## The ACA and Its Effects on Employers for Small Employers – Oregon

### 2012 - 2013

**Women’s Preventive Care**
The definition of preventive care was expanded to include additional services for women as groups and individual policies renew on or after August 1, 2012. Member cost-sharing and dollar limits are eliminated for certain services when received in-network.

These services include contraceptives, breast pumps and support, gestational diabetes screening, and screening and counseling services for things such as HPV, domestic violence, HIV, and sexually transmitted diseases.

**Summary of Benefits and Coverage**
This document allows for comparison between carriers and plan designs. It became effective September 23, 2012, and is being distributed to employers upon renewal or benefit change. Distribution of the SBC is a shared responsibility between employers and insurers.

**W-2 Reporting of Employer-sponsored Health Coverage**
For groups with fewer than 250 W-2s: this requirement is suspended until further guidance is provided by the IRS, but may be required in the future.

**Changes to Flexible Spending Accounts**
Beginning on or after January 1, 2013, there is a $2,500 maximum contribution to healthcare flexible spending accounts (FSAs).

### ACA Mandates at a Glance

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| 2012 - 2013 | *Women’s preventive care – upon renewal on or after August 1, 2012*  
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*W-2 reporting of employer-sponsored health coverage if 250 or more W-2s*  
*Changes to flexible spending accounts (FSAs)*  
*Notification of exchanges and premium subsidies*  
*Exchange begins open enrollment in October for January*  
| 2014 | *New plan designs available through the exchange and direct with carriers.*  
*Essential health benefits – no annual or lifetime dollar limits*  
*Maximum deductibles*  
*Maximum out-of-pocket limits*  
*Pre-existing condition exclusions eliminated*  
*Probationary waiting periods limited to 90 calendar days*  
*Hourly eligibility requirements remain at 17.5 - 40 for small groups*  
*Nondiscrimination rules (may be postponed)*  
*Additional eligibility and enrollment rules*  
*Employer-based wellness program incentives enhanced*  
*Proposed Oregon legislation to define small group as 1-50 employees*  
| 2016 | *Small group size definition changes to 1–100 employees.*  

### Notification of the Exchange
Health insurance exchanges are online marketplaces where individuals and small businesses can compare and shop for health plans. (Individuals will also be able to find out if they qualify for financial assistance.) Employers are not required to purchase their health plan through the exchange.

Employers will be required to notify current employees of the exchanges by October 1, 2013. After the initial notice, all new employees must receive the notice at their date of hire. The written notice must provide the following information:

- Basics: existence, services, how to contact
Exchange Enrollment Begins in October
Oregon's health insurance exchange, Cover Oregon, begins open enrollment in October 2013 for plans effective on or after January 1, 2014.

**Maximum Out-of-pocket Limits**

Upon renewal in 2014, the member cost sharing limit on any health plan can be no greater than those in a health savings account (HSA). The limit for 2014 will be $6,350 per year for individuals and $12,700 per year for families. This limit encompasses both medical and pharmacy member costs; however, it does not apply to cost sharing for out-of-network services.

**Essential Health Benefits**

Small group and individual plans must include “essential health benefits,” which includes:
1) ambulatory patient services, 2) emergency services, 3) hospitalization, 4) maternity and newborn care, 5) mental health, substance use, and behavioral health, 6) prescription drugs, 7) rehabilitative and habilitative services and devices, 8) laboratory services, 9) preventive, wellness, and chronic disease management, and 10) pediatric services, including oral and vision exams.

Annual and lifetime dollar limits are also eliminated for essential health benefits.

**Maximum Deductibles**

Deductibles for plans in the small group market are limited to $2,000 for an individual and $4,000 for a family, based on current guidelines and indexed for inflation.

**Pre-Existing Condition Exclusions**

Insurers will be prohibited from denying coverage or charging higher premiums due to a pre-existing condition. Insurers must also eliminate any pre-existing condition waiting periods based on state regulations.

**Probationary Waiting Periods**

Eligibility waiting periods for group health insurance cannot exceed 90 calendar days.

**Hourly Eligibility Requirements**

Small group employers can continue to set the minimum number of hours employees must work each week to be eligible for group health insurance between 17.5 and 40.

If an employer has 50 or more full-time equivalent employees as defined under the ACA’s shared responsibility provision, they may face a penalty if they set it at higher than 30 hours.

**Nondiscrimination Rules**

*Note: This provision may be postponed.*

Employers will be prohibited from providing better eligibility, health benefits, or employer contribution to highly compensated individuals. Differences based on age, years of service, or compensation is not permissible. Waiving of the probationary period for key employees will also not be allowed. The Department of Labor has suggested violators could face fines of up to $100 a day for each employee discriminated against.

**Additional Eligibility and Enrollment Rules**

For small employer groups that elect to obtain coverage directly through an insurer, these provisions will be determined by each of the insurers later this year.

**Mandatory Coverage for Clinical Trials of Life-Threatening Diseases**

Group health insurance plans are required to provide coverage of routine patient costs associated with approved clinical trials.

**Employer-Based Wellness Programs**

The proposed rules increase the maximum reward under a health-contingent wellness program. Employers will be allowed to offer a reward of up to 30 percent off the premium contribution. For example, the employer could pay 100 percent of the premium for those who participate and meet the criteria and 70 percent for those who don’t participate. An additional 20 percent will be allowed if it is in connection with a program to reduce or prevent tobacco use.

For more information, visit:

HealthCareLawGuide.com (for the general public) or PacificSource.com/reform (for PacificSource customers)

June 7, 2013. While every attempt has been made to ensure the accuracy of this information as of the publication date, federal and state rules and interpretations of the ACA continue to evolve, and every employer’s circumstances are unique. Please consult with your own legal and tax advisors for advice specific to your business.