Health Plan Finance and Risk Management

1. 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. 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.

B. 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.

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(s): C

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

D. 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.

Answer(s): D

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3. A health plan may experience negative working capital whenever healthcare expenses generated by plan members exceed the premium income the health plan receives.

A. Neither 1 nor 2

B. 1 only

C. Both 1 and 2

D. 2 only

Answer(s): C

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4. 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. 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

B. B only

C. Neither A nor B

D. Both A and B

E. A only

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

Answer(s): D

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5. Dr. Jacob Winburne is compensated by the Honor Health Plan under an arrangement in which Honor establishes at the beginning of a financial period a fund from which claims approved for payment are paid. At the end of the given period, any funds remaining are

A. Withhold, and any deficit in the fund at the end of the period would be paid by both Dr. Winburne and Honor according to percentages agreed upon at the beginning of the contract period

B. Risk pool, and any deficit in the fund at the end of the period would be paid by both Dr. Winburne and Honor according to percentages agreed upon at the beginning of the contract period

C. Risk pool, and any deficit in the fund at the end of the period would be the sole responsibility of Honor

D. Withhold, and any deficit in the fund at the end of the period would be the sole responsibility of Honor

Answer(s): C

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6. The theory of vicarious liability or ostensible agency can expose a health plan to the risk that it could be held liable for the acts of independent contractors. Factors that may give rise to the assumption that an agency relationship exists between a health plan and its independent contractors include:

A. Requiring the providers to supply their own office space

B. Employing nurses and other healthcare professionals to support the physician providers

C. Requiring providers to maintain their own medical records

D. All of the above

Answer(s): B

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7. 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:

A. Neither 1 nor 2

B. 1 only

C. Both 1 and 2

D. 2 only

Answer(s): A

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8. The medical loss ratio (MLR) for the Peacock health plan is 80%. Peacock's expense ratio is 16%.

A. Includes claims that have been paid but excludes claims that have not yet been reported

B. Measures Peacock's overall claims levels

C. Is the percentage of Peacock's end-of-period surplus to its earned premiums

D. Cannot adjust for growth in the health plan's business

Answer(s): B

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9. 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:

A. 1 and 3 only

B. 2 and 3 only

C. 1, 2, and 3

D. 1 and 2 only

Answer(s): B

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10. 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. Prohibits Zane from making adjusting entries to its accounting records at the end of each accounting year

B. Enables an interested party to view the consequences of obligations incurred by Zane, but only if the health plan ultimately completes the business transaction

C. Is not suitable for measuring Zane's profitability

D. Requires Zane to record revenues when they are earned and expenses when they are incurred, even if cash has not actually changed hands

Answer(s): D

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11. The goal of the investment department at the Wayfarer Health Plan is to maximize investment return. The investment department executes investments on time and at a low cost. However, these transactions often result in low returns or risks that are deemed too high for Wayfarer. With regard to effectiveness and efficiency, it is correct to say that Wayfarer's investment department is:

A. neither effective nor efficient

B. effective, but not efficient

C. efficient, but not effective

D. both effective and efficient

Answer(s): C

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12. A health plan's costs can be classified as committed costs or discretionary costs. An example of a discretionary cost for a health plan is the cost of its

A. Employee training

B. Equipment

C. Executive salaries

D. Facilities

Answer(s): D

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13. 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

A. Funds from Debt Markets: available to Noir only Funds from Equity Markets: available to Verde only

B. Funds from Debt Markets: available to Verde only Funds from Equity Markets: available to Noir only

C. Funds from Debt Markets: available to Verde and Noir Funds from Equity Markets: available to Verde only

D. Funds from Debt Markets: available to Verde and Noir Funds from Equity Markets: available to Verde and Noir

Answer(s): C

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14. The Atoll Health Plan must comply with a number of laws that directly affect the plan's contracts. One of these laws allows Atoll's plan members to receive medical services from certain specialists without first being referred to those specialists by a primary care provider (PCP). This law, which reduces the PCP's ability to manage utilization of these specialists, is known as _____.

A. A direct access law

B. A due process law

C. A fair procedure law

D. An any willing provider law

Answer(s): A

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15. 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.

A. Increasing its controllable investments

B. Increasing total revenues, accompanied by a proportionate increase in operating income

C. Focusing only on increasing its total revenues

D. Increasing expenses in order to increase operating income

Answer(s): B

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16. The core of a health plan's strategic financial plan is the development of its pro forma financial statements. The following statements are about these pro forma financial statements. Select the answer choice containing the correct statement.

A. Forecasting the balance sheet is more critical to the health plan than forecasting either the cash flow statement or the income statement, because the balance sheet drives the development of the other two statements.

B. A health plan can use its pro forma cash flow statement to calculate the net present value of the health plan's strategic plan.

C. In order to avoid allowing the desired financial results to drive the assumptions used in developing the pro forma income statement, a health plan should avoid linking these assumptions to the health plan's overall strategic plan.

D. A health plan's pro forma financial statements forecast what the plan's financial condition will be at the end of an accounting period, without regard to whether the health plan achieves its objectives.

Answer(s): B

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17. With regard to capitation arrangements for hospitals, it can correctly be Back to Top stated that

A. Most jurisdictions prohibit hospitals and physicians from joining together to receive global capitations that cover institutional services provided by the hospitals

B. The most common reimbursement method for hospitals is professional services capitation

C. Ahealth plan typically can capitate a hospital for outpatient laboratory and X-ray services only if the health plan also capitates the hospital for inpatient care

D. Many hospitals have formed physician hospital organizations (PHOs), hospital systems, or integrated delivery systems (IDSs) that can accept global capitation payments from health plans

Answer(s): D

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18. The Raven Health Plan is domiciled in a state that requires the health plan to offer small employers and their employees a comprehensive healthcare benefit plan that approximates the healthcare benefits available to large employer-employee groups. This type of uniform benefit plan is known as:

A. A basic plan

B. A standard plan

C. A low-option plan

D. An essential plan

Answer(s): B

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19. The following statements are about a health plan's underwriting of small groups. Select the answer choice containing the correct statement.

A. Almost all states prohibit health plan s from rejecting a small group because of the nature of the business in which the small business is engaged.

B. Generally, a health plan's underwriters require small employers to contribute at least 80% of the cost of the healthcare coverage.

C. Most states prohibit health plans from setting participation levels as a requirement for coverage, even when coverage is otherwise guaranteed issue.

D. In underwriting small groups, a health plan's underwriters typically consider both the characteristics of the group members and of the employer.

Answer(s): D

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20. Two sets of financial accounting standards are generally accepted accounting principles (GAAP) and statutory accounting practices (SAP). One true statement about these financial accounting standards is that

A. GAAP specifically focuses on the requirements of insurance regulators and policyholder interests

B. The Financial Accounting Standards Board (FASB) is a private organization whose purpose is to establish and promote SAP in the United States

C. Health plans must prepare their financial statements for their external users according to applicable laws, regulations, and accounting principles, particularly GAAP

D. State laws and regulations in the United States govern the implementation of GAAP, but not the implementation of SAP

Answer(s): C
