AHIP

Exam Questions AHM-520

Health Plan Finance and Risk Management

NEW QUESTION 1
- (Topic 1)
A health plan that capitates a provider group typically provides or offers to provide stop-loss coverage to that provider group.

A. True
B. False

Answer: A

NEW QUESTION 2
- (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 3
- (Topic 1)
The Brookhaven Company is the parent company of two subsidiaries: an HMO and an insurance company. The headings on Brookhaven's financial statements read "Consolidated Financial Statements of Brookhaven Company." From the following answer choices, select the response that correctly indicates, under the entity concept, whether the HMO and the insurance company are accounted for as separate entities and whether the subsidiaries' financial results would be included in Brookhaven's consolidated financial statements.

A. Accounted for as Separate Entities? = yes Results Included in Brookhaven's Statements? = yes
B. Accounted for as Separate Entities? = yes Results Included in Brookhaven's Statements? = no
C. Accounted for as Separate Entities? = noResults Included in Brookhaven's Statements? = yes
D. Accounted for as Separate Entities? = no Results Included in Brookhaven's Statements? = no

Answer: A

NEW QUESTION 4
- (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 5
- (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.
To prepare its cash flow statement, Caribou uses the direct method rather than the indirect method.

A. True
B. False

Answer: B

NEW QUESTION 6
- (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 7
- (Topic 1)
The Harp Company self-funds the health plan for its employees. The plan is administered under a typical administrative-services-only (ASO) arrangement. One true statement about this ASO arrangement is that

A. This arrangement prevents Harp from purchasing stop-loss coverage for its health plan
B. The amount that Harp pays the administrator to provide the ASO services is not subject to state premium taxes
C. The administrator is responsible for paying claims from its own assets if Harp's account is insufficient
D. The charges for the ASO services must be stated as a percentage of the amount of claims paid for medical expenses incurred by Harp's covered employees and their dependents

Answer: B

NEW QUESTION 8
- (Topic 1)
One true statement about the rate ratios used by a health plan is that the

A. End result of a typical family rate ratio is that the health plan's family rate is subsidized by its single premium rate
B. health plan cannot arbitrarily increase or decrease its rate ratio for a rate category
C. rate ratios used by the health plan most likely have been established by government regulations
D. health plan should determine its rate ratios by considering family size alone rather than competitive factors such as the ratios that competitors are using

Answer: A

NEW QUESTION 9
- (Topic 1)
The Lighthouse health plan operates in a state that allows the health plan to use an underwriting method of determining a group's premium in which underwriters treat several small groups as one large group for risk assessment purposes. This method, which helps Lighthouse more accurately estimate a small group's probable claims costs, is known as

A. Case stripping
B. The low-option rating method
C. The rate spread method
D. Pooling

Answer: D

NEW QUESTION 10
- (Topic 1)
The Zane health plan uses a base of accounting known as accrual-basis accounting. With regard to this base of accounting, it can correctly be stated that accrual-basis accounting

A. Enables an interested party to view the consequences of obligations incurred by Zane, but only if the health plan ultimately completes the business transaction
B. Is not suitable for measuring Zane's profitability
C. Requires Zane to record revenues when they are earned and expenses when they are incurred, even if cash has not actually changed hands
D. Prohibits Zane from making adjusting entries to its accounting records at the end of each accounting year

Answer: C

NEW QUESTION 10
- (Topic 1)
The Jasmine Company, which self funds the health plan for its 200 employees, has established a 501(c)(9) trust as a means of addressing possible claims fluctuations under the health plan. Thisplan is not a part of a collective bargaining process. A potential disadvantage to Jasmine of using a 501(c)(9) trust is that

A. The cost of maintaining the trust may be prohibitive to Jasmine
B. The trust must always maintain enough assets to pay the health plan's claims that have been incurred but not yet paid
C. Jasmine is prohibited from earning any return on the trust assets
D. The contributions to this trust are not deductible for federal income tax purposes

Answer: A

NEW QUESTION 11
- (Topic 1)
This concept, which holds that a company should record the amounts associated with its business transactions in monetary terms, assumes that the value of money is stable over time. This concept provides objectivity and reliability, although its relevance may fluctuate.
From the following answer choices, choose the name of the accounting concept that matches the description.

A. Measuring-unit concept
B. Full-disclosure concept
C. Cost concept
D. Time-period concept

Answer: A

NEW QUESTION 15
- (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 behigher 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 = subcapitationBengal = full professional capitation
C. Antler = global capitation Bengal = subcapitation
D. Antler = global capitationBengal = full professional capitation

Answer: D

NEW QUESTION 18
- (Topic 1)
Because a health plan cannot decline coverage for individuals who are eligible for conversion of group health coverage to individual health coverage, the bulk of the health plan's underwriting for conversion policies is accomplished through health plan design.

A. True
B. False

Answer: A

NEW QUESTION 20
- (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 policyholderinterests
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 23
- (Topic 1)
With regard to capitation arrangements for hospitals, it can correctly be Back to Top stated that

A. The most common reimbursement method for hospitals is professional services capitation
B. Most jurisdictions prohibit hospitals and physicians from joining together to receive global capitations that cover institutional services provided by the hospitals
C. Ahealth plan typically can capitate a hospital for outpatient laboratory and X-ray services only if the health plan also capitates the hospital for inpatient care
D. Many hospitals have formed physician hospital organizations (PHOs), hospital systems, or integrated delivery systems (IDSs) that can accept global capitation payments from health plans

Answer: D

NEW QUESTION 25
- (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 30
- (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 34
- (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 38
- (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 43
- (Topic 1)
A key factor that distinguishes the various types of health plans is the type and amount of risk that a health plan assumes with respect to the delivery and financing of healthcare benefits. An example of a type of health plan that typically assumes the financial risk of delivering and financing healthcare benefits is a

A. Third party administrator (TPA)
B. Utilization review organization (URO)
C. Preferred provider organization (PPO)
D. Pharmacy benefit management (PBM) plan

Answer: C

NEW QUESTION 48
- (Topic 1)
The following statements are about various reimbursement arrangements that health plans have with hospitals. Select the answer choice containing the correct statement.

A. A sliding scale per-diem charges arrangement differs from a sliding scale discount on charges arrangement in that only a sliding scale per-diem charges arrangement is based on total volume of admissions and outpatient procedures.
B. Under a typical reimbursement arrangement that is based on diagnosisrelated groups (DRGs), if the payment amount is fixed on the basis of diagnosis, then any reduction in costs resulting from a reduction in days will go to the health plan rather than to the hospital.
C. A negotiated straight per-diem charge requires payment of a single charge for a day in the hospital, regardless of any actual charges or costs incurred during the hospital stay.
D. A straight discount on charges arrangement is the most common reimbursement method in markets with high levels of health plans.

Answer: C

NEW QUESTION 51
- (Topic 1)
The Challenger Group is a type of management services organization (MSO) that purchases the assets of physician practices, provides practice management andadministrative support servicesto participating providers, and offers physicians a long- term contract and an equity position in Challenger. This information indicates that Challenger is a type of health plan

A. Known as
B. An integrated delivery system (IDS)
C. Amedical foundation
D. Aprovider-sponsored organization (PSO)
E. Aphysician practice management (PPM) company

Answer: D

NEW QUESTION 56
- (Topic 1)
Users of the Fulcrum Health Plan financial information include:

? The independent auditors who review Fulcrum's financial statements
? Fulcrum's controller (comptroller)
? Fulcrum's plan members
? The providers that deliver healthcare services to Fulcrum plan members
? Fulcrum's competitors
Of these users, the ones that most likely can correctly be classified as external users with a direct financial interest in Fulcrum are the

A. Independent auditors, the plan members, the providers, and the
B. Competitors only
C. Independent auditors, the controller, and the providers only
D. Controller and the competitors only
E. Plan members and the providers only

Answer: D

NEW QUESTION 57
- (Topic 1)
Provider reimbursement methods that transfer some utilization risk from a health plan to providers affect the health plan's RBC formula. A health plan's use of these reimbursement methods is likely to result in

A. An increase the health plan's underwriting risk
B. A decrease the health plan's credit risk
C. A decrease the health plan's net worth requirement
D. All of the above

Answer: C

NEW QUESTION 60
- (Topic 1)
The Fiesta Health Plan prices its products in such a way that the rates for its products are reasonable, adequate, equitable, and competitive. Fiesta is using blended rating to calculate a premium rate for the Murdock Company, a large employer. Fiesta has assigned a credibility factor of 0.6 to Murdock. Fiesta has also determined that Murdock's manual rate is $200 PMPM and that Murdock's experience rate is $180 PMPM. Fiesta would correctly calculate that its blended rate PMPM for Murdock should be Fiesta's retention charge plus

A. $152
B. $188
C. $192
D. $228

Answer: B

NEW QUESTION 63
- (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 68
- (Topic 1)
Under the doctrine of corporate negligence, a health plan and its physician administrators may be held directly liable to patients or providers for failing to investigate adequately the competence of healthcare providers whom it employs or with whom it contracts, particularly where the health plan actually provides healthcare services or restricts the patient's/enrollee's choice of physician.

A. True
B. False

Answer: A

NEW QUESTION 72
- (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 74
- (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 79
- (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 80
- (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 main purpose of Caribou's balance sheet is to

A. Reveal how Caribou obtained particular assets or liabilities
B. Show how much money Caribou has realized from its operations during an accounting period
C. Measure the owners' wealth
D. Reconcile the cash that Caribou has on hand at the beginning and at the end of an accounting period

Answer: C

NEW QUESTION 85
- (Topic 1)
The Fiesta Health Plan prices its products in such a way that the rates for its products are reasonable, adequate, equitable, and competitive. Fiesta is using blended rating to calculate a premium rate for the Murdock Company, a large employer. Fiesta has assigned a credibility factor of 0.6 to Murdock. Fiesta has also determined that Murdock's manual rate is $200 PMPM and that Murdock's experience rate is $180 PMPM.
According to regulations, Fiesta's premium rates are reasonable if they

A. vary only on the factors that affect Fiesta's costs
B. are at a level that balances Fiesta's need to generate a profit against its need to obtain or retain a specified share of the market in which it conducts business
C. are high enough to ensure that Fiesta has enough money on hand to pay operating expenses as they come due
D. do not exceed what Fiesta needs to cover its costs and provide the plan with a fair profit

Answer: D

NEW QUESTION 88
- (Topic 1)
Several federal agencies establish rules and requirements that affect health plans. One of these agencies is the Department of Labor (DOL), which is primarily responsible for _____.

A. Issuing regulations pertaining to the Health Insurance Portability and Accountability Act (HIPAA) of 1996
B. Administering the Medicare and Medicaid programs
C. Administering ERISA, which imposes various documentation, appeals, reporting, and disclosure requirements on employer group health plans
D. Administering the Federal Employees Health BenefitsProgram (FEHBP), which providesvoluntary health insurance coverage to federal employees, retirees, and dependents

Answer: C

NEW QUESTION 90
- (Topic 1)
Over time, health plans and their underwriters have gathered increasingly reliable information about the morbidity experience of small groups.
Generally, in comparison to large groups, small groups tend to

A. Have more frequent and larger claims fluctuations
B. Generate lower administrative expenses as a percentage of the total premium amount the group pays
C. More closely follow actuarial predictions regarding morbidity rates
D. All of the above

Answer: A

NEW QUESTION 95
- (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 97
- (Topic 1)
The following statements indicate the pricing policies of two health plans that operate in a particular market:
? The Accent Health Plan consistently underprices its product
? The Bolton Health Plan uses extremely strict underwriting practices for the small groups to which it markets its plan
From the following answer choices, select the response that correctly indicates the most likely market effects of the pricing policies used by Accent and Bolton.

A. Accent = unprofitable business Bolton = high acquisition rate
B. Accent = unprofitable business Bolton = low acquisition rate
C. Accent = high profits Bolton = high acquisition rate
D. Accent = high profits Bolton = low acquisition rate

Answer: B

NEW QUESTION 99
- (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 103
- (Topic 1)
Most organizations that obtain group healthcare coverage can be classified as one of three types of groups: employer-employee groups, multiple employer groups, and professional associations. One true statement about these types of groups is that

A. Anti selection risk is higher for both multiple-employer groups and professional associations than it is for an employer-employee group
B. Private employers typically present a higher underwriting risk to health plans than do public employers
C. Individual members of a multiple-employer group or a professional association typically are required to obtain healthcare coverage through the group or association
D. I health plan is prohibited, when evaluating the risks represented by a professional association, from considering the industry experience of the agent or broker that sells a group plan to the association

Answer: A

NEW QUESTION 105
- (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 108
- (Topic 1)
The following statements are about risk management in health plans. Select the answer choice containing the correct response.

A. Risk management is especially important to health plans because the Employee Retirement Income Security Act of 1974 (ERISA) allows plan members to recover punitive damages from healthcare plans.
B. With regard to the relative risk for health plan structures based upon the degree of influence and relationships that health plans maintain with their providers,

preferred provider organizations (PPOs) typically have a higher risk than do group HMOs and staff HMOs.
C. Although there are clear risks associated with the provision of healthcare services and coverage decisions surrounding that care, the bulk of risk in health plans is associated with a health plan's benefit administration and contracting activities.
D. A health plan generally structures its risk management process around loss reduction techniques and loss transfer techniques.

Answer: D

NEW QUESTION 112
- (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 115
- (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 117
- (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 ofadjustments. 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 118
- (Topic 1)
The methods of alternative funding for health coverage can be divided into the following general categories:
? Category A—Those methods that primarily modify traditional fully insured group insurance contracts
? Category B—Those methods that have either partial or total self funding
Typically, small employers are able to use some of the alternative funding methods in

A. Both Category A and Category B
B. Category A only
C. Category B only
D. Neither Category A nor Category B

Answer: C

NEW QUESTION 123
- (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 126
- (Topic 1)
Under GAAP, three approaches to expense recognition are generally allowed: associating cause and effect, systematic and rational allocation, and immediate

recognition. A health plan most likely would use the approach of systematic and rational allocation in order to

A. Report the payment of the health plan's utility bills
B. Spread the payment of sales force commissions over the premium paying period of healthcare coverage
C. Report the fees paid by the health plan to attorneys and consultants
D. Depreciate the cost of a new computer system over the useful life of the system

Answer: D

NEW QUESTION 128
- (Topic 1)
When pricing its product, the Panda Health Plan assumes a 4% interest rate on its investments. Panda also assumes a crediting interest rate of 4%.
The actual interest rate earned by Panda on the assets supporting its product is 6%. The following statements can correctly be made about the investment margin and interest margin for Panda's products.

A. Panda most likely built the crediting interest rate of 4% into the investment margin of its product.
B. Panda's investment margin is the difference between its actual benefit costs and the benefit costs that it assumes in its pricing.
C. The interest margin for this product is 2%.
D. All of these statements are correct.

Answer: C

NEW QUESTION 129
- (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.
The maximum amount for which Newfeld is at risk for any one Azalea plan member's treatment costs is

A. $10,000
B. $14,000
C. $30,000
D. $34,000

Answer: C

NEW QUESTION 130
- (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 134
- (Topic 2)
The Montvale Health Plan purchased a piece of real estate 20 years ago for $40,000. It recently sold the real estate for $80,000 and reported a capital gain of $40,000 on this sale. Even though the purchasing power of the dollar declined by half during this period and Montvale realized no actual gain in purchasing power, Montvale recorded in its accounting records the $40,000 gain from this sale. This situation best illustrates the accounting concept known as the:

A. Measuring-unit concept
B. Time-period concept
C. Full-disclosure concept
D. Concept of periodicity

Answer: A

NEW QUESTION 135
- (Topic 2)
With regard to alternative funding arrangements, the part of a health plan premium that is intended to contribute to the claims reserve that a health plan maintains to pay for unusually high utilization is known as the:

A. Interest charge
B. Retention charge
C. Risk charge
D. Surplus

Answer: C

NEW QUESTION 140
- (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 145
- (Topic 2)
The Puma health plan uses return on investment (ROI) and residual income (RI) to measure the performance of its investment centers. Two of these investment centers are identified as X and Y. Investment Center X earns $10,000,000 in operating income on controllable investments of $50,000,000, and it has total revenues of $60,000,000. Investment Center Y earns $2,000,000 in operating income on controllable investments of $8,000,000, and it has total revenues of $10,000,000. Both centers have a minimum required rate of return of 15%.
One difference between the RI method and the ROI method is that

A. The RI method demands greater goal congruence from Puma's managers than does the ROI method
B. The RI method favors Puma's small investment centers more than does the ROI method
C. Only RI can lead to decisions that improve Puma's short-term profits at the expense of its long-term objectives
D. Only RI is useful to Puma for comparing investment centers of different sizes

Answer: A

NEW QUESTION 146
- (Topic 2)
A health plan can use a SWOT (strengths, weaknesses, opportunities, and threats) analysis to analyze its relationships with the major providers in each market in which it conducts business.

A. True
B. False

Answer: A

NEW QUESTION 148
- (Topic 2)
A health plan can use cost accounting in order to

A. Determine premium rates for its products
B. Match the costs incurred during a given accounting period to the income earned in, or attributed to, that same period
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: A

NEW QUESTION 150
- (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 153
- (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 157
- (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 withproviding services to the Medicaid population than with providing services to the Medicare population
D. All of the above

Answer: D

NEW QUESTION 158
- (Topic 2)
The Longview Hospital contracted with the Carlyle Health Plan to provide inpatient services to Carlyle's enrolled members. Carlyle provides Longview with a type of stop-loss coverage that protects, on a claims incurred and paid basis, against losses arising from significantly higher than anticipated utilization rates among Carlyle's covered population. The stop-loss coverage specifies an attachment point of 130% of Longview's projected $2,000,000 costs of treating Carlyle plan members and requires Longview to pay 15% of any costs above the attachment point. In a given plan year, Longview incurred covered costs totaling $3,000,000. For the year in which Longview's incurred covered costs were $3,000,000, the amount for which Longview will be responsible is:

A. $2,000,000
B. $2,600,000
C. $2,660,000
D. $3,900,000

Answer: C

NEW QUESTION 161
- (Topic 2)
In a comparison of small employer-employee groups to large employer-employee groups, it is correct to say that small employer-employee groups tend to:

A. More closely follow actuarial predictions with respect to morbidity rates
B. Generate more administrative expenses as a percentage of the total premium amount the group pays
C. Have less frequent and smaller claims fluctuations
D. Expose an health plan to a lower risk of anti selection

Answer: B

NEW QUESTION 165
- (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 electricityVariable Cost = fire insurance on the home office facility

Answer: A

NEW QUESTION 166
- (Topic 2)
The traditional financial ratios that analysts use to study a health plan's GAAP-based financial statements include liquidity ratios, activity ratios, leverage ratios, and profitability ratios. Of these categories of ratios, analysts are most likely to use

A. Liquidity ratios to measure a health plan's ability to meet its current liabilities
B. Activity ratios relate the returns of a health plan to its sales, total revenues, assets, stockholders' equity, capital, surplus, or stock share price
C. Leverage ratios to measure how quickly a health plan converts specified financial statement items into premium income or cash
D. Profitability ratios to measure the effect that fixed costs have on magnifying a health plan's risk and return

Answer: A

NEW QUESTION 168
- (Topic 2)
The Longview Hospital contracted with the Carlyle Health Plan to provide inpatient services to Carlyle's enrolled members. Carlyle provides Longview with a type of stop-loss coverage that protects, on a claims incurred and paid basis, against losses arising from significantly higher than anticipated utilization rates among Carlyle's covered population. The stop-loss coverage specifies an attachment point of 130% of Longview's projected $2,000,000 costs of treating Carlyle plan members and requires Longview to pay 15% of any costs above the attachment point. In a given plan year, Longview incurred covered costs totaling $3,000,000. With regard to the type of stop-loss coverage provided to Longview by Carlyle and to whether this coverage is classified as insurance or reinsurance, the risk transfer approach used in this situation can be described as:

A. aggregate stop-loss reinsurance
B. aggregate stop-loss insurance
C. specific stop-loss reinsurance
D. specific stop-loss insurance

Answer: C

NEW QUESTION 170
- (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 175
- (Topic 2)
Juan Ramirez, a licensed social worker, and Dr. Laura Lui, a licensed psychiatrist, are under contract to the Peninsula Health Plan. Peninsula has contracted with CMS to provide services to Medicare and Medicaid beneficiaries. Both Mr. Ramirez and Dr. Lui provide the same type of counseling services to Peninsula's enrollees. With respect to amendments made to the Balanced Budget Act (BBA) of 1997 that impact provider reimbursement, the amount by which Peninsula will reimburse Mr. Ramirez will be equal to:

A. 50% of D
B. Lui's reimbursement
C. 75% of D
D. Lui's reimbursement
E. 90% of D
F. Lui's reimbursement
G. 100% of D
H. Lui's reimbursement

Answer: D

NEW QUESTION 176
- (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 177
- (Topic 2)
The theory of vicarious liability or ostensible agency can expose a health plan to the risk that it could be held liable for the acts of independent contractors. Factors that may give rise to the assumption that an agency relationship exists between a health plan and its independent contractors include:

A. Requiring the providers to supply their own office space
B. Employing nurses and other healthcare professionals to support the physician providers
C. Requiring providers to maintain their own medical records
D. All of the above

Answer: B

NEW QUESTION 181
- (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 185
- (Topic 2)
One difference between the internal and external analysis of a health plan's financial information is that

A. Internal analysis of the health plan can be more detailed and more specific than can external analysis
B. Internal analysts are more likely than external analysts to want comparative financial data about the health plan
C. Only internal analysts use trend analysis to analyze the health plan's financial statements
D. Only internal analysts typically conduct the financial analysis of the health planthemselves

Answer: A

NEW QUESTION 189
- (Topic 2)
All publicly traded health plans in the United States are required to prepare financial statements for use by their external users in accordance with generally accepted accounting principles (GAAP). In addition, health insurers and health plans that fall under the jurisdiction of state insurance departments are required by law to prepare certain financial statements in accordance with statutory accounting practices (SAP). In a comparison of GAAP to SAP, it is correct to say that:

A. GAAP is established and promoted by the National Association of Insurance Commissioners (NAIC), whereas SAP is established and promoted by the Financial Accounting Standards Board (FASB)
B. The going-concern concept is an underlying premise of GAAP, whereas SAP tends to focus on the liquidation value of the MCO or the insurer
C. GAAP provides for a single method of valuing all of a health plan's assets, whereas SAP offers the health plan more than one method for valuing its assets
D. The principle of conservatism is fundamental to GAAP, whereas SAP generally is not conservative in nature

Answer: B

NEW QUESTION 193
- (Topic 2)
The Puma health plan uses return on investment (ROI) and residual income (RI) to measure the performance of its investment centers. Two of these investment centers are identified as X and Y. Investment Center X earns $10,000,000 in operating income on controllable investments of $50,000,000, and it has total revenues of $60,000,000. Investment Center Y earns $2,000,000 in operating income on controllable investments of $8,000,000, and it has total revenues of $10,000,000. Both centers have a minimum required rate of return of 15%.
The following statements are about Puma's evaluation of these investment centers. Select the answer choice containing the correct statement.
A. Investment Center Y's RI is greater than Investment Center X's RI.
B. The ROI for Investment Center X is 16.7%, and the ROI for Investment Center Y is 20.0%.
C. Because Investment Centers X and Y are different sizes, Puma should not use ROI to compare these investment centers.
D. According to the evaluation of ROI, Investment Center Y achieves a higher return on its available resources than does Investment Center X.

Answer: D

NEW QUESTION 194
- (Topic 2)
The Amethyst Health Plan uses a budgeting approach that requires each line of business within Amethyst's operation to justify its continued operation. Amethyst begins with the premise that no resources will be allocated for the following period unless each dollar to be spent is justified and is shown to be within departmental plans and corporate goals and objectives. The budgeting approach used by Amethyst is known as:

A. Bottom-up budgeting
B. Top-down budgeting
C. Zero-based budgeting
D. Master budgeting

Answer: C

NEW QUESTION 195
- (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 200
- (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 201
- (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 206
- (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.
For the previous financial period, Fairway's net profit margin was

A. 2.50%
B. 3.00%
C. 3.60%
D. 7.50%

Answer: A

NEW QUESTION 210
- (Topic 2)
Cascade Hospital has negotiated with the McBee Health Plan a straight per-diem rate of $1,000 per day for medical admissions. One of McBee's plan members was admitted to Cascade for 10 days. Total billed charges equaled $10,000, of which $2,000 were for noncovered items. This information indicates that, for this admission, the amount that McBee was obligated to reimburse Cascade was:

A. $0
B. $8,000
C. $10,000
D. $12,000

Answer: C

NEW QUESTION 213
- (Topic 2)
The Danner Bank loaned money to the CareWell Health Plan to fund an expansion of a healthcare facility. With respect to the type of financial information user Danner represents to CareWell, it is correct to say that Danner is an:

A. Internal user with a direct financial interest
B. Internal user with an indirect financial interest
C. External user with a direct financial interest
D. Case-mix adjustment

Answer: C

NEW QUESTION 217
- (Topic 2)
In order to print all of its forms in-house, the Prism health plan is considering the purchase of 10 new printers at a total cost of $30,000. Prism estimates that the proposed printers have a useful life of 5 years. Under its current system, Prism spends $10,000 a year to have forms printed by a local printing company. Assume that Prism selects a 15% discount rate based on its weighted-average costs of capital. The cash inflows for each year, discounted to their present value, are shown in the following chart:

Prism will use both the payback method and the discounted payback methodto analyze the worthiness of this potential capital investment. Prism's decisionrule is to accept all proposed capital projects that have payback periods offour years or less.
After analyzing this information, Prism would accept this proposed capitalproject under

A. Both the payback method and the discounted payback method
B. The payback method but not the discounted payback method
C. The discounted payback method but not the payback method
D. Neither the payback method nor the discounted payback method

Answer: B

NEW QUESTION 222
- (Topic 2)
The following statements are about the Health Insurance Portability and Accountability Act (HIPAA) as it relates to the small group market. Three of these statements are true and one statement is false. Select the answer choice containing the FALSE statement:

A. A health plan that participates in the small group market is required to issue a contract to any employer that requests healthcare benefits, as long as the employer meets the statutory definition of a small group.
B. A small group must consist of more than 10 employees in order to be underwritten on a group, rather than an individual, basis.
C. A health plan is prohibited from canceling a small group's healthcare coverage because of poor claims experience.
D. A health plan that participates in the small group market is limited in placing restrictions such as waiting periods and pre-existing conditions exclusions to

individuals in high risk categories.

Answer: B

NEW QUESTION 227
- (Topic 2)
A primary reason that a financial analyst would measure the Tapestry health plan's return on assets (ROA) is to determine the

A. Amount of net income per share of Tapestry's common stock
B. Rate of return on the book value of the stockholders' investment in Tapestry
C. Proportion of earnings paid out to Tapestry stockholders in the form of cash dividends
D. Efficiency of Tapestry's management

Answer: D

NEW QUESTION 232
- (Topic 2)
A health plan's costs can be classified as committed costs or discretionary costs. An example of a discretionary cost for a health plan is the cost of its

A. Facilities
B. Executive salaries
C. Employee training
D. Equipment

Answer: A

NEW QUESTION 233
- (Topic 2)
Doctors' Care is an individual practice association (IPA) under contract to the Jasper Health Plan to provide primary and secondary care to Jasper's members. Jasper's capitation payments compensate Doctors' Care for all physician services and associated diagnostic tests and laboratory work. The physicians at Doctors' Care, as a group, determine how individual physicians in the group will be remunerated. The type of capitation used by Jasper to compensate Doctors' Care is known as:

A. PCP capitation
B. Partial capitation
C. Full professional capitation
D. Specialty capitation

Answer: C

NEW QUESTION 235
- (Topic 2)
Dr. Martin Cassini is an obstetrician who is under contract with the Bellerby Health Plan. Bellerby compensates Dr. Cassini for each obstetrical patient he sees in the form of a single amount that covers the costs of prenatal visits, the delivery itself, and post-delivery care . This information indicates that Dr. Cassini is compensated under the provider reimbursement method known as a:

A. global fee
B. relative value scale
C. unbundling
D. discounted fee-for-service

Answer: A

NEW QUESTION 237
- (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 241
- (Topic 2)
The medical loss ratio (MLR) for the Peacock health plan is 80%. Peacock's expense ratio is 16%.
Peacock's MLR and its expense ratio indicate that Peacock

A. Has a 4% potential profit margin
B. Has a combined ratio of 64%
C. Must increase its premium income in order to remain in business
D. Must rely on investment income in order to avoid financial losses

Answer: A

NEW QUESTION 246

- (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 250
- (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.
From this data, Fairway can determine both its current ratio and its net working capital. Fairway would correctly determine that its

A. Current ratio is 1.39
B. Current ratio is 2.00
C. Net working capital equals $1,000,000
D. Net working capital equals $3,000,000

Answer: B

NEW QUESTION 252
- (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 254
- (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 257
- (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 259
- (Topic 2)
The Column health plan is in the process of developing a strategic plan.
The following statements are about this strategic plan. Three of the statements are true, and one statement is false. Select the answer choice containing the FALSE statement.

A. Human resources most likely will be a critical component of Column's strategic plan because, in health plan markets, the size and the quality of a health plan's

provider network is often more important to customers than are the details of a product's benefit design.
B. Column's strategic plan should only address how the health plan will differentiate its products, rather than where and how it will sell these products.
C. Column most likely will need to develop contingency plans to address the need to make adjustments to its original strategic plan.
D. Column's information technology (IT) strategy most likely will be a critical element in successfully implementing the health plan's strategic plan.

Answer: B

NEW QUESTION 262
- (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 taxesonly 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 265
- (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 268
- (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 269
- (Topic 2)
Companies typically produce three types of budgets: operational budgets, cash budgets, and capital budgets. The following statements are about operational budgets. Select the answer choice containing the correct statement.

A. Expense budgets, a type of operational budget, typically describe fixed expenses rather than variable expenses.
B. Operational budgets can only show information by department or by line of business.
C. Operational budgets begin with a forecast of sales revenue and investment income.
D. Revenue budgets, a type of operational budget, indicate the amount of income from operations that a company received from the previous budget period

Answer: C

NEW QUESTION 270
- (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 274
- (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 thesegment's level of operating activity
D. Evaluates the profit center's effective use of assets employed to earn a profit

Answer: A

NEW QUESTION 279
- (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 282
- (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 283
- (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 286
- (Topic 2)
The following statements are about 501(c)(9) trusts. Select the answer choice containing the correct statement:

A. In the event a 501(c)(9) trust is terminated, any funds remaining in the trust revert backto the employer.
B. In order to satisfy Internal Revenue Code (IRC) requirements, membership in a 501(c)(9) trust is mandatory for all employees.
C. Contributions made by an employer to a 501(c)(9) trust are deductible for federal income tax purposes.
D. Typically, a 501(c)(9) trust is controlled solely by the employer that established the trust.

Answer: C

NEW QUESTION 291
- (Topic 2)
The following statements are about the option for health plan funding known as a self- funded plan. Select the answer choice containing the correct response:

A. In a self-funded plan, an employer is relieved of all risk associated with paying for the healthcare costs of its employees.
B. Self-funded plans are subject to the same state laws and regulations that apply to health insurance policies.
C. Employers electing to self-fund a health plan are required to pay claims from a separate trust established for that purpose.
D. An employer electing to self-fund a health plan has the option of purchasing stop-loss insurance to transfer part of the financial risk to an insurer.

Answer: D

NEW QUESTION 296
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