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# Healthcare Management: An Introduction

## AHIP AHM-250

**Version Demo**

**Total Demo Questions: 33**

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# Topic Break Down

| Topic | No. of Questions |
|---|---|
| Topic 1, Volume A | 116 |
| Topic 2, Volume B | 101 |
| Topic 3, Volume C | 181 |
| Total | 418 |

QUESTION NO: 1

More procedures or services may be fully covered within the PPO network than those out of network.

**A.** True

**B.** False

**ANSWER: A**

**Explanation:**

True is correct because a preferred provider organization (PPO) uses a network-based benefit design that generally gives members the most favorable coverage when they receive care from participating providers. PPO members may seek services outside the network, but the plan commonly applies less favorable benefit terms to nonnetwork care, such as a separate or higher deductible, higher coinsurance, a lower allowed amount, or member responsibility for amounts above the plan's allowed charge. As a result, a service that is paid in full under the applicable in-network benefit terms may not be paid in full when obtained from an out-of-network provider. The statement appropriately says "may," since the exact services and payment levels depend on the specific plan's evidence of coverage, benefit schedule, network contract status, and applicable medical-necessity rules. In practical benefit administration, using an in-network provider helps the member access negotiated rates and the plan's highest level of coverage. The Centers for Medicare & Medicaid Services defines a PPO as a plan with a network of contracted providers and explains that members can use out-of-network providers but generally pay more. See the HealthCare.gov PPO glossary and CMS's PPO coverage overview.

**QUESTION NO: 2**

The following statements are about the accessibility of healthcare coverage and medical care in the United States. Select the answer choice that contains the correct statement.

**A.** A person's employment status as a full-time employee guarantees that person access to healthcare coverage.

**B.** Most people who have healthcare coverage are covered under an individual insurance policy rather than a group insurance plan.

**C.** The percentage of the population without healthcare coverage is evenly distributed throughout the United States.

**D.** Hospital closings have occurred disproportionately in rural areas and inner cities and have reduced access to healthcare in these areas.

**ANSWER: D**

**Explanation:**

"Hospital closings have occurred disproportionately in rural areas and inner cities and have reduced access to healthcare in these areas." is correct because access to medical care depends not only on whether a person has insurance, but also on whether providers and facilities are available within a reasonable distance. Rural communities can be especially vulnerable when a hospital closes because they commonly have fewer alternative hospitals, fewer clinicians, longer travel distances, and more limited transportation infrastructure. A closure may therefore require patients to travel substantially farther for emergency services, inpatient care, maternity care, diagnostic services, and specialty treatment. The resulting delay or burden can be particularly consequential for urgent and time-sensitive conditions. The same access concern applies in underserved urban neighborhoods, where hospital closures or service reductions can remove an important source of care for populations that may already face transportation, financial, and provider-availability barriers. Federal rural-health resources recognize hospital closures as a major challenge to maintaining timely local access to care, and research has documented the effects of closures on access and utilization. See the Rural Health Information Hub's overview of rural hospitals and the National Academies discussion of hospital closures and access to care.

**QUESTION NO: 3**

The Acme HMO recruits and contracts directly with a wide range of physicians—both PCPs and specialists—in its geographic area on a non-exclusive basis. There is no separate legal entity that represents and negotiates the contracts for the physicians. The

**A.** an independent practice association (IPA) model HMO

**B.** a staff model HMO

**C.** a direct contract model HMO

**D.** a group model HMO

**ANSWER: C**

**Explanation:**

The correct answer is **a direct contract model HMO**. Under this arrangement, the HMO contracts individually and directly with physicians, including both primary care physicians and specialists. The physicians are not represented by an intermediary physician organization that negotiates on their behalf. This direct relationship allows the health plan to establish provider participation terms, reimbursement arrangements, quality expectations, utilization-management requirements, and network obligations with each contracted physician.

The description's emphasis on recruitment of a broad range of physicians in the service area, nonexclusive participation, and the absence of a separate legal entity for contracting identifies the direct contract model. Physicians generally remain independent practitioners and may maintain relationships with other payers, while participating in the HMO's network according to their individual contracts. This model can help an HMO assemble a geographically dispersed network without employing physicians or relying on a physician group or association to serve as the contracting entity.

More broadly, direct provider contracting is a central mechanism by which managed care organizations create provider networks and define the covered population's access to services. See the CMS overview of provider participation arrangements and the NCBI overview of managed care.

**QUESTION NO: 4**

Which of the following statements about the Title VII of the Civil Rights Act is WRONG?

**A.** Employers with 15 or more employees engaged in interstate commerce need to comply

**B.** Pregnancy Discrimination Act (an amendment to this act) requires health plans to provide coverage during childbirth and related medical conditions on the same basis as they provide coverage for other medical conditions

**C.** Allows HMOs to set different policies for people from different races, religions, sex or national origin to safeguard their interests.

**D.** Protects all employees

**ANSWER: C**

**Explanation:**

"Allows HMOs to set different policies for people from different races, religions, sex or national origin to safeguard their interests." is the wrong statement. Title VII of the Civil Rights Act of 1964 establishes a federal prohibition against employment discrimination based on race, color, religion, sex, and national origin. This protection extends to the terms, conditions, and privileges of employment, which can include employer-sponsored health benefits. An organization cannot use a person's protected characteristic as a basis for offering, limiting, administering, or structuring employment-related health-plan benefits differently. The fact that an insurer or HMO may have operational, financial, or other business interests does not create permission to apply policies differently on the basis of these protected characteristics. In the health-benefits context, covered employers must ensure that plan design and benefit administration comply with Title VII's nondiscrimination requirements. The Equal Employment Opportunity Commission explains that Title VII bars employment discrimination based on the listed protected characteristics and applies to covered employers. Its guidance also recognizes that discriminatory practices can arise in employee benefit plans. See the EEOC's Title VII statute page and the EEOC fact sheet on sex discrimination.

## QUESTION NO: 5

Medicaid is a jointly funded federal and state program that provides hospital and medical expense coverage to low-income individuals and certain aged and disabled individuals. One characteristic of Medicaid is that

**A.** providers who care for Medicaid recipients must accept Medicaid payment as payment in full for services rendered

**B.** Medicaid requires recipients to pay deductibles, copayments, and coinsurance amounts for all services

**C.** Medicaid is always the primary payer of benefits

**D.** benefits offered by Medicaid programs are federally mandated and do not vary by state

## ANSWER: A

**Explanation:**

“providers who care for Medicaid recipients must accept Medicaid payment as payment in full for services rendered” describes Medicaid’s payment-in-full, or anti-balance-billing, requirement. A provider that participates in Medicaid and furnishes a covered service to an eligible Medicaid beneficiary generally must accept the amount paid by the state Medicaid agency, together with any beneficiary cost sharing that is specifically permitted under the state plan, as full payment. The provider may not bill the beneficiary for the difference between the provider’s usual charge and Medicaid’s allowed payment amount. This protection is particularly important because Medicaid serves individuals with limited income and resources; it prevents a covered service from creating an additional provider balance that the beneficiary must pay.

The federal regulation establishes this condition directly: state Medicaid plans must limit participation to providers that accept Medicaid payment, plus any allowable deductible, coinsurance, or copayment, as payment in full. States administer their own Medicaid programs within federal requirements and set many operational details, including covered benefits and payment rates, but the payment-in-full principle applies to participating providers’ Medicaid-covered services. See 42 C.F.R. § 447.15 and CMS’s Medicaid program administration resources.

## QUESTION NO: 6

The Venus Hospital provides medical care to paying patients, as well as to people who either have no healthcare coverage and cannot pay for the care by themselves or who receive services at reduced rates because they are covered under government sponsored

**A.** anti selection

**B.** cost shifting

**C.** receivership

**D.** underwriting

## ANSWER: B

**Explanation:**

Cost shifting is correct because it describes a provider’s effort to recover some of the costs of treating patients whose care is unpaid or reimbursed below the provider’s costs by charging higher rates to other payers, commonly commercial insurers and self-paying patients with the ability to pay. In the scenario, Venus Hospital serves both paying patients and patients who are uninsured or covered by government-sponsored programs at reduced rates. When revenue from the latter groups does not fully cover the resources required to provide their care, the hospital may seek to offset that shortfall through the prices negotiated with private payers. This does not mean that every individual patient’s price is directly increased by the exact amount of another patient’s shortfall; rather, it is a financial and pricing concept used to describe how hospitals can attempt to support services across a mixed payer population. Medicare and Medicaid payment policies establish specific reimbursement methodologies that can differ from hospitals’ commercial payment arrangements, making payer mix central to hospital finance. CMS explains Medicare’s hospital prospective payment systems at https://www.cms.gov/medicare/payment/prospective-payment-systems, and MACPAC provides context on Medicaid hospital payment policy at https://www.macpac.gov/subtopic/hospital-payment-policy/.

## QUESTION NO: 11

Advantages of EDI over manual data management systems

**A.** Speed of data transfer

**B.** Loss of data integrity

**C.** All of the above

**D.** None of the above

## ANSWER: A

**Explanation:**

**Speed of data transfer** is an important advantage of electronic data interchange (EDI) over manual data-management processes. EDI enables organizations to exchange standardized business and administrative transactions directly between computer systems, rather than requiring staff to rekey information from paper forms, emails, faxes, or separate portals. For health plans and providers, this can accelerate the movement and processing of transactions such as claims, eligibility inquiries and responses, referrals, remittance advice, and enrollment data.

By automating transmission and using standard transaction formats, EDI reduces the elapsed time between creation, receipt, and processing of information. Faster exchange supports more timely operational workflows, including claim adjudication, payment activities, and responses to provider or member inquiries. It also supports more consistent handling of high transaction volumes than a process dependent on manual entry and routing. In the HIPAA administrative simplification context, covered entities use adopted electronic transaction standards to improve the efficiency of health-care administrative exchanges. The Centers for Medicare & Medicaid Services describes these standards and their role in electronic transactions at CMS Administrative Simplification. Additional information on HIPAA electronic transaction standards is available from HHS.

## QUESTION NO: 12

The Meadowcreek Group is an organization comprised of individual physicians and physicians in small group practices. Meadowcreek enters into contracts with health plans, and then Meadowcreek contracts separately with its physician members. In situations w

**A.** a group practice without walls (GPWW)

**B.** a messenger model

**C.** an individual practice association (IPA)

**D.** a Physician Practice Management (PPM) company

## ANSWER: C

**Explanation:**

**an individual practice association (IPA)** is correct because the described arrangement is the defining operational model of an IPA. An IPA is an organized entity made up of independent physicians or small physician practices that retains their separate practices while serving as an intermediary for managed-care contracting. The IPA negotiates and executes agreements with health plans, then separately establishes participation arrangements with its physician members. This structure allows independent practitioners to participate in health-plan networks and may centralize functions such as credentialing support, utilization-management coordination, claims-related administration, and quality initiatives, while the individual practices remain distinct entities.

The critical feature in the scenario is the two-level contractual relationship: the physician organization contracts with health plans, and the organization in turn contracts with its participating physicians. That is the standard hallmark of an IPA and is particularly useful for physicians who want the benefits of collective network participation without merging into one integrated, single-site medical group. Health-plan provider-network arrangements must also support adequate access to

participating providers, a central managed-care responsibility described in CMS guidance and regulation. See CMS Medicare Managed Care Manual and 42 CFR § 422.112, Access to services.

## QUESTION NO: 15

The following statements apply to enrollment statistics for HSAs. Select the answer choice that contains the CORRECT statement.

**A.** HSAs have helped expand health care coverage to consumers who were previously uninsured.

**B.** The vast majority of enrollees in HSA health plans are wealthy.

**C.** Most people receiving coverage through HSA health plans are individuals rather than families.

**D.** HSAs appeal primarily to young consumers.

## ANSWER: A

**Explanation:**

“HSAs have helped expand health care coverage to consumers who were previously uninsured.” is the correct statement. An HSA is paired with an HSA-qualified high-deductible health plan, so enrollment in this arrangement represents enrollment in comprehensive medical coverage rather than merely opening a savings account. The availability of these plans gave some people, including people who had not previously held private coverage, an additional coverage design to consider: premiums are generally lower than for plans with richer first-dollar benefits, while the HSA allows the account holder to set aside funds for qualified medical expenses on a tax-advantaged basis. Accordingly, enrollment research and policy discussions have recognized that HSA-qualified plans can contribute to coverage expansion by offering an alternative that may be more affordable or better suited to certain consumers’ preferences. The HSA arrangement is not limited to a single age group, income level, or household type; its relevant enrollment characteristic for this question is its role in making health-plan coverage available to some previously uninsured consumers. Federal eligibility rules also confirm that an individual must be covered by an eligible high-deductible health plan to contribute to an HSA. See IRS Publication 969, Health Savings Accounts and Other Tax-Favored Health Plans and HealthCare.gov’s HSA overview.

## QUESTION NO: 16

Utilization management techniques that most HMOs use for hospital providers include:

**A.** Discharge planning

**B.** Case management

**C.** Co-payment for office visits

**D.** A & B

## ANSWER: A B

**Explanation:**

Discharge planning and case management are core utilization-management techniques used by HMOs in the hospital setting. Discharge planning begins during the inpatient stay and coordinates the patient’s transition to the most appropriate next setting or services, such as home health care, rehabilitation, skilled nursing care, follow-up appointments, medications, and patient education. Effective planning supports safe, timely discharge and helps ensure that hospital resources are used appropriately.

Case management is a coordinated process in which clinicians assess a patient’s needs, develop and monitor a care plan, coordinate services among providers, and address barriers affecting care. For members with complex conditions or extended hospital stays, case management helps align treatment with medical necessity and promotes continuity across inpatient and post-discharge services. Together, these practices help HMOs manage utilization while maintaining quality and supporting appropriate care transitions. The Agency for Healthcare Research and Quality describes care coordination as

deliberately organizing patient-care activities and sharing information among participants to facilitate appropriate care delivery: AHRQ Care Coordination. CMS also identifies discharge planning as an important hospital responsibility for arranging an appropriate transition of care: CMS Hospital Conditions of Participation.

## QUESTION NO: 17

Historically most HMOs have been

**A.** Closed-access HMO

**B.** Closed-panel HMO

**C.** Open-access HMO

**D.** Open-panel HMO

## ANSWER: B

**Explanation:**

Closed-panel HMO is correct. Historically, the traditional HMO model was built around a defined, organized delivery system in which the plan arranged care through a limited set of participating physicians, medical groups, or facilities. This structure gave the HMO a substantial ability to coordinate members' care, apply utilization-management processes, establish provider-payment arrangements, and promote preventive services. A closed-panel arrangement generally means that physicians providing care within the HMO's delivery system have an exclusive or highly dedicated relationship to that HMO's enrolled population, rather than operating as broadly available community providers for patients covered by many unrelated plans. This approach reflects the early staff-model and group-model HMO designs that shaped managed care and helped distinguish HMOs from less integrated insurance arrangements. The historical emphasis on an organized provider panel also supported the HMO objective of delivering comprehensive services on a prepaid basis while managing access to specialists and other covered services through the plan's network and care-coordination rules. CMS describes HMOs as managed-care plans that generally require members to obtain covered care from network providers and coordinate specialty care through the plan's rules. See Medicare.gov's HMO overview and the CMS managed care resources.

## QUESTION NO: 18

The following statements are about information management in health plans. Three of the statements are true and one statement is false. Select the answer choice containing the FALSE statement:

**A.** Health plans find EDI useful for transmitting data among different health plan locations.

**B.** EDI is different from eCommerce in the EDI is the transfer of data, typically in batches, while ecommerce is a back-and-forth exchange of information concerning individual transactions.

**C.** The majority of health plan eCommerce occurs via proprietary computer networks.

**D.** Benefits that health plans can receive from using electronic data interchange.

## ANSWER: C

**Explanation:**

The statement "The majority of health plan eCommerce occurs via proprietary computer networks." is the false statement. Health plan electronic commerce increasingly relies on internet-based connectivity and standardized electronic transactions rather than being conducted predominantly through closed, proprietary networks. While proprietary networks and value-added networks have historically supported some health care data exchanges, they are not the defining or predominant channel for health plan eCommerce. Health plans use electronic systems to exchange administrative and clinical information with providers, members, employers, government programs, and vendors. These exchanges are supported by national transaction standards, operating rules, and interoperability initiatives designed to improve consistent, secure data sharing across organizations. CMS explains that HIPAA administrative-simplification standards establish requirements for electronic health care transactions, helping organizations exchange commonly used administrative data in a standardized manner.

CMS interoperability efforts likewise emphasize the use of modern, standards-based data exchange to reduce burden and improve information availability. Accordingly, characterizing most health plan eCommerce as occurring through proprietary computer networks is inaccurate. See CMS: HIPAA adopted standards and operating rules and CMS: Interoperability.

## QUESTION NO: 19

Brokers are one type of distribution channel that health plans use to market their health plans. One true statement about brokers for health plan products is that, typically, brokers

**A.** Are not required to be licensed by the states in which they market health plans

**B.** Are compensated on a salary basis

**C.** Represent only one health plan or insurer

**D.** Are considered to be an agent of the buyer rather than an agent of the health plan or Insurer

## ANSWER: D

**Explanation:**

Are considered to be an agent of the buyer rather than an agent of the health plan or Insurer is correct. In the usual health insurance distribution model, a broker acts on behalf of the insurance purchaser, such as an individual, employer, or group seeking coverage. The broker helps the buyer assess coverage needs, compare products available from different carriers, and select coverage that fits the buyer's circumstances. This buyer-focused representative role distinguishes a broker from an insurance agent, who generally represents the insurer under an appointment or contractual relationship. Although a broker may receive commissions associated with a sale and must comply with applicable state insurance licensing requirements, the defining characteristic is the broker's typical agency relationship with the purchaser. State insurance regulation commonly recognizes both agents and brokers as producer roles while allowing state law to establish their licensing and authority requirements. The National Association of Insurance Commissioners' producer-licensing standards describe the broad regulatory framework for insurance producers: NAIC Producer Licensing Model Act. The Centers for Medicare & Medicaid Services also describes broker and agent functions in helping consumers evaluate and enroll in health coverage: CMS Agents and Brokers Resources.

## QUESTION NO: 20

Prescription drug benefits in Medicare can be obtained through:

**A.** Stand-alone prescription drug plans (PDPs)

**B.** Traditional fee-for-service (FFS) Medicare

**C.** Medicare Advantage plans

**D.** Both stand-alone prescription drug plans (PDPs) and Medicare Advantage plans

## ANSWER: D

**Explanation:**

Both stand-alone Medicare prescription drug plans and Medicare Advantage plans that include drug coverage are valid ways for eligible beneficiaries to obtain Medicare outpatient prescription drug benefits. Medicare Part D is the voluntary outpatient prescription drug benefit. A person with Original Medicare generally obtains Part D coverage by enrolling in a stand-alone prescription drug plan, commonly called a PDP. Alternatively, an individual may enroll in a Medicare Advantage plan that provides both Medicare medical coverage and Part D prescription drug coverage; these are commonly known as Medicare Advantage prescription drug plans. Thus, the complete answer must include both coverage pathways rather than identifying only one of them. Medicare describes Part D plans as being offered either through stand-alone drug plans that supplement Original Medicare or through Medicare Advantage plans that include prescription drug coverage. Plan availability, covered drugs, pharmacy networks, premiums, and cost-sharing can differ by plan and service area, so beneficiaries should review plan-specific information before enrolling. See Medicare.gov: How Medicare drug coverage works and CMS: Part D plans.

## QUESTION NO: 21

The agreement by two or more independent competitors on the prices or fees that they will charge for services is known as:

**A.** Tying arrangements

**B.** Price fixing

**C.** Horizontal group boycott

**D.** Horizontal division of markets

## ANSWER: B

**Explanation:**

**Price fixing** is an agreement among independent competitors to establish, raise, lower, stabilize, or otherwise coordinate the prices or fees they charge. In healthcare, this can include competing providers agreeing on professional fees, reimbursement expectations, discounts, or other price-related terms for their services. The key element is that the parties are independent competitors and substitute coordinated decision-making for the normal competitive process in which each organization independently determines its own prices and business terms.

U.S. antitrust enforcement treats price-fixing agreements as especially serious because price competition is a central mechanism for protecting consumers and purchasers. The agreement need not set one exact fee to create antitrust risk; an understanding to use a common rate, minimum charge, fee schedule, or formula can constitute unlawful price coordination. The Department of Justice explains that agreements between competitors on prices are per se illegal under federal antitrust law, meaning the conduct is generally considered inherently harmful to competition without requiring a detailed analysis of its market effects. Healthcare leaders should ensure that pricing and contracting decisions are made independently and that competitively sensitive price information is not used to coordinate conduct with rivals.

See the U.S. Department of Justice Antitrust Division FAQ and the Federal Trade Commission guide to dealings among competitors.

## QUESTION NO: 22

Before the Hill Health Maintenance Organization (HMO) received a certificate of authority (COA) to operate in State X, it had to meet the state's licensing requirements and financial standards which were established by legislation that is identical to the

**A.** Hill had to have an initial net worth of at least $1.5 million in order to obtain a COA.

**B.** The COA most likely exempts Hill from any of State X's enabling statutes.

**C.** Hill had to be organized as a partnership in order to obtain a COA

**D.** The COA in no way indicates that Hill has demonstrated that it is fiscally sound.

## ANSWER: A

**Explanation:**

Hill had to have an initial net worth of at least $1.5 million in order to obtain a COA. The financial-solvency framework commonly used for HMO licensing is based on the National Association of Insurance Commissioners' Health Maintenance Organization Model Act. Under that model, an HMO must maintain a minimum net worth of not less than $1.5 million, subject to additional requirements or a higher amount that a state insurance commissioner may establish. This capital requirement is designed to help ensure that an HMO has sufficient financial resources to begin operations and meet its obligations to enrollees and participating providers. A certificate of authority is therefore tied to a regulator's review of the organization's compliance with applicable licensing, organizational, operational, and financial standards. The stated $1.5 million threshold reflects the model-law baseline for HMO net worth and is the fact pattern that supports Hill's ability to obtain authority to operate. The NAIC identifies its model laws as resources states may use in developing insurance regulation; the HMO Model Act provides the relevant minimum-net-worth standard. See the NAIC Health Maintenance Organization Model Act and the NAIC's Model Laws, Regulations, and Guidelines resources.

## QUESTION NO: 23

The Clover Group is a for-profit MCO that operates in the United States. The Valentine Group owns all of Clover's stock. The Valentine Group's sole business is the ownership of controlling interests in the shares of other companies. This information indic

**A.** holding company of the Valentine Group

**B.** sister corporation of the Valentine Group

**C.** parent company of the Valentine Group

**D.** subsidiary of the Valentine Group

## ANSWER: D

**Explanation:**

The information indicates that Clover is a subsidiary of the Valentine Group. A subsidiary is a company that is controlled by another company, generally because the controlling company owns more than half of its voting shares. Because the Valentine Group owns all of Clover's stock, it has complete ownership and control of Clover. This relationship makes Valentine the parent company and Clover its subsidiary. The fact that Valentine's sole business is owning controlling interests in other companies also identifies Valentine as a holding company. A holding company may own the stock of one or more operating businesses without itself providing the operating services those businesses provide. In this case, Clover remains the operating, for-profit managed care organization, while Valentine holds the ownership interest that gives it control. Understanding parent–subsidiary structures is important in managed care because corporate ownership can affect governance, financial reporting, strategic direction, and regulatory disclosures. The legal and organizational relationship is determined by ownership and control rather than by the services that each entity performs. See the U.S. Securities and Exchange Commission's definition of a subsidiary at 17 CFR § 210.1-02 and the Internal Revenue Service's discussion of corporate subsidiaries at IRS parent-subsidiary controlled groups.

## QUESTION NO: 26

Janet Riva is covered by a indemnity health insurance plan that specifies a $250 deductible and includes a 20% coinsurance provision. When Ms. Riva was hospitalized, she incurred $2,500 in medical expenses that were covered by her health plan. She incurred

**A.** $1,750

**B.** $1,800

**C.** $2,000

**D.** $2,250

## ANSWER: B

**Explanation:**

**$1,800** is the health plan's payment for the covered hospitalization expense. The deductible is applied first: Ms. Riva is responsible for the initial $250 of the $2,500 covered charge. That leaves $2,250 subject to the 20% coinsurance provision. Coinsurance is the percentage of covered expenses that the enrollee pays after meeting the deductible, so Ms. Riva's coinsurance amount is 20% of $2,250, or $450. Her total out-of-pocket responsibility for this covered service is therefore $700: the $250 deductible plus $450 coinsurance. Subtracting that $700 member responsibility from the $2,500 total covered expense leaves $1,800 payable by the health plan. This follows the standard sequence for a plan with both a deductible and coinsurance: determine the amount remaining after the deductible, apply coinsurance to that remaining amount, and then calculate the plan payment. The question stem appears truncated after "She incurred"; however, $1,800 correctly represents the insurer's expense/payment under the stated benefit design. See HealthCare.gov's definition of deductible and HealthCare.gov's definition of coinsurance.

## QUESTION NO: 28

The Conquest Corporation contracts with the Apex health plan to provide basic medical and surgical services to Conquest employees. Conquest entered into a separate contract with the Bright Dental Group to provide and manage a dental care program for employee

**A.** a negotiated rebate agreement

**B.** a carve-out arrangement

**C.** an indemnity plan

**D.** PBM

## ANSWER: B

**Explanation:**

The correct answer is **"a carve-out arrangement."** A carve-out occurs when an employer or plan sponsor removes a particular category of benefits from its principal health plan contract and obtains those benefits separately from a specialized vendor. Here, Conquest contracts with Apex for its core medical and surgical benefits, while separately contracting with Bright Dental Group to provide and administer the dental program. Dental benefits are therefore carved out of the broader medical plan arrangement and managed under a distinct contract.

Employers may use carve-outs for benefit categories such as dental care, vision care, behavioral health, prescription drug benefits, or employee assistance programs. This structure can allow the employer to access specialized expertise, networks, administrative capabilities, reporting, and benefit design for the carved-out service. The defining feature is not simply that the benefit is offered, but that it is administered and financed through a separate arrangement rather than being included in the comprehensive medical plan contract.

AHIP describes specialty-benefit arrangements and managed care contracting concepts in its educational resources. See AHIP and the U.S. Department of Labor's overview of employer-sponsored health plans at https://www.dol.gov/general/topic/health-plans.

## QUESTION NO: 30

The Titanium Health Plan and a third-party administrator (TPA) have entered into a TPA agreement with regard to the administration of a particular health plan. This agreement complies with all of the provisions of the NAIC TPA Model Law. One of the TPA's

**A.** Hold all funds it receives on behalf of Titanium in trust.

**B.** Assume full responsibility for ensuring that the health plan is administered properly

**C.** Obtain from the federal government a certificate of authority designating the organization as a TPA.

**D.** Assume full responsibility for determining the claim payment procedures for the plan

## ANSWER: A

**Explanation:**

"Hold all funds it receives on behalf of Titanium in trust." is correct because the NAIC Third-Party Administrator Model Act treats money received by an administrator for an insurer or plan sponsor as fiduciary funds. The administrator must maintain those funds in a fiduciary capacity and may not use, divert, or otherwise commingle them improperly with its own money. This safeguard is particularly important when a TPA receives premiums, contributions, claim-payment funds, or other amounts intended to meet obligations under the health plan. Holding the money in trust protects the health plan and its covered persons by making clear that the funds belong to Titanium and must be used only for authorized plan purposes. The arrangement also supports accountability: the TPA must provide appropriate records and account for the funds it handles, while the health plan retains responsibility for oversight of its delegated administrative functions. The fiduciary-funds requirement is a core consumer-protection and financial-integrity feature of the NAIC model framework for third-party administrators. See the NAIC Third-Party Administrator Model Act and the NAIC third-party administrator resources.

## QUESTION NO: 31

FSA is funded by

**A.** Employers

**B.** Employee

**C.** A & B

## ANSWER: A B C

**Explanation:**

A health flexible spending arrangement (FSA) can be funded through employee salary-reduction contributions, employer contributions, or a combination of both. Employee contributions are generally made under a cafeteria plan: the employee elects an annual amount, and the employer deducts that amount from pay on a pre-tax basis in equal installments during the plan year. An employer may also choose to contribute to the employee's FSA, subject to the plan's terms and applicable tax rules. Thus, both "Employers" and "Employee" identify permissible funding sources, and "A & B" accurately reflects that an FSA may receive contributions from both sources. Funding must occur under the employer's written benefit plan, which establishes eligibility, elections, contribution rules, reimbursement procedures, and any employer contribution formula. The Internal Revenue Service explains that health FSAs are generally funded through voluntary salary-reduction agreements and may also receive employer contributions. The U.S. Department of Labor likewise describes an FSA as an employer-established arrangement that reimburses employees for qualified expenses using contributions made through the workplace plan. See the IRS guidance on Health FSAs in Publication 969 and the Department of Labor's Flexible Spending Accounts overview.

## QUESTION NO: 32

The administrative simplification standards described under Title II of HIPAA include privacy standards to control the use and disclosure of health information. In general, these privacy standards prohibit

**A.** all health plans, healthcare providers, and healthcare clearinghouses from using any protected health information for purposes of treatment, payment, or healthcare operations without an individual's written consent

**B.** patients from requesting that restrictions be placed on the accessibility and use of protected health information

**C.** transmission of individually identifiable health information for purposes other than treatment, payment, or healthcare operations without the individual's written authorization

**D.** patients from accessing their medical records and requesting the amendment of incorrect or incomplete information

## ANSWER: C

**Explanation:**

"Transmission of individually identifiable health information for purposes other than treatment, payment, or healthcare operations without the individual's written authorization" is correct because the HIPAA Privacy Rule establishes national protections governing covered entities' uses and disclosures of protected health information (PHI). A covered entity may generally use or disclose PHI without an authorization for core health-care purposes: treatment, payment, and health-care operations. For uses and disclosures outside those permitted or required by the rule, the individual's valid written authorization is generally required. The authorization must be meaningful and contain specified elements, including a description of the information, the purpose of the disclosure, and an expiration date or event. This framework gives individuals control over disclosures of their identifiable health information while allowing essential care delivery, claims administration, quality improvement, and related operational activities to proceed. The U.S. Department of Health and Human Services summarizes these permitted uses and disclosures and explains when authorization is necessary in its HIPAA Privacy Rule guidance. The authorization requirements are also set out in 45 C.F.R. § 164.508.

## QUESTION NO: 33

The application of health plan principles to workers' compensation insurance programs has presented some unique challenges because of the differences between health plan for traditional group healthcare and workers' compensation. One key difference is that

**A.** limits coverage to eligible employees and excludes part-time employees

**B.** specifies an annual lifetime benefit maximum on dollar coverage for medical costs

**C.** provides benefits regardless of the cause of an injury or illness

**D.** provides benefits for both healthcare costs and lost wages

**ANSWER: D**

**Explanation:**

**provides benefits for both healthcare costs and lost wages** is correct because workers' compensation is designed to address both the medical and income consequences of a work-related injury or occupational illness. Like a health benefit program, it pays for medically necessary services associated with a covered condition, such as physician care, hospitalization, prescription drugs, rehabilitation, and related treatment. However, workers' compensation also includes indemnity benefits: partial wage-replacement payments for an employee who loses work time or earning capacity because of the covered condition. The amount, duration, waiting period, and eligibility rules for these payments are established primarily under applicable state workers' compensation laws. This combined medical-and-income-protection purpose creates administrative and benefit-design considerations that differ from traditional group healthcare coverage, which principally finances healthcare services rather than replacing earnings. The U.S. Department of Labor describes workers' compensation as providing medical treatment and wage-replacement benefits to employees injured or becoming ill in the course of employment. See the U.S. Department of Labor's workers' compensation overview and the Office of Workers' Compensation Programs benefits information for further detail.