Exam Questions AHM-510

Governance and Regulation

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NEW QUESTION 1
In the paragraph below, a statement contains two pairs of terms enclosed in parentheses. Determine which term in each pair correctly completes the statement. Then select the answer choice containing the two terms that you have chosen.
Inflation plays a role in the health plan environment by influencing the prices of healthcare services, supplies, and coverage. During an inflationary period, consumers typically have (more / less) purchasing power because the prices of goods and services increase (more / less) quickly than income.

A. More / more
B. More / less
C. Less / more
D. Less / less

Answer: C

NEW QUESTION 2
Some health plans qualify as tax-exempt organizations under Sections 501(c)(3) and 501(c)(4) of the Internal Revenue Code. One true statement regarding a health plan that qualifies as a 501(c)(4) social welfare organization, in comparison to a health plan that qualifies as a 501(c)(3) charitable organization, is that a

A. 501(c)(4) social welfare organization is allowed to distribute profits for the benefit of individuals,whereas a 501(c)(3) charitable organization can use surplus only for the benefit of the organization, the community, or a charity
B. 501(c)(4) social welfare organization can raise operating funds through the sale of tax-exempt bonds, whereas a 501(c)(3) charitable organization does not have this advantage
C. 501(c)(4) social welfare organization has less flexibility in determining use of funds for social or political activities than does a 501(c)(3) charitable organization
D. 501(c)(4) exemption is easier to obtain than a 501(c)(3) exemption, because 501(c)(4) social welfare organizations are allowed to benefit a comparatively smaller group of individuals

Answer: D

NEW QUESTION 3
In the course of doing business, health plans conduct basic corporate transactions. For example, when a health plan engages in the corporate transaction known as aggressive sourcing, the health plan

A. Chooses to contract with vendors who provide specific functions that would otherwise be performed in-house, such as paying claims
B. Seeks to obtain the best deals from various vendors for equipment, supplies, and services such as telephones, overnight mail, computer hardware and software, and copy machines
C. Merges with one or more companies to form an entirely new company
D. Joins with one or more companies, but retains its autonomy and relies on the other companies to perform specific functions

Answer: B

NEW QUESTION 4
The Wentworth Corporation uses a self-funded plan to provide its employees with healthcare benefits. One consequence of Wentworth's approach to providing healthcare benefits is that selffunding

A. Requires that Wentworth self-administer its healthcare benefit plan
B. Requires that Wentworth pay higher state premium taxes than do insurers and health plans
C. Eliminates the need for Wentworth to pay a risk charge to an insurer or health plan
D. Increases the number of benefit and rating mandates that apply to Wentworth's plan

Answer: C

NEW QUESTION 5
Antitrust laws can affect the formation, merger activities, or acquisition initiatives of a health plan. In the United States, the two federal agencies that have the primary responsibility for enforcing antitrust laws are the

A. Internal Revenue Service (IRS) and the Department of Justice (DOJ)
B. Office of Inspector General (OIG) and the Department of Defense (DOD)
C. Federal Trade Commission (FTC) and the Department of Labor (DOL)
D. Federal Trade Commission (FTC) and the Department of Justice (DOJ)

Answer: D

NEW QUESTION 6
Greenpath Health Services, Inc., an HMO, recently terminated some providers from its network in response to the changing enrollment and geographic needs of the plan. A provision in Greenpath's contracts with its healthcare providers states that Greenpath can terminate the contract at any time, without providing any reason for the termination, by giving the other party a specified period of notice.
The state in which Greenpath operates has an HMO statute that is patterned on the NAIC HMO Model Act, which requires Greenpath to notify enrollees of any material change in its provider network. As required by the HMO Model Act, the state insurance department is conducting an examination of Greenpath's operations. The scope of the on-site examination covers all aspects of Greenpath's market conduct operations, including its compliance with regulatory requirements. With respect to the type of change that constitutes a material change under the HMO Model Act's disclosure requirements, the termination of one healthcare provider from Greenpath's provider network

A. Always qualifies as a material change in the plan, and Greenpath must report the change to all plan enrollees
B. Always qualifies as a material change in the plan, and Greenpath must report the change to only those plan enrollees who have received care from the terminated provider
C. Qualifies as a material change in the plan only if the provider is a primary care provider, and in such a case Greenpath must report the change to all plan enrollees

D. Qualifies as a material change in the plan only if the provider is a primary care provider, and in such a case Greenpath must report the change to only those plan enrollees who receive primary care from the terminated provider

Answer: D

NEW QUESTION 7
Nightingale Health Systems, a health plan, operates in a state that requires health plans to allow enrollees to visit obstetricians and gynecologists without a referral from a primary care provider. This information indicates that Nightingale must comply with a type of mandate known as a:

A. Direct access law
B. Scope-of-practice law
C. Provider contracting mandate
D. Physician incentive law

Answer: A

NEW QUESTION 8
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A. Type of examination: comprehensive; Required frequency: annually
B. Type of examination: comprehensive; Required frequency: at least every three years
C. Type of examination: target; Required frequency: annually
D. Type of examination: target; Required frequency: at least every three years

Answer: B

NEW QUESTION 9
A federal law that significantly affects health plans is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In order to comply with HIPAA provisions, issuers offering group health coverage generally must.

A. Renew group health policies in both small and large group markets, regardless of the health status of any group member
B. Provide a plan member with a certificate of creditable coverage at the time the member enrolls in the group plan
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: B

NEW QUESTION 10
Congress enacted three clauses relating to the preemptive effect of the Employee Retirement Income Security Act of 1974 (ERISA). One of these clauses preserves from ERISA preemption any state law that regulates insurance, banking, or securities, with the exception of the exemption for self-funded employee benefit plans. This clause is called the

A. Savings clause
B. Preemption clause
C. Deemer clause
D. De novo clause

Answer: A

Explanation:
The savings clause preserves from preemption any state law that regulates insurance, banking or securities except as provided by the deemer clause.

NEW QUESTION 10
The following statements are about the Federal Employees Health Benefits Program (FEHBP), which is administered by the Office of Personnel Management (OPM). Three of the statements are true and one statement is false. Select the answer choice that contains the FALSE statement.

A. For every plan in the FEHBP, OPM annually determines the lowest premium that is actuarially sound and then negotiates with each plan to establish that premium rate.
B. Once a health plan has submitted its rate proposals for a contract year to the OPM, it cannot adjust its premium rate for any reason.
C. To cover its administrative costs, OPM sets aside 1% of all FEHBP premiums.
D. Each spring, OPM sends all plan providers its call letter, a document that specifies the kinds of benefits that must be available to plan participants and cost goals and procedural changes that the plans need to adopt.

Answer: A

NEW QUESTION 15
From the following answer choices, choose the term that best corresponds to this description. Barrington Health Services, Inc. contracts with a state Medicaid

agency as a fiscal intermediary. Barrington does not provide medical services, but contracts with medical providers on behalf of the state Medicaid agency.

A. Health insuring organization (HIO)
B. Independent practice association (IPA)
C. Physician practice management (PPM) company
D. Peer review organization (PRO)

Answer: A

NEW QUESTION 19
Arthur Dace, a plan member of the Bloom health plan, tried repeatedly over an extended period to schedule an appointment with Dr. Pyle, his primary care physician (PCP). Mr. Dace informally surveyed other Bloom plan members and found that many people were experiencing similar problems getting an appointment with this particular provider. Mr. Dace threatened to take legal action against Bloom, alleging that the health plan had deliberately allowed a large number of patients to select Dr. Pyle as their PCP, thus making it difficult for patients to make appointments with Dr. Pyle.
Bloom recommended, and Mr. Dace agreed to use, an alternative dispute resolution (ADR)
method that is quicker and less expensive than litigation. Under this ADR method, both Bloom and Mr. Dace presented their evidence to a panel of medical and legal experts, who issued a decision that Bloom's utilization management practices in this case did not constitute a form of abuse. The panel's decision is legally binding on both parties.
Different types of compensation arrangements in managed care plans, from fee-for-service (FFS) arrangements to capitation arrangements, lead to different types of fraud and abuse. From the answer choices below, select the response that identifies the form of abuse in which Bloom is allegedly engaging, according to Mr. Dace's complaint, and whether this form of abuse is more likely to occur in FFS compensation arrangements or in capitation arrangements.

A. Type of abuse underutilizationType of compensation arrangement FFS arrangement
B. Type of abuse underutilizationType of compensation arrangement capitation arrangement
C. Type of abuse overutilizationType of compensation arrangement FFS arrangement
D. Type of abuse overutilizationType of compensation arrangement capitation arrangement

Answer: B

NEW QUESTION 22
Directors on a health plan's board must demonstrate their compliance with three duties in all their decisions. Directors who exercise their duties in good faith and with the same degree of diligence and skill that an ordinary, reasonable person would be expected to display in the same situation are meeting the duty known as the

A. Duty of loyalty
B. Duty to supervise
C. Duty of care
D. Trustee duty

Answer: C

NEW QUESTION 27
The Westchester Health Plan is using a pricing strategy that involves setting a low price in a highly price-sensitive market to stimulate revenue growth. In following this strategy, Westchester is sacrificing short-term profits for fast growth in selected markets. This information indicates that Westchester is following the pricing strategy known as

A. Market skimming
B. Buying market share
C. Price skimming
D. Unitary pricing

Answer: B

NEW QUESTION 32
Health plans are allowed to appeal rules or regulations that affect them. Generally, the grounds for such appeals are limited either to procedural grounds or jurisdictional grounds. The Kabyle Health Plan appealed the following new regulations:
Appeal 1 - Kabyle objected to this regulation on the ground that this regulation is inconsistent with the law.
Appeal 2 - Kabyle objected to this regulation because it believed that the subject matter was outside the realm of issues that are legal for inclusion in the regulatory agency's regulations. Appeal 3 - Kabyle objected to the process by which this regulation was adopted.
Of these appeals, the ones that Kabyle appealed on jurisdictional grounds were

A. Appeals 1, 2, and 3
B. Appeals 1 and 2 only
C. Appeals 1 and 3 only
D. Appeals 2 and 3 only

Answer: B

NEW QUESTION 35
The following answer choices describe various approaches that a health plan can take to voice its opinions on legislation. Select the answer choice that best describes a health plan's use of grassroots lobbying.

A. The Delancey Health Plan is launching a media campaign in an effort to persuade the public that proposed health care legislation will increase the cost of healthcare.
B. The Stellar Health Plan is using direct mail and telephone calls to encourage people who support a patient rights bill to contact key legislators and voice their support for the bill.
C. The Bestway Health Plan is encouraging its employees to contribute to a political action committee (PAC) that is funding the political campaign of a pro-health plan candidate.

D. A representative of the Palmer Health Plan is attending a one-on-one meeting with a legislator to present Palmer's position on pending managed care legislation.

Answer: B

NEW QUESTION 40
One example of health plan's influence on the practice of medicine is that, during the past decade, the focus of healthcare has moved toward , which is designed to reduce the overall need for healthcare services by providing patients with decision-making information.

A. Demand management
B. Managed competition
C. Comprehensive coverage
D. Private inurement

Answer: A

NEW QUESTION 44
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