PassQueen
a.k.a dumpsqueen.com

Health Plan Finance and Risk Management

AHIP AHM-520

Version Demo

Total Demo Questions: 26

Total Premium Questions: 262

Buy Premium PDF

https://passqueen.com

support@passqueen.com

Topic Break Down

Topic	No. of Questions
Topic 1, Volume A	104
Topic 2, Volume B	138
Total	262

QUESTION NO: 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 income tax on its earnings, provided it continues to meet applicable tax-exempt requirements

C. Must distribute its earnings to its owners-investors for their personal gain

D. Is a privately held corporation

ANSWER: B

Explanation:

“Does not pay federal income tax on its earnings, provided it continues to meet applicable tax-exempt requirements” is correct because qualification for tax-exempt status under the Internal Revenue Code generally means that an organization is exempt from federal income tax on income related to its exempt purpose. A not-for-profit health plan does not operate to create distributions for private owners or investors; instead, it generally retains and uses revenue in support of its organizational mission, reserves, operations, and member services. Tax-exempt status is not unconditional or permanent: the plan must continue to satisfy the organizational and operational requirements applicable to its exemption and comply with federal filing and reporting obligations. It also may be subject to tax on unrelated business taxable income when it conducts activities that do not substantially further its exempt purpose. In addition, state and local tax treatment is governed by separate laws, so federal recognition alone does not establish exemption from every state or local tax. The IRS describes the federal tax-exempt framework and compliance expectations for charitable organizations at IRS: Charitable Organizations and explains unrelated business income tax at IRS: Unrelated Business Income Tax.

QUESTION NO: 2

With regard to the financial statements prepared by health plans, it can correctly be stated that

A. both for-profit, publicly owned health plans and not-for-profit health plans are required by law to provide all interested parties with an annual report

B. a health plan's annual report typically includes an independent auditor's report and notes to the financial statements

C. any health plan that owns more than 20% of the stock of a subsidiary company must compile the financial statements for the health plan's annual report on a consolidated basis

D. a health plan typically must prepare the financial statements included in its annual report according to SAP

ANSWER: B

Explanation:

A health plan's annual report typically includes an independent auditor's report and notes to the financial statements. The independent auditor's report communicates the auditor's opinion on whether the financial statements are presented fairly, in all material respects, under the applicable financial reporting framework. This external assurance is important to investors, regulators, creditors, employers, members, and other users because it increases confidence in the reported financial position and operating results. Notes to the financial statements are also an integral part of a complete set of financial statements. They provide essential detail about the accounting policies used and disclose material matters that cannot be understood fully from the primary statements alone, such as benefit obligations, investments, reserves, contingencies, related-party matters, and subsequent events. For publicly held entities, annual filings commonly contain audited financial statements and accompanying notes; the SEC specifically describes financial-statement notes as part of the information required in filings. Health-plan annual reports therefore ordinarily pair the core statements with both the independent auditor’s report and explanatory disclosures in the notes. See the SEC’s Exchange Act reporting overview and the AICPA’s audit and assurance resources.

QUESTION NO: 3

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

Explanation:

The process by which the original $1,000 deposit grows to $1,200 is known as compounding. Compounding describes the accumulation of an investment's value over time as interest is credited to the account and becomes part of the amount on which future interest can be earned. In time-value-of-money terms, the $1,000 deposited today is the present value, while the $1,200 available two years later is the future, or accumulated, value. The $200 increase reflects the return earned during the two-year accumulation period. This example does not need to specify whether interest is credited annually, monthly, or under another schedule to establish that compounding is the relevant accumulation concept: money invested at an earlier date has grown to a larger stated value at a later date. Understanding this relationship is fundamental to health plan finance because financial analysts use present values, future values, interest rates, and time periods to evaluate investments, reserves, and other cash-flow obligations. For an accessible explanation of compound interest and how earned interest can itself earn interest, see the U.S. Securities and Exchange Commission's Investor.gov compound-interest overview. A related discussion of present and future value is available from the CFA Institute.

QUESTION NO: 4

Under the doctrine of corporate negligence, a health plan and its physician administrators may be held directly liable to patients or providers for failing to investigate adequately the competence of healthcare providers whom it employs or with whom it contracts, particularly where the health plan actually provides healthcare services or restricts the patient's/enrollee's choice of physician.

A. True

B. False

ANSWER: A

Explanation:

True is correct. Corporate negligence is a theory of direct organizational liability: the claim concerns the health plan's own failure to meet a duty of reasonable care, rather than liability that exists only because of a clinician's conduct. In the managed-care setting, that duty can include reasonable provider selection, credentialing, verification of qualifications, and continuing oversight when the organization employs clinicians, contracts with them to furnish covered care, or meaningfully controls an enrollee's access to physicians. The rationale is strongest when a plan delivers healthcare services itself or limits the enrollee's practical ability to select another provider. In those circumstances, the plan's credentialing and network-management decisions can materially affect patient safety. Physician administrators also may face direct exposure when their professional responsibilities include reviewing provider competence or maintaining appropriate credentialing processes and they fail to exercise reasonable care. Although the precise scope of corporate-negligence liability depends on state law and the facts of the organization's role, the stated principle accurately describes the doctrine's application to health plans. Credentialing is also a recognized patient-safety function in federal health-center guidance; see HRSA's Clinical Staffing guidance. For a legal overview of negligent credentialing concepts, see Cornell Law School's negligence reference.

QUESTION NO: 5

Federal law addresses the relationship between Medicare- or Medicaid contracting 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: B

Explanation:

“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” is correct because federal managed-care requirements protect providers from excessive exposure created by incentive arrangements. When a contracting provider accepts risk for referral or other covered services that the provider does not itself furnish, the health plan must ensure that stop-loss protection is available if the arrangement creates substantial financial risk. Stop-loss coverage limits the provider’s liability after costs or losses reach a defined threshold, helping prevent financial arrangements from creating inappropriate incentives to restrict medically necessary care.

For Medicare Advantage arrangements, the governing rule requires an organization to provide stop-loss protection for physicians who are placed at substantial financial risk for services they do not directly provide. The regulation also defines substantial financial risk using a threshold based on more than 25 percent of the physician’s potential payments, rather than the 10 percent amount stated in the question. Comparable Medicaid managed-care rules require safeguards for provider incentive arrangements that place providers at substantial financial risk. See 42 CFR § 422.208 and 42 CFR § 438.6.

QUESTION NO: 6

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

Explanation:

“Accent = unprofitable business
Bolton = low acquisition rate

” is correct because premium rates must be sufficient to cover expected medical claims, administrative expenses, required contributions to reserves, and other costs over the rating period. When a health plan consistently prices its product below an actuarially adequate level, the premiums collected will not support the plan’s claim and operating obligations. The predictable market effect is unprofitable business, particularly if enrollment grows among members whose expected costs exceed the inadequate premium.

Extremely strict underwriting of small groups narrows the population that can qualify for coverage and can make the enrollment process less attractive to employer groups and brokers. Even where strict selection may improve the anticipated risk profile of the groups accepted, it reduces the number of groups the plan is willing or able to enroll. Therefore, the likely market outcome is a low acquisition rate. Sound health-plan pricing and underwriting require balancing actuarial adequacy, competitiveness, enrollment objectives, and applicable market rules. The National Association of Insurance Commissioners describes actuarial standards and insurance-rate regulation at https://content.naic.org/insurance-topics/health-insurance. The Centers for Medicare & Medicaid Services also provides small-group market-rating information at https://www.cms.gov/cciio/programs-and-initiatives/health-insurance-market-reforms/state-rating.

QUESTION NO: 7

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

Explanation:

Transaction 4 is consistent with conservatism because Lane recognized the $14,000 investment gain only after the investment was sold and the gain was realized. Conservatism, often described in current accounting standards as prudence, calls for care in making judgments under uncertainty so that assets and income are not overstated. A gain on an investment is uncertain until the transaction establishing the gain has occurred; recording it after the completed sale provides objective evidence of both the amount and realization of the gain.

This treatment also aligns with the general recognition framework for gains: the event giving rise to the gain must be complete and the amount must be measurable. The sale of the investment establishes the proceeds and the difference between those proceeds and the investment’s carrying amount. Therefore, Lane has a supportable, realized gain to report at that point. The Financial Accounting Standards Board’s conceptual framework discusses prudence as a component of faithful representation and notes that it supports neutral reporting when uncertainty is present. See the FASB Conceptual Framework and the FASB Accounting Standards Codification overview.

QUESTION NO: 8

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

Explanation:

Accrual-basis accounting requires Zane to record revenues when they are earned and expenses when they are incurred, even if cash has not actually changed hands. This approach recognizes the economic effects of business activity in the accounting period in which those effects occur, rather than delaying recognition until a payment is received or made. For a health plan, this means premium revenue is recognized as it is earned during the coverage period, while claims costs and other obligations are recognized when the underlying services, events, or obligations create an incurred expense. Matching earned revenue with the expenses incurred to generate it produces financial statements that more meaningfully portray operating results and profitability for the relevant period. Accrual accounting also entails end-of-period adjusting entries, such as recording receivables, payables, accrued claims liabilities, and unearned revenue when applicable, so reported assets, liabilities, revenues, and expenses are complete. The Financial Accounting Standards Board describes accrual accounting as recognizing transactions and other events in the periods in which they occur, regardless of when related cash receipts or payments happen. See the FASB Accounting Standards Codification and the SEC overview of accounting basics.

QUESTION NO: 9

A health plan that capitates a provider group typically provides or offers to provide stop-loss coverage to that provider group.

A. True

B. False

ANSWER: A

Explanation:

True is correct. Under a capitation arrangement, the health plan pays the provider group a fixed, prospective amount—commonly expressed as a per-member, per-month payment—to provide or arrange covered services for an assigned population. The provider group therefore accepts financial risk: its actual costs may exceed the fixed capitation revenue when members experience unusually high-cost claims or utilization. Stop-loss coverage is typically provided or made available to limit this exposure, generally by reimbursing or protecting the provider group when costs for an individual member or for the group as a whole exceed a specified threshold. This risk protection makes delegated or capitated arrangements more financially manageable and helps preserve the provider group’s ability to continue delivering covered services despite catastrophic or unusually adverse experience. The arrangement reflects the core purpose of stop-loss protection in risk-bearing provider contracts: retaining appropriate incentives for efficient care management while placing an upper limit on potentially destabilizing losses. CMS describes capitation as a fixed payment made for each enrolled beneficiary, and federal managed-care rules address actuarial soundness and risk-bearing arrangements. See CMS Risk Adjustment and 42 CFR § 438.6.

QUESTION NO: 10

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

Explanation:

A preferred provider organization (PPO) is the correct answer because it is a managed health plan arrangement that generally accepts responsibility for financing covered healthcare benefits. The PPO establishes a network of participating providers through negotiated contracts and gives enrolled members financial incentives, such as lower cost sharing, to receive care from those providers. In the typical insured PPO model, the plan receives premiums and uses those funds to pay covered claims; therefore, its financial performance depends on whether premium revenue and other funding are sufficient to cover medical claims and administrative costs. This is the core insurance or underwriting risk associated with delivering and financing benefits. PPO network contracts, benefit design, utilization-management practices, and provider reimbursement arrangements help the organization manage that exposure while preserving members' ability to obtain out-of-network care, usually at a higher member cost. The Centers for Medicare & Medicaid Services describes PPO coverage as using a preferred network and allowing access to out-of-network providers, while the National Association of Insurance Commissioners identifies managed care as an insurance-related system for financing and delivering health services. See HealthCare.gov's PPO glossary definition and NAIC's managed care overview.

QUESTION NO: 11

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.

One true statement about this specific stop-loss coverage is that

A. The carrier is Newfeld

B. The attachment point is $20,000

C. The shared-risk corridor is between $0 and $70,000

D. This coverage can also be activated when the total covered medical expenses generated by the hospitalizations of Azalea plan members reach a specified level

ANSWER: B

Explanation:

The attachment point is $20,000. In a specific stop-loss arrangement, the attachment point is the predetermined dollar amount of expenses for one covered case that must be reached before stop-loss protection begins. Here, the contract expressly states that Azalea provides specific stop-loss coverage once Newfeld's treatment costs reach $20,000 per case. Therefore, $20,000 is the per-case threshold at which the arrangement attaches.

The additional contract terms describe how financial responsibility is allocated after that threshold. Newfeld remains responsible for 20% of the next $50,000 in expenses, creating a shared-risk corridor from $20,000 through $70,000. Once costs exceed $70,000, Azalea assumes responsibility for all subsequent treatment costs. Those later risk-sharing provisions do not alter the initial attachment point; they define the provider's coinsurance obligation and the point at which the plan bears the full marginal cost of further services. Specific stop-loss is distinguished by its application to an individual case or claimant, with the attachment point serving as the case-level trigger for protection. The NAIC describes stop-loss insurance as coverage that protects against losses exceeding specified attachment points; see NAIC's stop-loss insurance overview. For an overview of stop-loss terminology, including specific coverage and attachment points, see IRMI's definition of specific stop-loss.

QUESTION NO: 12

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

Explanation:

static / rolling is correct. A static budget establishes a fixed spending plan for a defined period and does not ordinarily change as activity levels change. For a health plan seeking to reduce or place limits on expenses, this fixed-budget approach provides a clear financial ceiling against which managers can monitor actual expenditures and exercise cost control. It therefore supports accountability for staying within planned administrative, medical-management, and other operating costs.

A rolling budget continually extends the planning horizon as each budget period passes. For example, when one month is completed, the health plan can add another future month to preserve a forward-looking projection for the same specified length of time. This enables management to update anticipated revenues, membership, utilization, medical costs, and operating expenses using the most current information while continuously retaining visibility into the future. The approach is particularly useful in health-plan operations because changing enrollment and healthcare utilization can materially affect financial forecasts.

These definitions align with standard managerial-accounting descriptions of fixed/static and rolling budgets. See the OpenStax discussion of budgeting fundamentals and the Corporate Finance Institute overview of rolling budgets.

QUESTION NO: 13

The Danner Bank loaned money to the CareWell Health Plan to fund an expansion of a healthcare facility. With respect to the type of financial information user Danner represents to CareWell, it is correct to say that Danner is an:

A. Internal user with a direct financial interest

B. Internal user with an indirect financial interest

C. External user with a direct financial interest

D. Case-mix adjustment

ANSWER: C

Explanation:

External user with a direct financial interest is correct. Danner Bank is outside CareWell Health Plan’s organizational structure, so it is an external user of CareWell’s financial information. Because the bank has lent funds to CareWell, it has a direct financial stake in CareWell’s financial condition, operating performance, liquidity, and ability to meet its debt obligations. The bank would use CareWell’s financial statements and related information to assess creditworthiness, monitor compliance with loan terms or covenants, and evaluate the likelihood that principal and interest will be repaid. This is a direct financial interest because the bank’s own financial outcome is tied to CareWell’s repayment performance under a specific lending relationship. Financial reporting frameworks recognize lenders and other creditors as key external users of general-purpose financial reports, since those reports help them make decisions about providing resources to an entity and

assessing its stewardship and prospects for future cash flows. See the FASB Conceptual Framework and the IASB Conceptual Framework for Financial Reporting.

QUESTION NO: 14

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 competitors

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: E

Explanation:

Plan members and the providers only is correct because both groups are outside the health plan and have a direct economic relationship with it. Plan members pay premiums or contributions in exchange for covered benefits. Therefore, Fulcrum's financial condition, liquidity, and continuing ability to pay covered claims matter directly to members: financial weakness could affect access to benefits, network stability, or the plan's ability to meet its contractual obligations. Providers likewise have a direct financial interest because they deliver services to covered members and depend on Fulcrum for timely, accurate reimbursement under provider contracts. A health plan's financial information helps providers assess the organization's capacity to pay current and future obligations. This distinction aligns with the general purpose of financial reporting: financial statements provide useful information to parties making decisions about providing resources to, or doing business with, an organization. The Financial Accounting Standards Board describes financial reporting as supplying information useful to existing and potential investors, lenders, and other creditors, a framework that supports evaluating parties' direct financial exposure to an entity. See the FASB Conceptual Framework and the NAIC's financial reporting resources.

QUESTION NO: 15

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

Explanation:

The actions most likely to reduce physicians' utilization-review exposure are supporting a system that can quickly provide a second opinion when clinical judgment is disputed and informing the patient about disputes involving the recommended treatment and the health plan's coverage decision. A prompt second-opinion process creates a clinically focused mechanism for resolving disagreements, supports timely care decisions, and documents that a disputed recommendation received appropriate professional review. Clear patient communication is equally important because it allows the patient to understand the difference between the treating physician's recommendation and the plan's benefit or medical-necessity determination, participate in decisions, and use applicable appeal or grievance processes. These practices help preserve transparency, continuity of care, and the physician's responsibility to communicate material treatment-related information. CMS guidance describes coverage-determination notice and appeal protections designed to ensure that enrollees receive understandable information about adverse coverage decisions and their review rights. Professional ethics guidance also emphasizes that physicians retain responsibility for patient-centered clinical judgment and communication, even when coverage or administrative processes affect access to recommended care. See CMS Medicare Managed Care Appeals and Grievances and the AMA Code of Medical Ethics on physician responsibilities in health care systems.

QUESTION NO: 16

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

Explanation:

The health plan's estimate of the premium it would charge Medicare enrollees in the absence of Medicare payments to the health plan is the correct definition because the adjusted community rate is a prospective, actuarially developed estimate of the plan's cost or premium equivalent for furnishing covered services to its Medicare population. It is rooted in the plan's community-rated experience: the prices or costs that would apply to comparable non-Medicare members are adjusted to reflect material differences between the Medicare population and the plan's broader membership, such as demographic and utilization characteristics. The resulting figure represents what the plan would need to charge for the Medicare benefit package if it had to finance that coverage through premiums rather than through Medicare's payments. Thus, the ACR is an estimate used in the Medicare contracting and payment framework, not a retrospective statement of actual annual Medicare costs. The statutory Medicare managed-care framework describes the adjusted community rate as the rate the organization would charge for services if Medicare beneficiaries were not entitled to Medicare benefits, with appropriate adjustments for actuarial factors. See Social Security Act, §1876 and CMS's Medicare Managed Care Manual, Chapter 7.

QUESTION NO: 17

The Nuevo health plan's capital structure consists of 30% debt and 70% equity. Nuevo's average after-tax cost of debt is 6% and its cost of equity is 12%. The following statement(s) can correctly be made about Nuevo's weighted average cost of capital (WACC):

A. Nuevo has a WACC of 10.2%

B. If Nuevo establishes its WACC as the handle rate for capital investments, then it can expect an investment to add value to the health plan only if the investment is expected to earn a return of less than Nuevo's WACC

C. Both A and B

D. A only

E. B only

F. Neither A nor B

ANSWER: D

Explanation:

A only is correct because Nuevo's weighted average cost of capital is calculated by weighting each financing source's required return by its proportion of the organization's capital structure. The calculation is: (30% × 6%) + (70% × 12%) = 1.8% + 8.4% = 10.2%. Thus, the statement that Nuevo has a WACC of 10.2% is accurate.

WACC represents the blended opportunity cost of the capital supplied by creditors and owners. In capital-budgeting decisions, it commonly serves as a hurdle rate or required rate of return for investments with risk comparable to the organization's overall operations. An investment that earns more than this required return generates sufficient returns to cover the cost of the capital used to finance it and can create value for the health plan. This application makes WACC particularly useful when evaluating long-term projects, acquisitions, technology investments, or other uses of health-plan capital. For additional background on the WACC formula and its use in valuation and investment decisions, see Investopedia's WACC overview and NYU Stern Professor Aswath Damodaran's WACC resources.

QUESTION NO: 18

Under the alternative funding method used by the Trilogy Company, the insurer charges Trilogy an initial premium that is based on the assumption that claims will be 93% of the expected claims for the year. If claims exceed 93% of expected claims, then Trilogy must reimburse the insurer for any additional claims paid, up to 112% of expected claims. The insurer bears the responsibility for paying claims in excess of 112% of expected claims.

From the following answer choices, choose the name of the alternative funding method described.

A. Retrospective-rating arrangement

B. Premium-delay arrangement

C. Reserve-reduction arrangement

D. Minimum-premium plan

ANSWER: D

Explanation:

Minimum-premium plan is correct because it combines employer claim-risk retention within a defined corridor with insurer protection against catastrophic claim costs. Under this arrangement, the employer pays an initial, minimum premium calculated from an expected level of claims, plus applicable insurer expenses and risk charges. The employer then reimburses the insurer when actual claims rise above the minimum-premium claim assumption, but only until a stated maximum liability level is reached. In the scenario, Trilogy's minimum claim assumption is 93% of expected claims, and its reimbursement responsibility extends through 112% of expected claims. The insurer assumes claim costs above that maximum, providing stop-loss-like protection for unusually high experience.

This structure allows the employer to retain predictable claim costs and potentially reduce the initial premium compared with fully insured coverage, while retaining insurance against severe adverse experience. The defined minimum and maximum claim thresholds are characteristic features of a minimum-premium arrangement. IRMI describes a minimum-premium plan as an arrangement in which the employer pays a minimum premium and is responsible for claims up to an agreed limit, while the insurer covers claims beyond that limit: IRMI: Minimum Premium Plan. For broader context on employer-sponsored health-plan funding and stop-loss protection, see U.S. Department of Labor: ERISA.

QUESTION NO: 19

The following statements are about a health plan's evaluation of its responsibility centers. Select the answer choice containing the correct statement.

A. When analyzing budget variances, a health plan's management should pay attention to unfavorable variances only.

B. A health plan can reduce the problem of unattainable goals by involving responsibility managers in the preparation of their centers' budgets.

C. One reason that a health plan would use cost-based transfer prices to evaluate the performance of its profit centers and investment centers is because, under this method of setting transfer prices, the selling center has maximum incentive to operate effectively and control costs.

D. In responsibility accounting, all employees who have any influence over a health plan's department are held equally accountable for the operations and financial outcomes of that department.

ANSWER: B

Explanation:

A health plan can reduce the problem of unattainable goals by involving responsibility managers in the preparation of their centers' budgets. This is a central principle of participative budgeting and responsibility accounting. Managers responsible for a cost, revenue, profit, or investment center typically have the most direct knowledge of their unit’s operating conditions, available resources, workload, and practical constraints. Their involvement gives the organization more reliable information for developing performance targets and helps ensure that goals are realistic while still supporting the health plan’s overall strategic and financial objectives.

Participation also promotes commitment to the resulting budget. When responsibility-center managers understand how targets were developed and have an opportunity to provide operational input, they are more likely to view the measures as fair, controllable, and achievable. This improves accountability because performance can be assessed against standards that reflect conditions within the manager’s area of responsibility. The approach is consistent with management-accounting guidance on using budgets for planning, control, communication, and performance evaluation. See the Institute of Management Accountants’ management accounting resources and the overview of participative budgeting.

QUESTION NO: 20

The Cardinal health plan complies with all of the provisions of HIPA

A.

Cardinal has received requests for healthcare coverage from the following companies that meet the statutory definition of a small group:

The Xavier Company has excellent claims experience
The Youngblood Company has not previously offered group healthcare coverage to its employees
The Zebulon Company has poor claims experience

According to HIPAA's provisions, Cardinal must issue a healthcare contract to

A. Xavier, Youngblood, and Zebulon

B. Xavier and Youngblood only

C. Xavier only

D. None of these companies

ANSWER: A

Explanation:

Xavier, Youngblood, and Zebulon is correct because HIPAA's small-group market reforms established guaranteed availability protections for employers that meet the applicable definition of a small group. A health insurance issuer offering coverage in the small-group market generally must make its health insurance products available to every eligible small employer that applies for coverage. This requirement prevents an issuer from using the group's health-related risk profile as a basis for declining to issue coverage.

Consequently, the fact that Xavier has favorable claims experience and Zebulon has unfavorable claims experience does not affect Cardinal's duty to issue coverage. Guaranteed availability likewise applies to Youngblood even though it has not previously sponsored group health coverage. The relevant fact supplied in the question is that each requesting employer satisfies the statutory small-group definition; prior coverage status and expected medical cost experience do not remove that protection.

The guaranteed-availability rule is codified in the federal insurance market regulations at 45 C.F.R. § 146.150. Additional federal background on HIPAA's protections is available from CMS HIPAA-related regulations.

QUESTION NO: 21

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

Explanation:

"A decrease the health plan's net worth requirement" is correct because risk-based capital (RBC) requirements are intended to reflect the amount of capital a health plan should hold in relation to the risks it retains. Under provider reimbursement arrangements that shift utilization risk—such as qualifying capitation or other risk-sharing arrangements—the provider, rather than the health plan, assumes responsibility for some of the financial consequences when covered members use more services than expected. This reduces the plan's retained exposure to adverse utilization experience.

In the health organization RBC framework, this type of transfer of utilization risk can produce a managed-care credit within the underwriting-risk component of the RBC calculation, subject to the applicable formula requirements and limits. A lower underwriting-risk charge reduces total authorized-control-level RBC, and therefore reduces the related minimum capital or net-worth requirement derived from that formula. The result appropriately recognizes that the plan has transferred a portion of its insurance and utilization exposure to a financially accountable provider organization. The National Association of Insurance Commissioners describes RBC as a risk-sensitive capital standard for insurers and health organizations; its RBC resources are available at NAIC Risk-Based Capital. Additional NAIC health-organization RBC materials are available through NAIC Health Organizations RBC.

QUESTION NO: 22

If the total asset turnover ratio for the Fjord health plan is 1.08 and the total asset turnover ratio for the Grove health plan is 1.35, then a financial analyst could correctly infer that Fjord has used its assets more effectively than has Grove.

A. True

B. False

ANSWER: B

Explanation:

The correct answer is **False**. Total asset turnover measures how efficiently an organization uses its asset base to generate revenue. It is generally calculated as total revenue divided by average total assets. A higher ratio means that the organization produces more revenue for each dollar invested in assets, indicating more effective asset utilization, assuming the health plans are reasonably comparable in their business models, service mix, and accounting practices. Grove's total asset turnover ratio of 1.35 exceeds Fjord's ratio of 1.08. In practical terms, Grove generates approximately $1.35 of revenue per dollar of assets, while Fjord generates approximately $1.08 per dollar of assets. Therefore, the stated ratios support an inference that Grove, rather than Fjord, has used its assets more effectively to generate revenue. Asset turnover is an efficiency measure and should be interpreted alongside profitability, liquidity, capital structure, and relevant industry benchmarks; nevertheless, the direct comparison in this question is determined by the higher turnover ratio. The general definition and interpretation of asset turnover are described by Investopedia's asset turnover ratio reference and in the financial-ratio guidance from Corporate Finance Institute.

QUESTION NO: 23

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

Explanation:

The new methodology has decreased the rate of growth in payments from CMS to Medicare-contracting health plans. The Balanced Budget Act of 1997 substantially revised Medicare managed-care payment policy, replacing the prior approach with a county-level payment structure that incorporated a blend of local and national rates, payment floors for low-rate counties, and limits on annual payment increases. These provisions were designed in part to constrain Medicare spending growth while reducing geographic variation in plan payment rates. The result was slower growth in payments to Medicare-contracting health plans than would have occurred under the earlier adjusted average per capita cost methodology. In subsequent legislation, Congress modified elements of the BBA payment system in response to concerns about plan participation and beneficiary access, but the BBA's original methodology is recognized as having restrained payment growth. CMS's historical overview of the Medicare Advantage and managed-care program describes the payment changes enacted by the BBA and later legislation. Additional legislative background is available from the Congressional Research Service. See CMS Medicare Advantage Rates & Statistics and Congressional Research Service, Medicare Advantage.

QUESTION NO: 24

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

Explanation:

Funds from Debt Markets: available to Verde and Noir
Funds from Equity Markets: available to Verde only is correct because both organizational forms can obtain borrowed capital through debt financing. A health plan may borrow from lenders or issue debt instruments, subject to its financial condition, applicable regulation, and the terms available in the market. Not-for-profit organizations commonly use debt to finance capital needs because they cannot obtain capital by selling ownership interests. Their tax-exempt status can also permit access to tax-exempt bond financing when the applicable requirements are met.

Equity-market financing, however, is based on issuing an ownership interest to investors. Verde, as a for-profit health plan, can raise capital through equity markets by issuing stock or other equity interests. Investors contribute capital in exchange for an ownership claim and the potential to receive returns associated with the organization's financial performance. Noir's not-for-profit structure has no private owners or shareholders to whom equity interests can be issued; its resources instead are retained and used to support its organizational mission. This distinction between debt capital and ownership capital is central to the financing choices available to for-profit and not-for-profit health plans. The Internal Revenue Service describes the organizational and operational requirements for charitable organizations at IRS Charitable Purposes; the Securities and Exchange Commission explains stock as an ownership interest at Investor.gov: What Are Stocks?.

QUESTION NO: 25

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. Dr. Monroe and Exmoor are equally responsible for making up the difference if cost overruns exceed the amount of money withheld

B. Exmoor most likely distributes to Dr. Monroe the entire amount withheld from her if her costs are below the amount budgeted for the period

C. Exmoor pays Dr. 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

D. Exmoor most likely withholds between 3% and 5% of Dr. Monroe's total reimbursement

ANSWER: B

Explanation:

Exmoor most likely distributes to Dr. Monroe the entire amount withheld from her if her costs are below the amount budgeted for the period. A typical provider withhold arrangement retains a specified portion of the provider's otherwise payable reimbursement during a settlement period. The retained funds create a financial incentive for efficient, appropriate management of covered services and utilization. At the end of the period, the health plan compares the relevant costs or utilization experience with the established budget or performance target. When experience is favorable—meaning costs are below the budget for the period—the withhold pool is generally available for distribution back to the participating provider, subject to the arrangement's stated settlement methodology. Thus, a favorable cost result supports release of the full amount that was withheld from Dr. Monroe's payments. This structure places a limited amount of provider compensation at risk rather than requiring the provider to fund unlimited losses. CMS recognizes that physician incentive arrangements may place physicians at substantial financial risk and requires safeguards and disclosure standards for managed-care

arrangements involving such incentives. See CMS's Physician Incentive Plans resource and the related regulatory requirements at 42 CFR § 422.208.

QUESTION NO: 26

One true statement about a health plan's underwriting margin is that

A. the only way that the health plan can effectively reduce its exposure to underwriting risk, and therefore adjust its underwriting margin, is to control anti selection

B. a larger assumed underwriting margin will reduce the price of the health plan's product and will make the plan more competitive

C. the health plan's purchase of stop-loss insurance has no effect on its underwriting margin because stop-loss insurance can help the health plan control its expenses but not its underwriting risk

D. both the level of underwriting risk that the health plan assumes in providing benefits and the market competition it encounters most likely directly affect the size of its assumed underwriting margin

ANSWER: D

Explanation:

Both the level of underwriting risk that the health plan assumes in providing benefits and the market competition it encounters most likely directly affect the size of its assumed underwriting margin. An underwriting margin is the amount built into premium rates to compensate the plan for the uncertainty that actual claims and related costs may differ from projected costs. When a plan retains more risk—for example, by accepting greater volatility in utilization, claim severity, or enrollee health status—it generally needs a larger margin to provide an appropriate financial cushion. Conversely, risk-transfer arrangements can reduce the risk retained and can influence the margin required. The market also directly shapes pricing decisions: even when a plan's risk analysis supports a particular margin, competitive conditions may limit the premium level that customers will accept. Rate setting therefore requires balancing actuarial expectations for claims, administrative expenses, risk, and profit or contribution requirements against the prices and benefit designs offered by competitors. This reflects the broader principle that premiums must be adequate for the risk assumed while remaining viable in the marketplace. For background on health insurance rate review and the factors used in evaluating premium increases, see CMS Rate Review. The National Association of Insurance Commissioners also describes the regulatory role of actuarial review in insurance rates at NAIC Actuarial.