

Health Care Reform

On March 23, 2010, President Obama signed into law a comprehensive health care reform bill—the Affordable Care Act (ACA)—which includes numerous reforms aimed at improving the U.S. health care delivery system, controlling health care costs and expanding health coverage. The ACA’s reforms have staggered effective dates, with many key reforms that took effect in 2014.

The ACA is a federal law, which means that federal agencies—namely the Departments of Labor (DOL), Health and Human Services (HHS) and the Treasury—are primarily responsible for the law’s overall enforcement. However, the ACA also creates significant responsibilities for state governments. A number of the ACA’s key health care reforms will be carried out at the state level.

This Employment Law Summary provides a high-level overview of selected ACA reforms to be implemented by state governments and highlights the progress made in Oregon.

HEALTH INSURANCE EXCHANGES

The ACA requires each state to have a health insurance Exchange (Exchange) to provide a competitive marketplace where individuals and small businesses can purchase affordable private health insurance coverage, effective Jan. 1, 2014. The Exchanges first opened for enrollment on Oct. 1, 2013.

According to HHS, the Exchanges make it easier for individuals and small businesses to compare health plan options, receive answers to health coverage questions, determine eligibility for federal subsidies for private insurance or public health programs and enroll in suitable health coverage.

Individuals and small employers are eligible to participate in the Exchanges. Under the ACA, a “small employer” was defined as an employer with not more than 100 employees. However, for plan years beginning before Jan. 1, 2016, a state could elect to define “small employer” as an employer with not more than 50 employees.

However, on Oct. 7, 2015, President Obama signed into law the [Protecting Affordable Coverage for Employees](#) (PACE) Act, which **repeals the ACA’s small group market expansion requirement**. As a result, states now have the option, but are not required, to expand their small group markets to include businesses with up to 100 employees.

States had the following three options with respect to their Exchanges:

1	Create and operate its own Exchange (state-based Exchange)
2	Have HHS operate a federally-facilitated Exchange (FFE) for its residents
3	Partner with HHS so that some FFE functions are performed by the state

In addition, a state could elect to partner with HHS so that the state runs the Exchange’s small business health options program (SHOP) component and HHS runs the Exchange’s individual market component. As a default, HHS operates the FFE in states that did not move forward with their Exchange planning or select the partnership model.

Oregon has a state-based Exchange that receives administrative support from HHS. As a result, the state is responsible for performing all Exchange functions, but relies on the FFE’s information technology platform. Oregon residents apply for and enroll in coverage through www.HealthCare.gov. More information on Oregon’s Exchange is available at www.healthcare.oregon.gov.

This guide is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. It is provided for general informational purposes only. It broadly summarizes state statutes and regulations generally applicable to private employers, but does not include references to other legal resources unless specifically noted. Readers should contact legal counsel for legal advice.

Health Care Reform

ESSENTIAL HEALTH BENEFITS

Beginning in 2014, the ACA requires non-grandfathered plans in the individual and small group markets, both inside and outside of the Exchanges, to offer a core package of items and services. This core package is known as essential health benefits (EHBs), and includes items and services in 10 general benefit categories (such as hospitalization, maternity and newborn care, mental health and substance use disorder services and prescription drugs).

The ACA also directs that EHBs should be equal in scope to benefits offered by a typical employer health plan. To meet this requirement in every state, HHS further defines EHBs based on a state-specific benchmark plan. States could select a benchmark plan from among the following options:

- The largest plan by enrollment in any of the three largest products by enrollment in the state's small group market;
- Any of the largest three state employee health benefit plans options by enrollment;
- Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by enrollment; or
- The HMO plan with the largest insured commercial non-Medicaid enrollment in the state.

If a state did not select a benchmark, HHS selected the largest plan by enrollment in the largest product by enrollment in the state's small group market as the default benchmark plan.

Oregon selected a small group plan as its EHB benchmark—PacificSource Preferred CoDeduct Value, PPO. More information on Oregon's default benchmark plan is available on the Center for Consumer Information & Insurance Oversight (CCIIO) [website](#).

MEDICAID EXPANSION

When it was passed, the ACA required states to expand Medicaid eligibility by providing coverage for adults between ages 18 and 65 with incomes up to **133 percent** of the federal poverty level (FPL), regardless of their age, family status or health. Because of the way this is calculated, it effectively includes individuals with incomes up to **138 percent** of FPL. In 2012, the U.S. Supreme Court **made it optional** for states to expand their Medicaid eligibility.

In addition, the ACA provides federal subsidies for people with incomes between 100 percent and 400 percent of FPL to help pay for health insurance through an Exchange. Employees who are eligible for Medicaid cannot receive Exchange subsidies.

Starting in 2015, applicable large employers, or ALEs, (employers with 50 or more full-time employees, including full-time equivalents) may be subject to an employer shared responsibility penalty if one or more full-time employees receives an Exchange subsidy. (ALEs with fewer than 100 employees may be eligible for a one-year delay of the employer shared responsibility rules, until 2016). ALEs with employees in states that opt out of the expanded Medicaid eligibility may face an increased risk of penalties under the employer shared responsibility rules because fewer employees will be ineligible for subsidies based on Medicaid eligibility.

Oregon expanded its Medicaid program in 2014 to cover households with incomes up to 138 percent of FPL. The FPL guidelines are [published by HHS](#) each year.

EXPANSION OF SMALL GROUP MARKET

To make health insurance coverage for small groups more affordable and apply additional consumer protections (for example, the restrictions on using health status factors in setting premium rates), the ACA called for the small group market to be expanded. Under the ACA, a "small employer" was defined as an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year.

For plan years beginning before Jan. 1, 2016, a state could elect to define "small employer" as an employer that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year. Thus, states had the option to delay the ACA's expansion of the small

Health Care Reform

group market. Most states have traditionally defined a small employer as one with 50 or fewer employees.

However, on Oct. 7, 2015, President Obama signed the [PACE Act](#) into law, which repeals the ACA's small group market expansion requirement. As a result, states now have the option, but are not required, to expand their small group markets to include businesses with up to 100 employees.

Before the PACE Act became law, Oregon enacted legislation to align its small group market definition with federal law. This legislation gave the Oregon Insurance Division (OID) authority to adopt rules defining "small employer" differently in the event federal agencies issued more guidance. Due to the PACE Act, the OID adopted a [temporary rule](#) defining a "small employer" as an employer with 1-50 employees, effective Jan. 1, 2016. Thereafter, the OID implemented a [permanent rule](#) to replace the temporary rule. Thus, under Oregon law, the small group market will continue to include employers that employed an average of at least one but not more than 50 employees on business days during the preceding calendar year.

INSURANCE RATE REVIEW

To help hold insurance companies accountable for their proposed rate hikes, the ACA required HHS to establish a process for the review of certain premium increases. Effective Sept. 1, 2011, insurers seeking rate increases of **10 percent or more** for non-grandfathered plans in the individual and small group markets must publicly disclose the proposed increases, along with justification for the increases. After 2011, states may work with HHS to set state-specific thresholds for disclosure of rate increases, using data and trends that reflect cost trends particular to a state.

The proposed increases must be reviewed by either state or federal experts to determine whether they are unreasonable. States with effective rate review systems will conduct their own reviews, but if a state does not have the resources or authority to conduct rate reviews, HHS will conduct them.

According to HHS, Oregon has an effective system for reviewing rate increases in both the individual and small group markets. The [OID](#) conducts rate reviews for these markets. Oregon law exempts association plans that retain 95 percent or greater of their employer groups from rate review.

ENFORCEMENT OF INSURANCE MARKET REFORMS

Effective for 2014, the ACA requires health plans and health insurance issuers to comply with an additional set of insurance market reforms. For example, effective for plan years beginning on or after Jan. 1, 2014, health plans and issuers cannot impose pre-existing condition exclusions on any enrollees.

States have traditionally been the primary regulators of their health insurance markets. The ACA allows states to continue in this role, but does not require states to enforce the ACA's reforms. If a state chooses not to enforce the ACA's insurance reforms, the federal government will assume that role. Although states have varied significantly in their approach to implementing the ACA, many states have enacted laws related to the market reforms.

Oregon is taking an active role in enforcing the ACA's market reforms. State regulators perform functions such as collecting and reviewing policy forms for compliance, responding to consumer inquiries and complaints and taking enforcement action as necessary.

DEPENDENT COVERAGE REQUIREMENTS

Effective for plan years beginning on or after Sept. 23, 2010, the ACA requires group health plans to extend dependent coverage up to **age 26**. Some states may have laws that go beyond the federal minimums established by the ACA. For example, some states extend dependent coverage beyond age 26.

Oregon law does not require insured health plans to maintain dependent coverage beyond age 26.

The ACA amended the federal tax code so that, for federal tax purposes, the value of employer-provided coverage for young adult dependents is excluded from the employee's gross income through the tax year in which the dependent child turns 26.

Oregon's tax law conforms to the federal tax code. Therefore, the cost of group health coverage for an eligible adult child in Oregon will not be subject to state tax up to the end of the year in which the adult child attains age 26. However, health coverage for an adult child after the year in which the child turns age 26 will be subject to federal and state tax, unless he or she qualifies as a tax dependent.

Health Care Reform

EXTERNAL REVIEW REQUIREMENTS

The ACA requires non-grandfathered group health plans to follow minimum requirements for **external review** of claims appeals. Insured plans must comply with their state's external review process if it includes certain minimum consumer protections. If a state's external review process does not include the minimum consumer protections, health insurers in the state must comply with a federal process for conducting external reviews, effective Jan. 1, 2012. HHS determines whether a state's external review process includes the minimum consumer protections.

HHS concluded that the Oregon external review process includes the minimum consumer protections. Thus, insured health plans in Oregon must conduct external appeals in accordance with the Oregon external review process.