BUSINESS OF HEALTHCARE AND HEALTH POLICY PRACTICE TEST (SAMPLE)

STUDY GUIDE

SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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Table of Contents

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

1. What is a typical objective of managed care organizations in regulating providers?

A. Control costs

B. Expand scope of practice

C. Increase referrals

D. Create new insurance products

2. How can health policy influence innovation in digital health and telemedicine?

A. Telemedicine is unaffected by licensure or privacy rules.

B. Reimbursement parity reduces investment.

C. Unclear coverage always discourages innovation.

D. Payment parity for telemedicine supports investment.

3. Under the ACA, what does guaranteed issue require?

A. Insurers can deny coverage for preexisting conditions

B. Insurers must offer only high-deductible plans

C. Insurers must cover applicants regardless of health status

D. Insurers must cover only emergency services

4. The FDA also regulates which product category?

A. Medical devices

B. Hospital budgets

C. Physician licensing

D. Insurance plans

5. What percent of Medicare reimbursement do PAs receive?

A. 50%

B. 100%

C. 85%

D. 70%

6. In evaluating new healthcare interventions, how are economic evaluations typically used to inform policy decisions?

A. They assess costs and outcomes, and decision rules may use ICER thresholds.

B. ICER is never used in policy.

C. ICER measures only budget impact.

D. ICER is irrelevant to resource allocation.

7. How did the Affordable Care Act aim to expand coverage, and what mechanisms did it use?

A. Medicaid expansion optional by state; health insurance exchanges with subsidies; individual mandate (repealed in 2019); essential health benefits; guaranteed issue and community rating; no pre-existing condition exclusions.

B. Only expanded private market subsidies; no Medicaid.

C. Introduced a single payer system.

D. Reduced premiums only for employers.

8. Medicare reimburses physicians using which metric?

A. Salaries

B. Relative Value Units (RVUs)

C. Fixed amounts per visit

D. Capitation

9. What are the 4 models of care within HMOs?

A. Group, Independent Practice Association, Network, and Staff.

B. Group, IPA, Network, and Open Panel.

C. Group, Direct Care, Telehealth, and Network.

D. Group, IPA, Network, and Private Practice.

10. What is a potential effect of price transparency on payer-provider contracts?

A. It empowers buyers to compare prices and pressure discounts

B. It eliminates the need for negotiations

C. It can lead to more standardized pricing across providers

D. It always reduces the quality of care

Answers

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

Explanations

1. What is a typical objective of managed care organizations in regulating providers?

A. Control costs

B. Expand scope of practice

C. Increase referrals

D. Create new insurance products

The main idea is that managed care organizations regulate providers to control costs and ensure that care is cost-effective and coordinated. They use networks, negotiated rates, credentialing, and utilization management to steer patients to appropriate, efficient services. Tools like gatekeeping, prior authorization, and capitated or performance-based payments align provider incentives with cost containment and quality. Expanding scope of practice isn't the primary aim of MCOs; it's determined by licensing and professional regulation outside payer networks. Increasing referrals would typically raise utilization and costs, which runs counter to the goal of containment. Creating new insurance products is about product development, not how providers are regulated within the network.

2. How can health policy influence innovation in digital health and telemedicine?

A. Telemedicine is unaffected by licensure or privacy rules.

B. Reimbursement parity reduces investment.

C. Unclear coverage always discourages innovation.

D. Payment parity for telemedicine supports investment.

Policy shapes the economics and risk that drive innovation in digital health. When telemedicine is paid at parity with in-person visits, providers see a predictable and potentially equal revenue stream, making it financially viable to invest in telehealth platforms, remote monitoring, security, and integration with electronic health records. This financial certainty lowers the barriers to piloting new care models, scaling successful ones, and developing workflows that blend virtual and in-person care, all of which fuels ongoing innovation. Licensure and privacy rules matter too, since they affect cross-state practice and data protection, but they can act as barriers if not harmonized, influencing adoption and invention. Unclear coverage creates revenue risk, which tends to deter investment, whereas clear, parity-based payment policies encourage investment and experimentation.

3. Under the ACA, what does guaranteed issue require?

A. Insurers can deny coverage for preexisting conditions

B. Insurers must offer only high-deductible plans

C. Insurers must cover applicants regardless of health status

D. Insurers must cover only emergency services

Guaranteed issue means insurers must issue a policy to anyone who applies, regardless of health status or preexisting conditions. This ensures that health problems don't block someone from getting coverage, aligning with the ACA's aim to expand access to insurance for all. That's why the correct choice is that insurers must cover applicants regardless of health status. The other options conflict with guaranteed issue: denying coverage for preexisting conditions would violate this principle; requiring only high-deductible plans isn't a requirement and would limit plan types; and covering only emergency services doesn't reflect the comprehensive coverage protections guaranteed to applicants.

4. The FDA also regulates which product category?

A. Medical devices

B. Hospital budgets

C. Physician licensing

D. Insurance plans

The FDA's jurisdiction includes medical devices as a product category, aiming to ensure safety and effectiveness before and after a device reaches the market. Medical devices span items like pacemakers, joint implants, and imaging equipment. The agency uses a risk-based classification and requires premarket review—such as PMA for high-risk devices or 510(k) clearance for lower-risk ones—plus postmarket surveillance and adverse-event reporting. By contrast, hospital budgets are financial plans managed within healthcare facilities, physician licensing is handled by state medical boards, and insurance plans are regulated by state departments of insurance or federal programs, not the FDA. So the product category regulated by the FDA is medical devices.

5. What percent of Medicare reimbursement do PAs receive?

A. 50%

B. 100%

C. 85%

D. 70%

Medicare Part B pays for professional services provided by a physician assistant at 85% of the physician fee schedule. In practical terms, if the same service would be paid at $100 for a physician, the PA's service is reimbursed at $85. This reflects Medicare's standard approach to non-physician provider reimbursement, which is lower than the physician rate. The other percentages don't match Medicare's typical PA reimbursement: 100% would imply equal payment with physicians, which isn't the norm, while 50% or 70% are not the standard rates for PA-provided care.

6. In evaluating new healthcare interventions, how are economic evaluations typically used to inform policy decisions?

A. They assess costs and outcomes, and decision rules may use ICER thresholds.

B. ICER is never used in policy.

C. ICER measures only budget impact.

D. ICER is irrelevant to resource allocation.

Economic evaluations inform policy by comparing what a new healthcare intervention costs with the health benefits it produces relative to the current standard of care. The common metric is the incremental cost-effectiveness ratio (ICER), which is the additional cost divided by the additional health effect (often measured in QALYs or life-years gained). Policy decisions often rely on thresholds that reflect willingness to pay for an extra unit of health gain; if the ICER falls at or below the threshold, the intervention is considered cost-effective and more likely to be funded, whereas an ICER above the threshold suggests it may not be worth the extra cost unless prices or assumptions change or there are other compelling benefits. Remember that economic evaluations are one part of decision-making and should be considered alongside budget impact, feasibility, and equity considerations, not in isolation.

7. How did the Affordable Care Act aim to expand coverage, and what mechanisms did it use?

A. Medicaid expansion optional by state; health insurance exchanges with subsidies; individual mandate (repealed in 2019); essential health benefits; guaranteed issue and community rating; no pre-existing condition exclusions.

B. Only expanded private market subsidies; no Medicaid.

C. Introduced a single payer system.

D. Reduced premiums only for employers.

Expanding coverage under the ACA relied on a mix of public program expansion and private-market reforms paired with strong consumer protections. Medicaid expansion opened eligibility to more low income individuals in states that chose to participate, broadening public coverage. Health insurance exchanges (marketplaces) were created to offer plans with subsidies for individuals and families with modest incomes, making private coverage more affordable. The individual mandate was designed to encourage enrollment across the risk pool, helping to prevent adverse selection, with penalties tied to tax filings (the federal penalty was repealed in 2019). The law also prohibited denying coverage due to health status by requiring guaranteed issue and using community rating to prevent price discrimination. Finally, it set a floor of covered services by requiring essential health benefits, ensuring that plans provide a baseline of important care. Together, these mechanisms aimed to reduce the uninsured rate by widening access, subsidizing private coverage, and strengthening protections for people with health conditions.

8. Medicare reimburses physicians using which metric?

A. Salaries

B. Relative Value Units (RVUs)

C. Fixed amounts per visit

D. Capitation

Medicare reimburses physicians using Relative Value Units (RVUs), which quantify the value of a service based on the effort, skill, time, and risk involved. The system breaks RVUs into three parts: work RVU (physician labor), practice expense RVU (costs to deliver the service like staff and equipment), and malpractice RVU (professional liability costs). The total RVU for a service is then adjusted by geographic cost indices and multiplied by a conversion factor to determine payment. This setup lets Medicare standardize payments across specialties and regions while accounting for regional differences in costs. Other models don't apply here: salaries reflect a fixed employer-based pay rather than per-service reimbursement; fixed amounts per visit don't capture the broader cost and effort differences across services; capitation is a per-patient prepayment model used in some managed care contexts, not the Medicare Physician Fee Schedule.

9. What are the 4 models of care within HMOs?

A. Group, Independent Practice Association, Network, and Staff.

B. Group, IPA, Network, and Open Panel.

C. Group, Direct Care, Telehealth, and Network.

D. Group, IPA, Network, and Private Practice.

Four main delivery frameworks describe how physician care is organized and paid within HMOs: staff model, group model, independent practice association (IPA) model, and network model. In the staff model, the HMO directly employs physicians and runs its own clinics, paying doctors as employees. In the group model, the HMO contracts with an independent multi physician group that hires or coordinates the physicians, with care delivered through that group's practice. In the IPA model, physicians remain independent in private practice but contract with the HMO through an IPA, which negotiates terms and manages reimbursement while doctors continue private practice. In the network model, the HMO contracts with several physician groups to create a network, allowing patients to see any physician within that network. The option listing Group, Independent Practice Association, Network, and Staff reflects these four standard models. Terms like Open Panel or Private Practice describe variations within these models but are not typically counted as the four primary models themselves.

10. What is a potential effect of price transparency on payer-provider contracts?

A. It empowers buyers to compare prices and pressure discounts

B. It eliminates the need for negotiations

C. It can lead to more standardized pricing across providers

D. It always reduces the quality of care

Price transparency gives buyers visibility into what prices and negotiated rates look like across providers, which makes it possible to benchmark costs, compare alternatives, and press for better discounts in contracts. When payers can see who charges more or less and how rates stack up, they gain leverage to seek lower prices or more favorable terms, and providers are motivated to offer competitive discounts to win or renew contracts. The other statements aren't as accurate in this context. Transparency does not by itself eliminate negotiations—the contracting process still involves bargaining over discounts, value-based terms, and network design. It also doesn't guarantee standardized pricing across all providers, since actual rates depend on market dynamics and negotiated agreements. And transparency isn't inherently linked to a reduction in quality of care; pricing visibility can coexist with high-quality services, and quality is influenced by many factors beyond price.

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:

https://businessofhchealthpolicy.examzify.com

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