Comparison Chart: ACA vs. AHCA

	ACA	AHCA	Employer Consideration
Status	▪ Current law	▪ House introduced 3/6; Withdrawn 3/24/2017; Reintroduced and passed with amendments 5/4/2017; Senate is on the clock	▪ ACA remains the law of the land
Individual mandate	▪ Requires all U.S. citizens and legal residents to have qualifying health coverage (unless an exemption applies) ▪ Failure to have qualifying coverage may result in a penalty of the greater of $695 (as indexed) or 2.5% of household income (capped at the average national cost of Bronze level coverage)	▪ Eliminates the individual penalty ($0) effective January 1, 2016 ▪ Uses a 30% surcharge (based on the cost of the insurance premium) on individuals who are without coverage for at least 63 days and then buy coverage ¬ Surcharge would apply for a period of 12 months ¬ States may use health status underwriting as opposed to the 30% surcharge	▪ Without a requirement to have coverage, healthy individuals may forgo employer insurance, leading to adverse selection risks
Employer Mandate	▪ Applicable large employers may pay a penalty if full-time employees receive subsidized coverage in the Marketplace ▪ Penalties are assessed when there is no offer of minimum essential coverage to the full-time employee and children and when there is an offer of coverage, but the coverage is not affordable or does not meet minimum value ▪ Employers must report to the IRS on offers of coverage, affordability and minimum value using Forms 1094-C and 1095-C	▪ Eliminate penalties as of January 1, 2016 ($0) ▪ 1094-C and 1095-C remain ▪ Efforts may be made to condense reporting to align on Form W-2, making the 1094-C and 1095-Cs obsolete	▪ Possible penalty assessments for CY 2015 ▪ 1094-C and 1095-C reporting will continue to be required
High Cost Plan Excise Tax	▪ 40% excise tax on health insurance coverage that exceeds $10,200 for self-only and $27,500 for coverage other than self-only ▪ Effective date is January 1, 2020	▪ Same as prior column except the effective date is pushed out to January 1, 2026	▪ This tax continues to be delayed but included in legislation ▪ The “tax free” nature of employer-provided health benefits results in lost revenue of roughly $250B annually ▪ It’s the incentive that keeps employers in the game

Other Taxes and Fees	▪ Introduced a host of new taxes and fees	▪ Repeals additional Medicare tax on wages and investment income. ▪ Keeps the PCORI fee ▪ Repeals the health insurance carrier tax ▪ Removes $ cap on health FSA contributions	
Wellness	▪ Increases available wellness incentives under the HIPAA rules to 30% (50% for tobacco use) ▪ Care must be taken to coordinate with other federal rules (ADA and GINA)	▪ No change from prior column	▪ Employers still need to analyze incentives under three different laws (ADA, HIPAA and GINA) ▪ An incentive of no more than 30% of the total cost of self-only coverage in the lowest available plan option is permissible under all 3 – anything more requires closer scrutiny ▪ Legislation introduced to better coordinate laws affecting incentives
Benefit Design Reforms	All group health plans must: ▪ Not impose annual or lifetime dollar limits on essential health benefits ▪ Cover children to age 26 ▪ Not retroactively terminate coverage ▪ Not impose waiting periods of more than 90 days ▪ Not include pre-existing condition exclusions In addition, non-grandfathered group health plans must: ▪ Cover preventive care at 100% in-network ▪ No discriminate in favor of highly compensated in insured plans (not currently enforced) ▪ Adopt enhanced claims, appeals and external review procedures ▪ Limit individual out-of-pocket expenses to prescribed thresholds ($7,150 self-only/ $14,300 family for 2017) ▪ Cover routine costs associated with clinical trials ▪ Include certain patient protections and cover emergency services as in-network when provided out-of-network	▪ AHCA retains all of the benefit design reforms of the ACA except in the individual market where a 30% surcharge is permitted on individuals who have a gap in coverage of at least 63 days; the surcharge lasts 12 months ▪ Additionally, the AHCA gives power to the states (with approval from HHS) to reduce the essential health benefits currently defined under federal law	▪ For employers in the large market or self-insured these changes may result in fewer benefits subject to the prohibition of the annual and lifetime dollar limit if benchmarking to a state that reduces EHBs ▪ Contraceptive coverage (included in the preventive care mandate) may see regulatory changes under the Trump administration

Small Group and Individual Rules	▪ Offer at least a bronze level of coverage (60% plan) with all of the essential health benefits ▪ Costs of insurance may only differ based on the following: ¬ Plan and tier of coverage; ¬ Age (3:1); ¬ Geographic location; ¬ Tobacco-status (5:1)	▪ AHCA allows 5:1 age-banded rates ▪ Offer coverage below a Bronze level (i.e., 58% plan) ▪ Permits states to waive certain federal requirements for state based initiatives: ¬ Age rating above 5:1 ¬ Identify a state's own set of essential health benefits beginning in 2020 ¬ Beginning in 2019, use health status rating (assuming there is a high risk pool) as opposed to the 30% surcharge in the individual market when someone purchases coverage after a 63 day gap in coverage	▪ Employers may be able to impose annual and lifetime limits on more benefits if electing benchmark in a state that eliminates certain essential health benefits ▪ Small employers will see higher rates for older workers and lower rates for younger works in the small group market due to expanded age bracket ▪ Individuals may be excluded from the individual health insurance market due to health status if there is a gap in coverage
Health Savings Accounts (HSAs)	▪ Eligible individuals may contribute up to the statutory maximum contributions (for 2017, $3,400 self-only and $6,750 for family) ▪ Withdrawals from HSAs for non-qualified medical expenses are subject to a 20% penalty ▪ No joint HSAs ▪ No reimbursement of qualified medical expenses incurred prior to establishment of the HSA	▪ Effective January 1, 2018 increase the maximum HSA contribution for a calendar year to equal the out-of-pocket cost sharing under the QHDHP rules ($6,550 self-only; $13,100 family for 2017) ▪ Permit both spouses eligible for a $1,000 catch-up contribution to make the contribution to the same HSA ▪ Permit reimbursement of qualified medical expenses from the HSA when they were incurred up to 60 days before the HSA is established ▪ Reinstates the 10% penalty for withdrawals from the HSA for non-qualified expenses	▪ Permits a significantly larger annual HSA contribution which may encourage these types of programs
OTC	▪ Tax favored accounts cannot reimburse OTC medicines and drugs without a prescription	▪ Reinstates pre-ACA rules that permit reimbursement of OTC medicines and drugs without a prescription	
Association Health Plans	▪ Generally limits the ability for unrelated small employers to pool together under a single employer plan and take advantage of large employer underwriting	▪ Creates more flexibility for association medical plans to be established	▪ May create a federal regulatory environment that permits self-insurance and other flexibility for small employer groups to pool together

Expanded Medicaid	▪ Permitted states to expand access to Medicaid to adults with income of 133% (then to 138%) of FPL	▪ Pull back federal funding in states with expanded Medicaid eligibility	▪ More uninsured which increases costs due to uncompensated care in hospitals
Premium tax credits in Marketplace	▪ Makes available premium tax credits for individuals between 100%-400% of FPL without access to affordable MEC	▪ Phases out premium tax credits ▪ By 2020 introduce income based tax credits adjusted for age (and reduced for individuals with income over $75,000)	