

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.