on Question:

Candidates typically did well on this part of the question. A description was not required to obtain full credit for this part of the question since it only asked for a list.

1. Clinical/Face Validity
2. Empirical/Predictive Accuracy
3. Incentives for Prescription Drug Utilization
4. Sensitivity to Variations in Prescription Drug Utilization
5. Incentives for Diagnosis Reporting

(b) Describe the evaluation of each criterion for the illustrative models presented in the CMS discussion paper on the HHS-Operated Risk Adjustment Methodology Meeting.

1. Continued

Commentary on Question:
Candidates had trouble in providing relevant responses that showed their knowledge of this section of the CMS paper. Many candidates explained the five criteria from part (a), but the question asked for evaluation of each criterion for the illustrative models presented. Candidates often provided information from other parts of the discussion paper. Credit was not awarded for unclear or inappropriate responses that were unrelated to what the question was specifically asking.

Clinical/Face Validity

- The drug-diagnosis pairs used in all of the models were required to have clinical face validity as part of the process of selecting these pairs.
- The models that use drugs to indicate severity (models other than the pure imputation model) probably have the greater clinical face validity because use of a drug class typically contains information about severity.
- The Rx dominant model may have a greater clinical face validity than the completely flexible model because it may not be clear why the presence of a diagnosis should affect incremental cost when the drug class inputs the diagnosis.

Empirical/Predictive Accuracy

- All hybrid models have similar overall predictive accuracy.
- The hybrid models that add the most predictive accuracy are those that predict higher expenditures for individuals using expensive drug classes.

Incentives for Prescription Drug Utilization

- All hybrid models create incentives for providers to prescribe the drug classes used in the model.
- Imputation and Severity only create the least strong incentives.
- The Rx dominant and flexible models create the strongest incentives for drug utilization because incremental predicted cost increases the most with drug utilization in these models.

Sensitivity to Variations in Prescription Drug Utilization

- All of the hybrid models are sensitive to variations in drug utilization.
- Models most (and least) sensitive to incentives for prescription drug utilization are most (and least) sensitive to variation in drug utilization.

1. Continued

Incentives for Diagnosis Reporting

- There is no incentive for diagnostic reporting for the Imputation and the Rx dominant models, because incremental predictive cost is not affected by diagnosis reporting when drug utilization is present.
- The severity model is sensitive to diagnosis reporting because higher cost with a drug-diagnosis pair is only recognized when the diagnosis is present.

2. Learning Objectives:

3. The candidate will understand how to evaluate healthcare intervention programs.

Learning Outcomes:

(3a) Describe, compare, and evaluate programs.

Sources:

Managing and Evaluating Healthcare Intervention Programs, Duncan, Ian G., 2nd Edition, 2014, Ch. 8: Understanding the Economics of Care Management Programs

Commentary on Question:

Most candidates either performed well or performed poorly on this part of the question.

Solution:

(a)

(i) Explain why it is difficult to demonstrate the link between quality and cost improvement for a disease management (DM) program.

(ii) Describe ways to mitigate these difficulties.

Commentary on Question:

Most candidates either performed well or performed poorly on this part of the question.

(i) Measurement of financial outcomes is not sufficiently stable (e.g., external factors inadequately controlled).

Measurement techniques not able to detect positive financial outcomes.

Earlier DM programs not focused/not structured to optimize financial outcomes, but established to achieve clinical improvements. For example, to improve HEDIS scores that seldom correlate with financial outcomes.

Program sponsors do not understand the economics of DM programs – do not optimize the program for financial return with respect to resources required.

Some health outcomes may not be associated with financial savings. Increasing evidence that improved quality = lower cost is not necessarily true.

2. Continued

(ii) A better understanding of the economics of DM programs, to help set reasonable expectations.

More rigorous measurement of financial outcomes. Core problem is the way a methodology is applied, assumptions made, and data decisions affect the outcomes.

Reconciliation among DM program savings, overall claims costs, and cost trends.

(b) Contrast average savings and marginal savings.

Commentary on Question:
Most candidates only stated the two formulas without contrasting them.

Average savings = total savings net of program cost / total population.
Average savings tells how profitable the program is overall.

Marginal savings = increase in savings net of program cost due to intervention on the marginal population / marginal population.
Marginal savings tells what kind of program to implement, how large it should be, and whether the marginal intervention is justified.

(c) Calculate the net return on investment (ROI) for the program. Show your work.

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

(d) Explain how ROI can be a misleading metric.

Commentary on Question:
Most candidates were only able to provide one or two of the following responses.

No industry agreement in how to calculate savings or cost.

Comparison of ROI between program and vendor could be misleading.

Planned ROI vs actual ROI likely misleading.

Planned ROI is helpful metric to use in deciding whether to proceed with the program.

Actual ROI will be subject to operational factors that will cause actual ROI to diverge from planned ROI.

2. Continued

Other acceptable answers are –

ROI can be gross or net. Comparison of two ROIs must be on the same basis.

Net ROI can be negative, which is misleading to stakeholders and decision makers.

ROI is a ratio and does not reflect the true dimension of the savings. When comparing two ROIs, a greater ROI doesn't necessarily mean larger savings.

The program may take a long time to be fully efficient and the ROI for early time periods may be low.

3. Learning Objectives:

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

Learning Outcomes:

(1a) Describe structure of employee benefit plans and products offered and the rationale for offering these structures.

Sources:

Consumers to the Rescue? A Primer on HDHPs and HSAs, Health Watch, Feb 2019

Commentary on Question:

Most candidates performed well on this question. For parts of the question asking the candidate to provide a description, some candidates did not receive full credit if a clear description was not provided. Many candidates also struggled to correctly account for the manufacturer drug coupon in part (e).

Solution:

(a) Write a response to each question and for each savings account by completing the following table:

Feature	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)	Flexible Spending Account (FSA)
Who owns the account?			
Who can contribute?			
Are contributions tax-deductible?			
Are there contribution limits?			
Can the funds roll over to the next year?			
What distributions are tax-free?			
What distributions are not eligible?			
Is a High Deductible Health Plan (HDHP) required?			

3. Continued

Feature	Health Savings Account (HSA)	Health Reimbursement Arrangement (HRA)	Flexible Spending Account (FSA)
Who owns the account?	EE/Individual	ER	ER
Who can contribute?	EE/Individual and ER	ER	ER and EE
Are contributions tax-deductible?	Yes	Yes	Yes, except LTC ER contributions
Are there contribution limits?	Yes	No, unlimited	Yes
Can the funds roll over to the next year?	Yes	Yes	Yes, but not required
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 a High Deductible Health Plan (HDHP) required?	Yes	No	No

(b) Describe examples of consumer behavior for individuals enrolled in HDHPs.

Commentary on Question:
The below responses received full points on the exam. Other responses not listed here but relevant to the question were also acceptable.

- Saving for health care services.
  Because unused funds are owned by the HSA enrollee and are not lost, this encourages regular deposits into the account even if future health care expenses are not anticipated.
- Avoiding unnecessary care.
  Similarly, "shopping" may lead an enrollee to forgo treatment for minor ailments or avoid those treatments that have marginal benefit.
- Selecting generic prescription drugs instead of higher cost, brand-name prescription drugs.

3. Continued

In addition to the direct impact of lower costs, generic drug prices tend to grow more slowly than brand drug prices, so continued use of generic substitutes can lead to compounded savings.

- Comparing quality ratings of providers.
  Online tools for quality rankings of providers are also growing and becoming more sophisticated.
- Negotiating prices with providers, particularly for costs under the deductible.
  Lower cost-sharing requirements under many plans do not encourage enrollees to investigate or question provider charges as they have little stake in the outcome. In contrast, enrollees with HDHPs are exposed to potentially more out-of-pocket costs and "own" the money in their HSA (though not money in their HRA) so their interest in the outcome of a discussion with providers related to their charges is likely much greater.
- Improving their own health and taking other illness avoidance measures.
  If enrollees make the connection between better health and lower out-of-pocket costs, the combination of the HDHP and an HSA provides incentives for the enrollee to reap the benefits of any health improvement activities they might undertake.

(c) Describe factors that could make HDHPs more effective.

Commentary on Question:
The below responses received full points on the exam. Other responses not listed here but relevant to the question were also acceptable.

- Cost transparency
  - Costs in the health care system are not always transparent, and it is difficult for members to price shop in the current market.
- Discussions between providers and patients
  - Providers and patients should have discussions about the costs of potential treatments or prescription drugs.
- Pre-funding of HSAs.
  - Both employers and employees are eligible to contribute to HSAs. In most cases, HSA contributions are made evenly throughout the year. If medical services are incurred early in the year, individuals may not have enough HSA funds available to cover the costs. Allowing employers and employees to contribute funds in lump sums may ease this concern.

3. Continued

- Allowing more first dollar coverage.
  - The high deductible on all services is a blunt instrument that might cause people to forgo necessary services. Suggestions include paying for most primary care services (not just preventive care services) and paying for certain chronic condition supplies and testing, such as those related to diabetes.
- Lengthened consumerism.
  - HDHPs could be redesigned to increase an individual's "skin in the game." One way would be through different plan designs, such as allowing higher out-of-pocket maximums but lower deductibles, so the "consumerism" effects are felt longer by way of coinsurance.

(d) You are an employee at Company ABC. You will be electing family coverage and have the following plan options:

	PPO-HDHP	HMO-Major Med
Family Deductible	$3,000	$1,000
Coinsurance	30%	20%
Max Out of Pocket	$6,000	$1,500

You are expecting three claims to occur in the following order:

- Claim #1: Employee outpatient surgery with allowed cost of $1,000
- Claim #2: Dependent pharmacy claim for Drug X with allowed cost of $5,000
- Claim #3: Employee specialist visit with allowed cost of $500

Calculate the difference in total cost sharing between the two plans. Show your work.

Commentary on Question:
Most candidates performed well on this part of the question.

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

3. Continued

(e)

(i) Calculate the revised difference in total cost sharing between the two plans. Show your work.

(ii) Describe additional considerations in deciding which plan option to choose.

Commentary on Question:
The below responses for part (ii) received full points on the exam. Other responses not listed here but relevant to the question were also acceptable.

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

(ii)
- With the drug card, out of pocket expense is nearly identical for the high deductible plan and the major medical plan. This is important as the major medical plan likely has a much higher monthly premium.
- How much of the monthly premium is employer paid vs. employee paid for the two plans?
- Network differences may be important as the member could incur expenses for claims that end up out of network under the HMO. What if the PCP won't refer to a specialist that is planned for claim #3?
- Medical management practices may come into play for both, but likely to be tighter for the HMO. So, what if the outpatient procedure in claim #1 isn't approved under the HMO plan?

4. Learning Objectives:

2. The candidate will understand how to evaluate the effectiveness of different provider reimbursement methods from both a cost and quality point of view.

Learning Outcomes:

(2a) Calculate provider payments under various reimbursement methods.

(2b) Evaluate standard contracting methods from a cost-effective & quality perspective.

(2c) Understand contracts between providers and insurers.

(2d) Understand accountable care organizations and medical patient home models and their impact on quality, utilization and costs.

Sources:

- Provider Payment Arrangements, Provider Risk, and Their Relationship with Cost of Healthcare, 2015 (excluding Appendices)

- GHRM-114-23: Chapter 45 of *Group Insurance*, Skwire, Daniel, 8th Edition, 2021

Commentary on Question:
Commentary listed underneath question component.

Solution:

(a) Describe the following reimbursement arrangements from a provider risk perspective.

(i) Shared Savings

(ii) Global Capitation

Commentary on Question:
In part (a), the question asks about reimbursement and many candidates described only the shared savings portion and omitted the method of reimbursement. In the second part it was important to remember that the point of view is from the provider perspective, not the insurance company/payer.

(i) In a Shared Savings model, the provider reimbursement is based on a FFS agreement with a provision for additional payment if a benchmark is achieved. There may be a quality requirement as well.

(ii) The provider takes over the full risk of the population in return for a PMPM (per member per month) capitation payment. The PMPM may or may not be adjusted for population characteristics.

4. Continued

(b) Describe Shared Savings and Global Capitation from a provider perspective for the following risks by completing the table below:

	Shared Savings	Global Capitation
Utilization		
Technical		
Insurance		
Performance		

	Shared Savings	Global Capitation
Utilization	This varies depending on the nature of the contract.	Increased utilization and the associated costs are the responsibility of the provider.
Technical	There will be reconciliation with the benchmark measure and then any savings will need to be equitably dispersed among providers.	The umbrella provider organization needs to determine the proportion of the capitation rate that should go to the constituent providers.
Insurance	Since the savings benchmark relies on loss ratio, there is a risk that the revenue is not correctly set. In shared savings model the risk is not loss but not achieving savings. In a two sided model the risk is that costs exceed benchmark.	The provider is at risk for all costs which may exceed the revenue from capitation,.
Performance	Achieving the benchmark will require efficient care. If the agreement has a quality component there will be performance risk.	Efficient and high quality care are needed to manage performance risk in a capitated arrangement

4. Continued

(c) Calculate the Shared Savings to Alpha for calendar year 2023. Show your work.

Commentary on Question:
Commentary and solution in associated Excel files

(d) Beta has approached Alpha in early 2024 regarding a Global Capitation arrangement beginning immediately for 86.5% of revenue. You received the following message from Alpha's CEO.

> *"The board wants to accept this offer but has requested my input. They are excited that we "get to keep it all", but I am not so sure about this given the recent changes to the government risk adjustment model beginning this year and the payer industry's high claims trend. I need the loss ratio projection to be below 86% to agree to this."*

(i) Outline the risks of accepting this proposal.

(ii) Describe actions that can be taken to mitigate them.

Commentary on Question:
This question asks the candidate to identify risks, and then for the risks identified, suggest a mitigation plan of action. Credit was given for identifying the risks, but credit was only given if the mitigations could be tied with the identified risks.

In this arrangement Alpha assumes the risk for all costs of care for the population in return for the potential of larger share of the savings, but the capitation rate is at a lower loss ratio.
Revenue risks – The revenue would need to be sufficient to cover the expected risk of Alpha's population. This requires adequate coding of diagnoses, as well as reliance that the revenue was calculated correctly by Beta. Any changes in the risk adjustment model may adversely impact the projected revenue.
Expense Risk – higher costs and utilization will be Alpha's responsibility.

Revenue risk – increase coding accuracy to minimize missing diagnoses. Include a stipulation in the contract to revisit revenue amounts if the population or the risk adjusted methods change significantly or the realized revenue is significantly lower than expected.
Claims risk – Alpha might purchase reinsurance. Carve out conditions or members. Use best practices in care management. Involve practitioners in cost management programs.

5. Learning Objectives:

4. The candidate will understand how to apply risk adjustment in actuarial work.

Learning Outcomes:

(4b) Apply applicable Actuarial Standards of Practice

Sources:

Creating Stability in Unstable Times – A Look at Risk Adjustment and Market Stabilization, The Actuary, Dec 2017

ASOP 41: Actuarial Communications

GHRM-112-23: HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper, Ch. 4

Commentary on Question:

The sections of this question tested the candidate's knowledge of key market stabilization forces in the ACA, the design elements of the ACA's HHS-HCC Risk Adjustment Model, and the actuary's obligations under ASOP 41. Candidates who received full points were able to identify and summarize the relevant portions of the source material.

Solution:

(a)

(i) Describe the following aspects of the Affordable Care Act:

- Individual Mandate
- Subsidies
- Risk Corridors
- Reinsurance

(ii) Critique the effectiveness of each aspect in creating a stable and sustainable market.

Commentary on Question:

Candidates generally did well on this part of the question and were able to capture the main elements of each aspect. While candidates did not need to exhaustively cover all the bullets below to receive full points, only a subset of candidates identified enough salient elements, particularly for subsidies and risk corridors, to receive full points.

5. Continued

(i) Descriptions

Individual Mandate
• The individual mandate is a tax penalty on individuals able to afford coverage but choose not to purchase it.
• The mandate produces financial incentives for healthy individuals to purchase coverage to improve the risk pool.

Subsidies
• Advanced premium tax credits (APTCs) are calculated relative to the second lowest cost silver plan in an enrollee's area and reduce premiums substantially.
• By tying the subsidy amounts to the premium levels, eligible enrollees are protected from large increases in premiums.
• Subsidy amounts decrease as enrollee incomes increase and subsidies completely end above 400 percent of the federal poverty level (FPL).
• The subsidy structure has produced large increases in enrollment.

Risk Corridors
• The risk corridor program was a transitional program intended to protect issuers from large losses in the first three years of the ACA.
• It was expected that it would be difficult to estimate the costs of the new population since it would be much different from what had existed previously.
• Premiums may have been lower than they would have been because issuers expected this program to protect them from insufficient rates.

Reinsurance
• The reinsurance program covered a portion of large claims reducing the risk to issuers and lowering premium.
• It was successful at lowering premiums.
• Many states are now considering state-based programs.

(ii) Critiques

Individual Mandate
• There has been some concern that the financial penalties of the mandate are not large enough.
• The current political environment has produced uncertainty regarding the enforcement of the mandate
• Less enforcement of the mandate could increase risk selection.

Subsidies
• Enrollees without subsidies have felt the full impact of the recent large premium increases.

• The subsidy structure may need to be altered to encourage younger individuals to enroll since older enrollees are more likely to be eligible for subsidies.

Risk Corridors
• The risk corridor program paid out only a tiny fraction of the amount of calculated risk corridor payments.
• Insufficient risk corridor payments were likely a key factor in market instability and the wave of co-op plans becoming insolvent.

Reinsurance
• It was phased out over three years causing higher premium increases.

(b) Describe disclosure requirements of ASOP 41 for the use of assumptions and methods

(i) prescribed by law.

(ii) relied on from another party.

Commentary on Question:
Candidates who were familiar with ASOP 41 were able to reproduce the necessary sections of the ASOP and receive full points, however, some candidates referenced incorrect sections of the ASOP in their responses.

(i) Prescribed by law

• the applicable law under which the report was prepared;
• the assumptions or methods that are prescribed by the applicable law; and
• that the report was prepared in accordance with the applicable law.
• If the actuarial report is in a prescribed form that does not accommodate these disclosures, the actuary should make these disclosures in a separate communication.

(ii) Reliance on another party

• the assumption or method that was set by another party;
• the party who set the assumption or method;
• the reason that this party, rather than the actuary, has set the assumption or method;
• If the assumption or method does not conflict significantly with what, in the actuary's professional judgment, would be reasonable for the purpose of the assignment, the actuary has no further disclosure obligation
• If the assumption or method significantly conflicts with what, in the actuary's professional judgment, would be reasonable for the purpose of the assignment, the actuary must disclose that fact
• If the actuary has been unable to judge the reasonableness of the assumption or

method without performing a substantial amount of additional work beyond the scope of the assignment, or
• Or if the actuary not qualified to judge the reasonableness of the assumption.
• If the actuarial report is in a prescribed form that does not accommodate these disclosures, the actuary should make these disclosures in a separate communication.
• If the actuary believes circumstances are such that including certain content is not necessary or appropriate, the actuary must be prepared to identify such circumstances and justify limiting the content of the actuarial report.

(c) Describe factors for selecting drug-diagnosis pairs (RXC-HCC pairs) for the development of a hybrid HHS-HCC Risk Adjustment Model.

Commentary on Question:
Candidates received credit for considerations specific to selecting drug-diagnosis pairs for the HHS-HCC risk adjustment model.

• The goal is to gain the advantage of drug information while minimizing the disadvantages.
• Select drugs with patterns of non-discretionary prescribing
• Avoid drugs where there are incentives for over-prescribing
• Avoid drugs where there are variations in prescribing across providers, practices, and areas.
• Carefully consider including high-cost drugs as these costs may be the types of health risk variation across enrollee populations that risk adjustment is designed to account for.
• If issuers know that risk adjustment transfers will compensate for high cost drugs then this compensation may reduce incentives for issuers to strive for greater efficiency in drug utilization.
• Avoid drugs indicated for multiple diagnoses.
• Avoid drugs for diagnoses not included in the HHS-HCC model.
• Carefully consider drugs in an area exhibiting rapid rate of technological change because the cost predictions for previous years of data could be inaccurate.

(d) Describe CMS considerations and requests for public input for the following model design elements of the hybrid HHS-HCC Risk Adjustment Model.

(i) Imposing model restrictions based on days' supply or number of prescriptions.

(ii) Subdividing/splitting RXCs or including individual drugs.

5. Continued

Commentary on Question:
Some candidates struggled to provide a full response to this part of the question. Candidates did not need to describe all the considerations below to receive full points; an adequate response displaying knowledge of the source material was sufficient to receive full points.

(i) Imposing model restrictions based on days' supply or number of prescriptions.
• The models are intended to capture predictable cost variation CMS considered requiring evidence of prolonged usage of a particular drug to trigger a drug indication.
• Prolonged usage could be signaled by multiple prescriptions of the same drug (or class of drugs).
• Prolonged usage could be signaled by number of days' supply (at least 30 or 60 days).
• Clinical consultants suggested a few RXCs for which a minimum days' supply restriction would be useful to distinguish severely ill patients from those with milder conditions.
• CMS did not include these RXCs in the initial illustrative hybrid model.
• Public input is requested for on whether days' supply restrictions should be imposed on drug classes added to the HHS-HCC model.
• CMS is particularly interested in feedback on which drug classes warrant days' supply requirements.

ii. Subdividing/splitting RXCs or including individual drugs
• In discussions with clinicians, they suggested that a specific drug or therapeutic class within an RXC is appropriately linked to an HCC but other drugs in the RXC would confound this clinical connection.
• In each case CMS considered whether to split an RXC or restrict an HCC-RXC interaction to certain drugs within the RXC to give more clinical precision.
• The greater clinical precision advantage must be weighed against the added complexity, smaller sample size, and less statistical stability and the magnitude of the incremental predictive power.
• Public input was solicited on particular drugs and drug-diagnosis combinations that should be incorporated into the model.

6. **Learning Objectives:**

3. The candidate will understand how to evaluate healthcare intervention programs.

Learning Outcomes:

(3a) Describe, compare and evaluate programs.

(3b) Estimate savings, utilization rate changes and return on investment.

Sources:

Managing and Evaluating Healthcare Intervention Programs, Duncan, Ian G., 2nd Edition, 2014, Ch. 3: Care Management Programs and Interventions

Managing and Evaluating Healthcare Intervention Programs, Duncan, Ian G., 2nd Edition, 2014, Ch. 11: The Use of Propensity Scoring in Program Evaluation

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) Describe types of care management programs.

Commentary on Question:

Most candidates performed well on this part of the question. Candidates needed to provide a description of each type of program and not just a list of programs to receive full points.

- Care coordination – Integrated records (EHRs) and consistent care delivery to increase health care efficiencies.
- Case management – A health care professional coordinates the care of a patient with a serious disease or illness.
- Concurrent review – "Over the shoulder" nurse practitioner peer review of the physician's treatment plan while the member is receiving services.
- Clinics – Alternative site of care that has downward bias on cost.
- Prior authorizations – Insurer (or PBM) is made aware of an often-expensive treatment/prescription that could potentially be handled with an alternative measure. Insurer/PBM approval is required before service is rendered.
- P4H/PCMH (Patient Centered Medical Home) – Patient-centric and quality-focused payment models.
- Population health management – Intervention in which a broad set of medical conditions is addressed by looking at the population as a whole irrespective of its conditions.
- Pharmacy services – Focus on certain care management programs that can be led by pharmacists, including generic utilization review and medication adherence programs.

6. Continued

- Disease management – Focuses on chronic conditions with certain common characteristics that make them suitable for clinical intervention, such as coronary artery disease, diabetes, chronic obstructive pulmonary disease, asthma, and heart failure.
- Demand management – Informational intervention that is often provided by clinical staff over the telephone.
- Bundled Payment Initiatives – Alternative payment model that transitions utilization risk to the provider by providing one lump sum payment to cover all services associated with an episode of care.
- Specialty case management – Performed by a care manager who has expertise in a particular area and to whom the MCO has assigned primary responsibility for coordinating the patient's care.
- Telehealth – Over the phone healthcare (or video), allowing more frequent contact with members that have trouble accessing providers consistently.
- ACO (Accountable Care Organization) – Alternative payment model with shared savings elements with providers.
- Gaps in care and quality improvement initiatives – Used to improve the quality and quantity of care for members as needed.

In the Excel spreadsheet, you are provided data for members eligible for a palliative care management program. The goal of the program is to reduce total inpatient (IP) admissions and emergency department (ED) visits by at least 10% each.

(b) Evaluate whether the program achieved its goal using the following approaches. Show your work.

- With matching
- Without matching

Commentary on Question:
Candidates generally did well on this part of the question, if the candidate matched on individual age, gender, and county characteristics, as the dataset included exactly one candidate in the program and one candidate not in the program with these same demographic characteristics. Candidates who did not earn full points either often did not match on all three characteristics, did not correctly calculate the reduction in utilization, or did not state whether the program achieved its goal.

The response for this part is to be provided in the Excel spreadsheet.

6. Continued

(c) Recommend an approach from part (b). Justify your response.

Commentary on Question:
Few candidates received full points on this part of the question. Candidates generally did not provide enough justification for their recommendation and often just listed their results from part (b).

- The two groups of members, the treatment and control groups, are not equivalent.
- Males comprised 56% of the treatment group and only 47% of the control group.
- Matching was done to account for some differences between these two groups.
- Members could be matched based on having exact characteristics. For every member in the intervention group, there is exactly one member in the control group with the same provided demographics.
- This population was small enough such that matching could be performed on members having the same characteristics.
- Recommend matching for part (b)

7. Learning Objectives:

2. The candidate will understand how to evaluate the effectiveness of different provider reimbursement methods from both a cost and quality point of view.

Learning Outcomes:

(2b) Evaluate standard contracting methods from a cost-effective & quality perspective.

(2c) Understand contracts between providers and insurers.

Sources:

GHRM-109-23: Application of Tiering in Healthcare

Commentary on Question:

This question was testing a candidate's understanding of different aspects of provider contracting, including types of providers, regulations, and tiering. Candidates generally did well on parts (a) and (b), earning either full or partial points for describing types of providers and regulations. Candidates struggled on part (c) where they needed to identify and utilize the TNHP savings formula.

Solution:

(a) Describe the following categories of providers in a PPO.

(i) Preferred Providers

(ii) Non-Preferred Providers

(iii) Out of Network Providers

Commentary on Question:

Most candidates performed well on this part of the question.

(i) Preferred Providers are in-network providers of high value, with a mix of higher quality care and lower negotiated contract rates for services. Health plans will steer members to these providers through lower cost share.

(ii) Non-Preferred Providers are in-network providers which are still contracted with the health plan, but do not meet the same value or quality standards for Preferred Providers. Cost sharing for members will be higher to utilize these providers compared to the preferred tier.

7. Continued

(iii) Out of Network Providers do not have a direct contract with the health plan and are often lower value, either due to low quality of care, high service rates, or both. The quality of care could be on par with the preferred providers, but the cost of care may be much higher and/or the ability to offer discounts may not be possible.

(b) Describe regulatory guidance to ensure that quality is not diminished when a restrictive network is put into place.

Commentary on Question:
Most candidates provided a correct response that described standards for provider composition, access, and consumer protection. Candidates who received full points also included regulatory guidance related to NAIC Model Regulation as described in the source material.

NAIC Model Regulation Section 5B requires that health insurers must file an Access Plan with state insurance commissioner. State insurance department personnel typically perform a "Network Adequacy Analysis," which includes the review of the access plan. Standards which are reviewed in this analysis include:

- Provider Composition standards - adequate number and mix of provider types and specialists
- Access standards - reasonable and adequate access to all providers and facilities in a carrier's service area by specialty or type.
- Consumer Protection standards - balance bill and hold harmless the member not allowed

(c)

(i) Calculate the savings for each of the four service categories. Show your work.

(ii) Recommend whether the TNHP design should include tiering for each service category. Justify your response.

Commentary on Question:
Successful candidates applied the TNHP savings formula from the source material to calculate a savings percentage for each service category. Recommendations for part (ii) needed to align with the savings results calculated from part (i). Most candidates using the formula received partial credit for calculating several of the variables, but few candidates correctly calculated each variable to get to the correct solution. Several candidates did not use the formula and instead incorrectly performed a total dollar cost comparison between the 2023 data and the new 2025 plan design.

7. Continued

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

(ii) I recommend tiering for diagnostic lab tests, diagnostic imaging, and diagnostic imaging high tech as these all show generated savings under the TNHP design. I do not recommend tiering for OP surgery as this service category did not show savings under the TNHP design.

8. Learning Objectives:

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

Learning Outcomes:

(1a) Describe structure of employee benefit plans and products offered and the rationale for offering these structures.

Sources:

The Handbook of Employee Benefits, Rosenbloom, Jerry, 7th Edition, 2011, Ch. 24: Strategic Benefit Plan Management

Commentary on Question:

This question was testing the candidate's understanding of the structure, components, and constraints of employee benefit programs. It specifically asked about vendor summits and Summary Plan Descriptions (SPDs).

Solution:

(a) Describe factors that impact the level of complexity of administering an employee benefits program.

Commentary on Question:

Candidates generally did well on this part of the question and were able to describe at least a few factors impacting complexity. Other responses not listed below but relevant to the question were also acceptable.

- The complexity and comprehensiveness of the benefit design and coverage
- The size of the employee group covered
- The uniformity of the program for different categories of employees
- The geographic dispersion of employees

(b) Identify constraints a benefits manager must consider in the design of employee benefit plans.

Commentary on Question:

Candidates also did well on this section, with many receiving full credit. A list of constraints was sufficient. Other responses not listed below but relevant to the question were also acceptable.

- Cost considerations
- The culture/philosophy of the organization
- Competition
- Local market/regulatory conditions

8. Continued

(c)

(i) Define vendor summits.

(ii) Describe purposes of vendor summits.

Commentary on Question:
Candidates generally understood vendor summits at a very high level. Candidates who were able to provide a more comprehensive definition and description of vendor summits received more points.

(i) "Vendor summits" involve -

- Periodic meetings (annually)
- All the various service providers assisting in plan administration
- Discuss administrative processes
- Discuss client policies

(ii) Purpose

- They allow the various providers to meet each other and form a personal relationship
- They provide education on the entire administrative process
- They provide a forum in which the plan sponsor can explain its underlying benefit's philosophy, customer service expectations, and specific policy clarifications.
- They promote good communication amongst the various vendors involved in the administrative process.

(d)

(i) Define a Summary Plan Description (SPD)

(ii) Describe components of an SPD.

Commentary on Question:
Candidates performed well on part (i) but struggled with part (ii). Some candidates described additional types of plan descriptions rather than describing components of a SPD.

Summary plans descriptions (SPDs) are communication materials that provide a summary of the benefit plan's provisions in language that is supposed to be understandable to the average plan participant.

8. Continued

The following information must be included in the SPD:

- How to make a claim for benefits
- The procedure for appeal if a claim for benefits is denied
- The name and address of the person or persons to be served with legal process should a legal action be instituted against the plan