1. 5 key reform themes
a. Healthcare spending growth; cost controls

Steven Brill, "Bitter Pill: Why Medical Bills Are Killing Us", Time, Feb. 20, 2013

1. According to Brill (2012), high healthcare costs in the US are attributable in part to HOSPITALS for the following reason(s):
   a. They aggressively markup products and services above their actual cost
   b. They pay non-doctor hospital executives excessive salaries
   c. They consolidate with other hospitals and physician practices to improve their bargaining leverage against insurance payers
   d. They charge separately for basic instruments and supplies that are supposed to be included in the hospital's facility charge
   e. All of the above

2. According to Brill (2012), high healthcare costs in the US are attributable in part to PHYSICIANS for the following reason(s):
   a. They prescribe radiology tests that are not medically necessary to increase revenue and to protect themselves from potential claims of medical malpractice
   b. They order unnecessary patient lab test out of habit and conflicts of interest
   c. They are influenced in their selection of implantable medical devices by direct and indirect financial benefits from vendors, resulting in different vendors supplying multiple products that are functionally equivalent, undermining the prospect of hospitals reducing the number of vendors of virtually the same product and receiving reduced prices from volume purchasing discounts
   d. Under the fee-for-service model they have no disincentive for "overdoctoring"
   e. All of the above

3. According to Brill (2012), high healthcare costs in the US are attributable in part to CONGRESS for the following reason(s):
   a. It has failed to implement medical malpractice reforms which are opposed by plaintiffs' lawyers
   b. It has imposed restrictions on the Medicare program from negotiating drug prices and from using comparative-effectiveness research results to exclude any drug from reimbursement
   c. It has imposed restrictions on the Medicare program from negotiating prices for medical devices and equipment
   d. All of the above

4. According to Brill (2012), high healthcare costs in the US are attributable in part to DRUG COMPANIES for the following reason(s):

a. They lobby Congress to prohibit the Medicare program from negotiating drug prices and from using comparative-effectiveness research results to exclude any drug from reimbursement
b. They price prescription drugs in the U.S. 50% higher than for comparable products in other developed countries
c. They aggressively markup in the U.S. selective wonder drugs
d. All of the above

5. According to Brill (2012), high healthcare costs in the US are attributable in part to CONSUMERS for the following reason(s):

a. Consumers that are ill demand the most advanced treatment procedures
b. Consumers that are terminally ill demand continuing treatment
c. Consumers not knowing or caring about healthcare prices
d. Consumers with Medicare supplement insurance plans with virtually no co-payment have no disincentive to continuously seek doctor visits
e. All of the above

6. Medicare payments:

a. by law approximate a hospital's cost of provide a service, including overhead, equipment and salaries
b. for a particular drug are 6% above a drug company's average sales price for that drug
c. for durable medical devices like canes and wheelchairs, are 25% to 75% more than consumer retail store prices
d. all of the above

7. Healthcare spending in the U.S. accounts for almost 20% of gross domestic product (GDP). In relation to health care costs in other developed countries,

a. Healthcare spend as a percentage of GDP in most other developed countries is about half of the U.S. spend
b. U.S. healthcare spend on a per capita basis is an estimated 27% more than the same per capita spend in most other developed countries, even after adjusting for the relatively high per capita income in the U.S.
c. The U.S. spends more on health care than the next 10 biggest spenders combined
d. U.S. healthcare system results are no better or worse that the outcomes in other developed countries
e. All of the above

8. Increased hospital and physician practice consolidation increases the likelihood that in future negotiations with insurance payers regarding prices to be charged by the consolidated entity to patients insured by that payer

a. The hospital's bargaining leverage will increase, enabling the hospital to insist that the applicable benchmark prices be those determined for Medicare reimbursements
b. The hospital's bargaining leverage will increase, enabling the hospital to insist that the applicable benchmark prices be those reflected in the hospital's chargemaster
c. The hospital's bargaining leverage will decrease, enabling the hospital to insist that the applicable benchmark prices be those determined for Medicare reimbursements
d. The hospital's bargaining leverage will decrease, enabling the hospital to insist that the applicable benchmark prices be those reflected in the hospital's chargemaster

9. The average operating margin of hospital (i) outpatient emergency room care, (ii) non-emergency outpatient care, and (iii) inpatient care, are, respectively:

a. 15%, 35%, 2%
b. 2%, 15%, 35%
c. 35%, 15%, 2%
d. 2%, 2%, 2%

10. Public transparency into hospital prices for services

a. May be of limited utility to consumers in markets where there are limited or no competitive choices for consumer selection of healthcare providers
b. May be restricted contractually by pharmaceutical and medical-device companies
c. Has little effect on consumer purchasing decisions, which occur in marketplace circumstances favoring little price sensitivity
d. All of the above

11. Medicaid programs

a. Cover more beneficiaries than Medicare
b. Are more vulnerable to cuts and conditions that limit coverage than Medicare due to political dynamics
c. From state to state are not uniform in their benefits and restrictions
d. All of the above

12. The Affordable Care Act (a/k/a "ObamaCare") prohibits lifetime limits on health insurance policies and phases out all annual dollar limits. Insurance payers will therefore become liable

for payment of a larger amount of claims. As suggested by Brill (2012), such additional outlays by insurance payers are likely

a. To be absorbed by payers from their retained earnings
b. To be passed along to healthcare providers through negotiated reduced payer reimbursements for services provided
c. To be passed along to purchasers of health insurance coverage through higher premiums
d. None of the above

13. Medicare reimbursements can be audited by

a. Recovery audit contractors (RACs), private sector firms receiving 9% - 12.5% of the errors they uncover that are retrieved
b. The Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS)
c. A multi-agency federal healthcare fraud task force
d. All of the above

14. Medicare's leverage over hospitals, which is greater than with respect to physicians, arises from the potential reduction of reimbursements in response to hospital-reported quality and performance metrics, including:

a. Rates of injuries during a patient's hospital stay
b. Rates of infection
c. Readmissions within a month of discharge
d. All of the above

15. Brill (2012) proposes all of the following reforms to our healthcare financing structure, except:

a. Raise eligibility age for Medicare
b. Tighten antitrust laws related to hospitals to keep them from becoming so dominant in a region that insurance companies are helpless in negotiating prices with them
c. Remove restrictions on the Medicare program which restrict the negotiation of prices for drugs, medical devices and equipment, and the utilization of comparative-effectiveness research
d. Cap what Medicare and insurance companies pay for CT and MRI tests
e. None of the above

16. Brill (2012) proposes all of the following reform(s) applicable to hospitals, except:

a. Require hospital chargemasters to be reflective of actual hospital costs

b. Tax hospital profits at 75% and impose a tax surcharge on all non-doctor hospital salaries that exceed $750,000
c. Cap profits on lab tests done in-house by hospitals or doctors
d. Reform medical malpractice laws to provide a safe-harbor defense for providers to assert that the care provided was within industry norms of reasonable conduct under the circumstances
e. Reform medical malpractice laws to provide a safe-harbor defense to encourage greater use of CT scans

17. According to Brill (2012), the Affordable Care Act (a/k/a "ObamaCare")
a. Changed the rules related to who pays for what, but hasn't done much to change the prices we pay
b. Will result in higher health insurance premiums because of the prohibition on exclusions for pre-existing conditions, the restrictions on co-pays for preventive care and the end of annual or lifetime payout caps
c. In establishing insurance exchanges which encourage new entrants into the health insurance business, may increase the number of insurance payers with less market share and less negotiating leverage with dominant hospitals to reduce health care prices
d. All of the above

b. Patient Security/ Healthcare Quality (IOM)

Institute of Medicine (IOM), "To Err is Human: Building a Safer Health System", Nov. 1999 (report brief)

18. The IOM in its "To Err is Human" report (1999) concluded that the "epidemic of medical errors" being experienced in the U.S. healthcare system was "largely preventable". In support of this conclusion the IOM suggested that:
a. the "bad apples" in the healthcare delivery system, largely responsible for the "epidemic", could be identified and eventually removed through professional accreditation and licensure proceedings
b. the "bad apples" in the healthcare delivery system, largely responsible for the "epidemic", would be exposed to medical malpractice liability and eventually be unable to obtain affordable errors and omissions liability insurance and would become unemployable in the healthcare delivery system
c. the majority of medical errors do not result from individual recklessness, but more commonly are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them

d. none of the above

19. The IOM in its “To Err is Human” report (1999) concluded that the factors contributing to the “epidemic of medical errors” included:

a. Decentralized and fragmented nature of the healthcare delivery system
b. Minimal medical professional attention to error prevention
c. Medical liability concerns limit efforts to identify errors
d. Little financial incentive for healthcare providers to improve safety and quality
e. All of the above

Donald Berwick, “A user's manual for the IOM's 'Quality Chasm' report”, Health Affairs, 21, no. 3 (2002):80-90

20. The IOM in its “To Err is Human” report (1999) highlighted the issue of patient safety. The subsequent IOM “Quality Chasm” report (2001) noted that the issue of patient safety is part of a larger picture of healthcare delivery quality issues. In the following more extensive classification of quality issues, clinical point-of-care errors compromising patient safety largely falls within the domain of

a. “misuse”, meaning failure to execute clinical care plans and procedure properly
b. “overuse”, meaning the use of healthcare resources and procedures in the absence of evidence that they could help the patients subjected to them
c. “underuse”, meaning failures to employ health practices of proven benefit
d. None of the above.

21. The IOM’s “To Err is Human” report (1999) reflected a finding that patient safety, a reflection of a domain of health care quality, in the US was not what it could be. The subsequent IOM “Quality Chasm” report (2001) proposed six aims for improvement and noted that the capacity of the then current US healthcare system for achieving those desired aims

a. Required further study
b. Was sufficient
c. In its then current form, habits and environment was incapable of providing quality health care
d. None of the above

22. IOM’s “Quality Chasm” report (2001) noted that clinicians and other healthcare professionals in the then current healthcare workflow were accustomed to prerogatives associated with degree, profession, role or gender. The report called for a “new breed of

citizenship" in the system of work in which the primary professional obligation and value would be

a. Deference to seniority
b. Deference to diversity
c. Cooperation
d. None of the above

23. IOM's "Quality Chasm" report (2001) noted that the then current medical record was an embedded but important obstacle to the implementation of desired reforms. To effect a redesign of the medical record as a tool for care

a. would require simply the computerization of the current paper medical record
b. the private sector should lead the modernization effort
c. would require a major effort at a complete redesign, equivalent to a new public "moon shot"
d. none of the above

24. IOM's "Quality Chasm" report (2001) noted that a health care culture that is transparent, open, safe and honest about its defects and performance

a. Is unlikely to emerge without reform of the legal climate that provokes fear of legal liability
b. Is necessary to allow patients to make informed decisions
c. Requires a more directed national strategy and strong leadership
d. All of the above

c. Patient Access/ Equity > Affordable Care Act (2010). Market economy forces v. gov't control

Institute of Medicine (IOM), Crossing the Quality Chasm: A New Health System for the 21st Century (2001), p. 53

25. The IOM's "Quality Chasm" repot (2001) identifies "equity" as one of the six aims of the U.S. healthcare system, envisioning which of the following outcomes:

a. universal access to healthcare for all people in the U.S.
b. reduction of health disparities among particular subgroups
c. delivery of quality care to persons without differences due to personal characteristics as gender, race, age, ethnicity, income, education, disability, sexual orientation or location of residence
d. all of the above

Arnold Relman, [book review:] "Crossing the Quality Chasm: A New Health System for the 21st Century", New England J. of Med. Aug. 30, 2001

26. In the view of Arnold Relman (2001) the problems of delivering quality in healthcare services arise from

a. The healthcare system is being directly mainly by market forces, which are ill suited to the achievement of quality goals
b. The introduction of competitive business pressures among providers of care
c. The incompatibility of treating healthcare as an economic commodity while seeking to have healthcare attain social purposes
d. All of the above

d. Patient empowerment; Increased quality & cost transparency; Demonstrating value

Uwe Reinhardt, "The Disruptive Innovation of Price Transparency in Health Care", JAMA November 13, 2013, Volume 310, Number 18: 1927-28

27. Under "reference pricing"

a. The insurer contributes only a set amount for a particular medical procedure and the insured must pay the full difference between the reference price and whatever higher price provider selected by the insured may charge
b. Was used for hip and knee replacements for members of the California Public Employees Retirement System from 2008 to 2012, resulting in lower prices charged by hospitals
c. To be practical, consumers must have access to prices charged provider for their services in a format that allows for comparison shopping
d. All of the above

Ha Tu and Johanna Lauer, "Impact Of Health Care Price Transparency on Price Variation: The New Hampshire Experience", Center for Studying Health Care Change Issue Brief No. 128, November 2009

28. The public posting by the State of New Hampshire of claims-based median costs for common services performed at hospitals or other medical facilities was found not to have any meaningful impact on reducing price variation for such services. The key reason for the lack of impact was:

a. Weak provider competition throughout New Hampshire

b. Most New Hampshire consumers have little or no financial incentive to comparison shop for health services
c. Relatively easy access for cost-conscious New Hampshire residents to cheaper healthcare services in Canada
d. Relatively high percentage of New Hampshire residents are Medicare recipients

29. In New Hampshire the use by insurers of publicly-available comparative hospital pricing data was not successful to extract rate concessions from hospitals, which countered with all of the following shortcomings of the data, except:

a. The data are not recent enough to reflect current rates
b. The data are not accurate enough to capture actual rates
c. The data cover only a small subset of hospital services and present an incomplete picture
d. The data fail to account for the brand image of the hospital and loyal customer base

30. The State of New Hampshire posts claims-based median costs for 31 common services performed at hospitals or other medical facilities. The expansion of public price reporting beyond the relatively common and inexpensive outpatient procedures would be challenging for which reason(s):

a. Beyond the most common services, insurer claims volume may be insufficient to provide reliable provider-specific, insurance-specific price estimates
b. The more complex a procedure, the more difficult it becomes to adequately adjust for differences in patient mix so that prices can be compared accurately and fairly across different providers
c. Consumer price sensitivity falls with respect to expensive procedures, which often exceed a patient's insurance deductible, reducing the patient's incentive to shop for price
d. All of the above

e. Patient data privacy & security

2. 2 key statutory enactments

a. 2009: HITECH Act, as part of American Recovery and Reconstruction Act (ARRA)

William Yasnoff, Latanya Sweeney, Edward Shortliffe, "Putting Health IT on the Path to Success", JAMA, March 13, 2013—Vol. 309, No. 10

31. The key obstacles to successful implementation of a health information exchange (HIE) include:

a. Patient data privacy concerns
b. Lack of stakeholder cooperation
c. Minimal financial sustainability
d. All of the above

32. The maintenance of a patient's data in a distributed storage architecture among several data repositories is in the view of Yasnoff, Sweeney and Shortliffe (2013):

a. Superior to the utilization of a single central repository
b. Equivalent to the utilization of a single central repository
c. Seriously flawed and inferior to the utilization of a single central repository
d. None of the above

33. A distributed data storage architecture is complex and expensive for several reasons, including:

a. All EHR systems must remain online 24/7 to respond to queries
b. A network operations center (NOC) is needed to monitor the availability of the distributed data
c. Aggregation of the distributed data requires systems for the real-time reconciliation of records from multiple sources and a unique patient identifier
d. All of the above

b. 2010: Affordable Care Act (ACA), a/k/a "ObamaCare"

Jeff Goldsmith, "An Inconvenient Truth: The Health Care Cost Curve is Already Bent", Health Affairs Blog, January 20th, 2010

34. Jeff Goldsmith (2010) suggests that the U.S. healthcare industry recently was experiencing a drought in technological innovation, particularly in new drug introductions and in diagnostic technology, for all of the following reasons, except:

a. Bureaucratic corporate leadership
b. Lagging public research investment
c. Creative "menopause" in the scientific community
d. Food and Drug Administration (FDA) obstruction

35. Jeff Goldsmith (2010) suggests that the Affordable Care Act (ACA) response to the diminishing affordability of healthcare to most Americans

a. Is to reduce consumer health outlays by subsidizing the purchase of health insurance coverage and limiting subsequent out-of-pocket exposure
b. Shifts some of the burden of healthcare outlays from consumers onto the federal government, but doing next to nothing to reduce the costs themselves
c. With federal matching for expanded Medicaid coverage in addition to subsidizing health insurance purchases, federal health spending is likely to grow in double digits
d. All of the above

Ari Hoffman and Ezekiel Emanuel, "Reengineering US Health Care", JAMA Feb. 20, 2013, vol. 39, no. 7:661-62

36. According to Ari Hoffman and Ezekiel Emanuel (2013), which of the following healthcare system changes when implemented individually almost invariably fall short of expectations to improve quality and reduce costs, and need to be implemented together as a multimodality approach:

a. Pay for performance and payment reform
b. Health information technology and chronic disease management
c. Comparative effectiveness research and malpractice reform
d. All of the above

37. After suggesting that the implementation of several individual reforms in a multimodality approach is necessary, Ari Hoffman and Ezekiel Emanuel (2013) suggest:

a. The U.S. healthcare system is in trouble, and rather than single reforms it needs reengineering
b. To apply isolated solutions is to apply tools to a faulty delivery system
c. Individually implemented changes are divisive rather than unifying, and jeopardize the fundamental rethinking of health care delivery
d. All of the above

Ezekiel Emanuel, "Progress, With Caveats", Wall Street Journal, March 21, 2014

38. Ezekiel Emanuel (2014), a health policy adviser at the White House budget office during passage of the Affordable Care Act (ACA), credits the ACA on its fourth anniversary with "producing real, measurable, positive progress across the healthcare system", including all of the following, except:

a. Providing health insurance coverage to at least 12 million Americans
b. Preventing 15,000 deaths and saving over $4 billion
c. Slowing the rate of growth of healthcare spending

d. Increasing the average life expectancy of all Americans by 2.5%

39. Ezekiel Emanuel (2014) suggests that the federal and state health insurance exchanges established under the ACA, in addition to providing access to care also control healthcare costs by:

a. Increasing the demand for healthcare services without an increase in provider workforce and facilities supplying such services
b. Promoting insurance company competition
c. Requiring all exchange-listed qualified health plans to provide a required set of minimum essential health benefits, such as maternity benefits, to all Americans regardless of gender or age, enabling economies of scale
d. Facilitating the purchase of health insurance coverage at a lower administrative cost by reducing the involvement of expensive commission-earning agents and brokers, and managing the exchange as a government program

John Goodman, "A Costly Failed Experiment", Wall Street Journal, March 21, 2014

40. John Goodman (2014), on the fourth anniversary of the enactment of the Affordable Care Act (ACA), concluded that the ACA is a "costly failed experiment" because:

a. Between four million and seven million persons lost health insurance coverage they previously had
b. The insurance coverage generally available from the ACA-established health insurance exchanges provides access to only a narrow network of providers with high deductibles payable by the insured
c. Results in the artificial stratification of businesses into those employing low-wage earners who are not provided employer-subsidized health insurance, and those employing high-wage earners who are provided employer-subsidized health insurance
d. All of the above