

Health Insurance Terms

This glossary defines terms that are commonly used to describe aspects of private health insurance.

A number of references were used in developing the definitions below. They include:

- Health Insurance Glossary
(www.healthinsurance.org/glossary)
- Health Coverage Glossary
(www.bcbs.com/coverage/glossary)
- Consumers' Glossary of Health Insurance Terms
(www.insurance.ca.gov/0100-consumers/0070-health-issues/health-insurance-terms)
- Complete Glossary of Health Insurance Terminology
(www.agencyinfo.net/iv/medical/health-glossary.htm)
- Definitions of Health Insurance Terms
(www.bls.gov/ncs/ebs/sp/healthterms.pdf)
- How Private Health Coverage Works: A Primer, 2008 Update
(www.kff.org/insurance/7766.cfm)

[A]

active life reserves — Funds held by an insurer to pay future claims incurred by individuals covered by a nongroup policy. In the early years after a block is opened, claims are generally low. Monies put aside during this time are available to pay future claims, helping to moderate future premium increases. See also [block of policies](#).

adjusted community rating — A method of setting premiums or rates under which an insurer divides its policyholders into classes or groups based on demographic and other factors such as age, family composition, and geographic location, and then charges all members of a class or group the same premium. The insurer cannot consider the health status or claims experience of a class or group in developing premium rates. Also known as [community rating by class](#) or [modified community rating](#).

administrative services only (ASO) contract — An arrangement in which an employer hires a third party to deliver health care-related administrative services to the employer such as claims processing and billing. The employer bears the financial risk for claims.

adverse selection — The tendency of people who have a greater-than-average likelihood of using services to seek health care coverage to a greater extent than individuals who have an average or less-than-average likelihood of using services. Also known as anti-selection. Adverse selection occurs when less-healthy people disproportionately enroll in a risk pool.

agent — A person who is authorized by a plan or insurer to act on its behalf to negotiate, sell, and service insurance contracts.

anti-selection — See [adverse selection](#).

assuming company — See [reinsurance](#).

[B]

balance billing — Charges collected by a provider in excess of a plan's reimbursement rate for covered services. Balance billing does not include charging or collecting deductibles or co-insurance required by the plan. Balance billing may occur when plan participants use out-of-network providers who have not agreed to the plan's terms. Many states ban balance billing by in-network providers. See also [out-of-network](#).

blended rating — For groups with limited recorded claims experience or fewer than 500 employees covered, a method of setting premiums based partly on a plan's "manual rates" and partly on the group's experience. See also [manual rating](#).

block of policies — A group of enrollees in the same product, the same issue period (for example, three to five years), and perhaps the same region. Insurers' actions regarding blocks, such as closing or continuing to add to the block, can affect future premiums.

broker — A salesperson who has obtained a state license to sell and service contracts of multiple health plans or insurers, and who is considered to be an agent of the buyer, not of the health plan or insurer.

[C]

capitation — A flat, per-covered-individual fee paid to providers to supply all, or nearly all, covered services an individual may need within a specified time frame.

carrier — The insurance company or HMO offering a health plan.

carve-out — An arrangement whereby a plan contracts with another organization to supply specialty health services for members, such as pharmacy benefits or behavioral health care services.

certificate of creditable coverage — A written statement from an individual's prior insurance company or health plan documenting the length of time the individual was covered and that the coverage met specified requirements.

claim — An itemized statement of health care services and their charges provided by a hospital, physician's office, or other provider. Claims are submitted to the insurer by either the plan member or the provider for payment.

coinsurance — A method of cost sharing in a health insurance plan that requires the insured to pay a stated percentage of medical expenses after the deductible amount, if any, was paid. Coinsurance percentages may vary for specific types of services and whether they are provided by in-network or out-of-network providers.

community rating — A rating method that sets premiums according to the insurer's expected costs of providing medical benefits to all enrollees rather than to any subgroup of enrollees. Both low-risk and high-risk groups are factored into community rating, which spreads the expected medical care costs across all enrollees.

community rating by class — See [adjusted community rating](#).

Consolidated Omnibus Budget Reconciliation Act (COBRA) — A 1986 federal law that requires group health plans to allow employees and certain dependents to continue their group coverage at their own expense for a stated period of time, usually 18 or up to 36 months in certain situations, following a qualifying event that causes the loss of group health coverage. Qualifying events include reduced work hours, death or divorce of a covered employee, and termination of employment. COBRA applies to workers in firms with 20 or more employees.

copayment — A method of cost sharing in a health insurance plan that requires the insured to pay a fixed dollar amount when a medical service is received. (Copayment amounts can vary depending on the type of service.)

creditable coverage — The number of months an individual had health insurance without a break in coverage of 63 days or more before his/her current or new coverage became effective. Under HIPAA, creditable coverage must be counted towards any pre-existing condition exclusion in either an individual or group policy. The

prior insurance must have provided a minimum level of coverage; benefit policies, such as limited scope dental or vision benefits, do not qualify. See “The Basics: HIPAA Coverage Provisions” at www.nhpf.org/pdfs_basics/Basics_HIPAA_03-25-08.pdf for more information.

[D]

deductible — A fixed dollar amount during the benefit period, usually a year, that an insured person pays before the insurer starts to make payments for covered medical services. Plans may have both individual and family deductibles. Some services, such as preventive care, may be exempt from the deductible. Some plans may have separate deductibles for specific services such as a hospital admission or pharmacy benefits.

denial — The decision by an insurance company to refuse to issue a policy to an individual applying for individual insurance or to withhold a claim payment or preauthorization for services.

[E]

ERISA — The Employee Retirement Income Security Act (1974) is administered by the U.S. Department of Labor, Employee Benefits Security Administration. ERISA regulates employer-sponsored pension and insurance plans (self-funded plans) for employees.

elimination period — A period of time after enrolling in a health plan before benefits are payable. Also known as the waiting or qualifying period, policyholders must pay for services during this period.

Ethics in Patient Referrals Act — A 1989 federal law and its amendments, commonly called the Stark law, which prohibit a physician from referring patients to laboratories, radiology services, diagnostic services, physical therapy services, home health services, pharmacies, occupational therapy services, and suppliers of durable medical equipment in which the physician has a financial interest. Certain exceptions are allowed. For example, physicians are able to provide ancillary services such as laboratory, radiology, and physical therapy services in their offices.

exclusions and/or limitations — Conditions or circumstances described in an insurance policy that limit or exclude covered benefits, such as treatment for a condition present before enrolling in a plan or a maximum on the number of services per month or year. These exclusions and limitations must be clearly spelled out in plan documents.

experience rating — A rating method under which an insurer analyzes a group’s prior health care costs by type and calculates the group’s premium partly or completely according to the group’s claims experience.

experimental or investigational medical services — A drug, device, procedure, treatment plan, or other therapy which is currently not within the accepted standards of medical care as determined by an insurer. Plans often do not cover

experimental or investigational services; some may be covered if they are received as part of a clinical trial.

explanation of benefits (EOB) — An insurance company's written explanation of a claim's disposition, showing what they paid and what the insured must pay, if anything.

[F]

Federal Employees Health Benefits (FEHB) Program — A voluntary health insurance program administered by the Office of Personnel Management for federal employees, retirees, and their dependents and survivors.

fee-for-service payment (FFS) — A system in which the insurer will either reimburse (subject to deductibles, copayments, or coinsurance) the insured or pay the provider directly for each covered medical expense after the expense has been incurred.

fee schedule — The fee determined by a plan to be allowable for a procedure or service. Medicare uses the Resource Based Relative Value Schedule (RBRVS) to pay physicians, and private insurers frequently use a version of this schedule.

flexible spending arrangements — Accounts offered and administered by employers that allow employees to set aside, out of their paycheck, pre-tax dollars to pay certain specified expenses including the employee's share of insurance premiums or medical expenses not covered by the employer's health plan. Funds must be used within the given benefit period or the employee forfeits the money.

formulary — A list of drugs classified by therapeutic category or disease class, created by a plan. A plan may cover only drugs on its formulary or require higher copayments or coinsurance for non-formulary drugs. Many plans tier their formularies so that consumers pay differing copayments or coinsurance based on the drug's tier designation of generic, preferred, or non-preferred drugs.

fully insured plan — A plan where the employer contracts with another organization to assume financial responsibility for the enrollees' medical claims and for all administrative costs, usually for a 12-month period.

[G]

group insurance — Health plans offered to a group of individuals by an employer, association, union, or other entity.

group market — A segment of the insurance market that includes groups of two or more individuals that enter into a group contract with an insurer to provide coverage to the members of the group.

guaranteed issue — A requirement that a health insurance policy must be issued to an individual without regard to his/her health status or previous claims experience.

guaranteed renewability — This provision of an insurance policy or law guarantees a policyholder the right to renew his/her policy when the term of coverage expires. The insurer is generally allowed to change the premium rates at renewal.

[H]

health maintenance organization (HMO) — An entity that assumes or shares financial risk and assumes responsibility for delivering comprehensive medical services to a population in a particular geographic area, usually in return for a fixed, prepaid fee. While many HMOs remain tightly managed and tightly integrate insurance and the delivery of care, some now allow members to decide at the point of service whether to obtain care outside the HMO's network, typically with higher cost sharing.

health reimbursement arrangement (HRA) — A non-portable account established by an employer on behalf of an employee which can be used to pay for medical expenses. Only the employer can contribute to a health reimbursement account and unspent balances revert to the employer upon termination of employment. HRAs are used with high-deductible health plans.

health savings account (HSA) — An account established by an employer or an individual that can be used for medical expenses. Contributions to an HSA are excluded from income for tax purposes. Any balance remaining at the end of the year "rolls over" to the next year and is "portable" upon termination of employment. HSAs are used with high-deductible health plans.

high-deductible health plan — A plan with a high deductible (usually over \$1000 per individual) and a limit on annual out-of-pocket expenses. Some preventive services may not be subject to the deductible. This type of plan is usually coupled with a health savings account or health reimbursement arrangement (HSA or HRA).

high-risk pool — A state-operated program that offers coverage for individuals who cannot get health insurance in the individual market due to serious illness and who do not qualify for other government programs.

Health Insurance Portability and Accountability Act (HIPAA) — A 1996 federal law that defines certain requirements that employer-sponsored group insurance plans, insurance companies, and managed care organizations must satisfy in order to provide health insurance coverage in the individual and group health care markets. The act also specifies certain protections for people purchasing coverage who have changed jobs, are self-employed, or who have pre-existing medical conditions. See "The Basics: HIPAA Coverage Provisions" at www.nhpf.org/pdfs_basics/Basics_HIPAA_03-25-08.pdf for more information.

hold harmless provision — A contract clause that forbids providers from seeking compensation from patients if the health plan fails to compensate providers because of insolvency or for any other reason such as the denial of a claim for covered services.

[I]

incurred but not reported claims — Claims for services provided during a particular time period, but that have not yet been reported or submitted to an insurer or plan, so they remain unpaid at a point in time, such as the end of an accounting period.

indemnity insurance — Traditional, fee-for-service health insurance that does not limit where a covered individual can get care. The patient or provider is reimbursed as expenses are incurred.

individual health insurance — Coverage purchased independently (not as part of a group), usually directly from an insurance company or through an agent or broker.

individual market — A segment of the private insurance market that includes policies sold to persons that are not members of a group plan. Also known as the non-group market.

in-network — The use of health care services from physicians, hospitals, and other providers who participate in a health plan's network. Services provided in-network are subject to the plan's standard copayment or coinsurance. (See also [out-of-network](#).)

independent Practice Association — A type of health care provider organization composed of a group of independently practicing physicians who maintain their own offices and band together for the purpose of contracting with HMOs and other health plans.

insurance exchanges — An entity that facilitates the purchase of insurance in the individual and small group markets. Exchanges may assume a range of functions including setting standards for health plans to be offered, negotiating/contracting with insurers to establish plan offerings and premiums, marketing the exchange's services to individuals and/or employers, providing tools and services to help individuals select a plan, enrolling individuals and possibly collecting premiums, and possibly risk-adjusting premiums paid to plans.

investigational medical services — See also [experimental](#).

[L]

length of stay — The number of days, counted from the day of admission to the day of discharge, that a plan member is confined to a hospital or other facility.

lifetime maximum benefit — The maximum amount a health plan, or one insurer, will pay in benefits to an insured individual during that individual's lifetime.

limitations — See also [exclusions](#).

long-term care insurance — Coverage that pays for all or part of the cost of home care services or care in a nursing home or assisted living facility related to a disability.

[M]

mandated benefits — Services that, by federal or state law, are required to be covered by health insurance policies.

manual rating — A method of setting premiums or rates in which an insurer uses the insurer's average cost experience with all groups in a business segment—and sometimes the experience of other health plans—rather than a particular group's experience to calculate the group's premium.

maximum lifetime benefit — See [lifetime maximum benefit](#).

McCarran-Ferguson Act — A 1945 federal law that placed the primary responsibility for regulating health insurance companies and HMOs at the state level.

medical loss ratio — The share of premiums charged for an employer or insurer's covered beneficiaries that is paid for incurred medical claims. Administrative charges and profit are not included in the payments used to calculate this ratio.

medical savings account — A predecessor to HSAs authorized as a demonstration by HIPAA in 1995 and as an option under Medicare by the Balanced Budget Act of 1997. About 50,000 MSAs have been opened under HIPAA. They are not available currently under Medicare.

medical underwriting — The evaluation by an insurer of the health status of an individual or group applying for coverage to determine their insurability and the premium to be charged.

medically necessary services — A drug, device, procedure, treatment plan, or other therapy that is covered under an individual's health insurance policy and that the individual's doctor, hospital, or other provider has determined appropriate for managing or treating a specific illness or underlying condition.

Medigap insurance policies — Insurance offered by private companies that provides reimbursement for out-of-pocket expenses, such as deductibles and coinsurance payments, or benefits for some medical expenses specifically excluded from Medicare coverage. Medigap policies must generally offer one of 12 legislatively defined benefit packages.

Mental Health Parity and Addition Equity Act — A 2008 federal law that, with some exceptions, requires large group health plans that include coverage for mental health or substance use disorders to provide these benefits at parity with the plans' medical/surgical benefits. Small groups and individual policies are not included. The law prohibits plans from imposing more restrictive cost-sharing requirements or treatment limitations for mental health/substance use benefits than applied to medical/surgical benefits.

modified community rating — See [adjusted community rating](#).

[N]

network — A group of physicians, hospitals, and other providers who contract with a particular health care plan to provide services to the plan's enrollees at negotiated rates.

Newborns' and Mothers' Health Protection Act (NMHPA) — A 1996 federal law that specifies that, if they provide benefits for hospital stays following childbirth, group health plans and health insurance issuers in the group and individual markets cannot mandate that hospital stays following childbirth be shorter than 48 hours for normal deliveries or 96 hours for cesarean births.

nongroup market — See [individual market](#).

[O]

open enrollment — A set time of year when eligible individuals can enroll in health insurance or change from one plan to another. Individuals may also enroll at other times if a qualifying event (for example, marriage, divorce, birth of a child/adoption, or death of a spouse) occurs.

out-of-network — The use of health care services from physicians, hospitals, and other providers who are not members of a health plan's network. Services provided out-of-network may not be covered or the plan may require a higher copayment or coinsurance. The provider may also balance bill for amounts above a fee schedule. See also [in-network](#).

out-of-pocket maximum — A predetermined amount of money that an individual or family must pay in copayments, coinsurance, and deductibles before the plan will pay 100 percent of the individual's or family's health care expenses. With some insurers, only in-network claims qualify for the calculation of this maximum.

[P]

pharmacy benefit management (PBM) plan — A specialty service organization that provides pharmacy services under contract to an insurer.

point-of-service (POS) plan — A type of health plan that allows plan members to choose, at the time medical services are needed, between a provider within the plan's network of preferred providers or a provider outside the network. Some HMOs offer a POS option.

pooling — The assignment of individuals or groups to a class to determine premiums for the class. Pooling allows risk to be spread across a defined population.

pre-admission certification — Also called pre-certification review or pre-admission review. Approval by a case manager or other insurance company representative for a person to be admitted to a hospital or inpatient facility prior to admittance.

pre-existing condition — Any illness or health condition for which an individual has received medical advice or treatment during a period prior to obtaining health insurance. HIPAA requires group health care policies of three or more persons cover pre-existing conditions after the individual has been insured for six months, and individual policies cover preexisting conditions after one year. Creditable coverage must be counted toward any pre-existing condition exclusion in either an individual or group policy.

preferred provider organization (PPO) — A type of health plan that delivers care through a group of physicians, hospitals, and other providers who contract with the insurer to deliver medical services to plan participants at discounted rates and/or pursuant to certain utilization protocols. Plan member may be encouraged by their insurer to use "preferred providers" through incentives such as reduced cost-sharing.

premium — An agreed upon fee paid for coverage of medical benefits for a specified period, often a year. Premiums can be paid by employers, unions, employees,

or individuals. Premiums may be shared by both the insured individual and a plan sponsor, such as an employer or union.

primary care physician/provider — Usually a family practice doctor, internist, obstetrician-gynecologist, or pediatrician who is most often the individual's first point of contact with the health care system, particularly in a managed care plan.

prior authorization — A requirement that in order for a service to be covered for an individual, a physician or other provider must seek and obtain approval from the health plan prior to the service being delivered. Prior authorization may be required for particular tests or procedures, drugs, or referrals to certain specialists.

provider profiling — See [resource use profiling](#).

[Q]

qualifying period — See [elimination period](#).

[R]

rate bands — State laws can restrict the difference between the lowest and highest premiums that an insurer can charge for the same coverage. The rate bands may limit all factors by which rates vary such as age or gender, or may apply only to specified factors, such as health status or claims experience.

rating — The process of calculating the appropriate premium to charge purchasers, given the degree of risk represented by the individual or group, the expected costs to deliver medical services, and the expected marketability and competitiveness of the plan.

rating factors — Factors such as age, health status, chronic conditions, smoking/alcohol use, gender, industry, and geographic region that are used in determining premiums.

reinsurance — The acceptance by one or more insurers, called reinsurers or assuming companies, of a portion of the risk underwritten by another insurer that has contracted with an employer for the entire coverage. Typically, reinsurers pay when the costs of services for an individual or group exceed a relatively high threshold.

relative value scale — A method used by payers or plans of determining payment levels for physician services. The relative value for each service reflects the expected costs of the resources needed to produce the service relative to the resources needed to produce an index service. To determine the amount the plan will pay the physician for a service, the relative value is multiplied by a factor converting relative values to dollars.

renewal underwriting — The process by which an insurer calculates new insurance rates each year using all the factors that were considered when the contract was issued, and updates the group's premium using actual claims utilization and any changes in the population covered.

resource use profiling — The collection and analysis of information about the service provision and cost patterns of individual providers. Also called provider profiling.

retrospective review — A type of utilization review that occurs after treatment is completed to assess medical necessity and appropriateness of care and to authorize payment.

risk adjustment — An adjustment of payments to either insurers or providers to reflect the expected costliness of providing insurance or a service to an individual based on the characteristics of the individual, such as their gender and age, the seriousness of the treated conditions, and any other illnesses they may have. Also used to adjust measures of outcome or performance to reflect differences in the expected outcomes of services for individual patients.

[S]

self-insured plan — A health plan under which an employer or other group sponsor, rather than an insurance company, is financially responsible for paying plan expenses, including claims made by group plan members. Also known as a self-funded plan. Self-insured plans are subject to ERISA and exempt from state regulation.

standard community rating — See community rating.

Stark law — See the [Ethics in Patient Referrals Act](#).

stop-loss — An insurer pays 100 percent of covered benefit charges once an individual has met deductible and coinsurance requirements and his/her out-of-pocket maximum.

stop-loss insurance — A type of insurance coverage that enables provider organizations or self-insured groups to place a dollar limit on their liabilities for paying claims and requires the insurer issuing the insurance to reimburse the insured organization for claims paid in excess of a specified yearly amount. Similar to reinsurance.

[T]

third party administrator (TPA) — An individual or firm hired by an employer to handle claims processing, pay providers, and manage other functions related to the operation of health insurance. The TPA is not the insurer and does not assume risk.

[U]

underwriting — The process of assessing the health and other characteristics of an individual or group to determine their likely utilization of health services or risk.

underwriting requirements — Requirements, sometimes relating to group characteristics or financing measures, such as minimum employer contributions that plans at times impose in order to provide health care coverage to a given group and

which are designed to balance a health plan's knowledge of a proposed group with the ability of the group to voluntarily select against the plan (adverse selection).

usual, customary, and reasonable (UCR) fee — The amount commonly charged for a particular medical service by physicians within a particular geographic region. UCR fees are used by some health insurance companies as the basis for physician reimbursement for out-of-network providers. No longer a common form of payment.

utilization review — An evaluation of the medical necessity and appropriateness of health care services and treatment plans for a given patient. Utilization review may take place before, during, or after the services are rendered.

[W]

waiting period — A defined period of time before treatment for a specific condition or conditions will be covered by insurance.

withhold — A percentage of a provider's payment that is "held back" during a specified period to offset or pay for any services costs exceeding an agreed upon threshold. Any part of the withhold not used for these purposes is distributed to the provider. Not commonly used today. May be used as part of a quality improvement or pay for performance program.

Women's Health and Cancer Rights Act (WHCRA) — A 1998 federal law which generally requires group health plans, both fully insured and self-insured, and individual health insurance policies that offer medical and surgical benefits for mastectomy to provide coverage for reconstructive surgery following mastectomy.



The National Health Policy Forum is a nonpartisan research and public policy organization at The George Washington University. All of its publications since 1998 are available online at www.nhpf.org.