D Appendix: Abbreviations and Glossary

ABBREVIATIONS

AHCPR	Agency for Health Care Policy and Research (PHS)
AHP	Accountable Health Plan
AHSIM	Agency for Health Care Policy and Research's Simulation Model
ASPE	Office of the Assistant Secretary for Planning and Evaluation (DHHS)
BLS	Bureau of Labor Statistics (Department of Labor)
CalPERS	California Public Employees' Retirement System
CBO	Congressional Budget Office (U.S. Congress)
CES	Consumer Expenditure Survey
CHAMPUS	Civilian Health and Medical Program of the Uniformed Services (Department of Defense)
CHAMPVA	Civilian Health and Medical Program of the Veterans Administration
CHSOS	comprehensive health service organizations
CON	Certificate-of-Need
CPI	consumer price index
CPS	Current Population Survey
CRS	Congressional Research Service (Library of Congress)
DHHS	Department of Health and Human Services
DRG	diagnosis-related group
ESP	Economic Stabilization Program
ESRI	Economic and Social Research Institute
FEHBP	Federal Employees Health Benefits Program
FFS	fee-for-service
GAO	General Accounting Office (U.S. Congress)
GDP	gross domestic product
GHAA	Group Health Association of America
GP	general practitioner
HCFA	Health Care Financing Administration (DHHS)
HEP	Hospital Experimental Payments program
HIAA	Health Insurance Association of America
HIE	Health Insurance Experiment (Rand)
HIS	Health Interview Survey

HMO	health maintenance organization
HPPC	health plan purchasing cooperative
IPA	individual practice association
MFS	Medicare fee schedule
NHA	National Health Accounts
NHB	National Health Board
NHE	national health expenditures
NMCUES	National Medical Care Utilization and Expenditure Survey
NMES	National Medical Expenditure Survey
OBRA-1989	Omnibus Budget Reconciliation Act of 1989
OECD	Organisation for Economic Cooperation and Development
OMB	Office of Management and Budget (U.S. Executive Office of the President)
OTA	Office of Technology Assessment (U.S. Congress)
PHS	Public Health Service (DHHS)
PPO	preferred provider organization
PPS	prospective payment system (Medicare)
RCT	randomized clinical trial
SIPP	Survey of Income and Program Participation
SP1	Single payer 1 (CBO)
SP2	Single payer 2 (CBO)
SSA	Social Security Administration (DHHS)
TAB	Technology Assessment Board (OTA)
TEFRA	Tax Equity and Fiscal Responsibility Act of 1982
VPS	Volume Performance Standards (Medicare)

GLOSSARY

Accountable Health Plan (AHP)
Under the Managed Competition Act, the term accountable health plan means a health plan registered with the National Health Board that meets standards established by the National Health Board.

Acute care
Medical services offered within a hospital setting over a short period of time designed to treat patients for acute episodes of illness, injuries, and post-surgery.

Administrative costs
Expenses related to the management or supervision of the provision of health care coverage and/or services. Analyses of reform approaches, proposals, or plans frequently do not share a common definition of what components constitute administrative costs, but most commonly refer to insurer (including government programs and private plans) and provider (including hospital and physician) administrative costs.

Administrative load
With private health insurance, the difference between premiums and claims paid, including profit.

Adverse selection
In health insurance, the tendency of persons with poorer than average health expectations to apply for, or continue, insurance to a greater extent than persons with average or better heath expectations.

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.

Aging
Temporal extrapolation to actualize or further forecast a sample.

All-payer system
A payment system in which services are covered and paid for by multiple payers, but where all payers adopt the same payment methods and rates. Compare *singlc-payer system.*

Ambulatory encounters
Ambulatory encounters can include phone calls or visits to physicians' or other providers' offices, or visits to hospital outpatient departments. Surveys do not always distinguish among these types of encounters and settings for encounters, and studies using surveys do not always define their terms clearly. In the health services literature, *ambulatory* means other than on an inpatient basis.

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.

Analysis
In this report, an estimate of the impact of a health reform proposal.

Analysts
In this report, those individuals and organizations using analytical tools and methods for simulation of national health expenditures, redistributive, and macroeconomic effects of changes in policy.

Assumption
The supposition that something is true. In this report, assumption refers to the parameters used to estimate national health expenditures under reform.

Balance billing
In the Medicare program, the practice of billing a Medicare beneficiary in excess of Medicare's allowed charge. The *balance billing* amount would be the difference between Medicare's allowed charge and the physician's (or other qualifying provider's) fee.

Baseline
Baselines are projections of expenditures assuming no reform (e.g., assuming the continuation of current policies).

Baseline national health expenditures
See *baseline* and *national health expenditures.*

Behavioral assumptions
Assumptions concerning behavioral responses to a change in policy, that is, changes in behavior of an individual decision unit, such as a family, employer, or hospital. In turn, behavioral responses have feedback effects on program costs and recipients.

Benefit package
The package of health care services covered by a particular insurer.

Billings
The physician's (or provider's) actual (billed) charge for a service.

Budgets
A financial plan for allocating resources.

Cavitation (or per capita) payment
A method of payment for services in which a service provider (e.g., a physician, hospital, or other agency or individual) is paid a fixed amount for each person served regardless of the actual cost of services provided for the person.

Case mix index
A measure of the type of cases being treated by a particular health care provider that is intended to reflect the patients' different needs for resources.

Certificate-of-Need (CON)
A regulatory planning mechanism required (in order to receive certain federal funds) by the National Health Planning and Resources Development Act of 1974 (Public Law 93-641) to control expenditures for and distribution of expensive medical care facilities and equipment. Each State was required to enact a CON law with specific characteristics, such as expenditure thresholds. Compliance with this federal planning requirement has not been enforced because of a series of legislative amendments. In States where CON laws have been enacted and have not expired or

been repealed, CON applications by institutions are reviewed by local health systems agencies and are then denied or approved by State health planning agencies.

Charge
The price of a service or the amount billed for services rendered.

Coinsurance
That percentage of covered hospital and medical expenses, after subtraction of any deductible, for which an insured person is responsible. Under Medicare Part B, after the annual deductible has been met, Medicare will generally pay 80 percent of approved charges for covered services and supplies; the remaining 20 percent is the coinsurance, for which the beneficiary is liable.

Community hospitals
As defined by HCFA, those nonfederal acute care hospitals whose average length of stay is less than 30 days and whose facilities and services are open to the general public.

Community rating
Definitions of community rating vary. One definition is a method of determining premium rates that is based on the allocation of total costs without regard to past claims experience. Another definition is an approach to pricing health insurance premiums that requires an insurer to accept all applicants at virtually the same rates. The second definition is the one most applicable to the health reform proposals referred to in this report.

Comprehensive Family Health Access and Savings Act (S. 1807/H.R. 3918)
A proposal introduced by Sen. Phil Gramm and Rep. Rick Santorum in the 103d Congress that gives new federal tax exclusions, deductions, and refundable credits to individuals for the purchase of health insurance and/or for contributions to medical savings accounts. The proposal would also prohibit certain insurance underwriting practices, and would subsidize premium expenses for certain persons with pre-existing conditions. Phase-in of new federal subsidies would be contingent on the achievement of federal savings under the Medicare and Medicaid programs.

Comprehensive Health Reform Act of 1992 (H.R. 5919)
A proposal introduced by Rep. Robert Michel in the 102d Congress. It allows the self-employed to deduct their health insurance costs from taxable income, regulating employment-based health insurance to improve its availability and affordability, standardizing medical and health insurance information, and reforming the system of liability for medical malpractice.

Comprehensive health service organizations
As defined in the American Health Security Act of 1993 (H.R. 1200/S. 491), a public or private organization which, in return for a capitated payment amount, undertakes to furnish, arrange for the provision of, or provide payment with respect to: 1) a full range of health services (as identified by a National Health Board), including at least hospital and physician services, and 2) out-of-area coverage in the case of urgently needed services, to an identified population that is living in or in or near a specified service area and that enrolls voluntarily in the organization.

Consumer Choice Health Security Act of 1993 (S. 1743/H.R. 3698)
A bill introduced by Sen. Don Nickles and Rep. Cliff Steams in the 103d Congress in 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.

Copayment
In insurance, a form of cost-sharing whereby the insured pays a specific amount at the point of service or use (e.g., $10 per visit).

Corporate alliances
A term used in the Health Security Act (H.R. 3600/S, 1757) that refers to entities created by em-

ployers 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.

costs
Expenses incurred in the provision of services or goods. Many different kinds of costs are defined and used (e.g., allowable, direct, indirect, and operating costs). It is important not to confuse costs with charges, which are the price of a service or the amounts billed for services rendered.

Cost-sharing
The provisions of a health benefits 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.

Coverage
Promise by a third party to pay for all or a portion of expenses incurred for specified health care services.

Current law
Refers to the status quo or current health care policy and law as of the time of the analysis.

Current Population Survey (CPS)
Sponsored by the Department of Labor's Bureau of Labor Statistics, and the Department of Commerce's 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.

Demand for services
Use of services.

Depth of coverage
The aspect of insurance benefit plans related to the extent of patient cost-sharing.

Diagnosis-related groups (DRGs)
Entries in a taxonomy of types of hospitalizations based on groupings of diagnostic categories drawn from the International Classification of Diseases and modified by the presence of a surgical procedure, patient age, presence or absence of significant comorbidities or complications, and other relevant criteria. DRGs have been mandated for use in establishing payment amounts for individual admissions under Medicare's prospective hospital payment system as required by the Social Security Amendments of 1983 (Public Law 98-21).

Disproportionate share hospitals
Hospitals that serve a relatively large volume of low-income patients and therefore may be eligible for a payment adjustment under the prospective payment system (PPS).

Distributional analyses
Analyses of the distribution of costs and benefits of a particular policy across different sectors in the economy, populations, income groups, or other identifying characteristics of groups.

Durable medical equipment
Medical equipment that is capable of withstanding repeated use, generally not useful to someone in the absence of injury or illness, and appropriate for home use. Examples include intravenous poles and infusion pumps.

Economic efficiency
Economic efficiency exists when resources are allocated in an optimal way.

Employment-based health insurance
A group health plan that is sponsored by an employer for employees and their dependents.

Enrollee
An individual who qualifies for benefits under a health benefits plan and has taken any required action to register or otherwise signify his or her participation in the plan.

Estimate
An approximate calculation, a numerical value obtained from a statistical sample or economic model (in this report, used most often to refer to the outcome of simulations of national health expenditures).

Expenditures
In the context of health care, monies spent on the acquisition of heath care coverage and/or services.

Expenditure caps
An approach to government cost controls in which a regulatory authority sets a limit on aggregate spending levels or increases for a specific category of health services (e.g., physician or hospital services), and in which billings exceeding the cap trigger certain penalties, the effects of which would be felt in the current period. Compare with *expenditure targets.*

Expenditure limit
Refers broadly to a government regulatory strategy that set limits on aggregate spending levels or increases for large sources of funding for national health expenditures.

Expenditure targets
An approach to cost containment in which a regulatory authority sets targets or goals for aggregate spending levels or increases for a specific category of health services (e.g., physician or hospital services). However, billings exceeding the target do not necessarily trigger penalties. Compare with *expenditure caps.*

Experimental data
Data from experiments.

Federal poverty level
The official U.S. government definition of poverty based on cash income levels for families of different sizes. Responsibility for changing poverty concepts and definitions rests with the Office of Management and Budget.

Fee-for-service
A method of billing for health services under which a physician or other practitioner charges separately for each patient encounter or service rendered. Fee-for-service is used in this report and in most studies comparing fee-for-service and managed care to refer to insurance arrangements that do not "manage" care (i.e., pure indemnity arrangements), but managed care principles are increasingly being used in fee-for-service indemnity plans.

Fee-for-service plan
Used in this report to mean a traditional or conventional health insurance plan that permits insured individuals to select providers of services and that pays the providers according to the fees charged for such services. The term is used to distinguish such plans from HMOS, under which the enrollee generally must obtain services from HMO providers whose payments from the HMO are not necessarily directly related to the type or quantity of services actually provided.

Fee schedule
An exhaustive list of medical services and fees in which each entry is associated with a specific monetary amount that represents the approved payment amount for the service under a given insurance plan.

First-dollar coverage
Coverage without patient *cost-sharing* requirements.

Fixed costs
Operating expenses that do not vary, at least over the short term, with the volume of services provided.

Government cost controls
Measures by which federal, state, or local governments play a direct role in financing and paying health care facilities and providers. Government cost controls include limits on prices of health insurance (i.e., premiums), prices of particular categories of health services (e.g., physicians' fees), overall expenditures for a particular health care category or facility (e.g., hospital), or overall outlays for a particular source of funding (e.g., national, state, or local government budgets).

Gross **domestic product (GDP)**
The total value of the goods and services produced in a country.

Group-model HMO
An HMO that contracts with one independent group practice to provide health services.

Growth rate of national health expenditures
The extent to which national health expenditures increase, usually expressed as an annual percent**age** increase.

Health alliances
A term used in the Health Security Act (H.R. 3600/S. 1757) to refer to regional purchasing pools that would allow employees and individuals to comparison shop for health plans, along with other responsibilities.

Health Care Cost Containment and Reform Act of 1992 (H.R. 5502)
A proposal Rep. Pete Stark introduced in the 103d Congress that would make three major changes to the health system. It would attempt to slow the growth of health care spending by establishing limits on most health care expenditures and by setting payment rates for all personal health services. It would establish national standards for health insurance plans and simplify the administration of health insurance. Finally, it would expand benefits under Medicare and Medicaid and establish a new Federal program to provide health insurance to all children under age 19.

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 insurance
In this report, the term *health insurance* is used broadly to include various types of health plans that are designed to reimburse or indemnify individuals or families for the costs of medical care, or (as in HMOS) to arrange for the delivery of that care, including traditional private indemnity fee-for-service coverage, prepaid health plans such as HMOS, self-funded employment-based health plans, *Medicaid,* and *Medicare.*

Health maintenance organization (HMO)
A health care organization that acts as both insurer and provider of health care. A defined set of physicians (and, often, other health care providers such as physician assistants and nurse midwives) provide services to an enrolled population. Benefits are usually provided with minimal patient cost-sharing. Types of HMOS include *group-model HMOS, staff-model HMOS,* and *individual practice associations.*

Health plan
The term *health plan* has no standard definition, and different insurer organizations and health reform proposals define "health plan" differently. The term health plan was coined, in part, because the term health insurance plan does not indicate that many plans both provide insurance, that is they finance care through premiums collected from employers and individuals, and are involved in the delivery of care (e.g., through utilization management, by hiring providers, and/or providing setting). Thus, the term health plan is more general than the term health insurance plan and includes a wide spectrum of private health care financing and delivery arrangements, ranging from traditional fee-for-service plans to traditional health maintenance organizations.

Health plan purchasing cooperatives
Groups that arrange for the purchase of health insurance usually on behalf of a large number of people, such as employees of small businesses.

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 specifies a different inflation factor.

Home health services
Items and services provided as needed in patients' homes by a home health agency or by others under arrangements made by a home health agency.

Hospital mandatory rate setting
A state program that involves mandatory review and compliance by all hospitals in the state with hospital rates set by a state rate-setting authority.

Hospital market basket index
An index of the national average annual change in the price of goods and services that hospitals purchase to produce inpatient services.

Hospital operating budget
The fixed amount of revenues that pays for day-to-day costs of running a hospital. Generally, the budget does not include funds to finance capital expenditures such as the expansion of building facilities or the purchasing of expensive high-technology equipment.

Individual practice association (I PA)
A type of HMO that contracts directly with physicians in independent practice, with one or more associations of physicians in independent practice, and/or with one or more multi specialty group practices to provide health services.

Input (real)
A measure of cost defined in terms of the factors used to produce a good or service. In the context of the hospital sector, these factors include labor (e.g., nurses, nursing assistants, administrators, and custodial staff) and nonlabor units (e.g., buildings, equipment, and supplies).

Insurer overhead
The *administrative load* of private health insurance and the costs of operating public programs that provide health care coverage.

Length of stay
The number of days a patient stays in the hospital from admission to discharge.

Level
The amount of spending in a particular specified time period.

Managed care
A general term applied to a range of initiatives from organized health care delivery systems (e.g., HMOS) to features of health care plans (e.g., preadmission certification programs, utilization review programs) that attempt to control or coordinate enrollees' use of (and thus to control the cost of) services.

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 1992 (H.R. 5936)
A proposal sponsored by Rep. Jim Cooper in the 102d Congress that attempts to control costs and expand access to health insurance by restructuring the way health insurance and health care are provided. A national health board would oversee the health insurance market and establish criteria for accountable health plans (AHPs); regional health plan purchasing cooperatives (HPPCS) would allow individuals and small groups to purchase health insurance on the same terms as large groups. The tax deduction for health insurance premiums would be limited to the cost of the least expensive AHP in the region. The bill would replace the Medicaid program with a new Federal program that would help low-income people purchase health insurance coverage through their local HPPC. Other provisions of the bill are designed to improve access to health care in rural and other underserved areas, expand preventive health programs, establish uniform standards for malpractice claims, and simplify the administration of health insurance.

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 to 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 the area. An excise tax would be imposed on employer contributions in excess of this level.

Medicaid
A joint federal-state program intended to provide 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 for those services. 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.

Medical savings account
A trust created or organized exclusively for the purpose of paying the medical expenses of beneficiaries of such 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 2 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.

Medicare payment rates
The amounts that the Medicare program agrees to pay for hospital or physician services provided to Medicare beneficiaries.

Medigap insurance
Private supplementary medical insurance covering out-of-pocket expenditures (deductibles and coinsurance) of Medicare beneficiaries, but typically not covering the patient liability for physician services not covered by assignment.

Model
In this report, a general term applied to a collection of analytical tools used for estimating, projecting, or simulating national health expenditures under health care reform. A National Acade-

my of Sciences (N AS) panel defines formal models as "models that are based on a coherent modeling strategy and set of assumptions, developed for repeated application, and designed to produce consistent estimates for a range of policy proposals within a common framework that is, or can be, well documented and evaluated. By their nature, formal models circumscribe, although they do not eliminate, the role of individual analysts' judgments. Such models . . . vary in size, scope, and the types of data and modeling strategies they use, but they share the attributes we have listed." Not all of the analytical tools for making estimates and projections of national health expenditures, redistributive, and macroeconomic effects of policy changes meet the NAS criteria for formal models. NAS notes further that "formal models, as [NAS has] defined them, are at one extreme of a continuum of policy analysis tools." Between "back of the envelope" calculations and formal models are "models that are developed by an analyst on an ad hoc basis--often using personal computer spreadsheets—to respond to a specific policy debate. Such models, which vary greatly in complexity and approach, will reflect the analyst best efforts to use all available data to develop the estimates needed for the particular debate, but they are not generally designed with any future application in mind" (20).

Monopsonistic buying power
A market condition that allows a single buyer to control the demand side of the market for a product or service.

Multivariate econometric analysis
An analysis that uses statistical methods to estimate and test models of economic behavior and measures the effects of several factors on the variable of interest.

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 Board
A body that would be established under several health reform proposals and given varying degrees of responsibility for creating and regulating different aspects (i.e., a standard benefit package) of these proposals.

National health expenditures (NHE)
An estimate by HCFA of national spending on health care made up of two broad categories: 1) health services and supplies, which, in turn, 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 health expenditure-to-GDP ratio
The ratio of a country's national health expenditures to the country's gross domestic product.

National health insurance program
Any system of health insurance benefits, covering all or nearly all citizens, established by federal law, administered by the federal government, and supported or subsidized by taxation.

National Health Interview Survey
A continuing nationwide sample survey in which data are collected through personal household interviews. Information is obtained on personal and demographic characteristics, illnesses, injuries, impairment, chronic conditions, utilization of health resources, and other health topics. For individuals under age 17, information is collected from a proxy respondent, typically a parent or guardian. The survey is conducted by the National Center for Health Statistics in DHHS.

National Medical Care Utilization and Expenditure Survey, 1980 (NMCUES)
Sponsored by the National Center for Health Statistics in the DHHS, the NMCUES survey involved five rounds of data collection over a 15-month period around 1980 for a national sample of 6,000 households. Data were collected on health insurance coverage, episodes of illness,

number of bed days, hospital admissions, physician and dental visits, other medical care encounters, prescription purchases, access to medical care services, income, and demographic and socioeconomic characteristics. Information was also collected on provider characteristics, services provided, charges, sources, and amounts of payments.

National Medical Expenditure Survey (NMES)
A survey conducted by the DHHS involving five rounds of data collection, between February 1987 and July 1988, sampling 14,000 households (Household Survey). The NMES also surveys physicians and health care facilities providing care to members of a household sample during 1987 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.

Network-model HMO
An HMO that contracts with two or more independent group practices to provide health services.

Nominal
Variables (e.g., fees, expenditures, or gross domestic product) expressed in nominal terms means data that is not adjusted for the effects of price changes. Compare with *real.*

Open enrollment
A health insurance enrollment period when coverage is offered regardless of health status and without medical screening.

Out-of-pocket expenses (costs) or spending
Payments made by a plan enrollee, beneficiary, or insured for medical services that are not reimbursed by the health plan. These may include payments for deductibles and coinsurance for covered services, for services not covered by the plan, for provider charges in excess of the plan's limits, and for enrollee premium payments.

Per-case payment
A type of hospital payment system that pays the hospital a specific amount for each case treated, regardless of the number and types of services or number of days of care provided. Medicare's DRG payment system for inpatient services is a per-case payment system.

Per-diem **payment**
An established rate and method of payment based on the cost of providing a day of hospital inpatient care.

Personal health expenditures
Expenditures that include all services and products purchased that are associated with individual health care, such as hospital services, physician services, drugs, and nursing home care. Excludes expenditures for government public health activities, research and construction, and administrative costs. This is a subcategory of national health expenditures.

Point estimate
A single number rather than a range of numbers.

Preexisting condition
A condition (such as an injury, a disease, or a physical disability) existing in an individual before an insurance policy goes into effect that may in some way hinder the insurance coverage.

Preferred provider organization (PPO)
A term that refers to a variety of different insurance arrangements under which plan enrollees who choose to obtain medical care from a specified group of participating providers receive certain advantages, such as reduced cost-sharing charges. Providers usual] y furnish services at lower than usual fees in return for prompt payment by the health insurance plan and a certain assured volume of patients.

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

Premium limits
A limit on the growth rate or level of premiums.

Price controls
Government involvement in determining the level or growth in input prices (resource costs) or output prices (charges) for medical services, including fee schedules and fee updates for physician ser-

vices and per-diem, per-case, or per-service rate setting for hospital services.

Price elasticity of demand
Percent change in quantity demanded that results from a 1 percent change in the price of a product. For example, if a 10 percent increase in the fee for a physician's office visit caused a 5 percent decrease in patient visits, the price elasticity of demand would be minus 0.5.

Private health insurance
Health insurance that is taken up and paid for at the discretion of individuals, or employers on behalf of individuals.

Private insurance load
The difference between premiums and claims paid, including profit. (Also referred to in this report as private insurance overhead.)

Proposal
In this report, proposal refers to plans to reform the health care system, usually in the form of legislation.

Prospective budgets
An overall limit on the funds to pay for a specific category of health care services, fixed in advance of the payment period, regardless of where the funds originate.

Prospective payment
Payment for medical care on the basis of rates set in advance of the time period in which they apply. The unit of payment may vary from individual medical services to broader categories, such as hospital case, episode of illness, or person (cavitation). Medicare's DRG payment system for inpatient hospital services is a particular form of prospective payment.

Prospective payment system (PPS)
A payment system that pays health care providers for their services according to a predetermined, fixed amount. Although prospective payment rates may be related to the costs providers incur in providing services, the amount a provider is paid for a service under a prospective payment system is unrelated to the provider's actual cost of providing that specific service. Medicare and CHAMPUS use prospective payment systems to pay for inpatient hospital services.

Provider
A physician, hospital, group practice, nursing home, pharmacy, or any individual or group of individuals that provides a health care service.

Provider overhead
Provider expenses associated with activities not directly related to patient care. Definitions of what specific activities are included vary widely.

Provider volume offset
Provider behavior that changes the volume of services in response to changes in provider payment rates.

Public coverage
Third-party coverage that is chiefly administered, operated, or financed by federal or state governments. Examples are Medicaid, Medicare, and CHAMPUS. Compare *private health insurance.*

Rand Health Insurance Experiment (HIE)
A large-scale controlled trial in health care financing with the objective of examining the effects of different organizational and patient cost-sharing arrangements. The HIE was conducted between 1974 and 1982.

Randomized clinical trial (RCT)
An experiment designed to test the safety and efficacy of a medical technology in which people are randomly allocated to experimental or control groups, and outcomes are compared.

Rate-setting system
A method of payment in which a governmental regulatory body (usually a state) decides what prices a hospital, for example, may charge in a given year.

Real
Variables (e.g., fees, expenditures, or gross domestic product) expressed in real terms means data that is adjusted for the effects of price changes. Compare with *nominal.*

Real expenditures
Expenditures adjusted for inflation.

Regional alliance
As defined in the Health Security Act, 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 was available among plan offerings.

Relative value scale (RVS)
An index that assigns weights to each medical service. The RVS used in the development of the Medicare fee schedule consists of four cost components: physician work, practice work, practice expense, and malpractice expense.

Retrospective cost-based reimbursement
A payment method for health care services that pays hospitals (or other providers) their incurred costs for treating patients after the treatment has occurred. In this country, the term has traditionally referred to hospital payment, since other providers have generally been paid on the basis of charges instead of costs.

Risk-adjusted payments
Payments to providers or insurers that are adjusted for the relative risk of using health services. Common risk adjustment factors include age, gender, health status, and prior use of health services.

Scope of coverage
The services covered.

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

Service intensity
The number and complexity of patient care resources, or intermediate outputs, used in producing a patient care service.

Sickness fund
Organizations that administer national health insurance; the term is used primarily in European countries.

Simulation
Used in this report to mean an artificial model of the health care system, set up in order to test an outcome of a potential health reform proposal.

Single-payer system
A payment system in which all covered health care services are insured and paid for by a single insurer.

Skilled nursing facility
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.

Small-market reforms
Changes in the health insurance market for small businesses.

Staff-model HMO
An HMO in which physicians practice solely as employees of the HMO and are paid a salary.

Standardized benefit package
Under reform, a requirement that all or many health insurers must provide coverage for an identical scope and depth of services.

Statistically significant
The likelihood that an observed association is not due to chance.

Supplemental insurance
Coverage that is designed to insure expenses not covered by a basic plan.

Survey of Income and Program Participation (SIPP)
Sponsored by the Department of Commerce's Bureau of the Census, the SIPP is an ongoing panel survey of adults ages 15 and older in the civilian, noninstitutionalized population. The first panel,

held in the fall of 1983, completed nine interviews at 4-month intervals with 20,000 households. Subsequent panels have begun in February of each year with varying numbers of households and numbers of interviews. For the purposes of this report, the most important data collected concerned monthly information on detailed sources and amounts of income from public and private transfer payments, noncash benefits including food stamps, Medicaid, Medicare, and health insurance coverage.

Third-party payer
Private insurers or government insurance programs that pay providers for health care given to patients they insure, either directly or by reimbursing patients for payments they make.

Uncertainty
In this report, as in a recent report of the National Research Council, the term is used as "an umbrella term for the quantification of the differences between a model's estimates and the truth" (20).

Underwriting
The process by which a health insurer determines whether or not and on what basis it will accept an application for insurance.

Univariate econometric analysis
An econometric method for measuring the effect of only one factor on the variable of interest. Compare *multi variate econometric analysis.*

Universal coverage
Guaranteed health insurance coverage for all individuals in a given population.

Utilization
Use; commonly examined in terms of patterns or rates of a single service or type of service (e.g., hospital care, physician visits, prescription drugs). Measurement of utilization of all medical services in any given period is sometimes done in terms of dollar expenditures. Use is also expressed in rates per unit of population at risk for a given period (e.g., number of admissions to a hospital per 1,000 persons over age 65 per year or number of visits to physician per person).

Volume feedback
A method of reducing physician fees in the current or proceeding period based on the volume of *services* provided in the current or past period.

Volume Performance Standards (VPS)
Established under the Omnibus Budget Reconciliation Act of 1989 (Public Law 101 -239) as a means of affecting Medicare payments to physicians; volume performance standards act as a mechanism to update physician fees, as an expenditure target for physician expenditures that are used 2 years later to update fees under the Medicare fee schedule, and to assist in updating future payment rates based in part on the comparison of actual expenditure increases with the target.