Health Reform Glossary
Selected Insurance Terms

Annual Limits	A ceiling on the amount of claims insurance companies will pay in a given year for an individual. After which, individuals would then have to pay the full cost of any claims incurred above this ceiling during the course of they year.
Co-insurance	A method of cost-sharing in health insurance plans in which the plan member is required to pay a defined percentage of their medical costs after the deductible has been met.
Co-payment	A fixed dollar amount paid by an individual at the time of receiving a covered health care service from a participating provider. The required fee varies by the service provided and by the health plan.
Cost-sharing	A feature of health plans where beneficiaries are required to pay a portion of the costs of their care. Examples of cost sharing include co-payments, co-insurance and annual deductibles.
Grandfathered and Non-grandfathered Health Plans	A "grandfathered" or "non-grandfathered" plan refers to a health plan's status in regard to Health Reform. Different provisions apply to "grandfathered" and "non-grandfathered" plans. Health plans that covered individuals and families on the day that the health reform law was enacted, March 23, 2010, may be considered grandfathered plans. Health plans must inform members about whether they are "grandfathered" or "non-grandfathered" plans.
Group Health Plan	Health insurance that is offered to a group of people, such as employees of a company. The majority of Americans have group health insurance through their employer or their spouse's employer.
Premium(s)	The amount paid, often on a monthly basis, for health insurance. In group health plans, the cost of the premium may be shared between employers or government purchasers and the individuals getting coverage (i.e., employee).
Individual Insurance Market	The market where individuals who do not have group (usually employer-based) coverage purchase private health insurance. This market is also referred to as the non-group market.
Medical Loss Ratio	The percentage of premium dollars an insurance company spends on medical care, as opposed to administrative costs or profits. Starting in 2011, the health reform law requires insurers in the large group market to have a Medical Loss Ratio of 85% and 80% in the small group and individual markets
Out-of-pocket Cost(s)	Health care costs, such as deductibles, co-payments, and co-insurance that are not covered by insurance. Out-of-pocket costs do not include premium costs.
Pre-existing Condition(s)	An illness or medical condition for which a person had received a diagnosis or treatment within a specified period of time prior to becoming insured.
Rescissions	The practice where an approved health insurance policy is dropped (rescinded) by the insurer, often after a diagnosis of a major illness, or after a large claim has been filed.
Self-Insured Plan	A plan where the employer assumes direct financial responsibility for the costs of enrollees' medical claims. A type of group plan. The employer may contract with an insurance company, however, to administer the self-insured plan.

--adapted from Kaiser Family Foundation http://www.kff.org/healthreform/upload/7909.pdf

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