1. A DRG is best described as:

A) A drug rehab goal, meant to establish guidelines for using various pharmaceutical therapies
B) A code name for a government agency concerned with improving medical care in the United States
C) A diagnosis-related group, established to set limits on what health care organizations are reimbursed for treating various conditions
D) The Domiciliary Regulatory Commission that decides which state laws apply to malpractice claims that span state borders

2. Managed care was designed to make health care more affordable. Which of the following is true of the cost of health insurance premiums?

A) They have risen 26% since 2009.
B) They have largely stayed the same since 2001 despite an initial decrease.
C) They have decreased by only 10% since 2001.
D) Ironically, they have declined by 20% since 2009 for citizens earning more than $100,000 a year but increased for people earning less.

3. One of the main provisions of the Affordable Care Act is the individual mandate. This means:

A) People are required to have their children immunized by age 5.
B) People are given the freedom to have home health care rather than be admitted to hospitals.
C) All citizens, with a few exceptions, must maintain health insurance coverage.
D) People who are age 65 must register 2 years in advance to qualify for federally funded health insurance plans.

4. When patients who do not have insurance pay for their own care it is called:

A) Capitation
B) Fee for service
C) Reimbursement
D) The Cooperative Member Model

5. Which of the following offers the greatest incentive to keep people healthy?

A) A pluralistic health system
B) HMOs
C) A single-payer system
D) Universal coverage

6. According to experts cited in your book, the United States could save $100 billion a year by:

A) Requiring that everyone join an HMO
B) Lowering insurance administrative costs
C) Making vaccinations mandatory for preschoolers
D) Abolishing electronic medical records

7. _____ is based on a commitment to offer health services to everyone who needs them, regardless of age, ability to pay, or any other factor.

A) Free enterprise
B) Universal coverage
C) Communal taxation
D) The U.S. system

8. The employer mandate provision of the ACA is also known as pay or play. This means that they must:

A) Provide company-sponsored health plans or pay fines
B) Offer health education programs for their employees or pay for the employees to attend programs offered elsewhere
C) Take part in national health research studies or pay others to submit data on their behalf
D) Screen applicants for health concerns or pay stiff penalties

9. Which of the following best describes the use of electronic medical records in the United States?

A) Only about 46% of U.S. physicians utilize them.
B) The United States has been a leader in creating and using EMR technology.
C) Federal legislation passed in 2009 requires that all physicians use EMRs.
D) EMRs are banned in the United States because of privacy concerns.

10. How did René Descartes change the history of medicine?

A) He discovered germs.
B) He asserted that the mind and body are separate entities.
C) He said people must stop doubting so much and rely on spiritual faith to heal them.
D) He proposed that surgeries and autopsies should be outlawed because they interfere with the human body as God's creation.

11. Which of the following is most accurate?

A) The United States system is based on France's model.
B) The United States passed federal individual mandate laws in 1995.
C) The United States is primarily a multi-payer system.
D) The United States is a Six Sigma system.

12. Managed care was created mostly to:

A) Allow doctors to make more money
B) Control health care costs
C) Drive specialists out of business
D) Improve the quality of care Americans receive

13. When patients pay a set fee per year or month to cover all the medical services they will need, this is called:

A) Capitation
B) Fee for service
C) Reimbursement
D) The Cooperative Member Model

14. The difference between an HMO and a PPO is:

A) Patients who are members of a PPO have less opportunity to choose their own caregivers than do members of an HMO.
B) HMOs are affected by managed care, whereas PPOs are not.
C) HMOs are usually managed by physicians, whereas PPOs are usually managed by health care administrators and business graduates.
D) Physicians and other caregivers work directly for an HMO, whereas they maintain their own offices as affiliates of a PPO.

15. All of the following are considered to be potential disadvantages of managed care EXCEPT:

A) Medical records are less private than in former medical systems.
B) Caregivers may be tempted to undertreat patients to save money.
C) Gag rules prevent patients from talking to attorneys about their care.
D) Managed care requires a great deal of paperwork.

16. When the number of people without health care insurance in the United States topped 40 million, industry leaders realized major changes would be necessary. What is one result of cost-cutting efforts?

A) A return to the paternalistic model of patient–caregiver relationships
B) The creation of about 250 small, independent clinics across the country
C) Health professionals have become increasingly specialized in particular types of care
D) The advent of managed care

17. Which of the following is a strength of the U.S. health care system?

A) Health care leaders keep tight budget controls on prevention and health maintenance efforts.
B) The system has a reputation for highly skilled, high-tech care.
C) Care is available to anyone who needs it, regardless of income, race, or sex.
D) These are all strengths of the U.S. health care system.

18. Which of the following is NOT a benefit of providing more preventive health care?

A) People would have longer lifespans.
B) People with chronic health conditions such as diabetes and asthma would have fewer complications.
C) Patients would have fewer treatment options as costs are shifted to screening and health promotion efforts.
D) Diseases would be detected earlier resulting in improved outcomes.

19. All of the following are true about empowered health care consumers EXCEPT:

A) They tend to rely exclusively on their care providers for information on health issues.
B) They have considerable influence concerning their own health.
C) They work as partners with their caregivers to achieve their health-related goals.
D) They share their concerns and preferences with health care providers.

20. Today, if you are hoping to improve your mental health, you might see a psychologist or a counselor. However, if you are suffering from back pain, you probably see a physician or chiropractor. The division between what is considered the “mind” and what is considered the “body” originated with:

A) Hippocratic Separatism
B) The Empirical/Rational Approach
C) Cartesian dualism
D) Medical spiritualism

21. Which of the following is NOT typically an advantage of managed care?
A) Patient and health care organizations benefit if patients stay healthy.
B) Set copays may make health care more affordable for people with chronic illnesses.
C) The system is designed to reduce inefficiencies and waste.
D) The price patients pay has remained relatively stable over the last 10 years.

22. As a consumer, you subscribe to a health plan with relatively low premiums but a very high catastrophic cap. You are expected to pay for most services out of your own pocket and are rewarded with tax breaks for saving money to pay for your own care. Your plan is best described as:
A) A health maintenance organization
B) Indemnity insurance
C) A preferred provider organization
D) A high-deductible health plan

23. In the past, managed care organizations have sometimes punished caregivers for mentioning expensive treatment options to patients. The practice that limits what caregivers can say to patients is called:
A) A gag rule
B) Prohibition
C) Communication reticence
D) An information embargo

24. If a hospital cuts costs and is able to provide care for less money than the capitated fees it receives, what happens?
A) The hospital gets to keep the difference as profit.
B) The hospital reimburses the patient, providing an incentive for patients to get well quickly.
C) It is no longer considered capitation.
D) All of the above are likely to happen.

25. You are in charge of financial oversight for the hospital where you work. While reading the text you learned that one way to reduce the number of unnecessary procedures is to:
A) Implement a system of electronic medical records
B) Limit your patient load to people who are covered by Medicare or Medicaid
C) Raise the federal poverty line
D) Do all of the above

26. The World Health Organization asserts that the United States has the best health care system in the world.

A) True
B) False

27. The United States spends eight times the worldwide average, per capita, on health care.

A) True
B) False

28. The initial cost of ramping up health care will be about $1 billion nationwide.

A) True
B) False

29. The Affordable Care Act designates funding for scholarships and student-loan forgiveness programs for individuals who wish to become health professionals.

A) True
B) False

30. René Descartes is best known for introducing the theory of probability that influences medicine to this very day.

A) True
B) False

31. The Affordable Care Act mandates that U.S. residents have some type of health insurance but does not stipulate what services must be part of the policy.

A) True
B) False

32. Empowered patients seek health consultations only when they are ill.

A) True
B) False

33. Managed care organizations were created to improve the sanitary conditions at medical centers in developing countries. When it was discovered that costs fell as quality rose, managed care was introduced in the United States.

A) True
B) False

34. A PPO hires physicians and other care providers, who earn an established salary directly from the PPO.

A) True
B) False

35. One advantage of managed care is that it offers patients a greater level of privacy than they had previously.

A) True
B) False

36. From a consumer's perspective, how do fee-for-service and capitated systems differ? From a care provider's perspective?

37. Which type of managed care plan do/would you prefer as a consumer? As a health professional? Explain your reasons for each answer.

38. What does the term *universal coverage* mean? Are you in favor of universal coverage? Why or why not?

39. Name and describe at least four potential advantages and four potential disadvantages of the Affordable Care Act.

Answer Key

1. C
2. A
3. C
4. B
5. C
6. B
7. B
8. A
9. A
10. B
11. C
12. B
13. A
14. D
15. C
16. D
17. B
18. C
19. A
20. C
21. D
22. D
23. A
24. A
25. A
26. B
27. A
28. B
29. A
30. B
31. B
32. B
33. B
34. B
35. B
36.
37.
38.
39.