

TEXAS A&M UNIVERSITY (TAMU) PHLT313 HEALTH CARE AND PUBLIC HEALTH SYSTEM EXAM 2 PRACTICE (SAMPLE)

STUDY GUIDE



SAMPLE STUDY GUIDE WITH LIMITED QUESTIONS

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THE FULL VERSION STUDY GUIDE**

<https://tamu-phlt313exam2.examzify.com>



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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. What is the age requirement for most Medicare beneficiaries?**
 - A. 60 years or older
 - B. 65 years or older
 - C. 70 years or older
 - D. 55 years or older
- 2. What is Medicare primarily designed for?**
 - A. Individuals with low income
 - B. Older adults and certain disabled individuals
 - C. Children under the age of 18
 - D. Working-age adults without insurance
- 3. According to the ACA, what limitation is placed on physician-owned hospitals?**
 - A. They must operate only in rural areas
 - B. No new physician-owned hospitals can be opened or expanded
 - C. They cannot accept Medicare patients
 - D. They are required to provide free services
- 4. What type of insurance is characterized by an employer acting as the insurance provider?**
 - A. Managed care
 - B. Self insurance
 - C. Individual private insurance
 - D. Group insurance
- 5. Which of the following best describes a community hospital?**
 - A. Provides specialized and long-term care for chronic illnesses
 - B. Focuses on a narrow range of services for specific conditions
 - C. Open to the general public and primarily provides short stay services
 - D. Accepts only private health insurance patients

- 6. Which of the following is NOT a type of cost sharing?**
- A. Premium cost sharing
 - B. Deductibles
 - C. Referral fees
 - D. Copayments
- 7. Which demographic does the Medicare system typically serve?**
- A. Adults aged 18-64
 - B. Children under the age of 18
 - C. Adults aged 65 and older and certain younger individuals with disabilities
 - D. Working-age adults with employer-sponsored insurance
- 8. Which healthcare professional is tasked with managing drug interactions?**
- A. Physician
 - B. Nurse
 - C. Pharmacist
 - D. Therapist
- 9. Which of the following roles does NOT require advanced clinical education?**
- A. Advanced Practice Nurse
 - B. Clinical Nurse Specialist
 - C. Registered Nurse
 - D. Licensed Practical Nurse
- 10. How do non-profit hospitals assess their community needs according to the ACA?**
- A. By conducting market surveys
 - B. By using patient satisfaction scores
 - C. By performing community health assessments
 - D. By evaluating insurance claims data

Answers

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

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Explanations

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1. What is the age requirement for most Medicare beneficiaries?

- A. 60 years or older
- B. 65 years or older**
- C. 70 years or older
- D. 55 years or older

Medicare is primarily designed to serve individuals as they reach retirement age, which is set at 65 years or older. This age threshold reflects the program's aim to provide health insurance coverage to older adults, who are often more likely to encounter health issues that necessitate medical services. By establishing 65 as the eligibility age, Medicare seeks to ensure that seniors have access to necessary healthcare support as they transition out of the workforce. While there are provisions for younger individuals with disabilities or specific medical conditions to receive Medicare benefits, the standard requirement for most beneficiaries hinges on reaching the age of 65, making this the correct choice in understanding Medicare's eligibility criteria.

2. What is Medicare primarily designed for?

- A. Individuals with low income
- B. Older adults and certain disabled individuals**
- C. Children under the age of 18
- D. Working-age adults without insurance

Medicare is primarily designed to provide health insurance coverage for older adults, specifically those aged 65 and older, as well as certain younger individuals with disabilities and those with End-Stage Renal Disease (ESRD) or Amyotrophic Lateral Sclerosis (ALS). This program was established to ensure that older adults have access to necessary medical care as they often have higher health care needs and may face financial constraints related to medical expenses. The structure of Medicare reflects a recognition of the challenges faced by these populations, aiming to alleviate financial burdens associated with health care. By focusing on this demographic, Medicare plays a crucial role in supporting the health and well-being of seniors and specific disabled individuals, ensuring their access to essential services like hospital care, outpatient services, and long-term care. The other choices do relate to important aspects of public health and health insurance, but they are not the primary focus of Medicare's design. For instance, while programs exist to support low-income individuals or children, those are typically addressed through Medicaid or the Children's Health Insurance Program (CHIP).

3. According to the ACA, what limitation is placed on physician-owned hospitals?

- A. They must operate only in rural areas
- B. No new physician-owned hospitals can be opened or expanded**
- C. They cannot accept Medicare patients
- D. They are required to provide free services

The Affordable Care Act (ACA) implemented various reforms aimed at improving access to care and reducing healthcare costs, which included specific limitations on physician-owned hospitals. One key provision is that no new physician-owned hospitals can be opened, nor can existing ones expand their services significantly. This measure was introduced primarily to address concerns about potential conflicts of interest, where physicians might be incentivized to over-utilize services because they stand to profit from owning the facility. By placing this limitation, the ACA aimed to promote transparency and integrity within the healthcare system. The other options do not accurately reflect the regulations established by the ACA. While there may be certain controls regarding where hospitals can operate, the explicit prohibition on the opening or expansion of physician-owned hospitals is a critical and clear part of the ACA's approach to healthcare reform.

4. What type of insurance is characterized by an employer acting as the insurance provider?

- A. Managed care
- B. Self insurance**
- C. Individual private insurance
- D. Group insurance

The correct answer is self insurance. In self insurance, an employer takes on the financial risk of providing health care benefits to their employees instead of purchasing insurance from a traditional insurance provider. This approach allows the employer to directly handle the costs associated with employee health care, which can often lead to savings and greater control over the benefits structure. Employers who choose self insurance typically set aside funds to pay for health care claims as they occur, rather than paying fixed premiums to an insurance carrier. This model allows for a more tailored health plan that can reflect the specific needs of the workforce. Managed care refers to a health insurance strategy that combines the financing and delivery of health care services, often involving a network of providers. Individual private insurance involves individuals purchasing coverage on their own, which does not involve employers acting as providers. Group insurance typically involves an employer providing coverage for a group of employees through an insurance company rather than self-funding those benefits. This helps to understand why self insurance stands out in the context of employers directly acting as the insurance provider.

5. Which of the following best describes a community hospital?

- A. Provides specialized and long-term care for chronic illnesses
- B. Focuses on a narrow range of services for specific conditions
- C. Open to the general public and primarily provides short stay services**
- D. Accepts only private health insurance patients

A community hospital is best described as an institution that is open to the general public and primarily provides short-stay services. These hospitals are typically designed to serve a specific locality and focus on delivering a broad range of healthcare services, including emergency care, outpatient services, and inpatient care for a variety of medical issues. Their goal is to ensure accessible healthcare for community members, which includes providing services for acute medical conditions that often require only a brief hospitalization. While community hospitals may offer some specialized services, they are not limited to a narrow range of services as described in one of the other choices, nor do they primarily focus on chronic illnesses or provide long-term care like skilled nursing facilities would. Additionally, community hospitals generally aim to serve all patients regardless of their type of health insurance, making the notion of accepting only private health insurance inconsistent with the purpose of community hospitals, which seek to be accessible to everyone in the community.

6. Which of the following is NOT a type of cost sharing?

- A. Premium cost sharing
- B. Deductibles
- C. Referral fees**
- D. Copayments

Cost sharing refers to the practice of dividing the costs of healthcare services between the insurer and the insured. This typically includes different mechanisms like premiums, deductibles, and copayments, which are all designed to share the financial burden of healthcare expenses. Premium cost sharing occurs when the insurer and the insured share the cost of an insurance premium. This is a common practice in many employer-sponsored health insurance plans. Deductibles are the amounts that an insured individual must pay out-of-pocket for healthcare services before the insurance starts to pay. This directs some level of cost responsibility to the insured, encouraging individuals to be mindful of healthcare utilization. Copayments, often simply referred to as copays, are fixed amounts that an insured individual pays for specific services at the time of care, with the insurance covering the remaining balance. This also encourages more informed decision-making about healthcare use, as individuals have to consider out-of-pocket costs. Referral fees, on the other hand, typically pertain to payments made for directing patients to certain providers or services, and are not a systematic form of cost-sharing in health plans. They do not reflect the shared financial responsibility associated with typical insurance mechanisms; therefore, they do not fit within the definitions of cost sharing like the other options do

7. Which demographic does the Medicare system typically serve?

- A. Adults aged 18-64
- B. Children under the age of 18
- C. Adults aged 65 and older and certain younger individuals with disabilities**
- D. Working-age adults with employer-sponsored insurance

The Medicare system is primarily designed to serve adults aged 65 and older, as well as certain younger individuals who have disabilities or specific health conditions that qualify them for the program. This demographic is particularly significant because as people age, they often face increased health care needs and expenses, making access to affordable health care critical. Medicare provides a safety net for this population, ensuring they have coverage for hospital stays, outpatient services, and various other medical needs. Moreover, the inclusion of younger individuals with disabilities highlights Medicare's role in addressing chronic conditions or severe illnesses that can significantly impact health and quality of life, even before reaching retirement age. By focusing on these groups, Medicare plays a vital role in the U.S. health care system, facilitating access to necessary services and promoting overall health outcomes among older adults and those with disabilities.

8. Which healthcare professional is tasked with managing drug interactions?

- A. Physician
- B. Nurse
- C. Pharmacist**
- D. Therapist

The healthcare professional responsible for managing drug interactions is a pharmacist. Pharmacists are specifically trained in pharmacology and the effects of medications, which includes understanding how different drugs can interact with one another. This expertise is crucial in ensuring patient safety and efficacy of treatment regimens. Pharmacists play a pivotal role in reviewing medication orders and patient profiles to identify potential drug interactions, assess risks, and provide recommendations to optimize medication therapy. They are also integral in advising prescribers and patients about the proper use of medications, including potential side effects and interactions with other drugs, food, or therapeutic interventions. Physicians and nurses have significant roles in patient care, but their focus is generally broader, with physicians diagnosing conditions and prescribing medications, while nurses administer medications and monitor patient responses. Therapists, depending on their specialization, often concentrate on rehabilitation and therapeutic practices rather than medication management. Therefore, the specialized knowledge of pharmacists positions them as the key healthcare professionals for managing and mitigating drug interactions.

9. Which of the following roles does NOT require advanced clinical education?

- A. Advanced Practice Nurse
- B. Clinical Nurse Specialist
- C. Registered Nurse
- D. Licensed Practical Nurse**

The role that does not require advanced clinical education is that of the Licensed Practical Nurse (LPN). Unlike roles such as Advanced Practice Nurse and Clinical Nurse Specialist, which necessitate a master's or doctoral level of education, LPNs typically complete a practical nursing program that can be accomplished in about a year and often results in a diploma or certificate. This program provides essential training in direct patient care but does not delve into the advanced clinical concepts and independent practice that are vital for advanced nursing roles. Registered Nurses (RNs) also undergo a more extensive education, typically requiring an associate's or bachelor's degree, which equips them with a broader scope of practice and theoretical knowledge compared to LPNs. Therefore, the educational and training requirements for LPNs are distinctly different from those for advanced clinical roles, making it the correct choice for this question.

10. How do non-profit hospitals assess their community needs according to the ACA?

- A. By conducting market surveys
- B. By using patient satisfaction scores
- C. By performing community health assessments**
- D. By evaluating insurance claims data

Non-profit hospitals assess their community needs primarily by performing community health assessments, as mandated by the Affordable Care Act (ACA). These assessments are comprehensive and involve gathering data on the health status, needs, and resources of the community they serve. Non-profit hospitals must conduct these assessments every three years to identify health issues and determine how they can best respond to support public health within their communities. The focus on community health assessments aligns with the ACA's aim to enhance healthcare access and improve health outcomes. These assessments often include analyzing demographic data, understanding social determinants of health, and engaging with community stakeholders to gather insights on the most pressing health concerns. Other methods, such as market surveys, patient satisfaction scores, or evaluating insurance claims data, may provide valuable information but do not meet the specific requirement outlined by the ACA for non-profit hospitals to evaluate their community needs through formal health assessments. These other options can supplement the understanding of community health but are not the primary method mandated for assessing community needs.

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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