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TEXTBOOK TESTBANKS

Test Bank for Health Economics and Policy 8th Henderson

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Chapter 01: U.S. Medical Care: A System at the Crossroads

1. Charging higher prices for one category of patients in order to provide free or subsidized care to another group is called:

a. price discrimination.
b. cost shifting.
c. categorical costing.
d. reprehensible and unethical.
e. creative accounting.

ANSWER: b

FEEDBACK:

a. Incorrect. Cost shifting is the practice of charging higher prices to one group of patients, usually those with private health insurance, in order to subsidize the care of those whose payments do not cover the fully allocated cost of the care they receive.
b. Correct. Cost shifting is the practice of charging higher prices to one group of patients, usually those with private health insurance, in order to subsidize the care of those whose payments do not cover the fully allocated cost of the care they receive.
c. Incorrect. Cost shifting is the practice of charging higher prices to one group of patients, usually those with private health insurance, in order to subsidize the care of those whose payments do not cover the fully allocated cost of the care they receive.
d. Incorrect. Cost shifting is the practice of charging higher prices to one group of patients, usually those with private health insurance, in order to subsidize the care of those whose payments do not cover the fully allocated cost of the care they receive.
e. Incorrect. Cost shifting is the practice of charging higher prices to one group of patients, usually those with private health insurance, in order to subsidize the care of those whose payments do not cover the fully allocated cost of the care they receive.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-1a - Emergence of the Modern Medical System
DATE CREATED: 1/24/2022 3:04 AM
DATE MODIFIED: 2/9/2022 7:28 AM

2. In the 1960s, individuals paid for the majority of their medical care out of pocket. Increased insurance coverage, both private and public, displaced out-of-pocket spending as the primary source of payment. By 2020, what was the forecasted percentage amount of health care spending paid by individuals?

a. 6 percent
b. 10.4 percent
c. 11.6 percent
d. 17.4 percent
e. Whatever amount we are currently spending

ANSWER: b

FEEDBACK:

a. Incorrect. The amount that individuals paid out of pocket for health care expenditures declined from 17.4 percent in the 1960s to a forecasted 10.4 percent in 2020, according to Centers for Medicare and Medicaid Services (CMS.gov).
b. Correct. The amount that individuals paid out of pocket for health care

expenditures declined from 17.4 percent in the 1960s to a forecasted 10.4 percent in 2020, according to Centers for Medicare and Medicaid Services (CMS.gov).

c. Incorrect. The amount that individuals paid out of pocket for health care expenditures declined from 17.4 percent in the 1960s to a forecasted 10.4 percent in 2020, according to Centers for Medicare and Medicaid Services (CMS.gov).

d. Incorrect. The amount that individuals paid out of pocket for health care expenditures declined from 17.4 percent in the 1960s to a forecasted 10.4 percent in 2020, according to Centers for Medicare and Medicaid Services (CMS.gov).

e. Incorrect. The amount that individuals paid out of pocket for health care expenditures declined from 17.4 percent in the 1960s to a forecasted 10.4 percent in 2020, according to Centers for Medicare and Medicaid Services (CMS.gov).

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-1c - Recent Changes in the Payment Structure
DATE CREATED: 1/24/2022 3:09 AM
DATE MODIFIED: 2/9/2022 7:41 AM

3. When someone mentions the “managed care” approach to health care, what are they referring to? Be sure to include the term “horizontal integration” in your answer.

ANSWER: Managed care refers to a delivery system that originally integrated the financing and provision of medical care into one organization. Now the term encompasses different arrangements designed to coordinate services and control costs, such as an HMO, a PPO, or a point-of-service plan. Horizontal integration is the process by which this was carried out, transforming a highly fragmented industry into a single multihospital system.
POINTS: 1
QUESTION TYPE: Essay
HAS VARIABLES: False
STUDENT ENTRY MODE: Basic
LEARNING OBJECTIVES: 1-1b - Recent Changes in Medical Care Delivery
DATE CREATED: 1/24/2022 3:14 AM
DATE MODIFIED: 2/9/2022 7:41 AM

4. The 1974 federal legislation that exempted employers from certain state laws governing health insurance was:

a. COBRA.
b. ERISA.
c. CON.
d. HIPAA.
e. SCHIP.

ANSWER: b
FEEDBACK:

a. Incorrect. Passed to regulate the corporate use of pension funds, the Employee Retirement and Income Security Act (ERISA) of 1974 also exempted self-insured health plans from state-level health insurance regulations. Today, over two-thirds of all workers with employer-sponsored insurance are covered by self-insured plans.

b. Correct. Passed to regulate the corporate use of pension funds, the Employee

Retirement and Income Security Act (ERISA) of 1974 also exempted self-insured health plans from state-level health insurance regulations. Today, over two-thirds of all workers with employer-sponsored insurance are covered by self-insured plans.

c. Incorrect. Passed to regulate the corporate use of pension funds, the Employee Retirement and Income Security Act (ERISA) of 1974 also exempted self-insured health plans from state-level health insurance regulations. Today, over two-thirds of all workers with employer-sponsored insurance are covered by self-insured plans.

d. Incorrect. Passed to regulate the corporate use of pension funds, the Employee Retirement and Income Security Act (ERISA) of 1974 also exempted self-insured health plans from state-level health insurance regulations. Today, over two-thirds of all workers with employer-sponsored insurance are covered by self-insured plans.

e. Incorrect. Passed to regulate the corporate use of pension funds, the Employee Retirement and Income Security Act (ERISA) of 1974 also exempted self-insured health plans from state-level health insurance regulations. Today, over two-thirds of all workers with employer-sponsored insurance are covered by self-insured plans.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-1a - Emergence of the Modern Medical System
DATE CREATED: 1/24/2022 3:15 AM
DATE MODIFIED: 2/9/2022 7:42 AM

5. The key elements of the Affordable Care Act (ACA) passed in 2010 included all of the following except:

a. a mandate that required individuals and every employer with over 50 full-time workers to provide a qualified health plan at an affordable price or face penalties.

b. expanded insurance regulations include guaranteed issue, guaranteed renewability, and no exclusions for preexisting conditions.

c. the establishment of insurance exchanges where individuals who did not have access to employer-sponsored insurance could receive subsidies to purchase private coverage.

d. a federal requirement that states extend Medicaid coverage to individuals with family income less than 138 percent of the federal poverty level.

e. price controls on brand name pharmaceuticals.

ANSWER: e
FEEDBACK:

a. Incorrect. Mandates, new insurance regulation, health insurance exchanges, and a mandatory Medicaid expansion were all part of the original ACA passed in 2010. Two years later, the Supreme Court ruled that states were not required to expand Medicaid coverage, but could do so voluntarily. Pharmaceutical price controls were not a part of the legislation.

b. Incorrect. Mandates, new insurance regulation, health insurance exchanges, and a mandatory Medicaid expansion were all part of the original ACA passed in 2010. Two years later, the Supreme Court ruled that states were not required to expand Medicaid coverage, but could do so voluntarily. Pharmaceutical price controls were not a part of the legislation.

c. Incorrect. Mandates, new insurance regulation, health insurance exchanges, and a mandatory Medicaid expansion were all part of the original ACA passed in 2010. Two years later, the Supreme Court ruled that states were not required to expand Medicaid coverage, but could do so voluntarily. Pharmaceutical price controls were not a part of the legislation.

d. Incorrect. Mandates, new insurance regulation, health insurance exchanges,

and a mandatory Medicaid expansion were all part of the original ACA passed in 2010. Two years later, the Supreme Court ruled that states were not required to expand Medicaid coverage, but could do so voluntarily. Pharmaceutical price controls were not a part of the legislation.

e. Correct. Mandates, new insurance regulation, health insurance exchanges, and a mandatory Medicaid expansion were all part of the original ACA passed in 2010. Two years later, the Supreme Court ruled that states were not required to expand Medicaid coverage, but could do so voluntarily. Pharmaceutical price controls were not a part of the legislation.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-2b - The Key Elements of the ACA
DATE CREATED: 1/24/2022 3:18 AM
DATE MODIFIED: 2/9/2022 7:42 AM

6. One of the key elements of ACA was the establishment of health care insurance exchanges. Describe briefly what an insurance exchange is and cite at least one example of a government-run exchange.

ANSWER: A health care insurance exchange is a digital marketplace available in every state where individuals can shop for health insurance and receive government subsidies, making it more affordable. The so-called Obamacare is one plan, but several other states have their own exchanges, such as the plan in California, which is called “Covered California.”
POINTS: 1
QUESTION TYPE: Essay
HAS VARIABLES: False
STUDENT ENTRY MODE: Basic
LEARNING OBJECTIVES: 1-2b - The Key Elements of the ACA
DATE CREATED: 1/24/2022 3:21 AM
DATE MODIFIED: 2/9/2022 7:43 AM

7. Since ACA was passed in 2010, there have been many efforts to have the bill thrown out or at least watered down. Most attempts have been unsuccessful. However, one key elements of ACA was successful, which was to:

a. overturn expanded Medicaid availability.
b. eliminate health care exchanges.
c. eliminate the tax penalty for the individual mandate.
d. reduce Medicare spending to fund coverage for non-Medicare recipients.
e. expand regulation of the private health insurance market.

ANSWER: c
FEEDBACK:

a. Incorrect. Four of the five choices were accomplished in some respect, with the exception of the elimination of the tax penalty, which has been set at $0. The tax penalty was eliminated after the end of 2018, under the terms of the Tax Cuts and Jobs Act of 2017.
b. Incorrect. Four of the five choices were accomplished in some respect, with the exception of the elimination of the tax penalty, which has been set at $0. The tax penalty was eliminated after the end of 2018, under the terms of the Tax Cuts and Jobs Act of 2017.
c. Correct. Four of the five choices were accomplished in some respect, with the exception of the elimination of the tax penalty, which has been set at $0. The tax penalty was eliminated after the end of 2018, under the terms of the Tax Cuts and Jobs Act of 2017.

d. Incorrect. Four of the five choices were accomplished in some respect, with the exception of the elimination of the tax penalty, which has been set at $0. The tax penalty was eliminated after the end of 2018, under the terms of the Tax Cuts and Jobs Act of 2017.

e. Incorrect. Four of the five choices were accomplished in some respect, with the exception of the elimination of the tax penalty, which has been set at $0. The tax penalty was eliminated after the end of 2018, under the terms of the Tax Cuts and Jobs Act of 2017.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-2e - Changes in the System Since Passage
DATE CREATED: 1/24/2022 3:22 AM
DATE MODIFIED: 2/9/2022 7:43 AM

8. Self-insurance refers to the practice of setting aside funds to pay for medical care expenses instead of paying premiums to an insurance company. Approximately, how many of all employees who participate in group insurance plans work for firms that self-insure?

a. one-fourth
b. one-third
c. one-half
d. two-thirds
e. three-fourths

ANSWER: d
FEEDBACK:

a. Incorrect. Of the 157.6 million individuals insured by employer-sponsored plans in 2016, over 105 million received their coverage in self-insured plans. See Edmund Haislmaier and Drew Gonshorowski, “2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed,” Heritage Foundation, Issue Brief No. 4743, July 26, 2017.

b. Incorrect. Of the 157.6 million individuals insured by employer-sponsored plans in 2016, over 105 million received their coverage in self-insured plans. See Edmund Haislmaier and Drew Gonshorowski, “2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed,” Heritage Foundation, Issue Brief No. 4743, July 26, 2017.

c. Incorrect. Of the 157.6 million individuals insured by employer-sponsored plans in 2016, over 105 million received their coverage in self-insured plans. See Edmund Haislmaier and Drew Gonshorowski, “2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed,” Heritage Foundation, Issue Brief No. 4743, July 26, 2017.

d. Correct. Of the 157.6 million individuals insured by employer-sponsored plans in 2016, over 105 million received their coverage in self-insured plans. See Edmund Haislmaier and Drew Gonshorowski, “2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed,” Heritage Foundation, Issue Brief No. 4743, July 26, 2017.

e. Incorrect. Of the 157.6 million individuals insured by employer-sponsored plans in 2016, over 105 million received their coverage in self-insured plans. See Edmund Haislmaier and Drew Gonshorowski, “2016 Health Insurance Enrollment: Private Coverage Declined, Medicaid Growth Slowed,” Heritage Foundation, Issue Brief No. 4743, July 26, 2017.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False

LEARNING OBJECTIVES: 1-1b - Recent Changes in Medical Care Delivery
DATE CREATED: 1/24/2022 3:36 AM
DATE MODIFIED: 2/9/2022 7:43 AM

9. Since 1950, U.S. health care spending has grown from an average of 4.5 percent of GDP to an estimated forecast of _____ percent of GDP in 2020.

a. 5
b. 10
c. 12
d. 18
e. 25

ANSWER: d

FEEDBACK:

a. Incorrect. Since 1950, U.S. health care spending has grown from an average of 4.5 percent to an estimated forecast of 18 percent of GDP, according to the Centers for Medicare and Medicaid Services (April 2020).
b. Incorrect. Since 1950, U.S. health care spending has grown from an average of 4.5 percent to an estimated forecast of 18 percent of GDP, according to the Centers for Medicare and Medicaid Services (April 2020).
c. Incorrect. Since 1950, U.S. health care spending has grown from an average of 4.5 percent to an estimated forecast of 18 percent of GDP, according to the Centers for Medicare and Medicaid Services (April 2020).
d. Correct. Since 1950, U.S. health care spending has grown from an average of 4.5 percent to an estimated forecast of 18 percent of GDP, according to the Centers for Medicare and Medicaid Services (April 2020).
e. Incorrect. Since 1950, U.S. health care spending has grown from an average of 4.5 percent to an estimated forecast of 18 percent of GDP, according to the Centers for Medicare and Medicaid Services (April 2020).

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-1a - Emergence of the Modern Medical System
DATE CREATED: 1/24/2022 3:42 AM
DATE MODIFIED: 2/9/2022 7:44 AM

10. Even in the US, approximately, what percent of medical care is purchased through insurance, government programs or other third party insurers?

a. 50
b. 60
c. 75
d. 90
e. 100

ANSWER: d

FEEDBACK:

a. Incorrect. In the United States, out-of-pocket costs only account for 10.6 percent of health care spending, while the other 89.4 percent is made up of insurance or government-run institutions in 2020.
b. Incorrect. In the United States, out-of-pocket costs only account for 10.6 percent of health care spending, while the other 89.4 percent is made up of insurance or government-run institutions in 2020.
c. Incorrect. In the United States, out-of-pocket costs only account for 10.6 percent of health care spending, while the other 89.4 percent is made up of

insurance or government-run institutions in 2020.

d. Correct. In the United States, out-of-pocket costs only account for 10.6 percent of health care spending, while the other 89.4 percent is made up of insurance or government-run institutions in 2020.

e. Incorrect. In the United States, out-of-pocket costs only account for 10.6 percent of health care spending, while the other 89.4 percent is made up of insurance or government-run institutions in 2020.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-1c - Recent Changes in the Payment Structure
DATE CREATED: 1/24/2022 4:04 AM
DATE MODIFIED: 2/9/2022 7:44 AM

11. Opportunity cost measures:

a. foregone opportunities.
b. value-based prices.
c. value in terms of the cost of production.
d. the difference between production cost and resource cost.
e. total accounting cost.

ANSWER: a
FEEDBACK:

a. Correct. Opportunity cost is the cost of a decision based on the value of the next best alternative use of the resources.
b. Incorrect. Opportunity cost is the cost of a decision based on the value of the next best alternative use of the resources.
c. Incorrect. Opportunity cost is the cost of a decision based on the value of the next best alternative use of the resources.
d. Incorrect. Opportunity cost is the cost of a decision based on the value of the next best alternative use of the resources.
e. Incorrect. Opportunity cost is the cost of a decision based on the value of the next best alternative use of the resources.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-3 - Ten Key Economic Concepts
DATE CREATED: 1/24/2022 4:38 AM
DATE MODIFIED: 2/28/2022 8:11 AM

12. The opportunity cost of investing in a new lithotripter (a machine that pulverizes kidney stones with sound waves) is:

a. defined by the dollar cost of the equipment.
b. the same for every health care provider.
c. measured by the difference between the expected revenues from selling the services of the lithotripter and the invoice cost of the machine.
d. defined by the next best use of the money invested in the equipment.
e. impossible to calculate.

ANSWER: d
FEEDBACK:

a. Incorrect. Opportunity cost is the cost of a decision based on the value of the next-best alternative use of the resources.

b. Incorrect. Opportunity cost is the cost of a decision based on the value of the next-best alternative use of the resources.
c. Incorrect. Opportunity cost is the cost of a decision based on the value of the next-best alternative use of the resources.
d. Correct. Opportunity cost is the cost of a decision based on the value of the next-best alternative use of the resources.
e. Incorrect. Opportunity cost is the cost of a decision based on the value of the next-best alternative use of the resources.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-3 - Ten Key Economic Concepts
DATE CREATED: 1/24/2022 4:43 AM
DATE MODIFIED: 2/9/2022 7:45 AM

13. According to Adam Smith's terminology, the "invisible hand" refers to:
a. government control of the market.
b. market forces working through the price mechanism.
c. the money supply that serves to keep the economy working smoothly.
d. the role of innovation in maintaining a steady rate of growth.
e. "behind-the-scenes" policymaking to influence how markets allocate scarce resources.

ANSWER: b
FEEDBACK:
a. Incorrect. The term is a metaphor used by Adam Smith in his 1776 treatise The Wealth of Nations. It refers to the interaction of the forces of supply and demand in competitive markets that result in a free market equilibrium. Buyers willing to pay the equilibrium price can find willing providers to sell to them at that price. The market clears and resources are allocated efficiently.
b. Correct. The term is a metaphor used by Adam Smith in his 1776 treatise The Wealth of Nations. It refers to the interaction of the forces of supply and demand in competitive markets that result in a free market equilibrium. Buyers willing to pay the equilibrium price can find willing providers to sell to them at that price. The market clears and resources are allocated efficiently.
c. Incorrect. The term is a metaphor used by Adam Smith in his 1776 treatise The Wealth of Nations. It refers to the interaction of the forces of supply and demand in competitive markets that result in a free market equilibrium. Buyers willing to pay the equilibrium price can find willing providers to sell to them at that price. The market clears and resources are allocated efficiently.
d. Incorrect. The term is a metaphor used by Adam Smith in his 1776 treatise The Wealth of Nations. It refers to the interaction of the forces of supply and demand in competitive markets that result in a free market equilibrium. Buyers willing to pay the equilibrium price can find willing providers to sell to them at that price. The market clears and resources are allocated efficiently.
e. Incorrect. The term is a metaphor used by Adam Smith in his 1776 treatise The Wealth of Nations. It refers to the interaction of the forces of supply and demand in competitive markets that result in a free market equilibrium. Buyers willing to pay the equilibrium price can find willing providers to sell to them at that price. The market clears and resources are allocated efficiently.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-3 - Ten Key Economic Concepts

DATE CREATED: 1/24/2022 4:47 AM
DATE MODIFIED: 2/9/2022 7:45 AM

14. Economists use the term *marginal* to describe costs and benefits:
a. that are minimal and hardly worth noting.
b. that are incremental and thus relevant to decision making.
c. that are noteworthy but not the most important.
d. whose importance can be minimized through hard work.
e. that are poorly defined.

ANSWER: b
FEEDBACK:
a. Incorrect. Marginal analysis is the economic way of thinking about optimal decision making. Choices are seldom all-or-none propositions—decisions are made at the margin. Real-world decisions are usually a matter of trading off one option for another. Resources are scarce. There are never enough resources to satisfy everyone with everything they want.
b. Correct. Marginal analysis is the economic way of thinking about optimal decision making. Choices are seldom all-or-none propositions—decisions are made at the margin. Real-world decisions are usually a matter of trading off one option for another. Resources are scarce. There are never enough resources to satisfy everyone with everything they want.
c. Incorrect. Marginal analysis is the economic way of thinking about optimal decision making. Choices are seldom all-or-none propositions—decisions are made at the margin. Real-world decisions are usually a matter of trading off one option for another. Resources are scarce. There are never enough resources to satisfy everyone with everything they want.
d. Incorrect. Marginal analysis is the economic way of thinking about optimal decision making. Choices are seldom all-or-none propositions—decisions are made at the margin. Real-world decisions are usually a matter of trading off one option for another. Resources are scarce. There are never enough resources to satisfy everyone with everything they want.
e. Incorrect. Marginal analysis is the economic way of thinking about optimal decision making. Choices are seldom all-or-none propositions—decisions are made at the margin. Real-world decisions are usually a matter of trading off one option for another. Resources are scarce. There are never enough resources to satisfy everyone with everything they want.

POINTS: 1
QUESTION TYPE: Multiple Choice
HAS VARIABLES: False
LEARNING OBJECTIVES: 1-3 - Ten Key Economic Concepts
DATE CREATED: 1/24/2022 4:50 AM
DATE MODIFIED: 2/9/2022 7:45 AM

15. In spite of its early popularity, the Patient Protection And Affordable Care Act of 2010 (ACA) had not improved by 2020. What percentage of Americans considered its complete repeal a good thing?
a. 20 percent
b. 30 percent
c. 40 percent
d. 50 percent
e. 60 percent

ANSWER: c
FEEDBACK:
a. Incorrect. According to a study by Rasmussen in 2020, 40 percent considered

the complete repeal of ACA a good thing for most Americans, whereas 41 percent thought it would be bad. This negativity toward the ACA may be the result of the increased popularity of the single-payer approach.

b. Incorrect. According to a study by Rasmussen in 2020, 40 percent considered the complete repeal of ACA a good thing for most Americans, whereas 41 percent thought it would be bad. This negativity toward the ACA may be the result of the increased popularity of the single-payer approach.

c. Correct. According to a study by Rasmussen in 2020, 40 percent considered the complete repeal of ACA a good thing for most Americans, whereas 41 percent thought it would be bad. This negativity toward the ACA may be the result of the increased popularity of the single-payer approach.

d. Incorrect. According to a study by Rasmussen in 2020, 40 percent considered the complete repeal of ACA a good thing for most Americans, whereas 41 percent thought it would be bad. This negativity toward the ACA may be the result of the increased popularity of the single-payer approach.

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POINTS:	1
QUESTION TYPE:	Multiple Choice
HAS VARIABLES:	False
LEARNING OBJECTIVES:	1-4a - Summary and Conclusion
DATE CREATED:	1/24/2022 4:56 AM
DATE MODIFIED:	2/9/2022 7:45 AM