# Health Insurance Glossary

**Administration Expenses:** Expenses in health plans that encompass costs beyond direct patient care, including billing, enrollment, marketing, provider management, general business operations, and accounting for a significant portion of healthcare spending.

**Aggregate Attachment Point:** The total amount of health claims an employer incurs for all covered employees and dependents, above which the stop-loss insurer becomes liable for payment under the aggregate stop-loss coverage.

**Employee Retirement Income Security Act of 1974 (ERISA):** A federal law that sets minimum standards for most voluntarily established retirement and health plans in private industry. ERISA preempts state laws, meaning self-funded plans are not governed by state insurance regulations. Health plans must provide participants with plan information, establish a grievance and appeals process, and give participants the right to sue for benefits and breaches of fiduciary duty.

**Formulary / Preferred Drug List (PDL):** A list that outlines the plan's covered drugs and their associated costs.

**Fully Insured (FI) Health Plan:** A traditional health insurance model where employers purchase coverage from a commercial insurer, who then assumes the financial risk and pays medical claims for employees.

**Maximum Cost Attachment Point:** In the context of stop-loss insurance, it refers to the total amount of claims an employer is responsible for before the insurance policy kicks in and reimburses them for additional expenses.

**Pharmacy Benefit Manager (PBM):** A Third-Party administrator that manages prescription drug benefits for payers like insurers and employers, handling tasks like processing claims, negotiating discounts, and developing formularies.

**Premium Tax:** State levied tax assessed against health insurers. This expense is eliminated under self-funded health plans.

**Prescription Drug Rebate Credit:** Employers can receive prescription drug rebates, which are discounts from manufacturers to PBMs (Pharmacy Benefit Managers), and can choose how to use those rebates, either by passing them through to employees or using them to offset costs.

**Reserves:** Funds an insurer sets aside to cover future obligations, including claims and unearned premiums, ensuring they can meet policyholder obligations.

**Self-Funded (SF) Health Plan:** A type of plan in which an employer takes on most or all the cost of medical and pharmacy claims. The insurance company manages the payments, but the employer is the one who pays the claims.

**Specific Deductible:** The amount to be paid by the plan on each covered individual before the stop loss policy will reimburse incurred expenses.

**Stop Loss Insurance:** A critical protection tool for self-funded health plans. It limits financial exposure and protects the district from catastrophic or unexpected losses.

**Individual Stop Loss (ISL):** Protects the district from high-cost claims from a single employee or dependent. Claims exceeding the specific deductible will be reimbursed to the district.

**Aggregate Stop-Loss (ASL):** Protects from claims exceeding a maximum amount for the entire group.

**Third-Party Administrator (TPA):** An organization that handles the administrative tasks for an insurance plan or health benefit program, including claims processing, billing, and regulatory compliance, on behalf of a separate entity like an insurance company or employer.