E Appendix E: Abbreviations and Glossary

ABBREVIATIONS

AHA	American Hospital Association
AHCPR	Agency for Health Care Policy and Research (USDHHS)
AHSIM	Agency Health Simulation Model
BLS	Bureau of Labor Statistics (USDOC)
CBO	Congressional Budget Office (U.S. Congress)
CBP	County Business Patterns
CES	Consumer Expenditure Survey
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (USDOD)
CPS	Current Population Survey
CRS	Congressional Research Service (Library of' Congress)
FFS	fee-for-service
GDP	gross domestic product
HCFA	Health Care Financing Administration (USDHHS)
HIAA	Health Insurance Association of America
HIPS	Health Insurance Plan Survey
HMO	health maintenance organization
HPPC	health plan purchasing cooperative
IRS	Internal Revenue Service (U.S. Department of Treasury)
JCT	Joint Committee on Taxation (U.S. Congress)
NHA	National Health Accounts
NMES	National Medical Expenditure Survey
OMB	Office of Management and Budget (U.S. Executive Office of the President)
OTA	Office of Technology Assessment (U.S. Congress)
PPO	preferred provider organization
SOI	Statistics of Income
SPAM	Special Policy Analysis Model
USDHHS	U.S. Department of Health and Human Services
USDOC	U.S. Department of Commerce
USDOD	U.S. Department of Defense
USDOL	U.S. Department of Labor

GLOSSARY

Affordable Health Care Now Act of 1993 (H.R.3080/S.1533)
A health reform proposal sponsored primarily by Rep. Robert Michel and Sen. Trent Lott in the 103d Congress that would require employers to offer, but not pay for, a basic health benefit plan. The proposal includes regulation of underwriting and rating practices in the small group market and requirements that insurers offer three different health plans and portability of coverage. It also includes measures to encourage development of multiple employer purchasing groups.

American Health Security Act of 1993 (H. R.1200/S.491)
A health reform proposal sponsored by Rep. Jim McDermott and Sen. Paul Wellstone in the 103d Congress that would establish a single-payer national health insurance program, federally mandated and administered by the states. This program would replace private health insurance and public program coverage. The program would provide coverage of comprehensive health and long-term care benefits. A national board would establish a national health budget that would be distributed among the states, based on the national average per capita cost of covered services, adjusted for differences among the states in costs and the health status of their populations.

Baseline
The state of a system before any proposed policy change or reform. It is a benchmark for measuring the effects of proposed policy changes. It can refer to the expenditures, the demographic compositions, or the underlying macroeconomic factors that are generally used as the input parameters in estimating the effects of reform.

Cafeteria plan
A benefit plan provided by employers that allows all participating employees to choose among two or more benefits consisting of cash and qualified benefits (e.g., health insurance and life insurance). Under section 125 of the Internal Revenue Code, employers may contribute flexible benefit credits that employees can allocate toward the purchase of health benefits. Employers may also set up salary conversion mechanisms that allow employees to pay for health insurance premiums with pretax income. Employers may also provide flexible spending accounts allowing employees to contribute pretax funds for health care expenditures.

Consumer Choice Health Security Act of 1993 (S.1743/H.R.3698)
A bill introduced by Sen. Don Nickles and Rep. Cliff Stearns in the 103d Congress under which all persons would be required to purchase health insurance through a plan meeting federal standards relating to minimum benefits and rating and underwriting practices, or through a state-established health plan. Current tax exclusions for employer-sponsored health plans would be replaced with refundable tax credits for a portion of the premium cost of qualified health insurance plans and for other medical expenses. Employers currently providing health benefits would be required to convert them into added wages.

Corporate alliances
A term used in the Health Security Act (H. R.3600/S.1757) that refers to entities created by employers with 5,000 or more employees to provide health insurance. Corporate alliances would have to enroll all eligible persons and provide the comprehensive benefit package. They would have to offer a choice of at least three health plans, one of which would be a fee-for-service plan.

Cost-sharing
The provisions of a health benefit plan that require the enrollee to pay a portion of the cost of services covered by the plan, typically exclusive of premium cost-sharing (sharing the cost of a health care plan premium between the sponsor and the enrollee). Usual forms of cost-sharing include deductibles, coinsurance, and copayments. These payments are made at the time a service is received or shortly thereafter, and are only made by those insured people who seek treatment.

Cost-shifting
The condition that occurs when health care providers are not reimbursed, or not fully reimbursed, for providing health care and, therefore, charges to those who do pay are increased.

Current Population Survey (CPS)
Sponsored by the Department of Labor's Bureau of Labor Statistics, and the Department of Commerce Bureau of the Census, the CPS is a continuing monthly cross-sectional survey of about 60,000 U.S. households. Data collected includes labor force status for ages 15 and older. The March CPS includes supplementary questions on income, employment status, and health insurance coverage during the previous calendar year.

Disproportionate share hospitals
Hospitals that serve a relatively large volume of low-income patients and therefore receive a payment adjustment under the prospective payment system (PPS) from Medicare and Medicaid.

Elasticity of demand
The percentage change to be expected in the demand for an economic good in response to a specified percentage change in one of its determinants, such as price or income.

Entitlement programs
Programs that provide benefits paid out automatically to all who qualify unless there is a change in underlying law. These programs may or may not require an annual appropriation by Congress. Social Security and Medicare, for example, are autonomous trust funds that possess the authority to pay benefits without an annual appropriation by Congress. Many other individual benefit programs such as Medicaid, Supplemental Security Income, and Aid to Families with Dependent Children programs, are all considered entitlements by Congress.

Flexible spending account
A reimbursement account under which participating employees are reimbursed for medical expenses or other nontaxable employer-sponsored benefits. A flexible spending account can either be part of a cafeteria plan or a stand-alone benefit plan.

Health Equity and Access Reform Today Act of 1993 (H.R.3704/S.1770)
A reform proposal introduced by Rep. Bill Thomas and Sen. John Chafee and others in the 103d Congress that would require all persons to purchase coverage through a qualified health plan or face a penalty for noncompliance. All employers would be required to offer their employees enrollment in a qualified health plan or face a penalty for noncompliance, No employer, however, would be required to make contributions for coverage of an employee. Small employers and individuals could participate voluntarily in state-established purchasing cooperatives or select other qualified health plans. All plans would have to offer standard benefits and would be subject to restrictions on rating and underwriting practices. Federal subsidies in the form of vouchers would be phased in for low-income persons, subject to savings being achieved under the Medicare and Medicaid programs.

Health Security Act (H.R.3600/S.1757)
A proposal devised by the Clinton Administration that would require all persons to obtain a comprehensive health benefits package from large insurance purchasing cooperatives called health alliances. Health plan premiums would be paid through a combination of employer and individual contributions, supplemented by federal subsidies for some types of firms, early retirees, and persons with incomes below certain levels. A national health care budget would be established for expenditures for services covered under the comprehensive package. This budget would limit both initial premiums and the year-to-year rates of increase that could be charged by health plans participating in the alliances. Ultimately, premiums could grow no faster than the rate of growth in per capita gross domestic product, unless Congress specified a different inflation factor.

Home health care
Items and services such as nursing, therapy, and health-related homemaker or social services provided as needed in patients' homes by a home health agency or others under arrangements made by a home health agency,

Hospital insurance tax
The Medicare program consists of two parts: the hospital insurance (Part-A) program and the supplementary medical insurance (Part-B) program. The hospital insurance program is financed primarily through the hospital insurance payroll tax contributions paid by employers, employees and the self-employed. For wages paid in 1993, the total hospital insurance tax rate is 2.9 percent of the first $135,000 of wages. One half of the taxis imposed on the employee and one half on the employer. All wages paid after December 31, 1993, will be subject to hospital insurance taxes. Under current law, state and local government employees hired before April 1, 1996, are not covered under Medicare, thus are not subject to hospital insurance tax, unless a voluntary agreement is in effect.

Induced demand
The increase in the demand and utilization of health care services associated with an increase in the insurance coverage for the services or other nonprice factors.

Long-term care insurance
Insurance for medical and social services care provided by both institutional and noninstitutional providers to persons with debilitating chronic health conditions.

Managed competition
An approach to health reform that would combine health insurance market reform with health care delivery system restructuring. The theory of managed competition is that the quality and economy of health care delivery will improve if independent groups compete with one another for consumers in a government-regulated market.

Managed Competition Act of 1993 (H.R.3222/S.1579)
A proposal sponsored by Rep. Jim Cooper and Sen. John Breaux in the 103d Congress that would allow states would establish health plan purchasing cooperatives (HPPCs) that would contract with accountable health plans (AHPs), AHPs would be required to cover a uniform set of benefits and comply with premium rating and underwriting standards. All employers would be required to offer, but not pay for, coverage in an AHP. Small employers with 100 or fewer employees would have to participate in the HPPC; larger employers could offer their own AHP. Health plan expenses would be tax deductible up to the cost of the lowest-cost basic plan in an area. An excise tax would be imposed on employer contributions in excess of this level.

Medicaid
A joint federal/state program that provides health care and health-related services for low-income individuals. Medicaid regulations are established by each state within federal guidelines, and the eligibility requirements and services covered vary significantly among the states. In general, Medicaid pays for medical, nursing home, and home health care for individuals who meet the eligibility requirements. In some states, Medicaid also pays for adult day care and in-home services such as personal care and homemaker services. Financial eligibility for Medicaid is determined by a means test, in which a ceiling is placed on the maximum income and assets an individual may have in order to qualify for assistance. The income and assets levels are low in all states and very low in some states.

Medicaid noncash recipients
Individuals who are covered by Medicaid but do not receive cash assistance (e.g., persons who qualify for Medicaid as medically needy).

Medical Savings Accounts
A trust created or organized exclusively for the purpose of paying the medical expenses of beneficiaries of such a trust.

Medicare
A nationwide, federally administered health insurance program authorized by Title XVIII of the Social Security Act of 1965 to cover the cost of hospitalization, medical care, and some related services for eligible persons over age 65, persons receiving Social Security Disability Insurance payments for two years, and persons with end-stage renal disease. Medicare consists of two separate but coordinated programs--hospital insurance (Part-A) and supplementary medical insurance (Part-B). Health insurance protection is available to insured persons without regard to income, and is mainly funded through the U.S. Treasury and the Medicare portion of the payroll tax.

Medicare Part-B
See *Medicare.*

Microsimulation model
A model that essentially conducts program experiments (simulations) on large samples of microdata for individual decision units. In general terms, the first step, which serves the same function as the control group for an experiment, is to prepare a baseline database representing the current situation, that is, the situation in the absence of a program change. The second step is to simulate the program change and its impact. The third step is to summarize the differences between the baseline and alternative program databases. Microsimulation models typically include routines to generate the database, routines to mimic the rules of government programs, and routines to produce tabulations of the simulation results. They may also include routines to simulate behavioral responses to proposed program changes.

National Health Accounts (NHA)
The National Health Accounts are statistics representing total national health expenditures used to identify all goods and services relating to health care, and the amount spent on these goods and services.

National health expenditures (NHE)
An estimate of national spending on health care made up of two broad categories: 1) health services and supplies, which consist of personal health care expenditures (the direct provision of health care), program administration and the net cost of private health insurance, and government public health activities; and 2) research and construction of medical facilities.

National Medical Expenditure Survey (NMES)
A survey conducted by the USDHHS involving five rounds of data collection, between February 1987 and July 1988, sampling 14,000 households (Household Survey). The NMES also surveys physician and health care facilities providing care to members of a household sample during 1987 (Medical Provider Survey) and employers and insurance companies responsible for their insurance coverage (Health Insurance Plan Survey). The NMES also included an institutional survey of 13,000 residents of nursing and personal care homes, psychiatric hospitals, and facilities for mentally retarded persons.

Payroll taxes
Taxes based on wages and salaries that often are levied against both employer and employee but are collected for the government by employers.

Premium
The periodic payment made to an insurer under the terms of an insurance contract.

Regional alliance
As defined in the Health Security Act, a regional alliance can be a nonprofit organization, an independent state agency, or an agency of the state which contracts with certified health plans to provide coverage to residents of the region. An alliance would be required to offer a contract to any certified plan seeking to serve in its area unless the plan's proposed premium exceeded the per capita

premium target by more than 20 percent. The alliance would also be required to ensure that at least one fee-for-service plan is available among plan offerings.

Sensitivity analysis
An analysis of the effect of changes in key assumptions or uncertainties on the findings and outcome of an overall study.

Skilled nursing facilities
A facility that provides skilled nursing care. A "distinct part skilled nursing facility" is a distinct unit within the hospital that provides such care (i.e., beds set up and staffed specifically for this service), is owned and operated by the hospital, and meets Medicare certification criteria.

Tax credit
The amount that can be directly subtracted from the amount of tax due for a taxpayer.

Tax deductibility
Under the provision of the Internal Revenue Code, businesses can generally deduct, as a business expense, from their gross incomes certain expenses such as the full cost of health insurance coverage provided for their employees.

Tax exclusion
Under the provisions of the Internal Revenue Code, certain portions of an individual's income or noncash compensation, such as employer contributions for health benefits, is excludable from his or her gross income (for the purpose of determining income taxes) and wages (for the purpose of determining payroll taxes).

Tax expenditures
As defined by the Congressional Budget and Impoundment Act of 1974 (Public Law 93-344), tax expenditures are reductions in individual and corporate income tax liabilities that result from special tax provisions or regulations that provide tax benefits to particular taxpayers. These special provisions can take the form of exclusions, credits, deductions, preferential tax rates, or deferrals of tax liability.

Uncompensated care
Care for which a provider or health care facility does not expect to receive payment.

Voucher
A form or check indicating a credit against future purchases or expenditures.