



AHIP

Exam Questions AHM-520

Health Plan Finance and Risk Management

NEW QUESTION 1

- (Topic 1)

For this question, select the answer choice containing the terms that correctly complete blanks A and B in the paragraph below. The FASB mandates that accounting information must exhibit certain qualitative characteristics. One of these characteristics is _____. A _____, which means that a company's financial statements use the same accounting policies and procedures from one accounting period to the next, unless there is a sound reason for changing a policy or procedure. Another characteristic is _____. B _____, which requires a company to disclose in its financial statements all significant financial information about the company.

- A. A = reliability B = comparability
- B. A = reliability B = materiality
- C. A = consistency B = comparability
- D. A = consistency B = materiality

Answer: D

NEW QUESTION 2

- (Topic 1)

Health plans seeking to provide comprehensive healthcare plans must contract with a variety of providers for ancillary services. One characteristic of ancillary services is that

- A. Physician behavior typically does not impact the utilization rates for these services
- B. Package pricing is the preferred reimbursement method for ancillary service providers
- C. These services include physical therapy, behavior therapy, and home healthcare, but not diagnostic services such as laboratory tests
- D. Few plan members seek these services without first being referred to the ancillary provider by a physician

Answer: D

NEW QUESTION 3

- (Topic 1)

With regard to the Medicaid program in the United States, it can correctly be stated that

- A. The federal government provides none of the funding for state Medicaid programs
- B. Federal Medicaid law is different from Medicare law in that the federal government explicitly sets forth the methodology for payment of Medicaid-contracting plans but not Medicare-contracting plans
- C. A state's payment to health plans for providing Medicaid services cannot be more than it would have cost the state to provide the services under Medicaid fee-for-service (FFS)
- D. States are prohibited from carving out specific services from the capitation rate that health plans receive for providing Medicaid services

Answer: C

NEW QUESTION 4

- (Topic 1)

The Violin Company offers its employees a triple option of health plans: an HMO, an HMO with a point of service (POS) option, and an indemnity plan. Premiums are lowest for the HMO option and highest for the indemnity plan. Violin employees who anticipate that they will be individual low utilizers of healthcare services are most likely to enroll in the

- A. HMO and are least likely to enroll in the HMO with the POS option
- B. HMO and are least likely to enroll in the indemnity plan
- C. Indemnity plan and are least likely to enroll in the HMO
- D. Indemnity plan and are least likely to enroll in the HMO with the POS option

Answer: B

NEW QUESTION 5

- (Topic 1)

The following statements are about the new methodology authorized under the Balanced Budget Act of 1997 (BBA) for payments by the Centers for Medicaid & Medicare Services (CMS) to Medicare-contracting health plans.

Select the answer choice containing the correct statement.

- A. Under this new methodology, Medicare-contracting health plans are paid the lower of (a) a floor payment amount per enrollee covered or (b) the health plan's payment rate increased by 2% from the previous year.
- B. The new methodology has decreased the rate of growth in payments from CMS to Medicare-contracting health plans.
- C. Under this new methodology, Medicare-contracting health plans are paid 90% of the adjusted average per capita cost (AAPCC) of providing a service to a beneficiary.
- D. Under the principal inpatient diagnostic cost group (PIP-DCG), a new risk adjustment methodology, Medicare-contracting health plans will no longer be required to calculate and submit to CMS a Medicare adjusted community rate (ACR).

Answer: B

NEW QUESTION 6

- (Topic 1)

The purest form of a self-funded benefit plan is one in which the employer pays benefits from current revenue, administers all aspects of the plan, and bears the risk that actual benefit payments will exceed the expected amount of payments. A decision to use this kind of self-funding is generally considered most desirable when certain conditions are present. These conditions most likely include that the benefit plan

- A. Is a contributory plan

- B. Is subject to collective bargaining
- C. Is unable to secure discounts from the physicians who provide medical services to the plan members
- D. Has a relatively high frequency of low severity claims

Answer: D

NEW QUESTION 7

- (Topic 1)

Three general strategies that health plans use for controlling types of risk are risk avoidance, risk transfer, and risk acceptance. The following statements are about these strategies. Three of these statements are true, and one statement is false. Select the answer choice containing the FALSE statement.

- A. Generally, the smaller the likely benefits of accepting a risk, and the lower the costs of avoiding that risk, the greater the likelihood that a health plan will elect to avoid the risk.
- B. A health plan is seldom able to transfer any of the risk that utilization rates will be higher than expected and that its cost of providing healthcare will exceed the revenues it receives.
- C. If a risk is a pure risk from the point of view of a health plan, then the health plan most likely will attempt to avoid the risk.
- D. A health plan would most likely transfer some or all of its utilization risk if it pays a provider a rate that is based on the number of plan enrollees that choose the provider as their primary care provider (PCP).

Answer: B

NEW QUESTION 8

- (Topic 1)

Mandated benefit laws are state or federal laws that require health plans to arrange for the financing and delivery of particular benefits. Within a market, the implementation of mandated benefit laws is likely to cause _____.

- A. A reduction in the number of self-funded healthcare plans
- B. An increase in the cost to the health plans
- C. A reduction in the size of the provider panels of health plans
- D. A reduction in the uniformity among the healthcare plans of competing health plans

Answer: B

NEW QUESTION 9

- (Topic 1)

With regard to a health plan's underwriting of groups, it can correctly be stated that, generally, a

- A. Health plan will require that contributory healthcare plans have a participation level of between 50% and 70%
- B. Health plan will decline to cover a group that has been formed for the sole purpose of obtaining healthcare coverage
- C. Health plan's underwriters will not examine the age spread of the entire group being underwritten
- D. Health plan would expect a group with a large proportion of young females to have lower healthcare costs than does a similar group with a large proportion of young males

Answer: B

NEW QUESTION 10

- (Topic 1)

One true statement about a health plan's underwriting margin is that

- A. the only way that the health plan can effectively reduce its exposure to underwriting risk, and therefore adjust its underwriting margin, is to control anti selection
- B. a larger assumed underwriting margin will reduce the price of the health plan's product and will make the plan more competitive
- C. the health plan's purchase of stop-loss insurance has no effect on its underwriting margin because stop-loss insurance can help the health plan control its expenses but not its underwriting risk
- D. both the level of underwriting risk that the health plan assumes in providing benefits and the market competition it encounters most likely directly affect the size of its assumed underwriting margin

Answer: D

NEW QUESTION 10

- (Topic 1)

The following statements illustrate common forms of capitation:

* 1. The Antler Health Plan pays the Epsilon Group, an integrated delivery system (IDS), a capitated amount to provide substantially all of the inpatient and outpatient services that Antler offers. Under this arrangement, Epsilon accepts much of the risk that utilization rates will be higher than expected. Antler retains responsibility for the plan's marketing, enrollment, premium billing, actuarial, underwriting, and member services functions.

* 2. The Bengal Health Plan pays an independent physician association (IPA) a capitated amount to provide both primary and specialty care to Bengal's plan members. The payments cover all physician services and associated diagnostic tests and laboratory work.

The physicians in the IPA determine as a group how the individual physicians will be paid for their services.

From the following answer choices, select the response that best indicates the form of capitation used by Antler and Bengal.

- A. Antler = subcapitation Bengal = full-risk capitation
- B. Antler = subcapitation Bengal = full professional capitation
- C. Antler = global capitation Bengal = subcapitation
- D. Antler = global capitation Bengal = full professional capitation

Answer: D

NEW QUESTION 12

- (Topic 1)

Two sets of financial accounting standards are generally accepted accounting principles (GAAP) and statutory accounting practices (SAP). One true statement about these financial accounting standards is that

- A. State laws and regulations in the United States govern the implementation of GAAP, but not the implementation of SAP
- B. Health plans must prepare their financial statements for their external users according to applicable laws, regulations, and accounting principles, particularly GAAP
- C. GAAP specifically focuses on the requirements of insurance regulators and policyholder interests
- D. The Financial Accounting Standards Board (FASB) is a private organization whose purpose is to establish and promote SAP in the United States

Answer: B

NEW QUESTION 15

- (Topic 1)

The ability of a health plan to effectively perform the rating and underwriting functions has become critical to the plan's success. In developing its pricing strategy, a health plan has to address the marketplace's ongoing trends and factors, which include

- A. a decreased focus on small to mid-size employer groups
- B. an improvement in the financial performance of health plans
- C. a consolidation of the key players in the health plan industry
- D. a decreased complexity of the products being offered.

Answer: C

NEW QUESTION 20

- (Topic 1)

For each of its products, the Wisteria Health Plan monitors the provider reimbursement trend and the residual trend. One true statement about these trends is that

- A. The provider reimbursement trend probably is more difficult for Wisteria to quantify than is the residual trend
- B. Wisteria's residual trend is the difference between the total trend and the portion of the total trend caused by changes in Wisteria's provider reimbursement levels
- C. The residual trend most likely has more impact on Wisteria's total trend than does the provider reimbursement trend
- D. An example of a residual trend would be a 5% increase in the capitation rate paid to a PCP by Wisteria

Answer: B

NEW QUESTION 23

- (Topic 1)

The Newfeld Hospital has contracted with the Azalea Health Plan to provide inpatient services to Azalea's enrolled members. The contract calls for Azalea to provide specific stop-loss coverage to Newfeld once Newfeld's treatment costs reach \$20,000 per case and for Newfeld to pay 20% of the next \$50,000 of expenses for this case. After Newfeld's treatment costs on a case reach \$70,000, Azalea reimburses the hospital for all subsequent treatment costs. One true statement about this specific stop-loss coverage is that

- A. The carrier is Newfeld
- B. The attachment point is \$20,000
- C. The shared-risk corridor is between \$0 and \$70,000
- D. This coverage can also be activated when the total covered medical expenses generated by the hospitalizations of Azalea plan members reach a specified level

Answer: B

NEW QUESTION 28

- (Topic 1)

The following statements are about a health plan's pricing of a preferred provider organization (PPO) plan. Three of the statements are true, and one statement is false. Select the answer choice containing the FALSE statement.

- A. Typically, the first step in pricing a PPO is to develop a base indemnity claims cost, which results from adjusting the indemnity plan as though the entire eligible group of employees is enrolled in the indemnity plan.
- B. To develop the expected claims costs for the in-network PPO plan, the health plan's actuaries adjust the base indemnity claims costs to reflect pertinent characteristics of the plan, including the specific network plan design and provider discount arrangements.
- C. One difficulty in pricing a PPO is that the health plan's actuaries have no method of estimating which employees would be likely to select which provider groups.
- D. After the health plan's actuaries use risk adjustment factors to adjust the existing claims costs for selection issues, the actuaries weight the in network and out-of-network costs to arrive at a composite claims cost for the PPO plan.

Answer: C

NEW QUESTION 29

- (Topic 1)

The Eagle health plan wants to limit the possibility that it will be held vicariously liable for the negligent acts of providers. Dr. Michael Chan is a member of an independent practice association (IPA) that has contracted with Eagle. One step that Eagle could take in order to limit its exposure under the theory of vicarious liability is to

- A. Supply D
- B. Chan with office space
- C. Employ nurses, laboratory technicians, and therapists to support Dr.Chan
- D. Be responsible for keeping D
- E. Chan's medical records updated
- F. Ensure that documents provided to D
- G. Chan's patients describe him as an independent practitioner

Answer: D

NEW QUESTION 30

- (Topic 1)

The Sanford Group, a provider group, entered into a risk contract with a health plan. Sanford has purchased aggregate stop-loss coverage with an attachment point of 115% of the group's predicted healthcare costs of \$2,000,000 for the year. Sanford has a copayment of 10% for any costs above the attachment point. If Sanford's actual costs for the year are \$2,800,000, then, according to the terms of the aggregate stop-loss agreement, the amount that Sanford is responsible for is

- A. \$2,080,000
- B. \$2,300,000
- C. \$2,350,000
- D. \$2,380,000

Answer: C

NEW QUESTION 32

- (Topic 1)

One true statement about cash-basis accounting is that

- A. Cash receipt, but not cash disbursement, is an important component of cash-basis accounting
- B. Most companies use a pure cash-basis accounting system
- C. Cash-basis accounting records revenue according to the realization principle and expenses according to the matching principle
- D. Health insurance companies and health plans that fall under the jurisdiction of state insurance commissioners must report some items on a cash basis for statutory reporting purposes

Answer: D

NEW QUESTION 36

- (Topic 1)

The following statements are about pure risk and speculative risk—two kinds of risk that both businesses and individuals experience. Select the answer choice containing the correct statement.

- A. Healthcare coverage is designed to help plan members avoid pure risk, not speculative risk.
- B. Only pure risk involves the possibility of gain.
- C. An example of speculative risk is the possibility that an individual will contract a serious illness.
- D. Only speculative risk contains an element of uncertainty.

Answer: A

NEW QUESTION 41

- (Topic 1)

The sentence below contains two pairs of words enclosed in parentheses. Determine which word in each pair correctly completes the statement. Then select the answer choice containing the two words that you have chosen. Purchasing stop-loss coverage most likely (increases / reduces) a health plan's underwriting risk and (increases / reduces) the health plan's affiliate risk.

- A. increases / increases
- B. increases / reduces
- C. reduces / increases
- D. reduces / reduces

Answer: C

NEW QUESTION 46

- (Topic 1)

The Caribou health plan is a for-profit organization. The financial statements that Caribou prepares include balance sheets, income statements, and cash flow statements. To prepare its cash flow statement, Caribou begins with the net income figure as reported on its income statement and then reconciles this amount to operating cash flows through a series of adjustments. Changes in Caribou's cash flow occur as a result of the health plan's operating activities, investing activities, and financing activities.

Caribou is engaged in an operating activity when it

- A. Purchases or sells assets of the health plan
- B. Disposes of a subsidiary
- C. Repays funds loaned by its creditors
- D. Pays expenses associated with the healthcare services provided to its members

Answer: D

NEW QUESTION 50

- (Topic 1)

The Poplar Company and a Blue Cross/Blue Shield organization have contracted to provide a typical fully funded health plan for Poplar's employees. One true statement about this health plan for Poplar's employees is that

- A. Poplar bears the entire financial risk if, during a given period, the dollar amount of services rendered to Poplar plan members exceeds the dollar amount of premiums collected for this health plan
- B. Poplar and the Blue Cross/Blue Shield organization share the financial risk of paying for claims under Poplar's health plan
- C. The Blue Cross/Blue Shield organization, upon acceptance of a premium, becomes the group plan sponsor for Poplar's health plan
- D. The Blue Cross/Blue Shield organization, upon acceptance of a premium, bears the entire financial risk of paying for the administrative expenses associated

with health plan operations

Answer: D

NEW QUESTION 53

- (Topic 1)

State A, which requires guaranteed issue of at least two mandated healthcare plans, has established a typical health coverage reinsurance program for small employer groups. One true statement about this reinsurance program is that it most likely

- A. is administered by a commercial reinsurance company that operates in State A
- B. allows a small employer carrier operating in State A to reinsure either an entire small group or specific individuals within the group
- C. has, for the coverage on a plan, a base premium, which is multiplied by a factor of 2 in the case of reinsurance on entire groups or a factor of 3 for reinsurance on individuals
- D. prohibits a small employer carrier operating in State A from placing individuals enrolled in small groups in a reinsurance pool

Answer: B

NEW QUESTION 55

- (Topic 1)

The McGwire Health Plan is a for-profit health plan that issues stock. Events that will cause the owners' equity account of McGwire to change include

- A. McGwire's retention of net income
- B. McGwire's payment of cash dividends on the stock it issued
- C. McGwire's purchase of treasury stock
- D. All of the above

Answer: D

NEW QUESTION 57

- (Topic 1)

The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement. Health plans face four contingency risks (C-risks): asset risk (C-1), pricing risk (C-2), interest-rate risk (C-3), and general management risk (C-4). Of these risks, _____ is typically the most important risk that health plans face. This is true because a sizable portion of the total expenses and liabilities faced by a health plan come from contractual obligations to pay for future medical costs, and the exact amount of these costs is not known when the healthcare coverage is priced.

- A. Asset risk (C-1)
- B. Pricing risk (C-2)
- C. Interest-rate risk (C-3)
- D. General management risk (C-4)

Answer: B

NEW QUESTION 58

- (Topic 1)

A stop-loss contract may provide that claims are settled using a paid claims method or an incurred claims method. The Concord Company provides health coverage to its employees through a self-funded health plan. On March 17, a Concord employee who is enrolled in this plan underwent surgery, and the surgery was sufficiently expensive to trigger Concord's specific stop-loss coverage. On April 10, Concord paid the medical expenses associated with the surgery. The term of the stop-loss contract ended on April 1. This information indicates that the stop-loss carrier is responsible for paying a portion of the cost of the surgery under

- A. both the paid claims method and the incurred claims method
- B. the paid claims method but not the incurred claims method
- C. the incurred claims method but not the paid claims method
- D. neither the paid claims method nor the incurred claims method

Answer: C

NEW QUESTION 63

- (Topic 1)

As part of the first step in its strategic planning process, the Trout health plan developed the following statements:

? Statement A—Trout will deliver quality healthcare to our customers at a reasonable cost.

? Statement B—Within five years, Trout will be recognized as the industry leader in all of our markets.

Statement A can best be described as a

- A. Vision statement, and Statement B also can best be described as a vision statement
- B. Vision statement, whereas Statement B can best be described as a mission statement
- C. Mission statement, whereas Statement B can best be described as a vision statement
- D. Mission statement, and Statement B also can best be described as a mission statement

Answer: C

NEW QUESTION 66

- (Topic 1)

The physicians who work for the Sunrise Health Plan, a staff model HMO, are paid a salary that is not augmented with another type of incentive plan. Compared to the use of a traditional reimbursement method, Sunrise's use of a salary reimbursement method is more likely to

- A. Encourage Sunrise's physicians to perform services that are not medically necessary

- B. Completely eliminate service risk for Sunrise's physicians
- C. Decrease Sunrise's liability for any negligent acts of the physicians in the plan's network of providers
- D. Help stabilize expenses for Sunrise

Answer: D

NEW QUESTION 69

- (Topic 1)

The provider contract that Dr. Zachery Cogan, an internist, has with the Neptune Health Plan calls for Neptune to reimburse him under a typical PCP capitation arrangement. Dr. Cogan serves as the PCP for Evelyn Pfeiffer, a Neptune plan member. After hospitalizing Ms. Pfeiffer and ordering several expensive diagnostic tests to determine her condition, Dr. Cogan referred her to a specialist for further treatment. In this situation, the compensation that Dr. Cogan receives under the PCP capitation arrangement most likely includes Neptune's payment for

- A. All of the diagnostic tests that he ordered on M
- B. Pfeiffer
- C. His visits to M
- D. Pfeiffer while she was hospitalized
- E. The cost of the services that the specialist performed for M
- F. Pfeiffer
- G. All of the above

Answer: B

NEW QUESTION 72

- (Topic 1)

The Eclipse Health Plan is a not-for-profit health plan that qualifies under the Internal Revenue Code for tax-exempt status. This information indicates that Eclipse

- A. Has only one potential source of funding: borrowing money
- B. Does not pay federal, state, or local taxes on its earnings
- C. Must distribute its earnings to its owners-investors for their personal gain
- D. Is a privately held corporation

Answer: B

NEW QUESTION 77

- (Topic 1)

If Grace Wilson is eligible for benefits under both the Medicare and Medicaid programs, then

- A. Medicare is M
- B. Wilson's primary insurer
- C. A Medicare- or Medicaid-contracting health plan is allowed to lock-in M
- D. Wilson's enrollment for a maximum period of 24 months
- E. The BBA requires the state to guarantee M
- F. Wilson's eligibility for a minimum of 18 months once she enrolls in a health plan network
- G. M
- H. Wilson can only receive Medicare- or Medicaid-covered services from a provider who participates in a health plan network

Answer: A

NEW QUESTION 82

- (Topic 1)

The Atoll Health Plan must comply with a number of laws that directly affect the plan's contracts. One of these laws allows Atoll's plan members to receive medical services from certain specialists without first being referred to those specialists by a primary care provider (PCP). This law, which reduces the PCP's ability to manage utilization of these specialists, is known as _____.

- A. A due process law
- B. An any willing provider law
- C. A direct access law
- D. A fair procedure law

Answer: C

NEW QUESTION 87

- (Topic 1)

Health plans sometimes use global fees to reimburse providers. Health plans would use this method of provider reimbursement for all of the following reasons EXCEPT that global fees

- A. Eliminate any motivation the provider may have to engage in churning
- B. Transfer some of the risk of overutilization of care from the health plan to the providers
- C. Eliminate the practice of upcoding within specific treatments
- D. Reward providers who deliver cost-effective care

Answer: A

NEW QUESTION 91

- (Topic 1)

The Acorn Health Plan uses a resource-based relative value scale (RBRVS) to help determine the reimbursement amounts that Acorn should make to providers

who are compensated under an FFS system. With regard to the advantages and disadvantages to Acorn of using RBRVS, it can correctly be stated that

- A. An advantage of using RBRVS is that it can assist Acorn in developing reimbursement schedules for various types of providers in a comprehensive healthcare plan
- B. An advantage of using RBRVS is that it puts providers who render more medical services than necessary at financial risk for this overutilization
- C. A disadvantage of using RBRVS is that it will be difficult for Acorn to track treatment rates for the health plan's quality and cost management functions
- D. A disadvantage of using RBRVS is that it rewards procedural healthcare services more than cognitive healthcare services

Answer: A

NEW QUESTION 93

- (Topic 1)

The Caribou health plan is a for-profit organization. The financial statements that Caribou prepares include balance sheets, income statements, and cash flow statements. To prepare its cash flow statement, Caribou begins with the net income figure as reported on its income statement and then reconciles this amount to operating cash flows through a series of adjustments. Changes in Caribou's cash flow occur as a result of the health plan's operating activities, investing activities, and financing activities.

The basic formula for Caribou's income statement is

- A. Cash Inflows – Cash Outflows = Net Cash Inflow (Outflow)
- B. Revenues – Expenses = Net Income (Net Loss)
- C. Sources of Funds – Uses of Funds = Net Change in Cash
- D. Assets = Liabilities + Owners' Equity

Answer: B

NEW QUESTION 97

- (Topic 1)

The Kayak Company self funds the health plan for its employees. This plan is an example of a type of self-funded plan known as a general asset plan. Because Kayak's plan is a general asset plan, the funds that Kayak sets aside for the health plan are

- A. subject to the claims of Kayak's creditors
- B. available to Kayak solely for the purpose of paying for the healthcare expenses of Kayak's covered employees
- C. placed in a trust fund established by Kayak to pay for the health plan
- D. considered separate from Kayak's current operating funds

Answer: A

NEW QUESTION 100

- (Topic 1)

The reimbursement arrangement that Dr. Caroline Monroe has with the Exmoor Health Plan includes a typical withhold arrangement. One true statement about this withhold arrangement is that, for a given financial period,

- A. D
- B. Monroe and Exmoor are equally responsible for making up the difference if cost overruns exceed the amount of money withheld
- C. Exmoor most likely distributes to D
- D. Monroe the entire amount withheld from her if her costs are below the amount budgeted for the period
- E. Exmoor pays D
- F. Monroe at the end of the period an amount over and above her usual reimbursement, and this amount is based on the performance of the plan as a whole
- G. Exmoor most likely withholds between 3% and 5% of D
- H. Monroe's total reimbursement

Answer: B

NEW QUESTION 104

- (Topic 1)

The NAIC has developed a risk-based capital (RBC) formula for all health plans that accept risk. One true statement about the RBC formula for health plans is that it

- A. is a set of calculations, based on information in a health plan's annual financial report, that yields a target capital requirement for the organization
- B. fails to take into account a health plan's underwriting risk, which is the risk that the premiums the health plan receives will be insufficient to pay for the healthcare services it provides to its plan members
- C. applies to all health plans in the United States
- D. fails to assess the specific level of risk faced by each health plan

Answer: A

NEW QUESTION 109

- (Topic 2)

The Danube Health Plan's planning activities include tactical planning, which is primarily concerned with

- A. Establishing standards of performance for Danube's cost centers
- B. Forecasting Danube's premium income
- C. Planning for the short-term, day-to-day activities of Danube
- D. Identifying the markets in which Danube should concentrate its marketing efforts

Answer: C

NEW QUESTION 114

- (Topic 2)

The Jamal Health Plan operates in a state that mandates that a health plan either allow providers to become part of its network or reimburse those providers at the health plan's negotiated-contract rate, so long as the non-contract provider is willing to perform the services at the contract rate. This type of law is known as:

- A. A fair procedure law
- B. A direct access law
- C. An any willing provider law
- D. A due process law

Answer: C

NEW QUESTION 115

- (Topic 2)

One way that a health plan can protect itself against case stripping is by requiring:

- A. Employees covered by a small group plan to contribute 100% of the cost of the healthcare coverage
- B. The small group to have no more than 10 members
- C. A minimum level of participation in order for a small group to be eligible for healthcare coverage
- D. Its underwriters to consider the characteristics of the employer, but not of the group members, when underwriting the group

Answer: C

NEW QUESTION 117

- (Topic 2)

The types of financial risks and costs to which a health plan is subject depends on whether the health plan provides services to the Medicare and/or Medicaid populations or to the commercial population. One distinction between providing services to the Medicare and Medicaid populations and to the commercial population is that Medicare and Medicaid enrollees typically:

- A. Are locked into a plan for a 12-month period, whereas enrollees from the commercial population may disenroll from a plan on a monthly basis
- B. Require less enrollee education than do enrollees from the commercial population
- C. Have higher incidences of chronic illness than do enrollees from the commercial population
- D. Are enrolled in a health plan through a group situation, whereas the commercial population typically enrolls in a health plan on an individual basis

Answer: C

NEW QUESTION 121

- (Topic 2)

The following statements are about rate ratios used by health plans. Select the answer choice containing the correct statement:

- A. While rate ratios consider family size, they are most often based on competitive factors, such as the ratios being used by competitors and the ratios that plan sponsors are requesting.
- B. If the rate ratio for a couple rate category is 2.0, then the single premium is divided by 2.0 to derive the couple rate category premium.
- C. A rate ratio can only be increased if the health plan has obtained regulatory approval.
- D. The effect of a typical family rate ratio is that a family rate is somewhat higher than it otherwise should be, and the single rate is somewhat lower than it otherwise should be.

Answer: A

NEW QUESTION 124

- (Topic 2)

The Wallaby Health Plan purchased an asset two years ago for \$50,000. At the time of purchase, the asset had an appraised value of \$52,000. The asset carries a value on Wallaby's general ledger of \$47,000, and its current market value is \$80,000. According to the cost concept, Wallaby would report on its financial statements a value for this asset equal to:

- A. \$47,000
- B. \$50,000
- C. \$52,000
- D. \$80,000

Answer: B

NEW QUESTION 128

- (Topic 2)

The following statements are about a health plan's capital budgeting process. Select the answer choice containing the correct statement.

- A. Under sensitivity analysis, a health plan ranks all capital project proposals according to expected rates of return and accepts only those proposals with the highest rankings.
- B. A project that has a profitability index of 0.0 has an NPV of zero.
- C. An underlying assumption of capital budgeting is that a health plan should keep its investing decisions separate from its financing decisions.
- D. Under the internal rate of return (IRR) method, if a project's IRR is less than a health plan's weighted average cost of capital (WACC), then the project's benefits should exceed its costs and the health plan should accept the project.

Answer: C

NEW QUESTION 131

- (Topic 2)

The following paragraph contains two pair of terms enclosed in parentheses. Determine which term in each pair correctly completes the statements. Then select the answer choice containing the two terms you have chosen.

In a typical health plan, an (actuary / underwriter) is ultimately responsible for the determination of the appropriate rate to charge for a given level of healthcare benefits and administrative services in a particular market. The (actuary / underwriter) assesses and classifies the degree of risk represented by a proposed group or individual.

- A. actuary / actuary
- B. actuary / underwriter
- C. underwriter / actuary
- D. underwriter / underwriter

Answer: B

NEW QUESTION 134

- (Topic 2)

Correct statements about the financial risks associated with benefits that health plans provide to the Medicare and Medicaid markets include:

- A. That, because the government sets the payments received by health plans, the health plans cannot easily obtain an increase in those payments even in the face of rising costs
- B. That regulators determine which services must be provided under Medicare and Medicaid and which persons are eligible to enroll in a plan
- C. That there is typically more provider reluctance to accept risk in connection with providing services to the Medicaid population than with providing services to the Medicare population
- D. All of the above

Answer: D

NEW QUESTION 137

- (Topic 2)

Costs that can be defined by behavior are most commonly classified as fixed costs, variable costs, and semi-variable costs. From the following answer choices, select the response that correctly indicates a fixed cost and a variable cost for a health plan.

- A. Fixed Cost = depreciation on computer equipment Variable Cost = selling expenses
- B. Fixed Cost = premium processing expenses Variable Cost = rent on a regional office
- C. Fixed Cost = the cost for building maintenance Variable Cost = the cost for electricity
- D. Fixed Cost = the cost for electricity Variable Cost = fire insurance on the home office facility

Answer: A

NEW QUESTION 142

- (Topic 2)

Ways in which a company can increase its return on investment (ROI) include: 1.Reducing expenses to increase operating income 2.Increasing controllable investment

- A. Both 1 and 2
- B. 1 only
- C. 2 only
- D. Neither 1 nor 2

Answer: B

NEW QUESTION 147

- (Topic 2)

The Fairway health plan is a for-profit health plan that issues stock. The following data was taken from Fairway's financial statements:

Current assets.....\$5,000,000 Total assets.....6,000,000 Current liabilities.....2,500,000 Total liabilities.....3,600,000 Stockholders' equity.....2,400,000

Fairway's total revenues for the previous financial period were \$7,200,000, and its net income for that period was \$180,000.

Assume that the healthcare industry average for the debt-to-equity ratio is 0.90. The following statement(s) can correctly be made about Fairway's debt to equity ratio:

- A. Fairway's debt-to-equity ratio is 1.50
- B. Fairway relies less than most other healthcare organizations on borrowed funds to cover future and current benefit payments, to pay for ongoing business operations, and to finance growth
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: B

NEW QUESTION 151

- (Topic 2)

The Swann Health Plan excludes mental health coverage from its basic health benefit plan. Coverage for mental health is provided by a specialty health plan called a managed behavioral health organization (MBHO). This arrangement recognizes the fact that distinct administrative and clinical expertise is required to effectively manage mental health services. This information indicates that Swann manages mental health services through the use of a:

- A. Formulary
- B. Risk pod
- C. Carve-out
- D. Case rate

Answer: C

NEW QUESTION 155

- (Topic 2)

The following information was presented on one of the financial statements prepared by the Rouge Health Plan as of December 31, 1998:

This type of financial statement is called:

- A. A balance sheet
- B. An income statement
- C. A statement of owners' equity
- D. A cash flow statement

Answer: C

NEW QUESTION 160

- (Topic 2)

The core of a health plan's strategic financial plan is the development of its pro forma financial statements. The following statements are about these pro forma financial statements. Select the answer choice containing the correct statement.

- A. A health plan's pro forma financial statements forecast what the plan's financial condition will be at the end of an accounting period, without regard to whether the health plan achieves its objectives.
- B. Forecasting the balance sheet is more critical to the health plan than forecasting either the cash flow statement or the income statement, because the balance sheet drives the development of the other two statements.
- C. In order to avoid allowing the desired financial results to drive the assumptions used in developing the pro forma income statement, a health plan should avoid linking these assumptions to the health plan's overall strategic plan.
- D. A health plan can use its pro forma cash flow statement to calculate the net present value of the health plan's strategic plan.

Answer: D

NEW QUESTION 161

- (Topic 2)

Variance analysis is the study of the difference between expected results and actual results. Variances can be positive or negative. A positive variance is typically considered:

- A. favorable for both expenses and revenues
- B. favorable for expenses, but unfavorable for revenues
- C. favorable for revenues, but unfavorable for expenses
- D. unfavorable for both expenses and revenues

Answer: C

NEW QUESTION 166

- (Topic 2)

The following information relates to the Hardcastle Health Plan for the month of June:

? Incurred claims (paid and IBNR) equal \$100,000

? Earned premiums equal \$120,000

? Paid claims, excluding IBNR, equal \$80,000

? Total health plan expenses equal \$300,000

This information indicates that Hardcastle's medical loss ratio (MLR) for the month of June was approximately equal to:

- A. 40%
- B. 67%
- C. 83%
- D. 120%

Answer: C

NEW QUESTION 169

- (Topic 2)

The risk-based capital formula for health plans defines a number of risks that can impact a health plan's solvency. These categories reflect the fact that the level of risk faced by health plans is significantly impacted by provider reimbursement methods that shift utilization risk to providers. The following statements are about the effect of a health plan transferring utilization risk to providers. Select the answer choice containing the correct statement:

- A. The net effect of using provider reimbursement contracts to transfer risk is that the health plan's net worth requirement increases.
- B. Once the health plan has transferred utilization risk to its providers, it is relieved of the legal obligation to provide medical services to plan members in the event

of the provider's insolvency.

- C. The greater the amount of risk the health plan transfers to providers, the larger the credit-risk factor becomes in the health plan's RBC formula.
- D. By decreasing its utilization risk, the health plan increases its underwriting risk.

Answer: C

NEW QUESTION 171

- (Topic 2)

In order to determine a health plan's quick liquidity ratio, a financial analyst would divide the health plan's

- A. Total assets not invested in affiliates by its total liabilities
- B. Liquid assets by its total liabilities
- C. Liquid assets by its contractual reserves
- D. Total assets by its contractual reserves

Answer: C

NEW QUESTION 173

- (Topic 2)

The sentence below contains two pairs of terms enclosed in parentheses.

Determine which term in each pair correctly completes the statement. Then select the answer choice containing the two terms that you have selected. In analyzing its financial data, a health plan would use (horizontal/common size financial statement) analysis to measure the numerical amount that corresponding items change from one financial statement to another over consecutive accounting periods, and the health plan would use (trend/vertical) analysis to show the relationship of each financial statement item to another financial statement item.

- A. Horizontal / trend
- B. Horizontal / vertical
- C. Common-size financial statement / trend
- D. Common-size financial statement / vertical

Answer: B

NEW QUESTION 175

- (Topic 2)

Health plans have access to a variety of funding sources depending on whether they are operated as for-profit or not-for-profit organizations. The Verde Health Plan is a for-profit health plan and the Noir Health Plan is a not-for-profit health plan. From the answer choices below, select the response that correctly identifies whether funds from debt markets and equity markets are available to Verde and Noir:

- A. Funds from Debt Markets: available to Verde and Noir Funds from Equity Markets: available to Verde and Noir
- B. Funds from Debt Markets: available to Verde and Noir Funds from Equity Markets: available to Verde only
- C. Funds from Debt Markets: available to Verde only Funds from Equity Markets: available to Noir only
- D. Funds from Debt Markets: available to Noir only Funds from Equity Markets: available to Verde only

Answer: B

NEW QUESTION 180

- (Topic 2)

The following statement(s) can correctly be made about a health plan's cash receipts and cash disbursements budgets:

- A. To predict both the timing and the amount of its cash receipts, a health plan constructs the cash receipts budget using data from its sales forecast and investment forecasts.
- B. A health plan uses a cash disbursements budget in order to establish the amount, but not the timing, of all of its cash disbursements.
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: B

NEW QUESTION 183

- (Topic 2)

Mandated benefit laws are state or federal laws that require health plans to arrange for the financing and delivery of particular benefits. Ways that mandated benefits have the potential to influence health plans include:

- * 1. Causing a lower degree of uniformity among health plans of competing health plans in a given market
- * 2. Increasing the cost of the benefit plan to the extent that the plan must cover mandated benefits that would not have been included in the plan in the absence of the law or regulation that mandates the benefits

- A. Both 1 and 2
- B. 1 only
- C. 2 only
- D. Neither 1 nor 2

Answer: C

NEW QUESTION 185

- (Topic 2)

In order to achieve its goal of improved customer service, the Evergreen Health Plan will add three new customer service representatives to its existing staff, install

a new switching station, and install additional phone lines. In this situation, the cost that would be classified as a sunk cost, rather than a differential cost, is the expense associated with:

- A. Adding new customer service representatives
- B. Maintaining the existing staff
- C. Installing a new switching station
- D. Installing additional phone lines

Answer: B

NEW QUESTION 188

- (Topic 2)

If the total asset turnover ratio for the Fjord health plan is 1.08 and the total asset turnover ratio for the Grove health plan is 1.35, then a financial analyst could correctly infer that Fjord has used its assets more effectively than has Grove.

- A. True
- B. False

Answer: B

NEW QUESTION 190

- (Topic 2)

The following examples describe situations that expose an individual or a health plan to either pure risk or speculative risk:

Example 1 — A health plan invested in 1,000 shares of stock issued by a technology company.

Example 2 — An individual could contract a terminal illness.

Example 3 — A health plan purchased a new information system.

Example 4 — A health plan could be held liable for the negligent acts of an employee.

The examples that describe pure risk are

- A. Examples 1 and 2
- B. Examples 1 and 4
- C. Examples 2 and 3
- D. Examples 2 and 4

Answer: A

NEW QUESTION 193

- (Topic 2)

One typical characteristic of zero-based budgeting (ZBB) is that this budgeting approach

- A. Treats each activity as though it is a new project under consideration
- B. Applies only to income budgets
- C. Is the least time-consuming of all of the budgeting approaches
- D. Requires the input of top-level employees only

Answer: A

NEW QUESTION 194

- (Topic 2)

The Norton Health Plan used blended rating to develop a premium rate for the Roswell Company, a large employer group. Norton assigned Roswell a credibility factor of 0.7 (or 70%). Norton calculated Roswell's manual rate to be \$200 and its experience claims cost as \$180. Norton's retention charge is \$3. This information indicates that Roswell's blended rate is:

- A. \$186
- B. \$189
- C. \$194
- D. \$197

Answer: B

NEW QUESTION 199

- (Topic 2)

The following information was presented on one of the financial statements prepared by the Rouge Health Plan as of December 31, 1998:

Rouge's current ratio at the end of 1998 was approximately equal to:

- A. 0.84
- B. 1.06
- C. 1.19
- D. 1.31

Answer: C

NEW QUESTION 201

- (Topic 2)

Julio Benini is eligible to receive healthcare coverage through a health plan that is under contract to his employer. Mr. Benini is seeking coverage for the following individuals:

? Elena Benini, his wife
? Maria Benini, his 18-year-old unmarried daughter
? Johann Benini, his 80-year-old father who relies on Julio for support and maintenance
The health plan most likely would consider that the definition of a dependent, for purposes of healthcare coverage, applies to:

- A. Elena, Maria, and Johann
- B. Elena and Maria only
- C. Elena only
- D. Maria only

Answer: B

NEW QUESTION 203

- (Topic 2)

The HMO Model Act sets certain requirements that an entity that wishes to operate as an HMO must meet. These requirements include:

- A. Having an initial net worth of at least \$5 million
- B. Maintaining a net worth equal to at least 5% of premium revenues for the first \$150 million in premium revenue
- C. Using a prospective method to estimate future risk
- D. Obtaining a certificate of authority (COA) before beginning operations

Answer: D

NEW QUESTION 205

- (Topic 2)

The goals of Diane Tsai, the manager of the Oval Health Plan's accounting department, and the goals of Oval are mutually supportive. Oval's accounting department is able to establish and achieve the appropriate objectives, but the department's costs of operation are too high. The following statement(s) can correctly be made about this situation:

- A. M
- B. Tsai most likely is the manager of a profit center.
- C. The business goals of Oval are congruent with M
- D. Tsai's goals.
- E. Oval's accounting department is efficient but not effective.
- F. All of these statements are correct.

Answer: B

NEW QUESTION 207

- (Topic 2)

In a fee-for-service (FFS) reimbursement method, providers are paid per treatment or per service that they provide. One typical benefit of FFS reimbursement is that it:

- A. Is highly effective in preventing excessive services that take the form of churning, unbundling, and upcoding
- B. Provides physicians who attempt to control costs with a higher rate of compensation than is provided to physicians who make the effort to control costs
- C. Is relatively easy to initiate, especially in markets where managed care penetration is low
- D. Guards against the practice of defensive medicine

Answer: B

NEW QUESTION 209

- (Topic 2)

A health plan may experience negative working capital whenever healthcare expenses generated by plan members exceed the premium income the health plan receives.

Ways in which a health plan can manage the volatility in claims payments, and therefore reduce the risk of negative working capital, include:

* 1.Accurately estimating incurred but not reported (IBNR) claims 2.Using capitation contracts for provider reimbursement

- A. Both 1 and 2
- B. 1 only
- C. 2 only
- D. Neither 1 nor 2

Answer: A

NEW QUESTION 214

- (Topic 2)

Residual trend is the difference between total trend and the portion of the total trend caused by changes in provider reimbursement levels.

Consider the following events that could affect an health plan's provider reimbursement levels:

Event 1 — The disenrollment of a large group with unusually high utilization rates

Event 2 — The introduction of a new treatment for infertility

Event 3 — A serious flu epidemic

Event 4 — A shift in inpatient medical services from obstetrical care to neonatal intensive care

One cause of residual trend is change in intensity, which would be represented by:

- A. Event 1
- B. Event 2
- C. Event 3
- D. Event 4

Answer: D

NEW QUESTION 218

- (Topic 2)

The Rathbone Company has contracted with the Jarvin Insurance Company to provide healthcare benefits to its employees. Under this contract, Rathbone assumes financial responsibility for paying 80% of its estimated annual claims and for depositing the funds necessary to pay these claims into a bank account. Although Rathbone owns the bank account, Jarvin, acting as Rathbone's agent, makes the actual claims payments from this account. Claims in excess of Rathbone's contracted percentage are paid by Jarvin. Rathbone pays to Jarvin a premium for administering the entire plan and bearing the costs of claims in excess of Rathbone's obligation. This premium is substantially lower than would be charged if Jarvin were providing healthcare coverage under a traditional fully insured group plan. Jarvin is required to pay premium taxes only on the premiums it receives from Rathbone. This information indicates that the type of alternative funding method used by Rathbone is known as a:

- A. Premium-delay arrangement
- B. Reserve-reduction arrangement
- C. Minimum-premium plan
- D. Retrospective-rating arrangement

Answer: C

NEW QUESTION 219

- (Topic 2)

The following statements are about the capital budgeting technique known as the payback method. Select the answer choice containing the correct statement:

- A. The main benefit of the payback method is that it is simple to use.
- B. The payback method measures the profitability of a given capital project.
- C. The payback method considers the time value of money.
- D. The payback method states a proposed project's cash flow in terms of present value for the life of the entire project.

Answer: A

NEW QUESTION 224

- (Topic 2)

Assume that the Lambda, Mesa, and Novella health plans are equal in every way except that the health plans have obtained equal amounts of net cash inflows from different sources, as shown below:

HealthPlan Source LambdaFinancing activities MesaInvesting activities NovellaOperating activities

From the following answer choices, select the response which indicates the health plan that would most likely be the most attractive to a potential plan sponsor, to a potential creditor, and to a potential investor.

- A. Potential Plan Sponsor = Lambda Potential Creditor = Mesa Potential Investor = Novella
- B. Potential Plan Sponsor = Lambda Potential Creditor = Novella Potential Investor = Mesa
- C. Potential Plan Sponsor = Novella Potential Creditor = Lambda Potential Investor = Mesa
- D. Potential Plan Sponsor = Novella Potential Creditor = Novella Potential Investor = Novella

Answer: D

NEW QUESTION 226

- (Topic 2)

A cost for which a benefit is forfeited in choosing one decision alternative over another alternative is known as

- A. A marginal unit cost
- B. An opportunity cost
- C. An incremental cost
- D. A differential cost

Answer: B

NEW QUESTION 230

- (Topic 2)

The Landau health plan will switch from using top-down budgeting to using bottom-up budgeting. One potential advantage to Landau of making this switch is that, compared to top-down budgeting, bottom-up budgeting is more likely to

- A. Require little time or labor to complete
- B. Enable Landau to incorporate key changes in regulatory requirements on a timely basis
- C. Reflect top management's intentions for Landau
- D. Reflect the realities of day-to-day operations

Answer: B

NEW QUESTION 231

- (Topic 2)

The Northwest Company offers its employees the option of choosing to receive their healthcare benefits from an HMO or from a traditional indemnity plan. The premiums for the HMO are lower than for the traditional indemnity plan. In this situation, it is correct to assume that:

* 1. Individual low utilizers are more likely to enroll in the traditional indemnity plan 2. Individual high utilizers are more likely to enroll in the HMO

- A. Both 1 and 2
- B. 1 only

- C. 2 only
- D. Neither 1 nor 2

Answer: D

NEW QUESTION 233

- (Topic 2)

In evaluating the claims experience during a given rating period of the Lucky Company, the Calaway Health Plan determined that the claims incurred by Lucky were lower than Calaway anticipated when it established Lucky's premium rate for the rating period. Calaway, therefore, refunded a portion of Lucky's premium to reflect the better-than- anticipated claims experience. This rating method is known as:

- A. durational rating
- B. retrospective experience rating
- C. blended rating
- D. prospective experience rating

Answer: B

NEW QUESTION 235

- (Topic 2)

A health plan can use segment margins to evaluate the profitability of its profit centers. One characteristic of a segment margin is that this margin

- A. Is the portion of the contribution margin that remains after a segment has covered its direct fixed costs
- B. Incorporates only the costs attributable to a segment, but it does not incorporate revenues
- C. Considers only a segment's costs that fluctuate in direct proportion to changes in the segment's level of operating activity
- D. Evaluates the profit center's effective use of assets employed to earn a profit

Answer: A

NEW QUESTION 238

- (Topic 2)

The Proform Health Plan uses agents to market its small group business. Proform capitalizes the commission expense relating to this line of business by spreading the commissions over the premium-paying period of the healthcare coverage. This approach to expense recognition is known as:

- A. Systematic and rational allocation
- B. Matching principle
- C. Immediate recognition
- D. Associating cause and effect

Answer: D

NEW QUESTION 243

- (Topic 2)

The Essential Health Plan markets a product for which it assumed total expenses to equal 92% of premiums. Actual data relating to this product indicate that expenses equal 89% of premiums. This information indicates that the expense margin for this product has:

- A. a 3% favorable deviation
- B. a 3% adverse deviation
- C. an 11% favorable deviation
- D. an 11% adverse deviation

Answer: A

NEW QUESTION 246

- (Topic 2)

The process of converting the present value of a specified amount of money to its future value is known as

- A. Capital budgeting
- B. Compounding
- C. Capital rationing
- D. Discounting

Answer: B

NEW QUESTION 251

- (Topic 2)

In order to analyze costs for internal management purposes, the Banner health plan uses functional cost analysis. One characteristic of this method of cost analysis is that it

- A. Enables Banner's top management to analyze costs as they apply to workflow rather than to organizational structures
- B. Assumes that activities, not products, generate costs
- C. Cannot be used when Banner makes pricing and staffing decisions
- D. Identifies units of activity, calculates the costs of performing each unit of activity, and then assigns the cost of each unit of activity to Banner's products or lines of business

Answer: A

NEW QUESTION 255

- (Topic 2)

The following information was presented on one of the financial statements prepared by the Rouge health plan as of December 31, 1998:

When calculating its cash-to-claims payable ratio, Rouge would correctly divide its:

- A. Cash by its reported claims only
- B. Cash by its reported claims and its incurred but not reported claims (IBNR)
- C. Reported claims by its cash
- D. Reported claims and its incurred but not reported claims (IBNR) by its cash

Answer: B

NEW QUESTION 257

- (Topic 2)

Costs that can be defined by behavior are most commonly classified as fixed costs, variable costs and semi-variable costs. Examples of fixed costs include:

- A. Rent, insurance expense, and depreciation on computer equipment
- B. Rent, claims processing costs, and selling expenses
- C. Claims processing costs, telephone expense, and depreciation on computer equipment
- D. Premium processing, rent, and selling expenses

Answer: A

NEW QUESTION 261

- (Topic 2)

The Sesame health plan uses a method of accumulating cost data that enables the health plan to satisfy financial reporting requirements for compiling financial statements and corporate tax returns. Although this method assists Sesame's managers in studying which types of costs are rising and falling over time, it does not explain which areas of Sesame incur each cost. This method, which is the most basic level of cost accumulation, is known as accumulating costs by

- A. Cost center
- B. Type of cost
- C. Lines of business
- D. Function

Answer: B

NEW QUESTION 263

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