SOCIETY OF ACTUARIES®

Group & Health Risk Mitigation Exam

Exam GHRM

Date: Friday, May 3, 2024

INSTRUCTIONS TO CANDIDATES

General Instructions

1. This examination has 8 questions numbered 1 through 8 with a total of 60 points.

   The points for each question are indicated at the beginning of the question.

2. While every attempt is made to avoid defective questions, sometimes they do occur. If you believe a question is defective, the supervisor or proctor cannot give you any guidance beyond the instructions provided in this document.
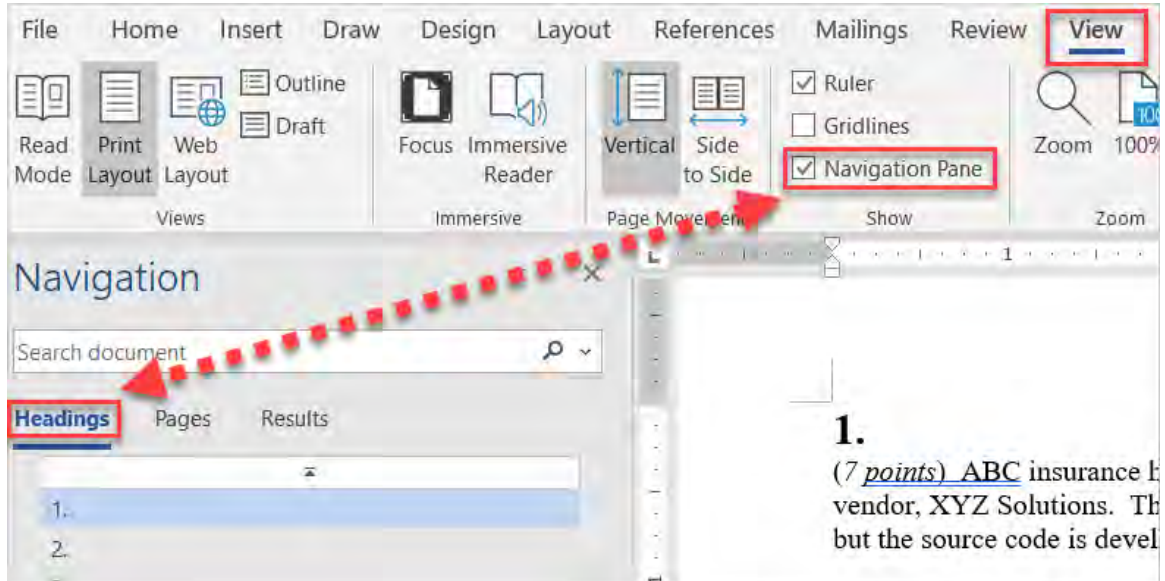
Written-Answer Instructions

1. Each question part or subpart should be answered either in the Word document or the Excel file as directed. Graders will only look at work in the indicated file.

   a) In the Word document, answers should be entered in the box marked ANSWER. The box will expand as lines of text are added. There is no need to use special characters or subscripts (though they may be used). For example, β_1 can be typed as beta_1 (and ^ used to indicate a superscript).

   b) In the Excel document formulas should be entered. Performing calculations on scratch paper or with a calculator and then entering the answer in the cell will not earn full credit. Formatting of cells or rounding is not required for credit.

   c) Individual exams may provide additional directions that apply throughout the exam or to individual items.

2. The answer should be confined to the question as set.

3. Prior to uploading your Word and Excel files, each file should be saved and renamed with your five-digit candidate number in the filename.

4. The Word and Excel files that contain your answers must be uploaded before the five-minute upload period expires.

Navigation Instructions

Open the Navigation Pane to jump to questions.

Press Ctrl+F, or click View > Navigation Pane:

1.

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

(a)   (*1 point*) List the five criteria.

ANSWER:

(b)   (*3 points*) Describe the evaluation of each criterion for the illustrative models presented in the CMS discussion paper on the HHS-Operated Risk Adjustment Methodology Meeting.

ANSWER:

2.
(*7 points*)

(a)   (*2 points*)

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

> ANSWER:

    (ii)   Describe ways to mitigate these difficulties.

> ANSWER:

(b)   (*1 point*) Contrast average savings and marginal savings.

> ANSWER:

You are given the following information on a DM program.

	Baseline Period	Change from Baseline	Measurement Period
Average Total Population	150,000	3.1%	
Chronic Prevalence	33.33%	0.0%	
Chronic Population Inpatient Admissions	30,000	-4.0%	
Cost/Admission	$7,500	5.6%	
Utilization (admission) trend (as measured in a reference population)		5.4%	
Direct Costs			$30,000,000
Indirect Costs			$10,000,000
Management Costs			$2,000,000
Overhead and other Allocated Costs			$8,000,000

2. **Continued**

    (c)   (*3 points*) Calculate the net return on investment (ROI) for the program. Show your work.

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

    (d)   (*1 point*) Explain how ROI can be a misleading metric.

> ANSWER:

3.

(*9 points*)

(a) (*2 points*) 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?			

(b) (*2 points*) Describe examples of consumer behavior for individuals enrolled in HDHPs.

ANSWER:

(c) (*2 points*) Describe factors that could make HDHPs more effective.

ANSWER:

3. **Continued**

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

(d)   (*1 point*) Calculate the difference in total cost sharing between the two plans. Show your work.

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

You discover that you now have access to a manufacturer drug coupon for Drug X and only have to pay $10 out of pocket per script. The value of the discount accrues towards the health plan cost sharing amount.

(e)   (*2 points*)

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

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

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

ANSWER:

4.

(*6 points*)

(a)   (*1 point*) Describe the following reimbursement arrangements from a provider risk perspective.

   (i)   Shared Savings

ANSWER:

   (ii)   Global Capitation

ANSWER:

(b)   (*2 points*) 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		

4. **Continued**

You are a consulting actuary assisting Alpha Health Network (Alpha), an integrated medical care delivery system. Alpha has a Shared Savings contract with Beta Insurance Company (Beta) for Beta's Medicare Advantage (MA) plans.

Alpha receives the following experience for calendar year 2023 for its MA members who have coverage through Beta.

- Average Monthly Members: 5,000
- Paid Claims: $961 PMPM
- Revenue: $1,172 PMPM
- 2023 contract terms include a 50% shared savings if the loss ratio is below 87%

(c)   (*1 point*) Calculate the Shared Savings to Alpha for calendar year 2023. Show your work.

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

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."

(d)   (*2 points*)

(i)   Outline the risks of accepting this proposal.

> ANSWER:

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

> ANSWER:

5.

(*11 points*)

(a)   (*4 points*)

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

- Individual Mandate
- Subsidies
- Risk Corridors
- Reinsurance

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

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ANSWER:
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(b)   (*3 points*) Describe disclosure requirements of ASOP 41 for the use of assumptions and methods

    (i)   prescribed by law.

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ANSWER:
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    (ii)   relied on from another party.

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ANSWER:
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(c)   (*2 points*) Describe factors for selecting drug-diagnosis pairs (RXC-HCC pairs) for the development of a hybrid HHS-HCC Risk Adjustment Model.

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ANSWER:
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5. **Continued**

    (d)   (*2 points*) 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.

> ANSWER:

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

> ANSWER:

6.

(*10 points*) You are an actuary who has been asked to evaluate a care management program for your company.

(a)   (*2 points*) Describe types of care management programs.

> ANSWER:

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

- With matching
- Without matching

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

(c)   (*1 point*) Recommend an approach from part (b). Justify your response.

> ANSWER:

7.

(*8 points*)

(a)   (*2 points*) Describe the following categories of providers in a PPO.

(i)   Preferred Providers

ANSWER:

(ii)   Non-Preferred Providers

ANSWER:

(iii)   Out of Network Providers

ANSWER:

(b)   (*2 points*) Describe regulatory guidance to ensure that quality is not diminished when a restrictive network is put into place.

ANSWER:

Company A is designing a Tiered Network Health Plan (TNHP) for its HMO plan option.

In the Excel spreadsheet, data has been collected from 2023 and fit to the new provider distribution.

(c)   (*4 points*)

(i)   (*3 points*) Calculate the savings for each of the four service categories. Show your work.

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

(ii)   (*1 point*) Recommend whether the TNHP design should include tiering for each service category. Justify your response.

ANSWER:

8.

(*5 points*)

(a) (*1 point*) Describe factors that impact the level of complexity of administering an
employee benefits program.

> ANSWER:

(b) (*1 point*) Identify constraints a benefits manager must consider in the design of
employee benefit plans.

> ANSWER:

(c) (*2 points*)

    (i)   Define vendor summits.

> ANSWER:

    (ii)   Describe purposes of vendor summits.

> ANSWER:

(d) (*1 point*)

    (i)   Define a Summary Plan Description (SPD)

> ANSWER:

    (ii)   Describe components of an SPD.

> ANSWER:

END OF EXAMINATION