AHIP

Exam AHM-520

Health Plan Finance and Risk Management

Version: 4.0

[Total Questions: 215]

Topic break down

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Topic 1, Volume A

Question No : 1 - (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

Question No : 2 - (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

Question No : 3 - (Topic 1)

One true statement about the rate ratios used by a health plan is that the

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

Answer: A

Question No : 4 - (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

Question No : 5 - (Topic 1)

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

The maximum amount for which Newfeld is at risk for any one Azalea plan member's treatment costs is

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

Answer: C

Question No : 6 - (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

Question No : 7 - (Topic 1)

The Acorn Health Plan uses a resource-based relative value scale (RBRVS) to help determine the reimbursement amounts that Acorn should make to providers who are compensated under an FFS system. With regard to the advantages and disadvantages to Acorn of using RBRVS, it can correctly be stated that

A. An advantage of using RBRVS is that it can assist Acorn in developing reimbursement schedules for various types of providers in a comprehensive healthcare plan
B. An advantage of using RBRVS is that it puts providers who render more medical

services than necessary at financial risk for this overutilization
C. A disadvantage of using RBRVS is that it will be difficult for Acorn to track treatment rates for the health plan's quality and cost management functions
D. A disadvantage of using RBRVS is that it rewards procedural healthcare services more than cognitive healthcare services

Answer: A

Question No : 8 - (Topic 1)

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

- Statement A—Trout will deliver quality healthcare to our customers at a reasonable cost.
- Statement B—Within five years, Trout will be recognized as the industry leader in all of our markets.

Statement A can best be described as a

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

Answer: C

Question No : 9 - (Topic 1)

Users of the Fulcrum Health Plan financial information include:

- The independent auditors who review Fulcrum's financial statements
- Fulcrum's controller (comptroller)
- Fulcrum's plan members
- The providers that deliver healthcare services to Fulcrum plan members
- Fulcrum's competitors

Of these users, the ones that most likely can correctly be classified as external users with a direct financial interest in Fulcrum are the

A. Independent auditors, the plan members, the providers, and the

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

Answer: D

Question No : 10 - (Topic 1)

The Zane health plan uses a base of accounting known as accrual-basis accounting. With regard to this base of accounting, it can correctly be stated that accrual-basis accounting

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

Answer: C

Question No : 11 - (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

Question No : 12 - (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

Question No : 13 - (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

Question No : 14 - (Topic 1)

Most organizations that obtain group healthcare coverage can be classified as one of three

types of groups: employer-employee groups, multiple employer groups, and professional associations. One true statement about these types of groups is that

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

Answer: A

Question No : 15 - (Topic 1)

When pricing its product, the Panda Health Plan assumes a 4% interest rate on its investments. Panda also assumes a crediting interest rate of 4%.

The actual interest rate earned by Panda on the assets supporting its product is 6%. The following statements can correctly be made about the investment margin and interest margin for Panda's products.

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

Answer: C

Question No : 16 - (Topic 1)

Provider reimbursement methods that transfer some utilization risk from a health plan to providers affect the health plan's RBC formula. A health plan's use of these reimbursement methods is likely to result in

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

Answer: C

Question No : 17 - (Topic 1)

Because a health plan cannot decline coverage for individuals who are eligible for conversion of group health coverage to individual health coverage, the bulk of the health plan's underwriting for conversion policies is accomplished through health plan design.

A. True
B. False

Answer: A

Question No : 18 - (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