GROOM LAW GROUP

Health Care Reform Proposals – Key Terms

Key Terms/Concepts	House	Senate
Acceptable Coverage	**Qualified health benefits plans**, **grandfathered health insurance coverage**, current group health plan coverage, Medicare, Medicaid, TRICARE, VA and such other coverage as the HCA shall decide. [AHCAA § 302] Individuals that do not obtain acceptable coverage will be taxed. [AHCAA § 501] Employers that do not provide acceptable coverage may be required to contribute to the **Exchange**. [AHCAA § 413]	See **minimum essential coverage**.
Affordability Credit	An **affordability premium credit** and an **affordability cost-sharing credit** (for **Exchange plans** only). Paid directly to the **QHBP offering entity**. [AHCAA § 341]	N/A. See **premium tax credit** and **reduced cost-sharing**.
Affordability Cost-Sharing Credit	To be set by the **HCA**. Should be set to equalize the actuarial value of coverage and limit cost-sharing. [AHCAA § 344]	See **reduced cost-sharing**.
Affordability Premium Credit	The amount by which the reference premium exceed the affordable premium amount. Formulas set forth in the statute for calculating an individual's credit. [AHCAA § 343]	See **premium tax credit**.
American Health Benefit Exchange	See **Health Insurance Exchange**.	A state-based **Exchange** for the sale of **qualified health plans** in the individual and small group market. [PPACA § 1311(b).] Plans may be offered outside an Exchange. [PPACA § 1312] Referred to throughout this chart as "**Exchange**."
Annual Limits	Cost-sharing under the **essential benefits package** is capped at $5,000/individual and $10,000 family for 2013. Increased annually by HHS. [AHCAA § 222(c)(2)]	Unreasonable annual limits on the dollar value of benefits is prohibited. Unreasonable is defined in reference to guidance from the IRC re: § 223. Applies to all self-insured plans and insured (group and individual) coverage, except for grandfathered self-insured plans and insured coverage. [New PHSA § 2711]
Basic Plan	**Essential benefits package** with an actuarial value of 70 percent. [AHCAA § 303(c)(2)]. **QHBP**s may offer only one basic plan per area. [AHCAA § 303(b)] Different than **State basic health plan.**	N/A. See **bronze plan** and **catastrophic plan** for closest analogues.

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Bronze Plan	N/A. See **Basic plan** for the lowest coverage level available.	**Essential health benefit plan** with the lowest coverage available on the individual and small group market, with the exception of the catastrophic plan available to individuals under the age of 30 and certain others. Requires plan to cover 60% of costs. [PPACA § 1302]
Catastrophic Plan	N/A. See **Basic plan** for the lowest coverage level available.	Plan available to individuals under 30 and certain individuals that are exempt from the requirement to obtain **minimum essential coverage** because of hardship or unaffordability. **Essential benefits** are covered and cost-sharing at up to the current HSA limits. [PPACA § 1302]
Co-Ops	Not-for-profit, member-run health insurance cooperatives. **HCA** may make grants to create co-ops to be offered through the **Exchange**. [AHCAA § 310]	Not-for-profit, member-run health insurance cooperatives. HHS may issue grants to create qualified non-profit health insurance issuers to offer **qualified health plans** in the individual and small group market. [PPACA § 1322]
Employer Responsibilities	See **Health Coverage Participation Requirements.**	Employers with more than 200 full-time employees and offers one or more **health benefits plans** must automatically enroll new full-time employees and continue the enrollment of current employees. Employees may opt-out of coverage. [PPACA § 1511] Employers must inform employees about the **Exchange** and the employees' eligibility for credits and forfeiture of employer contribution, if applicable. [PPACA § 1512] Employers with more than 50 full-time employees must offer coverage or, if at least one full-time employee receives **premium assistance** through an **Exchange**, the employer will have to make a payment of $750 per employee. If the employer does offer coverage, but an employee receives premium assistance, the employer will pay $3000 per tax credit employee or $750 per employee, whichever is lesser. Penalties will also apply to employers that require waiting periods before employee enrollment in an employer-sponsored health plan. Employers must report whether it offers coverage, along with plan information. [PPACA § 1513]

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Employment-Based Health Plan/Employment-Based Plan	**Group health plan** as defined by ERISA (§ 733(a)(1) – an **employee welfare benefit plan** that provides medical care), including federal, state and tribal government plans, and church plans. An individual is "enrolled" in an employment-based health plan if the individual is a participant or beneficiary (as defined by ERISA) in such a plan. [AHCAA § 201]	Defined in reference to the retiree reinsurance program. [PPACA § 1102]
Employer Contributions in Lieu of Coverage	See **Health Coverage Participation Requirements.**	N/A.
Enhanced Plan	**Essential benefits package** with lower level cost-sharing. [AHCAA § 303(c)(3)] **Health Benefits Advisory Committee** (HBAC) sets standards; cost-sharing should result in benefits that are actuarially equivalent to 85 percent of the essential benefits package. [AHCAA § 223(b)(6)(A)]	N/A. See **Silver plan** for closest analogue.
Essential Benefits Package/Essential Health Benefits Package	Coverage for certain minimum required benefits, limits cost-sharing to specified amounts, meets network adequacy requirements, and does not impose **annual** or **lifetime limits** on coverage of provided benefits. **Qualified health benefits plans** must provide at least the essential benefits package. [AHCAA §§ 221-222]	**Health insurance coverage** that provides coverage for certain minimum required benefits, limits cost-sharing to specified amounts, and provides **bronze, silver, gold** or **platinum** level coverage. [PPACA § 1302(a)] Health insurance coverage offered by a **health insurance issuer** in the **individual or small group market** must include the essential health benefits package. [PPACA § 1201(2)(A); New PHSA § 2707]
Excepted Benefits	Variously defined in reference to the PHSA (§ 2791) [AHCAA §§ 100(c)(13), 202(c)(2)] and ERISA (§ 733(c)) [AHCAA § 202(b)].	References to PHSA § 2791 [PPACA § 1501(b); New IRC § 5000A.]
Exchange	**Health Insurance Exchange.** Exchange established within the **HCA** to facilitate access to insurance coverage, including the **public health insurance option**. [AHCAA § 301] Referred to throughout this chart as "Exchange."	**American Health Benefit Exchanges**. A state-based **Exchange** for the sale of **qualified health plans** in the individual and small group market. [PPACA § 1311(b).] Plans may be offered outside an Exchange. [PPACA § 1312] Referred to throughout this chart as "Exchange."

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Exchange-Eligible Employer	In 2013, employers with 25 or fewer employees. In 2014, employers with 50 or fewer employees. In 2015, employers with 100 or fewer employees. Beginning in 2015, the **HCA** may permit employer with more than 100 employees to be eligible. [AHCAA §§ 302(c); 302(e)]	See **qualified employers**.
Exchange-Eligible Individual	All individuals unless already enrolled in another **qualified health benefits plan** or certain other **acceptable coverage**. [AHCAA § 302(a)]	See **qualified individual**.
Exchange-Participating Health Benefits Plan	**Qualified health benefits plans** offered through the **Exchange**. [AHCAA § 100(c)(9)] "Exchange plans" for purposes of this chart.	N/A. Plans offered through an **Exchange** must be qualified. [PPACA § 1311]
Federal Poverty Level	For 2009 individual $10,830, family of 4 $ 22,050. Higher in Hawaii and Alaska.	For 2009 individual $10,830, family of 4 $ 22,050. Higher in Hawaii and Alaska.
Gold Plan/Level	N/A. See **premium plan**.	**Essential health benefits plan** in the individual and small group market that covers 80% of the costs. [PPACA § 1302]
Grace Period	5 year period after which **employment-based health plans** must meet **qualified health benefits plan** requirements. Effective for most plans on January 1, 2018. [AHCAA § 202(b)(1)]	N/A.
Grandfathered Coverage/Grandfathered Health Plan	Individual **health insurance coverage** offered and in force before the first day of 2013, with certain limitations, including that the issuer may not change "any" terms. [AHCAA § 202(a)]	**Group health plan** or **health insurance coverage** in which an individual was enrolled on the date of enactment of the Act. Family members and new employees are permitted to enroll in grandfathered plans. Grandfathered health plans are not required to maintain the same terms or benefits to be grandfathered. [PPACA § 1251]

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Group Health Insurance	Not defined specifically for purposes of the Act, but used in PHSA sections. PHSA § 2791(b)(4) - health insurance coverage offered in connection with a group health plan.	Not defined specifically for purposes of the Act, but used in PHSA sections. PHSA § 2791(b)(4) - health insurance coverage offered in connection with a group health plan.
Group Health Plan	Not specifically defined for overall purposes of the Act. To the extent defined, in reference to ERISA § 733(a) [AHCAA §§ 100(c)(6); 302(e)(8); 802]	PHSA § 2791(a) (an employee welfare benefit plan (as defined in ERISA) that provides medical care) [PPACA § 1301(b)]
Health Benefits Advisory Committee (HBAC)	Public-private committee, chaired by the Surgeon General, to recommend covered benefits and **essential, enhanced** and **premium plans**. [AHCAA § 223]	N/A.
Health Benefits Plan	**Health insurance coverage** and **an employment-based health plan** (including the **public option**). [AHCAA § 100(c)(12)]	Term used, but not specifically defined.
Health Care Choice Compacts	N/A.	Compacts in which 2 or more states may join into an agreement (approved by HHS) that would allow **qualified health plans** to be offered in all such states, but only subject to the laws and regulations of the state in which the plan was issued, with certain exceptions. [PPACA § 1333.]
Health Choices Administration (HCA)	A new federal agency tasked with overseeing the **Exchange** and **essential benefits package** standards. [AHCAA § 241]	N/A

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Health Coverage Participation Requirements	**Qualified health benefits plan** coverage (or current employment-based health plan during grace period) offered by an employer. Employer must make required contributions (not less than 72.5% of the lowest cost premium (lowest cost reference premium for **Exchange plans**) for individual; 65% for family) if coverage is accepted by full-time employee. HCA, Labor, Treasury and HHS will determine minimum contribution for part-time employees. If coverage is declined, but employee gets coverage through the **Exchange,** employer must make a contribution of 8% of the average wages paid by the employer, but not more than the minimum contribution required if coverage was accepted, to the Exchange. Sliding scale applies for **small employers**. Employers may make contributions of 8% of the average wages paid by the employer but not more than the minimum contribution required if coverage was offered to the HCA **in lieu of offering coverage**. Sliding scale applies for **small employers**. [AHCAA §§ 411-413]	See **employer responsibilities**.
Health Insurance Coverage	PHSA § 2791, but does not include excepted benefits in (1)(c) or (2)-(4) if offered through a separate policy. [AHCAA § 100(c)(13)]	PHSA § 2791(b) ("benefits consisting of medical care … under any hospital or medical service policy or certificate" including HMOs) [PPACA § 1301(b)]
Health Insurance Exchange	Exchange established within the **HCA** to facilitate access to insurance coverage, including the **public health insurance option**. [AHCAA § 301] Referred to throughout this chart as "**Exchange.**"	See **American Health Insurance Exchange**.
Health Insurance Issuer	PHSA §2791(b)(2) ("an insurance company, insurance service or insurance organization" including HMOs. Does not include group health plans.)	PHSA § 2791(b) [PPACA § 1301(b)]

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Health Plan	Not specifically defined in the Act. Cross-references the SSA in one section. [AHCAA § 328] Health plan means an individual or group plan that provides or pays for medical care (as defined in PHSA § 2791). It includes: group health plans, health insurance issuers, HMOs, part A, B, or C of Medicare, Medicaid, Medicare supplemental policies, employee welfare benefit plans.	**Health insurance coverage** and **group health plans.** Self-insured plans and MEWAs are not included in the term health plan unless specifically provided for in Title I (Affordable Health Care). [PPACA § 1301(b)]
Individual Health Insurance Coverage	Not defined specifically for purposes of the Act, but used in PHSA sections. PHSA § 2791(b)(5) (health insurance coverage offered to individuals in the individual market, but does not include short-term limited duration insurance.)	Not defined specifically for purposes of the Act, but used in PHSA sections. PHSA § 2791(b)(5)
Large Employer **(Larger Employers)**	For purposes of **Exchange eligibility**, larger employers have more than 100 employees. [AHCAA § 302]	Definition varies. For purposes of participation in an **Exchange**, large employers have more than 100 employees, although states have the option beginning in 2016 to lower the threshold to more than 50. For purposes of the **employer responsibility** tax, large employers have at least 50 employees. For automatic enrollment of employees in health coverage purposes, large employers have more than 200 employees. [PPACA §§ 1304; 1513, 1511]
Lifetime Limits	**Group health plans** and **health insurance coverage** may not impose an aggregate dollar lifetime limit. [AHCAA § 109; New ERISA § 716.]	Lifetime limits on the dollar value of benefits prohibited. Applies to all self-insured plans and insured (group and individual) coverage, except for **grandfathered** self-insured plans and insured coverage. [New PHSA § 2711]
Medical Loss Ratio	**Health insurance issuers** shall rebate to enrollees the amount by which the issuer's medical loss ratio is less than an amount specified by the Secretary (but the Secretary may not set a level less than 85 percent). [New PHSA § 2714; AHCAA § 102]	Provision that requires **health insurance issuers** offering group or individual health insurance coverage to provide an annual rebate in the amount by which non-medical expenses exceed 20% in the group market and 25% in the individual market. States may lower these percentages. Sunsets December 31, 2013. Except that Blue Cross / Blue Shield non-profits must have at least a 85 percent medical loss ratio to take advantage of tax benefits under IRC § 833. [PPACA § 9016]

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Minimum Essential Coverage	See **minimum creditable coverage.**	Minimum essential coverage required to avoid a penalty. Penalty starts at $95 in 2014 and increases to $750 in 2016 and is indexed thereafter. Individuals who have no coverage for less than 3 months a year, individuals with incomes below 100% of the **federal poverty level** and others will be excepted from the penalty. Minimum essential coverage includes Medicare part A, Medicaid, CHIP, TRICARE, VA, eligible employer-sponsored coverage, individual health plans, **grandfathered health plans**, and such other coverage as designated by HHS. [PPACA § 1501; New IRC § 5000A]
National Plans/Nationwide Qualified Health Plans	**Health benefit plans** offered nationally. **HCA** has authority to enter into contracts with **Qualified Health Benefits Plan** offering entities to offer a nationwide plan through the **Exchange**, as long as the entity is licensed in every state and the plan meets the benefit requirements of each state. [AHCAA § 304(c)(6)]	Issuers of **qualified health plans** in the individual or small group market may offer qualified health plans in one or more states and only the laws of the state in which the plan is issued shall apply if the plan meets certain enumerated requirements, including being licensed in each state in which it offers a plan, complying with the benefit mandates in each state, and the issuer offers the plan in a minimum number of states each year the plan is offered. States may opt-out of a nationwide qualified health plan. [PPACA § 1333] See also **Health Care Choice Compacts.**
Navigators	N/A	Entities that educate the public about **qualified health plans**, distribute information on enrollment and tax credits, facilitate enrollment, and provide referrals on grievances, complaints, or questions for plans sold through an **Exchange**. [PPACA § 1311(i).]
Platinum Plan/Level	N/A. But see **premium plus plan** as the nearest analogue.	**Essential health benefits plan** in the individual and small group market that covers 90% of the costs. [PPACA § 1302]
Premium Assistance Credit	See **affordability premium credit**.	A credit provided to taxpayers to assist with health insurance premium payments for coverage under a **QHBP**. Eligibility for credit is set on a sliding scale ranging from 100 to 400% of **federal poverty level**. Certain employees are eligible (if employer plan covers less than 60% of costs or premium exceeds 9.8% of employee income). [PPACA § 1401; new IRC § 36B]

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Premium Plan	**Essential benefits package** with lower level cost-sharing. [AHCAA § 303(c)(4)] **Health Benefits Advisory Committee** (HBAC) should set standards; cost-sharing should result in benefits that are actuarially equivalent to 95 percent of the essential benefits package. [AHCAA § 223(b)(6)(A)]	N/A. But see **gold plan** as the nearest analogous coverage level.
Premium Plus Plan	**Premium plan** with additional benefits (like oral or vision care). [AHCAA § 303(c)(5)]	N/A. But see the **platinum plan** as the nearest analogous coverage level. **Platinum plan** varies the percentage plan pays costs from the **gold plan** whereas the **premium** and premium plus plans have the same actuarial values for minimum essential coverage but premium plus plans have additional benefits.
Public Health Insurance Option/Community Health Insurance Option	**Public Health Insurance Option:** New public health insurance plan offered through the national **Exchange** that will offer **basic**, **enhanced** and **premium** plans, may offer **premium plus** level plans. [AHCAA § 321] "Public option" for purposes of this chart.	**Community Health Insurance Option:** New public health insurance plan offered through an **Exchange** that will offer **essential health benefits** only. States may prohibit their exchange from offering the CHIO; states may also require additional benefits be provided in their CHIO, if states absorb any additional cost. [PPACA § 1323]
Qualified Health Benefits Plan/Qualified Health Plans	**Qualified Health Benefits Plan**: A **health benefits plan** that meets the necessary requirements (including the provision of **essential benefits**) and is offered by an entity that meets the necessary requirements (a **QHBP offering entity**). [AHCAA § 100(c)(25)]	**Qualified health plans (QHPs):** A health plan that is certified, meets the necessary requirements (including providing **essential health benefits**), and is offered by a licensed **health insurance issuer** that meets the necessary requirements. [PPACA § 1301(a)]
Qualified Employer	N/A. But see **Small Employers** for **qualified small employer** definition.	Employer that elects to make all full-time employees eligible for plans through an **Exchange**. Limited to small employers until 2017, when states may allow large employers to participate in the Exchange. [PPACA §§ 1311, 1312(f)]
Qualified Individual	N/A.	An individual that resides in a state with an **Exchange** and seeks to enroll in a **qualified health plan** in the individual market through an Exchange. [PPACA § 1312(f)]

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Reduced Cost-Sharing	See **affordability cost-sharing credit**.	For individuals in **QHP**s with incomes between 100-200% of the **federal poverty level**, out-of-pocket maximum is 1/3 standard ($5,950 individual/$11,900 family), 1/2 for incomes between 200-300% of the federal poverty level, 2/3 for incomes between 300-400% of the federal poverty level. Plan's share of costs would increase so that incomes between 100-150% would be on average 90%, 150-200% would be 80%. State mandated benefits are not included. [PPACA § 1402.]
Silver Plan/Level	N/A. But see **enhanced plan**.	**Essential health benefits plan** in the individual and small group market that covers 70% of the costs. [PPACA § 1302]
Small Employer (Smallest, Smaller, Small Employers; Qualified Small Employers)	Definition varies. For purposes of wellness program grants, HHS will define. For purposes of **Exchange eligibility**, smallest employers have 25 or fewer employees, smaller employers have 50 or fewer employees, small employers have 100 or fewer employees. For purposes of assistance for small employers in the Exchange, small employers have fewer than 100 employees. For purposes of **employer contributions in lieu of coverage**, small employers have annual payroll that does not exceed $750,000. For purposes of the small business employee health coverage credit, qualified small employers have no more than 25 employees and the average annual employee compensation meets certain requirements. [AHCAA §§ 112; 302; 305; 521]	Definition varies. For purposes of participation in an **Exchange**, small employers have no more than 100 employees, although states have the option beginning in 2016 to lower the threshold to no more than 50. For purposes of the **Employer Responsibility** tax, small employers have fewer than 50 employees. [PPACA §§ 1304; 1513]
State Basic Health Plan	N/A. Different than **Basic Plan**.	Option for states to create a program for low-income individuals who are not eligible for Medicaid. [PPACA § 1331]
Young Invincible Plan	N/A.	See **catastrophic plan**.

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