***Comprehensive Health Insurance, 3e* (Vines)**
Chapter 2 Understanding Managed Care: Insurance Plans

2.1 Multiple Choice Questions

1) The HMO Act of 1973 used federal funds to:
A) promote health maintenance organizations (HMOs).
B) increase restrictions on (HMOs).
C) develope new managed care corporations.
D) establish a regulatory board for (HMOs).
Answer: A

2) Before managed care most doctors were paid directly by:
A) preferred provider organizations (PPOs).
B) health maintenance organizations (HMOs).
C) government programs.
D) individuals.
Answer: D

3) As the costs of government healthcare programs increased, federal and state governments:
A) increased premiums.
B) increased taxes.
C) increased deductibles.
D) decreased benefits.
Answer: B

4) To avoid the higher costs of healthcare, employers:
A) hired younger employees.
B) refused to extend health insurance to employees.
C) increased employee premium contributions.
D) decreased the number of health plans available to employees.
Answer: C

5) The goals of managed care include all of the following EXCEPT:
A) medical care that is medically necessary and appropriate based on the patient's condition and diagnosis.
B) medical care rendered by the most appropriate provider.
C) medical care rendered in the most appropriate setting.
D) medical care rendered in the most profitable setting.
Answer: D

6) Managed care systems ensure the delivery of high-quality care while managing costs through:
A) provider networks and discounted fees for services.
B) provider networks and regular premium increases.
C) prohibiting the use of out-of-network providers.
D) discounted fees for services and mandatory high deductibles across all health plans.
Answer: A

7) Terms that refer to fees in an insurance contract include all of the following EXCEPT:
A) customary.
B) ordinary.
C) reasonable.
D) usual.
Answer: B

8) To determine the amount due from a patient, it is necessary to know the:
A) billed amount.
B) allowed amount.
C) adjusted amount.
D) diagnostic code.
Answer: B

9) Utilization guidelines are used to:
A) determine if services are medically necessary.
B) determine if care is provided by the most appropriate provider.
C) determine if the provider is in the network.
D) determine if an employee is covered under the plan.
Answer: A

10) Which of the following plan types does not use a network of providers?
A) Indemnity plan
B) PPO plan
C) HMO plan
D) EPO plan
Answer: A

11) In a managed care organization (MCO), a primary care physician (PCP) is any of the following EXCEPT:
A) general practitioner.
B) family practitioner.
C) dermatologist.
D) internal medicine doctor.
Answer: C

12) The purpose of a withhold program is to:
A) encourage providers to use cost-effective methods.
B) reward physicians for ordering extensive tests.
C) discourage preventive care.
D) promote the use of specialty physicians.
Answer: A

13) The duties of a primary care physician (PCP) in a health maintenance organization (HMO) include:
A) acting as a gatekeeper to services.
B) coordinating patient care.
C) referring patients to specialists.
D) all of the above.
Answer: D

14) All the following are true regarding HMOs EXCEPT:
A) regulated by federal and state law.
B) encourage preventative health services.
C) the least restrictive type of care plan.
D) require a referral for specialist services.
Answer: C

15) The subscriber in a health maintenance organization (HMO) can also be called a(n):
A) employer or policyholder.
B) policyholder or member.
C) member or provider.
D) patient or carrier.
Answer: B

16) The fixed dollar amount a member pays at each office visit or hospital encounter is the:
A) copayment.
B) coinsurance.
C) deductible.
D) premium.
Answer: A

17) The percentage of the provider's fees that the patient has to pay is known as:
A) copayment.
B) coinsurance.
C) deductible.
D) stoploss.
Answer: B

18) Beginning in 2014, employers with 50 or more workers who do not offer coverage will be fined what amount for each employee?
A) $250.
B) $500.
C) $1,000.
D) $2,000.
Answer: D

19) Which is true regarding health reimbursement arrangements (HRAs)?
A) unused reimbursements cannot be accessed.
B) participation ends upon termination of employment.
C) expenses must have incurred during the coverage period.
D) the funds cannot be used for dental and vision care.
Answer: B

20) The most restrictive type of managed care plan is the:
A) exclusive provider organization (EPO).
B) health maintenance organization (HMO).
C) individual practice association (IPA).
D) preferred provider organization (PPO).
Answer: B

21) By accepting lower payments from MCOs, physicians are forced to see more patients each day in order to:
A) deliver MCO-required preventive care.
B) minimize malpractice suits.
C) enroll more members in the health plan.
D) maintain their income.
Answer: D

22) A characteristic of a staff model health maintenance organization (HMO) is that it:
A) contracts with a multispecialty physician group.
B) is a decentralized healthcare delivery system.
C) employs salaried physicians.
D) agrees to contractual discounts with physicians.
Answer: C

23) Features of a preferred provider organization (PPO) include which of the following? (Select all that apply)
A) It contracts with healthcare providers to form a network.
B) It offers members financial incentives to use network providers.
C) It usually rewards providers for managing the cost of care.
D) It employs salaried physicians who treat members in facilities it owns and operates.
Answer: A, B

24) All of the following are types of health maintenance organizations (HMOs) EXCEPT the:
A) group model.
B) preferred provider model.
C) individual practice association.
D) open access model.
Answer: B

25) Health maintenance organization (HMO) plans add a point-of-service (POS) option to:
A) lower the cost of the plan.
B) lower the benefits of the plan.
C) provide physicians with more choice.
D) provide members with more provider choice.
Answer: D

26) All of the following are government plans under the Affordable Care Act EXCEPT:
A) catastrophic.
B) silver.
C) bronze.
D) titanium.
Answer: D

27) The type of health maintenance organization (HMO) plan that involves contracting with individual physicians to create a healthcare delivery system is a(n):
A) group model.
B) individual practice association (IPA) model.
C) network model.
D) staff model.
Answer: B

28) The type of health maintenance organization (HMO) plan that employs salaried physicians who treat members in facilities owned and operated by the HMO is a(n):
A) group model.
B) individual practice association (IPA) model.
C) network model.
D) staff model.
Answer: D

29) The type of health maintenance organization (HMO) that contracts with more than one community-based multispecialty group to provide wider geographical coverage is a(n):
A) group model.
B) individual practice association (IPA) model.
C) network model.
D) staff model.
Answer: C

30) All the following are true regarding the Affordable Care Act EXCEPT:
A) It is also known as Obamacare.
B) It cannot deny coverage due to a pre-existing condition.
C) It offers five different types of government plans.
D) It requires people to prove citizenship before receiving services.
Answer: D

31) Which of the following is a characteristic of a preferred provider organization (PPO)?
A) It includes a contracted network of providers.
B) Members select a primary care physician (PCP) as a gatekeeper.
C) The plan is more restrictive than a health maintenance organization (HMO).
D) Members must obtain referrals to see a specialist.
Answer: A

32) Advantages of managed care include all of the following EXCEPT:
A) Hospitals and physicians provide services more efficiently.
B) Providers strive to improve the quality of their care.
C) Physicians run the risk of unfavorable evaluations by enrollees.
D) Data is collected and analyzed to measure health outcomes.
Answer: C

33) Disadvantages of managed care include all of the following EXCEPT:
A) It includes disease management programs based on recent research.
B) It creates an increased administrative burden.
C) It may require physicians to carry additional malpractice insurance.
D) It restricts physicians' latitude in caring for patients.
Answer: A

34) An exclusive provider organization (EPO) is similar to a preferred provider organization (PPO) because they both have:
A) a limited provider network.
B) gatekeepers.
C) payment by capitation.
D) a flexible benefit design.
Answer: D

35) Which of the following is true of an exclusive provider organization (EPO)?
A) It is regulated under insurance statutes.
B) It is regulated under federal and state health maintenance organization (HMO) regulations.
C) Premiums are lower than with a health maintenance organization (HMO).
D) Premiums are higher than with a preferred provider organization (PPO).
Answer: A

36) How long does a physician have to give a written notice before closing the practice to members of a MCO plan?
A) 30-60 days.
B) 60-90 days.
C) 3-6 months.
D) 6-12 months.
Answer: A

37) Physician-hospital organizations (PHOs) may include:
A) nursing homes.
B) laboratories.
C) surgery centers.
D) all of the above.
Answer: D

38) Which of the following is true of self-insured plans?
A) They are regulated by the Employee Retirement Income Security Act (ERISA).
B) They use third-party administrators.
C) They assume the financial risk of providing benefits for employees or members.
D) They do not abide by state insurance regulations.
E) all of the above.
Answer: E

39) When compared to individual insurance, group insurance provides:
A) fewer benefits and lower costs.
B) fewer benefits and higher costs.
C) better benefits and higher costs.
D) better benefits and lower costs.
Answer: D

40) Group insurance is issued to an employer to provide coverage for:
A) employees only.
B) employees and spouses only.
C) employees and children only.
D) employees and all their dependents.
Answer: D

41) The type of insurance coverage that pays a per diem for each day a patient is in the hospital is:
A) hospital.
B) hospital indemnity.
C) medical.
D) major medical.
Answer: B

42) The type of insurance coverage that provides protection against a specific type of accident or illness is:
A) outpatient.
B) major medical.
C) special risk.
D) catastrophic health insurance.
Answer: C

43) The type of insurance that provides coverage for a designated period of time is:
A) medical insurance.
B) special risk.
C) short-term health insurance.
D) long-term care.
Answer: C

44) Consolidated Omnibus Reconciliation Act (COBRA) insurance is available to former employees of businesses that have a minimum of:
A) 5 employees.
B) 20 employees.
C) 50 employees.
D) 100 employees.
Answer: B

45) Examples of individuals who would qualify for COBRA include:
A) employees who are laid off from their jobs.
B) employees who quit their jobs.
C) children of covered employees who are no longer full-time students.
D) divorced ex-spouses of covered employees.
E) all of the above.
Answer: E

46) The type of policy that would provide coverage for custodial care in a nursing home is:
A) short-term health insurance.
B) long-term care insurance.
C) major medical insurance.
D) special risk insurance.
Answer: B

47) Which of the following is true of managed care contracts with providers?
A) They are irrevocable by the provider.
B) They are irrevocable by the managed care organization (MCO).
C) They are usually 1-year contracts.
D) Providers must provide a 1-year notice to cancel the contract.
Answer: C

48) Providers who contract with managed care organizations (MCOs) must provide care according to the MCO's policies and guidelines in order to:
A) increase revenue.
B) increase patient load.
C) be listed in the provider directory.
D) be paid for services provided.
Answer: D

49) An insurance identification card usually includes all of the following information EXCEPT:
A) name of the insurance policy.
B) name of the subscriber.
C) detailed benefit information.
D) insurance policy number.
Answer: C

50) Insurance information obtained by the medical office specialist:
A) should be kept in the medical record.
B) updated on a regular basis.
C) verified with the insurance company.
D) all of the above.
Answer: D

51) Which type of statement signed by the patient authorizes his or her insurance company to send payments directly to the provider?
A) assignment of benefits
B) authorization to release protected health information
C) advance directive
D) beneficiary designation
Answer: A

52) A physician who coordinates a patient's care and refers patients to specialists is a(n):
A) preferred provider physician (PPP).
B) referring gatekeeper.
C) primary care physician (PCP).
D) primary physician coordinator (PPC).
Answer: C

53) Which is true regarding a flexible spending account (FSA)?
A) The money deducted is subject to taxes.
B) The money can be withdrawn without penalty.
C) Funds are lost when the plan year is over.
D) It is used exclusively as a managed care plan.
Answer: C

54) At what age can an individual withdraw money from a health savings account (HSA) without penalty?
A) 18
B) 21
C) 65
D) 72
Answer: C

55) In 2011, the new health care reform law required insurers to offer dependent coverage for adult children up to age _____ so they could be included on their parents' coverage.
A) 26
B) 21
C) 18
D) 24
Answer: A

56) In 2011, what percentage of all U.S. citizens of working age experienced a gap in medical health insurance coverage?
A) 13%
B) 26%
C) 38%
D) 49%
Answer: B

57) The Patient Protection and Affordable Care Act requires that all individuals have health insurance beginning in:
A) 2012
B) 2013
C) 2014
D) 2015
Answer: C

2.2 True/False Questions

1) The majority of payments received in a medical facility come from insurance carriers.
Answer: TRUE

2) HIPAA was created in 1999.
Answer: FALSE

3) Managed care is a method of controlling healthcare costs and the delivery of care.
Answer: TRUE

4) As a result of managed care, providers have been required to revamp the way they operate their businesses and their methods of patient care.
Answer: TRUE

5) In a managed care organization (MCO) contract, the provider will bill the patient the difference between the standard fee and the contractual or discount amount.
Answer: FALSE

6) All health insurance contracts define medical necessity in the same way.
Answer: FALSE

7) If a physician has ordered surgery for a patient, a managed care organization (MCO) case manager may disallow an inpatient stay if the MCO guidelines designate the procedure as best suited for outpatient care.
Answer: TRUE

8) A goal of managed care is for the patient to receive care in the most appropriate and most restrictive setting.
Answer: FALSE

9) A primary care physician (PCP) in a health maintenance organization (HMO) can be an OB/GYN.
Answer: TRUE

10) An integrated delivery system (IDS) is a network of healthcare organizations under a parent holding company.
Answer: TRUE

11) Primary care physicians (PCPs) are sometimes referred to as gatekeepers because patients with HMO plans must obtain referrals from them in order to see specialists.
Answer: TRUE

12) The restrictions in a health maintenance organization (HMO) reduce members' premium costs.
Answer: TRUE

13) Preferred provider organization (PPO) members pay less out of pocket for medical services from a contracted provider than from a non-network provider.
Answer: TRUE

14) A point-of-service (POS) plan allows members to choose a health maintenance organization (HMO) or preferred provider organization (PPO) once a year at open enrollment.
Answer: FALSE

15) Point-of-service (POS) plans are becoming more popular because they offer more flexibility and freedom of choice than do standard health maintenance organizations (HMOs).
Answer: TRUE

16) If a member in a health maintenance organization (HMO) sees a specialist without a referral from his or her primary care physician (PCP), the HMO will not pay for the service.
Answer: TRUE

17) Point-of-service (POS) plans require members to select a primary care physician (PCP).
Answer: FALSE

18) Medical healthcare coverage cost in 2012 averaged $6,000 per employee.
Answer: FALSE

19) It is possible for a health maintenance organization (HMO) member to receive care from a non-network provider or facility in an emergency situation.
Answer: TRUE

20) A managed care organization (MCO) collects data on care delivery, such as identifying the percentage of children in a health maintenance organization (HMO) who have been immunized.
Answer: TRUE

2.3 Short Answer Questions

1) An individual or facility providing medical care is called the _____.
Answer: provider

2) The amount that insured individuals have to pay out of pocket before insurance begins paying is called the _____.
Answer: deductible

3) Managed care is a system that controls the _____ and _____ of health services to members.
Answer: cost and delivery/delivery and cost

4) A(n) _____ model health maintenance organization (HMO) contracts with more than one community-based multispecialty group to provide wider geographical coverage.
Answer: network

5) When a provider agrees to receive payment directly from the patient's insurance carrier, it is accepting _____.
Answer: assignment of benefits

6) Written approval from a managed care plan or insurer given before a patient is admitted to a hospital or receives a particular treatment is known as _____.
Answer: preauthorization

7) A(n) _____ medical condition is a diagnosis for which the insured has previously been treated and that may not be covered under the terms of some insurance plans.
Answer: preexisting

8) The federal law that makes it possible for most people to continue their group health coverage for a period of time after leaving a job is called _____.
Answer: COBRA

9) _____ is a general term for policies offered through for-profit companies such as Aetna and Prudential.
Answer: Commercial health insurance

2.4 Matching Questions

Match the following:

A) individual practice association (IPA) health maintenance organization (HMO)
B) staff model health maintenance organization (HMO)
C) major medical insurance
D) outpatient insurance
E) open access health maintenance
F) exclusive provider organization (EPO)
G) point-of-service (POS) plan
H) network model health maintenance organization (HMO)
I) long-term care insurance
J) preferred provider organization (PPO)

1) The type of managed care plan that hires the physicians and pays their salaries

2) The type of health maintenance organization (HMO) that does not require a referral from a PCP to see a specialist

3) The type of insurance that offers protection for large medical expenses beyond the coverage of routine healthcare

4) The type of managed care plan that combines the features of health maintenance organization (HMO) and preferred provider organization (PPO) plans

5) The type of plan that pays benefits only for services provided by network providers but does not have a health maintenance organization (HMO) license

6) The type of insurance that covers both medical and custodial services

7) The type of managed care plan that contracts with two or more multispecialty group practices to form a provider network

8) A type of HMO in which the MCO contracts with individual physicians and facilities to build the provider network

9) The type of managed care plan in which members have financial incentives, such as lower copayments, when they obtain care from network providers

10) This type of insurance provides protection for emergency department visits and other outpatient divisions in a hospital or medical facility.

Answers: 1) B 2) E 3) C 4) G 5) F 6) I 7) H 8) A 9) J 10) D

2.5 Essay Questions

1) What is the HMO Act of 1973?
Answer: The HMO Act was signed into law by President Nixon using federal funds and policy to promote health maintenance organizations (HMOs).

2) Why is knowledge of the history of healthcare in America important for a medical office assistant?
Answer: This knowledge will assist the medical office assistant in understanding the healthcare reimbursement system and in communicating with patients.

3) Explain the difference between a premium and a deductible.
Answer: A premium is the amount paid (usually in regular installments) to purchase insurance coverage. A deductible is the amount a policyholder must pay out of pocket before insurance begins to pay.

4) Explain the duties of a primary care physician (PCP) in a health maintenance organization (HMO).
Answer: A PCP (gatekeeper) coordinates all aspects of the member's healthcare and provides referrals to specialists when necessary.

5) Explain how members see a specialist in a health maintenance organization (HMO) plan.
Answer: Members can only see a specialist if they are referred by their primary care physician (PCP).

6) List three reasons why managed care organizations (MCOs) are criticized.
Answer: MCOs are criticized for making it difficult for members to obtain emergency services, for not adequately providing necessary long-term care for the chronically ill, and not offering patients the ability to appeal or hold the MCO liable in cases in which necessary procedures have been denied.

7) List four goals of managed care.
Answer: Goals of managed care are to ensure that:
• Providers deliver high-quality care in a facility that manages or controls costs.
• Medical care or procedures are medically necessary and appropriate for the patient's condition or diagnosis.
• Medical care is rendered by the most appropriate provider.
• Medical care is rendered in the most appropriate, least restrictive setting.

8) List some of the advantages of managed care.
Answer: Managed care organizations (MCOs) help to restrain the overall growth of healthcare costs. They collect and analyze data on how well care is delivered. MCOs make use of disease management programs and care pathways that can be beneficial to patients' health.

9) What are some of the ways that managed care organizations (MCOs) create an increased administrative burden on a physician's office?
Answer: Increased administrative burdens could include incompatible claim systems, the need for authorization before providing care, required physician interaction with utilization review departments, and required quality-assurance reporting.

10) What are the differences between an individual and group insurance contract?
Answer: Under group insurance, one master policy is issued to an organization or employer and covers eligible members or employees and their dependents. Individual insurance refers to a single policy issued to one individual that provides coverage for that person and may also cover his or her dependents.