

DUMPS ARENA

Health Plan Finance and Risk Management

AHIP AHM-520

Version Demo

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Topic Break Down

Topic	No. of Questions
Topic 1, Volume A	99
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QUESTION NO: 1

The following statement(s) can correctly be made about a health plan's underwriting of small groups:

A. Typically, a health plan medically underwrites both the employees of a small group and their dependents, even though small group reform laws prohibit health plans from singling out individuals for rejection or substandard rate-ups.

Both A and B

B. In the absence of laws mandating otherwise, a health plan's underwriting standards grow stricter as group size gets smaller.

A only

C. B only

D. Neither A nor B

ANSWER: A**QUESTION NO: 2**

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: 3**

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

QUESTION NO: 4

The following statements are about federal laws and regulations which affect health plans that offer products and services to the employer group market. Select the answer choice containing the correct statement.

- A. Amendments to the HMO Act of 1973 require federally qualified HMOs to adjust a group's prior premiums on the basis of the group's experience during the prior rating period.
- B. The Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986 requires that, if a plan sponsor elects to terminate its group coverage with a health plan, then the health plan must continue its coverage for the COBRA-qualified beneficiaries in the group.
- C. The Health Insurance Portability and Accountability Act (HIPAA) of 1996 generally requires the guaranteed renewal of healthcare coverage for certain individuals and for both small and large groups, regardless of the health status of any member.
- D. The Mental Health Parity Act (MHPA) of 1996 mandates that all health plans must offer benefits for mental healthcare.

ANSWER: C

QUESTION NO: 5

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

QUESTION NO: 6

A health plan most likely would use benchmarking in order to

- A. Measure its performance and practices against those of other companies to help identify those practices that will lead to superior performance in a variety of financial and non-financial areas
- B. Calculate the percentage changes in its financial statement items over several consecutive accounting periods
- C. Determine both the direction and velocity of trends in its financial statements
- D. Display only percentage relationships in its financial statements

ANSWER: A

QUESTION NO: 7

In evaluating the claims experience during a given rating period of the Lucky Company, the Calaway Health Plan determined that the claims incurred by Lucky were lower than Calaway anticipated when it established Lucky's premium rate for the rating period. Calaway, therefore, refunded a portion of Lucky's premium to reflect the better-than-anticipated claims experience. This rating method is known as:

- A. durational rating
- B. retrospective experience rating
- C. blended rating
- D. prospective experience rating

ANSWER: B

QUESTION NO: 8

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

QUESTION NO: 9

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

QUESTION NO: 10

In order to calculate a simple monthly capitation payment, the Argyle Health Plan used the following information:

- The average number of office visits each member makes in a year is two
- The FFS rate per office visit is \$55
- The member copayment is \$5 per office visit
- The reimbursement period is one month

Given this information, Argyle would correctly calculate that the per member per month (PMPM) capitation rate should be

- A.** \$4.17
- B.** \$8.33
- C.** \$9.17
- D.** \$10.00

ANSWER: B

QUESTION NO: 11

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

- A.** True
- B.** False

ANSWER: A

QUESTION NO: 12

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

QUESTION NO: 13

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

QUESTION NO: 14

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

QUESTION NO: 15

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