AHIP

Exam Questions AHM-510

Governance and Regulation

NEW QUESTION 1
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 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
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.
In creating Diversified, Tidewater formed the type of company known as

A. A mutual holding company
B. A spin-off company
C. An upstream holding company
D. A downstream holding company

Answer: D

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In order to become the type of company that is owned by people who purchase shares of the company's stock, Tidewater must undergo a process known as

A. management buy-out
B. piercing the corporate veil
C. demutualization
D. mutualization

Answer: C

NEW QUESTION 5
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 6
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 7
The Department of Health and Human Services (HHS) has delegated its responsibility for development and oversight of regulations under the Health Insurance Portability and Accountability Act (HIPAA) to an office within the Centers for Medicaid & Medicare Services (CMS). The CMS office that is responsible for enforcing the federal requirements of HIPAA is the

A. Center for Health Plans and Providers (CHPPs)
B. Center for Medicaid and State Operations
C. Center for Beneficiary Services
D. Center for Managed Care

Answer: B

NEW QUESTION 8
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 9
Several states have adopted clinical practice guidelines for treating workers' compensation injuries. Clinical practice guidelines can best be described as

A. Fee schedules that specify the maximum amount providers may charge for treating workers' compensation patients
B. A utilization management and quality management mechanism designed to aid providers in making decisions about the most appropriate course of treatment for a specific case
C. Detailed plans of medical treatment designed to facilitate a patient's return to the workplace
D. Payment practices that might technically violate the provisions of the anti-kickback statute but that will not be considered illegal and for which providers and health plans will not be subject to penalties

Answer: B

NEW QUESTION 10
While traditional workers' compensation laws have restricted the use of managed care techniques, many states now allow managed workers' compensation. One common characteristic of managed workers' compensation plans is that they

A. Discourage injured employees from returning to work until they are able to assume all the duties of their jobs
B. Use low copayments to encourage employees to choose preferred providers
C. Cover an employee's medical costs, but they do not provide coverage for lost wages
D. Rely on total disability management to control indemnity benefits

Answer: D

NEW QUESTION 10
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 14
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 19
The Opal Health Plan complies with all of the provisions of the Newborns' and Mothers' Health Protection Act of 1996 (NMHPA). Samantha Hill and Debra Chao are Opal enrollees. Ms. Hill was hospitalized for a cesarean birth, and Ms. Chao was hospitalized for a normal delivery. From the following answer choices, select the response that indicates the minimum hospital stay for which Opal, under NMHPA, must provide benefits for Ms. Hill and Ms. Chao.

A. M
B. Hill: 72 hours; M
C. Chao: 24 hours
D. M
E. Hill: 72 hours; M
F. Chao: 48 hours
G. M
H. Hill: 96 hours; M
I. Chao: 24 hours
J. M
K. Hill: 96 hours; M
L. Chao: 48 hours

Answer: D

NEW QUESTION 23
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.
Every employee benefit plan governed by the Employee Retirement Income Security Act (ERISA) must distribute a summary plan description (SPD) to participants within (90 / 120) days after the date on which the plan is adopted or made effective. Thereafter, if the plan is amended, a new SPD must be distributed every (5 / 10) years.

A. 90 / 5
B. 90 / 10
C. 120 / 5
D. 120 / 10

Answer: C

NEW QUESTION 27
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 31
Solvency standards for Medicare provider-sponsored organizations (PSOs) are divided into three parts: (1) the initial stage, (2) the ongoing stage, and (3) insolvency. In the initial stage, prior to CMS approval, a Medicare PSO typically must have a minimum net worth of

A. $750,000
B. $1,000,000
C. $1,500,000
D. $2,000,000

Answer: C

NEW QUESTION 33
States may impose nominal deductibles, coinsurance, or copayments on some Medicaid recipients for certain services. Services for which states can require copayments from Medicaid recipients include:

A. Emergency services
B. Family planning services
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: D

NEW QUESTION 35
There are several exceptions to the Ethics in Patient Referrals Act and its amendments (the Stark laws), which prohibit a physician from referring Medicare or Medicaid patients for certain designated services or supplies provided by entities in which the physician has a financial interest. Consider whether the situations described below qualify as exceptions to the Stark laws:
Situation A: Dr. Wong is a physician in the Marvel Health Plan's provider network and has a financial relationship with Marvel arising from the health plan's compensation for his services. Marvel is not a prepaid health plan.
Situation B: Dr. Ryder is a physician in the provider network of the Glen Health Plan, which is not a prepaid health plan. In situations of medical necessity, Dr. Ryder refers Glen patients to a physical therapy clinic that leases office space from him.
Situation C: Dr. Yost has a compensation arrangement with a health plan for providing health services under the Medicare+Choice program.
An arrangement that is exempt from the Stark laws is described in

A. All of these situations
B. Situations A and C only
C. Situation B only
D. Situation C only

Answer: D

NEW QUESTION 36
The following statements are about various provisions of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Three of the statements are true and one statement is false. Select the answer choice that contains the FALSE statement.

A. HIPAA permits group health plans that offer coverage through an HMO to impose affiliation periods during which no benefits or services are provided to a plan member.
B. HIPAA created a new category of federal healthcare crimes, called federal healthcare offenses that apply to private healthcare plans as well as to federally funded healthcare programs.
C. One effect of Section 231(h) of HIPAA, which amended the Social Security Act, has been to permit health plans with Medicare contracts to provide enrollees with value-added services such as discounted memberships to health clubs.
D. HIPAA provides that any fines and penalties recovered through regulatory proceedings to enforce the federal fraud and abuse statutes will be turned over to enforcement agencies to conduct additional investigations.

Answer: C

NEW QUESTION 41
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 46
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 51
The following statements appear in the Twilight Health Plan's strategic plan:
Increase the percentage of preventive health interventions for total eligible membership during each of the next three calendar years for the following services: mammography, Pap smears, immunizations, and first trimester visits for prenatal mothers

Improve customer satisfaction on an annual basis for each of the next three calendar years, as measured by satisfaction surveys for members, providers, and employer groups
Increase by 30% the number of claims processed by the automated claim payment system and reduce by 10% the cost of paying claims during the next three years
These statements are examples of Twilight's

A. Corporate objectives
B. Company mission
C. Company vision
D. Corporate strategies

Answer: A

NEW QUESTION 53
In developing its corporate strategies, the Haven Health Plan decided to implement a growth strategy that is focused on increasing the percentage of preventive health office visits from its current plan members. To accomplish this objective, Haven will send a direct mail kit to existing plan members to remind them of the variety of preventive health services that Haven currently offers, including physical exams, cholesterol tests, and mammograms. This information illustrates Haven's use of

A. An intensive growth strategy known as market penetration
B. An integrated growth strategy known as product development
C. An integrated growth strategy known as market development
D. A diversified growth strategy known as market penetration

Answer: A

NEW QUESTION 56
In examining accountability in the current managed care environment, one is likely to find that combinations of various models of accountability are in operation. Under one model of accountability, the primary mechanisms for accountability are the mechanisms of the marketplace- failure to meet standards will result in a loss of demand for services. By definition, this model of accountability is called the

A. Professional model of accountability
B. Political model of accountability
C. Due diligence model of accountability
D. Economic model of accountability

Answer: D

NEW QUESTION 58
Brighton Health Systems, Inc., a health plan, wants to modify its advertising and marketing materials to avoid liability risk under the principle of ostensible agency. One step that Brighton can take to reduce the likelihood of being liable for provider negligence under the theory of ostensible agency is to

A. Guarantee the quality of medical care provided to Brighton members
B. Use advertising materials which state that Brighton itself provides healthcare
C. Add disclaimers to advertising materials indicating that only physicians and not Brighton make medical decisions
D. Use advertising materials to characterize Brighton's role as providing physicians, hospitals, and other healthcare professionals rather than arranging for healthcare.

Answer: C

NEW QUESTION 60
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.
This information indicates that Bloom resolved its dispute with Mr. Dace by using an ADR method known as:

A. Corporate risk management
B. An ombudsman program
C. An ethics committee
D. Arbitration

Answer: D

NEW QUESTION 65
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 66
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 67
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 71
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