1.For most *privately* insured Americans, health insurance is:
*a. Employer based
b. Financed by the government
c. Privately purchased
d. None of the above

2. The role of the Federal government in the U.S. health care system is:
a. Regulator
b. Major financer
c. Medicaid reimbursement rate setter
*d. All of the above

3. A truly free market in health care would require:
a. Adequate information for patients
b. Independent actions between buyers (patients) and sellers (providers)
c. Unencumbered interaction of the forces of supply and demand
*d. All of the above

4. In 1965 Medicare was created as:
a. A program to ensure health insurance coverage for the poor
b. A program to reimburse hospitals for care of those over 65 and those with disabilities
c. An insurance program that focuses on those with disabilities
*d. An entitlement program for those 65 and above that provides health insurance

5. Health care in the United States:
a. Has emphasized intensive, high-technology care
b. Reimbursed primary care providers at a higher rate than specialists
c. Focused on community-based care rather than acute care
*d. All of the above

6. Big data:
a. Is the term used for all medical records in patient-centered medical homes
b. Is synonymous with the term *meaningful use data*
c. Uses a variety of data sources
*d. All of the above

7. All of the following are examples of cost sharing EXCEPT:
a. Deductibles that must be reached before insurance will reimburse providers
b. Copayments that must be paid at each provider visit
*c. Essential benefits
d. Premiums individuals pay to receive employer-based health insurance

8. An element of the health system that challenges the market principle “buyers have information about the product, or know how to get information about the product” is:
a. Required copayments at the time of reach visit
*b. Asymmetry of information between providers and patients
c. Antitrust law
d. All of the above

9. A diagnosis-related group (DRG) is a:
   a. Prospective payment system based upon a fixed reimbursement rate per day
   *b. Prospective payment system based upon a fixed reimbursement rate per admission diagnosis
   c. Payment system that financially incentivizes long hospital stays
   d. All of the above

10. A reimbursement method in which providers and payers share revenue when expenses are less than expected when serving a particular population:
   a. Capitation
   b. Fee for service
   c. Bundled payments
   *d. Accountable Care Shared Savings Program

11. Which of the following is a characteristic of care within fee-for-service reimbursement?
   a. Coordinated care across provider types
   *b. An emphasis on high technology, specialist care
   c. Focused attention on population health
   d. Focused attention on social determinants of health

12. Traditional universal principles of health care ethics include all of the following except:
   a. Beneficence
   b. Nonmaleficence
   c. Role fidelity
   *d. Population health accountability

13. In general, the best overall predictor of health status is:
   *a. Social determinants of health
   b. Access to specialty care
   c. The number of physicians per general population
   d. All of the above contribute equally

14. The U.S. employer-based health insurance system:
   a. Was the result of careful strategic planning
   b. Emerged in the 1920s as a consumer-driven social movement
   *c. Creates a de facto hidden tax on the employees of the employers who offer health insurance
   d. All of the above

15. Types of boards include:
   *a. Governing boards with fiduciary responsibility
   b. Advisory boards
   c. Regulatory boards
   d. All of the above

16. The term *payers* typically refers to all of the following EXCEPT:
   a. Insurance companies
   b. Governmental entities such as Medicare
   c. Governmental entities such as Medicaid
   *d. Patients