AHM – 250

1 A health plan can best be defined as an organization that

Integrates the delivery and financing of healthcare and seeks to manage healthcare costs, access, and quality.

2 the earliest version of health plans appeared in

1910

3 which is not an early form of health plan

Preferred provider organization

4 which is a provision of the HMO Act of 1973

Federally qualified HMOs were exempted from some state laws.

5 for an HMO, which was not an advantage of federal qualification

The HMO did not have to meet certain requirements that applied to other health plans.

6 the HMO Act of 1973

Played a major role in the early growth of HMOs.

7 In the 1990s HMOs

Were popular because they held down costs, but people objected to the lack of provider choice.

8 Janine can go to any doctor she chooses, but if she goes to one not in her plan's network, she has to pay a larger share of the cost, Janine is covered by

A preferred provider organization

9 Jacob must pay $2,000 in healthcare expenses each year before he receives benefits from his health plan, but he can use money from a tax-advantaged saving account, Jacob has

A consumer-directed health plan.

10 what are the roles of the state and federal governments in regulating health plans?

The states regulate health insurance, but federal governments also passes laws affecting it.

11 have government health coverage programs been a significant factor in the evolution of health plans?

Yes, because these programs have increasingly relied on health plans to provide coverage.

12 which is not a cause of higher healthcare spending?

A younger population because of immigration.

13 under the fee-for-service approach, healthcare providers have a financial incentive to provide.

More services.

14 which is not typical of managed care

Fee-for-service compensations.

15 which will probably have the lowest premium?

A consumer directed health plan

16 In relation to health plans, over the years the definition of quality.

Has become broader

17 Which is not an accrediting organizations?

HEDIS

18 in traditional indemnity health insurance, insured

Can go to any provider they choose

19 in traditional indemnity health insurance, how are providers compensated?

Fee-for-service

20 Owen pays 20 percent of the cost of healthcare services covered by his policy. This describes

Co-insurance

21 which is not common in traditional indemnity health insurance

Copayment

22 coordination of benefit is designed to

Prevent duplication of benefits when a person is covered by more than once health insurance policies.

23 increasing cost – sharing

a) help hold down healthcare expenditures through insured incentives and b) shift cost from insurer to insured both.

24 Cost containment helps hold down health insurance premiums primarily by

Reducing unnecessary healthcare services.

25 Coverage of preventive care is

Cost – effective in the long run and so has been adopted by insurers.

26 why is it useful in studying health plans to learn about indemnity insurance?

Some features of today's health plans are inherited from indemnity insurance or designed to address its problems.

27 Andy is covered by his employer's group health insurance policy. Who is the policyholder of this policy?

The employer.

28 who pays the premium of an

group policy?

Employees may pay all or part, but they do so through the employer.

29 what happens in adverse selection

People who need healthcare enroll in greater numbers than average people.

30 which employee group is most likely to have a higher-than-average loss rate?

A group made up mostly of women.

31 which employee group presents a high risk of adverse selection?

In company A a small percentage of employees enroll

32 in creating a provider network, health plans generally seek to ensure member access by

Considering number, type, and location of providers.

33 primary care physicians are typically involved in

Prevention, treatment of routine conditions, and care co-ordination.

34 if a health plan has a network, members

Either, depending on the plan design.

35 compared to indemnity insurance, health plan generally require _____ out of pocket expense by members

Less

36 managing the use of healthcare services so that patients receive necessary, appropriate, and high quality care in a cost-effective way is

Utilization management

37 which does not focus on individual with special needs or certain medical conditions?

Demand management

38 which is quality management technique?

Credentialing.

39 in this course “health plan” is defined as any entity that

Uses certain concept or techniques to manage the cost, access, and quality of healthcare

40 what is the trend in health plan products?

More types are being offered, and the distinctions between them are becoming blurred.

41 Members do not have to select how to receive services until they use them. This describes a

Point-of service product

42 A health saving account is combined with a high-deductible health plan. This describes a

Consumer directed health plan

43 Which of these health plan types uses managed care techniques and concept the most.

Health maintenance organization (HMO)

44 what goals do all health plans share?

Accessibility , cost effectiveness and quality

45 organizations that finance or reimburse the cost of healthcare services are known as

Payors

46 how are the roles of the key players in health plan evolving?

Roles are overlapping and becoming less distinct

47 Compared to indemnity insurance, health plan benefit packages are typically

More extensive and encourage the use of preventive care

48 Mandate benefits are imposed

Both by states and the federal government and apply to all forms of health insurance.

49 Carla pays a flat $10 fee to her doctor for an office visit, regardless of the cost of the service the receives, this is

A copayment

50 Jacob pays 20% of the cost of a hospital stay. This is

Co-insurance

51 Dan pays the first $1000 of his healthcare expenses each year, after which his health plan begins paying benefits. This is

A deductible

52 In traditional indemnity health insurance , the main provider compensation method is

Fee-for-service

53 under fee-for-service, providers have incentives to

Provide unnecessary care

54 Under fee-for-service, who bears financial risk?

The insurers and the providers.

55 Under capitation, provider compensations is based on

The number of members cared for.

56 Teresa, a doctor, is paid by a health plan by capitation, One month she delivers very few services to plan members, the next month she delivers about the projected amount, and third month she delivers well over the projected amount. Teresa is paid

The same amount each month.

57 Capitated physicians have incentive to

Not provide unnecessary services and promote prevention and wellness

58 Which statement about capitation is true?

It may be used for both primary and secondary cases

59 Currently, capitation accounts for what portion of physician compensation?

A small minority

60 Under a fee schedule, a provider receives

No more than a listed amount

61 Under a fee schedule or discounted fee-for-service, if a provider's normal fee is more than the amount allowed by the health plan

She must accept the plan's amount as payment in full

62 A health plan assigns a certain value to a service and multiplies this value by a negotiated dollar figure to yield the payment amount. This describes.

RVS

63 A member is hospitalized, her case is classified based on several factors, and the hospital is paid an amount based on that classification. This describes.

Diagnosis-related group (DRGs)

64 A hospital is paid a set amount for each day a plan member is in the hospital. This is

Per diem payments

65 A group of providers is paid a single amount for all the care related to a surgery, both in the hospital and for three months afterward. This is

An episode based payment

66 A plan holds back a percentage of PCP's monthly capitation payments. At the end of the year, some of this money is paid to the PCPs, but some is used to pay for higher than projected referral. This is an example of

A withhold

67 A plan pays money into a pool to cover hospitalization. At the end of the year, if there is money left over in the pool, some is given to PCPs, but if there is not enough money, PCPs must cover some of the cost. This is an example of

A risk pool

68 If a doctor meets certain performance targets related to quality of care and patient satisfaction, she receives a bonus. This is an example of

Pay for performance

69 Which compensation arrangement involves the most risk for providers?

Capitations

70 Which compensation arrangement involves the least risk for a hospital.

Fee-for-service

71 An HMO

Assumes or shares both financial and delivery risks

72 The HMO Act of 1973

Was instrumental in the initial growth of HMOs

73 HMOs are

Heavily regulated at both the federal and state levels.

74 Which is not a key characteristic of an HMO?

Loose relationship with providers

75 which is an employer most likely to consider in selecting and HMO?

Access

76 A person enrolls in an HMO

Most commonly through an employer, but sometimes individually.

77 HMOs were traditionally marketed to

Large groups, but they now serve large and small groups and individuals.

78 HMOs provide

Comprehensive medical benefits and usually special services such as dental and vision care, mental health care, and prescription dugs.

79 Compared to other health plan types, in HMOs members cost shareing tends to be

Low

80 HMOs typically provide

Extensive preventive care and charge little or no cost sharing for it.

81 An HMO provides medical care to its members by

Contracting with and/or employing providers

82 The delivery of healthcare is primarily

Local

83 In building and maintaining an HMO network, the location of a healthcare provider is primarily a factor in

Access

84 To see a specialist, must and HMO member obtain a referral from her PCP?

Usually

85 Do HMOs cover out-of-network services?

Traditionally they did not, but some HMOs now do at a higher cost

86 How are HMOs usually paid providing health care

By mean of fixed monthly premium

87 Which are most common in HMOs?

Copayments

88 Which is not a common HMO compensation arrangement for physicians?

DRGs

89 A physician is compensated by an HMO by capitation, but once her total cost have reached a certain level, additional costs are reimbursed by discounted FFS. This describes a

Stop-loss provision

90 which utilization management techniques is used primarily for physicians?

Risk pools

91 in the area of quality management, HMOs are subject to

Strict state and federal regulation

92 which statement describes and open-panel HMO?

Any physician who meets the HMO's standards is eligible to join its network but the HMO is not obligated to contract with anyone

93 which is true about a closed panel HMO?

Physicians are employees of the HMO or members of a contracted group

94 In an open-access HMO, members

Receive lower benefits for non-network care

95 which is true about closed-access HMOs?

In the past most HMOs had closed access, but this is no longer true

96 An HMO pays a doctor for his services based on a fee schedule. This is an example of

Discounted fee-for-service

97 An HMO pays a doctor a certain amount per member per month to provide care needed by HMO members. This describes

Capitation

98 In which compensation method do physicians assume risk?

Capitation

99 A mixed model HMO is on that

Combines features of different HMO models.

100 The current trend is toward

Mixed model HMOs

101 In an IPA model HMO, physicians are usually

Contracted with the IPA, which contract with the HMO

102 In which HMO model does each doctor manage her own office?

IPA model

102 How are IPA physician most commonly compensated?

Capitation for PCPc and discounted fee-for-service or RBRVS for specialist.

103 which is a disadvantage of the IPA model HMO?

The HMO has limited control of care management and quality

104 In a staff model HMO, physicians are normally

Employees of the HMO

105 In which HMO model do doctors normally work in a central facility owned and operated by the HMO

Staff model

106 How do staff model HMOs normally compensate physicians?

Salary

107 which is not an advantage of a staff model HMO?

Low facility costs.

108 The HMO contracts with a signle group practice. This describes

A group model HMO

109 In a group model HMO, physicians are

Employees (or employee/owners) of the group practice

110 What is the most common compensations system in a group model HMO?

The HMO Compensates the group practice by capitations , and the group practice pays physicians salaries and incentive payments.

111 An HMO contracts with six group practices. This is an example of a

Network model HMO

112. The trend in network model HMOs is toward

A mix of capitation and discounted fee-for-service

113 The most common HMO model today is the

IPA model

114 Which HMO model normally has closed panel?

Staff model

115 PPOs, EPOs, and POS products are

In the middle of the managed care continuum, between tightly managed and unmanaged.

116 PPO members receive

Lower benefits for non-network care

117 Which statement is true about a PPO?

Providers must participate in utilization review and quality management

118 What portion of U.S. employees are covered by PPOs?

A majority

119 A majority of PPOs are owned by

Insurance companies

120 Which statement is true about PPOs?

PPOs usually cover some specialty services

121 PPOs most commonly compensate physician by means of

Discounted fees

122 Providers contracting with PPOs

May or may not assume risk

123 EPOs are generally like PPOs except that

There is no coverage of out-of-network care

124 A POS product offers

Reduced coverage of non-network care

125 How is a POS product like an HMO?

PCPs coordinate referrals to specialist

126 how many employee are covered by POS products

A small but declining minority

127 ABC health plan has no provider network and reimburses providers on a fee-for-service basis, but it conducts precertification and utilization review. ABC can best be described as a

Managed indemnity plan

128 Historically, managed care plan

Focused on standard medical care (physician and hospital services)

129 Which is not generally considered a specialty service?

Hospital care

130 A health plan transfers to another organization some (but not all) of the activities involved in delivering and managing behavioral healthcare. This is a

Partial carve-out arrangement

131 In a mature health plan market, compensation for a comprehensive carve-out is typically by

Capitation

132 State laws

May restrict carve-outs

133 Managed dental care accounts for what portion of all dental coverage?

A majority

134 Managed dental care is

Growing

135 Plan members must, with a few exceptions, see a network dentist. This describes

An HMO

136 HMOs usually compensate dentist by means of

Capitation

137 Which is typical of a dental HMO?

Copayments

138 PPOs commonly compensate dentist by means of

Discounted fee-for-service.

139 Which are typical of a dental PPO?

Annual deductible, coinsurance , and annual maximum benefit

140 Andre does not have to choose a dentist or network during an annual open enrollment he can decide when he needs care. He has

A POS plan

141 Which dental plan type typically has the smallest network?

HMO

142 Which dental plan type typically costs the least?

HMO

143 About what percentage of U.S. adults experience some sort of behavioral health disorder during any year

25%

144 Douglas is in a substance abuse program. He spends most of his time in a facility but goes our during the day to attend school. What level of behavioral healthcare is this?

Partial hospitalization

145 Lilly receives 10 hours of therapy a week at a psychologist's office, but she is not confined to a facility. What level of behavioral healthcare is this?

Intensive outpatient care

146 Which is least common in health plans today?

Members must get a referral from their primary care provider to access

147 Which sentence best summarizes the requirements of federal mental health parity legislation for medium and large health plans?

It requires plans that provide behavioral healthcare coverage to provide coverage equivalent to medical coverage.

148 Which statement is true about federal mental health parity laws?

Cost-sharing for behavioral healthcare cannot be greater than for medical care

149 How many health plans use pharmacy benefits management (PBM) plans?

A large majority

150 Do pharmacy benefits management (PBM) plans concerns themselves with equality of care?

Yes, safe and effective drug use is a major concern, along with cost

151 A PBM notifies a doctor that this prescribing a certain drug much more frequently than his press and educates him on its use and alternative to it. This is an example of

Physician profiling

152 Repeated late refills indicate that Phil is not taking his low blood pressure medication as often as he should. This is an example of

Drug utilization review

153 Patrice's plan covers any drug her doctor prescribes, but she pays higher copayment for drugs not ion the plans formulary. This is

An open formulary

154 A PBM requires physicians to obtain certification of medical necessity before prescribing a drug. This is

Prior authorizations

155 A pharmaceutical card is not generally used in

Prior authorization

156 A PBM provides all pharmacy services to an employee group in exchange for a fixed dollar amount per employee per month. This is

Capitation

157 What are the recent trends in healthcare spending?

Annual increases were high in the 1980's lower in the mid- 1990s then high again since then

158 Beginning in the late 1990s there was a shift

To less restrictive forms of managed care in response to consumer demand

159 The consumer choice philosophy is based on giving consumers

More decision-making power and more responsibility for costs

160 What are the two main components of a consumer directed health plan?

A high-deductible health plan and a tax-advantaged personal healthcare account

161 Which is the oldest type of personal healthcare account?

The FSA, introduced in the 1970s

162 Which can contribute to an FSA?

Most commonly only employees contribute, but employers are allowed to

163 Which is not a feature of FSAs that has limited their popularity?

Low limits on contributions.

164 Who can contribute to an HRA?

Employers only

165 Which is a feature of an HRA?

Annual rollover (at employer option)

166 Which account offers annual rollover, full portability and tax-free investment growth?

HSA

167 To be eligible for an HSA, a person must be covered by

A qualified high-deductible health plan

168 According to studies, switching to a CDHP brings cost-saving

Initially and probably in the long run as well

169 According to studies, the cost-saving of CDHPs come mostly from

Consumers making cost-effective healthcare choices

170 what is the trend in CDHP enrollment?

Rapid growth, expected to continue

171 Which is not an element of consumer-directed health plans?

Higher premiums for coverage

172 Most CDHPs are based on

A high deductible health plan

173 Compared to traditional health coverage, the premium of high-deductible health plans are generally

Lower

174 An FSA

May be coupled with an employer health plan or may be stand-alone

175 How popular are FSAs?

Only a minority of workers have access to them, and most of those do not participate

176 Which statement is true about FSAs?

Employees can make contributions with pretax dollars

177 Which statement are true about HRAs?

An employer may offer annual rollover of funds

178 What portion of workers is covered by and HRA?

Only a few percent

179 An HSA offers

Full portability, annual rollover, and tax free investment growth of account funds

180 To be eligible for an HAS, a person must be covered by

A qualified HDHP, only not other broad health coverage or Medicare

181 A qualified HDHP must have

A deductible of at least a certain amount and total out-of-pocket expenses no greater than a certain level

182 Which may a qualified HDHP exclude from an annual deductible?

Preventive care

183 Who can contribute to an HSA?

An employer, an employee, a self-employed person, or a family member on behalf of an eligible person.

184 An HSA accountholder cannot use account funds tax-free to pay for

His HDHP premium

185 Which premium cannot be paid tax-free with HAS funds?

Medigap insurance

186 Can a person use HSA funds to pay non – medical expenses?

Yes, she may, but she must pay income tax and a tax penalty

187 Can a person 65 or older use HSA funds to pay non – medical expenses?

Yes, she may; she must pay income tax but not a tax penalty

188 What is the impact healthcare reform on CDHPs?

Probably modest-some rules will change, and HDHPs may be affected depending on how regulations are written.

189 Which provision of healthcare reform may stimulate growth in CDHPs?

The tax on high-value health plans

190 Two independent organizations are joined into on entity under common ownership and control. This is an example of

Structural integration

191 An example of partial structural integration is

A joint venture

192 A number of physicians join together and combine their billing and collections operations. This is an example of

Partial operational integration

193 Which physician hospital model is the least integrated?

The physician-hospital organization (PHO)

194 For a physician, what is a disadvantage of provider integration?

A loss of professional autonomy.

195 For purchases and consumers, what is not a potential advantage of provider integration?

Lower costs resulting from a stronger negotiating position.

196 Which physician-only is the least integrated?

The independent practice association (IPA)

197 What does and IPA generally do for its member physicians?

Negotiates contracts with health plans

198 what is the structure of most IPAs?

Physicians contracts with the IPA, and the IPA contacts with the health plan

199 If an IPA spends more than $80,000 a year providing care to a single individual, an insurance company covers any amount over $80,000. This is called

Stop-loss insurance

200 What is the main difference between a group practice without walls (GPWW) and an independent practice association (IPA)?

A GPWW handles business operations for members, but an IPA does not.

201 The main purpose of a management services organization (MSO) is to

Provide management and administrative services to physicians.

202 How does a physician practice management (PPM) company differ from a regular MSO?

It purchases physician entire practices.

203 Which physician-only model is the most integrated?

The consolidated medical group

204 What is the primary purpose of a physician-hospital organization (PHO)?

Contracting with health plans and marketing

205 When a physician-hospital organization (PHO) is formed, physician practices

Continue to be owned and operated by the physicians.

206 A hospital allows any of its admitting physicians to join its PHO. This is an example of

An open PHO

207 An integrated delivery system (IDS) may or may not be highly integrated

Structurally

208 What is the purpose of a medical foundation?

To set up something similar to an integrated delivery system in states that do not allow corporations to buy physician practices.

209 For a health plan, the main advantage of contracting with an at-risk provider organization is that the plan does not have to

Develop a provider network.

210 If a provider organization assumes insurance risk, is it regulated as an insurance company or HMO?

It depends on the state and how the organization operates.

211 A healthcare delivery model based on each patient having a personal physician who is responsible for providing or coordinating her care on a ongoing basis is

A patient-centered medical home (PCHM)

212 The affordable Care Act seeks to

Promote accountable care organizations (ACOs) and patient-centered medical homes (PCMHs)

213 Which is not true about a patient-centered medical home (PCMH)?

Provider compensation is by pure capitation

214 What distinguishes a corporation from other organizations?

It is a legal entity separate from its owners.

215 Company A exist for the purpose of owning other companies and it owns company B among others. Company A is

A holding company and the parent company and the parent company of Company B

216 Which statement is true about a for-frofit health plan compared to a not-for-frofit plan?

It is better able to raise capital

217 Which statement is true about tax exemption of not-for-profit health plans?

Tax exempt plans pay premium taxes but not income tax.

218 Who owns a mutual insurance company?

Its policyholders.

219 What statement is true about mutual and stock insurance companies?

Most insurers are stock companies.

220 Most health plans are

Corporations

221 The ultimate source of authority in health plan is

The owners

222 Which statement about a health plan's board of directors is true?

The board appoints the FEO

223 A health plan's day-to-day operations are typically the responsibility of

Key senior managers reporting to the CEO.

224 Which position is likely to increase in importance in the coming years?

Chief information officer

225 Who is responsible for advertisement?

Chief Marketing officer

226 Which position is typically found in health plans but not in corporations in other industries?

Network Management Director

227 Who is responsible for preventing misconduct in a health plan?

Chief compliance officer

228 A permanent committee to advise a health plan on compensation is an example of a

Standing committee

229 Which committee's primary responsibility is reviewing cases of poor equality healthcare?

Peer review committee.

230 Which committee administers a health plan's drug formulary?

Pharmacy and therapeutics committee.

231 A health plan determines that it will not cover an experimental therapy requested by Sharon. If Sharon appeals this decision, which committee will likely review the case?

Appeals review committee.

232 "Market Maturity" refers to the

Level of health plan activity in a market

233 In market analysis, what is considered in regard to providers?

Provider number, type, locations, utilizations, costs, referral, patters and relationship.

234 Which are generally most receptive to health plans?

Large employers.

235 Where is it most difficult to develop a comprehensive network?

Rural areas

236 Health plans that offer more than one type of plan typically have

Either separate networks or nested networks

237 “Network adequacy” refers to

Whether The number, types and locations of providers are adequate to meet member needs.

238 Which type of law might require a health plan to include a particular doctor in its network?

Any willing provider

239 “Open panel”, or “Closed panel” refers to whether a health plan’s

Providers can see non-plan members.

240 Devin is a neurologist who mostly provides outpatient care in his office. He is likely to be categorized by a network as a

Specialist.

241 Which plan types need fewer providers per 1,000 members?

Highly managed and large plans.

242 A health plan is developing a network, and it is believed that the most important consideration of potential members is accessibility. The plan will likely

Create a large, very inclusive primary care panel.

243 What is the purpose of credentialing?

Selecting the most qualified providers and meeting accreditation standards and minimizing legal risks.

244 In credentialing, do health plans verify information submitted by providers?

They generally do, before offering them a contact.

245 the information that a health plan can obtain from the National Practitioner Data Bank (NPDB) about a provider primarily relates to

Malpractice, licensure, and adverse actions.

246 A provider agrees to accept a health plan’s compensation as payment in full and not to also bill plan members. What contact provision does this describe?

No balance billing provision

247 A party that breaches a contact is given a certain amount of time to remedy the problem and avoid termination of the contract. What contact provision does this describe?

Cure provision.

248 Can a health plan terminate its contact with a provider when there has been no problem with the provider's performance?

Yes, if the state permits termination without cause and this is allow by the contract.

249 A provider already in a health plan's network is evaluated by another provider in the same specialty. This describes

Peer review

250 Medical management can be divided into three broad categories, which are

Utilization management, clinical practice management and quality management.

251 Managing the use of medical services so that plan receive necessary and appropriate care in a cost-effective manner is

Utilization management

252 A health plan conducts a health risk assessment (HRA) to determine a person's likelihood of developing certain illness. The purpose is to

Help her reduce her risk and thereby improve outcomes and reduce cost.

253 A health plan program seeks to determine if a member has ha health condition even if he has no symptoms, this is

A screening program

254 A program supports health plan members who want to stop smoking, lose weight, eat better, and exercise more. This is a

Wellness program

255 A program teaches health plan members how to treat minor illnesses and distinguish them from serious conditions. This is a

Self care program.

256 Colleen can access data about different drugs and healthcare providers on her health plan's website. This is an example of

Web-based decision support tools.

257 Telephone triage programs are typically staffed by

Nurses directed by physicians and supported by nonprofessional personnel.

258 Clark's doctor gives him information about the treatment options available to him, and Clark makes the final decision. This is an example of

Shared decision-making

259 While Gloria is being treated for an illness, her health plan conducts an evaluation of whether the services she is receiving are necessary, appropriate, and cost-effective. This is an example of

Concurrent utilization review.

260 Wilson is assigned a healthcare professional who assesses his needs, design a plan of care, and coordinates and monitors the services he receives. This describe

Case management

261 Case management is used for

High-risk, high-cost, and/or chronic cases

262 case managers are most commonly

Nurses

263 Which type of UM program focuses on populations instead of individuals?

Disease management

264 Disease management focuses on

Chronic diseases

265 Which statement is true about disease management programs?

They are typically an outreach and support program for plan members with certain diseases.

266 A doctor treating a patient with diabetes refers to guidelines for this condition in making decisions about the most appropriate course of action. This describes

Clinical practice guidelines

267 Jill, a pediatrician, is considering prescribing a certain drug for Eric. She asks herself "is there research that indicates that if Eric takes this drug he will likely get better quicker than if he did not?" Jill is

Engaging in evidence-based healthcare

268 Laurie has diabetes. She wants to stay well is willing to change her lifestyle, but sometimes she doesn't understand to problem here is

A lack of health literacy.

269 Utilization review

May be conducted before, during, or after treatment

270 Utilization review focuses primarily on whether a healthcare service is

Medically necessary and appropriate

271 The purpose of utilization review is to

Ensure correct payment of benefits, promote quality and cost-effective care and collect data for utilization management and other purpose.

272 UR staff decide what treatments

A health plan will pay for

273 UR programs use clinical practice guidelines to

Reduce unnecessary and ineffective practice variation.

274 If both prospective and retrospective review are possible, which is generally preferable?

Prospective review

275 Precertification is most commonly used for

Hospital admissions

276 The average number of days a patient with certain characteristics stays in a hospital. This describes

Length of stay guidelines

277 When are experience based criteria usually used?

When research-based utilization guidelines are not available

278 Testing needed before an inpatient treatment should be performed

Before admission to the hospital

279 For which is concurrent review not commonly used?

A specialist visit

280 Prior authorization is a feature of

Prospective review and sometimes concurrent review

281 Retrospective review most commonly

Analyzes data to improve utilization.

282 Which form of UR is most likely to discover billing and fraud?

Retrospective review

283 In order to receive a larger payment, a doctor improperly and deliberately bills two procedures separately instead of together. This is

Unbundling

284 Subjecting all healthcare services to UR is

Neither possible nor desirable

285 For which type of care is health plan member most likely to need a referral or authorization?

Non primary care

286 Which service is least likely to require authorization

A Frequently performed service

287 Emergency department use

Can increase or decrease health plan cost

288 Is emergency department care subject to unitization review?

Some plans require retrospective review and authorization

289 Do health plans cover urgent care centers?

Some do, and dome do not

288 Bill has chest pains and is awaiting test results. He does not need any treatment at this time, but he needs to be monitored. What is probably the best care setting for him?

Observation care unit.

289 Jack has had surgery. He does not need full hospital care anymore, but he does need 24 hour nursing care under supervision of doctor. What is probably the best care setting for him?

A sub acute care facility or hospital step-down unit.

290 Health plans generally pay for home health care for

Those recovering from an acute injury or illness, but not those with chronic condition

291 Do health plans pay for hospice care?

Most do for those who have six months or less to live and who forego certain medical treatment.

292 Which UR data transmittal method has the most problem with accuracy?

Manual

293 Which UR data transmittal method is the fastest and lead labor-intensive

Electronic

294 Which UR data transmittal method is the most regulated?

Electronic

295 In the UR process, administrative review focuses on whether a proposed service is

Covered

296 In the UR process, administrative review is performed by

Either, depending on the plan

297 Who can deny an authorization based on medical necessity and appropriateness?

A physicians only

298 May UR staff recommended a different treatment for a member?

Yes, but only when consensus is reached with the treating physician.

299 Which state is not true?

Once a PCP has referred a patient to a specialist, the specialist can generally provide whatever treatment and as many visit as she see fit.

300 The two main components of quality management are

Quality assessment and quality improvement

301 The two main categories of health plan quality are

Service quality and healthcare quality

302 Carol has a question about her health coverage ,but she tries all day and is unable to reach her health plan by phone. This is an issue of

Service quality.

303 Medical errors

Are both a patient safety issues and a cost issues.

304 The wrong medication is prescribed for a patient, causing an adverse event. This is an error of

Execution

305 Which problem is being addressed by national database

Lac of coordination among parties concerned with medical errors.

306 Consumer perceptions of healthcare quality

Are important because they reflect valid concerns and affect purchase decision.

307 A health plan's network has a certain number of primary care physicians. This is

A structure measure.

308 The percentage of health plan members who have received a medical checkup in the past two years is

A process measure.

309 Five year after treatment, 80 percent of cancer patient are still alive. This is

An outcomes measure.

310 The trend in quality measures is toward greater use of

Outcome measures.

311 What is the relationship structure, processes and outcomes?

Structure and processes produce outcomes.

312 The average claims processing time is a

Process measure of service quality

313 The main disadvantage of structure measures is that

Their link to outcomes is generally not proven by research.

314 A certain percentage of patients are able to return to work two years after a stroke.

Functional outcomes measures

315 Which is not a disadvantage of outcomes measures?

Outcomes are not directly related to quality.

316 Which is not a disadvantage of outcomes measures?

Outcomes are not directly related to quality.

317 Which generally present the most problem?

Clinical data

318 Which statement about quality improvement is true?

After actions are taken to improve quality, measurement and analysis of outcomes is repeated and on going

319 A hospital identifies another hospital with high cancer survival rate and adopts its practice. This is

Benchmarking

320 A health plan analyzes data from different gynecologists and notices that one of them performs certain procedure much more often than the rest. This is

Provider profiling

321 A panel of pediatricians evaluates the appropriateness and timeliness of the care provided by another pediatrician in a particular case. This is an example of

Peer review.

322 Which is most likely to be controversial among providers?

Provider profiling

323 Which statement is not true about health plans internal standards?

They are typically applied to healthcare services

324 NCQA accredits

Health plans of various types

325 Nationally, NCQA accreditation covers

Most health plan members.

326 The NCQA accreditation process

Includes both an onsite visit and offsite data review.

327 what form does NCQA accreditation take?

A plan earns one of five accreditation levels

328 URAC accredits

Health plans, health networks, and functional areas within organizations.

329 The URAC accreditation process

Includes both an onsite visit and offsite policy and procedure review.

330 HEDIS is designed primarily to be used by purchasers and consumers to compare

The quality of different health plans

331 Quality compass is

A national data base of performance and accreditation information

332 The agency for healthcare research and quality (AHRQ) is

A research branch of the department of health and human services

333 The affordable care act

Includes a variety of healthcare quality improvement provisions.

334 What will the

do with regard to Medicare Advantage plans?

It will lower payment to MA plans overall but give bonuses and higher rebates to plans that meeting quality criteria.

335 Ethics can best be designed as

Principles and values that guide decision of right and wrong

335 health plans and their providers must respect the right of plan members to make decisions about the course of their lives. This is the ethical principal of

Autonomy

336 Which is not an ethical obligation of a health plan?

To make decisions for members in complex ethical situations.

337 Character traits that dispose people to act well toward others are

Virtues

338 health plans have an ethical obligation to promote the good of

Both individual members and the membership as a whole

339 A health plan ethics task force

Providers forum for discussion of ethical issues and offers consultation when physicians and families faces ethical decisions.

340 Medicaid eligibility and coverage

Vary somewhat from state to state, within federal guidelines

341 Currently, Medicaid is available

Primarily to low-income children, pregnant women, elderly and disabled people and few parents.

342 Under PPACA, Medicaid will be available.

All people with income below a certain level

343 if a healthcare service is covered by both Medicare and Medicaid, who pays?

Medicare

344 purpose of CHIP is to provide health coverage to children who

Cannot afford private insurance but do not qualify for Medicaid.

345 Alex, Logan, Kaitlyn and are all 14 years old. Who may be eligible for CHIP?

Alex's family's income is about twice the FPL

346 State have the option of offering CHIP coverage to pregnant women.

But most do not

347 Under CHIP

Copayments and premiums can be charge within limits.

348 Over the years the importance of managed care in Medicaid has

Increased

349 Currently, what portion of Medicaid recipients are in managed care?

A large majority

350 Which is currently a rule governing Medicaid managed care?

Health plans serving Medicaid recipients must meet certain requirements related to quality and enrollee protection

351 Which is not a challenge generally faced by health plans serving the Medicaid population?

Most people in Medicaid managed care are elderly or disabled

352 What portion of CHIP enrollees are in managed care?

A majority

353 State can offer premium assistance instead of health coverage to

Both Medicaid and CHIP recipients, although it may be voluntary.

354 under FEHB, health coverage is provided by

A large number of health plans that employees choose from

355 FEHB health plans include

A variety of plans types

356 FEHB health plans

Must offer at least a minimal benefit package.

357 TRICARE serves

Active and retired members of the uniformed services and their spouses and dependent children.

358 Tricare coverage takes the form of

Fee for service insurance of HMO coverage

359 Who pays a premium for Tricare?

Most participant except for active duty service members.

360 What is workers compensation?

State programs that require employers to provide benefits for work-related injuries and illness

361 Worker's compensation pay benefits to cover

Both medical expenses and lost income

362 Which is a feature of worker's compensation?

No coverage of non-work-related injuries and illnesses.

363 An employee is eligible for worker's compensation benefits

Whether or not the employer is at fault for her injury or illness, but even if the employer is at fault, she cannot sue it for damages.

364 What is the recent trend in Medicare health plan enrollment?

It was declining, but since the MMA in 2003 it has been steadily rising.

365 Managed care was introduced into Medicare by

TEFRA in 1982

366 What is the main aspect of medicare managed care that the MMA of 2003 changed?

Types of plans available

367 what is the main impact of healthcare reform on Medicare advantage?

Funding

368 A Medigap policy is available to those enrolled in

Both Medicare Part A and part B

369 Which of these is covered by some Medigap policies?

Health care received outside the United States.

370 Medigap policies

Must provide one of a few standard benefit packages

371 Can an insurer deny medigap coverage to an eligible m beneficiary or charge him a higher than stand premium?

It can not do this if he enrolls when he first becomes eligible or otherwise qualifies for guaranteed issue, but otherwise it can.

372 Original Medicare consists of

Part A and Part B (Hospital and Medical coverage)

373 The main purpose of Medicare Part C (Medicare Advantage) is

To provide Medicare coverage through private-sector health plans

374 Medicare Part D prescription drug coverage is

Made available to Medicare beneficiaries at an extra cost

375 Medicare Part A beneficiaries who go into the hospital

Must pay a large deductible before Medicare pays any benefits

376 Medicare Part A skilled nursing facility and home health care benefits are paid

For a limited time to those recovering from an illness or injury

377 Medicare part A is available to persons 65 and older

But those who did not pay into the Medicare system pay a premium

378 For a disabled person to qualify for Medicare, her disability

Must be total and long-term

379 Medicare Part A is funded primarily by

Medicare payroll taxes

380 Does Medicare part b cover services provided by dentists, podiatrists, optometrsts, and chiropractors?

Only limited service are covered, and only when restrictive conditions are met.

381 Medicare Part B charges

An annual deductible and coinsurance for most items

382 For Medicare part B

Everyone pays a premium

383 For Medicare part B

Most people pay a standard premium, but those with high incomes pay more

384 How does Medicare enrollment work?

Most people are automatically enrolled in Medicare when they come eligble.

385 Tim decides not to enroll in Medicare Part B when he first becomes eligible, even though he has no employer- sponsored health coverage. Can he enroll later?

Yes, he can, but he may have to pay a higher premium

386 Medicare Advantage is

An alternative to original Medicare

387 Medicare advantage plan provide

Part A and Part B coverage and usually other benefits

388 Medicare Part D prescription drug coverage is offered by

Most but not all MA plans

389 Which statement is correct about MA plans?

Premiums and cost-sharing payment differ from plan to plan

390 Medicare part D prescription drug coverage is provided

By private-sector prescription drug plans (PDPs) and MA plans

391 Medicare Part D prescription drug plans (PDPs)

Must all provide a minimal level of benefits

392 Which statement is correct?

PDPs may have different deductibles, and coinsurance and copayment amount vary

393 In a typical Medicare part D PDP, after the PDP and the beneficiary have together paid a certain total amount for drugs, the beneficiary pays

All costs until catastrophic coverage is triggered.

394 Clarice Decides not to enroll in Medicare Part D when she first becomes eligible, even though she has no employer-sponsored drug coverage. Can she enroll later?

Yes, she can, but she will pay a higher premium

395 At which level of government is most health plan regulation?

Formerly at the state level, but after ACA at the federal level

396 State financial standards for HMOs are intended primarily to

Protect consumers from the risk of plan insolvency.

397 If a health plan risks becoming insolvent, what can an insurance commissioner do?

Intervene in the plan's operations, take over its management, or liquidate it.

398 The primary goal of receivership of a health plan is to

Return the plan to normal operation

399 State regulators review the description of an HMO's service area and the list of network providers. The regulators are concerned with

Network adequacy

400 State generally regulate

HMO, PPOs, and EPOs

401 Which plan type is often not governed by a state's regular insurance code?

HMO

402 Have states enacted laws to regulate PPOs?

Most have

403 An HMO with a point-of-service option

May be regulated under either, depending on the state

404 Which statement best describes state' regulation of utilization review organization

Most states license them, require certification, and regulate them to some extent.

405 Which statement best describes state' regulation of third-party administrators?

Most state have various requirements including a certificate of authority.

406 Which is not required by NAIC's Health Care professional Credentialing Verification Model Act?

If a provider meets a plan's credentialing criteria, she must be contracted by the plan

407 Which statement is true about the NAIC's Privacy of Consumer Financial and health information Model Regulation?

It addresses disclosure of nonpublic personal health information

408 Which of these is a component of healthcare reform?

The requirement that most people have health coverage or pay a tax penalty.

409 When will the new healthcare financing system become operational?

Most of the major component become operational in 2014, but some provisions go into effect earlier or later

410 With some exceptions, individual who do not have health coverage will

Have to pay an income tax penalty

411 large employers are

Required to sponsor health coverage or pay fees

412 Small employers are

Not required to sponsor health coverage but may be eligible for tax credit if they do

413 Tax credits will be available to help people pay for

Both premium and cost-sharing payment

414 Under the new requirement for health insurance plans, which of these will be permitted?

Premiums based on age

415 under the new requirement for health insurance plans, which can not be considered in setting premiums?

Health.

416 The medical laboratories in a community get together and decide how much they will all charge health plans for various tests. This is probably a case of

Price-fixing

417 A physician group refuses to provide certain specialty services to a health plan unless the plan agrees to contract with the group for all the services the group offers. This may be a case of

A typing arrangement

418 Which is an important provision of the Financial Services Modernization Act?

The protection of personal financial information

419 ERISA applies to

Employer and union sponsored health plan

420 Under ERISA what are the roles of the federal and state governments in regulating employer sponsored health plans?

An employer health plan is regulated by the federal government, but any insurer involved is regulated by the state.

421 Under ERISA, an individual challenging a coverage decision by an employer – sponsored health plan

Must sue in federal court any may not receive punitive damages

422 if an employee is laid off, under COBRA she has the right to continue her employer sponsored health coverage

For up to 18 months

423 Bill is covered under his wife Lorie's employer sponsored health plan. What rights does Bill have under COBRA to continue this coverage?

He has rights if Lorie's employment is terminated, she dies, or they are divorced.

424 has been laid off and is continuing his employer health coverage under COBRA. Who pays?

Noah pays the full cost of coverage, and the employee may charge him a certain amount for administrative costs.

425 What is the impact of the HMO Act of 1973?

HMOs that wish to be federally qualified must meet the standards, and while qualification is less important today, many HMOs are qualified.

426 Under ADEA, an employer sponsoring health coverage

May not decline to offer health coverage to older employees nor change them more.

427 Under FMLA, an employee who is ill or needs to care for a family member has the right to 12 weeks of

Unpaid leave, including health coverage

428 Health plans' member education focuses on

Either administrative matters or health or both.

429 Health Plan's member education is directed to

Both.

430 Which means of distributing information to health plan members is declining?

Letters and newsletters sent by mail

431 Jeff call his health plan's toll free number and i able, by following prompts and without talking to a person, to change his PCP, this is an example of

IVR

432 In health plan member services when are paper documents sent by mail?

For a variety of notifications and routine transactions.

433 Which statement about health plan communication with members is true?

Members can not only obtain information from websites but also sometimes performs transactions.

434 Why must a health plan adequately deal with complaints?

To comply with regulations, maintain member satisfaction, avoid bad publicity and reduce appeals.

435 A health plan's complaint resolution procedures (CRPs)

Are generally subject to state and federal regulation and accreditation requirements.

436 Who generally conducts a health plan's level two appeal of a member complaint?

The appeals committee

437 What happens if a health plan member does not win a level two appeal?

She may have the right to appeal to government agency or an external review organization

438 What are the two main ways of measuring member satisfaction with a health plan?

Members satisfaction surveys and complaint monitoring

439 What populations do health plan members satisfaction surveys target?

Members who have recently received services, all members, and former members.

440 Who conducts member satisfaction survey?

Plan employees or outside companies, but some accrediting bodies and purchasers require outside companies.

441 In traditional indemnity health insurance, which is most common?

Claims are submitted by provider

442 When is an encounter report submitted instead of a claim?

When the provider the compensated by capitation or salary

443 Health plan claims processing is similar to that of traditional insurance for

Hospitals and most (but not all) healthcare professionals

444 About what portion of a typical health plan's claims are processed electronically?

80 to 90 percent

445 Which statement is true about electronic claim processing?

It is promoted by federal legislation

446 A health plan employee who deals with claims that have been paid incorrectly is a claims

Adjustor

447 A claims examiner's responsibilities generally include

Reviewing and adjudicating claims not processed electronically

448 Under which type of provider compensation arrangement is the most claims information needed?

Discounted fee for service

449 Which standardized claim form is used by physicians?

CMS – 1500

450 What is the standard code set for diagnosis

ICD

451 A claim triggers an edit, usually the claim will be

Examined furthered

452 In which situation is it not uncommon for a health plan to make a partial payment on a claim?

Authorization was not obtained

453 Which statement is true about claim processing?

If a provider bills more than six month after delivering a service, a plan is not required to pay

454 coordination of benefit may apply when

A person is covered by more than once health plan

455 Most claim investigations

Are short and simple

456 The primary focus of the NAIC Unfair Claims Settlement Practices Act is

Ensuring that insurers handle claim fairly and promptly

457 An information management system incorporates membership data and provider reimbursement arrangement and analyses transactions according to contract rules. This describes a

Contract management system

458 A health plan has an automated system to facilitate the processing of requests for authorization of payment. What kind of information management system is this?

Utilization management

459 An information management system identifies physicians who tend to provide fewer services than the norm in certain situations. This is an example of

Provider profiling

460 The use of MRI machine is expensive, so a health plan needs to efficiently coordinate utilization by providers. What type of information management system address this need?

Enterprise scheduling

461 A health plan's members can go the plan's website to check on the status of their claims. What kind of information management system is this?

Member services

462 Which statement about the quality of health plan data is not true?

The use of codes largely eliminates problems of accuracy

463 The data used by health plans is

Often in different databases and in incompatible formats.

464 Which aspect of information management in health plans is most strongly addressed by government regulations?

Security and privacy

465 In health plans, information management is

Somewhat automated

466 Which term encompasses all types of electronic business functions?

E-business

466 Which statement best describes health plans and the internet?

Health plans have historically lagged behind other industries but are now handling many transactions online

467 A security device designed to block unauthorized access to a private network is

A firewall

468 A computer network is accessible only the employees of a health plan. This is an

Intranet

469 The main threat to a health plan's network is

Employees

470 How does electronic data interchange (EDI) differ from e-business?

It is the transfer of batches of data, not exchanges about a transactions.

471 Which generally results in more accurate data, manual processes or EDI?

EDI

472 The focus of business intelligence and decision support system is to

Help managers make decisions in specific cases

473 The main problem that a data ware house is designed to address is

Data in multiple data base

474 The main disadvantage of data warehouses is

The complexity and cost of implementing them

475 Medical information for an individual designed to be used at the site of care is

An electronic medical record.

476 The main advantage of health information networks (HINs) and health information exchange (HIE) is that providers treating a patient

Have access to all of her medical records and health information

477 How does an HIE (such as RHIO) differ from an HIN?

An HIN shares information within a health plan network, while and HIE share it across health care entities.

478 Which is owned by the individuals?

The personal health record (PHR)

479 Personal health records are available from

Health plans and other organizations

480 How does the electronic medical record differ from the personal health record?

The EHR adds information from providers.

481 An example of an insourcing-outsourcing hybrid is

Cloud computing

482 A health plan uses a group's past experience to estimate its expected experience, and if actual experience is different, the plan absorbs the gains or losses. This Describes.

Prospective experience rating

483 Which will PPACA do regarding rating as of 2014?

Limit premium differentials based on risk factors.

484 An MCO's income statement

Summarizes its revenue and expense activity during a specified period.

485 Community rating is least likely to be used for

Large groups

486 A health plan sets premiums for classes of members based on age, family composition, and geography, but not experience. This is an example of

Adjusted community rating (ACR)

487 A health plan sets premiums for a group based on the plan's average experience with all groups rather than that particular group. This describes

Manual rating

488 Which will be prohibited by PPACA?

Annual and lifetime benefit limit

489 In renewal underwriting of group, what are the two main factors?

Experience and participation

490 In rating, what are the main considerations?

Riske and expected costs balanced by marketability and competitiveness.

491 Setting premiums based on the expected costs of providing benefits to the community as whole rather than to any subgroup is called?

Community rating

492 Underwriting involves

Identifying and assessing risks.

493 Which statement best describes adverse selection (anti selection)?

Those more likely to need healthcare are more likely to obtain health coverage

494 In health underwriting, what are the most important risk factors for individuals?

Age and gender, and sometimes health status or occupation

495 Which will be prohibited by PPACA?

Preexisting condition exclusions.

496 The major categories of an MCO's balance sheet are

Assets, liabilities and capital

497 State insurance regulators are primarily concerned with and HMO's

Statuary solvency

498 A variance is the difference between

Expected and actual revenues and expenses

499 An insurance company is financially responsible for paying healthcare benefits to the employees of High Plateau company. High Plateau's health plan is

A fully funded plan

500 Big River Corporation takes responsibility for paying healthcare benefits to its employees, but if total claims rise above $10 million in a year, an insurer pays any claims above this level. This is an example of

Aggregate stop-loss coverage.

501 A third-party administrator generally

Administers benefit only

502 The term “Marketing mix” refers to

Product, price, promotion, and distribution

503 A health plan’s potential customers include

Employers, associations, employees, Medicare and Medicaid beneficiaries and other individuals.

504 Which is a market research technique?

Focus groups

505 How is marketing in health plans different from marketing in many other industries?

Markets are generally local

506 Will the Affordable Care Act (ACA) affect product development?

Yes, in relation to benefit packages, cost-sharing, and other matters.

507 Developing multiple product lines helps a health plan compete among

Large employers, but it makes marketing more complicated

508 What is the difference between

publicity?

Advertising is paid for, publicity is not.

509 The term “promotion mix” is commonly used to refer to

Advertising, publicity, personal selling and sales promotion

510 Which distribution channel is made up of health plan employees?

Internal sales force

511 Who are generally compensated by the buyer of a health plan, not by the seller?

Employee benefits consultants.

512 Who are considered to represent the health plan?

Agents.

513 Who sells the products of only once company?

A captive agent

514 Who commonly works with individuals rather than groups?

Agents

515 Which direct marketing method is commonly used today?

Direct mail

516 Dividing a market into smaller groups of customers is called

Market segmentation

517 Medicare beneficiaries are generally considered part of the

Non-group market

518 A health plan decides to compete in the small group market instead of the large group market by offering a basic and inexpensive product. This is an example of

Positioning

519 Who is not a member of the regular group market?

Joanne recently lost her job and her group health plan

520 Which is not a common distribution channel in the individual market?

Brokers

521 The Affordable Care Act (ACA) will affect the marketing of all health plans, but it will have the greatest impact on the

Individual market

522 Which is not true under the ACA?

The individuals market will be eliminated, and everyone will have group coverage

523 Which is not a common distribution method in the senior market?

Door – to door selling

524 People eligible for Medicare

May receive health and/or drug coverage through private-sector health plans

525 The group market is made up mostly of

Employers

526 Small business choosing a health plan usually focus strongly on

Price

527 Which is true of small employers?

Only one health plan is usually offered

528 Which is true of large employers?

They often use employee benefit consultant

1. Reese is not required to choose a dentist or network during an annual open enrollment. She can choose when she needs care. But if she uses a non-network dentist, she pays a higher copayment. What type of plan does she have?

   a. PPO
   b. HMO
   c. POS **(Correct)**
   d. Indemnity

2. Which of these is a method used in market research?

   a. Database marketing
   **b.** Focus Groups **(Correct)**
   c. Positioning
   d. Branding

3. What portion of participants in Medicaid and the Children's Health Insurance Program (CHIP) are in managed care?

   a. About Half
   b. About a Third
   c. A Small Minority
   d. A Large Majority **(Correct)**

4. The two main components typical of a consumer-directed health plan (CDHP) are:

   a. An Employer-Sponsored high-deductible health plan and an individual supplemental insurance policy
   b. A tax-advantaged personal healthcare account and enrollment in a health maintenance organization
   c. An individual high-deductible health plan and an employer-sponsored catastrophic plan
   d. A high-deductible health plan and a tax-advantaged personal healthcare account **(Correct)**

5. Which of these is not covered by any Medigap policy?

a. Health care received outside the United States
b. Medicare Deductibles
c. Medicare Coinsurance and Copayments
d. Dental, Vision, and hearing services and products **(Correct)**

6. Under Traditional Indemnity health insurance, Insured's can receive healthcare:

a. From any provider they choose, but they pay higher cost-sharing for non network providers
b. Only from a provider affiliated with the insurer's network
c. From any provider they choose **(Correct)**
d. From any provider with prior approval from the insurer

7. Workers' compensation is:

a. Coverage for work-related injuries and illnesses that states require employers to provide to their employees
b. A federal program that helps pay for medical expenses and lost wages resulting from a work-related injury or illness
c. Insurance that employers and/or employees may choose to purchase to cover work-related injuries and illnesses
d. State programs that help pay for medical expenses and lost wages resulting from a work-related injury or illness **(Correct)**

8. Which statement about trends in health plan products is correct?

a. Fewer types of plans are being offered, and the distinctions between them are becoming sharper
b. More types of plans are being offered, and the distinctions between them are becoming sharper
c. Fewer types of plans are being offered, and the distinctions between them are becoming blurred
d. More types of plans are being offered, and the distinctions between them are becoming blurred (Correct)

9. Under capitation, the amount a provider is paid is based on:

a. The cost of the services she performs
b. The number of hours she works
c. The number of members she is responsible for **(Correct)**
d. The number of services she performs

10. What kind of risk does an HMO assume or share?

a. Both financial and delivery risks **(Correct)**
b. Neither financial nor delivery risks
c. Financial risks only, not delivery risks
d. Delivery risks only, not financial risks

11. The percentage of stroke patients who are able to walk and speak normally after two years is:

a. A perception measure
b. An outcomes measure **(Correct)**
c. A structure measure
d. A process measure

12. What is the best definition of a health plan?

a. An organization that combines employer funding of a core set of health benefits, employee financial responsibility, and provider accountability
b. An organization that maintains a network of affiliated healthcare providers and pays benefits only for services rendered by those providers
c. An organization that integrates the delivery and financing of healthcare and seeks to manage healthcare costs, access, and quality **(Correct)**
d. An organization that provides health coverage to a group of people, most commonly the employees of a business

13. Most HMO models may have an open or closed panel. Which HMO model normally has a closed panel?

a. IPA Model
b. Staff Model **(Correct)**
c. Group Model
d. Network Model

14. NCQA provides accreditation for:

a. Many types of health plans **(Correct)**
b. Preferred provider organizations only
c. Health maintenance organizations only
d. Healthcare providers only

15. Does HMO cover out-of-Network services?

a. Traditionally they did, but almost all HMOs no loner do so
b. No, this is a defining characteristic of HMOs
c. Traditionally they did not, but some HMOs now do so at a higher cost of members (correct)
d. Traditionally they did not, but some HMOs now do so at no extra cost to members

16. URAC provides accreditation for:

a. Functional areas within organization only
b. Health plans and health networks
c. Health plans, health networks, and functional areas within organizations **(Correct)**
d. Entire health plans only

17. A health plan's utilization review staff make decisions about what healthcare services:

a. A member can receive
b. Can be accessed out of network
c. The plan will pay for **(Correct)**
d. A provider can provide

18. A contract between a health plan and its network providers requires providers to accept the plan's compensation as payment in full and prohibits them from billing plan members from additional amounts. What contract provision is this?

a. Due process clauses
b. No balance billing provision **(Correct)**
c. Cure provision
d. Hold harmless provision

19. What coverage do Medicare Advantage plans provide?

a. The coverage of one of the standard Medigap plans
b. Medicare Part A and Part B coverage only
c. Medicare part A and Part B coverage only, but without cost-sharing
d. Medicare Part A and Part B coverage, other benefits, and usually drug benefits **(Correct)**

20. In a health Plan, what is underwriting?

a. Indentifying and evaluating risks presented by individuals and groups **(Correct)**
b. Tracking revenue and expenses to meet budget projections
c. Calculating premium rates for individuals and groups
d. Evaluating and selecting potential network providers

21. What is the main source of the cost-savings of consumer-directed health plans?

a. Consumers receiving less healthcare
b. Consumers making cost-effective healthcare choices
c. Employers shifting costs to consumers **(Correct)**
d. Employers receiving favorable tax-treatment

22. Who receives Medicare Part D prescription drug coverage?

a. All Medicare beneficiaries have the option of enrolling and paying an additional premium **(Correct)**
b. All Medicare Part B beneficiaries are enrolled and charged an additional premium
c. All Medicare beneficiaries receive it at no additional cost
d. All Medicare Advantage beneficiaries receive it at no additional cost

23. Every time Doug visits his primary care physician, he the doctor $10, regardless of the cost of services provided. This describes:

a. A capitation fee
b. A copayment **(Correct)**
c. Coinsurance
d. A deductible

24. What is the standard code set for medical treatments and procedures?

a. ICD-10
b. CMS-1500
c. CPT **(Correct)**
d. UB-04

25. In which HMO Model are physicians' salaried employees working in HMO Facilities?

a. Staff Model **(Correct)**
b. IPA Model
c. Network Model
d. Group Model

26. Normally, what does a health plan's ethics task force do?

a. It provides a forum for discussion of ethical and promotes ethics education, but it does not involve itself in specific ethical decisions.
b. It provides a forum for discussion of ethical issues, promotes ethics education, and offers consultation is specific ethical decisions **(Correct)**
c. It only provides a forum for discussion of ethical issues
d. It provides a forum for discussion of ethical issues, promotes ethics education, and routinely makes specific ethical decisions

27. In utilization review
28. (UR), who has the authority to deny authorization of payment for a service based on medical necessity and appropriateness:

a. A plan benefit specialist only
b. A clinical UR staffer (Physician or Nurse)
c. A UR staffer, clinical or Nonclinical
d. A Physician Only **(Correct)**

29. The primary focus of a disease management program is:

a. Individuals with complicated and high-cost diseases
b. Providers who are not following clinical practice guidelines for certain diseases
c. Populations of people who have or are at risk for certain diseases **(Correct)**
d. Immunizations for common childhood diseases

30. Which is a common HMO compensation arrangement for hospitals but not physicians?

a. Capitation
b. Fee-for-Service

c. Diagnosis-Related Groups (DRGs) **(Correct)**
d. Discounted Fee-for-Service

31. Which of these healthcare services is not likely to be subject to concurrent utilization review?

a. A course of Physical Therapy
b. A lengthy Hospital Stay
c. A Visit to a Neurologist **(Correct)**
d. A course of Chemotherapy

32. Which is a provision of the HMO Act of 1973?

a. All employers with 100 or more employees had to offer a federally qualified HMO to their employees
b. All HMOs were required to become federally qualified
c. Federally qualified HMOs were exempted from State laws that restricted their development **(Correct)**
d. Federally qualified HMOs had to meet less rigorous standards than other health plans

33. To calculate how much to pay a physician for a procedure, a health plan assigns a numerical value to the procedure and multiples this number by a dollar figure negotiated with providers. This describes:

a. A relative value scale (RVS) **(Correct)**
b. Discounted Fee-for-Service (FFS)
c. Usual, Customary, and Reasonable (UCR) Fees
d. Diagnosis-Related Groups (DRGs)

34. A history of an individual's health and his encounters with the healthcare system that is owned by the individual is:

a. The personal health record (PHR) **(Correct)**
b. The computer-based patient record (CPR)
c. The electronic medical record (EMR)
d. The electronic health record (HER)

35. Which is an important factor driving increased healthcare spending?

a. Defensive Medicine
b. Consumer-Directed health plans
c. A younger population because of immigration
d. New drugs and technology **(Correct)**

36. Which is not typical of managed care?

a. Fee-for-Service Compensation **(Correct)**
b. Negotiating discounted rates with providers
c. Utilization, case, and disease management
d. An emphasis on preventive healthcare

37. How widespread are flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs)?

a. A majority of employees have one or the other
b. Nearly all employees have one or the other
c. Only a small minority of employees have either **(Correct)**
d. About half of employees have one or the other

38. To be eligible for a health savings account (HSA), what health coverage must a person have?

a. Any employer-sponsored health plan
b. A qualified HDHP, Medicare, or dependent coverage under someone else's plan
c. A qualified HDHP only, not other broad health coverage or Medicare **(Correct)**
d. Any high-deductible health plan (HDHP)

39. Under ERISA, does the Federal Government regulate employer-sponsored health plans?

a. It regulates fully insured but not self-funded plans
b. It regulates both self-funded and fully insured plans **(Correct)**
c. It regulates neither self-funded nor fully insured plans
d. It regulates self-funded but not fully insured plans

40. Which health plan types generally require a referral from a primary care physician to see a specialist?

a. PPOs
b. Traditional HMOs
c. HMOs and PPOs
d. Traditional HMOs and POS product **(Correct)**

41. Which statement about state regulation is correct?

a. Most states do not have laws specifically addressing HMOs or PPOs, but regulate them through the regular insurance code (Correct)
b. Most states have laws specifically addressing HMOs but not PPOs
c. Most states have laws specifically addressing PPOs but not HMOs
d. Most states have laws specifically addressing HMOs and PPOs

42. Which HMO Model has high facility costs but greatest control of care management and quality?

a. IPA Model
b. Network Model
c. Group Model
d. Staff Model **(Correct)**

43. What is the characteristic feature of a corporation that makes it different from other organizations?

a. It issues stock
b. It is a legal entity separate from its owners **(Correct)**
c. It is for-profit organization
d. It is owned by more than two people

44. Why has the popularity of flexible spending accounts (FSAs) been limited?

a. The prohibition on employee contributions
b. The tax penalty on funds withdrawn before age 65
c. The limited type of healthcare expenses on which funds can be spent
d. The "use it or lose it" rule and the lack of portability **(Correct)**

45. Which physician-only provider organization is the most integrated?

a. The consolidated medical group **(Correct)**
b. The independent practice association (IPA)
c. The group practice without walls (GPWW)
d. The management services organization (MSO)

46. Separate healthcare providers are brought under common ownership and control. This describes:

a. Clinical integration
b. Structural integration **(Correct)**
c. Business integration
d. Operational integration

47. Who owns a mutual insurance company?

a. The company's board of directors
b. The company's policyholders **(Correct)**
c. The company's stockholders
d. A non-profit organization

48. Typically, who submits encounter reports instead of claims to a health plan?

a. All hospitals and facilities but not healthcare professionals
b. All healthcare professionals but not hospitals and facilities
c. Healthcare professionals compensated by capitation **(Correct)**
d. Healthcare professionals compensated by fee-for-service

49. Primary care providers compensated by fee-for-service have an incentive to:

a. Provide unnecessary services
b. Not provide needed services
c. Refer patients to specialists
d. Promote prevention and wellness **(Correct)**

50. What is the measurement of how long it takes a health plan member services representative to complete a transaction request by a member?

a. First contact resolution rate
b. Turn-around time **(Correct)**
c. Wait time
d. Call abandonment rate

51. Does Medicare cover all healthcare expenses?

a. Medicare has only minor cost-sharing payments, and it covers nearly all health-related expenses
b. Medicare has substantial cost-sharing payments, but it covers nearly all health-related expenses
c. Medicare has substantial cost-sharing payments, and it does not cover routine dental, vision, and hearing care and some other items (Correct)
d. Medicare has only minor cost-sharing payments, but it does not cover routine dental, vision, and hearing care and some other items

52. Which personal healthcare account offers annual rollover of funds, tax-fee investment growth, and full portability?

a. Health Saving Account (HSA) **(Correct)**
b. FSA, HRA, and HAS
c. Health Reimbursement Arrangement (HRA)
d. Flexible spending account (FSA)

53. For which of these healthcare services is precertification (Prior Authorization) most likely to be required?

a. A visit to a specialist
b. A visit to a primary care provider
c. A routine laboratory test
d. A hospital admission **(Correct)**

54. Do states regulate utilization review organizations (UROs) and third party administrators (TPAs)?

a. Most states regulate both to some extent **(Correct)**
b. Most states regulate TPAs but not UROs
c. Only a few states regulate either
d. Most states regulate UROs but not TPAs

55. Who can receive Medicare coverage?

a. People 65 or older and younger people with low incomes
b. People 65 or older and younger people with severe, long-term disabilities or a few diseases **(Correct)**
c. People 65 or older only

d. People 65 or older and younger people with disabilities

56. In establishing and maintaining provider networks, health plans generally try to ensure member access to care by:

a. Recruiting as many providers of all types as they can
b. Considering the number, type, and location of providers needed **(Correct)**
c. Accepting all providers who meet minimal standards
d. Imposing no barriers or disincentives on the use of out-of-network care

57. After Sarah has been in treatment for a respiratory condition for a few months, her health plan conducts an evaluation to make sure the services she is receiving are necessary, appropriate, and cost-effective. This is an example of:

a. Disease Management
b. Utilization review
c. Case Management **(Correct)**
d. Shared Decision-Making

58. Compared to indemnity insurance, health plan typically have.

a. More extensive benefit packages and lower out-of-pocket costs **(Correct)**
b. More extensive benefit packages but higher out-of-pocket costs
c. Less extensive benefit packages but lower out-of-pocket costs
d. Less extensive benefit packages and higher out-of-pocket costs

59. How do PPOs most commonly compensate physicians?

a. Non-discounted fee-for-service
b. Capitation
c. Discounted fees **(Correct)**
d. Per-diem payments

60. May one use funds from a health savings account (HAS) for non-medical purposes?

a. Yes, but you will have to pay income tax on the money
b. Yes, but you will have to pay income tax and (if under 65) a tax penalty. **(Correct)**
c. Yes and the withdrawal will normally be tax-free.
d. No, this is not allowed.

61. Most regulation of health plans?

a. Has been at the state level but after the affordable care act (ACA) will be at the federal level. **(Correct)**
b. Has been at the Federal level but after the affordable care act (ACA) will be at the State level.
c. Has been and continues to be at the state level.
d. Has been and continues to be at the federal level.

62. Which statement is true about how health plans communicate with their members?

a. Regular mail is used only when required by regulations for important notifications **(Correct)**
b. Some interactive voice response (IVR) telephone systems enable members to conduct certain transactions without talking to a person
c. Websites can be used to obtain information but not perform transactions
d. Email is not frequently used because of strict regulations related to privacy and security.

63. Internal quality standards for health plans are?

a. Based on industry benchmarks and usually apply to healthcare services **(Correct)**
b. Developed by the health plan itself and usually apply to administrative services
c. Based on industry benchmarks and usually apply to administrative services
d. Developed by the health plan itself and usually apply to healthcare services

64. Dan has multiple medical conditions. A nurse is assigned to him to assess his needs, design a plan of care, and coordinate and monitor the services he receives. This describes:

a. Utilization review
b. Case management **(Correct)**
c. Value-based healthcare
d. Disease management

65. For small business buying a health plan, what is usually the key factor?

a. Healthcare quality
b. Employee satisfaction
c. Customization
d. Premium Price **(Correct)**

66. A computer program discovers that, based on repeated early refills, a plan member seems to be taking more of a pain reliever than he should. This is an example of.

a. Drug utilization review **(Correct)**
b. Physician Profiling
c. Prior authorization
d. Formulary management

67. What is the main purpose of the Children's health insurance program (CHIP
68. )?

a. To help pay the health insurance deductibles, coinsurance, and copayments of families with moderate incomes
b. To provide health coverage to children unable to obtain private-sector insurance because of the their medical history or a preexisting condition
c. To provide financial relief to families who have incurred very large medical expenses for children
d. To provide health coverage to children whose families cannot afford private-sector insurance but do not qualify for Medicaid. **(Correct)**

69. Which statement about raising capital is correct?

a. Stock companies find it easier than mutual companies, and for-profit plan find it easier than not-for-profit plans **(Correct)**
b. Mutual companies find it easier than stock companies, and not-for-profit plans find it easier than for-profit plans
c. Mutual companies find it easier than stock companies, and for-profit plans find it easier than not-for-profit plans
d. Stock companies find it easier than mutual companies, and not-for-profit plans find it easier than for-profit plans

70. A health plan decides to complete in the large group market instead of the small group market by offering a variety of product lines. This is an example of:

a. Positioning **(Correct)**
b. Branding
c. Marketing mix
d. Market segmentation

71. Under which compensation arrangement do providers assume the greatest financial risk?

a. Capitation **(Correct)**
b. Diagnosis-related groups (DRGs)
c. Resource-Based Relative Value Scale (RBRVS)
d. Discounted fee-for-service

72. A health plan has an obligation to respect the right of its members to make decisions about their own lives. This is the ethical principal of

a. Beneficence
b. Autonomy **(Correct)**
c. Altruism
d. Equity

73. Diane is a member of a private-sector health plan. She disagrees with a decision made by the plan. A level one review by the plan's medical director and a level two review by its appeals committee both uphold the plan's original decision. What are Diane's options?

a. Her case automatically goes to binging arbitration
b. She has no further recourse and must accept the decision
c. She may have the right to appeal to the state insurance department or an external review organization (depending on state laws) **(Correct)**
d. She may have the right to appeal to the state insurance department or, if no, to the federal Department of Health and Human Services.

74. What happens when adverse selection occurs?

a. People less likely to need healthcare are more likely to obtain health coverage
b. People who have health coverage are more likely to use healthcare services
c. People more likely to need healthcare are more likely to obtain health coverage **(Correct)**
d. Physicians who provide inferior care are more likely to join a health plan network

1. Which is not an early form of health plan?

    a. HMO
    b. Traditional Indemnity
    c. PPO **(Correct)**
    d. EPO

2. Janine can go to any doctor she chooses, but if she goes to one not in her plan's network, she has to pay a large share of the cost. Janine is covered by?

    a. POS
    b. PPO **(Correct)**
    c. Indemnity
    d. None of the above

3. Jacob must pay $2,000 in healthcare expenses each year before he receives benefits from his health plan, but he can use money from a tax-advantaged savings account. Jacob has

    a. CDHP **(Correct)**
    b. HSA
    c. Indemnity
    d. HRA

4. Which is not a cause of higher healthcare spending
5. ?

    a. Government Intervention
    b. A younger population because of immigration **(Correct)**
    c. New Technique in Healthcare
    d. All of the above

6. Under the fee-for-service approach, healthcare providers have a financial in
7. tive to provide?

a. More Services **(Correct)**
b. Less Services
c. Appropriate Service
d. Refer patient to different department

8. Which is not an accrediting organization?

a. NCQA
b. URAC
c. HEDIS **(Correct)**
d. None of the above

9. In traditional indemnity plan, how are providers compensated?

a. Capitation
b. DRG Payment
c. Fee-For-Service **(Correct)**
d. Discounted Payment

10. Which is not common in traditional indemnity health insurance?

a. Copayment **(Correct)**
b. Deductible
c. Coinsurance
d. Non of the Above

11. Coordination of benefits is designed to?

a. Prevent members to go out of network
b. Prevent members to get additional benefits
c. Prevent members to get unnecessary charged
d. Prevent Duplication of benefits **(Correct)**

12. Which health plan uses managed care techniques and concepts the most?

a. HMO **(Correct)**
b. POS
c. PPO
d. EPO

13. Managing the use of healthcare services so that patients receive necessary, appropriate and high quality care in a cost effective way is?

a. Utilization Review
b. Utilization Management **(Correct)**
c. Decease Management
d. Case Management

14. Teresa, a doctor is paid by a health plan by capitation. One month she delivers a very few services to plan members, the next month she delivers about the projected amount. Teresa is paid –

a. Double amount
b. Less Amount
c. The same amount each month **(Correct)**
d. Don't know

15. A plan holds back a percentage of PCP's monthly capitation payments. At the end of the year, some of this money is paid to the PCP's but some is used to pay for higher than projected referrals. This is -

a. Risk Pool
b. Withhold **(Correct)**
c. Capitation
d. RVS

16. Which compensation arrangement involves least risk for hospital?

a. Fee for Service **(Correct)**
b. Discounted Fees
c. Capitation
d. RVS

17. A plan pays money into a pool to cover hospitalization. At the end of the year, if there is money left over in the pool, same is given to the PCPs, but if there is not enough money, PCPs must cover some of the cost. This is –

a. Risk Pool (Correct)
b. Withhold
c. Capitation
d. RVS

18. A physician is compensated by an HMO by capitation but once her total costs have reached a certain level, additional costs are reimbursed by discounted FFS. This is-

a. DRG Provision
b. Stop Loss Provision **(Correct)**
c. Capitation
d. RVS

19. Which utilization management technique is used primarily for physicians?

a. Risk Pool **(Correct)**
b. Withhold
c. Capitation
d. RVS

20. An HMO contracts with six group practices. This is an example of –

a. Group Model HMO
b. Staff Model HMO
c. Network Model HMO **(Correct)**
d. IPA

21. What portion of U.S employees are covered by PPOs?

a. Majority of Employees **(Correct)**
b. Less number of Employees
c. 10 % of the employees
d. Don't know

22. A majority of PPOs are owned by?

a. Insurance companies **(Correct)**
b. Providers
c. Hospitals
d. Federal Government

23. In establishing and maintaining provider networks, health plans generally try to ensure member access to care by:

e. Recruiting as many providers of all types as they can
f. Considering the number, type, and location of providers needed **(Correct)**
g. Accepting all providers who meet minimal standards
h. Imposing no barriers or disincentives on the use of out-of-network care

24. How many employees are covered by POS products?

a. A small but declining minority **(Correct)**
b. A small but increasing
c. Majority of employees
d. Don't know

25. Which is typical of a dental HMO?

a. Deductible
b. Copayment **(Correct)**
c. Coinsurance
d. CDHP

26. Which is typically a dental PPO?

a. Annual Deductible
b. Annual deductible, coinsurance and annual maximum **(Correct)**
c. Annual Coinsurance
d. Annual Maximum

27. Which dental plan type typically has the smallest network?

a. PPO
b. HMO **(Correct)**
c. POS
d. Indemnity

28. About what percent of U.S. adults experience some sort of behavioral health disorder during any year?

a. 50 %
b. 25 % **(Correct)**
c. 100 %
d. 10 %

29. Douglas is in a substance abuse program. He spends most of his time in a facility but goes out during the day to attend school. This describes –

a. Partial hospitalization **(Correct)**
b. Acute Hospitalization

c. Intensive Care
d. None of the above

30. Which is not an element of consumer directed health plans?

a. High Premium **(Correct)**
b. Low Premium
c. High benefits
d. None of the above

31. Which premiums cannot be paid tax-free with HSA funds?

a. Medigap insurance **(Correct)**
b. Medicare Insurance
c. Medicaid Insurance
d. Cobra Insurance

32. Can a person 65 or older use HSA funds to pay non-medical expenses?

a. Yes, she may; she must pay income tax but not tax penalty **(Correct)**
b. No it is not possible
c. Yes, she may; she must pay income tax
d. Can't possible

33. What is the primary purpose of a PHO?

a. Contracting with health plans and marketing **(Correct)**
b. Contracting with Networks
c. Contracting with Providers
d. All of the above

34. Which statement is true about mutual and stock insurance companies?

a. Most insurers are stock companies **(Correct)**

b. Most insurers are mutual companies
c. Most insurers are combined companies
d. All of the above

35. Which plan types need fewer providers per 1,000 members?

a. Highly managed large plans **(Correct)**
b. Less managed large Plans
c. CDHP Plans
d. All of the above

36. A program teaches health plan members how to treat minor illness and distinguish them from serious conditions. This is –

a. Wellness Program
b. Self care program **(Correct)**
c. Online care program
d. None of the above

37. Case managers are most commonly?

a. Highly experienced providers
b. Nurses **(Correct)**
c. Hospitals
d. Managers

38. A doctor treating a patient with diabetes refers to guidelines for this condition in making decisions about the most appropriate course of action. This describes –

a. Length of stay guidelines
b. Clinical practice guidelines **(Correct)**
c. Hospital Stay guidelines
d. Room and board guidelines

39. If both prospective and retrospective reviews are possible, which is generally preferable?

    a. Prospective review **(Correct)**
    b. retrospective reviews
    c. Both are urgent
    d. We will go for Concurrent review

40. In order to receive a larger payment, a doctor improperly and deliberately bills two procedures separately instead of together. This is –

    a. Upcoding
    b. Unbundling **(Correct)**
    c. Bundline
    d. Coding

41. Who can deny an authorization based on medical necessity and appropriateness?

    a. Physician **(Correct)**
    b. Nurse
    c. Hospital
    d. Assistants

42. Carol has a question about her health coverage, but she tries all day and is unable to reach her health plan by phone. This is an issue of –

a. Medical Quality
b. Service Quality **(Correct)**
c. Cost Quality
d. All of the above

43. The percentage of health plan members who have received a medical checkup in the past two years is –

a. Process Measure **(Correct)**
b. Structure Measure
c. Outcome Measure
d. All of the above

44. The term "Marketing mix" refers to –

a. Product, price, promotion and distribution **(Correct)**
b. Production & Price
c. Product & Promotion
d. Product & Distribution

45. A health plan decides to compete in small group market instead of large group market by offering a basic and inexpensive product. This is an example of -

a. Branding
b. Positioning **(Correct)**
c. Benchmarking
d. Scoring

46. The Affordable Care Act (ACA) will affect the marketing of all health plans but it will have the greatest impact on the –

    a. Individual market **(Correct)**
    b. Group Market
    c. Network Market
    d. IPA Market

47. Which is not one of the main goals of HIPAA?

    a. Expanding Medicaid eligibility **(Correct)**
    b. Expanding Medicare eligibility
    c. Expanding Medigap eligibility
    d. Expanding state regulations

48. Tax credits will be available to help people pay for –

    a. Both premiums and cost-sharing payments **(Correct)**
    b. Premiums Only
    c. Cost-Sharing Payment
    d. None of the above

49. Under the new requirements for health insurance plans (ACA), which of these will be permitted?

    a. Premiums based on age **(Correct)**
    b. Premium based on health
    c. Premium Based on geography
    d. Premium based on community

50. State regulators review the description of an HMO's service area and the list of network providers. The regulators are concerned with –

    a. Network adequacy **(Correct)**
    b. Group Adequacy
    c. Provider Adequacy

d. Don't know

51. Which plan type is often not governed by a state's regular insurance code?

a. PPO
b. POS
c. HMO **(Correct)**
d. Indemnity

52. Tim decides not to enroll in Medicare Part B when he first becomes eligible, even though he has no employer sponsored health coverage. Can he enroll later?

a. Yes, but he may have to pay a higher premium **(Correct)**
b. No, they can not be enrolled
c. Tim needs to wait till 1st of Jan'11
d. Yes, he can enroll and also he does not need to pay any penalty

53. What is the main impact of healthcare reform on Medicare Advantage?

a. Rating
b. Funding **(Correct)**
c. Underwriting
d. Financing

54. A Medigap policy is available to those enrolled in?

a. Medicare Part A and B **(Correct)**
b. Medicare Part A
c. Medicare Part B
d. Medicare Advantage

55. Which of these is covered by some Medigap policies

a. Vision Services

b. Hearing Services
c. Healthcare received outside the US **(Correct)**
d. None of them

56. If a healthcare service is covered by both Medicare and Medicaid, who pays?

a. Medicare **(Correct)**
b. Medicaid
c. Can be paid by both
d. Person can not have both the coverage

57. Worker's compensation pays benefits to cover –

a. Medical Income
b. Lost Income
c. Both Medical & Lost Income **(Correct)**
d. None of the above

58. Health plans and their providers must respect the right of plan members to make decisions about the course of their lives. This is the ethical principal of –

a. Autonomy **(Correct)**
b. Justice and Equity
c. Beneficence
d. Non-maleficence

59. The percentage of stroke patients who are able to walk and speak normally after two years is:

a. A perception measure
b. An outcomes measure **(Correct)**
c. A structure measure
d. A process measure

60. What form does cost-sharing generally take in traditional indemnity health insurance?

a. An annual deductible and coinsurance **(Correct)**
b. An annual deductible and copayments
c. An annual deductible, coinsurance, and copayments
d. Coinsurance, but no deductible or copayments

61. The primary purpose of Medicare Advantage is to offer

a. A form of Medicare with a high premium but no deductibles, coinsurance, or copayments
b. A supplement to Medicare that covers many Medicare cost-sharing payments
c. The option of receiving Medicare coverage through a private-sector health plan **(Correct)**
d. Prescription drug coverage to Medicare beneficiaries

62. Who can receive Medicare coverage?

a. People 65 or older and younger people with low incomes
b. People 65 or older and younger people with severe, long-term disabilities or a few diseases **(Correct)**
c. People 65 or older only
d. People 65 or older and younger people with disabilities

63. Which way of accessing behavioral healthcare services used to be common but no longer is?

a. Direct Access
b. Employee Assistance Program (EAP)
c. Primary Care Provider (PCP) referral **(Correct)**
d. Centralized Telephone Referral System

64. After Sarah has been in treatment for a respiratory condition for a few months, her health plan conducts an evaluation to make sure the services she is receiving are necessary, appropriate, and cost-effective. This is an example of:

a. Disease Management
b. Utilization review
c. Case Management **(Correct)**
d. Shared Decision-Making

65. Which HMO model has high facility costs but greatest control of care management and quality?

    a. IPA model
    b. Group model
    c. Network model
    d. Staff model **(Correct)**

66. An HMO contracts with eight group practices. This is an example of

    a. An IPA model HMO
    b. A network model HMO **(Correct)**
    c. A mixed model HMO
    d. A group model HMO

67. Which of these healthcare services is not likely to be subject to concurrent utilization review?

    a. A course of physical therapy
    b. A lengthy hospital stay
    c. A course of chemotherapy
    d. A visit to a neurologist **(Correct)**

68. Under which compensation arrangement do providers assume the greatest financial risk?

    a. Capitation **(Correct)**
    b. Resource-Based Relative Value Scale (RBRVS)
    c. Diagnosis-related groups (DRGs)
    d. Discounted fee-for-service

69. A health plan identifies another plan with high immunization rates among children and adopts its practices in this area. This is an example of

    a. Benchmarking **(Correct)**
    b. Clinical practice guidelines
    c. Provider profiling
    d. Peer review

70. Robert is diagnosed with prostate cancer. There are several treatment options, each with advantages and disadvantages. His doctor informs him about these and discusses them with him, but she lets Robert make the final decision based on his values. This is an example of:

Disease management

a. Shared decision making **(Correct)**
b. A self-care program
c. Utilization review

71. A health plan projects the cost of providing benefits to a group based partly on the plan's rate manual and partly on the group's experience. This describes:

a. Experience rating
b. Manual rating
c. Blended rating **(Correct)**
d. Pooling

72. Diane is a member of a private-sector health plan. She disagrees with a decision made by the plan. A level one review by the plan's medical director and a level two review by its appeals committee both uphold the plan's original decision. What are Diane's options?

a. Her case automatically goes to binging arbitration
b. She has no further recourse and must accept the decision
c. She may have the right to appeal to the state insurance department or an external review organization (depending on state laws) **(Correct)**
d. She may have the right to appeal to the state insurance department or, if not, to the federal Department of Health and Human Services

73. For small businesses buying a health plan, what is usually the key factor?

a. Customization
b. Employee satisfaction
c. Healthcare quality
d. Premium price **(Correct)**

74. What is the compensation method for Group Model HMO employees?

a. Salaries & Incentives **(Correct)**
b. Capitation
c. Fee for Service
d. Discounted fees

75. How widespread are flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs)?

a. A majority of employees have one or the other
b. Nearly all employees have one or the other
c. Only a small minority of employees have either **(Correct)**
d. About half of employees have one or the other

1. What form does cost-sharing generally take in traditional indemnity health insurance?

a. An annual deductible and coinsurance (Correct)
b. An annual deductible and copayments
c. Coinsurance, but no deductible or copayments
d. An annual deductible, coinsurance, and copayments.

2. Any physician who meets the standards of GoodLife HMO is eligible to join its network. GoodLife does not pay benefits for out-of-network care. Members must get a referral from their primary care provider (PCP) to see a specialist GoodLife has

a. An open panel and open access

b. An open panel and closed access (Correct)
c. A closed panel and closed access
d. A closed panel and open access

3. The primary purpose of Medicare Advantage is to offer:

a. The option of receiving Medicare coverage through a private-sector health plan. (Correct)
b. A supplement to Medicare that covers many Medicare cost-sharing payments.
c. Prescription drug coverage to Medicare beneficiaries.
d. A form of Medicare with a high premium but no deductibles, coinsurance, or copayments.

4. Which of these will be permitted under the Affordable Care Act (ACA) (Healthcare reform)?

a. Premiums based on age (Correct)
b. Lifetime benefit limits
c. Preexisting condition exclusions
d. Annual Benefit Limits

5. It is most difficult to develop a comprehensive network in

a. Suburban areas
b. Rural areas (Correct)
c. Urban areas
d. Very large metropolitan areas

6. At the end of year, if there is more than enough money in a pool to cover specialty care, a health plan's primary care providers (PCPs) receive some of the excess. If there is not enough money to cover costs, they must make up some of the deficit. This is an example of

a. A withhold
b. Pay for performance
c. Capitation
d. A risk pool (Correct)

7. A panel of cardiologists evaluates the care provided by another cardiologist in a particular case. This is an example of

    a. Clinical practice guidelines
    b. Provider profiling
    c. Peer review (Correct)
    d. Benchmarking

8. When is utilization review conducted?

    a. Before treatments is provided
    b. During the course of treatment
    c. After treatment is provided
    d. Before, during, and/or after treatment (Correct)

9. Which HMO model has high facility costs but greatest control of care management and quality?

    e. IPA model
    f. Group model
    g. Network model
    h. Staff model (Correct)

10. Which communication channel between a health plan and its members is being used less and less?

    a. Website
    b. Emails
    c. Social media
    d. Regular mail (Correct)

11. Which is not a rule of federal mental health parity laws?

a. Cost-sharing for behavioral healthcare cannot be more than for medical care
b. Limitations on coverage of behavioral healthcare cannot be more restrictive than for medical care (Correct)
c. Annual and lifetime benefit caps cannot be lower than for medical care
d. All health plans must provide behavioral health coverage

12. Which of these healthcare services is not likely to be subject to concurrent utilization review?

e. A course of physical therapy
f. A lengthy hospital stay
g. A course of chemotherapy
h. A visit to a neurologist (Correct)

13. Under the principle of beneficence, health plans must promote the good of their

a. Individual members
b. Stockholders only
c. Individual members and their membership as a whole
d. Membership as a whole (Correct)

14. A certain percentage of the members of a health plan have received a cholesterol screening. What kind of quality measure is this?

a. Outcomes measure
b. Perception measure
c. Process measure (Correct)
d. Structure measure

15. Under which compensation arrangement do providers assume the greatest financial risk?

    e. Capitation (Correct)
    f. Resource-Based Relative Value Scale (RBRVS)
    g. Diagnosis-related groups (DRGs)
    h. Discounted fee-for-service

16. A health plan identifies another plan with high immunization rates among children and adopts its practices in this area. This is an example of

    a. Benchmarking (Correct)
    b. Clinical practice guidelines
    c. Provider profiling
    d. Peer review

17. Robert is diagnosed with prostate cancer. There are several treatment options, each with advantages and disadvantages. His doctor informs him about these and discusses them with him, but she lets Robert make the final decision based on his values. This is an example of:

    a. Disease management
    b. Shared decision making (Correct)
    c. A self-care program
    d. Utilization review

18. Which type of physician-hospital provider organization is the least integrated?

    a. The medical foundation
    b. Accountable care organization (ACO)
    c. The physician-hospital organization (PHO) (Correct)
    d. The integrated delivery system

19. The percentage of stroke patients who are able to walk and speak normally after two years is:

    a. A perception measure
    b. A process measure
    c. A structure measure
    d. An outcomes measure (Correct)

20. Which health plan designs are in the middle of the managed care continuum, between tightly managed and unmanaged?

    a. Indemnity insurance and EPOs
    b. Traditional HMOs
    c. PPOs, EPOs, and POS products (Correct)
    d. Traditional HMOs and PPOs

21. Kaltlyn is covered by her employer's health plan, and the employer pays part of the premium. She is laid off from her job. Under COBRA, she has the right to continue her health coverage:

    a. For up to 18 months, and her employer must continue its premium contribution
    b. For up to 18 months, but her employer does not have to continue its premium contribution (Correct)
    c. For up to 36 months, and her employer must continue its premium contribution for the first 18 months
    d. Until she obtains coverage through a new employer, but her employer does not have to continue its premium contribution

22. A health plan projects the cost of providing benefits to a group based partly on the plan's rate manual and partly on the group's experience. This describes:

    e. Experience rating
    f. Manual rating
    g. Blended rating (Correct)
    h. Pooling

23. Diane is a member of a private-sector health plan. She disagrees with a decision made by the plan. A level one review by the plan's medical director and a level two review by its appeals committee both uphold the plan's original decision. What are Diane's options?

    e. Her case automatically goes to binging arbitration
    f. She has no further recourse and must accept the decision

g. She may have the right to appeal to the state insurance department or an external review organization (depending on state laws) (Correct)
h. She may have the right to appeal to the state insurance department or, if no, to the federal Department of Health and Human Services.

24. The Affordable Care Act (ACA) (healthcare reform) will make tax credits available to

a. Employers to help them sponsor coverage but not to individuals
b. Individuals to help them pay premiums but not to employers
c. All employers to help them sponsor coverage and individuals to help them pay premiums and cost-sharing (Correct)
d. Small employers to help them sponsor coverage and individuals to help them pay premiums and cost-sharing

25. To be eligible for a health savings account (HSA), what health coverage must a person have?

a. Any employer-sponsored health plan
b. Any high-deductible health plan (HDHP)
c. A qualified HDHP, Medicare, or dependent coverage under someone else's plan
d. A qualified HDHP only, not other broad health coverage or Medicare (Correct)

26. What happens when adverse selection occurs?

e. People less likely to need healthcare are more likely to obtain health coverage
f. People who have health coverage are more likely to use healthcare services
g. People more likely to need healthcare are more likely to obtain health coverage (Correct)
h. Physicians who provide inferior care are more likely to join a health plan network

27. Most HMO modes may have an open or closed panel. Which HMO model normally has a closed panel?

a. Group Model
b. Network Model
c. Staff Model (Correct)
d. IPA Models

28. Which way of accessing behavioral healthcare services used to be common but no longer is?

a. Employee assistance program
b. Direct access
c. Primary care provider (PCP) referral (Correct)
d. Centralized telephone referral system

29. In which of these provider organizations do physicians normally now own and operate their own practices?

a. Consolidated medical group
b. Group practice without walls (GPWW) (Correct)
c. Independent practice association (IPA)
d. Physician-Hospital organization (PHO)

30. For small businesses buying a health plan, what is usually the key factor?

a. Customization
b. Employee satisfaction
c. Healthcare quality
d. Premium price (Correct)

31. Who receives Medicare Part D prescription drug coverage?

a. All Medicare Advantage beneficiaries receive it at no additional cost
b. All Medicare beneficiaries receive it at no additional cost
c. All Medicare beneficiaries have the option of enrolling and paying an additional premium (Correct)
d. All Medicare Part B beneficiaries are enrolled and charged an additional premium

32. Do HMOs typically provide preventive care?

a. They provide extensive preventive care but charge significant cost-sharing for it
b. They provide only limited preventive care and charge significant cost-sharing for it
c. They provide only limited preventive care but charge little or no cost-sharing for it
d. They provide extensive preventive care and charge little or no cost-sharing for it (Correct)

33. What population is eligible for health coverage from TRICARE?

a. Active members of the military and their spouses and dependents
b. Active members of the military only
c. Active and retired members of the military
d. Active and retired members of the military and their spouses and dependents (Correct)

34. Which physician-only provider organization is the most integrated?

a. The independent practice association (IPA)
b. The consolidated medical group (Correct)
c. The management services organization (MSO)
d. The group practice without walls (GPWW)

35. The primary purpose of states 'financial responsibility standards for HMOs is to protect

a. Insured's from the possibility that the HMO may become insolvent (Correct)
b. Shareholders from mismanagement of their investment
c. The state from nonpayment of taxes and fees
d. Providers from not receiving fair compensation for their services

36. A history of an individual's health and his encounters with the healthcare system that is owned by the individual is

a. The computer-based patient record (CPR)
b. The personal health record (PHR) (Correct)

c. The electronic medical record (EMR)
d. The electronic health record (EHR)

37. Medicare Part D

a. Does not charge a premium but has substantial cost-sharing
b. Does not charge a premium and has only nominal cost-sharing
c. Charges a premium but has only nominal cost-sharing (Correct)
d. Charges a premium and has substantial cost-sharing

38. A health plan sets premium rates for a group based on the expected cost or providing healthcare benefits to the whole community rather than to that group. This is:

a. Community rating (Correct)
b. Manual rating
c. Experience rating
d. Blended rating

39. In the marketing of health plans, who is compensated by the party buying a product, not the health plan selling it?

a. Agents and brokers
b. Employee benefits consultants (Correct)
c. Brokers
d. Brokers and employee benefits consultants

40. What kind of risk does an HMO assume or share?

a. Delivery risks only, not financial risks
b. Both financial and delivery risks (Correct)
c. Financial risks only, not delivery risks
d. Neither financial nor delivery risks

41. NCQA providers accreditation for:

a. Healthcare providers only
b. Health maintenance organization only
c. Many types of health plans (Correct)
d. Preferred provider organizations only

42. Which of these is a provision of the Affordable Care Act 2010 (ACA) (Healthcare reform)?

a. All employers will have to sponsor a health insurance plan
b. Most people will have to have health coverage or pay a tax penalty (Correct)
c. Medicare will be available to anyone 50 or older
d. All health plans will have to be structured like an HMO

43. How is Medicaid funded and administered?

a. The federal government pays all costs and makes all rules, but the states administer the program
b. The federal government pays all costs, makes all rules, and administers the program
c. The federal government contributes some funds, but the states pay most costs, make all rules, and administer the program
d. The federal government pays a majority of costs and sets guidelines, but the states pay some costs, make some rules, and administer the program (Correct)

44. What is the main function that an independent practice association handles for its member physicians?

a. Billing and collecting
b. Contracting with health plans (Correct)
c. Claims processing
d. Medical record keeping

45. Separate healthcare providers are brought under common ownership and control. This describes:

a. Business integration
b. Clinical integration
c. Operational integration
d. Structural Integration (Correct)

46. Under the Affordable Care ACT (ACA) (Healthcare reform), which may a health plan not consider in setting a person's premiums?

a. Age
b. Smoking
c. Locality
d. Health (Health)

47. Most regulation of health plans:

a. Has been at the State level but after the Affordable Care Act (ACA) will be at the Federal level. (Correct)
b. Has been at the Federal level but after the Affordable Care Act (ACA) will be at the state level
c. Has been and continues to be at the federal level
d. Has been and continues to be at the state level

48. What is the main problem a data warehouse is intended to solve?

a. Inaccurate data
b. Large amounts of data
c. Data in multiple databases (Correct)
d. Security and privacy requirements

49. Government regulation has the greatest impact on which aspect of health plan data?

    a. Usability
    b. Security and privacy
    c. Volume
    d. Quality (Correct)

50. What category of low-income people are not currently covered by Medicaid but will be covered under healthcare reform?

    a. Disabled people
    b. Pregnant women
    c. Elderly people
    d. Childless adults (Correct)

51. By the 1990s HMOs had become accepted by consumers and employers, but many people objected to their:

    a. Limited benefit packages
    b. High premiums
    c. Lack of provider choice (Correct)
    d. High coinsurance and deductibles

52. Which of these is an example of adverse selection (Anti-Selection)?

    a. An employer is located in a large city, where healthcare costs are considerable higher than the national average
    b. A higher percentage of unhealthy employees enroll in an employer's health plan compared to healthy employees (Correct)
    c. A very high percentage of the employees who are eligible for an employer's health plan choose to enroll in it
    d. An employer is engaged in a hazardous business, and its employees are more likely than average to be injured or become ill

53. Why is it important for a health plan to deal adequately with member complaints?

a. To comply with regulations are accreditation requirements and to maintain member satisfaction and a good public image (Correct)
b. To meet accreditation requirements-there are no regulations, and complaints are not a major element in member satisfaction
c. To comply with regulatory requirements-complaints are not a major element of member satisfaction or public image
d. To maintain member satisfaction and a good public image there are no regulatory or accreditation requirement.

54. A health plan has an obligation to respect the right of its members to make decisions about their own lives. This is the ethical principal of:

a. Autonomy (Correct)
b. Altruism
c. Equity
d. Beneficence

55. Under the Federal Employees Health Benefits (FEHB) program, employees:

a. Choose from a large number of health plans and plan types (Correct)
b. Are all enrolled in the PPO for their state or region
c. Are all enrolled in the same fee-for-service group plan
d. Choose from one HMO, one PPO, and fee-for-service plan in their state or region

56. In which health plan type do members not have to select how to receive services until they use them?

a. Consumer-Directed Health Plan (CDHP)
b. Point-Of-Service (POS) product (Correct)
c. Health Maintenance organization (HMO)
d. Preferred provider organization (PPO)

57. Who regulates HMOs?

a. HMOs are regulated under the federal HMO Act but not state laws
b. Neither the federal government nor the states substantially regulate HMOs
c. HMOs are regulated by the states but not the federal government
d. Both the federal government and the states heavily regulate HMOs (Correct)

58. The most common HMO model today is the

a. IPA model (Correct)
b. Staff model
c. Network model
d. Group model

59. A health plan's utilization review staff wants to know how long a certain member can be expected to remain in the hospital. They are most likely to use:

a. Utilization guidelines
b. Site-appropriateness listings
c. Experience-based criteria
d. Length-of-stay guidelines (Correct)

60. What coverage do Medicare Advantage plan provide?

a. Medicare Part A and Part B coverage, other benefits, and usually drug benefits (Correct)
b. Medicare Part A and Part B coverage only, but without cost-sharing
c. Medicare Part A and Part B coverage only
d. The coverage of one of the standard Medigap Plans

61. Which statement about trends in health plan products is correct?

a. Fewer types of plans are being offered, and the distinctions between them are becoming sharper
b. More types of plans are being offered, and the distinctions between them are becoming blurred (Correct)
c. More types of plans are being offered, and the distinctions between them are becoming sharper
d. Fewer types of plans are being offered, and the distinctions between them are becoming blurred

62. When a health plan compensates a provider by capitation, which generally occurs?

a. The provider submits encounter reports to the plan (Correct)
b. The member submits claims to the plan
c. The member submits encounter reports to the plan
d. The provider submits claims to the plan

63. What portion of health plans contract with pharmacy benefits management (PBM) plans?

    a. A large majority (Correct)
    b. A small minority
    c. Somewhat over half
    d. About a third

64. A computer program discovers that, based on repeated early refills, a plan member seems to be taking more of a pain reliever than he should. This is an example of:

    a. Formulary management
    b. Physician profiling
    c. Prior authorization
    d. Drug utilization review (Correct)

65. What are ethics?

    a. Character traits that dispose a person to act well toward other people
    b. Principles are values that guide a person or organization facing questions of right and wrong (Correct)
    c. Commonly held customs and beliefs that shape people's expectations of business conduct
    d. Written laws enforceable through the courts that govern professional and business conduct

66. Which utilization review data transmittal method is the fastest and least labor-intensive but also the most highly regulated?

    a. Telephone
    b. Manual
    c. Paper
    d. Electronic (Correct)

67. Which statement about health plan claims processing is true?

    a. A plan must process and investigate claims within timeframes set by regulation (Correct)

b. A plan must pay benefits for a medically necessary service even if authorization was not obtained
c. Electronic claims processing can handle only simple claim decisions
d. A plan may not deny a claim because it was submitted too long after the service was provided

68. How does electronic data interchange (EDI) differ from e-business?

a. EDI is the transfer of batches of data, not back-and-forth exchanges of information about a transaction (Correct)
b. Edi does not require a standardized data format
c. EDI requires considerable human involvement, for instance for data entry
d. EDI is an internal operation, not a transaction between two organizations

69. What portion of participants in Medicaid and the Children's Health Insurance Program (CHIP) are in managed care?

a. A small minority
b. About half
c. A large majority (Correct)
d. About a third

70. Which health plan types generally require a referral from a primary care physician to see a specialist?

a. PPOs
b. HMOs and PPOs
c. Traditional HMOs and POS products (Correct)
d. Traditional HMOs

71. Which type of quality data presents the most problems?

a. Structure measures
b. Process measures
c. Outcomes measures (Correct)
d. Customer satisfaction measures

72. What is the most secure and restrictive level of behavioral healthcare?

a. Acute Care
b. Partial Hospitalization
c. Intensive Outpatient Care (Correct)
d. Post-Acute Care

73. What is the best definition of a health plan?

a. An organization that integrates the delivery and financing of healthcare and seeks to manage healthcare costs, access, and quality (Correct)
b. An organization that provides health coverage to a group of people, most commonly the employees of a business
c. An organization that combines employer funding of a core set of health benefits, employee financial responsibility, and provider accountability
d. An organization that maintains a network of affiliated healthcare providers and pays benefits only for services rendered by those providers

74. Which personal healthcare account offers annual rollover of funds, tax-free investment growth, and full portability?

a. FSA, HRA and HSA
b. Heath Reimbursement Arrangement (HRA)
c. Health Saving Account (HSA) (Correct)
d. Flexible Spending Account (FSA)

75. By the 1990s HMOs had become accepted by consumers and employers, but many people objected to their:

a. High Coinsurance and deductible
b. Limited benefit packages
c. High Premiums (Correct)
d. Lack of provider choice

Q.The term “marketing mix” refers to

a. agents, brokers, and direct marketing.

b. **product, price, promotion, and distribution. (Correct)**

c. research, product price, and distribution.

d. publicity, advertising, and sales.

2. Which of the following statements best describes a health plan’s potential customers?
a. employers, associations, and government programs
b. individuals, including employees and Medicare beneficiaries.
c. Individuals, including employees and Medicaid beneficiaries
**d. employers, associations, employees, Medicare and Medicaid beneficiaries, and other individuals (correct)**

3. Which is a market research technique?
a. Focus groups. (Correct)
b. Direct response marketing.
c. Positioning.
d. Cold calling

4. How is marketing in health plans different from marketing in many other industries?
**a. Markets are generally local. (Correct)**
b. Markets are generally national.
c. Research is not very important.
d. There is little regulation.

5. Which of the following statements best describes how the Affordable Care Act (ACA) has affected product development?
a. The ACA has not affected product development; state laws continue to primarily govern this area.
b. The ACA has affected product development but only by requiring a minimal benefit package.
**c. The ACA has affected product development in relation to benefit packages, cost-sharing, and other matters. (Correct)**
d. The ACA has affected product development but just for the large group market.

6. Which of the following statements best describes why health plans develop multiple product lines?

a. The development of multiple product lines is required by many state laws.
b. The development of multiple product lines is required by the Affordable Care Act (ACA).
c. The development of multiple product lines assists health plans in competing, particularly among large employers, but it makes marketing more complicated. (Correct)

d. The development of multiple product lines assists health plans in competing, particularly among small employers, and it makes marketing simpler.

7. Which statement best describes the difference between advertising and publicity?
a. Advertising focuses on a product, publicity on an organization.
b. Advertising uses the mass media, publicity is personal contact.
c. Advertising is paid for, publicity is not. (Correct)
d. Advertising relies on use of free incentive, publicity on use of paid incentives.

8. The term "promotion mix" is commonly used to refer to
a. advertising, branding, and publicity.
b. advertising, publicity, personal selling, and sales promotion. (Correct)
c. publicity, personal selling, social media, and sales promotion.
d. personal selling and direct marketing.

9. Which distribution channel is typically made up of health plan employees?
a. Internal salesforce. (Correct)
b. Brokers.
c. Employee benefits consultants.
d. Independent agents

10. Who are generally compensated by the buyer of a health plan, not by the health plan?

a. Captive agents.

b. Independent agents

c. Brokers.

d. Employee benefits consultants. (Correct)

11. Who are considered to represent the health plan in the distribution of health insurance products?

I. Captive agents

II. Independent agents

III. Brokers

IV. Employee benefits consultants

a. I only

b. I and II only (Correct)

c. III only

d. III and IV only

12. Which of the following sells the products of only one company?

a. An independent agent.

b. A captive agent. (Correct)

c. A broker.

d. An employee benefits consultant.

13. Who commonly works with individuals rather than large groups?

a. Agents. (Correct)

b. Brokers.

c. Employee benefits consultants.

d. Third-party administrators.

14. Which direct marketing method is most commonly used today in the distribution of health insurance products?

a. Telemarketing.

b. Face-to-face cold calling.

c. Door-to-door selling in pre-selected neighborhoods.

d. Direct mail.(Correct)

15. According to the text, dividing a market into smaller groups of customers is called

a. market segmentation. (Correct)

b. targeting.

c. positioning.

d. branding.

16. Medicare beneficiaries are generally considered part of the

a. small group market.

b. large group market.

c. non-group market.(Correct)

d. individual market.

17. A health plan decides to compete in the small group market instead of the large group market by offering a basic and relatively inexpensive product. This is an example of

a. market segmentation.

b. positioning. (Correct)

c. targeting.

d. direct marketing.

**18. Who of the following would not be considered a member of the regular group market?**

a. Daniel is employed by a large employer offering several health coverage options.

b. Mark is employed by a mid-sized employer who offers just one coverage option that meets the requirements of the Affordable Care Act (ACA)

c. Joanne recently lost her job and her group health plan. (Correct)

d. Susan's small employer sponsors a group health plan but requires her to contribute an amount to premiums that meets the requirements of the Affordable Care Act (ACA).

**19. Who of the following would be considered a member of the Individual Market?**

I. Adam whose small employer does not sponsor a health plan.

II. Blake who choose not to enroll in the health plan offered by his employer.

III. Charlie who is attending a vocational IT school who is without student group coverage.

IV. Linda who is self-employed.

a. I and III only

b. I and IV only.

c. I, II, and III only

d. I, II, III and IV (Correct)

20. The Affordable Care Act (ACA) has affected the marketing of all health plans, but it has had the greatest impact on the

a. individual market . (Correct)

b. large group market inside the ACA Marketplaces.

c. large group market outside the ACA Marketplaces.

d. Medicare market.

**21. Which is not true under the ACA?**

a. Individuals enrolling in a health plan will no longer undergo medical underwriting.

b. The individual market will be eliminated, and everyone will have group coverage. (Correct)

c. Qualified individuals have the ability to purchase coverage through government-sponsored exchanges.

d. Some individuals will qualify for subsidies to help them cover the cost of coverage.

**22. Which is a common distribution method in the senior market?**

I. Direct marketing.

II. Meetings that provide information about Medicare.

III. Door-to-door selling.

IV. Unsolicited telephone calling.

a. I only

b. I and II only (Correct)

c. I, II, and III only

d. I, II, III and IV

23. People eligible for Medicare

a. may not enroll in private-sector health plans.

b. may receive health and/or drug coverage through private-sector Medicare Advantage plans. (Correct)

c. may receive drug (but not health) coverage through public-sector health plans.

d. may enroll in both Medicare Supplement (Medigap) and private-sector Medicare Advantage plans.

24. The group market is made up mostly of

a. employers. (Correct)

b. multi-employer groups.

c. associations.

d. self-employed individuals.

25. Small businesses choosing a health plan usually focus strongly on

a. Quality metrics.

b. price. (Correct)

c. scope of provider networks.

d. service.

26. Which is true of small employers?

a. Full self-funding is common.

b. Customization of a product is common.

c. Only one health plan is usually offered. (Correct)

d. Several options offered by different carriers are common.

27. Which is true of large employers?

a. They often use employee benefits consultants. (Correct)

b. They tend to change health plans more frequently than small plans.

c. They tend to choose very basic and inexpensive products.

d. They avoid self-funding due to its financial risks.

28. Which statements are correct about health care consumerism?

I. Consumerism began as workers began to take increased notice of their out-of-pocket costs in the early 2000s.

II. The implementation of the Affordable Care Act (ACA) temporarily set-back the rise of consumerism.

III. Health plans should consider health care decision support tools as they seek to build connections with individual consumers.

IV. Business-to-business (B2B) is the forward looking business model for health care marketing professionals to incorporate into their planning.

a. I only

b. I and II only

c. I and III only (Correct)

d. II, III and IV only

AHM – 250

1 A health plan can best be defined as an organization that

Integrates the delivery and financing of healthcare and seeks to manage healthcare costs, access, and quality.

2 the earliest version of health plans appeared in

1910

3 which is not an early form of health plan

Preferred provider organization

4 which is a provision of the HMO Act of 1973

Federally qualified HMOs were exempted from some state laws.

5 for an HMO, which was not an advantage of federal qualification

The HMO did not have to meet certain requirements that applied to other health plans.

6 the HMO Act of 1973

Played a major role in the early growth of HMOs.

7 In the 1990s HMOs

Were popular because they held down costs, but people objected to the lack of provider choice.

8 Janine can go to any doctor she chooses, but if she goes to one not in her plan's network, she has to pay a larger share of the cost, Janine is covered by

A preferred provider organization

9 Jacob must pay $2,000 in healthcare expenses each year before he receives benefits from his health plan, but he can use money from a tax-advantaged saving account, Jacob has

A consumer-directed health plan.

10 what are the roles of the state and federal governments in regulating health plans?

The states regulate health insurance, but federal governments also passes laws affecting it.

11 have government health coverage programs been a significant factor in the evolution of health plans?

Yes, because these programs have increasingly relied on health plans to provide coverage.

12 which is not a cause of higher healthcare spending?

A younger population because of immigration.

13 under the fee-for-service approach, healthcare providers have a financial incentive to provide.

More services.

14 which is not typical of managed care

Fee-for-service compensations.

15 which will probably have the lowest premium?

A consumer directed health plan

16 In relation to health plans, over the years the definition of quality.

Has become broader

17 Which is not an accrediting organizations?

HEDIS

18 in traditional indemnity health insurance, insured

Can go to any provider they choose

19 in traditional indemnity health insurance, how are providers compensated?

Fee-for-service

20 Owen pays 20 percent of the cost of healthcare services covered by his policy. This describes

Co-insurance

21 which is not common in traditional indemnity health insurance

Copayment

22 coordination of benefit is designed to

Prevent duplication of benefits when a person is covered by more than once health insurance policies.

23 increasing cost – sharing

a) help hold down healthcare expenditures through insured incentives and b) shift cost from insurer to insured both.

24 Cost containment helps hold down health insurance premiums primarily by

Reducing unnecessary healthcare services.

25 Coverage of preventive care is

Cost – effective in the long run and so has been adopted by insurers.

26 why is it useful in studying health plans to learn about indemnity insurance?

Some features of today's health plans are inherited from indemnity insurance or designed to address its problems.

27 Andy is covered by his employer's group health insurance policy. Who is the policyholder of this policy?

The employer.

28 who pays the premium of an employer-sponsored group policy?

Employees may pay all or part, but they do so through the employer.

29 what happens in adverse selection

People who need healthcare enroll in greater numbers than average people.

30 which employee group is most likely to have a higher-than-average loss rate?

A group made up mostly of women.

31 which employee group presents a high risk of adverse selection?

In company A a small percentage of employees enroll

32 in creating a provider network, health plans generally seek to ensure member access by

Considering number, type, and location of providers.

33 primary care physicians are typically involved in

Prevention, treatment of routine conditions, and care co-ordination.

34 if a health plan has a network, members

Either, depending on the plan design.

35 compared to indemnity insurance, health plan generally require _____ out of pocket expense by members

Less

36 managing the use of healthcare services so that patients receive necessary, appropriate, and high quality care in a cost-effective way is

management

37 which does not focus on individual with ub or certain medical conditions?

Demand management

38 which is quality management technique?

Credentialing.

39 in this course “health plan” is defined as any entity that

Uses certain concept or techniques to manage the cost, access, and quality of healthcare

40 what is the trend in health plan products?

More types are being offered, and the distinctions between them are becoming blurred.

41 Members do not have to select how to receive services until they use them. This describes a

Point-of service product

42 A health saving account is combined with a high-deductible health plan. This describes a

Consumer directed health plan

43 Which of these health plan types uses managed care techniques and concept the most.

Health maintenance organization (HMO)

44 what goals do all health plans share?

Accessibility , cost effectiveness and quality

45 organizations that finance or reimburse the cost of healthcare services are known as

Payors

46 how are the roles of the key players in health plan evolving?

Roles are overlapping and becoming less distinct

47 Compared to indemnity insurance, health plan benefit packages are typically

More extensive and encourage the use of preventive care

48 Mandate benefits are imposed

Both by states and the federal government and apply to all forms of health insurance.

49 Carla pays a flat $10 fee to her doctor for an office visit, regardless of the cost of the service the receives, this is

A copayment

50 Jacob pays 20% of the cost of a hospital stay. This is

Co-insurance

51 Dan pays the first $1000 of his healthcare expenses each year, after which his health plan begins paying benefits. This is

A deductible

52 In traditional indemnity health insurance , the main provider compensation method is

Fee-for-service

53 under fee-for-service, providers have incentives to

Provide unnecessary care

54 Under fee-for-service, who bears financial risk?

The insurers and the providers.

55 Under capitation, provider compensations is based on

The number of members cared for.

56 Teresa, a doctor, is paid by a health plan by capitation, One month she delivers very few services to plan members, the next month she delivers about the projected amount, and third month she delivers well over the projected amount. Teresa is paid

The same amount each month.

57 Capitated physicians have incentive to

Not provide unnecessary services and promote prevention and wellness

58 Which statement about capitation is true?

It may be used for both primary and secondary cases

59 Currently, capitation accounts for what portion of physician compensation?

A small minority

60 Under a fee schedule, a provider receives

No more than a listed amount

61 Under a fee schedule or discounted fee-for-service, if a provider's normal fee is more than the amount allowed by the health plan

She must accept the plan's amount as payment in full

62 A health plan assigns a certain value to a service and multiplies this value by a negotiated dollar figure to yield the payment amount. This describes.

RVS

63 A member is hospitalized, her case is classified based on several factors, and the hospital is paid an amount based on that classification. This describes.

Diagnosis-related group (DRGs)

64 A hospital is paid a set amount for each day a plan member is in the hospital. This is

Per diem payments

65 A group of providers is paid a single amount for all the care related to a surgery, both in the hospital and for three months afterward. This is

An episode based payment

66 A plan holds back a percentage of PCP's monthly capitation payments. At the end of the year, some of this money is paid to the PCPs, but some is used to pay for higher than projected referral. This is an example of

A withhold

67 A plan pays money into a pool to cover hospitalization. At the end of the year, if there is money left over in the pool, some is given to PCPs, but if there is not enough money, PCPs must cover some of the cost. This is an example of

A risk pool

68 If a doctor meets certain performance targets related to quality of care and patient satisfaction, she receives a bonus. This is an example of

Pay for performance

69 Which compensation arrangement involves the most risk for providers?

Capitations

70 Which compensation arrangement involves the least risk for a hospital.

Fee-for-service

71 An HMO

Assumes or shares both financial and delivery risks

72 The HMO Act of 1973

Was instrumental in the initial growth of HMOs

73 HMOs are

Heavily regulated at both the federal and state levels.

74 Which is not a key characteristic of an HMO?

Loose relationship with providers

75 which is an employer most likely to consider in selecting and HMO?

Access

76 A person enrolls in an HMO

Most commonly through an employer, but sometimes individually.

77 HMOs were traditionally marketed to

Large groups, but they now serve large and small groups and individuals.

78 HMOs provide

Comprehensive medical benefits and usually special services such as dental and vision care, mental health care, and prescription dugs.

79 Compared to other health plan types, in HMOs members cost shareing tends to be

Low

80 HMOs typically provide

Extensive preventive care and charge little or no cost sharing for it.

81 An HMO provides medical care to its members by

Contracting with and/or employing providers

82 The delivery of healthcare is primarily

Local

83 In building and maintaining an HMO network, the location of a healthcare provider is primarily a factor in

Access

84 To see a specialist, must and HMO member obtain a referral from her PCP?

Usually

85 Do HMOs cover out-of-network services?

Traditionally they did not, but some HMOs now do at a higher cost

86 How are HMOs usually paid providing health care

By mean of fixed monthly premium

87 Which are most common in HMOs?

Copayments

88 Which is not a common HMO compensation arrangement for physicians?

DRGs

89 A physician is compensated by an HMO by capitation, but once her total cost have reached a certain level, additional costs are reimbursed by discounted FFS. This describes a

Stop-loss provision

90 which utilization management techniques is used primarily for physicians?

Risk pools

91 in the area of quality management, HMOs are subject to

Strict state and federal regulation

92 which statement describes and open-panel HMO?

Any physician who meets the HMO's standards is eligible to join its network but the HMO is not obligated to contract with anyone

93 which is true about a closed panel HMO?

Physicians are employees of the HMO or members of a contracted group

94 In an open-access HMO, members

Receive lower benefits for non-network care

95 which is true about closed-access HMOs?

In the past most HMOs had closed access, but this is no longer true

96 An HMO pays a doctor for his services based on a fee schedule. This is an example of

Discounted fee-for-service

97 An HMO pays a doctor a certain amount per member per month to provide care needed by HMO members. This describes

Capitation

98 In which compensation method do physicians assume risk?

Capitation

99 A mixed model HMO is on that

Combines features of different HMO models.

100 The current trend is toward

Mixed model HMOs

101 In an IPA model HMO, physicians are usually

Contracted with the IPA, which contract with the HMO

102 In which HMO model does each doctor manage her own office?

IPA model

102 How are IPA physician most commonly compensated?

Capitation for PCPc and discounted fee-for-service or RBRVS for specialist.

103 which is a disadvantage of the IPA model HMO?

The HMO has limited control of care management and quality

104 In a staff model HMO, physicians are normally

Employees of the HMO

105 In which HMO model do doctors normally work in a central facility owned and operated by the HMO

Staff model

106 How do staff model HMOs normally compensate physicians?

Salary

107 which is not an advantage of a staff model HMO?

Low facility costs.

108 The HMO contracts with a signle group practice. This describes

A group model HMO

109 In a group model HMO, physicians are

Employees (or employee/owners) of the group practice

110 What is the most common compensations system in a group model HMO?

The HMO Compensates the group practice by capitations , and the group practice pays physicians salaries and incentive payments.

111 An HMO contracts with six group practices. This is an example of a

Network model HMO

112. The trend in network model HMOs is toward

A mix of capitation and discounted fee-for-service

113 The most common HMO model today is the

IPA model

114 Which HMO model normally has closed panel?

Staff model

115 PPOs, EPOs, and POS products are

In the middle of the managed care continuum, between tightly managed and unmanaged.

116 PPO members receive

Lower benefits for non-network care

117 Which statement is true about a PPO?

Providers must participate in utilization review and quality management

118 What portion of U.S. employees are covered by PPOs?

A majority

119 A majority of PPOs are owned by

Insurance companies

120 Which statement is true about PPOs?

PPOs usually cover some specialty services

121 PPOs most commonly compensate physician by means of

Discounted fees

122 Providers contracting with PPOs

May or may not assume risk

123 EPOs are generally like PPOs except that

There is no coverage of out-of-network care

124 A POS product offers

Reduced coverage of non-network care

125 How is a POS product like an HMO?

PCPs coordinate referrals to specialist

126 how many employee are covered by POS products

A small but declining minority

127 ABC health plan has no provider network and reimburses providers on a fee-for-service basis, but it conducts precertification and utilization review. ABC can best be described as a

Managed indemnity plan

128 Historically, managed care plan

Focused on standard medical care (physician and hospital services)

129 Which is not generally considered a specialty service?

Hospital care

130 A health plan transfers to another organization some (but not all) of the activities involved in delivering and managing behavioral healthcare. This is a

Partial carve-out arrangement

131 In a mature health plan market, compensation for a comprehensive carve-out is typically by

Capitation

132 State laws

May restrict carve-outs

133 Managed dental care accounts for what portion of all dental coverage?

A majority

134 Managed dental care is

Growing

135 Plan members must, with a few exceptions, see a network dentist. This describes

An HMO

136 HMOs usually compensate dentist by means of

Capitation

137 Which is typical of a dental HMO?

Copayments

138 PPOs commonly compensate dentist by means of

Discounted fee-for-service.

139 Which are typical of a dental PPO?

Annual deductible, coinsurance , and annual maximum benefit

140 Andre does not have to choose a dentist or network during an annual open enrollment he can decide when he needs care. He has

A POS plan

141 Which dental plan type typically has the smallest network?

HMO

142 Which dental plan type typically costs the least?

HMO

143 About what percentage of U.S. adults experience some sort of behavioral health disorder during any year

25%

144 Douglas is in a substance abuse program. He spends most of his time in a facility but goes our during the day to attend school. What level of behavioral healthcare is this?

Partial hospitalization

145 Lilly receives 10 hours of therapy a week at a psychologist's office, but she is not confined to a facility. What level of behavioral healthcare is this?

Intensive outpatient care

146 Which is least common in health plans today?

Members must get a referral from their primary care provider to access

147 Which sentence best summarizes the requirements of federal mental health parity legislation for medium and large health plans?

It requires plans that provide behavioral healthcare coverage to provide coverage equivalent to medical coverage.

148 Which statement is true about federal mental health parity laws?

Cost-sharing for behavioral healthcare cannot be greater than for medical care

149 How many health plans use pharmacy benefits management (PBM) plans?

A large majority

150 Do pharmacy benefits management (PBM) plans concerns themselves with equality of care?

Yes, safe and effective drug use is a major concern, along with cost

151 A PBM notifies a doctor that this prescribing a certain drug much more frequently than his press and educates him on its use and alternative to it. This is an example of

Physician profiling

152 Repeated late refills indicate that Phil is not taking his low blood pressure medication as often as he should. This is an example of

Drug utilization review

153 Patrice's plan covers any drug her doctor prescribes, but she pays higher copayment for drugs not ion the plans formulary. This is

An open formulary

154 A PBM requires physicians to obtain certification of medical necessity before prescribing a drug. This is

Prior authorizations

155 A pharmaceutical card is not generally used in

Prior authorization

156 A PBM provides all pharmacy services to an employee group in exchange for a fixed dollar amount per employee per month. This is

Capitation

157 What are the recent trends in healthcare spending?

Annual increases were high in the 1980's lower in the mid- 1990s then high again since then

158 Beginning in the late 1990s there was a shift

To less restrictive forms of managed care in response to consumer demand

159 The consumer choice philosophy is based on giving consumers

More decision-making power and more responsibility for costs

160 What are the two main components of a consumer directed health plan?

A high-deductible health plan and a tax-advantaged personal healthcare account

161 Which is the oldest type of personal healthcare account?

The FSA, introduced in the 1970s

162 Which can contribute to an FSA?

Most commonly only employees contribute, but employers are allowed to

163 Which is not a feature of FSAs that has limited their popularity?

Low limits on contributions.

164 Who can contribute to an HRA?

Employers only

165 Which is a feature of an HRA?

Annual rollover (at employer option)

166 Which account offers annual rollover, full portability and tax-free investment growth?

HSA

167 To be eligible for an HSA, a person must be covered by

A qualified high-deductible health plan

168 According to studies, switching to a CDHP brings cost-saving

Initially and probably in the long run as well

169 According to studies, the cost-saving of CDHPs come mostly from

Consumers making cost-effective healthcare choices

170 what is the trend in CDHP enrollment?

Rapid growth, expected to continue

171 Which is not an element of consumer-directed health plans?

Higher premiums for coverage

172 Most CDHPs are based on

A high deductible health plan

173 Compared to traditional health coverage, the premium of high-deductible health plans are generally

Lower

174 An FSA

May be coupled with an employer health plan or may be stand-alone

175 How popular are FSAs?

Only a minority of workers have access to them, and most of those do not participate

176 Which statement is true about FSAs?

Employees can make contributions with pretax dollars

177 Which statement are true about HRAs?

An employer may offer annual rollover of funds

178 What portion of workers is covered by and HRA?

Only a few percent

179 An HSA offers

Full portability, annual rollover, and tax free investment growth of account funds

180 To be eligible for an HAS, a person must be covered by

A qualified HDHP, only not other broad health coverage or Medicare

181 A qualified HDHP must have

A deductible of at least a certain amount and total out-of-pocket expenses no greater than a certain level

182 Which may a qualified HDHP exclude from an annual deductible?

Preventive care

183 Who can contribute to an HSA?

An employer, an employee, a self-employed person, or a family member on behalf of an eligible person.

184 An HSA accountholder cannot use account funds tax-free to pay for

His HDHP premium

185 Which premium cannot be paid tax-free with HAS funds?

Medigap insurance

186 Can a person use HSA funds to pay non – medical expenses?

Yes, she may, but she must pay income tax and a tax penalty

187 Can a person 65 or older use HSA funds to pay non – medical expenses?

Yes, she may; she must pay income tax but not a tax penalty

188 What is the impact healthcare reform on CDHPs?

Probably modest-some rules will change, and HDHPs may be affected depending on how regulations are written.

189 Which provision of healthcare reform may stimulate growth in CDHPs?

The tax on high-value health plans

190 Two independent organizations are joined into on entity under common ownership and control. This is an example of

Structural integration

191 An example of partial structural integration is

A joint venture

192 A number of physicians join together and combine their billing and collections operations. This is an example of

Partial operational integration

193 Which physician hospital model is the least integrated?

The physician-hospital organization (PHO)

194 For a physician, what is a disadvantage of provider integration?

A loss of professional autonomy.

195 For purchases and consumers, what is not a potential advantage of provider integration?

Lower costs resulting from a stronger negotiating position.

196 Which physician-only is the least integrated?

The independent practice association (IPA)

197 What does and IPA generally do for its member physicians?

Negotiates contracts with health plans

198 what is the structure of most IPAs?

Physicians contracts with the IPA, and the IPA contacts with the health plan

199 If an IPA spends more than $80,000 a year providing care to a single individual, an insurance company covers any amount over $80,000. This is called

Stop-loss insurance

200 What is the main difference between a group practice without walls (GPWW) and an independent practice association (IPA)?

A GPWW handles business operations for members, but an IPA does not.

201 The main purpose of a management services organization (MSO) is to

Provide management and administrative services to physicians.

202 How does a physician practice management (PPM) company differ from a regular MSO?

It purchases physician entire practices.

203 Which physician-only model is the most integrated?

The consolidated medical group

204 What is the primary purpose of a physician-hospital organization (PHO)?

Contracting with health plans and marketing

205 When a physician-hospital organization (PHO) is formed, physician practices

Continue to be owned and operated by the physicians.

206 A hospital allows any of its admitting physicians to join its PHO. This is an example of

An open PHO

207 An integrated delivery system (IDS) may or may not be highly integrated

Structurally

208 What is the purpose of a medical foundation?

To set up something similar to an integrated delivery system in states that do not allow corporations to buy physician practices.

209 For a health plan, the main advantage of contracting with an at-risk provider organization is that the plan does not have to

Develop a provider network.

210 If a provider organization assumes insurance risk, is it regulated as an insurance company or HMO?

It depends on the state and how the organization operates.

211 A healthcare delivery model based on each patient having a personal physician who is responsible for providing or coordinating her care on a ongoing basis is

A patient-centered medical home (PCHM)

212 The affordable Care Act seeks to

Promote accountable care organizations (ACOs) and patient-centered medical homes (PCMHs)

213 Which is not true about a patient-centered medical home (PCMH)?

Provider compensation is by pure capitation

214 What distinguishes a corporation from other organizations?

It is a legal entity separate from its owners.

215 Company A exist for the purpose of owning other companies and it owns company B among others. Company A is

A holding company and the parent company and the parent company of Company B

216 Which statement is true about a for-frofit health plan compared to a not-for-frofit plan?

It is better able to raise capital

217 Which statement is true about tax exemption of not-for-profit health plans?

Tax exempt plans pay premium taxes but not income tax.

218 Who owns a mutual insurance company?

Its policyholders.

219 What statement is true about mutual and stock insurance companies?

Most insurers are stock companies.

220 Most health plans are

Corporations

221 The ultimate source of authority in health plan is

The owners

222 Which statement about a health plan's board of directors is true?

The board appoints the FEO

223 A health plan's day-to-day operations are typically the responsibility of

Key senior managers reporting to the CEO.

224 Which position is likely to increase in importance in the coming years?

Chief information officer

225 Who is responsible for advertisement?

Chief Marketing officer

226 Which position is typically found in health plans but not in corporations in other industries?

Network Management Director

227 Who is responsible for preventing misconduct in a health plan?

Chief compliance officer

228 A permanent committee to advise a health plan on compensation is an example of a

Standing committee

229 Which committee's primary responsibility is reviewing cases of poor equality healthcare?

Peer review committee.

230 Which committee administers a health plan's drug formulary?

Pharmacy and therapeutics committee.

231 A health plan determines that it will not cover an experimental therapy requested by Sharon. If Sharon appeals this decision, which committee will likely review the case?

Appeals review committee.

232 "Market Maturity" refers to the

Level of health plan activity in a market

233 In market analysis, what is considered in regard to providers?

Provider number, type, locations, utilizations, costs, referral, patters and relationship.

234 Which are generally most receptive to health plans?

Large employers.

235 Where is it most difficult to develop a comprehensive network?

Rural areas

236 Health plans that offer more than one type of plan typically have

Either separate networks or nested networks

237 "Network adequacy" refers to whether

The number, types and locations of providers are adequate to meet member needs.

238 Which type of law might require a health plan to include a particular doctor in its network?

Any willing provider

239 "Open panel", or "Closed panel" refers to whether a health plan's

Providers can see non-plan members.

240 Devin is a neurologist who mostly provides outpatient care in his office. He is likely to be categorized by a network as a

Specialist.

241 Which plan types need fewer providers per 1,000 members?

Highly managed and large plans.

242 A health plan is developing a network, and it is believed that the most important consideration of potential members is accessibility. The plan will likely

Create a large, very inclusive primary care panel.

243 What is the purpose of credentialing?

Selecting the most qualified providers and meeting accreditation standards and minimizing legal risks.

244 In credentialing, do health plans verify information submitted by providers?

They generally do, before offering them a contact.

245 the information that a health plan can obtain from the National Practitioner Data Bank (NPDB) about a provider primarily relates to

Malpractice, licensure, and adverse actions.

246 A provider agrees to accept a health plan's compensation as payment in full and not to also bill plan members. What contact provision does this describe?

No balance billing provision

247 A party that breaches a contact is given a certain amount of time to remedy the problem and avoid termination of the contract. What contact provision does this describe?

Cure provision.

248 Can a health plan terminate its contact with a provider when there has been no problem with the provider's performance?

Yes, if the state permits termination without cause and this is allow by the contract.

249 A provider already in a health plan's network is evaluated by another provider in the same specialty. This describes

Peer review

250 Medical management can be divided into three broad categories, which are

Utilization management, clinical practice management and quality management.

251 Managing the use of medical services so that plan receive necessary and appropriate care in a cost-effective manner is

Utilization management

252 A health plan conducts a health risk assessment (HRA) to determine a person's likelihood of developing certain illness. The purpose is to

Help her reduce her risk and thereby improve outcomes and reduce cost.

253 A health plan program seeks to determine if a member has ha health condition even if he has no symptoms, this is

A screening program

254 A program supports health plan members who want to stop smoking, lose weight, eat better, and exercise more. This is a

Wellness program

255 A program teaches health plan members how to treat minor illnesses and distinguish them from serious conditions. This is a

Self care program.

256 Colleen can access data about different drugs and healthcare providers on her health plan's website. This is an example of

Web-based decision support tools.

257 Telephone triage programs are typically staffed by

Nurses directed by physicians and supported by nonprofessional personnel.

258 Clark's doctor gives him information about the treatment options available to him, and Clark makes the final decision. This is an example of

Shared decision-making

259 While Gloria is being treated for an illness, her health plan conducts an evaluation of whether the services she is receiving are necessary, appropriate, and cost-effective. This is an example of

Concurrent utilization review.

260 Wilson is assigned a healthcare professional who assesses his needs, design a plan of care, and coordinates and monitors the services he receives. This describe

Case management

261 Case management is used for

High-risk, high-cost, and/or chronic cases

262 case managers are most commonly

Nurses

263 Which type of UM program focuses on populations instead of individuals?

Disease management

264 Disease management focuses on

Chronic diseases

265 Which statement is true about disease management programs?

They are typically an outreach and support program for plan members with certain diseases.

266 A doctor treating a patient with diabetes refers to guidelines for this condition in making decisions about the most appropriate course of action. This describes

Clinical practice guidelines

267 Jill, a pediatrician, is considering prescribing a certain drug for Eric. She asks herself “is there research that indicates that if Eric takes this drug he will likely get better quicker than if he did not?” Jill is

Engaging in evidence-based healthcare

268 Laurie has diabetes. She wants to stay well is willing to change her lifestyle, but sometimes she doesn’t understand to problem here is

A lack of health literacy.

269

May be conducted before, during, or after treatment

270 Utilization review focuses primarily on whether a healthcare service is

Medically necessary and appropriate

271 The purpose of utilization review is to

Ensure correct payment of benefits, promote quality and cost-effective care and collect data for utilization management and other purpose.

272 UR staff decide what treatments

A health plan will pay for

273 UR programs use clinical practice guidelines to

Reduce unnecessary and ineffective practice variation.

274 If both prospective and retrospective review are possible, which is generally preferable?

Prospective review

275 Precertification is most commonly used for

Hospital admissions

276 The average number of days a patient with certain characteristics stays in a hospital. This describes

Length of stay guidelines

277 When are experience based criteria usually used?

When research-based utilization guidelines are not available

278 Testing needed before an inpatient treatment should be performed

Before admission to the hospital

279 For which is concurrent review not commonly used?

A specialist visit

280 Prior authorization is a feature of

Prospective review and sometimes concurrent review

281 Retrospective review most commonly

Analyzes data to improve utilization.

282 Which form of UR is most likely to discover billing and fraud?

Retrospective review

283 In order to receive a larger payment, a doctor improperly and deliberately bills two procedures separately instead of together. This is

Unbundling

284 Subjecting all healthcare services to UR is

Neither possible nor desirable

285 For which type of care is health plan member most likely to need a referral or authorization?

Non primary care

286 Which service is least likely to require authorization

A Frequently performed service

287 Emergency department use

Can increase or decrease health plan cost

288 Is emergency department care subject to unitization review?

Some plans require retrospective review and authorization

289 Do health plans cover urgent care centers?

Some do, and dome do not

288 Bill has chest pains and is awaiting test results. He does not need any treatment at this time, but he needs to be monitored. What is probably the best care setting for him?

Observation care unit.

289 Jack has had surgery. He does not need full hospital care anymore, but he does need 24 hour nursing care under supervision of doctor. What is probably the best care setting for him?

A sub acute care facility or hospital step-down unit.

290 Health plans generally pay for home health care for

Those recovering from an acute injury or illness, but not those with chronic condition

291 Do health plans pay for hospice care?

Most do for those who have six months or less to live and who forego certain medical treatment.

292 Which UR data transmittal method has the most problem with accuracy?

Manual

293 Which UR data transmittal method is the fastest and lead labor-intensive

Electronic

294 Which UR data transmittal method is the most regulated?

Electronic

295 In the UR process, administrative review focuses on whether a proposed service is

Covered

296 In the UR process, administrative review is performed by

Either, depending on the plan

297 Who can deny an authorization based on medical necessity and appropriateness?

A physicians only

298 May UR staff recommended a different treatment for a member?

Yes, but only when consensus is reached with the treating physician.

299 Which state is not true?

Once a PCP has referred a patient to a specialist, the specialist can generally provide whatever treatment and as many visit as she see fit.

300 The two main components of quality management are

Quality assessment and quality improvement

301 The two main categories of health plan quality are

Service quality and healthcare quality

302 Carol has a question about her health coverage ,but she tries all day and is unable to reach her health plan by phone. This is an issue of

Service quality.

303 Medical errors

Are both a patient safety issues and a cost issues.

304 The wrong medication is prescribed for a patient, causing an adverse event. This is an error of

Execution

305 Which problem is being addressed by national database

Lac of coordination among parties concerned with medical errors.

306 Consumer perceptions of healthcare quality

Are important because they reflect valid concerns and affect purchase decision.

307 A health plan's network has a certain number of primary care physicians. This is

A structure measure.

308 The percentage of health plan members who have received a medical checkup in the past two years is

A process measure.

309 Five year after treatment, 80 percent of cancer patient are still alive. This is

An outcomes measure.

310 The trend in quality measures is toward greater use of

Outcome measures.

311 What is the relationship structure, processes and outcomes?

Structure and processes produce outcomes.

312 The average claims processing time is a

Process measure of service quality

313 The main disadvantage of structure measures is that

Their link to outcomes is generally not proven by research.

314 A certain percentage of patients are able to return to work two years after a stroke.

Functional outcomes measures

315 Which is not a disadvantage of outcomes measures?

Outcomes are not directly related to quality.

316 Which is not a disadvantage of outcomes measures?

Outcomes are not directly related to quality.

317 Which generally present the most problem?

Clinical data

318 Which statement about quality improvement is true?

After actions are taken to improve quality, measurement and analysis of outcomes is repeated and on going

319 A hospital identifies another hospital with high cancer survival rate and adopts its practice. This is

Benchmarking

320 A health plan analyzes data from different gynecologists and notices that one of them performs certain procedure much more often than the rest. This is

Provider profiling

321 A panel of pediatricians evaluates the appropriateness and timeliness of the care provided by another pediatrician in a particular case. This is an example of

Peer review.

322 Which is most likely to be controversial among providers?

Provider profiling

323 Which statement is not true about health plans internal standards?

They are typically applied to healthcare services

324 NCQA accredits

Health plans of various types

325 Nationally, NCQA accreditation covers

Most health plan members.

326 The NCQA accreditation process

Includes both an onsite visit and offsite data review.

327 what form does NCQA accreditation take?

A plan earns one of five accreditation levels

328 URAC accredits

Health plans, health networks, and functional areas within organizations.

329 The URAC accreditation process

Includes both an onsite visit and offsite policy and procedure review.

330 HEDIS is designed primarily to be used by purchasers and consumers to compare

The quality of different health plans

331 Quality compass is

A national data base of performance and accreditation information

332 The agency for healthcare research and quality (AHRQ) is

A research branch of the department of health and human services

333 The affordable care act

Includes a variety of healthcare quality improvement provisions.

334 What will the Affordable care act do with regard to Medicare Advantage plans?

It will lower payment to MA plans overall but give bonuses and higher rebates to plans that meeting quality criteria.

335 Ethics can best be designed as

Principles and values that guide decision of right and wrong

335 health plans and their providers must respect the right of plan members to make decisions about the course of their lives. This is the ethical principal of

Autonomy

336 Which is not an ethical obligation of a health plan?

To make decisions for members in complex ethical situations.

337 Character traits that dispose people to act well toward others are

Virtues

338 health plans have an ethical obligation to promote the good of

Both individual members and the membership as a whole

339 A health plan ethics task force

Providers forum for discussion of ethical issues and offers consultation when physicians and families faces ethical decisions.

340 Medicaid eligibility and coverage

Vary somewhat from state to state, within federal guidelines

341 Currently, Medicaid is available

Primarily to low-income children, pregnant women, elderly and disabled people and few parents.

342 Under PPACA, Medicaid will be available.

All people with income below a certain level

343 if a healthcare service is covered by both Medicare and Medicaid, who pays?

Medicare

344 purpose of CHIP is to provide health coverage to children who

Cannot afford private insurance but do not qualify for Medicaid.

345 Alex, Logan, Kaitlyn and are all 14 years old. Who may be eligible for CHIP?

Alex's family's income is about twice the FPL

346 State have the option of offering CHIP coverage to pregnant women.

But most do not

347 Under CHIP

Copayments and premiums can be charge within limits.

348 Over the years the importance of managed care in Medicaid has

Increased

349 Currently, what portion of Medicaid recipients are in managed care?

A large majority

350 Which is currently a rule governing Medicaid managed care?

Health plans serving Medicaid recipients must meet certain requirements related to quality and enrollee protection

351 Which is not a challenge generally faced by health plans serving the Medicaid population?

Most people in Medicaid managed care are elderly or disabled

352 What portion of CHIP enrollees are in managed care?

A majority

353 State can offer premium assistance instead of health coverage to

Both Medicaid and CHIP recipients, although it may be voluntary.

354 under FEHB, health coverage is provided by

A large number of health plans that employees choose from

355 FEHB health plans include

A variety of plans types

356 FEHB health plans

Must offer at least a minimal benefit package.

357 TRICARE serves

Active and retired members of the uniformed services and their spouses and dependent children.

358 Tricare coverage takes the form of

Fee for service insurance of HMO coverage

359 Who pays a premium for Tricare?

Most participant except for active duty service members.

360 What is workers compensation?

State programs that require employers to provide benefits for work-related injuries and illness

361 Worker's compensation pay benefits to cover

Both medical expenses and lost income

362 Which is a feature of worker's compensation?

No coverage of non-work-related injuries and illnesses.

363 An employee is eligible for worker's compensation benefits

Whether or not the employer is at fault for her injury or illness, but even if the employer is at fault, she cannot sue it for damages.

364 What is the recent trend in Medicare health plan enrollment?

It was declining, but since the MMA in 2003 it has been steadily rising.

365 Managed care was introduced into Medicare by

TEFRA in 1982

366 What is the main aspect of medicare managed care that the MMA of 2003 changed?

Types of plans available

367 what is the main impact of healthcare reform on Medicare advantage?

Funding

368 A Medigap policy is available to those enrolled in

Both Medicare Part A and part B

369 Which of these is covered by some Medigap policies?

Health care received outside the United States.

370 Medigap policies

Must provide one of a few standard benefit packages

371 Can an insurer deny medigap coverage to an eligible m beneficiary or charge him a higher than stand premium?

It can not do this if he enrolls when he first becomes eligible or otherwise qualifies for guaranteed issue, but otherwise it can.

372 Original Medicare consists of

Part A and Part B (Hospital and Medical coverage)

373 The main purpose of Medicare Part C (Medicare Advantage) is

To provide Medicare coverage through private-sector health plans

374 Medicare Part D prescription drug coverage is

Made available to Medicare beneficiaries at an extra cost

375 Medicare Part A beneficiaries who go into the hospital

Must pay a large deductible before Medicare pays any benefits

376 Medicare Part A skilled nursing facility and home health care benefits are paid

For a limited time to those recovering from an illness or injury

377 Medicare part A is available to persons 65 and older

But those who did not pay into the Medicare system pay a premium

378 For a disabled person to qualify for Medicare, her disability

Must be total and long-term

379 Medicare Part A is funded primarily by

Medicare payroll taxes

380 Does Medicare part b cover services provided by dentists, podiatrists, optometrsts, and chiropractors?

Only limited service are covered, and only when restrictive conditions are met.

381 Medicare Part B charges

An annual deductible and coinsurance for most items

382 For Medicare part B

Everyone pays a premium

383 For Medicare part B

Most people pay a standard premium, but those with high incomes pay more

384 How does Medicare enrollment work?

Most people are automatically enrolled in Medicare when they come eligble.

385 Tim decides not to enroll in Medicare Part B when he first becomes eligible, even though he has no employer- sponsored health coverage. Can he enroll later?

Yes, he can, but he may have to pay a higher premium

386 Medicare Advantage is

An alternative to original Medicare

387 Medicare advantage plan provide

Part A and Part B coverage and usually other benefits

388 Medicare Part D prescription drug coverage is offered by

Most but not all MA plans

389 Which statement is correct about MA plans?

Premiums and cost-sharing payment differ from plan to plan

390 Medicare part D prescription drug coverage is provided

By private-sector prescription drug plans (PDPs) and MA plans

391 Medicare Part D prescription drug plans (PDPs)

Must all provide a minimal level of benefits

392 Which statement is correct?

PDPs may have different deductibles, and coinsurance and copayment amount vary

393 In a typical Medicare part D PDP, after the PDP and the beneficiary have together paid a certain total amount for drugs, the beneficiary pays

All costs until catastrophic coverage is triggered.

394 Clarice Decides not to enroll in Medicare Part D when she first becomes eligible, even though she has no employer-sponsored drug coverage. Can she enroll later?

Yes, she can, but she will pay a higher premium

395 At which level of government is most health plan regulation?

Formerly at the state level, but after ACA at the federal level

396 State financial standards for HMOs are intended primarily to

Protect consumers from the risk of plan insolvency.

397 If a health plan risks becoming insolvent, what can an insurance commissioner do?

Intervene in the plan's operations, take over its management, or liquidate it.

398 The primary goal of receivership of a health plan is to

Return the plan to normal operation

399 State regulators review the description of an HMO's service area and the list of network providers. The regulators are concerned with

Network adequacy

400 State generally regulate

HMO, PPOs, and EPOs

401 Which plan type is often not governed by a state's regular insurance code?

HMO

402 Have states enacted laws to regulate PPOs?

Most have

403 An HMO with a point-of-service option

May be regulated under either, depending on the state

404 Which statement best describes state' regulation of utilization review organization

Most states license them, require certification, and regulate them to some extent.

405 Which statement best describes state' regulation of third-party administrators?

Most state have various requirements including a certificate of authority.

406 Which is not required by NAIC's Health Care professional Credentialing Verification Model Act?

If a provider meets a plan's credentialing criteria, she must be contracted by the plan

407 Which statement is true about the NAIC's Privacy of Consumer Financial and health information Model Regulation?

It addresses disclosure of nonpublic personal health information

408 Which of these is a component of healthcare reform?

The requirement that most people have health coverage or pay a tax penalty.

409 When will the new healthcare financing system become operational?

Most of the major component become operational in 2014, but some provisions go into effect earlier or later

410 With some exceptions, individual who do not have health coverage will

Have to pay an income tax penalty

411 large employers are

Required to sponsor health coverage or pay fees

412 Small employers are

Not required to sponsor health coverage but may be eligible for tax credit if they do

413 Tax credits will be available to help people pay for

Both premium and cost-sharing payment

414 Under the new requirement for health insurance plans, which of these will be permitted?

Premiums based on age

415 under the new requirement for health insurance plans, which can not be considered in setting premiums?

Health.

416 The medical laboratories in a community get together and decide how much they will all charge health plans for various tests. This is probably a case of

Price-fixing

417 A physician group refuses to provide certain specialty services to a health plan unless the plan agrees to contract with the group for all the services the group offers. This may be a case of

A typing arrangement

418 Which is an important provision of the Financial Services Modernization Act?

The protection of personal financial information

419 ERISA applies to

Employer and union sponsored health plan

420 Under ERISA what are the roles of the federal and state governments in regulating employer sponsored health plans?

An employer health plan is regulated by the federal government, but any insurer involved is regulated by the state.

421 Under ERISA, an individual challenging a coverage decision by an employer – sponsored health plan

Must sue in federal court any may not receive punitive damages

422 if an employee is laid off, under COBRA she has the right to continue her employer sponsored health coverage

For up to 18 months

423 Bill is covered under his wife Lorie's employer sponsored health plan. What rights does Bill have under COBRA to continue this coverage?

He has rights if Lorie's employment is terminated, she dies, or they are divorced.

424 has been laid off and is continuing his employer health coverage under COBRA. Who pays?

Noah pays the full cost of coverage, and the employee may charge him a certain amount for administrative costs.

425 What is the impact of the HMO Act of 1973?

HMOs that wish to be federally qualified must meet the standards, and while qualification is less important today, many HMOs are qualified.

426 Under ADEA, an employer sponsoring health coverage

May not decline to offer health coverage to older employees nor change them more.

427 Under FMLA, an employee who is ill or needs to care for a family member has the right to 12 weeks of

Unpaid leave, including health coverage

428 Health plans' member education focuses on

Either administrative matters or health or both.

429 Health Plan's member education is directed to

Both.

430 Which means of distributing information to health plan members is declining?

Letters and newsletters sent by mail

431 Jeff call his health plan's toll free number and i able, by following prompts and without talking to a person, to change his PCP, this is an example of

IVR

432 In health plan member services when are paper documents sent by mail?

For a variety of notifications and routine transactions.

433 Which statement about health plan communication with members is true?

Members can not only obtain information from websites but also sometimes performs transactions.

434 Why must a health plan adequately deal with complaints?

To comply with regulations, maintain member satisfaction, avoid bad publicity and reduce appeals.

435 A health plan's complaint resolution procedures (CRPs)

Are generally subject to state and federal regulation and accreditation requirements.

436 Who generally conducts a health plan's level two appeal of a member complaint?

The appeals committee

437 What happens if a health plan member does not win a level two appeal?

She may have the right to appeal to government agency or an external review organization

438 What are the two main ways of measuring member satisfaction with a health plan?

Members satisfaction surveys and complaint monitoring

439 What populations do health plan members satisfaction surveys target?

Members who have recently received services, all members, and former members.

440 Who conducts member satisfaction survey?

Plan employees or outside companies, but some accrediting bodies and purchasers require outside companies.

441 In traditional indemnity health insurance, which is most common?

Claims are submitted by provider

442 When is an encounter report submitted instead of a claim?

When the provider the compensated by capitation or salary

443 Health plan claims processing is similar to that of traditional insurance for

Hospitals and most (but not all) healthcare professionals

444 About what portion of a typical health plan's claims are processed electronically?

80 to 90 percent

445 Which statement is true about electronic claim processing?

It is promoted by federal legislation

446 A health plan employee who deals with claims that have been paid incorrectly is a claims

Adjustor

447 A claims examiner's responsibilities generally include

Reviewing and adjudicating claims not processed electronically

448 Under which type of provider compensation arrangement is the most claims information needed?

Discounted fee for service

449 Which standardized claim form is used by physicians?

CMS – 1500

450 What is the standard code set for diagnosis

ICD

451 A claim triggers an edit, usually the claim will be

Examined furthered

452 In which situation is it not uncommon for a health plan to make a partial payment on a claim?

Authorization was not obtained

453 Which statement is true about claim processing?

If a provider bills more than six month after delivering a service, a plan is not required to pay

454 coordination of benefit may apply when

A person is covered by more than once health plan

455 Most claim investigations

Are short and simple

456 The primary focus of the NAIC Unfair Claims Settlement Practices Act is

Ensuring that insurers handle claim fairly and promptly

457 An information management system incorporates membership data and provider reimbursement arrangement and analyses transactions according to contract rules. This describes a

Contract management system

458 A health plan has an automated system to facilitate the processing of requests for authorization of payment. What kind of information management system is this?

Utilization management

459 An information management system identifies physicians who tend to provide fewer services than the norm in certain situations. This is an example of

Provider profiling

460 The use of MRI machine is expensive, so a health plan needs to efficiently coordinate utilization by providers. What type of information management system address this need?

Enterprise scheduling

461 A health plan's members can go the plan's website to check on the status of their claims. What kind of information management system is this?

Member services

462 Which statement about the quality of health plan data is not true?

The use of codes largely eliminates problems of accuracy

463 The data used by health plans is

Often in different databases and in incompatible formats.

464 Which aspect of information management in health plans is most strongly addressed by government regulations?

Security and privacy

465 In health plans, information management is

Somewhat automated

466 Which term encompasses all types of electronic business functions?

E-business

466 Which statement best describes health plans and the internet?

Health plans have historically lagged behind other industries but are now handling many transactions online

467 A security device designed to block unauthorized access to a private network is

A firewall

468 A computer network is accessible only the employees of a health plan. This is an

Intranet

469 The main threat to a health plan's network is

Employees

470 How does electronic data interchange (EDI) differ from e-business?

It is the transfer of batches of data, not exchanges about a transactions.

471 Which generally results in more accurate data, manual processes or EDI?

EDI

472 The focus of business intelligence and decision support system is to

Help managers make decisions in specific cases

473 The main problem that a data ware house is designed to address is

Data in multiple data base

474 The main disadvantage of data warehouses is

The complexity and cost of implementing them

475 Medical information for an individual designed to be used at the site of care is

An electronic medical record.

476 The main advantage of health information networks (HINs) and health information exchange (HIE) is that providers treating a patient

Have access to all of her medical records and health information

477 How does an HIE (such as RHIO) differ from an HIN?

An HIN shares information within a health plan network, while and HIE share it across health care entities.

478 Which is owned by the individuals?

The personal health record (PHR)

479 Personal health records are available from

Health plans and other organizations

480 How does the electronic medical record differ from the personal health record?

The EHR adds information from providers.

481 An example of an insourcing-outsourcing hybrid is

Cloud computing

482 A health plan uses a group's past experience to estimate its expected experience, and if actual experience is different, the plan absorbs the gains or losses. This Describes.

Prospective experience rating

483 Which will PPACA do regarding rating as of 2014?

Limit premium differentials based on risk factors.

484 An MCO's income statement

Summarizes its revenue and expense activity during a specified period.

485 Community rating is least likely to be used for

Large groups

486 A health plan sets premiums for classes of members based on age, family composition, and geography, but not experience. This is an example of

Adjusted community rating (ACR)

487 A health plan sets premiums for a group based on the plan's average experience with all groups rather than that particular group. This describes

Manual rating

488 Which will be prohibited by PPACA?

Annual and lifetime benefit limit

489 In renewal underwriting of group, what are the two main factors?

Experience and participation

490 In rating, what are the main considerations?

Riske and expected costs balanced by marketability and competitiveness.

491 Setting premiums based on the expected costs of providing benefits to the community as whole rather than to any subgroup is called?

Community rating

492 Underwriting involves

Identifying and assessing risks.

493 Which statement best describes adverse selection (anti selection)?

Those more likely to need healthcare are more likely to obtain health coverage

494 In health underwriting, what are the most important risk factors for individuals?

Age and gender, and sometimes health status or occupation

495 Which will be prohibited by PPACA?

Preexisting condition exclusions.

496 The major categories of an MCO's balance sheet are

Assets, liabilities and capital

497 State insurance regulators are primarily concerned with and HMO's

Statuary solvency

498 A variance is the difference between

Expected and actual revenues and expenses

499 An insurance company is financially responsible for paying healthcare benefits to the employees of High Plateau company. High Plateau's health plan is

A fully funded plan

500 Big River Corporation takes responsibility for paying healthcare benefits to its employees, but if total claims rise above $10 million in a year, an insurer pays any claims above this level. This is an example of

Aggregate stop-loss coverage.

501 A third-party administrator generally

Administers benefit only

502 The term "Marketing mix" refers to

Product, price, promotion, and distribution

503 A health plan's potential customers include

Employers, associations, employees, Medicare and Medicaid beneficiaries and other individuals.

504 Which is a market research technique?

Focus groups

505 How is marketing in health plans different from marketing in many other industries?

Markets are generally local

506 Will the Affordable Care Act (ACA) affect product development?

Yes, in relation to benefit packages, cost-sharing, and other matters.

507 Developing multiple product lines helps a health plan compete among

Large employers, but it makes marketing more complicated

508 What is the difference between

publicity?

Advertising is paid for, publicity is not.

509 The term “promotion mix” is commonly used to refer to

Advertising, publicity, personal selling and sales promotion

510 Which distribution channel is made up of health plan employees?

Internal sales force

511 Who are generally compensated by the buyer of a health plan, not by the seller?

Employee benefits consultants.

512 Who are considered to represent the health plan?

Agents.

513 Who sells the products of only once company?

A captive agent

514 Who commonly works with individuals rather than groups?

Agents

515 Which direct marketing method is commonly used today?

Direct mail

516 Dividing a market into smaller groups of customers is called

Market segmentation

517 Medicare beneficiaries are generally considered part of the

Non-group market

518 A health plan decides to compete in the small group market instead of the large group market by offering a basic and inexpensive product. This is an example of

Positioning

519 Who is not a member of the regular group market?

Joanne recently lost her job and her group health plan

520 Which is not a common distribution channel in the individual market?

Brokers

521 The Affordable Care Act (ACA)

will affect the marketing of all health plans, but it will have the greatest impact on the

Individual market

522 Which is not true under the ACA?

The individuals market will be eliminated, and everyone will have group coverage

523 Which is not a common distribution method in the senior market?

Door – to door selling

524 People eligible for Medicare

May receive health and/or drug coverage through private-sector health plans

525 The group market is made up mostly of

Employers

526 Small business choosing a health plan usually focus strongly on

Price

527 Which is true of small employers?

Only one health plan is usually offered

528 Which is true of large employers?

They often use employee benefit consultant

75. Reese is not required to choose a dentist or network during an annual open enrollment. She can choose when she needs care. But if she uses a non-network dentist, she pays a higher copayment. What type of plan does she have?

a. PPO
b. HMO
c. POS **(Correct)**
d. Indemnity

76. Which of these is a method used in market research?

a. Database marketing
**b.** Focus Groups **(Correct)**
c. Positioning
d. Branding

77. What portion of participants in Medicaid and the Children's Health Insurance Program (CHIP) are in managed care?

a. About Half
b. About a Third
c. A Small Minority
d. A Large Majority **(Correct)**

78. The two main components typical of a consumer-directed health plan (CDHP) are:

a. An Employer-Sponsored high-deductible health plan and an individual supplemental insurance policy
b. A tax-advantaged personal healthcare account and enrollment in a health maintenance organization
c. An individual high-deductible health plan and an employer-sponsored catastrophic plan
d. A high-deductible health plan and a tax-advantaged personal healthcare account **(Correct)**

79. Which of these is not covered by any Medigap policy?

a. Health care received outside the United States
b. Medicare Deductibles
c. Medicare Coinsurance and Copayments
d. Dental, Vision, and hearing services and products **(Correct)**

80. Under Traditional Indemnity health insurance, Insured's can receive healthcare:

a. From any provider they choose, but they pay higher cost-sharing for non network providers
b. Only from a provider affiliated with the insurer's network
c. From any provider they choose **(Correct)**
d. From any provider with prior approval from the insurer

81. Workers' compensation is:

a. Coverage for work-related injuries and illnesses that states require employers to provide to their employees
b. A federal program that helps pay for medical expenses and lost wages resulting from a work-related injury or illness
c. Insurance that employers and/or employees may choose to purchase to cover work-related injuries and illnesses
d. State programs that help pay for medical expenses and lost wages resulting from a work-related injury or illness **(Correct)**

82. Which statement about trends in health plan products is correct?

a. Fewer types of plans are being offered, and the distinctions between them are becoming sharper
b. More types of plans are being offered, and the distinctions between them are becoming sharper
c. Fewer types of plans are being offered, and the distinctions between them are becoming blurred
d. More types of plans are being offered, and the distinctions between them are becoming blurred (Correct)

83. Under capitation, the amount a provider is paid is based on:

a. The cost of the services she performs
b. The number of hours she works
c. The number of members she is responsible for **(Correct)**
d. The number of services she performs

84. What kind of risk does an HMO assume or share?

a. Both financial and delivery risks **(Correct)**
b. Neither financial nor delivery risks
c. Financial risks only, not delivery risks
d. Delivery risks only, not financial risks

85. The percentage of stroke patients who are able to walk and speak normally after two years is:

a. A perception measure
b. An outcomes measure **(Correct)**
c. A structure measure
d. A process measure

86. What is the best definition of a health plan?

a. An organization that combines employer funding of a core set of health benefits, employee financial responsibility, and provider accountability
b. An organization that maintains a network of affiliated healthcare providers and pays benefits only for services rendered by those providers
c. An organization that integrates the delivery and financing of healthcare and seeks to manage healthcare costs, access, and quality **(Correct)**
d. An organization that provides health coverage to a group of people, most commonly the employees of a business

87. Most HMO models may have an open or closed panel. Which HMO model normally has a closed panel?

a. IPA Model
b. Staff Model **(Correct)**
c. Group Model
d. Network Model

88. NCQA provides accreditation for:

a. Many types of health plans **(Correct)**
b. Preferred provider organizations only
c. Health maintenance organizations only
d. Healthcare providers only

89. Does HMO cover out-of-Network services?

a. Traditionally they did, but almost all HMOs no loner do so
b. No, this is a defining characteristic of HMOs
c. Traditionally they did not, but some HMOs now do so at a higher cost of members (correct)
d. Traditionally they did not, but some HMOs now do so at no extra cost to members

90. URAC provides accreditation for:

a. Functional areas within organization only
b. Health plans and health networks
c. Health plans, health networks, and functional areas within organizations **(Correct)**
d. Entire health plans only

91. A health plan's utilization review staff make decisions about what healthcare services:

a. A member can receive
b. Can be accessed out of network
c. The plan will pay for **(Correct)**
d. A provider can provide

92. A contract between a health plan and its network providers requires providers to accept the plan's compensation as payment in full and prohibits them from billing plan members from additional amounts. What contract provision is this?

a. Due process clauses
b. No balance billing provision **(Correct)**
c. Cure provision
d. Hold harmless provision

93. What coverage do Medicare Advantage plans provide?

a. The coverage of one of the standard Medigap plans
b. Medicare Part A and Part B coverage only
c. Medicare part A and Part B coverage only, but without cost-sharing
d. Medicare Part A and Part B coverage, other benefits, and usually drug benefits **(Correct)**

94. In a health Plan, what is underwriting?

a. Indentifying and evaluating risks presented by individuals and groups **(Correct)**
b. Tracking revenue and expenses to meet budget projections
c. Calculating premium rates for individuals and groups
d. Evaluating and selecting potential network providers

95. What is the main source of the cost-savings of consumer-directed health plans?

a. Consumers receiving less healthcare
b. Consumers making cost-effective healthcare choices
c. Employers shifting costs to consumers **(Correct)**
d. Employers receiving favorable tax-treatment

96. Who receives Medicare Part D prescription drug coverage?

a. All Medicare beneficiaries have the option of enrolling and paying an additional premium **(Correct)**
b. All Medicare Part B beneficiaries are enrolled and charged an additional premium
c. All Medicare beneficiaries receive it at no additional cost
d. All Medicare Advantage beneficiaries receive it at no additional cost

97. Every time Doug visits his primary care physician, he the doctor $10, regardless of the cost of services provided. This describes:

a. A capitation fee
b. A copayment **(Correct)**
c. Coinsurance
d. A deductible

98. What is the standard code set for medical treatments and procedures?

a. ICD-10
b. CMS-1500
c. CPT **(Correct)**
d. UB-04

99. In which HMO Model are physicians' salaried employees working in HMO Facilities?

a. Staff Model **(Correct)**
b. IPA Model
c. Network Model
d. Group Model

100. Normally, what does a health plan's ethics task force do?

a. It provides a forum for discussion of ethical and promotes ethics education, but it does not involve itself in specific ethical decisions.
b. It provides a forum for discussion of ethical issues, promotes ethics education, and offers consultation is specific ethical decisions **(Correct)**
c. It only provides a forum for discussion of ethical issues
d. It provides a forum for discussion of ethical issues, promotes ethics education, and routinely makes specific ethical decisions

101. In utilization review (UR), who has the authority to deny authorization of payment for a service based on medical necessity and appropriateness:

a. A plan benefit specialist only
b. A clinical UR staffer (Physician or Nurse)
c. A UR staffer, clinical or Nonclinical
d. A Physician Only **(Correct)**

102. The primary focus of a disease management program is:

a. Individuals with complicated and high-cost diseases
b. Providers who are not following clinical practice guidelines for certain diseases
c. Populations of people who have or are at risk for certain diseases **(Correct)**
d. Immunizations for common childhood diseases

103. Which is a common HMO compensation arrangement for hospitals but not physicians?

a. Capitation
b. Fee-for-Service
c. Diagnosis-Related Groups (DRGs) **(Correct)**

d. Discounted Fee-for-Service

104. Which of these healthcare services is not likely to be subject to concurrent utilization review?

a. A course of Physical Therapy
b. A lengthy Hospital Stay
c. A Visit to a Neurologist **(Correct)**
d. A course of Chemotherapy

105. Which is a provision of the HMO Act of 1973?

a. All employers with 100 or more employees had to offer a federally qualified HMO to their employees
b. All HMOs were required to become federally qualified
c. Federally qualified HMOs were exempted from State laws that restricted their development **(Correct)**
d. Federally qualified HMOs had to meet less rigorous standards than other health plans

106. To calculate how much to pay a physician for a procedure, a health plan assigns a numerical value to the procedure and multiples this number by a dollar figure negotiated with providers. This describes:

a. A relative value scale (RVS) **(Correct)**
b. Discounted Fee-for-Service (FFS)
c. Usual, Customary, and Reasonable (UCR) Fees
d. Diagnosis-Related Groups (DRGs)

107. A history of an individual's health and his encounters with the healthcare system that is owned by the individual is:

a. The personal health record (PHR) **(Correct)**
b. The computer-based patient record (CPR)
c. The electronic medical record (EMR)
d. The electronic health record (HER)

108. Which is an important factor driving increased healthcare spending?

a. Defensive Medicine
b. Consumer-Directed health plans
c. A younger population because of immigration
d. New drugs and technology **(Correct)**

109. Which is not typical of managed care?

a. Fee-for-Service Compensation **(Correct)**
b. Negotiating discounted rates with providers
c. Utilization, case, and disease management
d. An emphasis on preventive healthcare

110. How widespread are flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs)?

a. A majority of employees have one or the other
b. Nearly all employees have one or the other
c. Only a small minority of employees have either **(Correct)**
d. About half of employees have one or the other

111. To be eligible for a health savings account (HSA), what health coverage must a person have?

a. Any employer-sponsored health plan
b. A qualified HDHP, Medicare, or dependent coverage under someone else's plan
c. A qualified HDHP only, not other broad health coverage or Medicare **(Correct)**
d. Any high-deductible health plan (HDHP)

112. Under ERISA, does the Federal Government regulate employer-sponsored health plans?

a. It regulates fully insured but not self-funded plans
b. It regulates both self-funded and fully insured plans **(Correct)**
c. It regulates neither self-funded nor fully insured plans
d. It regulates self-funded but not fully insured plans

113. Which health plan types generally require a referral from a primary care physician to see a specialist?

a. PPOs
b. Traditional HMOs
c. HMOs and PPOs
d. Traditional HMOs and POS product **(Correct)**

114. Which statement about state regulation is correct?

a. Most states do not have laws specifically addressing HMOs or PPOs, but regulate them through the regular insurance code (Correct)
b. Most states have laws specifically addressing HMOs but not PPOs
c. Most states have laws specifically addressing PPOs but not HMOs
d. Most states have laws specifically addressing HMOs and PPOs

115. Which HMO Model has high facility costs but greatest control of care management and quality?

a. IPA Model
b. Network Model
c. Group Model
d. Staff Model **(Correct)**

116. What is the characteristic feature of a corporation that makes it different from other organizations?

a. It issues stock
b. It is a legal entity separate from its owners **(Correct)**
c. It is for-profit organization
d. It is owned by more than two people

117. Why has the popularity of flexible spending accounts (FSAs) been limited?

a. The prohibition on employee contributions
b. The tax penalty on funds withdrawn before age 65
c. The limited type of healthcare expenses on which funds can be spent
d. The "use it or lose it" rule and the lack of portability **(Correct)**

118. Which physician-only provider organization is the most integrated?

a. The consolidated medical group **(Correct)**
b. The independent practice association (IPA)
c. The group practice without walls (GPWW)
d. The management services organization (MSO)

119. Separate healthcare providers are brought under common ownership and control. This describes:

e. Clinical integration
f. Structural integration **(Correct)**
g. Business integration
h. Operational integration

120. Who owns a mutual insurance company?

e. The company's board of directors
f. The company's policyholders **(Correct)**
g. The company's stockholders
h. A non-profit organization

121. Typically, who submits encounter reports instead of claims to a health plan?

e. All hospitals and facilities but not healthcare professionals
f. All healthcare professionals but not hospitals and facilities
g. Healthcare professionals compensated by capitation **(Correct)**
h. Healthcare professionals compensated by fee-for-service

122. Primary care providers compensated by fee-for-service have an incentive to:

e. Provide unnecessary services
f. Not provide needed services
g. Refer patients to specialists
h. Promote prevention and wellness **(Correct)**

123. What is the measurement of how long it takes a health plan member services representative to complete a transaction request by a member?

e. First contact resolution rate
f. Turn-around time **(Correct)**
g. Wait time
h. Call abandonment rate

124. Does Medicare cover all healthcare expenses?

e. Medicare has only minor cost-sharing payments, and it covers nearly all health-related expenses
f. Medicare has substantial cost-sharing payments, but it covers nearly all health-related expenses
g. Medicare has substantial cost-sharing payments, and it does not cover routine dental, vision, and hearing care and some other items (Correct)
h. Medicare has only minor cost-sharing payments, but it does not cover routine dental, vision, and hearing care and some other items

125. Which personal healthcare account offers annual rollover of funds, tax-fee investment growth, and full portability?

e. Health Saving Account (HSA) **(Correct)**
f. FSA, HRA, and HAS
g. Health Reimbursement Arrangement (HRA)
h. Flexible spending account (FSA)

126. For which of these healthcare services is precertification (Prior Authorization) most likely to be required?

e. A visit to a specialist
f. A visit to a primary care provider
g. A routine laboratory test
h. A hospital admission **(Correct)**

127. Do states regulate utilization review organizations (UROs) and third party administrators (TPAs)?

i. Most states regulate both to some extent **(Correct)**
j. Most states regulate TPAs but not UROs
k. Only a few states regulate either
l. Most states regulate UROs but not TPAs

128. Who can receive Medicare coverage?

a. People 65 or older and younger people with low incomes
b. People 65 or older and younger people with severe, long-term disabilities or a few diseases **(Correct)**
c. People 65 or older only

d. People 65 or older and younger people with disabilities

129. In establishing and maintaining provider networks, health plans generally try to ensure member access to care by:

a. Recruiting as many providers of all types as they can
b. Considering the number, type, and location of providers needed **(Correct)**
c. Accepting all providers who meet minimal standards
d. Imposing no barriers or disincentives on the use of out-of-network care

130. After Sarah has been in treatment for a respiratory condition for a few months, her health plan conducts an evaluation to make sure the services she is receiving are necessary, appropriate, and cost-effective. This is an example of:

a. Disease Management
b. Utilization review
c. Case Management **(Correct)**
d. Shared Decision-Making

131. Compared to indemnity insurance, health plan typically have.

e. More extensive benefit packages and lower out-of-pocket costs **(Correct)**
f. More extensive benefit packages but higher out-of-pocket costs
g. Less extensive benefit packages but lower out-of-pocket costs
h. Less extensive benefit packages and higher out-of-pocket costs

132. How do PPOs most commonly compensate physicians?

e. Non-discounted fee-for-service
f. Capitation
g. Discounted fees **(Correct)**
h. Per-diem payments

133. May one use funds from a health savings account (HAS) for non-medical purposes?

e. Yes, but you will have to pay income tax on the money
f. Yes, but you will have to pay income tax and (if under 65) a tax penalty. **(Correct)**
g. Yes and the withdrawal will normally be tax-free.
h. No, this is not allowed.

134. Most regulation of health plans?

e. Has been at the state level but after the affordable care act (ACA) will be at the federal level. **(Correct)**
f. Has been at the Federal level but after the affordable care act (ACA) will be at the State level.
g. Has been and continues to be at the state level.
h. Has been and continues to be at the federal level.

135. Which statement is true about how health plans communicate with their members?

e. Regular mail is used only when required by regulations for important notifications **(Correct)**
f. Some interactive voice response (IVR) telephone systems enable members to conduct certain transactions without talking to a person
g. Websites can be used to obtain information but not perform transactions
h. Email is not frequently used because of strict regulations related to privacy and security.

136. Internal quality standards for health plans are?

e. Based on industry benchmarks and usually apply to healthcare services **(Correct)**
f. Developed by the health plan itself and usually apply to administrative services
g. Based on industry benchmarks and usually apply to administrative services
h. Developed by the health plan itself and usually apply to healthcare services

137. Dan has multiple medical conditions. A nurse is assigned to him to assess his needs, design a plan of care, and coordinate and monitor the services he receives. This describes:

e. Utilization review
f. Case management **(Correct)**
g. Value-based healthcare
h. Disease management

138. For small business buying a health plan, what is usually the key factor?

e. Healthcare quality
f. Employee satisfaction
g. Customization
h. Premium Price **(Correct)**

139. A computer program discovers that, based on repeated early refills, a plan member seems to be taking more of a pain reliever than he should. This is an example of.

e. Drug utilization review **(Correct)**
f. Physician Profiling
g. Prior authorization
h. Formulary management

140. What is the main purpose of the Children's health insurance program (CHIP
141. )?

e. To help pay the health insurance deductibles, coinsurance, and copayments of families with moderate incomes
f. To provide health coverage to children unable to obtain private-sector insurance because of the their medical history or a preexisting condition
g. To provide financial relief to families who have incurred very large medical expenses for children
h. To provide health coverage to children whose families cannot afford private-sector insurance but do not qualify for Medicaid. **(Correct)**

142. Which statement about raising capital is correct?

e. Stock companies find it easier than mutual companies, and for-profit plan find it easier than not-for-profit plans **(Correct)**
f. Mutual companies find it easier than stock companies, and not-for-profit plans find it easier than for-profit plans
g. Mutual companies find it easier than stock companies, and for-profit plans find it easier than not-for-profit plans
h. Stock companies find it easier than mutual companies, and not-for-profit plans find it easier than for-profit plans

143. A health plan decides to complete in the large group market instead of the small group market by offering a variety of product lines. This is an example of:

e. Positioning **(Correct)**
f. Branding
g. Marketing mix
h. Market segmentation

144. Under which compensation arrangement do providers assume the greatest financial risk?

e. Capitation **(Correct)**
f. Diagnosis-related groups (DRGs)
g. Resource-Based Relative Value Scale (RBRVS)
h. Discounted fee-for-service

145. A health plan has an obligation to respect the right of its members to make decisions about their own lives. This is the ethical principal of

e. Beneficence
f. Autonomy **(Correct)**
g. Altruism
h. Equity

146. Diane is a member of a private-sector health plan. She disagrees with a decision made by the plan. A level one review by the plan's medical director and a level two review by its appeals committee both uphold the plan's original decision. What are Diane's options?

i. Her case automatically goes to binging arbitration
j. She has no further recourse and must accept the decision
k. She may have the right to appeal to the state insurance department or an external review organization (depending on state laws) **(Correct)**
l. She may have the right to appeal to the state insurance department or, if no, to the federal Department of Health and Human Services.

147. What happens when adverse selection occurs?

i. People less likely to need healthcare are more likely to obtain health coverage
j. People who have health coverage are more likely to use healthcare services
k. People more likely to need healthcare are more likely to obtain health coverage **(Correct)**
l. Physicians who provide inferior care are more likely to join a health plan network

76. Which is not an early form of health plan?

a. HMO
b. Traditional Indemnity
c. PPO **(Correct)**
d. EPO

77. Janine can go to any doctor she chooses, but if she goes to one not in her plan's network, she has to pay a large share of the cost. Janine is covered by?

a. POS
b. PPO **(Correct)**
c. Indemnity
d. None of the above

78. Jacob must pay $2,000 in healthcare expenses each year before he receives benefits from his health plan, but he can use money from a tax-advantaged savings account. Jacob has

a. CDHP **(Correct)**
b. HSA
c. Indemnity
d. HRA

79. Which is not a cause of higher healthcare spending?

a. Government Intervention
b. A younger population because of immigration **(Correct)**
c. New Technique in Healthcare
d. All of the above

80. Under the fee-for-service approach, healthcare providers have a financial in
81. tive to provide?

a. More Services **(Correct)**
b. Less Services
c. Appropriate Service
d. Refer patient to different department

82. Which is not an accrediting organization?

a. NCQA
b. URAC
c. HEDIS **(Correct)**
d. None of the above

83. In traditional indemnity plan, how are providers compensated?

a. Capitation
b. DRG Payment
c. Fee-For-Service **(Correct)**
d. Discounted Payment

84. Which is not common in traditional indemnity health insurance?

a. Copayment **(Correct)**
b. Deductible
c. Coinsurance
d. Non of the Above

85. Coordination of benefits is designed to?

a. Prevent members to go out of network
b. Prevent members to get additional benefits
c. Prevent members to get unnecessary charged
d. Prevent Duplication of benefits **(Correct)**

86. Which health plan uses managed care techniques and concepts the most?

a. HMO **(Correct)**
b. POS
c. PPO
d. EPO

87. Managing the use of healthcare services so that patients receive necessary, appropriate and high quality care in a cost effective way is?

a. Utilization Review
b. Utilization Management **(Correct)**
c. Decease Management
d. Case Management

88. Teresa, a doctor is paid by a health plan by capitation. One month she delivers a very few services to plan members, the next month she delivers about the projected amount. Teresa is paid –

a. Double amount
b. Less Amount
c. The same amount each month **(Correct)**
d. Don't know

89. A plan holds back a percentage of PCP's monthly capitation payments. At the end of the year, some of this money is paid to the PCP's but some is used to pay for higher than projected referrals. This is -

a. Risk Pool
b. Withhold **(Correct)**
c. Capitation
d. RVS

90. Which compensation arrangement involves least risk for hospital?

a. Fee for Service **(Correct)**
b. Discounted Fees
c. Capitation
d. RVS

91. A plan pays money into a pool to cover hospitalization. At the end of the year, if there is money left over in the pool, same is given to the PCPs, but if there is not enough money, PCPs must cover some of the cost. This is –

a. Risk Pool (Correct)
b. Withhold
c. Capitation
d. RVS

92. A physician is compensated by an HMO by capitation but once her total costs have reached a certain level, additional costs are reimbursed by discounted FFS. This is-

a. DRG Provision
b. Stop Loss Provision **(Correct)**
c. Capitation
d. RVS

93. Which utilization management technique is used primarily for physicians?

a. Risk Pool **(Correct)**
b. Withhold
c. Capitation
d. RVS

94. An HMO contracts with six group practices. This is an example of –

a. Group Model HMO

b. Staff Model HMO
c. Network Model HMO **(Correct)**
d. IPA

95. What portion of U.S employees are covered by PPOs?

a. Majority of Employees **(Correct)**
b. Less number of Employees
c. 10 % of the employees
d. Don't know

96. A majority of PPOs are owned by?

a. Insurance companies **(Correct)**
b. Providers
c. Hospitals
d. Federal Government

97. In establishing and maintaining provider networks, health plans generally try to ensure member access to care by:

m. Recruiting as many providers of all types as they can
n. Considering the number, type, and location of providers needed **(Correct)**
o. Accepting all providers who meet minimal standards
p. Imposing no barriers or disincentives on the use of out-of-network care

98. How many employees are covered by POS products?

a. A small but declining minority **(Correct)**
b. A small but increasing
c. Majority of employees
d. Don't know

99. Which is typical of a dental HMO?

a. Deductible
b. Copayment **(Correct)**
c. Coinsurance
d. CDHP

100. Which is typically a dental PPO?

a. Annual Deductible
b. Annual deductible, coinsurance and annual maximum **(Correct)**
c. Annual Coinsurance
d. Annual Maximum

101. Which dental plan type typically has the smallest network?

a. PPO
b. HMO **(Correct)**
c. POS
d. Indemnity

102. About what percent of U.S. adults experience some sort of behavioral health disorder during any year?

a. 50 %
b. 25 % **(Correct)**
c. 100 %
d. 10 %

103. Douglas is in a substance abuse program. He spends most of his time in a facility but goes out during the day to attend school. This describes –

a. Partial hospitalization **(Correct)**
b. Acute Hospitalization
c. Intensive Care
d. None of the above

104. Which is not an element of consumer directed health plans?

a. High Premium **(Correct)**
b. Low Premium
c. High benefits
d. None of the above

105. Which premiums cannot be paid tax-free with HSA funds?

a. Medigap insurance **(Correct)**
b. Medicare Insurance
c. Medicaid Insurance
d. Cobra Insurance

106. Can a person 65 or older use HSA funds to pay non-medical expenses?

a. Yes, she may; she must pay income tax but not tax penalty **(Correct)**
b. No it is not possible
c. Yes, she may; she must pay income tax
d. Can't possible

107. What is the primary purpose of a PHO?

a. Contracting with health plans and marketing **(Correct)**
b. Contracting with Networks
c. Contracting with Providers
d. All of the above

108. Which statement is true about mutual and stock insurance companies?

a. Most insurers are stock companies **(Correct)**
b. Most insurers are mutual companies
c. Most insurers are combined companies

d. All of the above

109. Which plan types need fewer providers per 1,000 members?

a. Highly managed large plans **(Correct)**
b. Less managed large Plans
c. CDHP Plans
d. All of the above

110. A program teaches health plan members how to treat minor illness and distinguish them from serious conditions. This is –

a. Wellness Program
b. Self care program **(Correct)**
c. Online care program
d. None of the above

111. Case managers are most commonly?

a. Highly experienced providers
b. Nurses **(Correct)**
c. Hospitals
d. Managers

112. A doctor treating a patient with diabetes refers to guidelines for this condition in making decisions about the most appropriate course of action. This describes –

a. Length of stay guidelines
b. Clinical practice guidelines **(Correct)**
c. Hospital Stay guidelines
d. Room and board guidelines

113. If both prospective and retrospective reviews are possible, which is generally preferable?

a. Prospective review **(Correct)**
b. retrospective reviews
c. Both are urgent
d. We will go for Concurrent review

114. In order to receive a larger payment, a doctor improperly and deliberately bills two procedures separately instead of together. This is –

a. Upcoding
b. Unbundling **(Correct)**
c. Bundline
d. Coding

115. Who can deny an authorization based on medical necessity and appropriateness?

a. Physician **(Correct)**
b. Nurse
c. Hospital
d. Assistants

116. Carol has a question about her health coverage, but she tries all day and is unable to reach her health plan by phone. This is an issue of –

a. Medical Quality
b. Service Quality **(Correct)**
c. Cost Quality

d. All of the above

117. The percentage of health plan members who have received a medical checkup in the past two years is –

a. Process Measure **(Correct)**
b. Structure Measure
c. Outcome Measure
d. All of the above

118. The term "Marketing mix" refers to –

a. Product, price, promotion and distribution **(Correct)**
b. Production & Price
c. Product & Promotion
d. Product & Distribution

119. A health plan decides to compete in small group market instead of large group market by offering a basic and inexpensive product. This is an example of -

a. Branding
b. Positioning **(Correct)**
c. Benchmarking
d. Scoring

120. The Affordable Care Act (ACA) will affect the marketing of all health plans but it will have the greatest impact on the –

a. Individual market **(Correct)**
b. Group Market
c. Network Market
d. IPA Market

121. Which is not one of the main goals of ?

a. Expanding Medicaid eligibility **(Correct)**
b. Expanding Medicare eligibility
c. Expanding Medigap eligibility
d. Expanding state regulations

122. Tax credits will be available to help people pay for –

a. Both premiums and cost-sharing payments **(Correct)**
b. Premiums Only
c. Cost-Sharing Payment
d. None of the above

123. Under the new requirements for health insurance plans (ACA), which of these will be permitted?

a. Premiums based on age **(Correct)**
b. Premium based on health
c. Premium Based on geography
d. Premium based on community

124. State regulators review the description of an HMO's service area and the list of network providers. The regulators are concerned with –

a. Network adequacy **(Correct)**
b. Group Adequacy
c. Provider Adequacy
d. Don't know

125. Which plan type is often not governed by a state's regular insurance code?

a. PPO
b. POS
c. HMO **(Correct)**
d. Indemnity

126. Tim decides not to enroll in Medicare Part B when he first becomes eligible, even though he has no employer sponsored health coverage. Can he enroll later?

a. Yes, but he may have to pay a higher premium **(Correct)**
b. No, they can not be enrolled
c. Tim needs to wait till 1st of Jan'11
d. Yes, he can enroll and also he does not need to pay any penalty

127. What is the main impact of healthcare reform on Medicare Advantage?

a. Rating
b. Funding **(Correct)**
c. Underwriting
d. Financing

128. A Medigap policy is available to those enrolled in?

a. Medicare Part A and B **(Correct)**
b. Medicare Part A
c. Medicare Part B
d. Medicare Advantage

129. Which of these is covered by some Medigap policies

a. Vision Services
b. Hearing Services
c. Healthcare received outside the US **(Correct)**
d. None of them

130. If a healthcare service is covered by both Medicare and Medicaid, who pays?

a. Medicare **(Correct)**
b. Medicaid
c. Can be paid by both
d. Person can not have both the coverage

131. Worker's compensation pays benefits to cover –

a. Medical Income
b. Lost Income
c. Both Medical & Lost Income **(Correct)**
d. None of the above

132. Health plans and their providers must respect the right of plan members to make decisions about the course of their lives. This is the ethical principal of –

a. Autonomy **(Correct)**
b. Justice and Equity
c. Beneficence
d. Non-maleficence

133. The percentage of stroke patients who are able to walk and speak normally after two years is:

a. A perception measure
b. An outcomes measure **(Correct)**
c. A structure measure
d. A process measure

134. What form does cost-sharing generally take in traditional indemnity health insurance?

a. An annual deductible and coinsurance **(Correct)**
b. An annual deductible and copayments
c. An annual deductible, coinsurance, and copayments
d. Coinsurance, but no deductible or copayments

135. The primary purpose of Medicare Advantage is to offer

a. A form of Medicare with a high premium but no deductibles, coinsurance, or copayments
b. A supplement to Medicare that covers many Medicare cost-sharing payments
c. The option of receiving Medicare coverage through a private-sector health plan **(Correct)**
d. Prescription drug coverage to Medicare beneficiaries

136. Who can receive Medicare coverage?

a. People 65 or older and younger people with low incomes
b. People 65 or older and younger people with severe, long-term disabilities or a few diseases **(Correct)**
c. People 65 or older only
d. People 65 or older and younger people with disabilities

137. Which way of accessing behavioral healthcare services used to be common but no longer is?

a. Direct Access
b. Employee Assistance Program (EAP)
c. Primary Care Provider (PCP) referral **(Correct)**
d. Centralized Telephone Referral System

138. After Sarah has been in treatment for a respiratory condition for a few months, her health plan conducts an evaluation to make sure the services she is receiving are necessary, appropriate, and cost-effective. This is an example of:

a. Disease Management
b. Utilization review
c. Case Management **(Correct)**
d. Shared Decision-Making

139. Which HMO model has high facility costs but greatest control of care management and quality?

i. IPA model
j. Group model
k. Network model
l. Staff model **(Correct)**

140. An HMO contracts with eight group practices. This is an example of

e. An IPA model HMO
f. A network model HMO **(Correct)**
g. A mixed model HMO
h. A group model HMO

141. Which of these healthcare services is not likely to be subject to concurrent utilization review?

i. A course of physical therapy
j. A lengthy hospital stay
k. A course of chemotherapy
l. A visit to a neurologist **(Correct)**

142. Under which compensation arrangement do providers assume the greatest financial risk?

i. Capitation **(Correct)**
j. Resource-Based Relative Value Scale (RBRVS)
k. Diagnosis-related groups (DRGs)
l. Discounted fee-for-service

143. A health plan identifies another plan with high immunization rates among children and adopts its practices in this area. This is an example of

e. Benchmarking **(Correct)**
f. Clinical practice guidelines
g. Provider profiling
h. Peer review

144. Robert is diagnosed with prostate cancer. There are several treatment options, each with advantages and disadvantages. His doctor informs him about these and discusses them with him, but she lets Robert make the final decision based on his values. This is an example of:

Disease management
d. Shared decision making **(Correct)**
e. A self-care program
f. Utilization review

145. A health plan projects the cost of providing benefits to a group based partly on the plan's rate manual and partly on the group's experience. This describes:

i. Experience rating
j. Manual rating
k. Blended rating **(Correct)**
l. Pooling

146. Diane is a member of a private-sector health plan. She disagrees with a decision made by the plan. A level one review by the plan's medical director and a level two review by its appeals committee both uphold the plan's original decision. What are Diane's options?

e. Her case automatically goes to binging arbitration
f. She has no further recourse and must accept the decision
g. She may have the right to appeal to the state insurance department or an external review organization (depending on state laws) **(Correct)**
h. She may have the right to appeal to the state insurance department or, if not, to the federal Department of Health and Human Services

147. For small businesses buying a health plan, what is usually the key factor?

e. Customization
f. Employee satisfaction
g. Healthcare quality
h. Premium price **(Correct)**

148. What is the compensation method for Group Model HMO employees?

e. Salaries & Incentives **(Correct)**
f. Capitation
g. Fee for Service
h. Discounted fees

149. How widespread are flexible spending accounts (FSAs) and health reimbursement arrangements (HRAs)?

a. A majority of employees have one or the other
b. Nearly all employees have one or the other
c. Only a small minority of employees have either **(Correct)**
d. About half of employees have one or the other

6. What form does cost-sharing generally take in traditional indemnity health insurance?

a. An annual deductible and coinsurance (Correct)
b. An annual deductible and copayments
c. Coinsurance, but no deductible or copayments
d. An annual deductible, coinsurance, and copayments.

7. Any physician who meets the standards of GoodLife HMO is eligible to join its network. GoodLife does not pay benefits for out-of-network care. Members must get a referral from their primary care provider (PCP) to see a specialist GoodLife has

a. An open panel and open access
b. An open panel and closed access (Correct)
c. A closed panel and closed access
d. A closed panel and open access

8. The primary purpose of Medicare Advantage is to offer:

a. The option of receiving Medicare coverage through a private-sector health plan. (Correct)
b. A supplement to Medicare that covers many Medicare cost-sharing payments.
c. Prescription drug coverage to Medicare beneficiaries.
d. A form of Medicare with a high premium but no deductibles, coinsurance, or copayments.

9. Which of these will be permitted under the Affordable Care Act (ACA) (Healthcare reform)?

a. Premiums based on age (Correct)
b. Lifetime benefit limits
c. Preexisting condition exclusions
d. Annual Benefit Limits

10. It is most difficult to develop a comprehensive network in

a. Suburban areas
b. Rural areas (Correct)
c. Urban areas
d. Very large metropolitan areas

76. At the end of year, if there is more than enough money in a pool to cover specialty care, a health plan's primary care providers (PCPs) receive some of the excess. If there is not enough money to cover costs, they must make up some of the deficit. This is an example of

a. A withhold
b. Pay for performance
c. Capitation

d. A risk pool (Correct)

77. A panel of cardiologists evaluates the care provided by another cardiologist in a particular case. This is an example of

e. Clinical practice guidelines
f. Provider profiling
g. Peer review (Correct)
h. Benchmarking

78. When is utilization review conducted?

e. Before treatments is provided
f. During the course of treatment
g. After treatment is provided
h. Before, during, and/or after treatment (Correct)

79. Which HMO model has high facility costs but greatest control of care management and quality?

m. IPA model
n. Group model
o. Network model
p. Staff model (Correct)

80. Which communication channel between a health plan and its members is being used less and less?

e. Website
f. Emails
g. Social media
h. Regular mail (Correct)

81. Which is not a rule of federal mental health parity laws?

e. Cost-sharing for behavioral healthcare cannot be more than for medical care
f. Limitations on coverage of behavioral healthcare cannot be more restrictive than for medical care (Correct)
g. Annual and lifetime benefit caps cannot be lower than for medical care
h. All health plans must provide behavioral health coverage

82. Which of these healthcare services is not likely to be subject to concurrent utilization review?

m. A course of physical therapy
n. A lengthy hospital stay
o. A course of chemotherapy
p. A visit to a neurologist (Correct)

83. Under the principle of beneficence, health plans must promote the good of their

e. Individual members
f. Stockholders only
g. Individual members and their membership as a whole
h. Membership as a whole (Correct)

84. A certain percentage of the members of a health plan have received a cholesterol screening. What kind of quality measure is this?

e. Outcomes measure
f. Perception measure
g. Process measure (Correct)
h. Structure measure

85. Under which compensation arrangement do providers assume the greatest financial risk?

    m. Capitation (Correct)
    n. Resource-Based Relative Value Scale (RBRVS)
    o. Diagnosis-related groups (DRGs)
    p. Discounted fee-for-service

86. A health plan identifies another plan with high immunization rates among children and adopts its practices in this area. This is an example of

    e. Benchmarking (Correct)
    f. Clinical practice guidelines
    g. Provider profiling
    h. Peer review

87. Robert is diagnosed with prostate cancer. There are several treatment options, each with advantages and disadvantages. His doctor informs him about these and discusses them with him, but she lets Robert make the final decision based on his values. This is an example of:

    e. Disease management
    f. Shared decision making (Correct)
    g. A self-care program
    h. Utilization review

88. Which type of physician-hospital provider organization is the least integrated?

    e. The medical foundation
    f. Accountable care organization (ACO)
    g. The physician-hospital organization (PHO) (Correct)
    h. The integrated delivery system

89. The percentage of stroke patients who are able to walk and speak normally after two years is:

    e. A perception measure
    f. A process measure
    g. A structure measure
    h. An outcomes measure (Correct)

90. Which health plan designs are in the middle of the managed care continuum, between tightly managed and unmanaged?

    e. Indemnity insurance and EPOs
    f. Traditional HMOs
    g. PPOs, EPOs, and POS products (Correct)
    h. Traditional HMOs and PPOs

91. Kaltlyn is covered by her employer's health plan, and the employer pays part of the premium. She is laid off from her job. Under COBRA, she has the right to continue her health coverage:

    e. For up to 18 months, and her employer must continue its premium contribution
    f. For up to 18 months, but her employer does not have to continue its premium contribution (Correct)
    g. For up to 36 months, and her employer must continue its premium contribution for the first 18 months
    h. Until she obtains coverage through a new employer, but her employer does not have to continue its premium contribution

92. A health plan projects the cost of providing benefits to a group based partly on the plan's rate manual and partly on the group's experience. This describes:

    m. Experience rating
    n. Manual rating
    o. Blended rating (Correct)
    p. Pooling

93. Diane is a member of a private-sector health plan. She disagrees with a decision made by the plan. A level one review by the plan's medical director and a level two review by its appeals committee both uphold the plan's original decision. What are Diane's options?

    m. Her case automatically goes to binging arbitration

n. She has no further recourse and must accept the decision
o. She may have the right to appeal to the state insurance department or an external review organization (depending on state laws) (Correct)
p. She may have the right to appeal to the state insurance department or, if no, to the federal Department of Health and Human Services.

94. The Affordable Care Act (ACA) (healthcare reform) will make tax credits available to

e. Employers to help them sponsor coverage but not to individuals
f. Individuals to help them pay premiums but not to employers
g. All employers to help them sponsor coverage and individuals to help them pay premiums and cost-sharing (Correct)
h. Small employers to help them sponsor coverage and individuals to help them pay premiums and cost-sharing

95. To be eligible for a health savings account (HSA), what health coverage must a person have?

e. Any employer-sponsored health plan
f. Any high-deductible health plan (HDHP)
g. A qualified HDHP, Medicare, or dependent coverage under someone else's plan
h. A qualified HDHP only, not other broad health coverage or Medicare (Correct)

96. What happens when adverse selection occurs?

m. People less likely to need healthcare are more likely to obtain health coverage
n. People who have health coverage are more likely to use healthcare services
o. People more likely to need healthcare are more likely to obtain health coverage (Correct)
p. Physicians who provide inferior care are more likely to join a health plan network

97. Most HMO modes may have an open or closed panel. Which HMO model normally has a closed panel?

e. Group Model
f. Network Model
g. Staff Model (Correct)
h. IPA Models

98. Which way of accessing behavioral healthcare services used to be common but no longer is?

e. Employee assistance program
f. Direct access
g. Primary care provider (PCP) referral (Correct)
h. Centralized telephone referral system

99. In which of these provider organizations do physicians normally now own and operate their own practices?

e. Consolidated medical group
f. Group practice without walls (GPWW) (Correct)
g. Independent practice association (IPA)
h. Physician-Hospital organization (PHO)

100. For small businesses buying a health plan, what is usually the key factor?

e. Customization
f. Employee satisfaction
g. Healthcare quality
h. Premium price (Correct)

101. Who receives Medicare Part D prescription drug coverage?

e. All Medicare Advantage beneficiaries receive it at no additional cost
f. All Medicare beneficiaries receive it at no additional cost
g. All Medicare beneficiaries have the option of enrolling and paying an additional premium (Correct)
h. All Medicare Part B beneficiaries are enrolled and charged an additional premium

102. Do HMOs typically provide preventive care?

e. They provide extensive preventive care but charge significant cost-sharing for it
f. They provide only limited preventive care and charge significant cost-sharing for it
g. They provide only limited preventive care but charge little or no cost-sharing for it
h. They provide extensive preventive care and charge little or no cost-sharing for it (Correct)

103. What population is eligible for health coverage from TRICARE?

e. Active members of the military and their spouses and dependents
f. Active members of the military only
g. Active and retired members of the military
h. Active and retired members of the military and their spouses and dependents (Correct)

104. Which physician-only provider organization is the most integrated?

e. The independent practice association (IPA)
f. The consolidated medical group (Correct)
g. The management services organization (MSO)
h. The group practice without walls (GPWW)

105. The primary purpose of states 'financial responsibility standards for HMOs is to protect

e. Insured's from the possibility that the HMO may become insolvent (Correct)
f. Shareholders from mismanagement of their investment
g. The state from nonpayment of taxes and fees
h. Providers from not receiving fair compensation for their services

106. A history of an individual's health and his encounters with the healthcare system that is owned by the individual is

e. The computer-based patient record (CPR)
f. The personal health record (PHR) (Correct)

g. The electronic medical record (EMR)
h. The electronic health record (EHR)

107. Medicare Part D

e. Does not charge a premium but has substantial cost-sharing
f. Does not charge a premium and has only nominal cost-sharing
g. Charges a premium but has only nominal cost-sharing (Correct)
h. Charges a premium and has substantial cost-sharing

108. A health plan sets premium rates for a group based on the expected cost or providing healthcare benefits to the whole community rather than to that group. This is:

e. Community rating (Correct)
f. Manual rating
g. Experience rating
h. Blended rating

109. In the marketing of health plans, who is compensated by the party buying a product, not the health plan selling it?

e. Agents and brokers
f. Employee benefits consultants (Correct)
g. Brokers
h. Brokers and employee benefits consultants

110. What kind of risk does an HMO assume or share?

e. Delivery risks only, not financial risks
f. Both financial and delivery risks (Correct)
g. Financial risks only, not delivery risks
h. Neither financial nor delivery risks

111. NCQA providers accreditation for:

e. Healthcare providers only
f. Health maintenance organization only
g. Many types of health plans (Correct)
h. Preferred provider organizations only

112. Which of these is a provision of the Affordable Care Act 2010 (ACA) (Healthcare reform)?

e. All employers will have to sponsor a health insurance plan
f. Most people will have to have health coverage or pay a tax penalty (Correct)
g. Medicare will be available to anyone 50 or older
h. All health plans will have to be structured like an HMO

113. How is Medicaid funded and administered?

e. The federal government pays all costs and makes all rules, but the states administer the program
f. The federal government pays all costs, makes all rules, and administers the program
g. The federal government contributes some funds, but the states pay most costs, make all rules, and administer the program
h. The federal government pays a majority of costs and sets guidelines, but the states pay some costs, make some rules, and administer the program (Correct)

114. What is the main function that an independent practice association handles for its member physicians?

e. Billing and collecting
f. Contracting with health plans (Correct)
g. Claims processing
h. Medical record keeping

115. Separate healthcare providers are brought under common ownership and control. This describes:

e. Business integration
f. Clinical integration
g. Operational integration
h. Structural Integration (Correct)

116. Under the Affordable Care ACT (ACA) (Healthcare reform), which may a health plan not consider in setting a person's premiums?

e. Age
f. Smoking
g. Locality
h. Health (Health)

117. Most regulation of health plans:

e. Has been at the State level but after the Affordable Care Act (ACA) will be at the Federal level. (Correct)
f. Has been at the Federal level but after the Affordable Care Act (ACA) will be at the state level
g. Has been and continues to be at the federal level
h. Has been and continues to be at the state level

118. What is the main problem a data warehouse is intended to solve?

e. Inaccurate data
f. Large amounts of data
g. Data in multiple databases (Correct)
h. Security and privacy requirements

119. Government regulation has the greatest impact on which aspect of health plan data?

e. Usability
f. Security and privacy
g. Volume
h. Quality (Correct)

120. What category of low-income people are not currently covered by Medicaid but will be covered under healthcare reform?

e. Disabled people
f. Pregnant women
g. Elderly people
h. Childless adults (Correct)

121. By the 1990s HMOs had become accepted by consumers and employers, but many people objected to their:

e. Limited benefit packages
f. High premiums
g. Lack of provider choice (Correct)
h. High coinsurance and deductibles

122. Which of these is an example of adverse selection (Anti-Selection)?

e. An employer is located in a large city, where healthcare costs are considerable higher than the national average
f. A higher percentage of unhealthy employees enroll in an employer's health plan compared to healthy employees (Correct)
g. A very high percentage of the employees who are eligible for an employer's health plan choose to enroll in it
h. An employer is engaged in a hazardous business, and its employees are more likely than average to be injured or become ill

123. Why is it important for a health plan to deal adequately with member complaints?

e. To comply with regulations are accreditation requirements and to maintain member satisfaction and a good public image (Correct)
f. To meet accreditation requirements-there are no regulations, and complaints are not a major element in member satisfaction
g. To comply with regulatory requirements-complaints are not a major element of member satisfaction or public image
h. To maintain member satisfaction and a good public image there are no regulatory or accreditation requirement.

124. A health plan has an obligation to respect the right of its members to make decisions about their own lives. This is the ethical principal of:

e. Autonomy (Correct)
f. Altruism
g. Equity
h. Beneficence

125. Under the Federal Employees Health Benefits (FEHB) program, employees:

e. Choose from a large number of health plans and plan types (Correct)
f. Are all enrolled in the PPO for their state or region
g. Are all enrolled in the same fee-for-service group plan
h. Choose from one HMO, one PPO, and fee-for-service plan in their state or region

126. In which health plan type do members not have to select how to receive services until they use them?

e. Consumer-Directed Health Plan (CDHP)
f. Point-Of-Service (POS) product (Correct)
g. Health Maintenance organization (HMO)
h. Preferred provider organization (PPO)

127. Who regulates HMOs?

e. HMOs are regulated under the federal HMO Act but not state laws
f. Neither the federal government nor the states substantially regulate HMOs
g. HMOs are regulated by the states but not the federal government
h. Both the federal government and the states heavily regulate HMOs (Correct)

128. The most common HMO model today is the

e. IPA model (Correct)
f. Staff model
g. Network model
h. Group model

129. A health plan's utilization review staff wants to know how long a certain member can be expected to remain in the hospital. They are most likely to use:

e. Utilization guidelines
f. Site-appropriateness listings
g. Experience-based criteria
h. Length-of-stay guidelines (Correct)

130. What coverage do Medicare Advantage plan provide?

e. Medicare Part A and Part B coverage, other benefits, and usually drug benefits (Correct)
f. Medicare Part A and Part B coverage only, but without cost-sharing
g. Medicare Part A and Part B coverage only
h. The coverage of one of the standard Medigap Plans

131. Which statement about trends in health plan products is correct?

e. Fewer types of plans are being offered, and the distinctions between them are becoming sharper
f. More types of plans are being offered, and the distinctions between them are becoming blurred (Correct)
g. More types of plans are being offered, and the distinctions between them are becoming sharper
h. Fewer types of plans are being offered, and the distinctions between them are becoming blurred

132. When a health plan compensates a provider by capitation, which generally occurs?

e. The provider submits encounter reports to the plan (Correct)
f. The member submits claims to the plan
g. The member submits encounter reports to the plan
h. The provider submits claims to the plan

133. What portion of health plans contract with pharmacy benefits management (PBM) plans?

e. A large majority (Correct)
f. A small minority
g. Somewhat over half
h. About a third

134. A computer program discovers that, based on repeated early refills, a plan member seems to be taking more of a pain reliever than he should. This is an example of:

e. Formulary management
f. Physician profiling
g. Prior authorization
h. Drug utilization review (Correct)

135. What are ethics?

e. Character traits that dispose a person to act well toward other people
f. Principles are values that guide a person or organization facing questions of right and wrong (Correct)
g. Commonly held customs and beliefs that shape people's expectations of business conduct
h. Written laws enforceable through the courts that govern professional and business conduct

136. Which utilization review data transmittal method is the fastest and least labor-intensive but also the most highly regulated?

e. Telephone
f. Manual
g. Paper
h. Electronic (Correct)

137. Which statement about health plan claims processing is true?

e. A plan must process and investigate claims within timeframes set by regulation (Correct)
f. A plan must pay benefits for a medically necessary service even if authorization was not obtained
g. Electronic claims processing can handle only simple claim decisions
h. A plan may not deny a claim because it was submitted too long after the service was provided

138. How does electronic data interchange (EDI) differ from e-business?

e. EDI is the transfer of batches of data, not back-and-forth exchanges of information about a transaction (Correct)
f. Edi does not require a standardized data format
g. EDI requires considerable human involvement, for instance for data entry
h. EDI is an internal operation, not a transaction between two organizations

139. What portion of participants in Medicaid and the Children's Health Insurance Program (CHIP) are in managed care?

e. A small minority
f. About half
g. A large majority (Correct)
h. About a third

140. Which health plan types generally require a referral from a primary care physician to see a specialist?

e. PPOs
f. HMOs and PPOs
g. Traditional HMOs and POS products (Correct)
h. Traditional HMOs

141. Which type of quality data presents the most problems?

e. Structure measures
f. Process measures
g. Outcomes measures (Correct)
h. Customer satisfaction measures

142. What is the most secure and restrictive level of behavioral healthcare?

e. Acute Care
f. Partial Hospitalization
g. Intensive Outpatient Care (Correct)
h. Post-Acute Care

143. What is the best definition of a health plan?

e. An organization that integrates the delivery and financing of healthcare and seeks to manage healthcare costs, access, and quality (Correct)
f. An organization that provides health coverage to a group of people, most commonly the employees of a business
g. An organization that combines employer funding of a core set of health benefits, employee financial responsibility, and provider accountability
h. An organization that maintains a network of affiliated healthcare providers and pays benefits only for services rendered by those providers

144. Which personal healthcare account offers annual rollover of funds, tax-free investment growth, and full portability?

a. FSA, HRA and HSA
b. Heath Reimbursement Arrangement (HRA)
c. Health Saving Account (HSA) (Correct)
d. Flexible Spending Account (FSA)

145. By the 1990s HMOs had become accepted by consumers and employers, but many people objected to their:

a. High Coinsurance and deductible
b. Limited benefit packages
c. High Premiums (Correct)
d. Lack of provider choice

Q.The term “marketing mix” refers to

a. agents, brokers, and direct marketing.

b. **product, price, promotion, and distribution. (Correct)**

c. research, product price, and distribution.

d. publicity, advertising, and sales.

2. Which of the following statements best describes a health plan’s potential customers?
a. employers, associations, and government programs
b. individuals, including employees and Medicare beneficiaries.
c. Individuals, including employees and Medicaid beneficiaries
**d. employers, associations, employees, Medicare and Medicaid beneficiaries, and other individuals (correct)**

3. Which is a market research technique?
a. Focus groups. (Correct)
b. Direct response marketing.
c. Positioning.
d. Cold calling

4. How is marketing in health plans different from marketing in many other industries?
**a. Markets are generally local. (Correct)**
b. Markets are generally national.
c. Research is not very important.
d. There is little regulation.

5. Which of the following statements best describes how the Affordable Care Act (ACA) has affected product development?
a. The ACA has not affected product development; state laws continue to primarily govern this area.
b. The ACA has affected product development but only by requiring a minimal benefit package.
**c. The ACA has affected product development in relation to benefit packages, cost-sharing, and other matters. (Correct)**
d. The ACA has affected product development but just for the large group market.

6. Which of the following statements best describes why health plans develop multiple product lines?

a. The development of multiple product lines is required by many state laws.
b. The development of multiple product lines is required by the Affordable Care Act (ACA).

c. The development of multiple product lines assists health plans in competing, particularly among large employers, but it makes marketing more complicated. (Correct)
d. The development of multiple product lines assists health plans in competing, particularly among small employers, and it makes marketing simpler.

7. Which statement best describes the difference between advertising and publicity?
a. Advertising focuses on a product, publicity on an organization.
b. Advertising uses the mass media, publicity is personal contact.
c. Advertising is paid for, publicity is not. (Correct)
d. Advertising relies on use of free incentive, publicity on use of paid incentives.

8. The term "promotion mix" is commonly used to refer to
a. advertising, branding, and publicity.
b. advertising, publicity, personal selling, and sales promotion. (Correct)
c. publicity, personal selling, social media, and sales promotion.
d. personal selling and direct marketing.

9. Which distribution channel is typically made up of health plan employees?
a. Internal salesforce. (Correct)
b. Brokers.
c. Employee benefits consultants.
d. Independent agents

10. Who are generally compensated by the buyer of a health plan, not by the health plan?

a. Captive agents.

b. Independent agents

c. Brokers.

d. Employee benefits consultants. (Correct)

11. Who are considered to represent the health plan in the distribution of health insurance products?

I. Captive agents

II. Independent agents

III. Brokers

IV. Employee benefits consultants

a. I only

b. I and II only (Correct)

c. III only

d. III and IV only

12. Which of the following sells the products of only one company?

a. An independent agent.

b. A captive agent. (Correct)

c. A broker.

d. An employee benefits consultant.

13. Who commonly works with individuals rather than large groups?

a. Agents. (Correct)

b. Brokers.

c. Employee benefits consultants.

d. Third-party administrators.

14. Which direct marketing method is most commonly used today in the distribution of health insurance products?

a. Telemarketing.

b. Face-to-face cold calling.

c. Door-to-door selling in pre-selected neighborhoods.

d. Direct mail.(Correct)

15. According to the text, dividing a market into smaller groups of customers is called

a. market segmentation. (Correct)

b. targeting.

c. positioning.

d. branding.

16. Medicare beneficiaries are generally considered part of the

a. small group market.

b. large group market.

c. non-group market.(Correct)

d. individual market.

17. A health plan decides to compete in the small group market instead of the large group market by offering a basic and relatively inexpensive product. This is an example of

a. market segmentation.

b. positioning. (Correct)

c. targeting.

d. direct marketing.

**18. Who of the following would not be considered a member of the regular group market?**

a. Daniel is employed by a large employer offering several health coverage options.

b. Mark is employed by a mid-sized employer who offers just one coverage option that meets the requirements of the Affordable Care Act (ACA)

c. Joanne recently lost her job and her group health plan. (Correct)

d. Susan's small employer sponsors a group health plan but requires her to contribute an amount to premiums that meets the requirements of the Affordable Care Act (ACA).

**19. Who of the following would be considered a member of the Individual Market?**

I. Adam whose small employer does not sponsor a health plan.

II. Blake who choose not to enroll in the health plan offered by his employer.

III. Charlie who is attending a vocational IT school who is without student group coverage.

IV. Linda who is self-employed.

a. I and III only

b. I and IV only.

c. I, II, and III only

d. I, II, III and IV (Correct)

20. The Affordable Care Act (ACA) has affected the marketing of all health plans, but it has had the greatest impact on the

a. individual market . (Correct)

b. large group market inside the ACA Marketplaces.

c. large group market outside the ACA Marketplaces.

d. Medicare market.

**21. Which is not true under the ACA?**

a. Individuals enrolling in a health plan will no longer undergo medical underwriting.

b. The individual market will be eliminated, and everyone will have group coverage. (Correct)

c. Qualified individuals have the ability to purchase coverage through government-sponsored exchanges.

d. Some individuals will qualify for subsidies to help them cover the cost of coverage.

**22. Which is a common distribution method in the senior market?**

I. Direct marketing.

II. Meetings that provide information about Medicare.

III. Door-to-door selling.

IV. Unsolicited telephone calling.

a. I only

b. I and II only (Correct)

c. I, II, and III only

d. I, II, III and IV

23. People eligible for Medicare

a. may not enroll in private-sector health plans.

b. may receive health and/or drug coverage through private-sector Medicare Advantage plans. (Correct)

c. may receive drug (but not health) coverage through public-sector health plans.

d. may enroll in both Medicare Supplement (Medigap) and private-sector Medicare Advantage plans.

24. The group market is made up mostly of

a. employers. (Correct)

b. multi-employer groups.

c. associations.

d. self-employed individuals.

25. Small businesses choosing a health plan usually focus strongly on

a. Quality metrics.

b. price. (Correct)

c. scope of provider networks.

d. service.

26. Which is true of small employers?

a. Full self-funding is common.

b. Customization of a product is common.

c. Only one health plan is usually offered. (Correct)

d. Several options offered by different carriers are common.

27. Which is true of large employers?

a. They often use employee benefits consultants. (Correct)

b. They tend to change health plans more frequently than small plans.

c. They tend to choose very basic and inexpensive products.

d. They avoid self-funding due to its financial risks.

28. Which statements are =h care consumerism?

I. Consumerism began as workers began to take increased notice of their out-of-pocket costs in the early 2000s.

II. The implementation of the Affordable Care Act (ACA) temporarily set-back the rise of consumerism.

III. Health plans should consider health care decision support tools as they seek to build connections with individual consumers.

IV. Business-to-business (B2B) is the forward looking business model for health care marketing professionals to incorporate into their planning.

a. I only

b. I and II only

c. I and III only (Correct)

d. II, III and IV only