AHIP

Exam Questions AHM-520

Health Plan Finance and Risk Management

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NEW QUESTION 1
- (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 2
- (Topic 1)
Three general strategies that health plans use for controlling types of risk are risk avoidance, risk transfer, and risk acceptance. The following statements are about these strategies. Three of these statements are true, and one statement is false. Select the answer choice containing the FALSE statement.

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

Answer: B

NEW QUESTION 3
- (Topic 1)
The Harp Company self-funds the health plan for its employees. The plan is administered under a typical administrative-services-only (ASO) arrangement. One true statement about this ASO arrangement is that

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

Answer: B

NEW QUESTION 4
- (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 Medicaid population than with providing services to the Medicare population.

Answer: C

NEW QUESTION 5
- (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 6
- (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 7
- (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 8
- (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 9
- (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 10
- (Topic 1)
Provider reimbursement methods that transfer some utilization risk from a health plan to providers affect the health plan's RBC formula. A health plan's use of these reimbursement methods is likely to result in

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

Answer: C

NEW QUESTION 10
- (Topic 1)
Over time, health plans and their underwriters have gathered increasingly reliable information about the morbidity experience of small groups.
Generally, in comparison to large groups, small groups tend to

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

Answer: A

NEW QUESTION 15
- (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 20
- (Topic 1)
As part of the first step in its strategic planning process, the Trout health plan developed the following statements:
? Statement A—Trout will deliver quality healthcare to our customers at a reasonable cost.
? Statement B—Within five years, Trout will be recognized as the industry leader in
all of our markets.
Statement A can best be described as a

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

Answer: C

NEW QUESTION 23
- (Topic 1)
One law prohibits Dr. Laura Cole from making a referral to another provider entity for designated health services if Dr. Cole or one of her immediate family members has a financial relationship with the entity. This law is known as the

A. safe harbor law
B. upper payment limit law
C. anti-kickback law
D. physician self-referral law

Answer: D

NEW QUESTION 24
- (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 27
- (Topic 1)
The Eclipse Health Plan is a not-for-profit health plan that qualifies under the Internal Revenue Code for tax-exempt status. This information indicates that Eclipse

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

Answer: B

NEW QUESTION 31
- (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 34
- (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 39
- (Topic 1)
The reimbursement arrangement that Dr. Caroline Monroe has with the Exmoor Health Plan includes a typical withhold arrangement. One true statement about this withhold arrangement is that, for a given financial period,

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

Answer: B

NEW QUESTION 42
- (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 46
- (Topic 1)
The following statements are about carve-out programs. Three of these statements are true, and one statement is false. Select the answer choice containing the FALSE statement.

A. In the type of carve-out in which entire categories of care are administered by independent organizations, a health plan typically reimburses these organizations under an FFS contract.
B. Typically, a health plan will offer carved-out services to its enrollees, but will manage these services separately.
C. Carve-outs are services that are excluded from a capitation payment, a risk pool, or a health benefit plan.
D. The most rapidly growing area related to carve-outs is disease management (DM).

Answer: A

NEW QUESTION 48
- (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 50
- (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 55
- (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 58
- (Topic 2)
In a comparison of small employer-employee groups to large employer-employee groups, it is correct to say that small employer-employee groups tend to:

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

Answer: B

NEW QUESTION 60
- (Topic 2)
The traditional financial ratios that analysts use to study a health plan's GAAP-based financial statements include liquidity ratios, activity ratios, leverage ratios, and profitability ratios. Of these categories of ratios, analysts are most likely to use

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

Answer: A

NEW QUESTION 61
- (Topic 2)
The Longview Hospital contracted with the Carlyle Health Plan to provide inpatient services to Carlyle's enrolled members. Carlyle provides Longview with a type of stop-loss coverage that protects, on a claims incurred and paid basis, against losses arising from significantly higher than anticipated utilization rates among Carlyle's covered population. The stop-loss coverage specifies an attachment point of 130% of Longview's projected $2,000,000 costs of treating Carlyle plan members and requires Longview to pay 15% of any costs above the attachment point. In a given plan year, Longview incurred covered costs totaling $3,000,000. With regard to the type of stop-loss coverage provided to Longview by Carlyle and to whether this coverage is classified as insurance or reinsurance, the risk transfer approach used in this situation can be described as:

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

Answer: C

NEW QUESTION 64
- (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 68
- (Topic 2)
The Swann Health Plan excludes mental health coverage from its basic health benefit plan. Coverage for mental health is provided by a specialty health plan called a managed behavioral health organization (MBHO). This arrangement recognizes the fact that distinct administrative and clinical expertise is required to effectively manage mental health services. This information indicates that Swann manages mental health services through the use of a:

A. Formulary

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

Answer: C

NEW QUESTION 70
- (Topic 2)
One difference between the internal and external analysis of a health plan's financial information is that

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

Answer: A

NEW QUESTION 75
- (Topic 2)
The Coral Health Plan, a for-profit health plan, has two sources of capital:
Debt and equity. With regard to these sources of capital, it can correctly be stated that

A. Coral's equity holders have an ownership interest in the health plan
B. The interest that Coral pays on its debt most likely is not tax deductible to Coral
C. Coral's debt holders have no legal claim to Coral's assets
D. Equity is a more risky source of capital, from Coral's perspective, than is debt

Answer: A

NEW QUESTION 78
- (Topic 2)
The Jade Health Plan used a profitability index (PI) to rank the following capital proposals:
ProposalPI
A0.45
B1.05
This information indicates that, of these two projects, Jade would most likely select:

A. Proposal A, and the PI indicates that the net present value (NPV) for this project is less than zero
B. Proposal A, and the PI indicates that the net present value (NPV) for this project is greater than zero
C. Proposal B, and the PI indicates that the net present value (NPV) for this project is less than zero
D. Proposal B, and the PI indicates that the net present value (NPV) for this project is greater than zero

Answer: C

NEW QUESTION 82
- (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 86
- (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 91
- (Topic 2)
The Fairway health plan is a for-profit health plan that issues stock. The following data was taken from Fairway's financial statements:
? Current assets.....$5,000,000

? Total assets.....6,000,000
? Current liabilities.....2,500,000
? Total liabilities.....3,600,000
? Stockholders' equity.....2,400,000
Fairway's total revenues for the previous financial period were $7,200,000, and its net income for that period was $180,000.
For the previous financial period, Fairway's net profit margin was

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

Answer: A

NEW QUESTION 96
- (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 97
- (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 102
- (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 106
- (Topic 2)
Doctors' Care is an individual practice association (IPA) under contract to the Jasper Health Plan to provide primary and secondary care to Jasper's members. Jasper's capitation payments compensate Doctors' Care for all physician services and associated diagnostic tests and laboratory work. The physicians at Doctors' Care, as a group, determine how individual physicians in the group will be remunerated. The type of capitation used by Jasper to compensate Doctors' Care is known as:

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

Answer: C

NEW QUESTION 110
- (Topic 2)
The following examples describe situations that expose an individual or a health plan to either pure risk or speculative risk:

Example 1 — A health plan invested in 1,000 shares of stock issued by a technology company.
Example 2 — An individual could contract a terminal illness.
Example 3 — A health plan purchased a new information system.
Example 4 — A health plan could be held liable for the negligent acts of an employee.
The examples that describe pure risk are

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

Answer: A

NEW QUESTION 111
- (Topic 2)
Advantages to a company that elects to self-fund and to administer all aspects of its healthcare benefit plan include:

A. Eliminating state premium taxes
B. Avoiding state-mandated benefit requirements
C. Improving its cash flow position
D. All of the above

Answer: D

NEW QUESTION 115
- (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 118
- (Topic 2)
One typical characteristic of zero-based budgeting (ZBB) is that this budgeting approach

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

Answer: A

NEW QUESTION 123
- (Topic 2)
The HMO Model Act sets certain requirements that an entity that wishes to operate as an HMO must meet. These requirements include:

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

Answer: D

NEW QUESTION 124
- (Topic 2)
For a given healthcare product, the Magnolia Health Plan has a premium of $80 PMPM and a unit variable cost of $30 PMPM. Fixed costs for this product are $30,000 per month. Magnolia can correctly calculate the break-even point for this product to be:

A. 274 members
B. 375 members
C. 600 members
D. 1,000 members

Answer: C

NEW QUESTION 127
- (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 128
- (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 132
- (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 133
- (Topic 2)
The Proform Health Plan uses agents to market its small group business. Proform capitalizes the commission expense relating to this line of business by spreading the commissions over thepremium-paying period of the healthcare coverage. This approach to expense recognition is known as:

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

Answer: D

NEW QUESTION 136
- (Topic 2)
The Essential Health Plan markets a product for which it assumed total expenses to equal 92% of premiums. Actual data relating to this product indicate that expenses equal 89% of premiums. This information indicates that the expense margin for this product has:

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

Answer: A

NEW QUESTION 141
- (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 146
- (Topic 2)
One true statement about variance analysis is that

A. A price variance is the difference between the budgeted quantities to be sold and theactual quantities sold, multiplied by the budgeted amount
B. Variance analysis suggests solutions to a particular problem
C. Positive variances generally are favorable, from a health plan's point of view, for the plan's expenses but unfavorable for the plan's revenues
D. An effective variance system typically focuses on matters that require management's attention

Answer: D

NEW QUESTION 151
- (Topic 2)
The following statements are about the option for health plan funding known as a self- funded plan. Select the answer choice containing the correct response:

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

Answer: D

NEW QUESTION 156
- (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 160
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