Quiz Unit I.E. Affordable Care Act (ACA), a/k/a "ObamaCare"

1. Introduction

2. Insurance market reform

Cary Sennett and Donald Nichols, "An Overview of How Healthcare Is Paid for in the United States", pp. 21-42, Chapter 2 in K. McCormick and B. Gugerty (eds.), Healthcare Information Technology Exam Guide for CompTIA® Healthcare IT Technician and HIT Pro™ Certifications, 2013

1. Under health insurance policies which of the following contribute to the individual insured's total annual out-of-pocket contribution towards the cost of the individual's health care:
   a. premium, based on predicted expenses for all individuals in the covered population
   b. deductible, generally making the individual responsible for expenses up to the deductible amount
   c. copayment, generally making the individual more price sensitive to the total cost of the services purchase
   d. all of the above

2. Healthcare in the United States is paid for by which of the following:
   a. The federal government, through Tricare, the Medicare and Medicaid programs
   b. The states, through the Medicaid program
   c. Private sector employers, by providing health insurance to their employees and their families
   d. Individual Americans
   e. All of the above

3. Which of the following is the source of health insurance for most Americans:
   a. Most Americans do not have health insurance
   b. Most Americans receive health insurance through Medicare
   c. Most Americans receive health insurance through Medicaid
   d. Most Americans receive health insurance through employer-sponsored health insurance
   e. Most Americans buy health insurance policies as individuals

4. The expansion of enrollment eligibility for the Medicaid program would primarily be funded by:
   a. the individuals newly enrolled in Medicaid
   b. an increase in the premiums charged for private health insurance
   c. the federal government

d. both the federal government and those state governments which expand Medicaid program eligibility

5. An increase in the number of individuals who purchase private health insurance in a plan with little price differentiation among members (“community rating”) would generally have what effect overall on the per person private health insurance premium prices for all the enrollees in that health insurance plan:

a. premium prices would increase regardless of the age or health status of the new enrollees, as the aggregate consumption of health services would likely increase
b. premium prices would decrease regardless of the age or health status of the new enrollees, as the cost of the aggregate consumption of health services would be spread over more individuals
c. premium prices would decrease if the new enrollees are young and healthy, as the marginal per person increase in the consumption of health services by the new enrollees would likely be less than the average per person consumption of health services by the existing enrollees
d. premium prices would decrease if the new enrollees had a pre-existing adverse health condition, as the marginal per person increase in the consumption of health services by the new enrollees would likely be greater than the average per person consumption of health services by the existing enrollees

6. In general, Medicare pays physicians:

a. Based on what physicians charge for each service they provide (FFS)
b. Based on fees that are negotiated with physicians for each service they provide
c. Based on a fee schedule that is based on the resources required to deliver different services
d. On a capitated (per-member per-month [PMPM]) basis
e. Physician services are not covered by Medicare

7. In general, Medicare pays hospitals

a. Based on what hospitals charge for each service they provide (FFS)
b. Based on fees that are negotiated with hospitals for each service they provide
c. Through a shared savings program that rewards hospitals for saving money
d. Through a “bundled payment" system that offers a fixed price for all hospital services delivered during a hospital stay
e. Hospital services are not covered by Medicare

8. The strategy of "cost-shifting", the charging of higher prices to patients covered by private insurance, is employed by some providers in order to recover losses associated with which of the following:

a. uncompensated charity care
b. uncompensated bad debt
c. shortfalls when Medicaid payment rates fall below the provider's actual cost
d. all of the above

9. Under a fee-for-service (FFS) payment model, providers generally bear no financial risk from the quantity of healthcare services consumed by any individual exceeding available payment to the provider. Which of the following would be at the opposite end of the range of payment models, with the provider assuming the greatest amount of risk that the healthcare services consumed exceed the amount of payments:

a. DRG
b. RBRVS
c. PMPM/ capitation
d. episode-based bundled payment

10. The performance of P4P programs, under which providers are offered additional payment for achieving performance targets, has been found to be "lackluster" in driving quality improvements and/or cost savings. Which of the following implementation challenges would support such a finding:

a. quality metrics tend to focus on easily determinable events, such as the completion of a specific diagnostic or treatment protocol, without consideration of its actual outcomes
b. while mortality is an outcome that is easily determinable, improvements in patient outcomes in the short term are difficult to objectively quantify
c. to draw fair performance comparisons among providers, significant relevant performance data and analytics are needed to adjust for patient population attributes in particular patient settings and health-influencing factors beyond the provider's control
d. all of the above

11. The payment to providers of an episode-based, or bundled, payment:

a. is a payment model that is more discrete and clinically manageable than capitation
b. is at the foundation of Medicare's DRG system
c. is unattractive to providers without an established integrated delivery network when the bundle is broadened to include pre- and post- hospital care
d. all of the above

12. Which of the following is true regarding innovations in payment:
    a. Accountable-care organizations (ACOs) are delivery system entities that are emerging in response to financial incentives to reduce the cost and improve the quality of health care
    b. Patient-centered medical homes (PCMHs) are nursing homes that are designed to assist patients to make the transition from hospital care to home care
    c. The Medicare Shared Savings Program (MSSP) is a way that Medicare beneficiaries can share in savings that derive from their efforts to take better care of themselves
    d. Bundled payment programs are an exciting innovation, but to date there is very little experience with them
    e. All of the above

Elisabeth Askin and Nathan Moore, The Health Care Handbook, 2013, Chapter 5 "Policy and Reform", pp. 178-231

13. Under the Affordable Care Act nearly all consumers are "guaranteed issue" of a health insurance policy, and the extent to which premium prices may vary between different consumers obtaining the same coverage is limited. Which of the following may no longer be considered by payers in the determination of an individual's premium ("rating"):
    a. age
    b. geographic location
    c. smoking status
    d. pre-existing health condition

14. Federal financial assistance is provided to individuals purchasing health insurance coverage on a health insurance exchange established pursuant to the Affordable Care Act in the form of:
    a. only an income tax credit to reduce the net cost of the insurance premium, the amount being determined in relation to the taxpayer's income as a percentage of Federal Poverty Level (FPL)
    b. only an income tax credit to reduce the net out-of-pocket healthcare costs (premium, deductible and copayments) to a specified maximum amount, the amount being determined in relation to the taxpayer's income as a percentage of FPL
    c. an income tax credit for both the premium cost and out-of-pocket expenses
    d. none of the above

15. The Affordable Care Act changes how healthcare in the U.S. is financed, shifting certain financial burdens and redistributing wealth. Which of the following does not result in the shifting of a financial burden principally upon federal taxpayers:

a. expanding the eligibility for participation in Medicaid benefits
b. providing a federal income tax credit to certain individuals to subsidize their purchase of private health insurance
c. eliminating denial of private insurance enrollment on the basis of a pre-existing health condition
d. none of the above

16. The reforms to the healthcare system effected by the Affordable Care Act include which of the following:

a. creation of a "single payer" system, wherein health insurance coverage is offered only by the federal government
b. creation of a "public option", wherein all residents can obtain health insurance coverage offered by the government (such as through the expansion of Medicare eligibility to all U.S. residents)
c. creation of national private health insurance plans, eliminating state-specific insurance regulation of private plans
d. improved availability of health insurance coverage, through expansion of eligibility for government-sponsored plans (Medicaid) and private plans (e.g. "guaranteed issue")

a. Medicaid expansion

American College of Physicians (ACP) Division of Governmental Affairs and Public Policy, "An Internist's Practical Guide to Understanding Health System Reform", Oct. 2013, "Medicaid Coverage Expansion" (vi4-medicaid-coverage-expansion.pdf) (link)

17. Prior to the expansion of enrollment eligibility for Medicaid pursuant to the Affordable Care Act, which of the following individuals were generally not eligible for Medicaid coverage, despite having income below the Federal Poverty Level (FPL):

a. children
b. pregnant women
c. parents with children
d. non-elderly childless adults

18. Approximately one-half of the States have decided not to expand enrollment eligibility for Medicaid pursuant to the Affordable Care Act, continuing the inconsistent availability of governmental health care coverage entitlements to similarly situated persons resident in

different States. Which of the following is the principal reason that States were able to opt-out of Medicaid program expansion under the ACA:

a. poor drafting of the ACA created a loophole
b. the Supreme Court ruled that the ACA could not expand Medicaid eligibility
c. the Supreme Court ruled that the ACA could expand Medicaid eligibility, but that the ACA's penalty to States for not participating in Medicaid expansion (loss of federal funding for the existing Medicaid program) was unconstitutionally coercive
d. States are not required to implement federal laws for which they lack the needed funding

b. Federal Exchanges, State-based Exchanges, Hybrids

American College of Physicians (ACP) Division of Governmental Affairs and Public Policy, "An Internist's Practical Guide to Understanding Health System Reform", Oct. 2013, "Health Insurance Marketplaces" (vi1-health-insurance-exchanges.pdf) (link)

19. Which of the following is the best rationale advanced for the establishment pursuant to the Affordable Care Act of health insurance exchanges/marketplaces where consumers can electronically enroll in private health insurance plans:

a. The government (federal and state) has particular expertise and a competitive advantage in the establishment and operation of electronic commerce websites
b. The government (federal and state) enjoys greater public trust and confidence in its ability to handle commercial matters and protect electronic consumer information than does the private sector
c. The government (federal and state) has unlimited financial resources
d. The private sector marketplace for private health insurance plans is difficult for the average consumer to navigate, and a marketplace under the control of the government (federal and state) could provide a more consumer-friendly and informed shopping experience

20. Which of the following reflected the establishment pursuant to the Affordable Care Act of health insurance exchanges/marketplaces at the start of open enrollment in October, 2013:

a. A single national federal health insurance exchange exists for the use by residents of all 50 States
b. Separate State health insurance exchanges exist in all 50 States for use by residents of those States
c. A hybrid situation exists, with a federal health insurance exchange for the use by residents of 34 States and separate State health insurance exchanges for the use by residents of 17 States

d. None of the above

21. Which of the following groups were eligible to purchase health insurance through health insurance exchanges/marketplaces establishment pursuant to the Affordable Care Act at the start of open enrollment in October, 2013:

a. Individual persons only
b. Employers only
c. Individual persons and small businesses with up to 100 employees who want to purchase insurance for their employees
d. Any person or business resident in the U.S.

22. Which of the following types of health insurance plans are available for purchase through health insurance exchanges/marketplaces establishment pursuant to the Affordable Care Act at the start of open enrollment in October, 2013:

a. Qualified Health Plans (QHP) arranged in four benefit tiers, from a Bronze plan with higher cost-sharing and lower premiums, to a Platinum plan, which has lower cost-sharing but higher premiums
b. "Universal" health insurance provided by the federal government
c. Medicare health insurance provided by the federal government
d. None of the above

c. Mandated private insurance enrollment

American College of Physicians (ACP) Division of Governmental Affairs and Public Policy, "An Internist's Practical Guide to Understanding Health System Reform", Oct. 2013, "Tax Penalties for Individuals Who Do Not Purchase Coverage and Large Employers That Do Not Offer It" (vi6-tax-penalties-individuals-who-do-not-purchase-coverage.pdf) (link)

23. The proponents of the "individual mandate" in the Affordable Care Act maintain that when an individual's "pre-existing (health) condition" is no longer grounds for health insurance denial it is necessary to require healthy young individuals to purchase insurance, in order to reduce the risk to the remaining insured pool members of "adverse selection", meaning that:

a. In the event of illness or injury, the uninsured individual would seek hospital emergency room treatment, subjecting providers to the financial risk of uncompensated care
b. Healthy individuals would delay purchasing insurance until an event of illness or injury, creating a risk pool comprised primarily of sick enrollees who would drive up the cost of coverage
c. In the event of illness or injury, the uninsured individual would relocate to the State with the most generous Medicaid benefits
d. None of the above

24. Under the Affordable Care Act's "individual mandate", the penalties applicable to an individual for failure to purchase health insurance coverage are described by which of the following:

a. Starting in 2014, the penalty is the greater of a flat fee of $95 per adult (up to $285 per family) or 1.0 percent of total income, with the penalty flat fee and percentage amounts increasing in subsequent years
b. Cannot include criminal prosecution of the individual
c. Determined by the Supreme Court to be a "tax", and thus constitutional
d. All of the above

3. Provider Cost & Quality Reforms

a. Required provider reports re: pricing of services

American College of Physicians (ACP) Division of Governmental Affairs and Public Policy, "An Internist's Practical Guide to Understanding Health System Reform", Oct. 2013, "Value-Based Payment Modifier" (vii2-value-based-payment-modifier.pdf) (link)

25. Pursuant to the Affordable Care Act, CMS is implementing a value-based payment (VBP) program under which certain physicians receive a positive adjustment in their Medicare payments (a bonus), while others will receive a negative adjustment (a penalty). The bonus amounts will be funded by:

a. an additional appropriation from Congress
b. the amount of the penalties imposed; the program is "budget neutral", meaning that it will receive no additional budgeted funds, and is funded on the principle of "rob Peter to pay Paul"
c. reductions in Medicare payments to hospitals
d. none of the above

26. Under the value-based payment (VBP) program, which of the following conditions must be satisfied in order for a physician practice group to be eligible to receive a Medicare payment bonus for 2015:

a. practice group numbers 100 or more eligible professions in 2013
b. practice group reports its 2013 quality metrics in the Physician Quality Reporting System (PQRS)
c. practice group voluntary chooses to participate in the CMS "quality-tiering" analysis
d. all of the above

27. A physician practice group that fails to reports its 2013 quality metrics in the Physician Quality Reporting System (PQRS) will face a Medicare payment reduction for 2015 equal to:

a. a negative 1% reduction under the value-based payment (VBP) program
b. a negative 1.5% reduction under the Affordable Care Act for failure to meet the satisfactory reporting criteria under PQRS
c. an aggregate negative 2.5% reduction
d. none of the above

American College of Physicians (ACP) Division of Governmental Affairs and Public Policy, "An Internist's Practical Guide to Understanding Health System Reform", Oct. 2013, "Independent Payment Advisory Board" (vi10-independent-payment-advisory-board) (link)

28. The Independent Payment Advisory Board (IPAB) to be created under the Affordable Care Act and empowered to recommend reductions in Medicare expenditures which become binding if Congress fails to address reduction in the growth of Medicare expenditures, primarily reflects a belief in which of the following:

a. the Secretary of HHS is subject to stakeholder political pressure and is unable to implement adequate measures to reduce Medicare expenditures
b. Congress is subject to stakeholder political pressure and is unable to enact through legislation adequate measures to reduce Medicare expenditures
c. the implementation of any reductions in Medicare expenditures by the Secretary of HHS or Congress is subject to protracted stakeholder litigation and resulting delay
d. none of the above

b. Required provider reports re: quality of services

American College of Physicians (ACP) Division of Governmental Affairs and Public Policy, "An Internist's Practical Guide to Understanding Health System Reform", Oct. 2013, "Payment Penalties under Medicare's Pay-for-Reporting Program" (vii1-payment-penalties-under-medicares-pay-for-reporting.pdf) (link)

c. Cost control experiments:

American College of Physicians (ACP) Division of Governmental Affairs and Public Policy, "An Internist's Practical Guide to Understanding Health System Reform", Oct. 2013, "National Pilot Program on Payment Bundling" (v2-national-pilot-program-payment-bundling.pdf) (link)

29. Under the Bundled Payments for Care Improvement (BPCI) initiative established pursuant to the Affordable Care Act, service bundle pricing applies to 48 specific medical conditions addressed during an "episode of hospitalization", which is defined as:

a. inpatient status for at least two midnights following the time of the patient's admission
b. from inpatient admission to discharge
c. from inpatient admission to 30 days following discharge
d. none of the above

30. The Bundled Payments for Care Improvement (BPCI) initiative established pursuant to the Affordable Care Act includes which of the following payment models:

a. agreed standard discount applied to the usual Medicare Part A hospital inpatient payments
b. retrospective bundled payment arrangement, where actual expenditures are reconciled against a target price for an episode of care
c. prospective bundled payment arrangement, where a lump sum payment is made to a provider for the entire episode of care
d. all of the above

Allison Viola and Lydia Washington, "Accountable Care: Implications for Managing Health Information", AHIMA 2011 (link)

31. Accountable Care Organizations (ACOs), in accepting risk for the quality and cost of care for a defined patient population potentially receiving services from multiple providers, would be interested in receiving which of the following health information technology capabilities:

a. tools for enabling care coordination among providers, including real-time interoperable information exchange
b. tools for predictive modeling, including patient population morbidity stratification
c. tools for enabling patient engagement, including patient portals and patient reminder communications
d. tools for generating and reporting provider quality metrics
e. all of the above

32. The limitations of a provider's administrative patient billing data in supporting the analytics required for the provider to prepare clinical quality measures include:

a. distinguishing between co-morbidities and complications
b. limits number of secondary diagnoses that can be reported
c. may not fully leverage ICD codes due to existing coding regulations
d. all of the above

33. A provider has traditionally been responsible for assuring the accuracy and integrity of the patient record that it created and maintained within its organization. Which of the following

events potentially place in question the extent to which a provider should be legally responsible for the assuring the accuracy and integrity of an expanded longitudinal patient record in its custody:

a. patient data has been obtained from other providers through information exchange regarding episodes of care at other providers
b. health information has been provided by the patient regarding lifestyle and management of chronic conditions
c. selected data elements from the custodian's record have been exported to another provider in response to a data exchange request
d. all of the above

34. To effectively perform its care coordination role, Accountable Care Organizations (ACOs) will necessarily need to share patient information among multiple providers, which often may be legally separate entities. The rule pertaining to the formation of ACOs provides that with respect to such disclosure of patient information among the ACO providers, the patient's consent to such disclosures:

a. is not necessary, in accordance with the TPO exception under HIPAA
b. needs to expressly obtained from each patient (an "opt-in")
c. is assumed, but a patient is allowed to expressly withdraw such assumed consent (an "opt-out")
d. none of the above

Donald Berwick, "Launching Accountable Care Organizations — The Proposed Rule for the Medicare Shared Savings Program", The New England Journal of Medicine, 365; 19 pp. 1753-1756, Nov. 10, 2011 (link)

35. The Managed Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs) envisions the ACOs assuming responsibility for a defined population of Medicare beneficiaries. Which of the following describes the method to be used in determining the composition of the patient pool attributed to an ACO, whose provider participants may or may not include all of a particular patient's providers:

a. each patient will be attributed based on the patient's pattern of primary care use
b. each patient will be attributed based on the patient's pattern of acute care use
c. each patient will be allowed to select membership in an ACO
d. none of the above

36. The Managed Shared Savings Program (MSSP) for Accountable Care Organizations (ACOs) envisions that patient beneficiaries of fee-for-service Medicare assigned to an ACO will have which of the following provider selection choices:

a. the patient will be limited to seeking care from providers participating in that ACO
b. the patient will be free to seek care from any Medicare provider they wish
c. the patient will be limited to seeking primary care from providers participating in that ACO, but will be free to seek specialty and acute care from any Medicare provider they wish
d. none of the above

37. Under the MSSP ACO program as initially proposed by CMS, which of the following models is offered to participants for sharing with CMS the upside of savings and the downside risk of losses:

a. participants during the three-year program obtain a small share of upside savings but no risk of losses for the first two years, but transition in year three to also accepting risk of losses
b. participants during the three-year program share both in the upside of savings as well as the risk of losses
c. participants can select either the model described in (a) or (b) above
d. none of the above

38. Contemporaneously with the release by CMS of its proposed rules for Accountable Care Organizations (ACOs), Dr. Don Berwick, as the then current administrator of CMS, published a perspective in which he acknowledged which of the following:

a. the Medicare Physician Group Practice (PGP) Demonstration, which served as the basis for the ACO shared savings model, had met expectations
b. most of the PGP Demonstration quality goals were actually process measures related to coronary artery disease, diabetes, heart failure, hypertension and preventive care
c. accountable care is not a panacea but rather one of a number of complimentary initiatives chartered by the ACA
d. all of the above

Matthew Peterson and David Muhlestein, "ACO Results: What We Know So Far", Health Affairs blog, posted May 30, 2014 (link)

39. In the opinion of Peterson and Muhlestein (2014), the Pioneer ACO Program, in which 32 selected integrated delivery networks were invited by CMS to participate, should be characterized as:

a. a stellar success, with total savings to Medicare of $147 million
b. having attained mixed results, with 12 ACOs sharing in savings, 19 sharing neither in savings nor in losses, and one sharing in losses
c. a resounding failure, as the 32 IDN participants, arguably more sophisticated and capable than most providers in the healthcare ecosphere and recruited by CMS to clearly demonstrated the viability of the ACO concept, failed to do so
d. none of the above

40. Peterson and Muhlestein (2014) report that by the end of 2013, the number of ACOs operating across the U.S. had grown to more than 600, with approximately how many having commercial contracts with commercial payers:

a. 50%
b. 25%
c. 10%
d. 5%