

## Exam Questions AHM-520

Health Plan Finance and Risk Management

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#### NEW QUESTION 1

- (Topic 1)

The following statements illustrate the use of different rating methods by health plans:

? The Dover health plan established rates for small groups by using a rating method which requires that the average premium in each group cannot be more than 120% of the average premium for any other group. Under this method, all members of each group pay the same premium, which is based on the experience of the group.

? Under the rating method used by the Rolling Hills health plan, the health plan

calculates the ratio of a group's experience to the group's historical manual rate. Rolling Hills then multiplies this ratio by the group's future manual rate. Rolling Hills cannot consider the group's experience in determining premium rates.

From the following answer choices, select the response that correctly indicates the rating methods used by Dover and Rolling Hills.

- A. Dover = modified community rating Rolling Hills = factored rating
- B. Dover = modified community rating Rolling Hills = adjusted community rating (ACR)
- C. Dover = community rating by class (CRC) Rolling Hills = factored rating
- D. Dover = community rating by class (CRC) Rolling Hills = adjusted community rating (ACR)

**Answer: D**

#### NEW QUESTION 2

- (Topic 1)

With regard to the Medicaid program in the United States, it can correctly be stated that

- A. The federal government provides none of the funding for state Medicaid programs
- B. Federal Medicaid law is different from Medicare law in that the federal government explicitly sets forth the methodology for payment of Medicaid-contracting plans but not Medicare-contracting plans
- C. A state's payment to health plans for providing Medicaid services cannot be more than it would have cost the state to provide the services under Medicaid fee-for-service (FFS)
- D. States are prohibited from carving out specific services from the capitation rate that health plans receive for providing Medicaid services

**Answer: C**

#### NEW QUESTION 3

- (Topic 1)

One true statement about a type of capitation known as a percent-of-premium arrangement is that this arrangement

- A. Is the most common type of capitation
- B. Is less attractive to providers when the arrangement sets provisions to limit risk
- C. Sets provider reimbursement at a specific dollar amount per plan member
- D. Transfers some of the risk associated with underwriting and rating from a health plan to a provider

**Answer: D**

#### NEW QUESTION 4

- (Topic 1)

The Brookhaven Company is the parent company of two subsidiaries: an HMO and an insurance company. The headings on Brookhaven's financial statements read "Consolidated Financial Statements of Brookhaven Company." From the following answer choices, select the response that correctly indicates, under the entity concept, whether the HMO and the insurance company are accounted for as separate entities and whether the subsidiaries' financial results would be included in Brookhaven's consolidated financial statements.

- A. Accounted for as Separate Entities? = yes Results Included in Brookhaven's Statements? = yes
- B. Accounted for as Separate Entities? = yes Results Included in Brookhaven's Statements? = no
- C. Accounted for as Separate Entities? = no Results Included in Brookhaven's Statements? = yes
- D. Accounted for as Separate Entities? = no Results Included in Brookhaven's Statements? = no

**Answer: A**

#### NEW QUESTION 5

- (Topic 1)

If the Ascot health plan's accountants follow the going-concern concept under GAAP, then these accountants most likely

- A. Assume that Ascot will pay its liabilities immediately or in full during the current accounting period
- B. Defer certain costs that Ascot has incurred, unless these costs contribute to the healthplan's future earnings
- C. Assume that Ascot is not about to be liquidated, unless there is evidence to the contrary
- D. Value Ascot's assets more conservatively than they would under SAP

**Answer: C**

#### NEW QUESTION 6

- (Topic 1)

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

#### NEW QUESTION 7

- (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 8

- (Topic 1)

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

- A. The most common reimbursement method for hospitals is professional services capitation
- B. Most jurisdictions prohibit hospitals and physicians from joining together to receive global capitations that cover institutional services provided by the hospitals
- C. A health 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:** D

#### 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)

Several federal agencies establish rules and requirements that affect health plans. One of these agencies is the Department of Labor (DOL), which is primarily responsible for \_\_\_\_\_.

- A. Issuing regulations pertaining to the Health Insurance Portability and Accountability Act (HIPAA) of 1996
- B. Administering the Medicare and Medicaid programs
- C. Administering ERISA, which imposes various documentation, appeals, reporting, and disclosure requirements on employer group health plans
- D. Administering the Federal Employees Health Benefits Program (FEHBP), which provides voluntary health insurance coverage to federal employees, retirees, and dependents

**Answer:** C

#### NEW QUESTION 14

- (Topic 1)

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

#### NEW QUESTION 17

- (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 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 21

- (Topic 1)

Most organizations that obtain group healthcare coverage can be classified as one of three types of groups: employer-employee groups, multiple employer groups, and professional associations. One true statement about these types of groups is that

- A. Anti selection risk is higher for both multiple-employer groups and professional associations than it is for an employer-employee group
- B. Private employers typically present a higher underwriting risk to health plans than do public employers
- C. Individual members of a multiple-employer group or a professional association typically are required to obtain healthcare coverage through the group or association
- D. A health plan is prohibited, when evaluating the risks represented by a professional association, from considering the industry experience of the agent or broker that sells a group plan to the association

Answer: A

#### NEW QUESTION 23

- (Topic 1)

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 due process law
- B. An any willing provider law
- C. A direct access law
- D. A fair procedure law

Answer: C

#### NEW QUESTION 25

- (Topic 1)

The methods of alternative funding for health coverage can be divided into the following general categories:

? Category A—Those methods that primarily modify traditional fully insured group insurance contracts

? Category B—Those methods that have either partial or total self funding

Typically, small employers are able to use some of the alternative funding methods in

- A. Both Category A and Category B
- B. Category A only
- C. Category B only
- D. Neither Category A nor Category B

Answer: C

#### NEW QUESTION 28

- (Topic 1)

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

#### NEW QUESTION 30

- (Topic 1)

Under GAAP, three approaches to expense recognition are generally allowed: associating cause and effect, systematic and rational allocation, and immediate recognition. A health plan most likely would use the approach of systematic and rational allocation in order to

- A. Report the payment of the health plan's utility bills
- B. Spread the payment of sales force commissions over the premium paying period of healthcare coverage
- C. Report the fees paid by the health plan to attorneys and consultants
- D. Depreciate the cost of a new computer system over the useful life of the system

**Answer:** D

#### NEW QUESTION 35

- (Topic 1)

The accounting department of the Enterprise health plan adheres to the following policies:

- ? Policy A—Report gains only after they actually occur
- ? Policy B—Report losses immediately
- ? Policy C—Record expenses only when they are certain
- ? Policy D—Record revenues only when they are certain

Of these Enterprise policies, the ones that are consistent with the accounting principle of conservatism are Policies

- A. A, B, C, and D
- B. A, B, and D only
- C. A and B only
- D. C and D only

**Answer:** B

#### NEW QUESTION 37

- (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 38

- (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 40

- (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 42

- (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. 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

#### NEW QUESTION 47

- (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 50

- (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.

Assume that the healthcare industry average for the debt-to-equity ratio is 0.90. The following statement(s) can correctly be made about Fairway's debt to equity ratio:

- A. Fairway's debt-to-equity ratio is 1.50
- B. Fairway relies less than most other healthcare organizations on borrowed funds to cover future and current benefit payments, to pay for ongoing business operations, and to finance growth
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

Answer: B

#### NEW QUESTION 55

- (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 60

- (Topic 2)

All publicly traded health plans in the United States are required to prepare financial statements for use by their external users in accordance with generally accepted accounting principles (GAAP). In addition, health insurers and health plans that fall under the jurisdiction of state insurance departments are required by law to prepare certain financial statements in accordance with statutory accounting practices (SAP). In a comparison of GAAP to SAP, it is correct to say that:

- A. GAAP is established and promoted by the National Association of Insurance Commissioners (NAIC), whereas SAP is established and promoted by the Financial Accounting Standards Board (FASB)
- B. The going-concern concept is an underlying premise of GAAP, whereas SAP tends to focus on the liquidation value of the MCO or the insurer
- C. GAAP provides for a single method of valuing all of a health plan's assets, whereas SAP offers the health plan more than one method for valuing its assets
- D. The principle of conservatism is fundamental to GAAP, whereas SAP generally is not conservative in nature

Answer: B

### NEW QUESTION 63

- (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 67

- (Topic 2)

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

**Answer:** D

### NEW QUESTION 70

- (Topic 2)

The following information relates to the Hardcastle Health Plan for the month of June:

? Incurred claims (paid and IBNR) equal \$100,000

? Earned premiums equal \$120,000

? Paid claims, excluding IBNR, equal \$80,000

? Total health plan expenses equal \$300,000

This information indicates that Hardcastle's medical loss ratio (MLR) for the month of June was approximately equal to:

- A. 40%
- B. 67%
- C. 83%
- D. 120%

**Answer:** C

### NEW QUESTION 72

- (Topic 2)

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

### NEW QUESTION 73

- (Topic 2)

Cascade Hospital has negotiated with the McBee Health Plan a straight per-diem rate of \$1,000 per day for medical admissions. One of McBee's plan members was admitted to Cascade for 10 days. Total billed charges equaled \$10,000, of which \$2,000 were for noncovered items. This information indicates that, for this admission, the amount that McBee was obligated to reimburse Cascade was:

- A. \$0
- B. \$8,000
- C. \$10,000
- D. \$12,000

**Answer:** C

### NEW QUESTION 76

- (Topic 2)

The following statements are about the Health Insurance Portability and Accountability Act (HIPAA) as it relates to the small group market. Three of these statements are true and one statement is false. Select the answer choice containing the FALSE statement:

- A. A health plan that participates in the small group market is required to issue a contract to any employer that requests healthcare benefits, as long as the employer meets the statutory definition of a small group.
- B. A small group must consist of more than 10 employees in order to be underwritten on a group, rather than an individual, basis.
- C. A health plan is prohibited from canceling a small group's healthcare coverage because of poor claims experience.

D. A health plan that participates in the small group market is limited in placing restrictions such as waiting periods and pre-existing conditions exclusions to individuals in high risk categories.

**Answer:** B

#### NEW QUESTION 80

- (Topic 2)

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.
- 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.
- C. Both A and B
- D. A only
- E. B only
- F. Neither A nor B

**Answer:** B

#### NEW QUESTION 85

- (Topic 2)

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

#### NEW QUESTION 88

- (Topic 2)

A primary reason that a financial analyst would measure the Tapestry health plan's return on assets (ROA) is to determine the

- A. Amount of net income per share of Tapestry's common stock
- B. Rate of return on the book value of the stockholders' investment in Tapestry
- C. Proportion of earnings paid out to Tapestry stockholders in the form of cash dividends
- D. Efficiency of Tapestry's management

**Answer:** D

#### NEW QUESTION 93

- (Topic 2)

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

#### NEW QUESTION 98

- (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 103

- (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 104

- (Topic 2)

The Norton Health Plan used blended rating to develop a premium rate for the Roswell Company, a large employer group. Norton assigned Roswell a credibility factor of 0.7 (or 70%). Norton calculated Roswell's manual rate to be \$200 and its experience claims cost as \$180. Norton's retention charge is \$3. This information indicates that Roswell's blended rate is:

- A. \$186
- B. \$189
- C. \$194
- D. \$197

**Answer:** B

#### NEW QUESTION 106

- (Topic 2)

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

Ways in which a health plan can manage the volatility in claims payments, and therefore reduce the risk of negative working capital, include:

\* 1.Accurately estimating incurred but not reported (IBNR) claims 2.Using capitation contracts for provider reimbursement

- A. Both 1 and 2
- B. 1 only
- C. 2 only
- D. Neither 1 nor 2

**Answer:** A

#### NEW QUESTION 110

- (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 112

- (Topic 2)

In order to show the efficiency of a health plan's managers in using the health plan's investments to earn a return for stockholders, a financial analyst most likely would use a type of profitability ratio known as

- A. A net gain-to-total income ratio
- B. An insurance leverage ratio
- C. A statutory return on assets (ROA) ratio
- D. A gross profit ratio

**Answer:** C

#### NEW QUESTION 117

- (Topic 2)

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

#### NEW QUESTION 120

- (Topic 2)

Analysts will use the capital asset pricing model (CAPM) to determine the cost of equity for the Maxim health plan, a for-profit plan. According to the CAPM, Maxim's cost of equity is equal to

- A. The average interest rate that Maxim is paying to debt holders, adjusted for a tax shield
- B. Maxim's risk-free rate minus its beta
- C. Maxim's risk-free rate plus an adjustment that considers the market rate, at a given level of systematic (non diversifiable) risk
- D. Maxim's risk-free rate plus an adjustment that considers the market rate, at a given level of nonsystematic (diversifiable) risk

**Answer:** C

#### NEW QUESTION 122

- (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. Carlyle most likely is responsible for paying Longview for the claims incurred before Longview has actually paid the medical expenses.

- A. True
- B. False

**Answer: B**

#### NEW QUESTION 127

- (Topic 2)

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**

#### NEW QUESTION 131

- (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 134

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