AHM-510 Q&As

Governance and Regulation

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QUESTION 1

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.

Correct Answer: C

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)

Correct Answer: B

QUESTION 3

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.

Correct Answer: C

QUESTION 4

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

Correct Answer: D

QUESTION 5

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 and 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

Correct Answer: C

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 and 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

Correct Answer: B

QUESTION 7

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

Correct Answer: C

QUESTION 8

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

Correct 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.

QUESTION 9

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

Correct Answer: D

QUESTION 10

State X issued a nonresident license to Tamara Pensky, a sales representative of the Verity Health Plan. In doing so, State X imposed a countersignature requirement, which requires that

A. An officer of Verity sign a written statement which indicates that Verity appoints Ms. Pensky as an agent who is authorized to market Verity\\'s products

B. An officer of Verity sign a written statement which certifies that Verity has investigated Ms. Pensky\\'s qualifications and background and believes she is trustworthy and competent

C. Applications solicited by Ms. Pensky must be signed by an individual who holds a resident License

D. Applications solicited by Ms. Pensky must be signed by an officer of Verity

Correct Answer: C

QUESTION 11

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 ofreason 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

Correct Answer: A

QUESTION 12

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 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

Correct Answer: C

QUESTION 13

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

Correct Answer: C

QUESTION 14

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

Correct Answer: B

QUESTION 15

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

Correct Answer: C