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 utilizes 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 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)
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 7
- (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 8
- (Topic 1)
The following statements are about a health plan's underwriting of small groups. Select the answer choice containing the correct statement.

A. Almost all states prohibit health plan s from rejecting a small group because of the nature of the business in which the small business is engaged.
B. Most states prohibit health plans from setting participation levels as a requirement for coverage, even when coverage is otherwise guaranteed issue.
C. In underwriting small groups, a health plan's underwriters typically consider both the characteristics of the group members and of the employer.
D. Generally, a health plan's underwriters require small employers to contribute at least 80% of the cost of the healthcare coverage.

Answer: C

NEW QUESTION 9
- (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. The fact that this is a completely self-funded plan indicates that

A. The plan has no funding vehicle
B. Kayak passes to its employees the financial risk of providing healthcare coverage
C. The plan most likely is exempt from ERISA requirements concerning the limits on benefit discrimination for classes of employees
D. The plan is exempt from the state laws and regulations that apply to health insurance policies

Answer: D

NEW QUESTION 10
- (Topic 1)
The provider contract that Dr. Timothy Meyer, a pediatrician, has with the Cardigan health plan states that Cardigan will compensate him under a capitation arrangement. However, the contract also includes a typical low enrollment guarantee provision. Statements that can correctly be made about this arrangement include that the low enrollment guarantee provision most likely:

A. Causes D
B. Meyer's capitation contract with Cardigan to transfer more risk to him than the contract otherwise would transfer
C. Specifies that Cardigan will pay D
D. Meyer under an arrangement other than capitation until a specified number of children covered by the plan use him as their PCP
E. Both A and B
F. A only
G. B only
H. Neither A nor B

Answer: C

NEW QUESTION 10
- (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 15
- (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 16
- (Topic 1)
The Health Maintenance Organization (HMO) Model Act, developed by the National Association of Insurance Commissioners (NAIC), represents one approach to developing solvency standards. One drawback to this type of solvency regulation is that it

A. Uses estimates of future expenditures and premium income to estimate future risk
B. Fails to adjust the solvency requirement to account for the size of an HMO's premiums and expenditures
C. Assumes that the amount of premiums an HMO charges always directly corresponds to the level of the risk that the HMO faces
D. Fails to mandate a minimum level of capital and surplus that an HMO must maintain

Answer: C

NEW QUESTION 20
- (Topic 1)
Experience rating and manual rating are two rating methods that the Cheshire health plan uses to determine its premium rates. One difference between these two methods is that, under experience rating, Cheshire

A. Uses a purchaser's actual experience to estimate the group's expected experience, whereas, under manual rating, Cheshire uses its own average experience—and sometimes the experience of other plans—to estimate the group's expected experience
B. can establish rates for groups that have no previous plan experience, whereas, under manual rating, Cheshire cannot establish rates for groups with no previous plan experience
C. charges each group in the same class the same premium whereas, under manual rating, Cheshire charges lower premiums to groups that have experienced lower utilization rates
D. can use group demographics to help determine the rate for a block of business, whereas, under manual rating, Cheshire cannot use group demographics when determining the rate for a block of business

Answer: A

NEW QUESTION 22
- (Topic 1)
An actuary for the Noble Health Plan observed that the plan's actual morbidity was lower than its assumed morbidity and that the plan's actual administrative expenses were higher than its assumed administrative expenses. In this situation, Noble's actual underwriting margin was

A. larger than its assumed underwriting margin, and the plan's actual expense margin was higher than its assumed expense margin
B. larger than its assumed underwriting margin, but the plan's actual expense margin was lower than its assumed expense margin
C. smaller than its assumed underwriting margin, but the plan's actual expense margin was higher than its assumed expense margin
D. smaller than its assumed underwriting margin, and the plan's actual expense margin was lower than its assumed expense margin

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 27
- (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 29
- (Topic 1)
A product is often described as having a thin margin or a wide margin. With regard to the factors that help determine the size of the margin of a health plan's product, it can correctly be stated that the

A. greater the risk a health plan assumes in a health plan, the thinner the product margin should be
B. more that competition acts to force prices down, the wider the product margins tend to become
C. greater the demand for the product, the thinner the margin for this product tends to become
D. longer the premium rates are guaranteed to a group, the wider the health plan's margin should be

Answer: D

NEW QUESTION 34
- (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 36
- (Topic 1)
One true statement about mandated benefit laws is that they

A. Apply equally to self-funded and fully funded groups
B. Require a health plan to cover certain conditions or treatments or to pay a specified level of benefits for certain conditions or treatments
C. Have no impact on a health plan's underwriting and rating decisions
D. Typically decrease a health plan's risk because the health plan may need to delay premium rate decreases or may be prevented from increasing premium rates

Answer: B

NEW QUESTION 38
- (Topic 1)
Reconciliation is the process by which a health plan assesses providers' performance relative to contractual terms and reimbursement.
With regard to this process, it can correctly be stated that

A. Areconciliation typically includes payment to the providers of any withholds or bonuses due to them
B. Ahealth plan typically should conduct a reconciliation immediately after the evaluation period has ended
C. Most agreements between health plans and providers require reconciliations to be performed quarterly
D. Ahealth plan typically should not conduct reconciliation for a provider until the plan has received all claims or other documentation of services that the physician provided during the evaluation period

Answer: A

NEW QUESTION 39
- (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 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 45
- (Topic 1)
With regard to the financial statements prepared by health plans, it can correctly be stated that

A. both for-profit, publicly owned health plans and not-for-profit health plans are required by law to provide all interested parties with an annual report
B. a health plan's annual report typically includes an independent auditor's report and notes to the financial statements
C. any health plan that owns more than 20% of the stock of a subsidiary company must compile the financial statements for the health plan's annual report on a consolidated basis
D. a health plan typically must prepare the financial statements included in its annual report according to SAP

Answer: B

NEW QUESTION 50

- (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 51
- (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 52
- (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 53
- (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 57
- (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 59
- (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 61
- (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 65
- (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 67
- (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 70
- (Topic 1)
Providing services under Medicare or Medicaid can impose on health plans financial risks and costs that are greater than those related to providing services to the commercial population. Reasons that an health plan's financial risks and costs for providing services to Medicare and Medicaid enrollees tend to be higher include

A. Most Medicare and Medicaid enrollees can disenroll from a health plan on a monthly basis
B. The high incidences of chronic illness in both the Medicare and Medicaid populations results in higher costs related to coordinating care and case management
C. Medicare and Medicaid enrollees tend to have a high level of costs in the first few months of enrollment as the health plan educates them about the health plan system and performs initial health screening to evaluate their health
D. all of the above

Answer: D

NEW QUESTION 73
- (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 75
- (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 78
- (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 providermay 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 80
- (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 84
- (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 87
- (Topic 1)
The Marble Health Plan sets aside a PMPM amount for each specialty.
When a PCP in Marble's provider network refers a Marble plan member to a specialist and
the specialist provides medical services to the member, the specialist begins to receive a share of those funds on a monthly basis. Marble determines the monthly payment for each specialist by dividing the number of active patients for that specialty by the total specialty pool for that month.
This form of payment, which is similar to a case rate, is known as

A. Referral circle capitation
B. Risk pod capitation
C. Contact capitation
D. Retrospective reimbursement capitation

Answer: C

NEW QUESTION 92
- (Topic 1)
The accounting department of the Enterprise health plan adheres to the following policies:
? Policy A—Report gains only after they actually occur
? Policy B—Report losses immediately
? Policy C—Record expenses only when they are certain
? Policy D—Record revenues only when they are certain
Of these Enterprise policies, the ones that are consistent with the accounting principle of conservatism are Policies

A. A, B, C, and D
B. A, B, and D only
C. A and B only
D. C and D only

Answer: B

NEW QUESTION 95
- (Topic 1)
With regard to the major risk factors associated with group underwriting, it can correctly be stated that, typically,

A. The age and gender of group plan members are not predictors of utilization of health services by group members
B. A health plan's product design or delivery system has an impact on member selection of the health plan, unless the members are in an environment in which employees have at least two benefit options or health plans from which to choose
C. A health plan should track demographic factors of groups only if the plan specifically adjusts for demographic factors on a group basis
D. A large group is more likely to exhibit a consistent claims pattern, level of healthcare cost, or utilization of services than is a small group

Answer: D

NEW QUESTION 97
- (Topic 1)
In the following paragraph, a sentence 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 selected.
The Igloo health plan recognizes the receipt of its premium income during the accounting
period in which the income is earned, regardless of when cash changes hands. However, Igloo recognizes its expenses when it earns the revenues related to those expenses, regardless of when it receives cash for the revenues earned. This information indicates that the (realization/capitalization) principle governs Igloo's revenue recognition, whereas the (matching/initial-recording) principle governs its expense recognition.

A. realization / matching
B. realization / initial-recording
C. capitalization / matching
D. capitalization / initial-recording

Answer: A

NEW QUESTION 101
- (Topic 1)
Under the alternative funding method used by the Trilogy Company, the insurer charges Trilogy an initial premium that is based on the assumption that claims will be 93% of the expected claims for the year. If claims exceed 93% of expected claims, then Trilogy must reimburse the insurer for any additional claims paid, up to 112% of expected claims. The insurer bears the responsibility for paying claims in excess of 112% of expected claims.
From the following answer choices, choose the name of the alternative funding method described.

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

Answer: A

NEW QUESTION 106
- (Topic 2)
One true statement about capital and surplus ratios for health plans is that

A. This ratio is calculated by dividing a health plan's total liabilities by its capital and surplus
B. A health plan's capital and surplus position would be likely to weaken because of reserve valuation changes that reduce the health plan's reserves
C. The primary purpose of these ratios is to compare a health plan's obligations to its ability to meet those obligations
D. An increase in the value of a health plan's capital and surplus ratio most likely indicates that the health plan's financial position has strengthened

Answer: D

NEW QUESTION 108
- (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 110
- (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 120
- (Topic 2)
The Savanna health plan used a risk analysis technique which defines the key assumptions of Savanna's strategic financial plan in terms of mathematical formulas that can be correlated to each other or analyzed independently. This technique allowed Savanna to simulate probable future events on a computer and produce a distribution of possible outcomes. This risk analysis technique, which can be used to predict Savanna's distribution of expected claims, is known as

A. A hurdle rate simulation
B. Optimistic, most likely, pessimistic scenario modeling
C. A Monte Carlo simulation
D. Debt covenant modeling

Answer: C

NEW QUESTION 124
- (Topic 2)
The Nuevo health plan's capital structure consists of 30% debt and 70% equity. Nuevo's average after-tax cost of debt is 6% and its cost of equity is 12%. The following statement(s) can correctly be made about Nuevo's weighted average cost of capital (WACC):

A. Nuevo has a WACC of 10.2%
B. If Nuevo establishes its WACC as the handle rate for capital investments, then it can expect an investment to add value to the health plan only if the investment is expected to earn a return of less than Nuevo's WACC
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: B

NEW QUESTION 126
- (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 127
- (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 128
- (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 132
- (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 134
- (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 136
- (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 139
- (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 144
- (Topic 2)
The following information was presented on one of the financial statements prepared by the Rouge Health Plan as of December 31, 1998:

Assets		
Current assets	$	950,000
Other assets		100,000
Total Assets	$	1,050,000
Liabilities		
Current liabilities	$	800,000
Other liabilities		100,000
Total Liabilities	$	900,000
Stockholders' Equity		
Common stock	$	50,000
Additional paid-in capital		100,000
Total Liabilities and Stockholders' Equity	$	1,050,000

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 148
- (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 150
- (Topic 2)
The Lindberg Company has decided to terminate its group healthcare coverage with the Benson Health Plan. Lindberg has several former employees who previously experienced qualifying events that caused them to lose their group coverage. One federal law allows these former employees to continue their group healthcare coverage. From the answer choices below, select the response that correctly identifies the federal law that grants these individuals with the right to continue group healthcare coverage, as well as the entity which is responsible for continuing this coverage:

A. Federal law: Consolidated Omnibus Budget Reconciliation Act (COBRA) Entity: Lindberg
B. Federal law: Consolidated Omnibus Budget Reconciliation Act (COBRA) Entity: Benson
C. Federal law: Employee Retirement Income Security Act (ERISA) Entity: Lindberg
D. Federal law: Employee Retirement Income Security Act (ERISA) Entity: Benson

Answer: A

NEW QUESTION 151
- (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 156
- (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 159
- (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 161
- (Topic 2)
The goal of the investment department at the Wayfarer Health Plan is to maximize investment return. The investment department executes investments on time and at a low cost. However, these transactions often result in low returns or risks that are deemed too high for Wayfarer. With regard to effectiveness and efficiency, it is correct to say that Wayfarer’s investment department is:

A. both effective and efficient
B. efficient, but not effective
C. effective, but not efficient
D. neither effective nor efficient

Answer: B

NEW QUESTION 165
- (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 168
- (Topic 2)
In the following paragraph, a sentence contains two pairs of words enclosed in parentheses. Determine which word in each pair correctly completes the sentence. Then select the answer choice containing the two words that you have selected.
Budgeting approaches can be classified as static or flexible budgets, or as rolling or period budgets. A health plan most likely would use a (static / flexible) budget when a budget's objective is to reduce or limit expenses, and the health plan most likely would use a (rolling / period) budget if it would like to continually maintain projections for a certain time period into the future.

A. static / rolling
B. static / period
C. flexible / rolling
D. flexible / period

Answer: A

NEW QUESTION 172
- (Topic 2)
The Arista Health Plan is evaluating the following four groups that have applied for group
healthcare coverage:
? The Blaise Company, a large private employer
? The Colton County Department of Human Services (DHS)
? A multiple-employer group comprised of four companies
? The Professional Society of Daycare Providers
With respect to the relative degree of risk to Arista represented by these four companies, the company that would most likely expose Arista to the lowest risk is the:

A. Blaise Company
B. Colton County DHS
C. Multiple-employer group
D. Professional Society of Daycare Providers

Answer: A

NEW QUESTION 177
- (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 178
- (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 183
- (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 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 189
- (Topic 2)
Dr. Jacob Winburne is compensated by the Honor Health Plan under an arrangement in which Honor establishes at the beginning of a financial period a fund from which claims approved for payment are paid. At the end of the given period, any funds remaining are paid out to providers. This information indicates that the arrangement between Dr. Winburne and Honor includes a provider incentive known as a:

A. Risk pool, and any deficit in the fund at the end of the period would be the sole responsibility of Honor
B. Risk pool, and any deficit in the fund at the end of the period would be paid by both D
C. Winburne and Honor according to percentages agreed upon at the beginning of the contract period
D. Withhold, and any deficit in the fund at the end of the period would be the sole responsibility of Honor
E. Withhold, and any deficit in the fund at the end of the period would be paid by both D
F. Winburne and Honor according to percentages agreed upon at the beginning of the contract period

Answer: A

NEW QUESTION 191
- (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 196
- (Topic 2)
The Raven Health Plan is domiciled in a state that requires the health plan to offer small employers and their employees a comprehensive healthcare benefit plan that approximates the healthcare benefits available to large employer-employee groups. This type of uniform benefit plan is known as:

A. A basic plan
B. A low-option plan
C. A standard plan
D. An essential plan

Answer: C

NEW QUESTION 201
- (Topic 2)
The following information was presented on one of the financial statements prepared by the Rouge Health Plan as of December 31, 1998:

Assets		
Current assets	$	950,000
Other assets		100,000
Total Assets	$	1,050,000
Liabilities		
Current liabilities	$	800,000
Other liabilities		100,000
Total Liabilities	$	900,000
Stockholders' Equity		
Common stock	$	50,000
Additional paid-in capital		100,000
Total Liabilities and Stockholders' Equity	$	1,050,000

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 204
- (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 206
- (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 210
- (Topic 2)

A financial analyst wants to learn the following information about the Forest health plan for a given financial period:

A. Forest's beginning-of-period cash balance
B. Forest's minimum cash balance
C. The cash needs of Forest during the period
D. Forest's end-of-period cash balanceFrom Forest's cash budget, the analyst most likely can obtain information about
E. A, B, C, and D
F. A, B, and C only
G. A and D only
H. B and C only

Answer: A

NEW QUESTION 214
- (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 219
- (Topic 2)
An investor deposited $1,000 in an interest-bearing account today. That sum will accumulate to $1,200 two years from now. One true statement about this transaction is that:

A. The process by which the original $1,000 deposit grows to $1,200 is known as compounding
B. $1,200 is the present value of the $1,000 deposit
C. The $200 increase in the deposit’s value is its incremental cash flow
D. The $200 difference between the original deposit and the accumulated value of the deposit is known as the deposit’s discount

Answer: A

NEW QUESTION 222
- (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 223
- (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 224
- (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 228
- (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 231
- (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 234
- (Topic 2)
The following transactions occurred at the Lane Health Plan:
? Transaction 1 — Lane recorded a $25,000 premium prior to receiving the payment
? Transaction 2 — Lane purchased $500 in office expenses on account, but did not record the expense until it received the bill a month later
? Transaction 3 — Fire destroyed one of Lane’s facilities; Lane waited until the facility was rebuilt before assessing and recording the amount of loss
? Transaction 4 — Lane sold an investment on which it realized a $14,000 gain; Lane recorded the gain only after the sale was completed.
Of these transactions, the one that is consistent with the accounting principle of conservatism is:

A. Transaction 1
B. Transaction 2
C. Transaction 3
D. Transaction 4

Answer: D

NEW QUESTION 238
- (Topic 2)
If the operational budget prepared by the Satilla health plan is typical of most operational budgets, then

A. Its purpose is to track Satilla's operations and short-term profitability
B. The key information source for this operational budget is Satilla's external environment
C. The time frame for this operational budget is three to five years
D. Its focus is on the threats that Satilla faces from its external environment

Answer: A

NEW QUESTION 241
- (Topic 2)
The Chamber Health Plan reimburses primary care physicians on a monthly basis by using a simple capitation method. Chamber assumes an annual utilization rate of three visits per year. The FFS rate per office visit is $75, and all plan members are required to make a $10 copayment for each office visit. This information indicates that the capitation rate that Chamber calculates per member per month (PMPM) is equal to:

A. $6.25
B. $16.25
C. $18.75
D. $21.25

Answer: B

NEW QUESTION 243
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