AHIP AHM-520 Exam

Volume A~B: 215 Questions

Volume A

Question No: 1
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

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: D

Question No: 2
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, state, or local taxes on its earnings

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

D. Is a privately held corporation

Answer: B

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Question No: 3
The Challenger Group is a type of management services organization (MSO) that purchases the assets of physician practices, provides practice management and administrative support services to participating providers, and offers physicians a long-term contract and an equity position in Challenger. This information indicates that Challenger is a type of health plan

A. Known as

B. An integrated delivery system (IDS)

C. Amedical foundation

D. Aprovider-sponsored organization (PSO)

E. Aphysician practice management (PPM) company

Answer: D

Question No: 4
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

Question No: 5
The following statements are about pure risk and speculative risk–two kinds of risk that both businesses and individuals experience. Select the answer choice containing the correct statement.

A. Healthcare coverage is designed to help plan members avoid pure risk, not speculative risk.

B. Only pure risk involves the possibility of gain.

C. An example of speculative risk is the possibility that an individual will contract a serious illness.

D. Only speculative risk contains an element of uncertainty.

Answer: A

Question No: 6
The following paragraph contains an incomplete statement. Select the answer choice containing the term that correctly completes the statement. Health plans face four contingency risks (C-risks): asset risk (C-1), pricing risk (C-2), interest-rate risk (C-3), and general management risk (C-4). Of these risks, _____ is typically the most important risk that health plans face. This is true because a sizable portion of the total expenses and liabilities faced by a health plan come from contractual obligations to pay for future medical costs, and the exact amount of these costs is not known when the healthcare coverage is priced.

A. Asset risk (C-1)

B. Pricing risk (C-2)

C. Interest-rate risk (C-3)

D. General management risk (C-4)

Answer: B

Question No: 7
The Health Maintenance Organization (HMO) Model Act, developed by the National Association of Insurance Commissioners (NAIC), represents one approach to developing solvency standards. One drawback to this type of solvency regulation is that it

A. Uses estimates of future expenditures and premium income to estimate future risk

B. Fails to adjust the solvency requirement to account for the size of an HMO's premiums and expenditures

C. Assumes that the amount of premiums an HMO charges always directly corresponds to the level of the risk that the HMO faces

D. Fails to mandate a minimum level of capital and surplus that an HMO must maintain

Answer: C

Question No: 8
The NAIC has developed a risk-based capital (RBC) formula for all health plans that accept risk. One true statement about the RBC formula for health plans is that it

A. is a set of calculations, based on information in a health plan's annual financial report, that yields a target capital requirement for the organization

B. fails to take into account a health plan's underwriting risk, which is the risk that the premiums the health plan receives will be insufficient to pay for the healthcare services it provides to its plan members

C. applies to all health plans in the United States

D. fails to assess the specific level of risk faced by each health plan

Answer: A

Question No: 9
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

Question No: 10
Three general strategies that health plans use for controlling types of risk are risk avoidance, risk transfer, and risk acceptance. The following statements are about these strategies. Three of these statements are true, and one statement is false. Select the answer choice containing the FALSE statement.

A. Generally, the smaller the likely benefits of accepting a risk, and the lower the costs of avoiding that risk, the greater the likelihood that a health plan will elect to avoid the risk.

B. A health plan is seldom able to transfer any of the risk that utilization rates will be higher than expected and that its cost of providing healthcare will exceed the revenues it receives.

C. If a risk is a pure risk from the point of view of a health plan, then the health plan most likely will attempt to avoid the risk.

D. A health plan would most likely transfer some or all of its utilization risk if it pays a provider a rate that is based on the number of plan enrollees that choose the provider as their primary care provider (PCP).

Answer: B

Question No: 11
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

Question No: 12
The Eagle health plan wants to limit the possibility that it will be held vicariously liable for the negligent acts of providers. Dr. Michael Chan is a member of an independent practice association (IPA) that has contracted with Eagle. One step that Eagle could take in order to limit its exposure under the theory of vicarious liability is to

A. Supply Dr. Chan with office space

B. Employ nurses, laboratory technicians, and therapists to support Dr.Chan

C. Be responsible for keeping Dr. Chan's medical records updated

D. Ensure that documents provided to Dr. Chan's patients describe him as an independent practitioner

Answer: D

Question No: 13
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: