Link : [Sign in (ahipinsuranceeducation.org)](https://topclass.ahipinsuranceeducation.org/topclass/login.do?redirectTo=%2Fexpand.do%3Ftemplate%3DUserWelcome%26) AHM250

Chapter 1:

1. Ahealth plan can best be denied as an origination that?
2. Integrates the delivery and financing of health care seeks to manage health care costs, access,and quality.

2.The earliest versions of health plans appeared in the ?

EARLY 1900s.

3.which is a very early type of health plan?

a.Perpaid group practice.

4.which was a provision of the HMO act 1973?

1.Fedreally qualified HMO’s has access to federal funding.

5. in the 1990’s,HMOs?

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

6.to receive benefits from her health plan, Janine must first go to her primary care physician and remain within the plan’s network for other health services, Janine is most likely to be covered by ?

A, a traditional health maintenance originations.

7.Jacob must pay $5000 in health care expenses each year before he receives benefits from his health plan, but he can use money from a tax-adv savings account. Jacob has?

a. A consumer – directed health plan.(CDHP)

8.what is the involvement of the state and federal government in health plans?

A. They legislate and regulate in this area and purchase health coverage.

9. under the fee-for service compensation method, health plan provider have a financial incentive to provide?

a. More services.

10. which of these do health plans generally seek to replace?

a. Fee-for service compensation.

11. A consumer – directed health plan seeks to lower premiums through ?

a. high -deductible.

12.in relation to health plans, over the years the definition of quality?

a. has become a broader.

13.which is an organization accrediting health plan?

a.NCQA.

Chapter 2:

1.Why is it useful studying health plans to learn about indemnity insurance?

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

2.Andy and his family are covered by his employers group health insurance policy who is the policyholder of the policy?

a. The employer.

3. who pays the premium of an employer -sponsored group policy?

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

4.what happens in adverse selection?

a. People who need health care enroll in greater numbers then average people.

5.Which employee group is most likely to have a higher-than- average loss rate?

a. A group made up mostly of women.

6.which employee group presents a high risk of adverse selection?

a. in company A, small percentage of employees enroll.

7. In traditional indemnity health insurance, insureds?

a. can go to any provider they choose.

8. in traditional indemnity health insurance, how are providers compensated?

a. Fee-for service.

9. Owen pays 20 % of the cost of health care services covered by his policy. This describe?

a.Coinsurance.

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

a.copayment.

11. Coordination of benefits is designed to ?

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

12. Increasing cost-sharing

a. all the above

13. According to the text, cost Containment helps hold down health insurance premiums primarily by ?

a. Reducing unnecessary health care services.

14. Coverage of preventive care is?

a.Cost effective in the long-run

Chapter 3:

1.in this course, ‘health Plan’ is defined as any entity that?

A.users certain concepts or techniques to manage the cost,access, and quality of healthcare.

2.what is the trend in health plan products?

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

3.Memebrs do not have to select how to receive services until they use them, this is a describe?

a.POS product.

4.A health savings account is combined with a high-deductible health plan. This describes a?

A.CDHP.

5.Which of these health plan types users managed care techniques and concepts the most?

a.HMO.

6. What goals do all health plans share?

a. Accessibility, cost, effectiveness and quality.

7. Organizations that finance or reimburse the cost of healthcare services are known as?

a. Payors.

8. How are the roles of the key players in health plans evolving?

a.Roles are overfapping and becoming less distinct.

9. Compared to indemnity insurance, health plan benefit packages are typically?

a. more effectiveness and encourage the use of preventive care.

10. mandated benefits are imposed?

A. both by states and the federal government and apply to both indemnity and managed care plans.

11. Carla pays a flat $ 20 fee to her doctor for an office visit regardless of the cost of the services she receives. This is ?

a. a copayment.

12. Jacob pays 20 % of the cost of a hospital stay, this is ?

a. Coinsurance.

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

A. deductibles.

14. in creating a provider network, health plans generally seek to ensure member access by?

a. Considering numbers, type,and location of providers.

15. Primary care physicians are typically involved in?

a. prevention, treatment of routine conditions and care coordination.

16. if a health plan has a network,members?

a. Can elect to go in and or out of network, depending on the plan design

17. compared to indemnity insurance, health plans generally require out of pocket expense by members?

a. Less.

18.managing the use of healthcare services so that patients receive necessary appropriate and high quality care is a cost effective way is?

A. Utilization management.

19. which of the following focuses on individuals with special needs or certain medical conditions? Ans: B

Graphical user interface

Description automatically generated

20. According to the text, which is quality management technique?

A. Credentialing.

Chapter 4:

1.In traditional indemnity health insurance, the main provider compensation method is?

a.Fee for service.

2.Under fee for service providers have incentives to?

a.Provide unnecessary care.

3.Under fee for service, who bears financial risks?

a. the insurer.

4.under capitation, provider compensation is based on?

a.the number of members care for.

5.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 the third month the delivers well over the projected amount, Teresa is paid?

a. The same amount each month.

6.Capitated physicians have incentives to ?

a. Not provide unnecessary services and promote prevention and wellness.

7.Which statement about capitation is true?

a.it may be used fir both primary and secondary care.

8.Under a fee schedule, a provider receives?

A, No more then a listed amount.

9.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. ?

A.she must accept the paln’s amount as payment as full.

10. 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 ?

a.RVS.

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

a. Diagnosis related groups(DRGs).

12.a hospital is paid a set of amount for each day a plan member is in the hospital. This is ?

a. Per diem payments.

13.A plan holds back a percentage of PCP’s monthly capitation pay on 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 then projected referrals. This is example of?

A. Withhold.

14.a plan plays money into a pool to cover hospitalization. At end of the year, if there is money left over in the pool. Some given to PCP’s, but of there is not enough money. pCPS must cover some of the cost. This is example of ?

a. A risk pool.

15.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 ?

a. An episode based payment.

16.If a doctor meets certain performance targets related to quality of care and patient satisfaction. She receives bonus . this is example of ?

a.pay of performance.

17. Which compensation arrangements typically involves the most risk of providers?

a. full risk global payments.

18.which compensation arrangements involves the least risk for a hospital?

a. Fee for service.

19.which payments model can best be described as paying providers for a portion of any savings achieved in relation to an anticipated cost level for the care of a specified group of patients?

a. Shared savings.

20. Which payment model provides a single payment to a providers for all the healthcare services associated with a defined episode of care?

a.Bundled payment.

21.Which of the following statements are correct about medicare and provider compensation under medicare?

a. C.

Graphical user interface, application

Description automatically generated

Chapter 5:

1.A HMO?

a.Assumes or shares both financial and delivery risks.

2.the HMO act of 1973?

a. Was instrumental in the initial growth of HMOs.

3.which of the following statements are correct about the HMO’s Act of 1973 and its amendments?

a. 1,2&4.

Graphical user interface, text, application

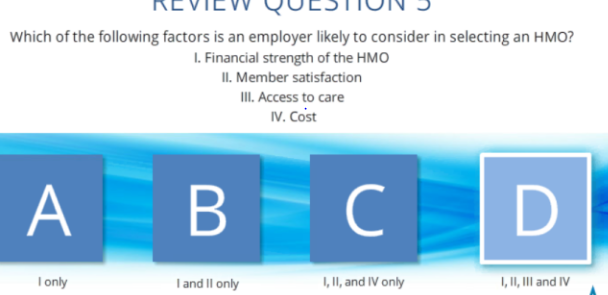
Description automatically generated

4. Which is not a key charactertic of HMO?

A.Loose relationships with providers.

5. Which of the following factors is an employer likely to consider is selecting an HMO?

a.1,2,3&4.



6. A person enrolls in an HMO?

a.Most commonly through an employer, but sometimes individually.

7.HMO’s were traditionally marketed to ?

a. Large groups, but they now serve large and small groups and individual.

8.HMO’s typically provide.

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

9. Compared to other health plan types, in HMO’s member cost sharing tends to be ?

a. Lower.

10. HMOs typically provide?

a. extensive preventive care and charge little or no cost sharing it to.

11. An HMO’s providers medical care to its members by ?

a. Contracting with and/or employing providers.

12.The delivery of healthcare can be best described as primarily?

a. Local.

13.in Builiding and maintaining an HMO network, the location of a healthcare provider is primarily a factor in?

A. access.

14. To see a specialist, must an HMO member obtain a referral from her PCP’s?

a.Usually.

15. Which statement best describes whether or not HMO’s cover out of network services?

a. Traditionally they did not but some HMO’s now do at a higher cost.

16. Which statement best describes how HMO’s are usually paid for providing healthcare?

a. HMO’s are usually paid by means of a fixed monthly premium.

17. Which are most common in HMO’S?

a. Copayments.

18. which is common HMO compensation arrangements for physicians?

a. 2,3&4.

Graphical user interface, application

Description automatically generated

19. 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 best described.

a. Stop loss provision.

20. which utilization management technique is used primarily for physicians?

a.Risk pools.

21. in the area of quality management, HMO’s are subject to?

a. Strict state and federal regulation.

Chapter 6 :

1.Which statement best describes an open -panel HMO?

A. Any physicians who meets the HMO’s standards is eligible to join its network but the HMO is not obligated to contract with anyone.

2.Which is true about a closed-panel HMO?

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

3. In an open access HMO, members typically?

a.receive lower benefits for non -network care.

4.which is true about closed-access HMOs?

a. In the past most HMO’s had closed access, but this is no longer true.

5. An HMO pays doctor for his services based on a fee schedule. This is a example?

a. Discounted fee for service.

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

a. Capitation.

7. in which compensation method do physicians assume risk?

a. Capitation.

8. which statement best describes a mixed model HMO?

a. A mixed model HMO combines features of different HMO models.

9. The current trend is toward?

a. Mixed models HMO’s.

10. In an IPA model HMO, physicians are usually?

a. Contracted with the IPA, which contracts with the HMO’s.

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

a.IPA model.

12.How are IPA Physicians most commonly compensated?

A. capitation for PCP’s and discounted fee for service or RBRVS for specialist.

13. Which of the following statements best describes a disadvantage of the IPA model HMO?

A. The HMO’s has limited control of care management and quality.

14. In a Staff model HMO, physicians are normally?

a. employees of the HMO.

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

A. Staff model.

16. How do staff model HMO’s normally compensate physicians?

a. Salary.

17.which is not an advantage of a staff model of HMO?

a. Low facility costs.

18. The HMO contracts with a single group practice. This describes?

a. A group model HMO.

19. In a group of model HMO, physicians are?

a. Employees (or employee/owners) of a group practice.

20. What is the most common compensation system in a group model HMO?

A. The HMO compensates the group practice by capitation, and the group practice pays physicians salaries and incentive payment.

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

a. network model HMO.

22.What statement best describes an accountable care organization?

a. A group of healthcare providers who give coordinated care and chronic disease management and improve the quality of care patients received which in turn results in cost savings.

23. Which of the following do health plans hope accomplish by encouraging the formation of ACO’s and participating in them?

a. 1,2,&4.

Graphical user interface, application

Description automatically generated

24. The ACO model offers private health plans opportunities to leverage their expertise to both improve the quality of care and bend the cost curve. Which of the following statements describes these opportunities.?

a. 1,2,3,4.

Graphical user interface, application

Description automatically generated

25.Which of the following statements are correct about the medicare shared savings program MSSP?

a. 1,2&4.

Graphical user interface, application

Description automatically generated

Chapter 7:

1.PPOs, EPOs, and POS products ?

a. Are in the middle of the managed care Continuum, between tightly managed and unmanaged.

2.PPO members receive?

a.Lower benefits for non network care.

3.Which statements are true about PPOs?

A. 1&4

1.providers must participate in utilization review and quality management.

4. members generally do not require a referral from their PCP to see a specialist.

Q4. What portion of U.S. employees are covered by PPOs?

A.majority, roughly 48 %.

5.a majority of PPOs Owned by ?

a.Insurance companies.

6. Which of the following statements are true about PPOs?

a. 1&4.

1. PPOs usually cover some specialty services. & 4. Affiliation with a PPO generally brings a high volume of patients.

7.PPOs commonly compensate physicians by which of the following means?

a.discounted fees.

8.Providers contracting with PPOs?

a.may or may not assume risk.

9.EPOs are generally like PPOs except that?

a.there is no coverage of out of network care.

10.A POS product offers?

a.reduced coverage of nonnetwork care.

11. which statements are correct in regard to how POS and HMO products are similar?

a.1,3&4

Graphical user interface, application

Description automatically generated

12. How many employees are covered by POS products?

a.a significant number approximately 10 %.

13.which of the following statements best describes an exclusive provider organization?

a.An EPO is structured and operates like a PPO but out of network care is generally not covered.

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

a. Managed indemnity plans.

Chapter 8:

1.Historically, managed care plans?

a.Focused on standard medical care (physicians and hospital services).

2.Which of the following is generally considered a specialty healthcare services?

a.1,3&4 – Chiropractic care, home healthcare, dental care.

3.A health plan transfers to another organization some (But not all) of the activities involved in delivering and managing behavioral healthcare. This is described as a ?

a. partial carve out arrangement.

4.in a mature health plan market, compensation for a comprehensive carve out is typically by?

a. Capitation.

5.Which of the following activities may be transferred in a comprehensive carve-out arrangement?

a.network management, quality management, utilization review, claims administration. (1,2,3,4)

6. Managed dental care accounts for what portion of all dental coverage?

a.A majority.

7.According to the text, managed dental care is

A, growing,

8.Plan members must, with a few exceptions, see a network dentist. The best describes?

a.An HMO.

9.HMOs usually compensate dentists by means of ?

a. Capitation.

10.Which is typical of a dental HMO?

a.Copayments.

11.PPOs commonly compensate dentists by means of ?

a.discounted fee for services.

12.which are typical of a dental PPO?

a. Annual deductible coinsurance and annual maximum benefits.

13.Andre does not have to choose a dentist or network during an annual open enrollment – he can decide when he needs care. This is best describes?

a.A POS plan.

True or false

14.An HMO dental plan typically has the smallest network?

a.True.

15.An HMO typically costs less than a PPO dental plan?

a.True.

16.Vision plans typically cover which of the following?

a.eye examinations once every 12 months & eyeglass lenses.

17.which of the following statements is correct about vision care plan?

a.1,3&4.

Graphical user interface, application

Description automatically generated

18.Some experts estimate that what percentage of Americans experience some sort of behavioral health disorders?

a.18%.

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

a. Partial hospitalization.

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

a. Intensive outpatient care.

21. Which is least common in health plans covering large numbers of employees today?

a. members must get a referral from their primary care provider to access behavioral healthcare.

22.which sentence best summarizes the requirements of federal mental health parity legislation under the provisions of the mental health parity At of 1996 (MHPA) and the mental health parity and addiction equity act of 2008 (MHPAEA)?

A.MHPA& MHPAEA required large group plans that provided behavioral healthcare coverage to provide coverage equivalent to medical coverage.

23.Which statement best describes the provisions of the affordable care act (ACA) and mental health parity?

a. The ACA mandates coverage at parity for mental health and substance use disorders as one of the ten essential health benefits.

24.which statement best describes prescription drugs and healthcare spending in the United States?

a. Prescription drugs accounts for a substantial portion of healthcare spending and have been rising at a faster rate than overall medical costs.

25. According to the text, how many health plans contract with pharmacy benefits managers?

a. A majority of health plans.

26.which of the following statements best describes pharmacy benefit management (PBM) plans and quality of care?

a. PBMs are concerned with safe and effective drug use along with costs.

27.A PBM notifies a doctor that he is prescribing a certain drug much more frequently than his peers and educate him on alternatives to it. This is an example of?

a. Physician profiling.

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

a. drug utilization review.

29. Patrice’s plan covers any drug her doctor prescribes, but she pays a higher copayment for drugs not on the plan’s formulary, this is ?

a. an open formulary.

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

a. Prior authorization.

31. Which of the following statements is correct about rebates and pharmacy benefit managers(PBM)?

a. Most PBMs enter into discount rebate agreements with pharmaceutical manufactures.

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

a. Capitation.

Chapter 9 :

1.A consumer directed health plan consists of ?

a. a high -deductible health plan and a tax advantaged account.

2.Which statements is true about consumer directed health plans?

a. Employers can reduce the shifting of costs to employees by contributing to employee accounts.

3.Which statement is true about flexible spending accounts (FSAs)?

a.both employer and employee contributions are not taxable income for the employee.

4.Which statement is correct about annual rollover of FSA balances?

a. An employers may offer a grace period or limited rollover, but not both.

5. Which of these questions is not up to the employer sponsoring a health reimbursement arrangement?

a.Will employees make contributions.

6. Which employer can sponsor a QSEHRA?

A. Employer B has 40 employees and does not offer a group health insurance plan.

7.Which of the following is allowed in a QSEHRA?

A. Older employees paying higher health insurance premiums receive more than younger employees.

Chapter 10:

1.which statement is true about health savings accounts (HSAs)?

a.Money can be withdrawn for non-health care expenses, but it is taxable.

2. who is eligible to contribute to a health savings account?

a.Isabel has a qualified high deductible health plan and also dental and vision care plans.

3. which premiums can be paid tax -free with HSA funds?

a. Medicare advantages.

4.Can a person use Has funds to pay non-health-related expenses or premiums?

A. Yes,she may but she must pay income tax and (if she under 65) an excise tax.

5. Which tax -advantages account is/are never portable?

a.FSA only.

6.Which tax-advantages accounts do/does not allow employee contributions?

a. HRA only.

7. Which tax-advantages accounts can be set up by an individual, without employer involvement?

a. HAS only.

Chapter 11 &12 :

1.Two independent organizations are joined into one entity under common ownership and control. This is best described as an example of ?

A.Structural integration

2.An example of partial structural Integration is?

a.A joint venture.

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

a.Partial operational Integration.

4.Which physician – hospital model is the least integrated?

a.The physician- hospital Organization (PHO)

5. For a physician, what is a disadvantages of provider integration?

a.A loss of a professional autonomy.

6.Which physician – only model is the least integrated?

a.the independent practice association (IPA).

7.What does an IPA generally do for its member physicians?

a. Negotiates contracts with health plans

8.What is the structure of most IPAs?

a. Physicians contract with the IPA, and the IPAs contract with health plans.

9.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?

a.Stoploss insurance.

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

a. A GPWW handles business operations for member but an IPA doesnot.

11.The main purpose of a management services organization (MSO) is to ?

a. Provide management and administrative services to physician.

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

A. It purchases physician’s entire practices.

13.what is the primary purpose of a physician – hospital organization (PHO)?

a. Contracting with health plans and marketing.

14. when a physician – hospital organization (PHO) is formed, physician practices?

a. Continue to be owned and operated by the physician.

15. A hospital allows any of its admitting physicians to join its PHO. This is example of?

a. An open PHO.

16. An integrated delivery system (IDS) may or may not be highly integrated?

a. Structurally.

17.what is the purpose of a medical foundation?

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

18. Compensation models for accountable care organizations (ACOs) typically?

a. Involve shared savings and assumption of risk – upside,downside, or both.

19. 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 of ?

a. a patient – centered, medical home (PCMH)

20.The Affordable care act?

a. Promoted accountable care organizations (ACOs).

21. Which of the following statement are correct about the patient -centered medical home (PCMH)

Model?

a.2,3,&4.

Graphical user interface, application

Description automatically generated

Chapter 13:

1.”Market maturity “ refers to the ?

a. level of health plan activity in a market.

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

a. Provider number, Types, locations utilization, costs referral patterns and relationships.

3. which are generally most receptive to adopting and offering a choice of health plans?

a.Large employers with 1000 or more employees.

4.where is the most difficult to develop a comprehensive network?

a.Rural areas.

5.Health plans that offer more than one type of plan typically have?

a. Either separate networks or nested networks.

6.Which statement best describes network adequacy?

a. whether the number types, and locations of providers are adequate to meet member needs.

7.which type of law might require a health plan to include a particular doctor In its network?

a.Any willing providers.

8. Open panel or closed panel refers to whether a health plans?

a.Providers can see non- plan members.

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

a. Specialist.

10.which plan types need fewer providers per 1000 members?

a. Highly managed and large plans with geographically close membership.

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

a. Create a large very inducive primary care panel.

12. Narrow networks plan?

a. All of the above.

13.Which statement best describes the purpose of provider credentialing?

a. The purpose of credentialing is to select the most qualified providers, meet accreditation standards and minimize legal risks.

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

a.They generally do, before offering them a contract.

15.The information that a health plan can obtain from the national practitioner data bank (NPDB) and the healthcare integrity and protection bank (HIPDP) about a provider primarily relates to ?

a. malpractice licensure, and adverse actions.

16. Provider agrees to accept a health plan’s compensation as payment in full and not to also bill plan members. What contract provision does this describe?

a.no balance billing provision.

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

a. Cure provision.

18.Can a health plan terminate its contract with a provider when there has been no problem with provider’s performance?

a.Yes if the state permits termination without cause and this is allowed by the contract.

19. A provider already in a health plan’s network is evaluated by another provider in the same specialty. This describes?

a.peer review.

Chapter 14:

1.Medical management can be divided into three broad categories, which are?

a. Utilization management, clinical practice management and quality management.

2.Managing the use of medical services so that plan members receive necessary and appropriate care in a cost – effective manner is ?

a. Utilization management

3. A health plan conducts a health risk assessment (HRA) to determine a person’s likelihood of developing certain illnesses. The primary purpose is to ?

a. Higher

4.A health plan program seeks to determine if a member has a health condition even if he has no symptoms. This can best be described as an?

a. Screening program.

5. A program supports health plan members who want to stop smoking, lose weigh, eat better, and exercise more, this can best be described as a?

a.wellness program.

6. A program teaches health plan members how to treat minor illnesses and distinguish them from serious conditions, this can best be described as a?

a.Self care program

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

a. Web-based decision support tools.

8. Telephone triage programs are typically staffed by ?

a. Nurses directed by physicians and supported by nonprofessional personnel.

9.Clark’s doctor give him information about the treatment options available to him, and clark makes the final decision. This is an example of?

a. Shared decision making.

10. 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 ?

a.Concurrent utilization review.

11.Wilson is assigned a healthcare professional who assesses his needs, designs a plan of care, and coordinates and monitors the services he receives, this best describes?

a.Case management.

12. Case management is typically used for ?

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

13.which of the following may serve as case managers?

a.1,2,3,4. (Physicians, nurses,social workers, community health workers.

14.which type of UM program focuses on populations instead of individuals?

a. Disease management.

15. Disease management focuses on?

a.Chronic diseases.

16.which statement best describes disease management programs?

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

17. A doctor treating a patient with diabetes refers to guidelines for this condition is making decisions about the most appropriate course of action. This statement?

a. Clinical practice guidelines.

18.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

a. engaging in evidence -bases healthcare.

19.Laurie has diabetes, she wants to stay well and is willing to change her lifestyle, but sometimes she doesn’t follow instructions about diet because she doesn’t understand. This best describes the problem of ?

a. A lack of health literacy.

Chapter 28:

1.Ethics can best be defined as?

A. principles and values that guide decisions of right and wrong.

2. 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 principle of ?

a.Autonomy.

3. Character traits that dispose people of act well toward other are?

a.Virtues.

4.Health plans have an ethical obligation to promote the good of ?

a.both individual members and the membership as a whole.

5.A health plan ethics task force providers?

a.a forum for discussion of ethical issues and offers consultation when physicians and families face ethical decisions.

6.A health plan’s code of conduct requires recognizing and addressing conflicts of doing interest. In doing so it address?

a. Integrity.

7.Which of these actions by a health plan is most likely ethical?

a.Allowing patient preference to override recommendations generated by predictive analytics in some cases.

8.Jill,devin, and mark are insurance agents, Jill sells clients policies that are no better (but no worse) that the ones they already have.Devin coaches clients to give answers on insurance applications that will give them the lowest premium, even if they are not strictly true. Mark signs the insurance application for a client who is unable to do so. Who is behaving unethically?

a.All three.

Chapter 27:

1.Which of the following statements best describes state variation in Medicaid coverage of benefits?

A.Benefits vary somewhat from state to state, within federal Guidelines.

2.Currently, Medicaid is available in all states and the districts of Columbia?

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

3.ACA as written sought to make Medicaid available in all states?

a.All people with incomes below 133 (138 as adjusted) precent of the federal poverty level (FPL).

4.Which of the following is a mandated benefit under Medicaid ?

a. Inpatient hospital services.

5. If a healthcare service is fully covered by both medicare and Medicaid, who pays?

a.Medicare.

6.the primary purpose of CHIP is to provide health coverage to children who?

a.Are from families with incomes too high to quality for Medicaid but too poor to afford health coverage.

7. Alex, Logan, Kaitlyn, and Roger are all 14 years old. Who is most likely be eligible for CHIP?

a. Alex’s family has income that is about twice the FPL.

8. Which of the following would be considered acceptable coverage packages under CHIP ?

a. 1,2,4

Graphical user interface, application

Description automatically generated

9.Under CHIP?

A.copayments and premiums can be charged within limits.

10.Which of the following statements best describes the children’s health insurance program (CHIP)?

a.CHIP is not an entitlement program and is heavily dependent on federal reauthorization of funding.

11.The Portion of Medicaid recipients enrolled in managed care is ?

a.growing and is now a sizable majority.

12.Which of the following Medicaid care arrangements provides comprehensive coverage ?

a. Managed care organization (MCO).

13.Which of the following statements about Medicaid managed care is correct?

a.Both an MCO and a prepaid health plan are paid by capitation and assume financial risk.

14.The central focus of this innovative health model is on coordinating services for those with multiple chronic conditions. This describes the?

a. Medical health home. (HH)

15. A group of providers agrees to share savings and (sometimes) losses with a payor, based on a benchmark. This describes the?

a. Accountable care Organizations (ACO).

16.TRICARE serves ?

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

17.TRICARE coverage takes the form of?

a.fee-for-service insurance or HMO coverage.

18.Who pays a premium for TRICARE?

a. Most participants except for active duty service members.

19. TRICARE Young adult is a type of plan available to?

a.single young adults up to age 26 whose coverage under “regular” TRICARE ended.

Chapter 26:

1.Original medicare consist of ?

a. Part A and Part B (Hospital and medical coverage).

2.The main purpose of medicare Part C (medicare advantage) is ?

a.To provide medicare coverage through private-sector health plans.

3. Medicare part D prescription drug coverage is?

a.made available to medicare beneficiaries at an extra cost.

4.Medicare Part A beneficiaries who go into the hospital?

a.must pay a large deductible before medicare pays any benefits.

5.Medicare part A skilled nursing facility and home health care benefits are paid?

a.for a limited time to those recovering from an illness or injury.

6.medicare Part A is available to persons 65 and older?

a.but those who did not pay into the medicare system pay a premium.

7.For a disabled person to qualify for medicare, her disability?

a.must be total and long term.

8.Medicare part A is funded primarily by?

a.medicare payroll taxes.

9.Does medicare part B cover services provided by dentists, podiatrists, optometrists, and chiropractors?

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

10.Medicare part B charges?

a. An annual deductible and coinsurance of 20 percent for most items.

11.For medicare Part B,?

a.most individual pay a monthly premium.

12. For medicare Part B,?

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

13.which of the following statements correctly describes enrollment in Medicare Part A?

a.Those collecting social security benefits are automatically enrolled in medicare when they become eligible.

14.Tim decides not to enroll in medicare part B when he first becomes eligible,even through he has no employer – sponsored health coverage, Can he enroll later?

a.Yes, he can, but he may have to pay a premium penalty equal to 10 % for each 12-month period he waits to enroll.

15.Which of the following statements best describes Medicare advantages (MA)?

a. MA is an alternative to original medicare.

16. Medicare Advantages (MA) plans typically provide?

a. Part A and Part B coverage and usually other benefits.

17.which statement is correct about MA plans?

a. Premiums cost -sharing payments differ from plan to plan.

18.Medicare Part D prescription drug coverage is provided?

a.by private -sector prescription drug plans(PDPs) and MA plans.

19.Medicare Part D prescription drug coverage is offered by ?

a.Most but not all MA plans usually for an additional cost.

20. Medicare Part D prescription drug plans(PDPs)?

a.Must all provide a minimal level of benefits.

21. which statement is correct about Part D prescription drug plans(PDPs)?

A. PDPs may have different deductibles (or no deductible), and coinsurance and copayment amounts vary.

22.In a typical Medicare Part D prescription drug plans (PDP), after the PDP and the beneficiary have together paid a certain total amount for drugs, the beneficiary pays?

a.all costs until catastrophic coverage is triggered.

23.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?

a. Yes, he can, but she will pay a higher premium due to late enrollment penalty.

24.Which of the following statements best describes the recent trend in Medicare Advantages (MA) enrollment?

a. It has been steadily rising in recent years.

25.Managed care was introduced into Medicare by?

a. TEFRA in 1982.

26.What is the main aspect of Medicare managed care that the MMA of 2003 changed?

a. Types of plans available.

27. As enacted, what was the main impact of the Affordable Care Act (ACA) on Medicare Advantages?

A. Reduced funding.

28.Which of the following statements are correct about Medicare supplement (Medigap) policies?

a. 1,4 only.

Graphical user interface, application

Description automatically generated

29.Which of the following statements about changes to Medicare supplement (Medigap) coverage are correct?

a.2,3,4 only.

Graphical user interface, application

Description automatically generated

Chapter 25:

1.Which of the following statements about the impact of the Affordable Care Act (ACA) on the regulation of health plans is correct?

a.The ACA allows for regulatory flexibility which is likely to result in additional variation in state laws.

2.At which level of government is there the most health plan regulation?

a. At the state level.

3.State financial standards for HMOs are intended primarily to?

a. Protect consumers from the risk of plan insolvency.

4. If a health plans risks becoming insolvent, what can state insurance commissioner do?

a. Intervene in the plans operations, take over its management, or liquidate it.

5.The primary goal of receivership of a health plan is to ?

a. Return the plan to normal operation.

6. Which statements best describes the scope of state regulation of health insurance regulation?

a.States regulate entities accepting financial risk other entities performing services for health plans.

7.Which plan type is subject to the least state’s regularly authority?

a.Employer self- funded plans.

8. Have states enacted laws to regulate PPOs?

a. Most have

9.Which statements best describes states’ regulation of entities covering only limited benefits?

a. States generally require these organizations to obtain a certificate of authority, regulate their solvency and provide for further oversight of their activities.

10. Which statements best describes states’ regulation of utilization review organizations?

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

11. Which statement best describes states’ regulation of third -party administrators (TPAs)?

a. Most states have various requirements including a certificate of authority.

12. Which is required by NAIC’s health care professional Credentialing verification Model Act?

a. 2,3,4.

Graphical user interface, application

Description automatically generated

13. True-False : the same consumer protection laws apply regardless of whether an individual has employer – based insurance or purchases it individually?

A. False.

14. True-False : state law focuses solely on consumer protection.

A. False.

15.Which statements is true about state regulation of the privacy of health information?

a. Health plans should be aware that state law may be more restrictive than federal law with regard to the allowable uses and disclosures of health information.

Chapter 24:

1.with regard to health coverage , the main concerns addressed by the affordable care act are?

a. access, affordability, and comprehensiveness.

2. Under the ACA’s guaranteed issue rule, when an individual with a serious health problem applies for health coverage, a health plan?

a. Cannot deny coverage, charge a higher premium, or exclude coverage for the preexisting condition.

3. which statement is correct about ACA rules?

a. As of 2019, consumers will no longer have to pay a tax penalty if they have no health coverage.

4.the ACA Medicaid expansion extends eligibility primarily to?

a. More law income nonelderly adults.

5. Trey is a student. Jack is financially dependent on his parents but does not live with them. Amber is married. Paul could enroll in a health plan offered by his employer. They are all 25 years old. Their parents all have health plans that offer dependent coverage for children. Who has the right to be covered under their parent’s plan?

a.All of them.

6. Which essential health benefits (EHBs) category is required only for children, not adults?

a. Vision and dental care.

7.which statement is true about the essential health benefits (EHBs) is required for some health plans by the ACA?

A. Annual or lifetime limits are generally prohibited for EHBs but still allowed for non-EHB benefits.

8. which statement is true about the levels of coverage offered by plans under the ACA?

A. Of the metal plans, bronze plans trend to charge the lowest premium.

9. which statement is true about ACA rules for individual premiums?

a. Individuals cannot be charged more because they have a medical condition.

10.who is likely eligible for a premium tax credit under the ACA?

a. Sophia’s income is about 300 percent of the federal poverty level, and she enrolled in a gold plan through a Marketplace.

11. who is likely eligible for cost-sharing reductions under the ACA?

a. Quinn’s income is about 200 percent of the federal poverty level, and he enrolled in a silver plan through a marketplace.

12. Living well health is a small group health plan. What percentage of the money it receives in premiums must it spend on members health care and quality improvement?

a.80%.

Chapter 23:

1.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 ?

a. Price-fixing.

2. 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. A tying arrangement.

3. Which is an important provision of the financial services modernization Act?

a. The protection of personal financial information.

4. ERISA Applies to ?

a. employer – and sponsored retirement plans.

5. Under ERISA, what are the roles of the federal and state governments is regulating employer – sponsored health plans?

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

6. Under ERISA, an individual challenging a coverage decision by an employer - sponsored health plan?

a. Must sue in federal court and may not receive punitive damages.

7. If an employee is laid off, under COBRA she has the right to continue her employer- sponsored health coverage?

a. For up to 18 month.

8. Bill is covered under his wife Lorie’s employer - sponsored health plan. What rights does bill have under COBRA to continue this coverage?

a. He has rights of Lorie’s employment is terminated, she dies, or they are divorced.

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

a. Noah pays the full cost of coverage, and the employer may charge him up to 12 % for administrative costs.

10. which of the following statements regrading the health insurance portability and accountability act (HIPAA) are correct?

a.1,2,3,4.

Graphical user interface, application

Description automatically generated

11. Which of the following statements is correct under the provisions of the health insurance portability and accountability act (HIPAA)?

a. Health providers must generally obtain an individual’s written consent to use protected health information.

12.HITECH extends the HIPAA privacy and security rules business associates?

a.True.

13.Which of the following statements is correct about the 21st century cures act ?

A. 2 &3.

Graphical user interface, application

Description automatically generated

**Chapter -15**

1. Utilization Review?
2. May be conducted before, during or after treatment.
3. Which of the following is Primary focus of Utilization review ?
4. Whether a health care service is medically necessary and appropriate.
5. Which of the following statement best describes the purpose of Utilization review?
6. Ensure correct payment of benefits, promote quality, cost effective and safe care and collect data for utilization management and other purposes.
7. UR staff decide what treatments?
8. A health plan will pay for
9. UR programs use clinical practice guidelines to?
10. Reduce unnecessary and ineffective practice variation.
11. If both prospective and retrospective review are possible which is generally preferable?
12. Prospective review

1. Precertification (Prior authorization) is most commonly used for?
2. Hospital admissions.
3. The average number of days a patient with certain characteristics stays in a hostel that best describes?
4. Length of stay guidelines.
5. When are experience based criteria usually used?
6. When research-based utilization guidelines are not available

10) Testing needed for an inpatient treatment should be performed?

a) Before admission to the hospital

1. For which is concurrent review is commonly used?
2. A long hospital stay and A course of chemotherapy
3. Prior authorization is a feature of?
4. Prospective review and sometimes concurrent review.
5. Retrospective review most commonly and primarily?
6. Analyzes data to improve utilization

14)Which form of UR is most likely to discover billing errors and fraud?

a) Retrospective review

15) In order to receive a larger payment a doctor improperly and deliberately bills two procedures separately instead of together. This best describes as?

a) Unbundling

16) Subjecting all healthcare services to UR is?

a) Neither possible nor desirable

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

a) Non primary care

18) Which service is least likely to require authorization?

a) A frequently performed service

19) Is emergency department care subject to utilization review?

a) Some plans require retrospective review and authorization

20) Which of the following statements are correct about visits to urgent care centers?

i) An individual with a injury that is not serious to health such as sprain may best treated in an urgent care center

ii) Almost all urgent care centers are physically located onsite within hospitals.

iii) The cost of care in an urgent care centre is generally lower than a hospital emergency department.

iv) Many plans cover the cost of urgent care centre visits.

1. I, iii and iv

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

a) Observation care unit

22) Jack had surgery he does not full hospital care anymore, but he does need 24 hours nursing care under the supervision of a doctor. What it probably the best care setting for him?

a) A sub acute care facility or hospital step down unit

23) Health plan generally pay home health care for?

a) Those recovering from an acute injury or illness. But not those with chronic conditions.

24) Do health plans pay for hospital care?

a) Most do for those who have six mots or less to live and who forego certain medical treatments.

25) Which UR data transmittal method has traditionally been favored by providers?

a) Manual

26) Which UR data transmittal method is the fastest and least labor intensive?

a) Electronic

27) In the UR process administrative review focuses on whether a propose service is?

a) Covered.

28) In the UR process administrative review is performed by?

a) Either, Clinical professionals or non-clinical employees depending on the plan.

29) According to the text who can typically deny an authorization based on medical necessity and appropriateness?

a) A physician or nurse.

30) May UR staff recommend a different treatment for a member?

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

31) Which statement is not true?

a) Once a PCP has referral a patient to a specialist the specialist can generally provide whatever treatment and as many visits as she sees fit.

**Chapter -16**

1) The two main components of quality management are?

a) Quality assessment and quality improvement.

2) The two main categories of health plan quality are?

a) Service quality and health care quality.

3) 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) Service quality.

4) Medical errors?

a) Are both patient safety issue and a cost issue.

5) The wrong medication is prescribed for a patient, causing an adverse event. This is an error for?

a) Execution.

6) The triple Aim posits that health plan services are optimized when?

a) They simultaneously pursue improving the patient experience of care, improving the health of populations, and reducing the per captia of healthcare.

7) Which of the following statement best describes the medical error?

a) A medical error is a preventable adverse event.

8) Which of the following are examples of hospital acquired conditions?

I) Objects left in a body during surgery

ii) Provision of incompatible blood

iii) Provision of medication following guidelines.

iv) Facture that occurs within the hospital facility.

a) I, ii and IV

9) Consumer perceptions of health care quality?

a) Are important because they reflect valid concerns and affect purchaser decisions.

10) A health plan’s network has a certain number of primary care physicians. This is?

a) A structure measure.

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

a) A process measure

12) Five years after treatment, 80 percent of cancer patients are still alive. This is?

a) An outcome measure

13) The trend in quality measures is towards greater use of?

a) Outcome measures

14) What is the relationship of structure, processes, and outcomes?

a) Structure and processes produce outcomes.

15) The main disadvantage of structure measures is that?

a) Their link to outcomes is generally not proven by research

16) A certain percentage of patients are able to return to work two years after a stroke. This is best described as a?

a) Functional outcomes measure.

17) Which statement about quality improvement is true?

a) After actions are taken to improve quality. Measurement and analysis of outcomes is repeated and ongoing.

18) A hospital identifies another hospital with high cancer survival rates and adopts is practices. This is best describes as?

A) Bench marking.

19) A health plan analyzes data from different gynecologists and notices that one of them performs a certain procedure much mor often than the rest. This is best describes as?

a) Provider profiling

20) A panel of pediatricians evaluates the appropriateness and timeliness of the care provided by another pediatrician in a particular case. This is best describes as?

a) Peer review.

21) The data health plans collect for quality assessment is ?

a) Based on three resources – Financial data, clinical data and customer satisfaction and experience data.

22) Health plans uses a variety of strategies and tools to improve quality some of the most common are?

i) Benchmarking

ii) Monte carlo analysis

iii) clinical practice guidelines

iv) Peer review.

1. I, iii and iv

**Chapter -17**

1) Which statement is true about health plans internal and external standards?

i) Internal standards are often based on a plan’s past performance

ii) Internal standards are typically applied to administrative services.

iii) Benchmarks are an example of external standards

iv) Internal standards usually used to evaluate health care services.

a) i, ii and iii

2) NCQA accredits?

a) Health plans of various types

3) Nationally NCQA accreditation covers?

a) A majority of health plan members

4) The NCQA accreditation process?

a) Includes both an onsite visit and offsite data review.

5) What form does NCQA accreditation take ?

a) A plan earns one of five accreditation levels.

6) Which statement best describes the organization URAC accredits?

a) URAC accredits health plans, dental plans, health networks (Medical and dental) as well as other organizations and functional areas within organizations.

7) The URAC standards consists of components?

a) These components are called elements of two types. Primary and secondary.

8) HEDIS is designed primarily to be used by purchasers and consumers to compare?

a) The quality of different health plans

9) Quality compass is?

a) A quality awareness program for health plan executives.

10) The agency for healthcare research and quality is (AHRQ)?

a) A research branch of the department of health and human services.

11) The Affordable Care Act?

a) Includes a variety of health care improvement provisions

12) What did the Affordable Care Act do in regard to Medicare Advantage plans?

a) It sought to lower payments to MA plans overall but gives incentives to plans that meet quality criteria.

13) Which of the following statement is correct about the Medicare star rating program?

i) The system has been sunset and will gradually phase out under the provisions of MACRA.

ii) The star rankings are based on in part on HEDIS and CAHPS data.

iii) There are three possible rankings under the system.

iv) There are five possible rankings under the system.

a) ii and iv only

14) Which of the following statements is correct about Medicare access and CHIP Reauthorization act (MACRA)?

i) MACRA is an example of bipartisan legislation.

ii) MACRA is intended to keep physicians and other health care professionals from leaving medicare.

iii) MACRA seeks to move medicare away from fee-for-service to a value-based system

iv) under the Merit based incentive payment system (MIPS) compensation may be increased for good performance or decreased for poor performance.

a) I, ii, iii and iv

**Chapter -18**

1. The term marketing mix refers to?
2. Product, Price, promotion, and distribution
3. Statement best describes a health plan’s potential customers.
4. Employers, Associations, employees, Medicaid and Medicare beneficiaries and other individuals.
5. What is a market research technique?
6. Focus groups
7. How is marketing in health plans different from marketing in many other industries?
8. Markets are generally local .
9. Statement best describes how the affordable care act has affected product development? (ACA)
10. The ACA has affected product development in relation to benefit packages, cost sharing and other manners.
11. Statement best describes why health plans develop multiple product lines?
12. The development of multiple product lines assists health plans in competing, particularly among large employers, but it makes marketing more complicated.
13. Statement best describes the difference between advertising and Publicity?
14. Advertising is paid for publicity is not
15. The term promotion mix is commonly used to refer to ?
16. Advertising, Publicity, Personal selling, and sales promotion.
17. Which distribution channel is typically made up of health plan employees?
18. Internal sales force

10) who are generally compensated by the buyer of a health plan, not by the health plan?

a) Employee benefits consultants

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

a) Graphical user interface, application

Description automatically generated

12) Which of the following sells the products of only one company?

a) A Captive agent

13)Who commonly works with individuals rather than large groups?

a) Agents

14) Which direct marketing method is most commonly used to day in the distribution of health insurance products?

a) Direct mail

15)According to the text, dividing a market into smaller groups of customers is called?

a) Market Segmentation

16)Medicare beneficiaries are generally considered part of the ?

a) Non-group market

17)A health plan decides to compete in the smaller group market instead of the large group market by offering as basic and relatively inexpensive product. This is an example of ?

a) Positioning

18) The following would not be considered a member of the regular market product?

a) Joanne recently lost her job and her group health plan

19)Which of the following would not be considered a member of the Individual Market?

a) Graphical user interface, application

Description automatically generated

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

21)Which is not true under ACA?

A) The individual market will be eliminated and everyone will have group coverage

22)Which is a common distribution method in the senior market?

a) Graphical user interface, application

Description automatically generated

23) People eligible for Medicare?

a) May receive health and or drug coverage through private sector medicare Advantage plans.

24)The group market is made up mostly of?

a) Employers.

25) Small businss chossing a health plan usualy focus strongly on?

a) Price.

26) Whch is true of small employers?

a) Only one healthplan is usually offered

27)Which is true of large employers?

a) They often use employee benefit consultants.

28) Whih statements are correct about healh care consumers?

a) Graphical user interface, application

Description automatically generated

Chapter-19

1) Underwriting involves?

a) Indentfying nd assessing risks.

2) Statemnet best describes adverse selection ( anti-selection)?

a) Those more likely to need healthcare are more likely to obtain health coverage.

3) In health Underwriting, which statement best describes the most important risk factors for individuals?

a) Age and gender, and sometimes health status or occupation.

4) The Affordable Care Act (ACA) permits the following factors to be considered in establishing rates?

a) Graphical user interface, application

Description automatically generated

5) Which of the following is prohibited by the Affordable Care Act (ACA)?

a) Annual and life time benefits.

6) In renewal underwriting of a group, what are the two main factors have traditionally been taken into account?

a) Experience and participation

7) In rating, what are the main considerations?

a) Risk and expected and cost balanced by marketability and competitiveness

8) Setting premiuums based on the expected costs of providing benefits to the community as a whole rather than to any subgroup is called ?

a) Communtiy rating

9) A health plan sets premiums for a group based on the plans experience with all groups rathe than that particular group. This describes.

a) manual rating

10) A health plan uses as groups past experience to estimates it expected experience, and if actual experience is different, the plan absorbs the gains or losses. This describes?

a) Prospective experience rating

11) An insurance company is financially responsible for paying health care benefits to the employees of High plateau company. High plateaus health plan is?

a) A fully funded plan

12) Big river corporation takes responsibility for paying health care benefits to its employees, but if total claims risks above $10 million in a year, an insurer pays any claims above this level. This is best described an example of?

a) Aggregate stop-loss covergae.

Chapter-20

1) An IM system incorporates membership data and provider reimbursement arrangements and analyzes tranactions according to contract rules. This describes ?

a) Contract management system

2) A health plan has an automated system to facilitate the processing of requests for pre-authorization of payment. what kind of IM system is this?

a) Utilization management

3) An IM system identifies physicians who tend to provide fewer services than the norm in certain situations. This is an exmaple of ?

a) Provider profilling

4) The use of an MRI machine is expensive, so a health plan needs to efficiently coordinate uitlization by providers. What type of IM system addresses this need?

a) Enterprise scheduling

5) A health plans members can go the plans website to check on the status of their claims. What kind of IM system is this?

a) Member services

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

a) The use of codes largely elminates problems of accuracy

7) The data used by health plan is?

a) Often in different data bases and incompatible formats

8) Which aspect of IM in health plans is most strongly addressed by government regutlation?

a) Security and Privacy

9) Whichof the following represent challenges in managing information and data for health plans?

a) Graphical user interface, application

Description automatically generated

10) Which of the following statemnts about HITRUST common security Framework (CSF) is correct?

a) Graphical user interface, application

Description automatically generated

11) According to the text which term encompasses all types of electronic business functions?

a) E-business

12) Which statement best describes health plans and the internet?

a) Health plans have historically lagged behind other industries but are now increasing adopting the use of the internet

13) A security device designed to block unauthorized access to a private network is ?

a) A firewall

14) A computer network is accessible only the employess of a health plan. This is best described as?

a) Intranet

15) According to the test, the main threat to a health plans network is?

A) Employees

16) Which of the following statement best describes the reasons for the rise of retailization of health care?

a) It provides health care consumers with increased convinence and empowerment regarding their health care choices.

17) How does Electronic data interchange (EDI) differ from E-business?

a) It is the transfer of bacthes of data, not exchanges about a transaction

18) Which genrally more results in accurate data, manual process or EDI?

A) EDI

19) The foucs of business intelligence and decision support systems is to?

a) help managers make decisions in specific cases

20) The main issue that a data ware house is designed to address is?

a) Data in mulitple databases

21) Which statement best describes the focus of a data mart?

a ) It is often focused on one or more specific lines of business.

22) The main disadvantage of data ware house is ?

a) The complexity and cost of implementing them

23) Medical information for an individual is designed to be used at the site of care is?

a) An electronic medical record

24) The main advantage of health information network (HINs) and health information exchanges (HIEs) is that providers treating a patient?

a) health access to all of her medical records and health information

25) Which of the following statement best describes a health information network (HIN) or its operations?

a) A HIN is a computer network that gives the providers of a health plan access a data base of medical information

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

a) An HIN shares information within a health plan network. While an HIE shares it across healthcare entities

27) Which of the following statements about personal health records are correct?

a) Graphical user interface, application

Description automatically generated

28) Whih is owned by the indiviuals?

a) The personal health record

29) personal health records are available from ?

a) health plans and other organizations

30) which of the following best describes a health care information exchange or its operations?

a) Graphical user interface

Description automatically generated

31) An electronic health record can reduce the risk of data replication?

a) True

32) which of the following statements about cloud computing are correct?

a) Graphical user interface, application

Description automatically generated

33) which of the following statements about blockchain are correct?

a) Graphical user interface, application

Description automatically generated

34) How does the electronic medical record differ from the personal health record?

a) The EHR adds information from providers

35) An example of insourcing-outsoucring hybrid is?s

a) Cloud computing

Chapter 21

1. In traditional indemnity health insurance, which is most common?
2. Claims are submitted by the provider to the health plan
3. When is an encounter report submitted instead of a claim?s
4. When the provider is compenstaed by salary
5. Health plan claims processins is similar to that of traditional insurance for?
6. Hospitals and many but not all health care professionals
7. About what portion of a typical health plans claims are processed electronically?
8. 80 to 90 percent
9. Which statement is true about electronic claim processing?
10. It is promoted by federal legislation
11. A health plan employee who deals with claims that have been paid incorrectly is a claims?
12. Adjustor
13. A claims examiner responsiblities generally include?
14. Reviewing and adjusting claims not processed electronically
15. Under which type of provider compensation arrangement is the most claims information needed?
16. Discounted fee for service
17. Which standard claim form is used by healthcare professionals such as Physicians?
18. CMS-1500

10)What is currently the standard set for diagnoses?

a) ICD-10

11) A claim triggers can edit. Usually the claim will be?

a) Examined further

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

a) Authorization was not obtained

13) Which statement is true about claims processing?

a) If a provider bills more than 180 days after delivering a serivce a plan is typically not required to pay

14) Coordination of benefits may apply when?

a) A person is covered by more than one helath plan

15) Most claim invetigations?

a) Are short and simple

16) The primary focus of NAIC unfair claims settlement practices act is?

a) Ensuring the insurers handle claims fairly and promptly

Chapter -22

1. Which of the following statements is correct about health plan member education?

a) Graphical user interface, application

Description automatically generated

2) Health plan member education may be directed at?

Graphical user interface, application

Description automatically generated

1. Which means of distributing information to health plan member is declining?
2. Letters and newsletters sent by mail
3. Jeff class his health plans toll free number and is able by following prompts and without talking to a person to change his PCP. This is an example of ?
4. IVR
5. In health plan member services, when are paper documents typically sent by mail ?
6. When required by regulations for important notification
7. Which statement about health plan commmunication with members is true?
8. Members can not only obtain information from websites but also sometimes perform transactions
9. Contact centers may be ?
10. On -premise, hosted, or cloud-based
11. Which statement best describes why must a health plan must adequately deal with complaints?
12. To comply with regulations, maintain member satisfaction, avoild bad publicity and reduce appeals
13. A health plans complaint resolution preocedures?
14. Are generally subject to state and federal regulation and accrediation and requirements

10) Who generaaly conduts a health plans level two appeal of a member complaint?

a) The appeals committee

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

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

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

a) Member satisfaction surveys and complaint monitoring

13)What popluations do health plan Member satisfaction surveys target?

a) Member who have recently received services, all members, and former members

14) Who conduts member satisfaction surveys ?

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

15) According to the text, which statement about the structure of health plan member services is true?  
a) Among plan types PPOs are least likely to have a dedicated member services department

16) Which is likely to decrease the number of employees needed for adequate member services staffing?

a) The use of CTI

17) Which statement about member services representatives is true?

a) They are subject to high stress and burn out so retention is a concern

18) Which statement about member services technology is not true?

a) IVR systems and websites can only provide information, not handle transactions

19) The amount of time required to complete transaction requested by a member is?

a) Turn- around time

20) Which is a measure of both quality and cost effectiveness?

a) First contact resolution rate