

AHIP

Exam Questions AHM-510

Governance and Regulation



NEW QUESTION 1

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 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. 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 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

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. 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

Answer: C

NEW QUESTION 5

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 6

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 7

Any willing provider laws have their share of proponents and opponents. Arguments commonly made in opposition to any willing provider laws include

- A. That such laws reduce the number of providers in a health plan's network
- B. That such laws limit consumer choice to coverage options that are more costly than networkbased plans
- C. That such laws encourage providers to offer discounts in exchange for patient volume
- D. All of the above

Answer: B

NEW QUESTION 8

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 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

The Good & Well Pharmacy, a Medicaid provider of outpatient drugs, is subject to the prospective drug utilization review (DUR) mandates of the Omnibus Budget Reconciliation Act of 1990 (OBRA '90). One component of prospective DUR is screening. In this context, when Good & Well is involved in the process of screening, the pharmacy is

- A. Updating a formulary to represent the current clinical judgment of providers and experts in the diagnosis and treatment of disease
- B. Reviewing patient profiles for the purpose of identifying potential problems
- C. Consulting directly with prescribers and patients in the planning of drug therapy
- D. Denying coverage for the off-label use of approved drugs

Answer: B

NEW QUESTION 10

SoundCare Health Services, a health plan, 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 12

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 17

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 19

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 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 26

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 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 32

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 34

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 35

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 36

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 41

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 46

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 47

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 48

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 51

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