

PUBPOL 2350 THE U.S. HEALTH CARE SYSTEM PRELIM 1 PRACTICE TEST (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Introduction

Preparing for a certification exam can feel overwhelming, but with the right tools, it becomes an opportunity to build confidence, sharpen your skills, and move one step closer to your goals. At Examzify, we believe that effective exam preparation isn't just about memorization, it's about understanding the material, identifying knowledge gaps, and building the test-taking strategies that lead to success.

This guide was designed to help you do exactly that.

Whether you're preparing for a licensing exam, professional certification, or entry-level qualification, this book offers structured practice to reinforce key concepts. You'll find a wide range of multiple-choice questions, each followed by clear explanations to help you understand not just the right answer, but why it's correct.

The content in this guide is based on real-world exam objectives and aligned with the types of questions and topics commonly found on official tests. It's ideal for learners who want to:

- Practice answering questions under realistic conditions,
- Improve accuracy and speed,
- Review explanations to strengthen weak areas, and
- Approach the exam with greater confidence.

We recommend using this book not as a stand-alone study tool, but alongside other resources like flashcards, textbooks, or hands-on training. For best results, we recommend working through each question, reflecting on the explanation provided, and revisiting the topics that challenge you most.

Remember: successful test preparation isn't about getting every question right the first time, it's about learning from your mistakes and improving over time. Stay focused, trust the process, and know that every page you turn brings you closer to success.

Let's begin.

How to Use This Guide

This guide is designed to help you study more effectively and approach your exam with confidence. Whether you're reviewing for the first time or doing a final refresh, here's how to get the most out of your Examzify study guide:

1. Start with a Diagnostic Review

Skim through the questions to get a sense of what you know and what you need to focus on. Your goal is to identify knowledge gaps early.

2. Study in Short, Focused Sessions

Break your study time into manageable blocks (e.g. 30 – 45 minutes). Review a handful of questions, reflect on the explanations.

3. Learn from the Explanations

After answering a question, always read the explanation, even if you got it right. It reinforces key points, corrects misunderstandings, and teaches subtle distinctions between similar answers.

4. Track Your Progress

Use bookmarks or notes (if reading digitally) to mark difficult questions. Revisit these regularly and track improvements over time.

5. Simulate the Real Exam

Once you're comfortable, try taking a full set of questions without pausing. Set a timer and simulate test-day conditions to build confidence and time management skills.

6. Repeat and Review

Don't just study once, repetition builds retention. Re-attempt questions after a few days and revisit explanations to reinforce learning. Pair this guide with other Examzify tools like flashcards, and digital practice tests to strengthen your preparation across formats.

There's no single right way to study, but consistent, thoughtful effort always wins. Use this guide flexibly, adapt the tips above to fit your pace and learning style. You've got this!

Questions

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- 1. Which mechanism is used to reduce moral hazard?**
 - A. Removing all out-of-pocket costs.
 - B. Eliminating deductibles.
 - C. Automatically increasing premiums.
 - D. Patient cost-sharing.

- 2. Why does NHE exceed Personal Health Care Expenditures?**
 - A. NHE exceeds because the latter excludes research spending, investments, and net exports
 - B. Personal Consumption Expenditure excludes hospital expenses
 - C. NHE and Personal Expenditure are measured the same way
 - D. Personal Expenditure includes net exports

- 3. Which factor contributes to the growing demand for long-term care as the population ages?**
 - A. Decreasing life expectancy
 - B. Increasing birth rates
 - C. Aging population leading to greater demand for long-term care
 - D. Decreased prevalence of chronic diseases

- 4. What does the Dartmouth Atlas conclude about regional variation in spending and outcomes?**
 - A. There are large differences in care and cost between regions, with little evidence that outcomes are better in high-cost regions (and they may be worse).
 - B. Regions with higher costs always have better outcomes.
 - C. There is no variation in spending across regions.
 - D. Lower-cost regions always have worse outcomes.

- 5. On the supply-side approach, which statement is true?**
 - A. The government restricts access to technologies and pays only for high-value tech.
 - B. Markets alone determine all technology pricing with no government role.
 - C. Insurers determine prices without government involvement.
 - D. Patients bear all costs without any negotiated pricing.

6. What is the primary objective of utilization management?

- A. Increase utilization of high-cost services
- B. Minimize low-value, high-cost care
- C. Expand network to every provider
- D. Maximize premium revenue

7. Pure premium is defined as?

- A. The expected medical spending for a person or group with the same risk level.
- B. The insurer's expected profit.
- C. The total annual cost of coverage.
- D. The average deductible across a plan.

8. Which statement best describes regulatory oversight of hospital mergers?

- A. Regulators never review hospital mergers
- B. Regulators always block all hospital mergers
- C. Regulators consider only medical quality, not price
- D. Regulators evaluate mergers to maintain competition and prevent price increases and reduced quality of care

9. Which statement about the Choosing Wisely campaign is true?

- A. It has achieved its goals.
- B. It has not succeeded yet.
- C. It has reduced patient costs.
- D. It has eliminated waste.

10. What does the Iron Triangle of Health Care describe?

- A. The trade-off among high quality, broad access, and low cost
- B. A fixed rule that all three can be maximized simultaneously
- C. The relationship between health outcomes and GDP
- D. The determinants of health

Answers

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1. D
2. A
3. C
4. A
5. A
6. B
7. A
8. D
9. B
10. A

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Explanations

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1. Which mechanism is used to reduce moral hazard?

- A. Removing all out-of-pocket costs.
- B. Eliminating deductibles.
- C. Automatically increasing premiums.
- D. Patient cost-sharing.**

Moral hazard in health care comes from people consuming more services when they don't feel the full cost. The way to curb this behavior is to require patients to share in the costs of care at the point of use. This cost-sharing—through copays, coinsurance, and deductibles—creates a price signal that makes people think twice before seeking care, helping to reduce unnecessary or low-value utilization while still allowing access to needed services. Removing all out-of-pocket costs or eliminating deductibles would remove that price signal and likely increase overuse. Automatically increasing premiums doesn't directly address the patient's on-the-spot decision to seek care. Therefore, patient cost-sharing is the mechanism that best reduces moral hazard.

2. Why does NHE exceed Personal Health Care Expenditures?

- A. NHE exceeds because the latter excludes research spending, investments, and net exports**
- B. Personal Consumption Expenditure excludes hospital expenses
- C. NHE and Personal Expenditure are measured the same way
- D. Personal Expenditure includes net exports

National Health Expenditure is broader than Personal Health Care Expenditures. NHE covers all health spending in the economy, including personal outlays plus government health spending, plus health-related investments and research, and even health-related net exports. Personal Health Care Expenditures focus on what individuals spend directly on personal health services and products and do not include government payments, capital investments, or cross-border health transactions. So NHE will be larger because it adds those extra components that PHCE leaves out, such as research, investments in facilities and equipment, and any net exports of health services. This is why the correct explanation is that PHCE excludes those items, while NHE includes them.

3. Which factor contributes to the growing demand for long-term care as the population ages?

- A. Decreasing life expectancy
- B. Increasing birth rates
- C. Aging population leading to greater demand for long-term care**
- D. Decreased prevalence of chronic diseases

As people get older, they're more likely to need help with daily activities and to live with chronic conditions that require ongoing support. This shift means a larger segment of the population will require long-term care services, whether in facilities, at home, or through community programs. A growing older population translates into higher overall demand for long-term care. The other options don't fit this trend. Decreasing life expectancy would reduce the number of people reaching ages where long-term care is common. Increasing birth rates adds more younger people, not the older adults who typically need long-term care. A decreased prevalence of chronic diseases would lower the number who need ongoing assistance.

4. What does the Dartmouth Atlas conclude about regional variation in spending and outcomes?

- A. There are large differences in care and cost between regions, with little evidence that outcomes are better in high-cost regions (and they may be worse).**
- B. Regions with higher costs always have better outcomes.
- C. There is no variation in spending across regions.
- D. Lower-cost regions always have worse outcomes.

The main idea is that spending and care vary widely by region, yet higher spending does not reliably lead to better outcomes. The Dartmouth Atlas shows large differences in how much care is delivered and how much is spent across regions, and after adjusting for patient health and risk, regions with higher costs do not consistently achieve better health results; in fact, some high-cost areas have outcomes that are no better or even worse. This highlights that spending differences are not driven by superior outcomes, suggesting potential inefficiency and overuse in some regions, and underuse in others.

5. On the supply-side approach, which statement is true?

- A. The government restricts access to technologies and pays only for high-value tech.**
- B. Markets alone determine all technology pricing with no government role.
- C. Insurers determine prices without government involvement.
- D. Patients bear all costs without any negotiated pricing.

In a supply-side approach, decisions about which medical technologies are actually available and paid for are made by authorities and payers, not by the market alone. The aim is to control costs and steer adoption toward high-value, proven technologies. The statement that the government restricts access to technologies and pays only for high-value tech fits this idea perfectly: it captures the idea that access is rationed and reimbursement is contingent on value, not on consumer demand alone. Why the other ideas don't fit: if markets alone determined technology pricing with no government role, there would be little centralized control over which technologies are funded or how they're priced, likely leading to inefficiency and inequities. If insurers alone decided prices without government involvement, there would still be payer influence, but supply-side policy typically includes broader regulatory or public payer decisions about coverage and value. If patients bore all costs with no negotiated pricing, there'd be no systematic effort to curb waste or ensure access to high-value technologies through value-based reimbursement.

6. What is the primary objective of utilization management?

- A. Increase utilization of high-cost services
- B. Minimize low-value, high-cost care**
- C. Expand network to every provider
- D. Maximize premium revenue

Utilization management focuses on making sure health care resources are used wisely. The main aim is to curb spending on care that is high-cost but provides little or no value, while ensuring necessary services are accessible and appropriately used. This is done through tools like prior authorizations, reviews of medical necessity, evidence-based guidelines, and care coordination to prevent unnecessary tests or procedures. That's why the best answer is to minimize low-value, high-cost care. The other options miss the point: increasing the use of expensive services would raise costs, expanding the network is about access and contracting rather than how care is used, and maximizing premium revenue is a financial goal not about optimizing clinical decisions.

7. Pure premium is defined as?

- A. The expected medical spending for a person or group with the same risk level.
- B. The insurer's expected profit.
- C. The total annual cost of coverage.
- D. The average deductible across a plan.

Pure premium is the amount needed to cover the expected medical spending for individuals or groups with the same risk profile. It reflects projected claims costs based on the risk level (age, health status, etc.) and represents the part of the premium that directly pays for anticipated medical care, without adding administrative costs, profit, or other loads. So, if a risk group is expected to incur \$X in medical expenses next year, the pure premium is \$X. The total premium charged to a policyholder would typically be higher, because insurers add loading to cover administrative costs, risk margins, and profit. Choices that refer to the insurer's profit, the overall cost of coverage, or plan deductibles mix in additional factors beyond the expected medical claims, which is why they aren't the pure premium.

8. Which statement best describes regulatory oversight of hospital mergers?

- A. Regulators never review hospital mergers
- B. Regulators always block all hospital mergers
- C. Regulators consider only medical quality, not price
- D. Regulators evaluate mergers to maintain competition and prevent price increases and reduced quality of care

Regulators assess hospital mergers to protect competition and prevent negative effects on prices and quality. When hospitals merge, they can gain greater market power, which may push up prices for insurers and patients or influence the availability and quality of care. Regulators, such as antitrust authorities, analyze how a merger would change market concentration, potential price effects, and any impact on patient access and care quality. They may approve with conditions (like divestitures or behavioral remedies) or block the deal if the competitive harm is too great. This is why the statement that regulators evaluate mergers to maintain competition and prevent price increases and reduced quality of care is the best description. The other options are incomplete or inaccurate because regulators do review mergers, they don't always block them, and they consider factors beyond quality alone, including price and competition.

9. Which statement about the Choosing Wisely campaign is true?

- A. It has achieved its goals.
- B. It has not succeeded yet.
- C. It has reduced patient costs.
- D. It has eliminated waste.

Choosing Wisely aims to cut unnecessary tests and treatments by encouraging honest conversations between clinicians and patients about value in care. It started with specialty societies publishing lists of low-value practices to avoid, and it has helped raise awareness and drive changes in some areas. However, there isn't robust, nationwide evidence that all of its goals have been met or that healthcare waste has been eliminated. Measuring impact is complex, and while some settings show reductions in overuse, others do not, and overall patient costs have not fallen uniformly. Because progress is uneven and ongoing, saying it has not succeeded yet best reflects the current reality.

10. What does the Iron Triangle of Health Care describe?

- A. The trade-off among high quality, broad access, and low cost**
- B. A fixed rule that all three can be maximized simultaneously
- C. The relationship between health outcomes and GDP
- D. The determinants of health

The Iron Triangle in health care is about the trade-offs among three aims: high quality, broad access, and low cost. The idea is you can usually optimize two of these at once, but not all three simultaneously. For instance, expanding access or boosting quality tends to raise costs because more services and resources are used; cutting costs can limit either access or quality. So you end up prioritizing two goals and accepting a concession on the third. This differs from thinking you can maximize all three at once, and it's not about the link between health outcomes and GDP or about the broad determinants of health.

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Next Steps

Congratulations on reaching the final section of this guide. You've taken a meaningful step toward passing your certification exam and advancing your career.

As you continue preparing, remember that consistent practice, review, and self-reflection are key to success. Make time to revisit difficult topics, simulate exam conditions, and track your progress along the way.

If you need help, have suggestions, or want to share feedback, we'd love to hear from you. Reach out to our team at hello@examzify.com.

Or visit your dedicated course page for more study tools and resources:

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We wish you the very best on your exam journey. You've got this!

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