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
The Sawgrass Health Center is an institution that trains healthcare professionals and performs various clinical and other types of healthcare-related research. Because Sawgrass receives government funding, it is required to provide medical care for the poor. Of the following types of health plans, Sawgrass can best be described as:

A. A medical foundation
B. An academic medical center (AMC)
C. A healthcare cooperative
D. A community health center (CHC)

Answer: B

NEW QUESTION 3
The Surrey Medical Supply Company was formed as a limited partnership. In this partnership, Victoria Lewin is one of the limited partners and Oscar Gould is a general partner. This information indicates that, with respect to the typical characteristics of limited partnerships,

A. M
B. Lewin has more freedom to opt out of the partnership than does M
C. Gould
D. M
E. Lewin has more liability for the debts of Surrey than does M
F. Gould
G. both M
H. Lewin and M
I. Gould participate in the day-to-day management of Surrey
J. the partnership will continue upon the death of M
K. Gould, whereas it will end with the death of M
L. Lewin

Answer: A

NEW QUESTION 4
The Tidewater Life and Health Insurance Company is owned by its policy owners, who are entitled to certain rights as owners of the company, and it issues both participating and nonparticipating insurance policies. Tidewater is considering converting to the type of company that is owned by individuals who purchase shares of the company's stock. Tidewater is incorporated under the laws of Illinois, but it conducts business in the Canadian provinces of Ontario and Manitoba.
With regard to the state in which Tidewater is domiciled, it is correct to say that, from the perspective of both Ontario and Manitoba, Tidewater is considered to be the type of corporation known as:

A. A foreign corporation
B. An alien corporation
C. A sister corporation
D. A domestic corporation

Answer: B

NEW QUESTION 5
The Tidewater Life and Health Insurance Company is owned by its policy owners, who are entitled to certain rights as owners of the company, and it issues both participating and nonparticipating insurance policies. Tidewater is considering converting to the type of company that is owned by individuals who purchase shares of the company's stock. Tidewater is incorporated under the laws of Illinois, but it conducts business in the Canadian provinces of Ontario and Manitoba.
Tidewater established the Diversified Corporation, which then acquired various subsidiary firms that produce unrelated products and services. Tidewater remains an independent corporation and continues to own Diversified and the subsidiaries. In order to create and maintain a common vision and goals among the subsidiaries, the management of Diversified makes decisions about strategic planning and budgeting for each of the businesses.
Tidewater's participating policy owners have the right to

A. Elect the board of directors on the basis of one vote per policy owner
B. Elect the board of directors on the basis of one vote for each policy a person owns
C. Participate in developing a corporate mission statement and strategic plans
D. Receive stock dividends for each policy they own

Answer: A

NEW QUESTION 6
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.
One type of acquisition is called a stock purchase. In a typical stock purchase, a company acquires (51% / 100%) of the voting shares of another company's stock, thereby making the acquired company a subsidiary. The (acquired / acquiring) company holds all of the assets and liabilities of the acquired company.

A. 51% / acquired
B. 51% / acquiring
C. 100% / acquired
D. 100% / acquiring

Answer: C

NEW QUESTION 7
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 8
One federal law amended the Social Security Act to allow states to set their own qualification standards for HMOs that contracted with state Medicaid programs and revised the requirement that participating HMOs have an enrollment mix of no more than 50% combined Medicare and Medicaid members. This act, which was the true stimulus for increasing participation by health plans in Medicaid, is called the

A. Omnibus Budget Reconciliation Act of 1981 (OBRA-81)
B. Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)
C. Employee Retirement Income Security Act of 1974 (ERISA)
D. Federal Employees Health Benefits Act of 1958 (FEHB Act)

Answer: A

NEW QUESTION 9
Regulators of health plans have set standards in a number of areas of plan operations. Requirements with which health plans must comply typically include

A. providing enrollees and prospective enrollees with detailed information about various aspects of health plan policies and operations
B. maintaining internal grievance and appeals processes to resolve enrollee complaints against the organization
C. maintaining quality assurance programs that reflect the plan's activities in monitoring quality
D. all of the above

Answer: D

NEW QUESTION 10
The National Association of Insurance Commissioners (NAIC) adopted the Health Maintenance Organization Model Act (HMO Model Act) to regulate the development and operations of HMOs. One true statement regarding the HMO Model Act is that the act

A. includes mental health services in its definition of basic healthcare services
B. authorizes only one state agency-the department of insurance-to regulate HMOs
C. requires HMOs to place a deposit in trust with the state insurance commissioner for the purpose of protecting the interests of enrollees should an HMO become financially impaired
D. requires HMOs that wish to offer a point-of-service (POS) product to contract with a licensed insurance company to provide POS options to plan members

Answer: C

NEW QUESTION 10
Third party administrators (TPAs) provide various administrative services to health plans or groups that provide health benefit plans to their employees or members. Many state laws that regulate TPAs are based on the NAIC Third Party Administrator Model Statute. One provision of the TPA Model Law is that it

A. Prohibits TPAs from performing insurance functions such as underwriting and claims processing
B. Prohibits TPAs from entering into an agreement under which the amount of the TPA's compensation is based on the amount of premium or charges the TPA collects
C. Requires TPAs, upon the termination of a TPA agreement with a group, to immediately transfer all its records relating to the group to the new administrator
D. Requires TPAs to notify the state insurance department immediately following any material change in the TPA's ownership or control

Answer: D

NEW QUESTION 13
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 18
Certificate of need (CON) laws apply to health plans in a variety of ways, depending upon the state. By definition, CON laws are laws that are designed to

A. Regulate the construction, renovation, and acquisition of healthcare facilities as well as the purchase of major medical equipment in a geographical area
B. Protect commerce from unlawful restraint of trade, price discrimination, price fixing, reduced competition, and monopolies
C. Determine benefit payments when a person is covered by more than one plan, such as two group health plans
D. License and regulate health plans that wish to establish and operate an HMO

Answer: A

NEW QUESTION 22
The Nonprofit Institutions Act allows the Neighbor Hospital, a not-for-profit hospital, to purchase at a discount drugs for its 'own use'. Consider whether the following sales of drugs were not for Neighbor's own use and therefore were subject to antitrust enforcement:
Elijah Jamison, a former patient of Neighbor, renewed a prescription that was originally dispensed when he was discharged from Neighbor.
Neighbor filled a prescription for Camille Raynaud, who has no connection to Neighbor other than that her prescribing physician is located in a nearby physician's office building.
Neighbor filled a prescription for Nigel Dixon, who is a friend of a Neighbor medical staff member. With respect to the United States Supreme Court's definition of 'own use,' the drug sales that were not for Neighbor's own use were the sales that Neighbor made to

A. M
B. Jamison, M
C. Raynaud, and M
D. Dixon
E. M
F. Jamison and M
G. Raynaud only
H. M
I. Dixon only
J. None of these individuals

Answer: A

NEW QUESTION 23
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. From the following answer choices, select the response that identifies the type of market conduct examination that is being performed on Greenpath and the frequency with which the HMO Model Act requires state insurance departments to conduct an examination of an HMO's operations.

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 24
Health maintenance organizations (HMOs) seeking federal qualification under the HMO Act of 1973 and its amendments must meet requirements in four basic operational areas. One operational requirement for qualification is that an HMO must

A. Ensure that at least 1/3 of its policy-making body is comprised of HMO members
B. Ensure that there is adequate representation of underserved communities on its policy-making body
C. Have an ongoing quality assurance program that meets the requirements of the Centers for Medicaid & Medicare Services (CMS), stresses health outcomes, and provides for review by health professionals
D. Test, safeguard, and promote quality of care by following detailed programmatic techniques that are explained in CMS's Federally Qualified HMO (FQHMO) Manual

Answer: C

NEW QUESTION 26
One provision of the Mental Health Parity Act of 1996 (MHPA) is that the MHPA prohibits group health plans from

A. Setting a cap for a group member's lifetime medical health benefits that is higher than the cap for the member's lifetime mental health benefits
B. Imposing limits on the number of days or visits for mental health treatment
C. Charging deductibles for mental health benefits that are higher than the deductibles for medical benefits
D. Imposing annual limits on the number of outpatient visits and inpatient hospital stays for mental health services

Answer: A

NEW QUESTION 29
In 1994, the Department of Justice (DOJ) and the Federal Trade Commission (FTC) revised their 1993 healthcare-specific antitrust guidelines to include analytical

principles relating to multiprovider networks. Under the new guidelines, the regulatory agencies will use the rule of reason to analyze joint pricing activities by competitors in physician or multiprovider networks only if

A. Provider integration under the network is likely to produce significant efficiencies that benefit consumers
B. The providers in a network share substantial financial risk
C. The combining of providers into a joint venture enables the providers to offer a new product
D. All of the above

Answer: A

NEW QUESTION 32
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 36
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 37
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 38
The Balanced Budget Act (BBA) of 1997 created the Medicare+Choice plan. One provision of the BBA under Medicare+Choice is that the BBA

A. Requires health plans to qualify as either a competitive medical plan (CMP) or a federally qualified HMO in order to participate in the Medicare program
B. Eliminates funding for demonstration projects such as the Medicare Enrollment Demonstration Project
C. Narrows the geographic variations in payments to Medicare health plans by lowering the growth rate of payments in high-payment counties and raising the rates in low-payment counties
D. Increases Graduate Medical Education (GME) payments to hospitals for the training and cost of educating and training residents

Answer: C

NEW QUESTION 39
From the following answer choices, choose the term that best corresponds to this description. The
SureQual Group is a group of practicing physicians and other healthcare professionals paid by the federal government to review services ordered or furnished by other practitioners in the same medical fields for the purpose of determining whether medical services provided were reasonable and necessary, and to monitor the quality of care given to Medicare patients.

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

Answer: D

NEW QUESTION 41
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 43
One typical difference between a for-profit health plan's board of directors and a not-for-profit health plan's board of directors is that the directors in a for-profit health plan

A. Can serve on the board for a period of no more than ten years, whereas the terms of service fora not-for-profit board's directors are usually unlimited by the director's age or by a preset maximum number of years of service
B. Must participate in raising capital for the health plan, whereas a not-for-profit board's directors are prohibited from participating directly in raising capital for the health plan
C. Are directly accountable to shareholders, whereas a not-for-profit board's directors are accountable to plan members and the community
D. Are not compensated for board participation, whereas a not-for-profit board's directors are compensated for board participation

Answer: C

NEW QUESTION 45
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 48
SoundCare Health Services, an MCO, recently conducted a situation analysis. One step in this analysis required SoundCare to examine its current activities, its strengths and weaknesses, and its ability to respond to potential threats and opportunities in the environment. This activity
provided SoundCare with a realistic appraisal of its capabilities. One weakness that SoundCare identified during this process was that it lacked an effective program for preventing and detecting violations of law. SoundCare decided to remedy this weakness by using the 1991 Federal Sentencing Guidelines for Organizations as a model for its compliance program.
By definition, the activity that SoundCare conducted when it examined its strengths, weaknesses, and capabilities is known as

A. An environmental analysis
B. An internal assessment
C. An environmental forecast
D. A community analysis

Answer: B

NEW QUESTION 51
Health plans typically divide their costs into medical and administrative expenses. Examples of medical expenses are.

A. Equipment costs
B. Salaries and benefits for executives and for all functional areas
C. Sales and marketing costs
D. Payments to providers for the delivery of healthcare

Answer: D

NEW QUESTION 56
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. The contracts between Greenpath and its healthcare providers contain a termination provision known as

A. An 'economic credentialing' termination provision
B. A 'breach of contract' termination provision
C. A 'fair procedure' termination provision
D. A 'without cause' termination provision

Answer: D

NEW QUESTION 57
The government uses various tools within the realm of two broad categories of public policyallocative policies and regulatory policies. In the context of public policy, laws that fall into the
category of allocative policy include

A. The Balanced Budget Act (BBA) of 1997
B. The Health Insurance Portability and Accountability Act (HIPAA) of 1996
C. Laws affecting health plan quality oversight
D. Laws specifying procedures for health plan handling of consumer appeals and grievances

Answer: A

NEW QUESTION 62
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 67
Health plans should monitor changes in the environment and emerging trends, because changes in society will affect the managed care industry. One true statement regarding recent changes in the environment in which health plans operate is that

A. Women as a group receive more healthcare and interact more often with health plans than do men over the course of a lifetime
B. The focus of healthcare during the past decade has shifted away from outpatient care to inpatient hospital treatment
C. The uninsured population in the United States has been decreasing in recent years
D. The decline in overall inflation in the 1990s failed to slow the growth in healthcare inflation

Answer: A

NEW QUESTION 72
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 74
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