Chapter Three

MULTIPLE CHOICE

1) Health insurance is:

A) a PPO.

B) shifting the risk of loss.

C) an HMO.

D) All of the above

2) The _____ calculates risk and helps set premiums.

A) actuary

B) government

C) benefits manager

D) employer

3) John's recent physician office visit was not paid by the insurance company. It was his first claim of the year. The claim totaled $200. The reason the claim was denied was likely related to John's:

A) copayment.

B) subscriber.

C) deductible.

D) premium.

4) A deductible is the:

A) portion of services paid by the patient.

B) amount paid by the patient before the third-party payer begins to pay.

C) fee paid by employers and employees to the insurance company.

D) negotiated payment for services between the payer and the provider.

5) The copayment is the:

A) fee paid by employers and employees to the insurance company.

B) negotiated payment for services between the payer and the provider.

C) portion of services paid by the patient.

D) amount paid by the patient before the third-party payer begins to pay.

6) Premiums are the:

A) portion of services paid by the patient.

B) amount paid by the patient before the third-party payer begins to pay.

C) negotiated payment for services between the payer and the provider.

D) fee paid by employers and employees to the insurance company.

7) The typical fee charged by providers in a geographic area is known as:

A) usual charge, reasonable cost plan.

B) usual, customary, and reasonable..

C) universal charge and reimbursement plan.

D) ordinary and customary cost program.

8) The amount paid to a provider monthly to provide health care services to an employee is:

A) premium.

B) capitation.

C) copayment.

D) deductible.

9) An HMO contracts with more than one group practice for service in which arrangement?

A) Staff model HMO

B) Network HMO

C) IPA

D) PPO

10) This organization negotiates and manages provider's contracts.

A) Staff model HMO

B) PPO

C) Network HMO

D) IPA

11) Third-party payers are covered by both state and federal regulations. Two of the federal regulations are:

A) COBRA and PPO.

B) ERISA and HIPAA.

C) COBRA and EPO.

D) ERICA and HIPAA.

12) A policy is:

A) a binding contract between the payer and the employer.

B) the time in which employees can utilize benefits.

C) a time when employees can change providers.

D) a binding contract between the payer and the employee.

13) An enrollment period is a:

A) binding contract between the payer and the employee.

B) binding contract between the payer and employer.

C) time when employees can utilize benefits.

D) time when employees can change providers.

14) Determining who is responsible for health claim payments is known as:

A) explanation of benefits.

B) COBRA.

C) coordination of benefits.

D) ERISA.

15) John is known as a(n) _____ in his HMO.

A) actuary

B) enrollee

C) subscriber

D) policy holder

16) Which of the following describes Blue Cross/Blue Shield?

A) A health insurance company.

B) Blue Cross pays hospital expenses.

C) Blue Shield pays physician expenses.

D) All of the above 17) All of the following are true about the Healthcare Common Procedure Coding System (HCPCS) except:

A) it consists of two levels.

B) the current procedural terminology (CPT) is for procedures and services performed by providers.

C) it involves indemnification.

D) the national codes (HCPCS level II codes) are for procedures, services, and supplies not found in CPT.

18) A third-party payer may be:

A) an insurance company.

B) a government agency.

C) a service provider.

D) All of the above

19) With EPOs all of the following are true except:

A) patients must select their care providers from those in the network.

B) patients may choose their physician or hospital.

C) if the patient chooses to go outside the network the services are not covered.

D) they are regulated by state insurance law.

20) A PPO:

A) is a delivery network.

B) does not receive premiums or assume financial risk.

C) decreases cost of service if a preferred provider is used.

D) All of the above

21) All of the following are true except:

A) 22 states insist on mental health parity.

B) all 50 states mandate breast cancer screening.

C) 16 states mandate payment of prenatal care.

D) 44 states require external review of health plan decisions.

22) A _____ is a system where payment is made in advance of services being provided.

A) prepaid health plan

B) preauthorization

C) coordination of benefits

D) copayment

23) HIPAA regulates all of the following except:

A) portability.

B) coverage on a family plan until 26 years old.

C) access.

D) mandated benefits.

24) The American Health Benefit Exchanges and Small Business Health Option Exchanges:

A) are part of the Patient Protection and Affordable Care Act.

B) require states to establish insurance options for the uninsured and small businesses.

C) require states to establish an office of health insurance consumer assistance.

D) All of the above

25) Prepaid health plans:

A) are attractive to employers because they know in advance what the cost of providing health care will be.

B) all involve an IPO.

C) are attractive to the service provider because the number of patients is fixed and a certain revenue level is guaranteed.

D) Both A and C

TRUE/FALSE

26) Employers must provide health insurance.

27) Employers pay the entire insurance premium for their employees in most instances.

28) Once a policy is in place the employer is the insured.

29) Physicians are always independent contractors in third-party payer arrangements.

30) Like hospitals, insurance companies must be licensed.

FILL IN THE BLANK

31) According to the text, _____% of Americans under age 65 are uninsured.

32) _____ insurance does not restrict a patient's choice of providers.

33) In a _____, the employer acts as the insurance company and pays for its employees' health care costs out of its own pocket.

34) _____-_____ _____ manage health care benefits and process claims for their clients.

35) _____ is a type of prepaid health care plan.

ESSAY

36) Define the term *third-party payer* and describe the role of the insurance company as the third party in the patient–provider relationship.

37) Explain the gatekeeping concept, and include an example of how it benefits the patient, payer, and provider.

Answer Key

1) D

2) A

3) C

4) B

5) C

6) D

7) B

8) B

9) B

10) B

11) B

12) A

13) D

14) C

15) B

16) D

17) C

18) D

19) B

20) D

21) C

22) A

23) B

24) D

25) B

26) false

27) false

28) false

29) false

30) true

31) about 17

32) Indemnity

33) self-insured plan

34) Third-party administrators

35) Managed care

36) Responses will vary but should include that the patient contracts with the insurance company to pay the provider for services rendered to the patient.

37) Responses will vary but should include the use of primary care physicians and referrals.