HM 550 - Insurance, Reimbursement and Managed Health Care

Exam Instructions

Thank you for enrolling into HM 550 - Insurance, Reimbursement and Managed Health Care. This is your online examination. Please follow these instructions:

- Before attempting, carefully read the question text.
- Then choose the correct answer.
- Click on **"Next"** to go to the next question.
- Use the **"Next"** and **"Previous"** buttons to navigate between questions.
- Bookmark difficult questions to return to them later.
- Click the **"Submit All**" button to submit your exam for grading.
- Use the Question List in the upper left corner to view and jump to a certain question.
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Full Name: _____

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AH Number: _____

1. The term "moral hazard" refers to which of the following?

A) The inherent immorality of health insurance

B) The reason for "What Happens in Vegas Stays in Vegas"

C) A gambling game that was the forerunner of what we call "poker"

D) A change in behavior caused by being at least partially insulated from the full economic consequences of an action.

E) Bad behavior resulting from being insured

2. "In the Agent - Principal Problem as understood in the context of moral hazard, the Agent refers to:"

A) The insurance agent

B) The physician

C) The patient

D) The insurer

3. The term Asymmetric Knowledge as understood in the context of moral hazard refers to:

A) A good balance of understanding by both the insured and the insurer of financial risk.

B) A skill required by insurance company underwriters in order to calculate premiums.

C) When either the insured of the insurer knows something that the other one doesn't.

D) When the insured has less education than the insurer.

4. The pooling of unequal risks means happens when healthy and sick people are in the same risk pool.

A) True

B) False

5. . Inherent vice may or may not include real vice.

A) True

B) False

6. . Induced demand does not refer to:

A) Patients being induced to seek medical services because they do not need to pay the entire cost for them

B) Consumers may be induced to request or demand a medical service that is costlier than is necessary

C) Physicians consciously or unconsciously are induced to provide more services than may be needed

D) A patient has a sudden craving for ice cream induced by receiving a mild electrical stimulation to the hypothalamus

7. Blue Cross began as a physician service bureau in the 1930s.

A) True

B) False

8. Prior to the 1970s, organized health maintenance organizations (HMOs) such as Kaiser Permanente were often referred to as:

A) Hospital associations

B) Preferred Provider Organizations

C) Prepaid Group Practices

D) Service Bureaus

E) The future of healthcare

9. . The Balanced Budget Act (BBA) of 1997 resulted in a major increase in HMO enrollment.

A) True

B) False

10. . The "managed care backlash" resulted in:

A) A reduction in HMO membership

B) New federal and state laws and regulations

C) Improvements in quality of care

D) Reduced administrative costs

E) All of the above

F) a & b only

11. TEFRA had an intent to encourage HMO's to offer more comprehensive benefits than traditional Medicare, but that intent was never achieved.

A) True

B) False

12. The existence of hospitals, physicians, and a licensed HMO and or PPO under one corporate umbrella is referred to as vertical integration.

A) True

B) False

13. Carve-out companies are generally licensed as HMO's or insurers.

A) True

B) False

14. The Medicare Modernization Act did away with the Medicare Part D drug benefits program.

A) True

B) False

15. The Patient Protection and Affordable Care Act has its greatest impact on the health plan industry and on access to coverage.

A) True

B) False

16. The ACA required a guaranteed issue, confined to an annual limited period of open enrollment.

A) True

B) False

17. The provisions of the ACA has the effect of expanding the number of individuals in both Medicaid and private health care plans.

A) True

B) False

18. Accountable care organizations were created to assume the full financial risks for cost increases of the Medicare Parts A and Part B benefits for a defined population of beneficiaries in the traditional Medicare fee-for-service program.

A) True

B) False

19. Physicians are increasingly finding it unattractive to be employees of hospitals.

A) True

B) False

20. When hospitals employee physicians, costs increase.

A) True

B) False

21. HMO's have demonstrated that inpatient length of stay could be reduced without ill effects.

A) True

B) False

22. Which of the following is not considered to be a type of defined health benefits plan?

A) Individual health insurance

B) A self-funded employer plan

C) A Medical Savings Account

D) Medicare

E) Medicaid

23. Copayment is:

A) Money that a member must pay before the plan begins to pay.

B) A fixed amount of money that a member pays for each office visit or prescription.

C) A percentage of the allowable charge that the member is responsible for paying.

D) Not a type of cost-sharing.

24. Coinsurance is:

A) Money that a member must pay before the plan begins to pay.

B) A fixed amount of money that a member pays for each office visit or prescription.

C) A percentage of the allowable charge that the member is responsible for paying.

D) Not a type of cost-sharing.

25. State mandated benefits coverage applies to all types of health benefits plans that provide coverage in that state.

A) True

B) False

26. Which of the following is not used in the Affordable Care Act to describe a benefit level based on the amount of cost-sharing:

A) Platinum

B) Silver

C) Gold

D) Copper

E) Bronze

27. Reinsurance and health insurance are subject to the same laws and regulations.

A) True

B) False

28. Employer Group Benefits Plans are a form of Entitlement Benefits Programs

A) True

B) False

29. Key common characteristics of PPOs do not include:

A) Limited provider panels

B) Discounted payment rates

C) Consumer choice

D) Utilization management

E) Benefits limited to in-network care

30. Health insurers and Blue Cross Blue Shield plans can act as third-party administrators (TPAs).

A) True

B) False

31. A Flexible Savings Account (FSA) is the same as a Medical Savings Account (MSA).

A) True

B) False

32. Commonly recognized types of HMOs include all but:

A) IPAs

B) Direct-contract plans

C) PHOs

D) Staff and group

33. Health insurers and HMOs are licensed differently.

A) True

B) False

34. IPAs are intermediaries between a payer such as an HMO, and its network physicians.

A) True

B) False

35. The defining feature of a direct contract model HMO is the HMO contracting directly with a hospital to provide acute services to its members.

A) True

B) False

36. . Identify which of the following comes the closest to describing a "Rental PPO," also called a "Leased Network""

A) A PPO that rents space in physicians' offices for use by the PPO's own physicians

B) A provider network that rents a PPO license

C) A provider network that contracts with various payers to provide access and claims repricing

D) A PPO that rents the product name and logo from a larger and better-known payer so it can compete in the market

37. In health benefit plans, cost refers to what the provider wants to charge.

A) True

B) False

38. Under the Affordable Care Act no cost sharing is permitted for preventative and wellness services.

A) True

B) False

39. Deductibles and coinsurance can apply to the same health plan benefit.

A) True

B) False

40. The maximum dollar amount of coverage of a health plan is generally based on what the provider charges.

A) True

B) False

41. Medicare provides health care benefits to those with low or no income.

A) True

B) False

42. In traditional Medicaid and Medicare programs, the government uses private payers such as Blue Cross/Blue Shield plans or other private companies to administer the program.

A) True

B) False

43. Employer-based group health plans are the smallest source of health benefit coverage in the United States.

A) True

B) False

44. Reinsurance is not the same as health insurance.

A) True

B) False

45. An example of a service plan would be one that is pre-paid, is a Blue Cross/Blue Shield plan and operates as a PPO and remains licensed as a service plan.

A) True

B) False

46. Point of Service Plans combine features of HMOs and traditional insurance plans, but have similarities to PPO's in some ways.

A) True

B) False

47. In HMO's, members must access non-emergency care by going through their primary care provider.

A) True

B) False

48. In a Group Model Plan the HMO contracts with many different medical groups to provide services to its members.

A) True

B) False

49. In Staff Model Plans the HMO employs its physicians and these plans are not as common today.

A) True

B) False

50. Licensure and regulation of companies providing Utilization Management Services is uniform across all States and all States in the USA require licensing.

A) True

B) False

51. . An IDS may not operate primarily as a vehicle for negotiating terms with private payers.

A) True

B) False

52. The GPWW requires the participation of a hospital and the formation of a group practice.

A) True

B) False

53. Advantages of an IPA do not include:

A) Broader physician choice for members

B) The ability of the payer to directly hire and fire a doctor

C) Requires less start-up capital

D) More convenient geographic access

54. Consolidation of hospitals and health systems has resulted in:

A) Lower costs

B) No change in costs

C) Higher costs

55. . Basic elements of routine payer credentialing include all but which of the following:

A) Hospital Privileges

B) Malpractice History

C) Medical License

D) Board Certification

E) Onsite office inspection

56. Which of the following provider contract "clauses" state that the provider agrees not to sue or assert any claims against the enrollee for payments that are the responsibility of the payer?

A) Force Majeure Clause

B) Hold-Harmless Clause

C) Non-discrimination Clause

D) b and c

57. Managed care plans do not usually perform onsite credentialing reviews of hospitals and ambulatory surgical centers.

A) True

B) False

58. Which organizations may not conduct primary verification of a physician's credentials?

A) HMOs

B) URAC

C) PPOs

D) CVOs

59. State network access (network adequacy) standards are:

A) The same for physicians and hospitals

B) Based on drive times to any contracted provider

C) Based on open practices only

D) Apply equally to HMOs, POS plans, and PPOs

60. Most ancillary services are broadly divided into the following two categories:

A) Pharmacy and Diagnostic

B) Laboratory and Therapeutic

C) Diagnostic and Therapeutic

D) Pharmacy and Radiology

61. The right to audit in an Insurance Plan contract may include that the audits be performed as part of a plan's Quality Management program.

A) True

B) False

62. One example of non-physician professional health care provider that insurance plans will contract with is a Podiatrist.

A) True

B) False

63. A Hospital Based Physician would include a Primary Care Physician who is employed by the Hospital and sees patients at a hospital-owned annex or office building.

A) True

B) False

64. The basic ways that HMOs may pay for PCP services are:

A) Capitation
B) APGs
C) Fee-for-service
D) Both a and c
E) a, b, and c

65. Capitation is usually defined as:

A) Prepayment for services on a fixed, per member per month basis
B) Fee-for-service including withhold provisions
C) Pay for Performance (P4P)
D) Stop-loss reinsurance provisions
E) A fixed monthly salary

66. Which of the following is not a reason that HMOs prefer to capitate physicians?

A) Eliminates the FFS incentive to over-utilize
B) Costs are predictable
C) Is less costly to administer than FFS
D) Typically results in lower physician payments

67. Fee-for-service payment is the most common method used by HMOs to pay specialists.

A) True
B) False

68. Payers prefer using a sliding scale discount on charges to pay hospitals because they can provide such a high volume of patients.

A) True
B) False

69. Which of the following term refers to an all-inclusive rate paid by the HMO for both institutional and professional services?

A) MS-DRGs
B) Case rate
C) Per diem
D) Bundled payment

70. The same methodology used to pay a hospital for inpatient care is usually also used to pay for outpatient care.

A) True

B) False

71. Which of the following forms of hospital payment contains no financial incentives for the hospital to control costs?

A) Capitation

B) DRGs and MS-DRGs

C) Per diem

D) Sliding scale FFS

E) c and d

72. There are different forms of hospital per diem payment methodologies.

A) True

B) False

73. In commercial payer-hospital contracts that contain a provision for outliers, how are outliers usually determined by hospitals?

A) Based on cost-accounting

B) Based on a Resource Based Relative Value Scale

C) Based on the chargemaster

D) None of the above

74. Payers usually do not use a consistent payment methodology or amounts for different products such as HMOs, PPOs, Medicare Advantage plans, and POS plans.

A) True

B) False

75. A participating provider is permitted to balance bill a member for any copayments, coinsurance, or deductibles that are applicable to a claim payment.

A) True

B) False

76. A participating provider is permitted to balance bill a member for any amount above the amount paid under the payer's fee schedule.

A) True

B) False

77. Which of the following is rarely if ever involved in payment for prescription drugs?

A) Average Wholesale Price
B) Copay
C) Coinsurance
D) Rebates
E) Capitation
F) Reference Pricing

78. Payers usually pay the same amount for ancillary services regardless of where those services are provided

A) True
B) False

79. Diagnostic Related Groups Codes have been replaced with MS-DRG's by Medicare for inpatient care

A) True
B) False

80. Value-Based Payments are affected by both costs and quality or outcomes, and applies only to physicians and dose not exempt Medicare Fee-for-Service.

A) True
B) False

81. . Surprise Billing can expose plan members to costly balance billing for care from providers that they had no ability to choose.

A) True
B) False

82. There are no specific CPT-4 and HCPS codes for E-visits.

A) True
B) False

83. Capitation is a predictable amount of income for providers, it is prepaid and the provider does not need to collect money after the fact, except for any cost-sharing such as coinsurance or deductibles.

A) True
B) False

84. Nurse-on-call or medical advice programs are considered demand management strategies.

A) True
B) False

85. Utilization Management works by telling doctors and hospitals what to do.

A) True

B) False

86. Hospital utilization varies by geographical area.

A) True

B) False

87. Utilization management seeks to reduce practice variation while promoting good outcomes and "_____"

A) reducing access

B) reducing costs

C) increasing patients

D) none of the above

88. The most common measurement of inpatient utilization is:

A) members per thousand bed days per year

B) admissions per thousand bed days per year

C) encounters per thousand members per year

D) bed days per thousand members per year

89. Claims review is an example of:

A) prospective review

B) concurrent review

C) retrospective review

D) discharge planning

90. Most of the care in disease management systems is delivered in the inpatient setting because the patients are sicker than average.

A) True

B) False

91. Costs of non-catastrophic, recurring outpatient care have risen significantly in the past few decades.

A) True

B) False

92. The typical practicing physician has a good understanding of what is happening with his/her patient between office visits.

A) True

B) False

93. Two desirable outcomes of tiered prescription benefits design are:

A) Brand drug use increases and generic drug use declines

B) The use of less expensive generic drugs increases, and members save money by paying lower copayments

C) Member costs increase and brand name drug use increases

D) Members pay higher copayments and pharmacies make higher gross profit margins

94. . One potential negative consequence of drug formularies with high copayments is:

A) Increased use of generic drugs.

B) Increased use of brand drugs.

C) High copayments may be a barrier to adherence.

D) Decreased use of the most cost-effective medications

95. Which of the following was not proposed by The Institute of Medicine's Committee on the Quality of Health Care in America as one of the six aims for improvement in our health care system?

A) Safe

B) Effective

C) Outcomes-focused

D) Timely

E) Efficient

F) Equitable

96. Which of the following is not included in Donabedian's quality paradigm?

A) Outcome

B) Structure

C) Efficiency

D) Process

97. The organizations that have developed accreditation programs for managed care organizations are:

A) NCQA

B) URAC

C) AAAHC

D) All of the above

E) a and b only

98. All managed care plans are required by the federal government to participate in accreditation and performance measurement programs.

A) True

B) False

99. "_____" is a set of standardized measures that look at plan performance across a variety of important dimensions, such as delivery of preventive health services, provider credentialing, and treatment efficacy for various illnesses.

A) CVO

B) UM

C) CAHPS

D) HEDIS

E) HOS

100. Under the Affordable Care Act, the costs for Quality Assessment and the costs of providing wellness and prevention services are considered to be administrative costs.

A) True

B) False

101. Wellness programs focus on helping members make changes to their lifestyles.

A) True

B) False

102. For Ambulatory procedures, per-hundred metrics is the most often used.

A) True

B) False

103. Managed health care plans make coverage decisions and medical care decisions.

A) True

B) False

104. Regarding medical necessity, something may not be covered for a patient because a less costly alternative was not tried first.

A) True

B) False

105. Basic Utilization Management is only carried out by the payer.

A) True

B) False

106. Most forms of Utilization Management are now used in cases of emergency services.

A) True

B) False

107. A retail clinic staffed by Nurse Practitioners is an example of Demand Management.

A) True

B) False

108. In Referral Management it is the Primary Care Provider who determines if a health problem or condition requires treatment by a specialist.

A) True

B) False

109. An example of when concurrent Utilization Management is used would be for extensive periods of physical therapy.

A) True

B) False

110. Discharge Planning is a unique process that is not considered to be a Utilization Management process.

A) True

B) False

111. Retrospective Utilization Management consists of discharge planning and pattern analysis.

A) True

B) False

112. In the appeals process, with an External Review, an overturned denial is not binding on the plan.

A) True

B) False

113. Disease Management works with a smaller number of disease conditions with a goal to proactively work with clients to manage their condition in order to avoid hospitalization.

A) True

B) False

114. In Case Management, the site of interaction is primary hospital, hospice, subacute facility, or health and home care.

A) True

B) False

115. In Disease Management the value relies heavily on price negotiations and benefit flexing and often community resources as well.

A) True

B) False

116. Patient-Centered Medical Home is confined to post-discharge patients and reflects a shift in focus on Primary Care Physician's and a limited and specific range of medical personnel and approaches to care.

A) True

B) False

117. Regarding medical necessity for ancillary services, standards of care are used for pre-certification and evidence-based clinical guidelines may be applied to individual cases.

A) True

B) False

118. Step Therapy in Drug Utilization Management is no longer used as it has resulted in many patient deaths.

A) True

B) False

119. An example of an outcome that a payer's Quality Management program might look for would be; access for disabled individuals.

A) True

B) False

120. . "The Finance Director, not the Marketing Director, has responsibility for enrollment forecasting.

A) True

B) False

121. IBNR stands for which of the following?

A) Interest-Bearing Non-Revocable Assets

B) Investment Board Non-Binding Notices

C) Incurred But Not Reported claims liabilities

D) Investments Based on Normalized Revenues

E) Incurred Before Normal Reviews

122. Statutory capital is best understood as:

A) The amount of money a health insurer or HMO must pay to the government

B) A balance sheet entry under GAAP

C) Funding that payers use to subsidize local sculptors

D) Cash, short term assets, and other funds that can be quickly liquidated

E) b and d

123. Which of the following formulas has been adopted by NAIC and most regulators to determine how much statutory capital a managed care plan is required to have?

A) Risk-Based Capital (RBC)

B) Readily Available Capital (RAC)

C) Risk-Share Capital (RSC)

D) Reasonable Estimated Capital (REC)

124. Intermediaries in the employer-sponsored business market segment are:

A) Brokers

B) Consultants

C) Suppliers

D) a and b

E) a, b, and c

125. "_____" are intermediaries typically focused on smaller employers and are compensated based on commissions paid by the health plan.

A) Brokers

B) Consultants

C) Individual State Insurance Exchanges

D) a and b

126. The employee selection between carrier options chosen by the employer is called the second sale

A) True

B) False

127. Employers can restrict enrollment in their group plan to full time employees only.

A) True

B) False

128. HMOs and Health Insurers keep two sets of books or financial statements.

A) True

B) False

129. The most common form of claims submission is electronic.

A) True

B) False

130. One reason for payers to contract with providers is that the contract is to define the conditions that determine where a clinical service will be covered as a benefit, and when it will not be covered.

A) True

B) False

131. Member services is responsible for all of the following activities, except:

A) Providing information to members

B) Handling member grievances and complaints

C) Enhancing the relationship between the members of the plan and the plan itself.

D) Adjusting claims

132. There is no legal distinction between a member complaint and a grievance.

A) True

B) False

133. Appeal of coverage denial reviews are a distinctly formal process governed by both state and federal laws.

A) True

B) False

134. Enrollment and Billing errors can affect all parts of an HMO or health insurer and its customers.

A) True

B) False

135. Which of the following are not required to be licensed by states?

A) Brokers

B) Agents

C) Benefits consultants

D) Health insurers

E) HMOs

F) All of the above

136. Which of the following electronic transactions is not standardized under HIPAA?

A) Claims

B) Authorizations

C) Payments to providers

D) Enrollment

E) Electronic medical records

137. Under the ACA, the federal government is now responsible for regulating health insurance premium rates in the small group market, not the states.

A) True

B) False

138. Which of the following is not a typical function of the claims department?

A) Claims capture

B) Coordination of Benefits (COB) and Other Party Liability (OPL)

C) Application of correct provider payment schedules based on date of service and type of plan

D) Determination of member eligibility on the date of service

E) Member enrollment

F) Provider payment

G) Adjudication

139. Dependent Coverage was extended to age 29 under the Affordable Care Act (ACA)

A) True

B) False

140. The ACA requires health insurers to community rate all business.

A) True

B) False

141. Medicare is provided without cost to the Medicare beneficiary.

A) True

B) False

142. Dual Eligible Special Needs Plans enroll only which type of individual?

A) Individuals who are eligible for Medicare and have Long-Term care insurance

B) Individuals who are eligible for Medicare and Medicaid

C) Individuals who are eligible for Medicare and are institutionalized

D) Individuals who are eligible for Medicare and have a severe or disabling chronic condition

E) Individuals who are eligible for Medicare and for Employer Group Coverage

143. Medicare Advantage plans are authorized under Part D.

A) True

B) False

144. Medicare Advantage plans can receive bonus payments for high star quality ratings. The bonus payments cannot be used to:

A) Provide additional benefits

B) Reduce cost sharing

C) Reduce enrollee premiums

D) Take as profit

145. Which of the following is not a measure in the Medicare Quality Bonus Program (QBP; i.e. the "Stars" program) for Medicare Advantage plans?

A) Health Outcomes

B) Intermediate Outcomes

C) Patient Experience

D) Reducing costs

E) Access

F) Administrative processes

146. Marketing and sales activities of Medicare Advantage or managed Medicaid plans do not allow

A) Using a purchased list of email addresses or other types of lists to contact non-members

B) Door-to-door solicitation or leaflet distribution

C) Completing any portion of the enrollment application for a prospective enrollee

D) Requesting any beneficiary identification numbers such as their Social Security number, or their personal contact information

E) All of the above

F) b and d only

147. Which of the following is not a type of managed Medicaid plan?

A) HMO

B) PCCM

C) PFFS

D) PHP

E) HIO

148. Medicaid is enabled as a FFS system, so states must first obtain a federal waiver if they want use managed care for their Medicaid program.

A) True

B) False

149. Payments in the traditional Medicare program uses non-risk methods, such as the resource-based value scale.

A) True

B) False

150. Medicare Part A provides for 120 Life Time Reserve Days.

A) True

B) False

151. The most common type of HMO is the independent practice association (IPA) model plan.

A) True

B) False

152. Medicare Part A provides for 50 days of Hospice care per illness.

A) True

B) False

153. Medicare Part B covers diagnostic procedures but excludes durable medical equipment.

A) True

B) False

154. The Hold Harmless Clause in an Insurance Contract with a provider means the provider agrees to accept as payment in full for medical services provided to plan members the amount that the plan determines to be appropriate.

A) True

B) False

155. Medicare Part D is provided through private plans that contract with Medicare.

A) True

B) False

156. Medicare Part C is not a benefit but rather a provision.

A) True

B) False

157. The enrollment period for Medicare Part D lasts 7 months.

A) True

B) False

158. Service Area Network Access Standards, in some cases, are defined by appointment availability.

A) True

B) False

159. Medicare Part D coverage has no deductibles but does have a 25% co-insurance requirement.

A) True

B) False

160. Private Medicare Fee-for-Service Plans have seen the most significant number of plans and enrollments in recent years.

A) True

B) False

161. All Medicare Advantage Plans are required to all telephonic enrollments originated by the beneficiary and with no agent or representative present during the call.

A) True

B) False

162. When comparing utilization data of commercial health plans to Medicare Advantage health plans, the average rate of inpatient hospital bed days per thousand for Medicare Advantage is almost 6 times higher.

A) True

B) False

163. Medicaid covers less people than Medicare does.

A) True

B) False

164. In all states, core eligibility for Medicaid is children, the elderly needing nursing home care who are either impoverished at the time of their admission or become so by "spending down" and becoming "medically needy."

A) True

B) False

165. Medicaid benefits will usually cover prosthetics, dentures, eyeglasses, and transportation services.

A) True

B) False

166. Most all states have all or some of their Medicaid beneficiaries in some form of managed care plans.

A) True

B) False

167. Global Capitation is the near-complete transfer of risk to provider for professional and facility-related costs.

A) True

B) False

168. Fee-for-Service payment systems are not considered to be a driver of cost inflation.

A) True

B) False

169. An example of a non-risk based physician payment system is percentage of Medicare RBRVS.

A) True

B) False

170. . Which of the following is not a federal law affecting health insurance, health benefits plans, or HMOs?

A) ERISA

B) COBRA

C) CSNY

D) HIPAA

E) ACA

171. Hierarchical Condition Categories Services includes factors such as age, gender, place of residence and prior health condition of each individual Medicare beneficiary enrolled in each Medicare Advantage Plan.

A) True

B) False

172. American citizens and lawfully residing immigrants who have resided in the United States for two years can qualify for Medicaid.

A) True

B) False

173. Those enrolled in a Medicare Advantage Plan who then develop End Stage Renal Disease, under the law, are dis-enrolled from the plan.

A) True

B) False

174. States regulate all employer-sponsored health benefit plans.

A) True

B) False

175. Risk-based limited benefit plans and comprehensive managed Medicaid plans are almost always structured as HMOs.

A) True

B) False

176. Which of the following is not a key function of state regulation affecting health insurers and HMOs?

A) Licensure of insurers, HMOs and producers

B) Plan compliance with Medicare Advantage network adequacy requirements

C) Premium review and approval

D) Consumer Protections

E) Financial Solvency

F) Market Conduct

177. The National Association of Insurance Commissioners (NAIC) has no power to regulate insurers or state regulators.

A) True

B) False

178. Federal preemptions under ERISA, HIPAA, and/or the ACA apply to all but which of the following?

A) Insured health plans and HMOs

B) Self-funded health benefits plans

C) Provider payment

D) Appeal and Grievance Rights

E) Health care privacy rights

F) Electronic transactions and code sets

179. Transition Management has its goal as preventing avoidable re-admissions.

A) True

B) False

180. Which of the following federal agencies is not involved in regulating health benefits plans?

A) Department of Health and Human Services

B) Department of Homeland Security

C) Department of Defense

D) Department of Labor

E) Department of the Interior

F) Department of the Treasury

G) Department of Justice

181. States laws do not allow Managed Care Organizations the right, without consent, to use an individual's health information for purposes of paying claims

A) True

B) False

182. All state laws require Managed Care Organizations (MCO) to cover specified medical conditions, and the MCO cannot determine medical necessity on these specified medical conditions.

A) True

B) False

183. The States set limits on the premiums that can be charged by a Managed Care Organization in the individual and small group markets.

A) True

B) False

184. The Mental Health Parity Act and Mental Health Parity Act and Addiction Equity Act, requires coverage for the treatment of behavioral health conditions and substance abuse disorders on the same basis as coverage provided for medical and surgical benefits.

A) True

B) False

185. The Affordable Care Act provides for the following; coverage for children up to age 23, MCO's must provide coverage for emergency services, women are permitted to designate their own OB/GYN as their primary care physician, and guaranteed availability and renewability of coverage.

A) True

B) False