ALTHOUGH THE Senate’s effort to repeal and replace the Affordable Care Act has failed, the Trump administration seems intent on not enforcing the regulations governing the law in order to make it fail.

In the last weeks of July Senate Republicans were busy trying to repeal the ACA, but each of their efforts fell short. A vote on legislation to repeal and replace the ACA failed, as did a vote on a straight-out repeal, as concerns mounted about the fallout for millions of Americans.

Then came the death knell when the Senate failed to pass a “skinny” repeal, which the leadership had hoped would be the basis for a bill that was sent to a conference committee and that would be hashed out with assistance from the House.

The GOP failed in part because of the likely fallout from their legislation. The Congressional Budget Office in January said in a report that repealing the Medicaid expansion and exchange subsidies while not touching other parts of the ACA would spell the end for many insurance markets. It noted that under such a scenario 32 million more people would be uninsured and premiums would almost double.

Senate Majority Leader Mitch McConnell in early July said publicly that if the GOP could not move the current legislation or repeal the ACA, they would quickly have to cooperate with Democrats to shore up some state insurance markets which have been losing insurers willing to write coverage.

Letting it implode
So what’s left now is a law that is still in jeopardy as President Trump has promised to let the ACA die by not enforcing the regulations that govern it. That would mean:

- Not enforcing the employer mandate.
- Not enforcing the individual mandate to purchase coverage for people who do not receive it from their work.
- Not enforcing the penalties for not complying with the employer and individual mandates.
- Not pursuing an appeal against a lawsuit challenging the legality of the tax credits used to help people buying coverage to afford it. If the Trump administration fails to appeal an earlier ruling, which has been stayed pending appeal, the subsidies would be deemed illegal and disappear.
- Not enforcing the IRS reporting requirements

See ‘Penalties’ on page 2
Health Legislation

Trump Wants to Ease Tax Credits Rule for Small Firms

The Trump administration is crafting regulations allowing small employers to bypass government-run exchanges to purchase coverage and still be eligible for a tax subsidy.

Part of the Affordable Care Act provides for small employers to be eligible for a tax credit if they purchase health insurance for their workers on federally operated exchanges for small businesses.

However, the Small Business Health Care Tax Credit is only available to employers that bought coverage on the Small Business Health Options Program (SHOP), leaving those who bought plans on the private market out of luck.

Now the Centers for Medicare & Medicaid Services (CMS) has announced its intention to bring in changes that would allow small business to be eligible for a tax credit even if they don’t purchase plans directly from the government-run SHOP marketplaces.

The CMS noted that as of January 2017, 7,600 employers had active SHOP-purchased insurance covering some 39,000 workers around the country. If SHOP-purchased coverage from state-run exchanges (like California) is included, then 27,000 employers had active coverage through SHOP marketplaces, covering nearly 230,000 individuals.

These numbers are far below the 4 million individuals it expected to be covered by SHOP-purchased policies.

To give small firms more flexibility in buying coverage, the CMS is proposing new regulations that would allow a small business or its broker to directly enroll employees with an insurance company, rather than having to do so through the SHOP marketplace, and still be eligible for tax credits.

Firms could still be eligible to utilize the ACA’s Small Business Health Care Tax Credit, even if the plan was obtained outside the SHOP marketplaces.

The move follows the Obama administration in December repealing a rule that required insurers to offer a SHOP plan in a given state if they wanted to participate in that state’s individual marketplace.

Under the approach that the CMS envisions, “Instead of enrolling online at HealthCare.gov, employers would enroll directly with an insurance company offering SHOP plans, or with the assistance of an agent or broker registered with the Federally-facilitated SHOP.”

Employers would still obtain a determination of eligibility by going to HealthCare.gov.

Employers that have enrolled in SHOP coverage for plan years that began in 2017 would be able to continue using HealthCare.gov in 2018 for enrollment and premium payment, until their current plan year ends and it’s time to renew.

Under the planned CMS changes, it is anticipated that states operating state-based SHOP marketplaces would be able to provide for online enrollment, or could opt to direct small employers to insurance companies and SHOP-registered agents and brokers to directly enroll in SHOP plans.

---

Removal of Penalties Would Drive up Premiums

The individual mandate and its associated penalties are a key pillar of the ACA.

If there is no penalty for people not to comply with the law and purchase coverage, exchanges are likely to be left with a sicker and older pool of insureds, which will drive up premiums.

And if the appeal against the subsidy lawsuit is dropped and subsidies disappear, it would put the cost of insurance out of reach for many individuals and families that currently purchase insurance on exchanges.

Trump said that if he let it fail by not funding tax credits and not enforcing regulations, the Republicans would not “own it.”

“We’ll let Obamacare fail, and then the Democrats are going to come to us to repair it,” he said.

Is a bipartisan effort on the horizon?

There seems to be some willingness to explore a bipartisan solution to shore up the ACA, particularly in markets that have seen an exodus of insurers willing to write coverage in the individual market and through government-run exchanges.

Lamar Alexander, the Republican chair of the Senate Health, Education, Labor and Pensions Committee, said in a statement that his panel would hold hearings to explore “how to stabilize the individual market” under the existing law.

And Democrats seem willing to work with the GOP, as Senate Minority Leader Charles Schumer and House Minority Leader Nancy Pelosi have called on Republicans to work with Democrats on making the ACA stronger.
NEW LEGISLATION in Congress would lower the age of Medicare eligibility to 55, from the current 65. The Medicare at 55 Act is sponsored by eight Democratic senators and the trade press has reported that similar legislation is in the works in the House of Representatives.

This move really cuts at the crux of the GOP’s efforts to repeal and replace the Affordable Care Act, in part by significantly raising rates on older individuals who account for a disproportionate amount of the insureds in government-operated health insurance exchanges. And interestingly, some Republicans seem open to the idea as a way to fix ACA problems.

Before the ACA became law in 2010, about 4 million people aged between 55 and 64 were uninsured, according to a 2009 study by the Kaiser Family Foundation. Additionally, nearly 25% of those uninsured individuals were in fair to poor health, compared to 16% of 35- to 54-year-olds.

Also, 20% of individuals who were aged 55-59 were denied coverage prior to the creation of the ACA individual market, as were 29% of 60- to 64-year-olds.

If it were implemented, the Medicare at 55 Act would pull many people with pre-existing conditions out of the individual market, which would reduce the overall “riskiness” of the pool and in turn lower premiums for those that remain in the pool.

One of the reasons for the ACA’s problems is that many young people feel the premiums are too high and so they opt to pay a penalty for not buying coverage, which also drives up premiums since they are not evening out the risk pool.

Additionally, the bill would address one of the other big anchors in the ACA: people in the 50-64 age bracket are often burdened with extremely high premiums and many people in this category have been priced out of the market.

In other words, it would open up a reliable market for people 55 and over who are having trouble paying the steep premium tabs from exchange-purchased plans.

“People between the ages of 55 and 64 often have more health problems and face higher health care costs, but aren’t yet eligible for Medicare,” said Sen. Debbie Stabenow, D-MI, when introducing the legislation in early August. “If you live in Michigan, are 58 years old, and are having a hard time finding coverage that works for you, this bill will let you buy into Medicare before you turn 65.”

In turn, there could be a third benefit in that overall Medicare premiums could also be reduced as the overall risk pool would improve with the addition of the relatively younger new enrollees.

Meanwhile, Democrats in the House of Representatives have said they plan to introduce similar legislation in September: the Medicare Buy-In and Health Care Stabilization Act.

The measure would allow Americans 50 or older to buy in to Medicare for $8,212 a year.
AS HEALTH care costs continue rising and employees are being asked to shoulder more of the expense burden, you can help them by offering a tax-advantaged plan that allows them to save for medical expenses.

These cafeteria plans, which are governed by Section 125 of the Internal Revenue Service Code, allow your employees to withhold a portion of their pre-tax salary to cover certain medical or child-care expenses. Employees can save an average of 30% in federal, state and local taxes on items they already pay out of pocket.

Because these benefits are free from federal and state income taxes, an employee’s taxable income is reduced, which increases the percentage of their take-home pay.

Moreover, the plans benefit employers, as well. Since the pre-tax benefits aren’t subject to federal social security withholding taxes, employers don’t have to pay FICA or workers’ comp premiums on those funds. A cafeteria plan can save employers an average of almost $115 per participant in FICA payroll taxes.

Being able to pay for your benefits on a pre-tax basis, you are looking at a 25-30% saving on your contributions, when compared with using after-tax dollars. There are three primary types of cafeteria plans:

### TYPES OF CAFETERIA PLANS

#### Premium-only plan:
POP plans allow employees to elect to withhold a portion of their pre-tax salary to pay for their premium payments. Most companies currently have this set up through their payroll provider. A POP plan is the simplest type of Section 125 plan and requires little maintenance once it’s been set up through your payroll.

#### Flexible spending account:
With an FSA an employee pays – on a pre-taxed basis through salary reduction – for out-of-pocket medical expenses that aren’t covered by insurance (for example, annual deductibles, doctor’s office copayments, prescriptions, eyeglasses and dental costs).

#### Dependent care flexible spending accounts:
The dependent care FSA is an attractive benefit for employees who pay for child care or long-term care for their parents. Employees may hold back as much as $5,000 annually of their pre-tax salary for dependent care expenses, which include expenses they pay while they work, look for work or attend school full time.

### HOW AN FSA WORKS

Before the start of the year, employees estimate how much they expect to spend on medical expenses and dependent care over the course of the year.

Employees should be careful to not put too much into the account. (They can carry over $500 in unused funds from the prior year into the new year, but any funds in excess of that would be forfeited.)

Whatever amount they choose to deduct for the year will be deducted on a pro-rated basis from each paycheck and deposited into their FSA.

On or after the first day of the plan year, an employee is restricted from changing or revoking the Section 125 agreement with respect to the pre-tax premiums until the plan year has ended, unless a change in family status occurs.

Your employees pay out-of-pocket expenses up-front and then submit a claim and documentation to the plan administrator. They are then reimbursed for their expense in the form of a check or account transfer.