AHM-510 Dumps

Governance and Regulation

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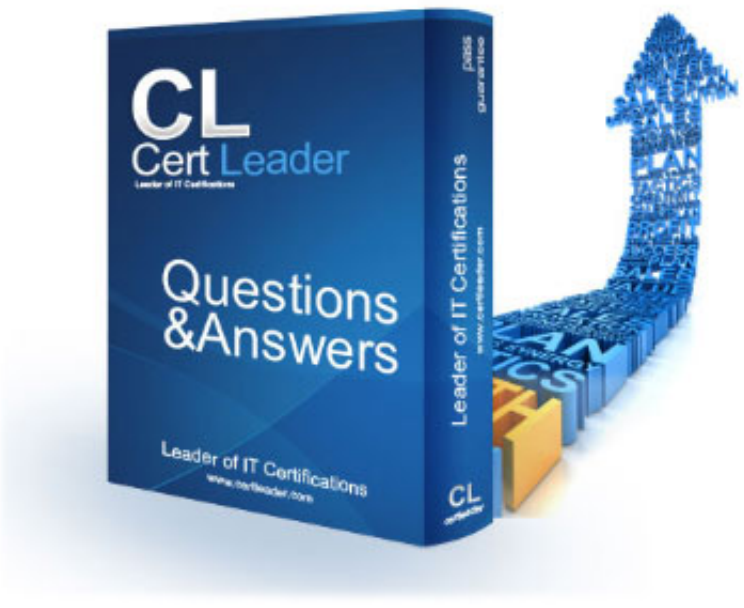

NEW QUESTION 1
Regulatory and legislative bodies are among the important environmental forces in the health plan industry. The following statements are about such regulation and legislation. Select the answer choice that contains the correct statement.

A. Federal guidelines exist to direct health plans on compliance issues when a health plan encounters conflicting state laws in a given service area.
B. Administrative rules and regulations do not carry the force of law.
C. As stakeholders in the health plan industry, federal and state governments exert tremendous influence over a health plan's formation and operations.
D. In recent years, the number of health plan bills in the state and the federal legislatures has decreased.

Answer: C

NEW QUESTION 2
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 3
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 4
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 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
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 7

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 8
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 9
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 10
The following statements are about market conduct examinations of health plans. Select the answer choice that contains the correct statement.

A. Multistate examinations are not appropriate for financial examinations, because regulatory requirements concerning a health plan's financial condition tend to vary from state to state.
B. Market conduct examinations of a health plan's advertising and sales materials include comparing the advertising materials to the policies they advertise.
C. Once an examination report is provided to the state insurance department, a health plan is not given an opportunity to present a formal objection to the report.
D. In imposing sanctions on health plans, state insurance departments are required to follow federal sentencing guidelines.

Answer: B

NEW QUESTION 15
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 20
Determine whether the following statement is true or false:
Although most-favored-nation (MFN) clauses in contracts between health plans and healthcare providers are not per se illegal, they should be reviewed under the rule of reason analysis for antitrust purposes.

A. True, because the Federal Trade Commission (FTC) ruled that MFN clauses are not per se illegal and the FTC encourages health plans to include them in provider contracts.
B. True, because although MFN clauses are not per se illegal, they violate antitrust laws if they have a predatory purpose and an anticompetitive effect.
C. False, because MFN clauses involve decisions by providers concerning the level of fees to charge, and thus they are per se illegal.
D. False, because MFN clauses are not per se illegal, and thus they are exempt from antitrust laws and regulation by the FTC.

Answer: B

NEW QUESTION 24
TRICARE, a military healthcare program, offers eligible beneficiaries three options for healthcare services: TRICARE Prime, TRICARE Extra, and TRICARE Standard. With respect to plan features, both an annual deductible and claims filing requirements must be met, regardless of whether care is delivered by network providers, under

A. TRICARE Prime and TRICARE Extra only
B. TRICARE Extra and TRICARE Standard only
C. TRICARE Standard only
D. None of these healthcare options

Answer: C

NEW QUESTION 29
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 34
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 35
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 40
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 42
After conducting a business portfolio analysis, the Acorn Health Plan decided to pursue a harvest strategy with one of its strategic business units (SBUs)-Guest Behavioral Healthcare. By following a harvest strategy with Guest, Acorn most likely is seeking to

A. Maximize Guest's short-term earnings and cash flow
B. Increase Guest's market share
C. Maintain Guest's market position
D. Sacrifice immediate earnings in order to fund Guest's growth

Answer: A

NEW QUESTION 46
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 48
The Hanford Health Plan has delegated the credentialing of its providers to the Sienna Group, a credential verification organization (CVO). If the contract between Hanford and Sienna complies with all of the National Committee for Quality Assurance (NCQA) guidelines for delegation of credentialing, then this contract

A. Transfers to Sienna all rights to terminate or suspend individual practitioners or providers in Hanford's provider network
B. Describes the process by which Hanford evaluates Sienna's performance in credentialing providers
C. Both A and B
D. A only
E. B only
F. Neither A nor B

Answer: C

NEW QUESTION 51
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)
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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 56
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