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Governance and Regulation

AHIP AHM-510

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QUESTION NO: 1

Indigo Health Plan advertised a specific individual health insurance policy through a direct mail advertisement that provided detailed information about the product. In order to comply with the NAIC Model Rules Governing Advertisements of Accident and Sickness Insurance, Indigo must disclose whether the advertised policy contains any exceptions, reductions, or limitations. Thus, Indigo disclosed in the advertisement that one policy provision limits coverage for dental exams to $50 per exam and to one exam per calendar year. This information indicates that, with respect to the definitions in the NAIC Model Rules, Indigo's advertisement is an example of an

A. Invitation to contract, and it discloses a policy provision known as an exception

B. Invitation to contract, and it discloses a policy provision known as a reduction

C. Invitation to inquire, and it discloses a policy provision known as an exception

D. Invitation to inquire, and it discloses a policy provision known as a reduction

ANSWER: B

Explanation:

Invitation to contract, and it discloses a policy provision known as a reduction is correct. Under the NAIC Model Regulation governing advertisements of accident and sickness insurance, an invitation to contract is an advertisement that provides enough detail about a policy's benefits, features, limitations, and terms to encourage a consumer to apply for the coverage. Because Indigo's direct-mail piece provides detailed information about a specific individual policy, it is an invitation to contract rather than merely a general solicitation for additional information.

The dental-exam provision is a reduction because it decreases the amount of benefits payable for that covered service. The $50 maximum per examination and the annual frequency cap operate to restrict the benefit available under the policy for dental exams. When an advertisement is an invitation to contract, the insurer must accurately and clearly disclose applicable exceptions, reductions, and limitations so consumers can evaluate the scope and value of the coverage being offered. These disclosure standards are intended to prevent misleading impressions about policy benefits. See the NAIC's Model Regulation to Implement the Accident and Sickness Insurance Minimum Standards Act and the NAIC's health insurance resources.

QUESTION NO: 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

Explanation:

"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" is correct. A charitable organization must be organized and

operated exclusively for purposes recognized under Section 501(c)(3), and its activities must serve a public rather than a private interest. For a health plan, this standard generally requires that the organization's benefits and services be directed to a sufficiently broad charitable class and that the organization meet the more restrictive operational requirements applicable to charitable entities. A social welfare organization under Section 501(c)(4), by contrast, is evaluated under the social-welfare standard: it must be operated primarily to promote the common good and general welfare of the people of the community. In the health-plan context, this can permit an organization to serve a more limited group than the broad charitable class required for Section 501(c)(3) status. That comparatively less restrictive beneficiary scope is the basis for describing Section 501(c)(4) recognition as easier to obtain in this comparison. The IRS discusses the distinct exemption requirements for charitable and social-welfare organizations in its guidance on charitable purposes and social welfare organizations.

QUESTION NO: 3

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

Explanation:

The statement that the act "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" accurately reflects an important financial-solvency safeguard in the NAIC Health Maintenance Organization Model Act. The model framework requires an HMO to maintain a deposit of cash or eligible securities with the commissioner. That deposit is held in trust and is intended to protect enrollees if the organization encounters financial difficulty or fails to meet obligations arising from its health-care arrangements. This requirement reflects the distinct nature of HMOs: enrollees depend on the organization's continuing ability to arrange and pay for covered health services, so financial protections are central to state oversight. The deposit requirement works alongside other HMO regulatory provisions—such as licensing, financial reporting, examinations, and reserve standards—to support an HMO's ongoing solvency and its responsibility to its enrolled population. Because the NAIC model act serves as a template for state regulation rather than federal law, individual states may enact variations, but the model's deposit-in-trust protection is the governing principle tested here. See the NAIC's Health Maintenance Organization Model Act and its Model Laws, Regulations, and Guidelines resources.

QUESTION NO: 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

Explanation:

“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” is correct because aggressive sourcing is a purchasing and procurement strategy. In this context, the health plan actively evaluates competing external suppliers and negotiates for favorable price, quality, service, and contractual terms for commonly purchased goods and support services. The focus is on leveraging competition among vendors and disciplined purchasing practices to control administrative expenses while obtaining the resources the plan needs to operate effectively. This type of sourcing can include comparing bids, consolidating purchases where appropriate, standardizing products, and using the plan’s purchasing volume to secure more advantageous arrangements. It is therefore a basic corporate transaction directed at acquiring equipment, supplies, and services efficiently, rather than a change to the plan’s corporate structure or core operating model. Federal procurement guidance similarly describes strategic sourcing as an approach that analyzes spending and supplier markets to obtain best value and improve purchasing outcomes. See the U.S. General Services Administration’s purchasing-program overview and the Federal Acquisition Regulation definition of “best value”.

QUESTION NO: 5

The following statements describe various state benefit mandates. Select the answer choice that describes a state law pertaining to off-label uses for drugs.

A. State A mandates that health plans provide benefits for experimental drugs for the treatment of terminal diseases such as AIDS and cancer.

B. State B mandates that health plans have a procedure in place to allow a patient to have a non-formulary drug covered under certain conditions.

C. State C mandates that, in dispensing generic drugs, pharmacies must label drug containers with the name of the substituted generic medication.

D. State D mandates that health plans provide benefits for the treatment of one form of cancer with specific drugs that had originally been approved by the Food and Drug Administration (FDA) to treat other forms of cancer.

ANSWER: D

Explanation:

State D mandates that health plans provide benefits for the treatment of one form of cancer with specific drugs that had originally been approved by the Food and Drug Administration (FDA) to treat other forms of cancer. This describes an off-label drug use mandate. “Off-label” use means that an FDA-approved drug is prescribed for a use, condition, patient population, dosage, or route of administration that differs from the specific use included in the drug’s FDA-approved labeling. In this example, the drugs have FDA approval and are being used in cancer treatment, but they are being used to treat a different form of cancer than the one or ones identified in their original FDA approval. State mandates addressing off-label cancer-drug coverage commonly require health plans to cover these uses when they are supported by recognized medical evidence, such as authoritative drug compendia or peer-reviewed clinical literature. These laws can improve access to clinically accepted cancer therapies when FDA labeling has not yet been updated for every evidence-supported indication. The FDA explains that clinicians may prescribe approved drugs for unapproved uses when medically appropriate, although FDA approval is based on the labeled indication: FDA: Understanding Unapproved Use of Approved Drugs. Additional context on off-label prescribing is available from the National Cancer Institute.

QUESTION NO: 6

The Northstar Health Plan receives a request from an enrollee for an expedited review of an adverse benefit determination involving urgently needed care. Northstar's utilization management department determines that applying the standard review timeframe could seriously jeopardize the enrollee's life, health, or ability to regain maximum function.

Under the Affordable Care Act's internal claims and appeals requirements, Northstar generally must provide notice of its benefit determination on expedited review as soon as possible, but no later than

A. 24 hours after receipt of the claim

B. 72 hours after receipt of the claim

C. 15 calendar days after receipt of the claim

D. 30 calendar days after receipt of the claim

ANSWER: B

Explanation:

72 hours after receipt of the claim is correct. For an urgent care claim, the internal claims and appeals rules require a group health plan or health insurance issuer to notify the claimant of its benefit determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim. The expedited timeframe recognizes that a delayed decision may adversely affect the claimant's health.

The plan may need additional information before reaching a determination. In that circumstance, the applicable rules provide accelerated procedures for requesting and receiving the missing information. The basic requirement remains that urgent-care determinations be handled more quickly than pre-service or post-service claims. See 29 C.F.R. § 2560.503-1 and the Department of Labor's ACA claims and appeals guidance.

QUESTION NO: 7

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

Explanation:

Women as a group receive more healthcare and interact more often with health plans than do men over the course of a lifetime. This is an important environmental and demographic consideration for health plans because women commonly serve as healthcare decision-makers for themselves and family members, and they have healthcare needs that generate recurring contact with providers and insurers across the life span. These needs include preventive services, reproductive and maternity care, and care associated with a longer average life expectancy. Accordingly, patterns of enrollment, benefit use, care management, member communications, provider-network planning, and quality measurement must account for women’s substantial use of health services. The U.S. Department of Health and Human Services’ Office on Women’s Health notes that women use healthcare services more than men and are more likely to seek preventive care. AHRQ’s evidence resources likewise recognize sex-related differences in healthcare use and the importance of measuring them. Monitoring these utilization patterns helps a health plan anticipate member needs, design accessible benefits and outreach, and manage health services effectively as population characteristics and expectations evolve. See the HHS Office on Women’s Health and the Agency for Healthcare Research and Quality’s women’s health resources.

QUESTION NO: 8

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. Both A and B

B. A only

C. B only

D. Neither A nor B

ANSWER: B

Explanation:

A only is correct because HIPAA established guaranteed-renewability protections for group health coverage. Subject to limited statutory exceptions, an issuer that offers group health insurance coverage must renew or continue coverage at the option of the plan sponsor. This protection applies without regard to the health status, claims experience, receipt of health care, medical condition, or disability of an individual participant or beneficiary. In practical terms, an issuer cannot decline to renew a group policy simply because a member of the group has high health costs or an adverse medical condition. The rule supports HIPAA's portability and nondiscrimination goals by reducing the risk that health-related factors will disrupt a group's access to coverage. The guaranteed-renewability requirement is codified in the Public Health Service Act at 42 U.S.C. § 300gg-42 and is reflected in the implementing regulations at 45 C.F.R. § 146.152. Accordingly, the applicable HIPAA compliance obligation described in the question is renewal of group health policies in both the small- and large-group markets regardless of any group member's health status.

QUESTION NO: 9

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

Explanation:

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 is correct because the Mental Health Parity Act of 1996 established parity requirements specifically for aggregate lifetime dollar limits and annual dollar limits. When a group health plan elected to offer mental health benefits and also imposed a lifetime dollar limit on medical and surgical benefits, it could not set a lower lifetime dollar limit for mental health benefits. In practical terms, the plan could not provide a more generous lifetime maximum for medical and surgical care than for mental health care. The original MHPA did not require every group health plan to offer mental health benefits; rather, its parity rule applied when such benefits were offered and the plan used aggregate annual or lifetime dollar limits. This historic statute was later supplemented and expanded by the Mental Health Parity and Addiction Equity Act, but the lifetime-limit rule described here is a core provision of the 1996 law. The U.S. Department of Labor summarizes MHPA's original focus on annual and lifetime dollar limits at https://www.dol.gov/general/topic/health-plans/mental. The statutory text is available through Congressional Public Law 104-204.

QUESTION NO: 10

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

Explanation:

A downstream holding company is correct because Tidewater, an operating insurance company, established and retained ownership of Diversified, which in turn acquired and controlled businesses that provide unrelated products and services. The ownership direction runs from the insurer downward into a holding company and its subsidiary enterprises. This structure permits the insurer to remain an independent operating company while using the downstream entity to own and coordinate a diversified group of noninsurance or related businesses. Diversified's centralized strategic-planning and budgeting functions also reflect the role of a parent-level organization in aligning the operations and goals of its subsidiaries.

Insurance holding-company regulation focuses on control relationships, affiliated entities, and the potential effect of those relationships on an insurer's financial condition and policyholders. Illinois law defines an insurance holding company system broadly around common control of insurers and other persons, which is consistent with Tidewater's continuing ownership and control of Diversified and its acquired firms. The National Association of Insurance Commissioners likewise addresses these systems through its Insurance Holding Company System Regulatory Act framework. See the Illinois Insurance Code, Section 131.1 and the NAIC Insurance Holding Company System Regulatory Act.