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Health Plan Finance and Risk Management

AHIP AHM-520

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Topic Break Down

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QUESTION NO: 1

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

QUESTION NO: 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

QUESTION NO: 3

Variance analysis is the study of the difference between expected results and actual results. Variances can be positive or negative. A positive variance is typically considered:

A. favorable for both expenses and revenues

B. favorable for expenses, but unfavorable for revenues

C. favorable for revenues, but unfavorable for expenses

D. unfavorable for both expenses and revenues

ANSWER: C

QUESTION NO: 4

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.

Both A and B

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.

A only

C. B only

D. Neither A nor B

ANSWER: B

QUESTION NO: 5

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

QUESTION NO: 6

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 provider may 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

QUESTION NO: 7

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

A. Causes Dr. Meyer's capitation contract with Cardigan to transfer more risk to him than the contract otherwise would transfer

Both A and B

B. Specifies that Cardigan will pay Dr. Meyer under an arrangement other than capitation until a specified number of children covered by the plan use him as their PCP

A only

C. B only

D. Neither A nor B

ANSWER: C

QUESTION NO: 8

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

QUESTION NO: 9

The following statements are about various reimbursement arrangements that health plans have with hospitals. Select the answer choice containing the correct statement.

A. A sliding scale per-diem charges arrangement differs from a sliding scale discount on charges arrangement in that only a sliding scale per-diem charges arrangement is based on total volume of admissions and outpatient procedures.

B. Under a typical reimbursement arrangement that is based on diagnosis related groups (DRGs), if the payment amount is fixed on the basis of diagnosis, then any reduction in costs resulting from a reduction in days will go to the health plan rather than to the hospital.

C. A negotiated straight per-diem charge requires payment of a single charge for a day in the hospital, regardless of any actual charges or costs incurred during the hospital stay.

D. A straight discount on charges arrangement is the most common reimbursement method in markets with high levels of health plans.

ANSWER: C

QUESTION NO: 10

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

QUESTION NO: 11

Many clinicians are concerned about the development of practice guidelines that seek to define appropriate healthcare services that should be provided to a patient who has been diagnosed with a specific condition. To avoid the risk associated with using such guidelines, health plans should advise clinicians that the existence of such a guideline:

1. Establishes standards of care to be routinely utilized with all patients presenting a specific condition

2. Preempts a physician’s judgment when assessing the specific factors related to a patient’s condition

A. Both 1 and 2

B. 1 only

C. 2 only

D. Neither 1 nor 2

ANSWER: D

QUESTION NO: 12

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

QUESTION NO: 13

In order to analyze costs for internal management purposes, the Banner health plan uses functional cost analysis. One characteristic of this method of cost analysis is that it

A. Enables Banner's top management to analyze costs as they apply to workflow rather than to organizational structures

B. Assumes that activities, not products, generate costs

C. Cannot be used when Banner makes pricing and staffing decisions

D. Identifies units of activity, calculates the costs of performing each unit of activity, and then assigns the cost of each unit of activity to Banner's products or lines of business

ANSWER: A

QUESTION NO: 14

A cost for which a benefit is forfeited in choosing one decision alternative over another alternative is known as

A. A marginal unit cost

B. An opportunity cost

C. An incremental cost

D. A differential cost

ANSWER: B

QUESTION NO: 15

With regard to the major risk factors associated with group underwriting, it can correctly be stated that, typically,

A. The age and gender of group plan members are not predictors of utilization of health services by group members

B. A health plan's product design or delivery system has an impact on member selection of the health plan, unless the members are in an environment in which employees have at least two benefit options or health plans from which to choose

C. A health plan should track demographic factors of groups only if the plan specifically adjusts for demographic factors on a group basis

D. A large group is more likely to exhibit a consistent claims pattern, level of healthcare cost, or utilization of services than is a small group

ANSWER: D