VIEWS & VISIONS

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The State of Obamacare: Efforts to Repeal and Replace Leaving Employers in Limbo

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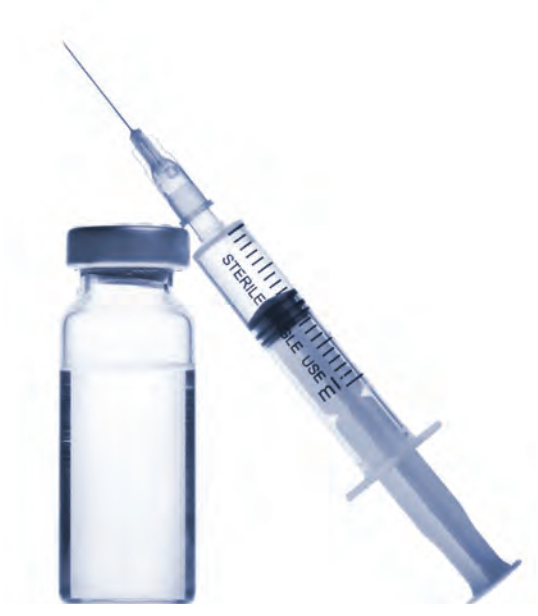
She earned her law degree from the West Virginia University College of Law, Order of the Coif, in 2001. While attending WVU, she was a member of The West Virginia Law Review, as well as secretary of the Student Bar Association. She earned her bachelor's degree, *summa cum laude*, from Bethany College.

Hall is the recipient of several distinguished honors, including 2017 Elite Lawyer of the South by Martindale-Hubbell and American Lawyer Media, Benchmark Litigation's Top Litigator Under 40 and *Best Lawyers'* 2018 Lawyer of the Year in West Virginia for Employee Benefits - ERISA.

She is the law firm's diversity partner and associate review chair. She also is a member of The Health Plan's board of directors and the former president of the board of West Virginia Kids Count.

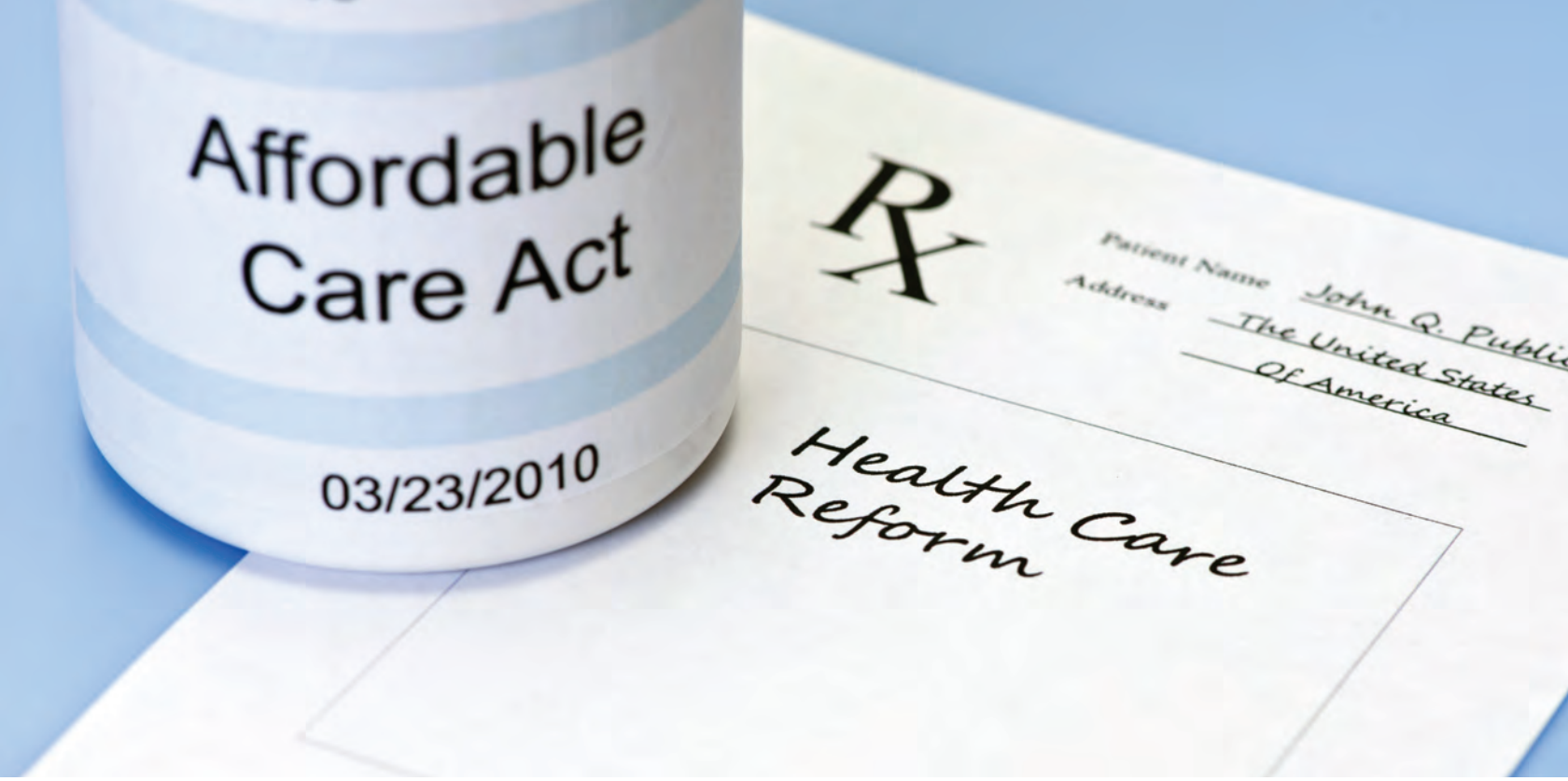
On September 26, 2017, the latest attempt by Republicans to repeal and replace the Patient Protection and Affordable Care Act (ACA), otherwise known as Obamacare, was quashed when the Senate Majority Leader, along with sponsors of the proposed legislation, announced no vote would be taken on the Graham-Cassidy bill. It was the latest in a line of failed attempts by Republicans to capitalize on their campaign promise to repeal and replace Obamacare.

Large employers, in particular, have waited anxiously since the November election to learn the fate of the ACA. For these employers, the issue is more than a political one. No matter which side of the health care debate they stand on, the practical implications of the repeal and replace efforts have had employers scrambling to assess their obligations with respect to the health care coverage required to be offered to their employees. Many employers are quickly approaching open enrollment season, as well as budget season, and they have been left scratching their heads over what will be required of them in 2018 and beyond. With the Graham-Cassidy bill now extinct, it appears that employers finally have their answer – nothing much has changed.



As a refresher, the ACA's employer mandate requires large employers (those with 50 or more full-time equivalent employees) to offer all full-time employees (those regularly working 30 hours or more per week) and their dependents adequate and affordable coverage under an employer-sponsored health plan or else pay a penalty to the federal government. This was a monumental shift in the law when the ACA was passed in 2010, and again when the employer mandate became effective a few years later. Although providing health benefits to employees has become quite common, often considered an effective recruiting tool to attract talent, employers had never before been required to provide health coverage to employees. Although the ACA also does not require that an employer provide health coverage to employees, it comes close by presenting large employers with what is, at least for some, a difficult choice – offer coverage in accordance with the ACA's requirements or pay a penalty. This is the so-called "pay or play" mandate.

Even those large employers who would offer health coverage to employees regardless of whether or not they are required by law to do so have seen a change in the parameters of the coverage required since the implementation of the employer mandate. The definition of "full-time employee" under the ACA (those regularly working at least 30 hours per week) resulted in many more employees becoming entitled to coverage under plans sponsored by large employers who had previously offered



coverage to employees working a more traditional full-time schedule (typically 37- 40 hours per week). Dependents of full-time employees also must be offered coverage under the ACA, and coverage for all must be "affordable" and provide "minimum value."

Large employers also must track hours worked by part-time, seasonal and variable hour employees to determine their entitlement to coverage. Perhaps most daunting of all ACA requirements, employers must comply with rigorous employer information reporting requirements so that the IRS knows whether to assess a penalty for an employer's failure to offer affordable coverage to full-time employees and their dependents. The ACA also bans health care-related discrimination by employers, including protecting employees who inform the federal government of ACA violations, and prohibiting discrimination in favor of certain highly compensated employees with respect to the provision of health benefits.

Many employers have been hedging their bets since the November election, convinced that the employer mandate and other provisions of the ACA would be wiped clean with whatever repeal and replace measure was ultimately adopted by Congress. No one can fault them for thinking this way. Every major bill submitted for consideration to repeal and replace the ACA since January has contained a provision that would eliminate the employer mandate (or at least the penalties associated with it), as well as a retroactive reprieve from the assessment of penalties for failure to offer affordable coverage. Even if this had ultimately happened, though, employer obligations under the ACA would not have been completely wiped away.

As has been widely reported, Republicans sought to repeal Obamacare using the fast-track budget reconciliation process as opposed to being passed by regular order. Using the reconciliation process may have accomplished a quick fix with respect to repealing certain aspects of the ACA, but the reconciliation process would have limited the scope of alterations Congress could make to the ACA, likely leaving in place some of the obligations placed on employers by the ACA law. For example, under the reconciliation rules, Congress could not have entirely repealed the current reporting requirements or the ACA's anti-discrimination provisions.

There is one substantive change on the horizon that may impact how small employers offer health insurance. On October 12, 2017, President Trump signed an executive order intended to allow small businesses (and potentially individuals) to avoid state regulation and certain ACA protections by pooling together to purchase health insurance as a single large group through "association health plans." In the past, these health plans have been subject to strict rules intended to limit the number of permissible association plans. The move by the President, directing federal agencies to ease these rules, will allow expanded access to these types of health plans. The order also intends to widen employers' ability to use pretax dollars in "health reimbursement arrangements" to help workers pay for any medical expenses, not just for health policies that meet ACA rules.

With the clock ticking toward year-end, it is becoming clearer every day that the ACA, and particularly the employer mandate, remains the law of the land, at least for the near future. To be

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sure, Republican efforts to repeal and replace Obamacare are not over. Even bipartisan efforts to improve on Obamacare are already underway. Until such time as new legislation is passed, however, the only certainty is that employers must continue to comply with the ACA, including the employer mandate, employer information reporting requirements (deadlines for which are fast approaching), and all other provisions governing the scope of health benefits to be offered to employees. Failure to comply with employer obligations under the ACA could result in steep penalties. Employers who ignore their obligations under the ACA in hopes of an eventual reprieve do so at their own risk.

The Triple Aim: (What's So Funny 'Bout) Better Care, Healthier Populations and Lower Cost?

Huy Nguyen

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my first startup in 2012 and wanted to resume practicing when I got recruited to Plateau Medical Center in Oak Hill. I started Care 24/7 while practicing there, recognizing a need to provide 24/7 patient access to virtual management and care coordination as part of automating population health management. In fact, I first met with Tom Heywood, John Moore and the Bowles Rice team because I wanted West Virginia Medicaid and the Bureau of Public Health to consider our services. Even back in 2013, Tom and I foresaw that Medicaid expansion, as afforded by the ACA, would eventually come under threat, and that the state would have to look for cost-effective, innovative and proactive means to drive quality and control costs.

Unfortunately, the bureaucracy was too preoccupied then with the initial thrall of Medicaid expansion and enrollment. Regardless, Medicare in 2015 began to reimburse providers for chronic care management, so our business has grown rapidly, helping providers and practices derive unfulfilled, new revenues. Care 24/7 currently has 50-plus clients in 20-plus states. In West Virginia, we have contracted with Mon General, Plateau Medical Center, Boone Medical, Coplin Health, Change Inc. and Minnie Hamilton Health System to facilitate provider-based population health management. As part of our growth, I have relocated the business to Nashville, but Care 24/7 and I will always have a bit of history in West Virginia.

The health care challenges in West Virginia can be a burden, but they can also be an opportunity. As the state with the largest per capita expansion of Medicaid, it must look for means and policies to sustain that expansion, and, if the bureaucracy can be open minded, there are plenty of innovators and entrepreneurs within the state who can pilot new approaches. Furthermore, if properly nurtured, these public-private collaborations can also generate new enterprises that will help West Virginia diversify from its traditional industries.

The paradigm shift from fee-for-service to value-based care presents an enormous pressure, hence a once-in-a-generation opportunity to achieve the Triple Aim. So, again I ask… (What's So Funny 'Bout) Better Care, Healthier Populations, and Lower Cost?