Glossary of Insurance Terms

COBRA (Consolidated Omnibus Reconciliation Act) is Federal legislation that requires employers to offer individuals leaving their workforce continued health insurance coverage, at the individual's expense, under the employer's group plan. Coverage can be continued for 18 months and an additional 20 months for individuals leaving employment due to a disability.

A health insurance premium is a specified dollar amount paid to an insurance company, usually on a monthly basis, in exchange for coverage (*i.e.*, the insurance company will pay the insured's medical expenses, less any co-payment or deductible amount specified in the insurance policy).

Risk pools are mechanisms to provide insurance for people in a variety of situations: when individuals have lost their coverage, are ineligible for Medicaid or Medicare, cannot purchase insurance due to eligibility criteria that exclude pre-existing conditions, and/or cannot otherwise afford insurance.

The following terms reflect key aspects of a State's health insurance market-many of which vary by State law.

Conversion policy: A group policy that can be converted to an individual policy, usually at a premium rate higher than the group premium rate.

Guaranteed issue: Requirement for an insurer to offer policies to an individual regardless of health status or claims experience.

Guaranteed renewal: Requirement for insurers to allow persons to renew their coverage from year-to-year regardless of health status or claims experience of the insured as long as the plan continues to be offered in that market.

Waiting period: The length of time required before an individual becomes eligible for health insurance coverage. The waiting period must be applied consistently for all members of a group.

Pre-existing conditions: Any condition, either physical or mental, for which medical advice, diagnosis, care, or treatment was recommended or received during the look-back period.

Look-back period: The maximum number of months an insurer can go back into a person's medical history to determine if a condition has already been diagnosed. Look-back periods can range across States from six months to two years but are usually six months.

Pre-existing condition exclusion period: The time during which coverage for the pre-existing condition is denied after a policy takes effect—typically up to 12 months. A State program may make premium payments in addition to paying for services directly from Title II funds (including ADAP) during this period.

Rating restrictions: Restrictions a State places on the premium insurers can charge in the individual restrictions market. Ratings are either based on community rating or experience rating. Community rating refers to premium rates that are set for the community as a whole. Rates cannot be set based on an individual's claim experience (experience rating), health status, or duration of coverage.