AHIP

Exam Questions AHM-520

Health Plan Finance and Risk Management

NEW QUESTION 1
- (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 2
- (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 3
- (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 4
- (Topic 1)
Federal law addresses the relationship between Medicare- or Medicaidcontracting health plans and providers who are at "substantial financial risk."
Under federal law, Medicare- or Medicaid-contracting health plans

A. Place a provider at "substantial risk" whenever incentive arrangements put the provider at risk for amounts in excess of 10% of his or her total potential reimbursement for providing services to Medicare and Medicaid enrollees
B. Must provide stop-loss coverage to a provider who is placed at "substantial financial risk" for services that the provider does not directly provide to Medicare or Medicaid enrollees
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: C

NEW QUESTION 5
- (Topic 1)
The following statements are about the financial risks for health plans in Medicare and Medicaid markets. Three of these statements are true, and one statement is false. Select the answer choice containing the FALSE statement.

A. One reason that health plans in the Medicare and Medicaid markets experience financial risk is that government regulations determine which services must be provided to Medicare and Medicaid enrollees.
B. Effective use of hospital utilization is the single most likely factor to contribute to the success of a Medicare-contracting health plan.
C. If a Medicare-contracting health plan is a provider-sponsored organization (PSO), it is prohibited from sharing financial risk with its providers.
D. Typically, providers are more reluctant to accept financial risk in connection with providing services to the Medicare population.

Answer: C

NEW QUESTION 6
- (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 7
- (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 8
- (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 9
- (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 10
- (Topic 1)
The following statements illustrate common forms of capitation:
* 1. The Antler Health Plan pays the Epsilon Group, an integrated delivery system (IDS), a capitated amount to provide substantially all of the inpatient and outpatient services that Antler offers. Under this arrangement, Epsilon accepts much of the risk that utilization rates will 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 10
- (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 15
- (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 16
- (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 21
- (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 23
- (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 28
- (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 29
- (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 33

- (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 34
- (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 39
- (Topic 1)
Rasheed Azari, the risk manager for the Tower health plan, is attempting to work with providers in the organization in order to reduce the providers' exposure related to utilization review. Mr. Azari is considering advising the providers to take the following actions:
? 1-Allow Tower's utilization management decisions to override a physician's independent medical judgment
? 2-Support the development of a system that can quickly render a second opinion
in case of disagreement surrounding clinical judgment
? 3-Inform a patient of any issues that are being disputed relative to a physician's recommended treatment plan and Tower's coverage decision
Of these possible actions, the ones that are likely to reduce physicians' exposures related to utilization review include actions

A. 1, 2, and 3
B. 1 and 2 only
C. 1 and 3 only
D. 2 and 3 only

Answer: D

NEW QUESTION 44
- (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 47
- (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 51
- (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 56
- (Topic 1)
The NAIC has developed a risk-based capital (RBC) formula for all health plans that accept risk. One true statement about the RBC formula for health plans is that it

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

Answer: A

NEW QUESTION 60
- (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 63
- (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 68
- (Topic 2)
The Titanium health plan's product has a unit price of $120 PMPM and a unit variable cost of $80 PMPM. Titanium has $100,000 in fixed costs per month. This information indicates that, for its product, Titanium's

A. Unit contribution margin is $80
B. Unit contribution margin is $200
C. Break-even point is 500 members
D. Break-even point is 2,500 members

Answer: D

NEW QUESTION 70
- (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 73
- (Topic 2)
Contingency risks, or C-risks, are general categories of risk that have a direct bearing on both the cash flow and solvency of a health plan. One of these C-risks, pricing risk (C-2 risk), is typically the most important risk a health plan faces. Pricing risk is crucial to a health plan’s solvency because:

A. A sizable portion of any health plan’s assets are held in long-term investments and anyshift in interest rates can significantly impact a health plan’s ability to pay medical benefits
B. A health plan relies heavily on the sound judgment of its management, and poor management decisions can result in financial losses for the health plan
C. A situation in which actual expenses exceed the amounts budgeted for those expenses may result in the health plan failing to retain assets sufficient to cover current obligations
D. A sizable portion of the total expenses and liabilities faced by a health plan come from contractual obligations to pay future medical costs, and the exact amounts of those costs are not known at the time a product’s premium is established

Answer: D

NEW QUESTION 74
- (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 75
- (Topic 2)
Geena Falk is eligible for both Medicare and Medicaid coverage. If Ms. Falk incurs a covered expense, then:

A. Medicaid will be M
B. Falk’s primary insurer
C. Medicare will be M
D. Falk’s primary insurer
E. Either Medicare or Medicaid will be M
F. Falk’s primary insurer depending on her election
G. Medicare and Medicaid will each be responsible for one-half of M
H. Falk’s covered expense

Answer: B

NEW QUESTION 77
- (Topic 2)
The types of financial risks and costs to which a health plan is subject depends on whether the health plan provides services to the Medicare and/or Medicaid populations or to the commercial population. One distinction between providing services to the Medicare and Medicaid populations and to the commercial population is that Medicare and Medicaid enrollees typically:

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

Answer: C

NEW QUESTION 79
- (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 80
- (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 82
- (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 87
- (Topic 2)
Health plans have access to a variety of funding sources depending on whether they are operated as for-profit or not-for-profit organizations. The Verde Health Plan is a for-profit health plan and the Noir Health Plan is a not-for-profit health plan. From the answer choices below, select the response that correctly identifies whether funds from debt markets and equity markets are available to Verde and Noir:

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

Answer: B

NEW QUESTION 92
- (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 93
- (Topic 2)
One way that the Medicare and Medicaid programs differ is that under Medicare, a smaller proportion of provider reimbursement goes to the primary care providers and a greater proportion of the reimbursement goes to hospitals and specialists.

A. True
B. False

Answer: A

NEW QUESTION 94
- (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 95
- (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 99
- (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 104
- (Topic 2)
The following statement(s) can correctly be made about a health plan's cash receipts and cash disbursements budgets:

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

Answer: B

NEW QUESTION 108
- (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 111
- (Topic 2)
The amount of risk for health plan products is dependent on the degree of influence and the relationships that the health plan maintains with its providers. Consider the following types of managed care structures:
? Preferred provider organization (PPO)
? Group model HMO
? Staff model health maintenance organization (HMO)
? Traditional health insurance
Of these health plan products, the one that would most likely expose a health plan to the highest risk is the:

A. preferred provider organization (PPO)
B. group model HMO
C. staff model health maintenance organization (HMO)
D. traditional health insurance

Answer: C

NEW QUESTION 115
- (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 117
- (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 118
- (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 122
- (Topic 2)
Julio Benini is eligible to receive healthcare coverage through a health plan that is under contract to his employer. Mr. Benini is seeking coverage for the following individuals:
? Elena Benini, his wife
? Maria Benini, his 18-year-old unmarried daughter
? Johann Benini, his 80-year-old father who relies on Julio for support and maintenance
The health plan most likely would consider that the definition of a dependent, for purposes of healthcare coverage, applies to:

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

Answer: B

NEW QUESTION 125
- (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 127
- (Topic 2)
In order to show the efficiency of a health plan's managers in using the health plan's investments to earn a return for stockholders, a financial analyst most likely would use a type of profitability ratio known as

A. A net gain-to-total income ratio
B. An insurance leverage ratio
C. A statutory return on assets (ROA) ratio
D. A gross profit ratio

Answer: C

NEW QUESTION 132
- (Topic 2)
Health plans with risk-based Medicare contracts are required to calculate and submit to CMS a Medicare adjusted community rate (Medicare ACR). Medicare ACR can be defined as the:

A. Estimated cost of providing services to a beneficiary under Medicare FFS, adjusted for factors such as age and gender
B. Health plan’s estimate of the premium it would charge Medicare enrollees in the absence of Medicare payments to the health plan
C. Average amount the health plan expects to receive from CMS per beneficiary covered

D. Health plan’s actual costs of providing benefits to Medicare enrollees in a given year

Answer: B

NEW QUESTION 134
- (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 136
- (Topic 2)
Costs that can be defined by behavior are most commonly classified as fixed costs, variable costs and semi-variable costs. Examples of fixed costs include:

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

Answer: A

NEW QUESTION 137
- (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 142
- (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 144
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