Health Care Delivery Statistics Glossary of Terms

This glossary defines the major acronyms, terms and phrases used in *The Numbers* reports and bibliographies produced by the Harvard University Kennedy School of Government Health Care Delivery Policy Program. Definitions describe the relationship of the term to the theme of health care delivery statistics. All acronyms are defined under the listing for their associated phrase.

AD – *Alzheimer's Disease*

AHA – *American Hospital Association*

AHIP – *America's Health Insurance Plans*

AHRQ – *Agency for Healthcare Research and Quality*

AIDS – *Acquired Immunodeficiency Syndrome*

AMA – *American Medical Association*

ANOVA – *Analysis of Variance*

ARIC – *Artherosclerosis Risk in Communities*

ASEC – *Annual Social and Economic Supplement*

Acquired Immunodeficiency Syndrome (AIDS) – a contagious disease of the immune system caused by human immunodeficiency virus (HIV) that affects specific cells needed to fight disease and can lead to various infections or lesions. An HIV-positive diagnosis may or may not develop into AIDS.

Adult – 18 years of age or older

Agency for Healthcare Research and Quality (AHRQ) – a federal research organization that administers the Medical Expenditure Panel Survey (MEPS) and publishes Research Activities to contribute to the policymaking process.

Alzheimer's Disease (AD) – a brain disease that can result in memory loss, impaired thinking, confusion and/or changes in personality or mood. AD is a form of dementia and often worsens over time.

American Hospital Association (AHA) – a national professional organization that represents and serves hospitals, health care networks, and their patients and communities. The AHA conducts an annual survey of hospitals in the United States and tracks and analyzes trends in hospital utilization, personnel, revenues and expenditures across local, regional and national markets.

American Medical Association (AMA) – a national professional organization for physicians that collects, maintains, and disseminates primary source physician data. The AMA conducts an annual mail questionnaire that collects information on each physician's professional activity, practice specialty, type of practice, employment, hospital affiliation and group practice affiliation.

America's Health Insurance Plans (AHIP) – a national trade association representing companies that provide health insurance. AHIP conducts an annual survey of health plans. The AHIP Center for Policy and Analysis tracks and analyzes data on issues such as access, cost, disease management, e-health, HRA/HSA/MSA, individual insurance, long term care, Medicare and Medicaid.

Analysis of Variance (ANOVA) – a statistical technique used to analyze whether there are differences between the average value (mean) across several groups of people. For example, ANOVA methods could be used to compare the effectiveness of three different drugs in lowering blood pressure.

Annual Demographic Supplement – *now the Annual Social and Economic Supplement (ASEC)*

Annual Social and Economic Supplement (ASEC) – *(formerly Annual Demographic Supplement)* – The ASEC is part of the Current Population Survey (CPS), an annual supplement conducted by the United States Census Bureau in March.

Artherosclerosis Risk in Communities (ARIC) – a study conducted in four U.S. communities sponsored by the National Heart, Lung and Blood Institute to investigate natural history of atherosclerosis and variation in cardiovascular risk factors.

Average – the sum of a group of numbers divided by how many numbers are in the group. For example, the average of the series 1,2,3,4 is 1+2+3+4, which is 10, then divided by 4, which is 2.5.

BEA – *Bureau of Economic Analysis*

BLS – *Bureau of Labor Statistics*

BRFSS - *Behavioral Risk Factor Surveillance System*

Behavioral Risk Factor Surveillance System (BRFSS) - The Centers for Disease Control and Prevention (CDC) conducts a monthly telephone survey of adults over 18 years of age to determine health risk behaviors, such as smoking.

Beneficiary – a person entitled to receive covered health care services and reimbursement as determined by the health care plan they subscribe to

Board of Governors of the Federal Reserve System – tracks banking related financial activities at the federal level

Boutique Medicine – *(also known as Concierge Care)* – Patients pay an annual fee directly to their provider to receive benefits like same/next-day appointments, longer examination times, and off duty access to their physicians by cell-phone or pager.

Bureau of Economic Analysis (BEA) – a federal agency that releases monthly updates of Gross Domestic Product (GDP) estimates.

Bureau of Labor Statistics (BLS) – a federal agency that collects data on employer costs, employee compensation and provision of employee benefit plans. Calculates the Consumer Price Index (CPI), Producer Price Index (PPI), Employment, Hours and Earnings Series (EHE), Employment Cost Index (ECI) and conducts the National Compensation Survey (NCS)

CAM – *Complimentary and Alternative Medicine*

CAPI – *Computer-Assisted Personal Interviewing*

CBO – *Congressional Budget Office*

CDC – *Centers for Disease Control and Prevention*

CHS – *Cardiovascular Health Study*

CHAMPUS – *Civilian Health and Medical Program of the Uniformed Services*

CHAMPVA – *Civilian Health and Medical Program of the Department of Veterans Affairs*

CMS – *Centers for Medicare & Medicaid Services*

CMS 64 Reports - an accounting statement of actual expenditures made by the states that receive federal reimbursement for Medicaid services

COBRA - *Consolidated Omnibus Budget Reconciliation Act of 1986*

COPD – *Chronic Obstructive Pulmonary Disease*

CPI – *Consumer Price Index*

CPS – *Current Population Survey*

CTS – *Community Tracking Study*

Cardiovascular Health Study (CHS) – a National Heart, Lung and Blood Institute-funded observational study of risk factors for cardiovascular disease in adults 65 years or older.

Categorically Eligible – individuals regarded by the United States Census Bureau as eligible for Medicaid because they receive other public benefits, such as public assistance payments

Census – The United States Bureau of the Census conducts a decennial (every ten years) survey to collect data on sex, race, age and marital status on the entire population that the government has on record. The Census does not collect data about health status or health insurance. The March Supplement of the Census Bureau's Current Population Survey (CPS) asks questions about health insurance coverage. Supplemental surveys estimate expenditures for nursing home, home health care and services of health professionals and the government

Census-Based Weights – data are adjusted to U.S. Census totals for sex, age, and race/ethnicity for a certain year, such as 2000. Often, estimates differ by less than 1 percentage point after adjusting for census-based weights.

Center for Studying Health System Change (HSC) – The HSC conducts a Community Tracking Study (CTS) with site visits to 12 nationally representative metropolitan communities over a two-year period to track changes in local health care markets.

Centers for Disease Control and Prevention (CDC) – the Centers for Disease Control and Prevention (CDC) provides the FASTSTATS website with an A-Z index of their most current statistics on disease prevalence and incidence, mortality and health care utilization.

Centers for Medicare & Medicaid Services (CMS) – *(formerly Health Care Financing Administration – HCFA)* – The CMS is the federal agency primarily responsible for administering and tracking the Medicare and Medicaid programs at the national level. Medicaid data are collected from the states, through the Medicaid Statistical Information System (MSIS) and CMS-64 quarterly fund reports. The Medicare program collects data from many sources and programs, including the Medicare Current Beneficiary Survey, national claims history files, standard analytic files, final action claims data, stay records files, Part B Medicare files, Medicare provider and analysis review files, inpatient hospital and skilled nursing facility final action stay records, denominator files about each beneficiary enrolled in Medicare during a calendar year, vital status files about each beneficiary ever entitled to Medicare, group health plan master files on all beneficiaries ever enrolled in a managed care organization contracted by CMS and other files.

Children – under 18 years of age

Chronic Condition – a medical condition that can be treated, but not cured once it is acquired (such as diabetes). Some surveys require that conditions must be present a minimum amount of time (e.g., 3 months) to be considered chronic.

Chronic Obstructive Pulmonary Disease (COPD) – a group of lung diseases that cause swelling of the airways. Emphysema is a form of COPD.

Civilian – a person who is not a member of the Armed Forces

Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) – see TRICARE

Civilian Health and Medical Program of the Department of Veterans Affairs (CHAPMVA) – see TRICARE

Coinsurance – a fixed percentage of covered expenses paid by a health plan and an enrollee once a deductible has been met. 80/20 coinsurance means that 80% of the fees are paid by the plan and 20% by the beneficiary.

Community Tracking Study (CTS) – Administered every other year by the Center for Studying Health System Change, the CTS household survey provides point-in-time and full year estimates of health insurance status.

Complimentary and Alternative Medicine (CAM) – health care systems, practices, or products not considered to be part of conventional medicine or practiced by doctors of medicine or osteopathy

Comorbid Condition – a person's medical condition that exists at the same time as another condition, and can be related (emphysema and bronchitis) or unrelated (diabetes and gallbladder disease).

Computer Assisted Personal Interviewing (CAPI) – survey instruments used to collect data (i.e., for the Medicare Current Beneficiary Survey)

Confidence Interval – a range of values around a statistic where the "true" statistic can expect to be located

Concierge Care – *(also known as Boutique Medicine)* – Patients pay an annual fee directly to their provider to receive benefits like same/next-day appointments, longer examination times, and off duty access to their physicians by cell-phone or pager.

Congressional Budget Office (CBO) – Provides Congress with analyses needed for economic and budgetary decisions.

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) – allows certain workers leaving their jobs to retain healthcare coverage through their former employer's plan by paying the entire premium cost plus an administrative fee

Constant Price GDP – Constant price GDP (also called real GDP) is used to adjust for inflation. Constant price GDP is deflated using chain-type price index, which uses mathematical formulas that take into consideration costs from a base year and the current year. *See Gross Domestic Product*

Consumer Driven Health Plan – a health plan that involves the consumer (customer) in health care purchasing decisions that take into account both cost and appropriateness of care

Consumer Price Index (CPI) – The Bureau of Labor Statistics prepares the Consumer Price Index, which is a measure of the average change in prices paid by consumers for fixed goods and services over a specified period.

Copayment – a fixed dollar amount that a beneficiary is required to pay out-of-pocket for specific health care services (e.g., $25 for an emergency room visit)

Covered Lives – the number of distinct individuals counted as enrolled members of a health plan or program

Cross-Sectional Data – observations on various persons or events collected at a single point in time. A cross-sectional study could involve giving a group of 1,000 adults with asthma a lung function test to find out if they were experiencing asthma at that time.

Current Population Survey (CPS) – Conducted by the United States Census Bureau and Bureau of Labor Statistics, the CPS is a monthly survey of over 130,000 individuals designed to collect data on the civilian, noninstitutionalized population's employment status. The March supplement asks questions about health insurance coverage.

Current Prevalence – the number or percentage of people who are diagnosed with or report having a disease or condition at the time of a survey or study. Surveys can also look at prevalence over a specific period; 12-month prevalence would be the number of people who had been diagnosed with or reported having a disease or condition within the last 12 months of the survey or study.

Customers by Market Segment – a breakdown of the consumer market for health insurance by type of customer (age, employed/unemployed, etc.) and product (such as Medicare, Medicaid, employer-sponsored health insurance, etc.)

DM – *Disease Management*

DRG – *Diagnostic Related Group*

DSM-IV – *Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition*

Decennial – every ten years

Deductible – a specified amount of money that the covered individual or family must pay out-of-pocket during a given time period (usually a year) before a health insurer will pay for covered services in excess of the deductible.

Defined Contribution Plan - a plan that provides an individual account for each participant (such as a 401K), where employers and employees may contribute funds, and benefits to enrollees are largely based on funds contributed and income/losses generated from those funds

Department of Commerce – a federal agency that compiles and reports the Gross Domestic Product

Dependent – someone in one's family (or through adoption or a legal arrangement) who is covered under the subscriber's health insurance plan. Examples include a child, grandchild, stepchild, parent, brother or sister. States can legislate whether same-sex couples qualify for dependent coverage.

Descriptive Statistics – written summaries used to describe the basic features of data in a study, such as the sample size and results

Diagnostic and Statistical Manual of Mental Disorders - Fourth Edition (DSM-IV) – The American Psychiatric Association began publishing the DSM-IV in 1994. Each entry contains a general description of a disorder followed by a listing of possible symptoms, which enables identification of patients' illnesses. The next edition, DSM-V, is scheduled for publication in 2010.

Diagnostic Related Group (DRG) – a patient classification system that provides a way of describing the types of patients a hospital treats, developed by a group of researchers at Yale University in the l960s. DRGs are structured by principal diagnosis, then separated into surgical and medical cases, and can be further broken down by actual surgical procedures performed.

Direct Costs of Disease – tangible, measurable expenses that can be clearly attributed to the patient's disease, such as doctor's office visits, diagnostic testing, medical equipment, hospital, nursing home and home health care services, medications, immunizations, payments to physicians and other professionals and treatment of general medical conditions attributed to the condition

Disabled – a person with physical or mental limitation(s) that may impact his or her ability to participate in certain activities. People with disabilities are eligible for health insurance coverage through the federal Medicaid and/or Medicare programs.

Disease Management (DM) – a system of coordinated healthcare assistance and education for people with medical conditions where patient self-care efforts can lead to major improvements. Disease management programs may be offered through providers, insurers, employers, agencies and/or online sources. DM typically focuses on heart disease, diabetes, COPD and asthma.

Doctor-Diagnosed – a medical disease or condition is confirmed by a licensed doctor following examination and/or diagnostic testing

EBRI – *Employee Benefit Research Institute* – a research organization that conducts the Retirement Confidence Survey and the Health Confidence Survey and publishes the Data Book on Employee Benefits

ECI – *Employment Cost Index*

EHE – *Employment, Hours and Earnings Series*

EPO – *Exclusive Provider Organization*

EQ-5D – *EuroQual-5D*

e-Health – health care delivery that uses electronic technology (such as the Internet) to communicate between suppliers, providers and/or customers.

Elderly – counted as 65 years of age or older for purposes of certain health insurance eligibilities

Eligible – meets requirements for health insurance coverage under Medicare, Medicaid, other government program, or through employer, union or association**.**

Employee – a person on the payroll of a company or organization. Excludes temporary and contract workers but includes the owner or manager if that person works at the company or organization.

Employment-Based Health Insurance – health insurance coverage provided through one's own employment or that of a family member.

Employment Cost Index (ECI) – The Bureau of Labor Statistics (BLS) measures change in cost of labor, regardless of employment shifts among occupations and industries. The ECI tracks the civilian economy, including the total private nonfarm economy (excluding households) and the public sector (excluding the Federal government). Data includes the Compensation Series (changes in wages and salaries and employer costs for employee benefits), Wage and Salary Series and Benefit Cost Series.

Employment, Hours and Earnings Series (EHE) – Payroll costs for hospitals are obtained from the Bureau of Labor Statistics Employment, Hours and Earnings Series (EHE). This data excludes nonsalaried health professionals, such as workers contracted through temporary agencies.

Enrolled – recorded as a member of a health plan or program

Enrollee – an individual who qualifies for health benefits and has taken action to register for or make a request for participation in the plan

Episode – an occurrence of a medical condition or event, such as an asthma attack

Estimate – to roughly determine the size, cost or extent of something, usually based on analysis of available data. Estimates may be based on the judgment of the individual(s) studying the data.

EuroQual-5D (EQ-5D) – a health status classification system that generates preference-weighted scores to show the desirability of various health states. The EQ-5D is used in the Medical Expenditure Panel Survey (MEPS), for example, to measure anxiety/depression for people with no problems, moderate problems or extreme problems.

Expense – cost to an organization for payroll, employee benefits, operations, goods, services, debt and/or professional fees

Expenditure – the issuance of checks, disbursement of cash, or electronic transfer of funds made as payment for an expense regardless of the fiscal year the service was provided or the expense was incurred

Exclusive Provider Organization (EPO) – a Preferred Provider Organization (PPO) that does not provide coverage for care performed outside the PPO's network or facilities

FEHB – *Federal Employee Health Benefits Program*

FHS – Framingham Heart Study

FSA – *Flexible Spending Account*

FTC – *Federal Trade Commission*

FY – *Fiscal Year*

Family – a group of two or more persons related by birth, marriage, adoption or legal arrangement

FASTSTATS – the Centers for Disease Control and Prevention (CDC) provides the FASTSTATS website with an A-Z index of their most current statistics on disease prevalence and incidence, mortality and health care utilization.

Federal Budget Outlays – the amount that the federal government spends in a given year. The figure includes governmental spending on private sector programs (such as private health insurance) as well as government sponsored programs.

Federal Employee Health Benefits Program (FEHB) – a program administered by the Office of Personnel Management for US federal government employees, dependents, survivors and retirees to choose from among Fee-for-Service Plans (FFS), Preferred Provider Organizations (PPO), Point of Service Plans (POS) or Health Maintenance Organizations (HMO) if they live (or sometimes work) within the area serviced by the plan.

Federal Outlays on Health – the amount that the federal government (not state and local governments, consumers or private organizations) spends on health and medical care, services, equipment, facilities and research in a given year

Federal Trade Commission (FTC) – a federal agency that conducts economic research to enforce consumer and antitrust protections and contribute to governmental policy efforts

Fee-for-Service Health Insurance – also known as indemnity insurance, fee-for-service health insurance is private (commercial) health insurance that reimburses health care providers for each specific health service provided to an insured person. Examples are Medicare Part A and B.

Fiscal Year (FY) – A period of 12 months, used for accounting purposes for a company, organization or government. A fiscal year can run from January 1 through December 31, or any other specified start and end time covering 12 complete months.

Flexible Spending Account (FSA) – a benefit plan that allows an employee a tax exemption from Federal and most state taxes to pay for approved expenses out of an account managed by the employer

Framingham Heart Study (FHS) – a study to identify common factors of cardiovascular disease by following its development over a long period of time in a large group of participants who had not yet developed overt symptoms of cardiovascular disease or suffered a heart attack or stroke.

GAO – *General Accounting Office*

GCNKSS – *Greater Cincinnati/Northern Kentucky Stroke Study*

GDP – *Gross Domestic Product*

GHP – *Group Health Plan*

GNP – *Gross National Product*

Gallup Poll – The Gallup Poll conducts random telephone interviews of 1000 people or less in the US over a five-day period on their opinions on current issues, including health care.

General Accounting Office (GAO) – Reports on federal economic activities

Genetically Personalized Care – medical care based on an individual's genes (body sequences that control traits). Data on the expressions of genes for large populations are analyzed so that scientists can create targeted tests and treatments by disease and genetic profile.

Greater Cincinnati/Northern Kentucky Stroke Study (GCNKSS) – a large US population-based metropolitan study of stroke and transient ischemic attack incidence rates and outcomes.

Gross Domestic Product (GDP) – The Gross Domestic Product (GDP) is considered the most basic and comprehensive measure of the US economy's performance. GDP is measured and reported by the US Department of Commerce, and measures total production of all goods and services in the economy within national borders, over a specified period. The GDP is obtained by valuing outputs of goods and services at market prices (the actual prices that items sell for).

Gross National Product (GNP) – Prior to 1991, the US used Gross National Product (GNP) as the primary measure of economic performance. The GNP measured output of all goods and services in the economy over a specified period at market prices, whether production took place within the country or in foreign nations.

Group Health Insurance – health insurance purchased through an employer, labor union or professional organization

Group Health Plan (GHP) Master File – The Medicare GHP Master File contains data on beneficiaries currently enrolled or have ever been enrolled in a managed care organization under contract with the Centers for Medicare & Medicaid Services. Each data record represents one beneficiary.

Group Purchasing Organization – an entity whose main function is to negotiate contracts to purchase goods or services for members of a group

HBSM – *Health Benefits Simulation Model*

HCFA – *Health Care Financing Administration*

HC – *Household Component*

HIV – *Human Immunodeficiency Virus*

HMO – *Health Maintenance Organization*

HRA – *Health Reimbursement Arrangement/Account*

HRS – *Health and Retirement Survey*

HRET – *Health Research and Educational Trust*

HSA – *Health Savings Account*

HSC – *Center for Studying Health System Change*

HUI2/HUI3 – *Health Utilities Index Mark 2/ Health Utilities Index Mark 3*

Harris Interactive Poll - a private weekly survey conducted by Harris Interactive by telephone and online on various topics, including health status and opinion on health care issues

Health and Retirement Study (HRS) – Every two years, the University of Michigan (with support provided by the National Institute on Aging) surveys over 22,000 people over 50 years of age on their health insurance coverage and health status.

Health Benefits Simulation Model (HBSM) – The Lewin Group, a research consulting organization, developed an analytic model to be used in conjunction with existing health benefits surveys to estimate costs and impacts and identify unintended consequences.

Health Care Delivery – The National Academy of Engineering and the Institute of Medicine define health care delivery as the interactions that involve the patient in the promotion of an individual's health.

Health Care Financing Administration (HCFA) – now the Centers for Medicare & Medicaid Services (CMS)

Health Coach – Some health plans and workplace benefits and wellness programs provide access to a trained individual who can answer subscribers' questions about treatment options, provide healthy lifestyle information and recommend ways to optimize health plan usage. Plans may provide financial incentives for subscribers who work with the coach prior to seeking medical treatment.

Health Coverage Tax Credit Program – created in 2002 to offer tax credits to jobless workers who buy private health insurance

Health Insurance – payment or reimbursement for health or medical expenses (such as hospital services or prescription drugs) by a plan or program. If an individual were not covered by health insurance, that person would be uninsured and pay out-of-pocket for all health or medical expenses.

Health Insurance Survey – The Commonwealth Fund works with Princeton Research Associates to conduct 25-minute telephone interviews of a nationally representative sample of adults 19 years of age or older as to their health insurance status

Health Maintenance Organization (HMO) - a health care system responsible for the financing and delivery of medical services to a voluntarily enrolled population, in return for a fixed, prepaid fee. HMO models can be group (contracting with a multi-specialty medical group), staff (care providers are employees of the HMO), network (contracting with multiple physician groups), individual practice association (contracting with independently practicing physicians) or mixed.

Health Reimbursement Arrangement (HRA) – *(also called personal care account or health reimbursement account)* – Employers make an annual contribution to their employee's health care account. Employees draw from their account to pay for a defined list of medical expenses. When the account is exhausted, employees pay out-of-pocket until they meet an annual deductible, then coverage reverts to a major medical plan.

Health Research and Educational Trust (HRET) – HRET sponsors the annual Kaiser/HRET Employer Health Benefits Survey along with the Kaiser Family Foundation

Health Savings Account – Employers and employees make an annual contribution to the employee's health savings account. Employees draw from their account to pay for a defined list of medical expenses. The account can be invested and can grow tax-free, and can be transferred to a spouse on a tax-free basis if the policyholder dies. When the account is exhausted, employees pay out-of-pocket until they meet an annual deductible, then coverage reverts to a major medical plan. Annual HSA deposits cannot exceed the amount of the deductible, and cannot exceed a government-specified amount.

Health Utilities Index Mark 2/Mark 3 (HUI2/HUI3) – a health status classification systems that generates preference-weighted scores to show the desirability of various health states. The HUI3 has been used in the Health and Retirement Survey. It is a 15-item questionnaire that defines health status by the attributes of sensation, mobility, emotion, cognition, self-care and pain.

High-Deductible Health Insurance – a health insurance policy available to employers who offer a medical savings account program. The policy covers beneficiary expenses exceeding the medical savings account deductible level as prescribed by law.

Household – all persons who occupy a housing unit (i.e., house, apartment, occupied room, etc.), regardless of whether they belong to the same family

Household Component (HC) – a component of the Agency for Healthcare Quality and Research (AHRQ) Medical Expenditure Panel Survey (MEPS). The HC is a nationally representative survey of the civilian noninstitutionalized population from a subsample of the previous year's National Health Interview Survey (NHIS). The HC is a two-year survey that produces estimates of healthcare use, expenditures, sources of payment, insurance coverage and quality of care.

Human Immunodeficiency Virus (HIV) – a virus that infects and destroys helper T cells of the immune system. HIV can cause AIDS (acquired immunodeficiency syndrome), but an HIV-positive diagnosis does not necessarily lead to AIDS.

IC – *Insurance Component*

IHS – *Indian Health Services*

IPA – *Independent Practice Association*

Incidence – the number of new cases of a disease or medical condition that began during a set period of time (usually one year).

Incidence Rate – new cases of a disease or medical condition per number of individuals in a population (for example: the incidence of asthma per 1,000 children under 18)

Indemnity Insurance – also known as fee-for-service health insurance, indemnity insurance is private (commercial) health insurance that reimburses health care providers for each specific health service provided to an insured person.

Independent Practice Association (IPA) – a legal entity that holds contracts with managed care organizations and with physicians, to provide care on a fee-for-services or a capitated basis. IPAs generally work with solo physicians.

Indian Health Services (IHS) – IHS provides health services to American Indians and Alaska Natives. IHS is administered through the United States Department of Health and Human Services (DHHS) and consists of hospitals, health centers, health stations, and residential treatment centers and includes health care purchased from private providers. The US Census counts those covered by Indian Health Services as uninsured.

Indirect Costs of Disease – intangible, not easily quantifiable expenses that may be a result of the disease incurred, such as: absenteeism of employees who care for family members, financial assistance to persons with chronic disease, household allergy control measures, loss of productivity at work, pain and suffering, quality of life and transportation to and from healthcare visits.

Individual Health Insurance – private (commercial) health insurance purchased directly by an individual or family (not provided through an employer, union, the military or the government)

Institute for Supply Management – *(formerly National Association of Purchasing Managers)* – Calculates the Purchasing Managers Index (PMI) and conducts the Report on Business survey.

Insurance Component (IC) – a component of the Agency for Healthcare Quality and Research (AHRQ) Medical Expenditure Panel Survey (MEPS). The IC has two samples, a household sample and a list sample. The IC household sample collects data from employers on health insurance held by and offered to respondents to the MEPS HC. The list sample collects data on types and costs of workplace health insurance from about 40,000 employers.

JNC7 - *Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure*

KCMU – *Kaiser Commission on Medicaid and the Uninsured*

Kaiser Commission on Medicaid and the Uninsured (KCMU) – provides information and analysis on health care coverage and access for the low-income population, with a special focus on Medicaid's role and coverage of the uninsured.

Kaiser/HRET Annual Employer Health Benefits Survey – a telephone survey of over 1,000 randomly selected small and large, public and private employers as to the nature of employer-provided health benefits conducted by the Henry J. Kaiser Family Foundation and the Health Research and Educational Trust (HRET).

Lifetime Prevalence – the total number or percentage of people in a population who've been diagnosed with or reported having a disease or condition for at least some point in their lives

Limited Benefit Health Plans – *(also known as mini-medical health plans)* – low-cost health insurance plans that provide limited coverage such as routine doctor visits, but not usually catastrophic care

Long Term Care – medical and personal care services for people with a chronic illness or disability who cannot perform activities of daily living (bathing, dressing, etc.) independently. Long term care can take place at home or in an institution, like a nursing home.

Longitudinal – repeated observation of a group of people over time with respect to one or more study variables

Low-Income – There is no standard definition for low-income. Poor is defined as an individual's or family's income falling at or below the U.S. poverty threshold. Poverty thresholds are updated annually by the Census Bureau and take into account family size and elderly status. There are different poverty thresholds for Alaska and Hawaii. The DHHS creates poverty guidelines based on the thresholds each year. Federal programs use poverty guidelines to decide whether people are eligible for financial assistance from the government (including Medicaid, Medicare and SCHIP). However, "poor" and "low-income" may be used subjectively in surveys and reports, and "near poor" can also be used. Although poverty thresholds are standard throughout the 48 continuous U.S. states, a family of four with an income of $30,000 may be *considered* low-income in one US region and poor in another, due to cost of living.

MANOVA – *Multiple Analysis of Variance*

MCBS – *Medicare Current Beneficiary Survey*

MEPS – *Medical Expenditure Panel Survey*

MMI – *Milliman Medical Index*

MMWR – *Morbidity and Mortality Weekly Report*

MPC – *Medical Provider Component*

MSA – *Medical Savings Account; Metropolitan Statistical Area*

MSIS – *Medicaid Statistical Information System*

Managed Care – a health care delivery system where a health insurance organization, program or plan administers costs. Managed care can include health maintenance organizations (HMO), preferred provider organizations (PPO), and Medicare and Medicaid Managed Care.

Markov Model – a tool that analyzes complicated systems based on sequences of events where the likelihood of an event occurring depends on the fact that a preceding event occurred

Median – a value for which one-half of the numbers in a series fall above and the other half fall below. For example, in the series 2,4,6,8,10, the median is 6. When the number of values in the sample is even, the median is the average of the two middle figures (in the series 10,20,30,40, the median is 25).

Medicaid – a federal insurance program for persons of all ages whose income and resources are insufficient to pay for health care. States determine eligibility guidelines, and administer their own programs. States may pay health care providers directly on a fee-for-service basis, or though prepayment arrangements, such as Medicaid Managed Care. Certain Medicare beneficiaries may also be eligible for Medicaid.

Medicaid Managed Care – a method of providing comprehensive care to Medicaid beneficiaries on a risk basis through a network of managed care providers (such as health maintenance organizations) affiliated with the Medicaid program

Medicaid Statistical Information System (MSIS) – a state-reported eligibility and claims database for the Medicaid population

Medical Expenditure Panel Survey (MEPS) – a nationally representative survey by the Association for Healthcare Research and Quality (AHRQ) of the United States nonelderly civilian noninstitutionalized population that collects data on medical expenses and health insurance status for individuals and households for the entire year, at some point during the year, or throughout the first half of the year.

Medical Expenses – the costs of diagnosis, cure, treatment or prevention of disease, injury or problems affecting any part of the body. From a health insurance perspective, medical expenses generally do not include expenses that are beneficial, but not medically necessary to the diagnosis, cure, treatment or prevention of disease or medical condition, such as vitamins or membership in a gym.

Medical Member – From the perspective of covered lives, individual health insurers define their own medical members. One insurer may define medical members as management service and network service members - while another may count all members, excluding dental and group members, as medical members.

Medical Provider Component (MPC) – a component of the Agency for Healthcare Quality and Research (AHRQ) Medical Expenditure Panel Survey (MEPS). The MPC collects data from hospitals, physicians and home health providers on expenditures.

Medical Savings Account (MSA) – Medical Savings Accounts were enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Employees contribute to and draw from their medical savings account to pay for a defined list of medical expenses. The employee may contribute an amount not to exceed a specified percentage of the deductible. Contributions to an MSA are tax-deductible, and can earn tax-deferred interest. *The acronym MSA is also used for metropolitan statistical area.*

Medicare – a federal program that provides hospital and medical benefits to people age 65 and older, people entitled to social security disability payments for two years or more, people with end-stage renal disease and others with short-term acute medical conditions.

Medicare+Choice – *(was known as Medicare Part C, replaced by Medicare Advantage)* – an expanded set of health care delivery options for Medicare beneficiaries, including health maintenance organizations (HMO), provider sponsored organizations (PSO), preferred provider organizations (PPO) and medical savings accounts (MSA).

Medicare Advantage – *(also known as Medicare Part C, formerly Medicare+Choice)* – a plan offered by a private company which contracts with Medicare to provide someone with Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans.

Medicare Current Beneficiary Survey (MCBS) – a continuous survey of a nationally representative sample of about 18,000 Medicare beneficiaries in households or long-term-care facilities. The MCBS provides data on health service utilization, health status, expenditures and other beneficiary information. Each person is interviewed 3 times a year for 4 years, with proxy respondents (such as nurses) providing information if the beneficiary cannot answer questions. The MCBS uses computer-assisted personal interviewing (CAPI) instruments.

Medicare Fee-for-Service - Medicare Part A and/or Part B

Medicare Managed Care – *(was known as Medicare+Choice, replaced by Medicare Advantage)* **–** a plan offered by a private company which contracts with Medicare to provide someone with Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans.

Medicare Part A – Medicare fee-for-service hospital insurance

Medicare Part B – Medicare fee-for-service supplemental medical insurance, that pays for a portion of physician services, outpatient hospital services and other services defined by the Medicare program. Medicare Part B does not pay for inpatient hospital services.

Medicare Part C – *(was known as Medicare+Choice, replaced by Medicare Advantage)* **–** a plan offered by a private company which contracts with Medicare to provide someone with Medicare Part A and Part B benefits. Medicare Advantage Plans are HMOs, PPOs, or Private Fee-for-Service Plans.

Medicare Part D – *(also known as Medicare Prescription Drug Plan)* – a stand-alone drug plan, offered by insurers and private companies to Medicare beneficiaries. Medicare Part D began in 2006.

Medicare Payment Advisory Commission (MedPAC) - an independent federal body of 17 members set up to advise Congress on issues affecting the Medicare program. MedPAC issues reports to Congress in March and June of each year.

Medicare Prescription Drug Plan – *(also known as Medicare Part D)* – a stand-alone drug plan, offered by insurers and private companies to Medicare beneficiaries. Medicare Part D began in 2006.

Medigap – individually purchased supplemental Medicare insurance. Medigap consists of 10 standardized policies (A-J) that can be marketed by private insurance companies. Medigap premiums are regulated by states.

MedPAC – *Medicare Payment Advisory Commission*

Metropolitan Statistical Area (MSA) – a community or group of connected communities that contains at least one city/urbanized area with a large population. The surrounding communities must have a high degree of economic and social integration with the city to be considered part of the MSA. The National Health Interview survey data is based on metropolitan statistical areas. *The acronym MSA is also used for medical savings account.*

Military – employed by the United States Armed Forces

Military Health Care – includes health care provided by CHAMPVA (Civilian Health and Medical Program of the Department of Veterans Affairs), TRICARE or any other care provided by the Department of Veterans Affairs (VA) or the military.

Milliman Medical Index (MMI) – Developed by healthcare business and actuarial consultant Milliman in 2005, the MMI measures average spending by a typical American family of four if covered by an employer sponsored PPO. It provides a benchmark by annually assessing changes in those costs over a five-year period.

Mini-Medical Health Plans – *(also known as limited benefit health plans)* – low-cost health insurance plans that provide limited coverage such as routine doctor visits, but not usually catastrophic care

Morbidity and Mortality Weekly Report (MMWR) – The Centers for Disease Control and Prevention (CDC) Epidemiology Program Office (EPO) publishes the MMWR. The report tracks epidemiological data on diseases defined as notifiable by the Council of State and Territorial Epidemiologists (CSTE). Data on HIV/AIDS, arthritis and asthma are reported in the MMWR.

Multicenter Study – a clinical trial conducted by more than one medical institution

Multiple Analysis of Variance (MANOVA) – *see Analysis of Variance (ANOVA)* – MANOVA is an ANOVA statistical study with at least two dependent variables. For example, researchers may use MANOVA to study pain and depression in arthritis patients, as each symptom may be affected by the other one.

NCHS – *National Center for Health Statistics*

NCS – *National Compensation Survey*

NED – *National Enrollment Database (Department of Veteran's Affairs)*

NHANES - *National Health and Nutrition Examination Survey*

NHCS – *National Health Care Survey*

NHE – *National Health Expenditures*

NHIS – *National Health Interview Survey*

NIH – *National Institutes of Health*

NIHCM – *National Institute for Healthcare Management Research and Educational Foundation*

NSAF – *National Survey of America's Families*

NSF – *National Science Foundation*

National Academy of Social Insurance – Reports on state-operated worker's compensation programs

National Association of Purchasing Managers – now the Institute for Supply Management

National Center for Health Statistics (NCHS) – conducts the National Health and Nutrition Examination Survey (NHANES) and the National Health Care Survey (NHCS), which includes the National Ambulatory Medical Care Survey (NIAMCS), National Hospital Ambulatory Medical Care Survey (NHAMCS), National Hospital Discharge Survey (NHDS), National Survey of Ambulatory Surgery (NSAS), National Home and Hospice Care Survey (NHHCS) and National Nursing Home Survey (NHHS).

National Compensation Survey (NCS) – The Bureau of Labor Statistics (BLS) collects and integrates data from multiple surveys for the National Compensation Survey, including a 3-stage design with a sample of 154 metropolitan and nonmetropolitan areas. BLS field economists visit businesses and interview employers on health insurance benefits participation.

National Debt – The national debt is the total of all the outstanding borrowings of the US government, including borrowings by national, state and local governments. The figure does not include debts incurred by individual citizens or private organizations.

National Enrollment Database (NED) – Data are collected locally at each Veteran's Affairs (VA) medical center and are transmitted electronically to the VA Automation Center to produce national statistics.

National Health Accounts – The federal Office of the Actuary compiles estimates of United States expenditures for health based on National Health Accounts annually.

National Health and Nutrition Examination Survey (NHANES) – Conducted by the National Center for Health Statistics (NCHS), NHANES is a continuous, annual, cross-sectional, nationally representative survey of civilian, noninstitutionalized people of all ages, providing estimates of prevalence of selected diseases and risk factors, such as nutritional deficiency, asthma and arthritis. In addition to in-home interviews, medical professionals examine participants. Over 9,000 individuals are surveyed in NHANES.

National Health Care Survey (NHCS) – a family of surveys conducted by the National Center for Health Statistics (NCHS). The NHCS includes: National Ambulatory Medical Care Survey (NIAMCS), National Hospital Ambulatory Medical Care Survey (NHAMCS), National Hospital Discharge Survey (NHDS), National Survey of Ambulatory Surgery (NSAS), National Home and Hospice Care Survey (NHHCS) and National Nursing Home Survey (NHHS).

National Health Expenditures (NHE) – an estimate of the amount spent for all health services and supplies and health-related research and construction activities consumed in the United States during the calendar year

National Health Interview Survey (NHIS) – Administered by the National Center for Health Statistics (NCHS), the NHIS is a continuous household interview survey of the civilian noninstitutionalized population. Over 100,000 individuals are surveyed for each sample. Proxy responses are collected for individuals who cannot answer the questions, such as children. NHIS provides estimates on the number of persons uninsured at a point-in-time, a full-year or at any point during the year. Data are also collected on illnesses and chronic conditions and utilization of health resources.

National Institute for Healthcare Management Research and Educational Foundation (NIHCM) – a non-profit organization that tracks and analyzes data on prescription drug costs, Medicare, Medicaid, individual health insurance and the uninsured.

National Institutes of Health (NIH) – Composed of 27 Institutes and Centers, the NIH is the primary Federal agency for conducting and supporting medical research.

National Science Foundation (NSF) – an independent federal agency that funds research in the sciences and engineering. The NSF tracks medical research expenditures, budgets, workforce, facilities, education, and public attitudes and understanding of the sciences and engineering.

National Survey of America's Families (NSAF) – The Urban Institute NSAF surveys a nationally representative sample every other year on their health insurance status to provide point-in-time, full year and any point within the year estimates. It is a telephone and personal household interview of children and nonelderly noninstitutionalized adults.

Nationally Representative Data – a sample with adequate and consistent representation from all variables that comprises a demographic (age, gender, work status, etc.) and geographic (regional, urban/rural, etc.) view of the nation's population

Nonelderly – under 65 years of age

Noninstitutionalized – not living in a prison, long-term-care facility, or psychiatric facility

Nonresponse Rate – the amount of people or organizations that refuse to be interviewed in a survey

Nonsampling Error – an error in a survey that can result from many factors, such as incorrect responses, incomplete responses, or lack of responses

Notifiable Disease – a disease that health providers are required by law to report to state and/or local public health officials upon diagnosis (such as HIV/AIDS)

OCHAMPUS Information Systems Division Statistics Branch – Collects and reports TRICARE/CHAMPUS cost data

Out-of-Pocket – health care expenses that individuals pay themselves, which are not reimbursed by an insurer. Examples include deductibles, copayments and over-the-counter medications. People who are uninsured pay out-of-pocket for all their medical expenses.

Overall Prevalence – the total number or percentage of people in a population covering a specified time period who are diagnosed with or report having a disease or condition. A study conducted over ten years covering the United States, Canada and Mexico could find the overall prevalence of diabetes in North America.

Oversampling – a procedure designed to give a group larger participation in a survey than the its actual representation in the population

PMI – *Purchasing Manager's Index*

POS – *Point-of-Service*

PPI – *Producer Price Index*

PPO – *Preferred Provider Organization*

PSO - *Provider Sponsored Organization*

Panel Study – a survey where the same groups of people are interviewed at different times over a period of time

Part-Time Worker – classified by the US Census Bureau as those working fewer than 35 hours per week for the majority of weeks in the year

Participant – someone who has had at least one contact with a group that they belong to

Personal Health Care Expenditures – outlays for goods and services relating directly to patient care. This measure is derived from the total national health expenditures minus expenditures for research, construction, health insurance administration and governmental public health activities.

Point-in-Time Estimate – reports the number of people with a certain status at any one point in time (e.g.; on a given day)

Point-of-Service (POS) Plan – a health plan that allows members to choose to receive health services from participating and/or non-participating providers. POS Plans can be offered through health maintenance organizations (HMO), preferred provider organizations (PPO) or employers.

Population – The US Census Bureau counts total population as the entire population of the United States, including all members of the Armed Forces living in foreign countries. Resident population excludes US citizens working, studying or living in foreign countries. Civilian population excludes those in the Armed Forces, but includes their families. Noninstitutionalized population includes US citizens not living in a prison, long-term-care facility, or psychiatric facility.

Poor – poor is defined as an individual's or family's income falling at or below the U.S. poverty threshold. Poverty thresholds are updated annually by the Census Bureau and take into account family size and elderly status. There are different poverty thresholds for Alaska and Hawaii. The DHHS creates poverty guidelines based on the thresholds each year. Federal programs use poverty guidelines to decide whether people are eligible for financial assistance from the government (including Medicaid, Medicare and SCHIP). However, "poor" and "low income" may be used subjectively in surveys and reports, and "near poor" can also be used.

Preferred Provider Organization (PPO) – a health plan where health care is provided through a network of selected providers (such as hospitals and physicians). Members can receive care outside the network at a higher cost.

Premium – periodic (e.g., monthly, biweekly, annually) health insurance cost charged to an enrollee or someone else (such as an employer)

Prescription Drug Expenditures – retail sales of medications prescribed by a licensed healthcare provider

Prevalence – the number or percentage of people diagnosed with or who report having a disease or condition in a population

Prevalence Rate – cases of a disease or condition per number of individuals in a population (for example: the prevalence of asthma per 1,000 children under 18)

Private Expenditures – outlays for services provided by or paid for by nongovernmental sources (such as consumers, insurance companies, private employers, etc.)

Private Health Insurance – health insurance provided through a commercial plan or program, not through the US government

Producer Price Index (PPI) – The Bureau of Labor Statistics (BLS) randomly selects hospital patient bills for a predetermined set of Diagnosis Related Groups (DRGs) and records the full price paid for the services received. The BLS returns in future periods to obtain new price quotes and attempts to reprice the original patient bills.

Projection – an educated guess at future behavior made by observing past and current trends

Provider Sponsored Organization (PSO) – a health plan offered by a private provider sponsored organization that is not organized as a preferred provider organization (PPO), but can be licensed by states.

Purchasing Manager's Index (PMI) – developed by the United States Department of Commerce and the National Association of Purchasing Managers (NAPM, now the Institute for Supply Management - ISM) in 1985. The PMI is a weighted average of seasonally adjusted indexes for production, new orders, employment, supplier deliveries and inventories. The weights reflect the maximum relationship between the indexes and Gross National Product (GNP)/Gross Domestic Product (GDP).

Quinquennial Census of Service Industries – a survey conducted by the US Census Bureau once every five years, that collects data on expenditures for services of health professionals (doctors, nurses, chiropractors, etc.)

REACH – *Resources for Enhancing Alzheimer's Caregiver Health*

ResDAC – *Medicare Research Data Center*

Randomization – the process of placing individuals in study groups according to chance, where each person has a fixed probability of being selected

Rate – a measure of an event, state, disease or condition in relation to part or all of a population, over a period of time

Resources for Enhancing Alzheimer's Caregiver Health (REACH) – established in 1995 by the National Institutes of Health (NIH), to carry out research on how family caregivers can better care for patients with Alzheimer's Disease and related disorders. Six research projects conducted by various medical organizations have been funded through cooperative agreements with the National Institute on Aging and the National Institute of Nursing Research.

Real GDP – Real GDP (also called constant price GDP) is used to adjust for inflation. Real GDP is deflated using chain-type price index, which uses mathematical formulas that take into consideration costs from a base year and the current year. *See Gross Domestic Product*

Registered Hospitals – hospitals that meet American Hospital Association's (AHA) criteria for registration as a hospital facility. Registered hospitals include AHA member hospitals as well as nonmember hospitals.

Report on Business Survey – Each month, over 350 National Association of Purchasing Managers (NAPM, now the Institute for Supply Management - ISM) members from the manufacturing sector are asked to assess their performance through non-quantitative questions about their levels of production, orders, supplier deliveries, employment, prices and inventories.

SCHIP – *State Children's Health Insurance Program*

SEER – *Surveillance, Epidemiology, and End Results Program*

SIPP – *Survey of Income and Program Participation*

Sampling – the process of selecting a number of individuals from all the people in a particular group

Self-Reported – a survey participant tells an interviewer that he/she has a specific disease or condition.

Seventh Report of the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (JNC7) – the seventh report by a coalition of 39 major professional, public, and voluntary organizations and 7 Federal agencies on guidelines for high blood pressure management.

Single Payer – a healthcare system where all health care for the entire population is paid for by only one program or plan. Universal coverage could be, but does not have to be, accomplished through a single payer system.

Sociodemographic Groups – segments of a population broken down by factors such as age, ethnicity, education, income level, etc.

Specialty Member – From the perspective of covered lives, individual health insurers define their own specialty members. Specialty members may include, but are not limited to: dental, group, pharmacy benefit and behavioral health members.

Standard Error – a measure of variation or deviation from the mean (number that is the midway point between a group of numbers)

State Children's Health Insurance Program (SCHIP) – a federally sponsored program that allows states to provide health insurance coverage to poor children who do not quality for Medicaid. SCHIP also provides health coverage to children while they are waiting to find out about their Medicaid eligibility status. The SCHIP program also includes adult demonstration members.

Supplemental Medical Insurance – *(also known as Medicare Part B)* – Medicare Part B is Medicare fee-for-service supplemental medical insurance, that pays for a portion of physician services, outpatient hospital services and other services defined by the Medicare program. Medicare Part B does not pay for inpatient hospital services.

Surveillance, Epidemiology, and End Results Program (SEER) – The National Cancer Institute (NCI) contracts with population-based registries in the US to provide data on all residents diagnosed with cancer during the year, as well as previously diagnosed patients.

Survey of Income and Program Participation (SIPP) – administered by the United States Census Bureau, the SIPP is a 36-month longitudinal panel survey that measures health insurance status on a point-in-time basis, monthly, annually or for three years.

TOPSSM – *Tracking Operations and Outcomes for Plastic SurgeonsSM*

Take-Up Rate – an estimate of the percentage of individuals with access to a plan who participate in that plan

Tracking Operations and Outcomes for Plastic SurgeonsSM (TOPSSM) – an online national database of statistics for plastic surgery procedures operated by the American Society of Plastic Surgeons

TRICARE – TRICARE is the health program for active duty and retired uniformed services members and their dependents. TRICARE includes the former CHAMPUS (Civilian Health and Medical Program of the Uniformed Services) program that supported health care only for dependents of active and retired uniformed services members.

Tiered Provider Network – a plan that allows patients to choose providers (such as physicians or hospitals) within the network based on cost and other factors

Treasury Department – Primary agency responsible for national economic security, advises the president on economic issues, manages federal finances and the public debt

Uninsured – persons who do not have private, employer/union/association-supplied, governmental, or military health insurance. Counts of the uninsured sometimes include those eligible for federal programs, but not enrolled. Some surveys, such as the Current Population Report, count those with Indian Health Services coverage as uninsured.

Universal Coverage – a healthcare system where all the healthcare needs of the entire population are provided for. Universal coverage could be accomplished through single or multiple payers, and through governmental or private plans (or a combination of both).

VA – *Veteran's Affairs*

Veteran's Affairs (VA) – the government agency that provides medical care and other benefits and services to people who have served in the United States armed forces and their families.