GH DPC Model Solutions
Fall 2020

1. Learning Objectives:

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

Learning Outcomes:

(2c) Calculate and recommend assumptions.

(2d) Calculate and recommend a manual rate.

Sources:

GHDP-128-19: Pricing Medicare Supplement Benefits

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) List and describe factors that impact Medicare Supplement pricing.

Commentary on Question:

Eight items with descriptions were required for full credit. Additional items beyond the list below were given credit if they related to Medicare Supplement products.

1. Morbidity - Industry studies can be a good source for developing expected claims.

2. Mortality - Not a significant assumption, included with persistency as a single decrement.

3. Persistency (lapsation) - Should be based on the company's experience for similar products.

4. Investment Earnings - Can be credited to the claim reserve

5. Selection Factors/ Underwriting - can be used to modify the claim costs for the first one to three years.

1. Continued

6. Age/Sex Distribution - It is preferable to use the company's own experience if available

7. Smoker/Non-smoker consideration - An adjustment to the claim costs for the insured population that will be smokers. Smokers have higher claims than non-smokers.

8. Area Factors - Claim costs vary by geographic area, generally by 3-digit zip codes or by county.

9. Expenses & Taxes - Includes acquisition and maintenance expenses, and premium and income tax

(b) Describe the different loss ratio standards which must be met as part of a Medicare Supplement annual filing.

Commentary on Question:
No credit was given if the loss ratio standards were listed without a description. Full credit required the candidate to describe the loss ratios, and how each relates to the applicable loss ratio standard.

1. Lifetime Loss Ratio - The accumulated value of past plus present value of future claims, divided by the accumulated value of past plus present value of future premium, must meet or exceed the applicable loss ratio standard.
2. Future Loss Ratio - The present value of future claims, divided by the present value of future premium, must meet or exceed the applicable loss ratio standard.
3. The expected third year loss ratio must meet or exceed the applicable standard.

The applicable standard is either the company's original expected loss ratio, or the statutory minimum, whichever is greater.

(c) Explain how insurers are prevented from recouping past Medicare Supplement losses.

Commentary on Question:
Candidates who did well explained the specific mechanism that prevented recouping of losses: the future loss ratio standard.

The loss ratio standards, specifically the future loss ratio, prevent a company that has had poor experience from recouping losses. Increasing premiums to offset poor prior experience will result in the future loss ratio being too low.

1. Continued

(d) Assess whether or not a $2,400 annual premium satisfies the 65% loss ratio requirement for each of the loss ratio standards. Show your work.

Commentary on Question:
Candidates generally did poorly on this part. Full credit required the candidates to show their work. Common issues with this exercise were a misapplication of the survivor counts, lapse or mortality rates; applying the smoker or sex factor to the premium; and a failure to weight policy years by survivors.

Policy Year	Adjusted Claim Cost	Incurred Claim Cost	Premium Income	years of discount	PV Future Claims	PV Future Premium	Loss Ratio
1	$1,671.50	$1,671,504	$2,400,000	0	$1,631,221	$2,400,000	67.97%
2	$1,728.54	$1,279,120	$1,776,000	1	$1,188,850	$1,691,429	70.29%
3	$1,773.72	$993,285	$1,344,000	2	$879,226	$1,219,048	72.12%
		$3,949,902	$5,520,000		$3,699,297	$5,310,476	69.66%

- Adjusted Claim Cost = Unadjusted Claim Cost * Sex Adj * Smoker Adj
- Incurred Claims = Adjusted Claim Cost * Survivors
- Premium Income = $2,400 * Survivors
- PV Future Premium = The present value, at time of issue, of all premium income, using a 5% discount factor.
- Example Policy Year 2 = $1,691,429 = $1,776,000 * (1/1.05)^1
- PV Future Claims = The present value, at time of issue, of all premium income, using a 5% discount factor.
- Example Policy Year 2 = $879,226 = $993,285 * (1/1.05)^1.5
- Loss Ratio #1 = Loss Ratio #2 (since these are rating assumptions, assume no actual/past experience has been observed) = PV Future Claims / PV Future Premium = 69.7%)
  Loss Ratio #3 = 73.9% (Incurred Claim Cost in Year 3 / Premium Income in Year 3, no PV)
- All loss ratios exceed 65% with a $2,400 annual premium. This premium satisfies the 65% requirement.

2. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   - Group and Individual medical, dental and pharmacy plans.
   - Group and Individual long-term disability plans.
   - Group and Individual short-term disability plans.
   - Supplementary plans, like Medicare Supplement.
   - Group and Individual long-term care insurance.

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

Learning Outcomes:

(1b) Describe each of the coverages listed above.

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

Sources:

Group Insurance, Chapters 7, 23

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) Describe four factors that influence prescription drug costs and benefit offerings.

Commentary on Question:

Candidates generally performed well on part (a). This model solution describes 4 items as requested, but any of the 10 options identified in the text received credit provided the item was described and not merely listed.

Prescription Drug Pipeline – Research and development (R&D) brings powerful new drugs to market, providing new solutions for patients.

Brand Patent Protection – New drugs are covered by patents that protect the original manufacturer from competition for a period of time.

Direct-to-consumer advertising – Marketing to consumers has increased consumer awareness of new, high cost drugs.

Aging population – Older people typically have more medical conditions.

(b) Describe analytical pricing considerations in developing prescription drug plan premiums.

2. Continued

Commentary on Question:
Many candidates listed important rating factors instead of the analytic pricing considerations requested. Both appear in the same chapter of the Group Insurance text.

Timing of Rebates – Plans typically collect rebates from the PBM quarterly or semi-annually, which creates a lag between when rebates are earned and when the plan receives the rebate payment.

Credibility – Some plans may not have sufficient experience to use when projecting future claims.

Integrated Plans – Many plans integrate the medical and drug benefit designs.

Fixed Cost Leveraging – Trend in plan liability will be greater than the trend in allowed costs whenever deductibles or copays are part of the plan design.

(c) Calculate the change in plan liability from 2018 to 2019 for the generic drug tier. Show your work.

Commentary on Question:
Candidates generally performed well on part (c). Common mistakes included using the wrong assumptions (discount, copay, or dispensing fee) from the case study or applying the discount incorrectly.

2018 Ingredient Cost = (100% - Discount) X AWP
= (1 - 0.75) x 50
= 12.50

2018 Allowed Amount = Ingredient Cost + Dispensing Fee + Vaccine Fee + Sales Tax
= 12.50 + 1.50 + 0 + 0
= 14.00

2018 Expected Plan Liability = Allowed Amount – Effective Cost Share
= 14.00 - 10
= 4.00

2019 Ingredient Cost = (100% - Discount) X AWP
= (1 - 0.75) x 55
= 13.75

2. Continued

2019 Allowed Amount = Ingredient Cost + Dispensing Fee + Vaccine Fee + Sales Tax
= 13.75 + 2 + 0 + 0
= 15.75

2019 Expected Plan Liability = Allowed Amount – Effective Cost Share
= 15.75 - 10
= 5.75

Expected Plan Liability Change = 2019 Expected Plan Liability - 2018 Expected Plan Liability
= 5.75 – 4.00
= 1.75

(d) Calculate the price protection rebate required to maintain the same net plan liability for the remainder of 2018. Show your work.

Commentary on Question:
Candidate performance on part (d) was mixed. The most common mistake was not realizing that the discount on AWP, the dispensing fee, and the member copay would not change for the final month of 2018.

Before the Change

Discounted Cost = AWP x (1-Discount) = $2,675 x (1-0.08) = $2,461
Member Copay = $150
Net Plan Liability = Discounted Cost + Dispensing Fee – Member Copay – Price Protection Rebate + Sales Tax + Vaccine Fee = $2,461 +$1.50 - $150 - $0 + $0 + $0 = $2,312.50

After the Change

Discounted Cost = AWP x (1-Discount) = $2,700 x (1-0.08) = $2,484
Member Copay = $150
Net Plan Liability = Discounted Cost + Dispensing Fee – Member Copay – Price Protection Rebate + Sales Tax + Vaccine Fee = $2,484 +$1.50 - $150 – Price Protection Rebate + $0 + $0 = $2,312.50
= $2,335.5 – Price Protection Rebate = $2,312.50
Price Protection Rebate = $23

3. Learning Objectives:

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

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

Learning Outcomes:

(2e) Identify critical metrics to evaluate actual vs. expected results.

(3a) Describe structure of employee benefit plans and products offered and the rationale for offering these structures.

(3b) Describe elements of flexible benefit design and management.

(3c) Recommend an employee benefit strategy in light of an employer's objectives.

Sources:

- The Handbook of Employee Benefits, Ch. 2: Functional Approach to Designing and Evaluating Employee Benefits
- GHDP-106-16: Health Plan Payroll Contribution Strategies and Development for Employers
- GHDP-130-19: Recommend an Employee Benefits Strategy
- The Handbook of Employee Benefits, Ch. 24: Functional Approach to Designing and Evaluating Employee Benefits
- Consumers to the Rescue? A Primer on HDHPs and HSAs, Health Watch, Feb 2019
- Timing's Everything: The Impact of Benefit Rush, Health Watch, May 2008

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) List reasons a holistic and functional approach to employee benefits is needed.

Commentary on Question:

Candidates who responded with steps of the functional approach instead of the rationale for why it is necessary did not receive full credit.

3. Continued

Employee benefits represent a significant part of the total compensation for employees and a significant portion of total labor costs. Therefore, effective planning and hence avoidance of waste in providing benefits can be an important cost-control measure for employers. It is important to determine where overlapping benefits may exist and costs can be saved, and where gaps in benefits may exist and new benefits or revised benefits may be in order. A functional approach allows you to keep your benefits program current, competitive, and in compliance with regulations.

(b) Identify consequences of transitioning from an employer cost-subsidized model to a fully employee-paid benefits approach.

Commentary on Question:
Many candidates were able to identify items from the bulleted list below.

- There may be negative response from employees, as this would represent a significant cost increase for them.
- The participation in the employee benefits plans may drop, as employees seek more affordable coverage through a spouse or elsewhere.
- Anti-selection may occur, where higher-risk employees would continue to remain in the benefits program, and lower-risk employees drop out to avoid paying the full cost of premiums.
- Costs would be directly reduced for the employer, since employees would pay for the benefits in full.
- The benefits may be deemed unaffordable to employee (more than 9.5% of total payroll) and the employer may face penalty under the ACA's employer shared responsibility rule (ESR)
- It may not be consistent with employers' total compensation philosophy. Employers might need to increase pay in order to offset the benefit reduction at a less tax advantaged level.

(c) List the defining characteristics of a Health Saving Account (HSA) compatible High Deductible Health Plan (HDHP).

Commentary on Question:
Many candidates described Health Savings Accounts rather than the attached HDHP medical plan.

3. Continued

- HDHPs must meet a specific definition from the IRS in order to be offered with HSAs.
- There is a minimum deductible set by the IRS.
- IRS also sets an upper limit on the out-of-pocket maximum (OOPM).
- There is limited first dollar coverage, except for preventive care.
- Plan design promotes consumerism: save for healthcare, select more appropriate venues (urgent care vs ER), avoid unnecessary care, generic instead of brand, compare provider quality, negotiate prices, etc.

(d) Identify the advantages and disadvantages to ABC of offering a single medical plan vs. multiple plan options.

Commentary on Question:
Most candidates were able to provide both advantages and disadvantages.

Advantages of multiple options
- Employees may like having multiple options and may pick a plan better suited for their needs.
- Having multiple options makes ABC's benefits in-line with competitors.

Disadvantages of multiple options
- Offering choice often leads to anti-selection.
- Offering multiple choices may be more complex to administer.

(e) Describe two sources of financial savings and two concerns that might arise from ABC offering an HSA-compatible HDHP.

Commentary on Question:
Many candidates provided savings and/or concerns from the member's perspective instead of ABC's perspective.

Sources of financial savings:
- Lower utilization due to more member cost sharing with a HDHP. Causes members to avoid unnecessary care.
- Members become better consumers and try to find least expensive providers for treatments, opt for generic Rx, etc.

Concerns:
- High cost sharing means members might not get care they need and cause higher claims down the line when they get very sick.
- Amount of employer HSA contributions can affect the savings impact of an HDHP. The larger the contributions to the HSA, the more the impact is lowered.

3. Continued

(f) Recommend strategies for ABC to ensure implementation of a new HDHP will be successful. Justify your response.

Commentary on Question:
Many candidates made recommendations around plan pricing or design, though the question asks for strategies around the implementation phase, after design and pricing is finalized.

Many candidates did not provide sufficient justification to their recommendations to receive full credit.

I recommend that ABC introduce the new HDHP plan with several communication campaigns. ABC should send emails, have a town hall meeting, and put flyers around the office to get their employees educated on the new plan offering and what the changes mean. This targeted campaign should start well before open enrollment. The more educated employees are, the better they will be able to decide which plan they should enroll in.

I recommend that ABC also pre-fund some of the HSA. This will encourage employees to enroll in the HDHP plan and become consumers of their medical benefit. ABC should communicate to employees what HSA dollars can be used for and how they can contribute to their account.

(g) Explain the impact on employee behavior and claims utilization:

(i) After the change is announced

(ii) During the first plan year following the change

(iii) During the second plan year following the change

Commentary on Question:
Candidates only received full credit if they defined explicitly what happens to utilization and member behavior in each phase. Simply referencing "rush-hush-crush" received no credit.

(i) After the change is announced, there will be a rush to use the rich benefits of the PPO compared to what they may get with the HDHP and claims utilization will be higher than usual.

3. **Continued**

(ii) During the first year the HDHP is offered, there will be a hush or reduction in utilization as members learn how best to use the new plan and after receiving all their elective services the prior year while using the PPO.

(iii) During the second year, utilization and cost will go back to normal, but this will cause a crush in trend as there was such low usage in the prior year.

4. Learning Objectives:

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

Learning Outcomes:

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

(2c) Calculate and recommend assumptions.

(2e) Identify critical metrics to evaluate actual vs. expected results.

(2f) Describe the product development process including risks and opportunities to be considered during the process.

Sources:

Group Insurance, Chapters 3, 22

Commentary on Question:

Commentary listed underneath question component.

Solution:

(a) List and describe three drivers of product ideas.

Commentary on Question:

Most candidates did well as many were able to list and describe at least three drivers of product ideas. Partial credit was given to candidates who only listed the drivers but did not provide description or did not provide accurate description. Credit was also given for reasonable answers not included in the model solution. Note that only three of the following bullets (with corresponding descriptions) were needed to earn full credit.

- **Innovator for Follower** – There are companies that successfully innovate, and there are companies that successfully follow the market. The company that innovates must invest in the development of concepts, while the company that follows can learn from their competitors by observing what works and does not work for the products that their competitors bring to the market.

- **Changing Laws and Regulations** – When new laws or regulations are created, or existing laws or regulations are changed, products are developed to operate within these new sets of rules.

- **Consumer Demand** – It is very important that companies remain attentive to the needs and desires of consumers. Companies interested in remaining competitive must constantly seek consumer feedback and market intelligence.

4. Continued

- **Marketing and Sales Demand** – Marketing and sales teams have direct access to the market, and are often aware of the demand from the market. They can spot gaps in the product spectrum where consumer demand is not being fully met. This insight may lead to new ideas. Incorporating sales feedback into the product development process is essential to gaining a comprehensive understanding of market needs.

- **Leveraging Insurer's Capabilities** – While insurers are looking for ideas to develop new products and even acquire other companies to grow in new areas, product development does not necessarily need to encourage growth into new product areas. There are efficiencies gained by leveraging the insurer's existing capabilities.

- **Social Need** – Products are developed to address specific social needs.

- **Changing Demographics** – With the aging baby boomers and people generally living longer, the demographics in the insurance markets are changing. Changing demographics means a shift in the types of products that will be marketable and saleable.

- **Changing Economy and Financial Markets** – Shifts in the economy and financial markets change purchasers' views of their need for insurance. Insurance products that do not appear critical to the market may lose members during downward swings in the economy and financial markets. However, insurance products that purchasers believe will increase their financial stability may gain members.

- **Competitive Advantage:** Insurers often have a competitive advantage in one or more areas. Any competitive advantage should be utilized to its fullest extent, and thus should influence product development ideas.

(b) Compare and contrast the following dental provider reimbursement methods:

(i) Fee-for-service (FFS)

(ii) Preferred Provider Organization (PPO)

(iii) Capitation

Commentary on Question:
Most candidates received partial credit on this question as they simply described the three reimbursement methods without providing further contrast.

4. Continued

	FFS	PPO	Capitation
Method of reimbursement	A dentist performs a service for a covered member and is paid for that service	Contracts with a limited number of dentists in each region and agrees to list the dentist in its network in exchange for a reduced fee schedule, above which the dentist may not bill	The dentist is paid a fixed amount per member enrolled, or a per capita amount.
Maximum reimbursement level	Lower of a high percentile of nationally charged fees; a high percentile of the locally charged fees This stat provides a R&C fee that varies by geography	Typically set by insurers based on an analysis of the distribution of fee levels in the local community, similar to the analysis of R&C maximum schedules but with lower percentile, thus lower maximum.	No maximum fee schedule established
Balance bill	Permitted	Not permitted	Not permitted
Network restriction	Least restrictive	Narrower than FFS, may use tiered network and reward providers with lower cost, best outcome at the lowest cost or higher ACO scores	Usually associated with Dental HMO plans. Network is a narrowest subset of providers.

(c) Calculate the dampening effect on trend of a $1,500 annual maximum. Show your work.

Commentary on Question:
Most candidates received at least partial credit. Some candidates did not correctly recall the definition of the dampening effect. Instead, they calculated the 2020 cost with the maximum compared to the 2019 costs without the maximum.

4. Continued

Percent Insureds	Expected Claim Cost	No Maximum		$1,500 Maximum	
		Before Trend	After Trend	Before Trend	After Trend
30.0%	$0.00	$0.00	$0.00	$0.00	$0.00
25.0%	$20.00	$20.00	$21.00	$20.00	$21.00
20.0%	$70.00	$70.00	$73.50	$70.00	$73.50
15.0%	$250.00	$250.00	$262.50	$250.00	$262.50
9.0%	$800.00	$800.00	$840.00	$800.00	$840.00
1.0%	$2000.00	$2000.00	$2100.00	$1500.00	$1500.00
Average claims		$148.50	$155.93	$143.50	$149.93
Cost Increase			5.0%		4.5%

Dampening effect = 5.0% - 4.5% = 0.5%

5. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   - Group and Individual medical, dental and pharmacy plans.
   - Group and Individual long-term disability plans.
   - Group and Individual short-term disability plans.
   - Supplementary plans, like Medicare Supplement.
   - Group and Individual long-term care insurance.

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

Learning Outcomes:

(1c) Evaluate the potential moral hazard and financial and legal risks associated with each coverage.

(2d) Calculate and recommend a manual rate.

Sources:

Group Insurance, Chapters 6, 21

Commentary on Question:

Candidates struggled with parts (a) and (b) but performed well on part (c). Parts (a) and (b) required the candidate to perform a series of calculations in order to arrive at the answer. Partial credit was given if candidates performed some of the calculations correctly, even if the final answer was incorrect.

Solution:

(a) Calculate the value of the following deductibles in 2020:

(i) $50

(ii) $100

Show your work.

Commentary on Question:

Candidates struggled more with the $100 deductible than the $50 deductible. Many candidates attempted to calculate the value of the $100 deductible directly by making assumptions about the claims within the $50-$150 corridor. Instead, candidates should have calculated the value of a $150 deductible and then interpolated between the $50 and $150 deductible values.

5. Continued

Range of Claims	Percent Insureds	2019 Expected Claim Cost	2020 Expected Claim Cost	Annual Cost	Accumulated Frequency	Accumulated Annual Cost
	(a)		(b)	(c) = (a)*(b)	(d)	(e)
$0	15.0%	$0.00	$0.00	$0.00	100.0%	$162.00
$0.01 - $50	25.0%	$19.05	$20.00	$5.00	85.0%	$162.00
$50.01 - $150	30.0%	$66.67	$70.00	$21.00	60.0%	$157.00
$150.01 - $500	20.0%	$238.10	$250.01	$50.00	30.0%	$136.00
$500.01 - $1500	9.5%	$761.90	$800.00	$76.00	10.0%	$86.00
>$1,500.01	0.5%	$1,904.76	$2,000.00	$10.00	0.5%	$10.00

Value of claims with no deductible: $162
Value of claim cost in excess of $50 = $157 – ($50 x 60%) = $127
Value of claim cost in excess of $150 = $136 – ($150 x 30%) = $91

Value of $50 deductible = $162 - $127 = **$35**

Value of $150 deductible = $162 - $91 = $71
Value of $100 deductible = $35 + ½ x ($71 - $35) = **$53**

(b) Calculate the 2020 net benefit cost. Show your work.

Commentary on Question:
Most candidates performed poorly on this part of the question. Many candidates did not back out the 2019 provider discount (35%) from the 2019 average costs before applying the 2020 provider discount (40%). Some candidates also struggled to correctly apply the utilization rates in calculating the net benefit cost, perhaps not realizing that utilization was provided at an annual rate per 1,000 members.

5. Continued

	(1) Annual Services per 1k Members	(2) Avg Cost per Service	(3) New Cost Per Service= (2) * (1 - 40%) / (1 - 35%)	(4) New Gross PMPM Benefit Cost= (1) / 1k * (3) / 12	(5) Preferred Provider Coins	(6) Value of Cost sharing= (4) * (5)	(6) Net Benefit Cost PMPM= (4) - (6)
Class I	4,500	$75	$69.23	$25.96	0%	$0.00	$25.96
Class II	1,500	$238	$219.69	$27.46	20%	$5.49	$21.97
Class III	500	$2,500	$2,307.69	$96.15	50%	$48.08	$48.08
Subtotal				$149.58		$53.57	**$96.01**

(c) Recommend cost mitigation strategies to limit antiselection risk for dental insurance. Justify your response.

Commentary on Question:
Most candidates performed well on this part of the question. For full credit, candidates needed to provide at least 3 strategies with definitions or explanations about how the strategies mitigate antiselection. Credit was given for strategies found in the source material beyond those listed here.

I recommend the following mitigation strategies:
- Extend waiting period. Typically 3 months, might extend it to 6-9 months to further reduce antiselection.
- Increase cost sharing for certain procedures. Introduce deductible to class II and class III to avoid patients choosing to have higher level services performed unless necessary.
- Introduce some lower cost benefits, such as oral cancer screening to have early detection and lower the overall treatment cost
- Introduce benefit max, so the increased liability will deter the patients from seeking services rendered when not medically necessary.

6. Learning Objectives:

1. The candidate will understand how to describe plan provisions typically offered under:
   - Group and Individual medical, dental and pharmacy plans.
   - Group and Individual long-term disability plans.
   - Group and Individual short-term disability plans.
   - Supplementary plans, like Medicare Supplement.
   - Group and Individual long-term care insurance.

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

Learning Outcomes:

(1c) Evaluate the potential moral hazard and financial and legal risks associated with each coverage.

(3a) Describe structure of employee benefit plans and products offered and the rationale for offering these structures.

(3c) Recommend an employee benefit strategy in light of an employer's objectives.

Sources:

GHDP-130-19: Recommend an Employee Benefits Strategy

GHDP-132-19: Ch. 7 and 16 of Canadian Handbook of Flexible Benefits

GHDP-106-16: Health Plan Payroll Contribution Strategies and Development for Employers

Group Insurance, Chapter 5

Commentary on Question:

This question tested the candidate's strategic knowledge of employer benefit offerings.

Solution:

(a) Describe strategies for designing a total benefits package offered to each of:

(i) Highly skilled employees in a tight labor market

(ii) Less skilled employees with a high turnover rate

Commentary on Question:

Candidates provided general considerations for these groups of employees. Not many candidates drew directly from the text, but most provided reasonable responses based on knowledge of the material. Most candidates received at least partial credit.

6. Continued

(i) If competing for highly skilled employees in a tight labor market, they may wish to offer benefits comparable to what their competitors are offering, and offer some additional perks such as 401(k) match, to attract and retain high performing employees.

(ii) On the other hand, if your client is in a business requiring a less skilled workforce with a relatively high turn-over rate, they may wish to offer benefits that have low out-of-paycheck costs and minimize investment in wellness programs, which don't have an immediate return on investment.

(b) Describe adverse selection considerations for the current benefits package.

Commentary on Question:
Although there was limited information to provide a full critique of the benefit structure, candidates needed to note the point value and provide a more in-depth response than the other parts of the question. Candidates were also expected to draw on information from multiple source materials.

- Medical – XYZ offers this to their employees with no contribution to premiums. This may create antiselection, as only those who need medical coverage will sign up. However, with only 1 plan offering, there may be less spread in the health needs and antiselection because there is no choice.
- Dental – Dental has a considerable problem with antiselection. Claims costs are generally higher with small groups, but this is even more true when the coverage is voluntary and there is no minimum participation requirement.
- Vision – Antiselection will likely occur with this offering as well, as only employees who wish to use the benefit are likely to sign up

(c) Calculate the minimum annual employer payroll contribution for a single employee such that XYZ's coverage will be considered affordable under the Affordable Care Act. State your assumptions. Show your work.

Commentary on Question:
Most candidates did well on this section. Any affordable percentage published for the past 7 years was deemed a reasonable assumption, though the example will use the 9.56% from the text. Credit was given for clearly showing work.

Affordable percentage: 9.56%

Salary * Affordable Percentage = Affordable Employee Premium
$70,000 * 9.56% = $6,692

6. Continued

Employer Minimum Contribution =
Current Employee Premium - Affordable Employee Premium
$8,700 - $6,692 = $2,008 minimum contribution

(d) Describe the purpose of cost sharing in group medical insurance.

Commentary on Question:
Many candidates recalled the list of purposes, but full credit required providing a description of each item. Responses that did not utilize this list were given credit if the information was detailed and correct.

- Control of utilization – members who share in cost are more aware of the cost of services, causing them to avoid unnecessary care
- Control of cost – requiring cost sharing reduces the necessary premiums charged by insurers, which improves affordability of the plan for employees, and reduces the plan liability for employers
- Control of risk to insurer – requiring cost sharing creates a benefit plan that more closely resembles an insurable risk (an insurable event requires a degree of uncertainty of costs and limited control by the insured)

(e) Compare defined benefit and defined contribution employee benefit strategies.

Commentary on Question:
Candidates often defined each term without comparing them. Comparisons were needed to receive full credit.

Defined benefit strategies pay a percent of total premium for each employee. Defined contribution strategies pay a fixed amount of the total premium for each employee.

- Both are used to determine contribution strategies for an employee benefit plan.
- Both help reduce the employee's cost in the employee benefit plan. However, defined contribution may help predict future employer costs by providing an exact amount of subsidy.
- Both will be required to increase over time to prevent offloading too much cost onto employees (burden of inflation). For DB plans, this will be automatic, and the employer subsidy will increase proportionally. For DC plans, this will need to be manually updated.

6. Continued

(f) Recommend a payroll contribution strategy for XYZ. Justify your response.

Commentary on Question:
Many candidates did not attempt this part of the question. Candidates needed to make a relevant recommendation and provide a clear justification of the recommendation to receive full credit. The recommendation did not need to use the terms from (d), but needed to be specific to payroll.

I recommend XYZ offer a defined contribution. Since they are a small plan (only 55 employees) their costs can be very volatile, so a defined contribution will help keep cost increases in line. XYZ will need to increase the defined contribution over time, but they can do that at their own discretion.