



INTERMOUNTAIN

I N S U R A N C E



Your Guide to Group Insurance Benefits

Employee health benefit guidance for Eastern Oregon employers

A well-designed benefits program can help an employer recruit and retain employees, protect workers and their families from major health costs, and give employees more predictable access to care. But choosing a group plan involves more than comparing premiums.

Intermountain Insurance helps Eastern Oregon employers evaluate medical, dental, and vision benefits in the context of workforce needs, employer budget, employee contributions, provider networks, plan design, and the practical realities of receiving health care in a rural region.

Whether you are offering benefits for the first time, preparing for a renewal, or trying to improve an existing program, this guide explains the major decisions and the questions worth asking before you select coverage.

Need help now?

Call Intermountain Insurance at (541) 314-9075 or email josh@intermountain.insure.

Group health insurance in Oregon: the basics

Oregon small-group coverage is generally available to businesses with **one to 50 employees**. Oregon states that a business with at least one W-2 employee can purchase small-group coverage for the employer and workers, and small-group coverage is available throughout the year rather than only during the individual-market Open Enrollment period. (Oregon Health Insurance Marketplace)

Employers with fewer than 50 employees are generally not required by federal law to offer health insurance. Employers that average at least 50 full-time and full-time-equivalent employees can become **Applicable Large Employers (ALEs)** and may be subject to the Affordable Care Act employer shared-responsibility rules. (Oregon DFR)

A headcount issue worth checking

The number used to determine whether a business is in the small-group insurance market and the federal **FTE calculation** used for ACA employer responsibility are related concepts, but they are not always counted in exactly the same way. Growing employers should review their status before assuming which rules apply.

What can a group benefits package include?

For many employers, the foundation of the benefit package is medical insurance, with dental and vision offered alongside it. Each benefit should be evaluated separately because the employee need, employer contribution strategy, network, and plan economics can be different.

Benefit	What it generally covers	What employers should compare
Medical	Hospital, physician, prescription, preventive and other covered medical services.	Premium, deductible, copays, coinsurance, network, formulary, out-of-pocket maximum and HSA compatibility.
Dental	Preventive, basic and major dental services depending on the plan.	Annual maximum, waiting periods, network, preventive coverage, major-service coinsurance and orthodontia if offered.
Vision	Routine eye exams and allowances or discounts for lenses, frames or contacts.	Exam frequency, hardware allowance, network and employee cost.

Employers can choose to contribute toward employee-only coverage, dependent coverage, or both, subject to carrier rules and applicable law. The contribution strategy is often as important to employees as the plan itself because it determines the amount deducted from each paycheck.

How small-group medical premiums are determined

Oregon explains that small-group premiums depend on factors including employee and dependent ages, the benefits selected, geographic location, family enrollment, and tobacco use. Health status and an employee's medical history are not used to set an ACA-compliant premium. (Oregon DFR)

This means a group quote begins with an accurate **employee census**. For each employee and dependent who may enroll, insurers typically need information such as date of birth or age, home ZIP code, relationship, and tobacco status, along with who intends to enroll or waive coverage.

Before requesting quotes

A census should not include Social Security numbers or medical-history information for a preliminary small-group quote. Intermountain Insurance can provide a standardized Group Quote Request and census template to make this process easier.

Plan design: premium is only one part of the decision

Two plans with similar premiums can create very different employee experiences. A useful comparison should include the deductible, primary and specialty care copays, coinsurance, prescription coverage, emergency and hospital cost sharing, and the annual maximum out-of-pocket amount.

Design choice	Usually emphasizes	Trade-off to watch
Lower-premium / higher-deductible	Lower fixed monthly cost and greater employee cost sharing when care is used.	Can create affordability concerns for employees who use regular services or prescriptions.
Richer copay plan	More predictable office-visit and prescription costs with a lower deductible in many designs.	Higher monthly premium for employer and employee.
HSA-qualified HDHP	Tax-advantaged HSA eligibility and potential employer HSA contributions.	Employees need to understand deductible exposure and how to use the HSA.
Multiple-plan choice	Lets employees choose between different premium and cost-sharing structures.	Adds communication and enrollment complexity; carrier rules may limit combinations.

The right design often depends on the workforce. A younger workforce may value a lower premium and HSA option, while employees with families, prescriptions, or recurring medical needs may place greater value on predictable copays and lower out-of-pocket exposure.

Why provider networks matter even more in Eastern Oregon

In Eastern Oregon, the strongest-looking plan on paper can be a poor fit if it does not work well with the doctors, hospitals, and referral patterns employees actually use.

Employees may receive routine care locally but travel to another community - or to a larger regional medical center - for specialty care, surgery, cancer treatment, advanced imaging, behavioral health, or other services. Before choosing a plan, confirm how the network works both locally and when an employee is referred outside the immediate area.

- Check the local hospital and major primary care clinics used by employees.
- Review access to specialty providers and common out-of-area referral destinations.
- Consider employees who live in different counties or commute across a broad service area.
- Review pharmacy access, mail-order options, and prescription formularies.
- Ask how urgent and emergency care works when employees travel.

Local access matters

Eastern Oregon rule of thumb: A lower premium is not a bargain if employees cannot reasonably access the providers they need. Network fit should be evaluated before cost differences are allowed to drive the decision.

Employer contribution and employee participation

Employers decide how much of the premium they will pay, within the rules of the carrier and plan. Some employers pay a percentage of the employee premium; others pay a fixed dollar amount. The contribution can also be structured differently for dependents, where permitted.

Participation rules also matter. For SHOP coverage, HealthCare.gov generally requires at least **70% of employees who are offered coverage** to enroll, with employees who have other qualifying coverage generally excluded from the rejection count. The SHOP minimum-participation requirement is waived during the annual November 15 through December 15 window. Carrier requirements outside SHOP can vary. (HealthCare.gov)

Waiting periods for eligible employees cannot exceed **90 days**. Employers should define eligibility consistently - including how many hours an employee must work, when coverage begins, and which dependent classes can enroll. (HealthCare.gov)

High-deductible plans and Health Savings Accounts

An HSA-qualified high-deductible health plan can be attractive when an employer wants to pair lower premiums with a tax-advantaged account that employees can use for qualified medical expenses. Employers may also contribute to employee HSAs.

For **2026**, the HSA contribution limit is **\$4,400 for self-only coverage** and **\$8,750 for family coverage**. An HSA-qualified HDHP generally must have a deductible of at least **\$1,700 self-only / \$3,400 family** and an out-of-pocket limit no higher than **\$8,500 self-only / \$17,000 family**. (IRS Rev. Proc. 2025-19)

An HSA plan works best when employees understand both the insurance plan and the account. If the deductible is materially higher than employees are accustomed to, education and an employer HSA contribution can make the transition easier.

Could your business qualify for the Small Business Health Care Tax Credit?

Some very small employers may qualify for a federal tax credit when they provide health insurance. The maximum credit is generally **50% of qualifying premiums paid by a taxable small business** and **35% for an eligible tax-exempt employer**, and the credit is generally available for two consecutive taxable years. (IRS)

Eligibility is targeted to employers with fewer than **25 full-time-equivalent employees**, lower average wages, and an employer contribution toward employee premiums. For tax years beginning in **2026**, the IRS inflation-adjusted wage amount used in the credit calculation is **\$34,100**; the credit phases down as FTE count and average wages rise and is fully phased out at the statutory limits. SHOP coverage is generally required to claim the credit. (IRS Rev. Proc. 2025-32)

Tax note

The tax credit rules are detailed and should be reviewed with a tax professional. Intermountain Insurance can help identify the insurance options and SHOP availability, but tax-credit eligibility should be confirmed with your accountant or tax adviser.

When a traditional group plan is not the right fit

A traditional group health plan is not the only way an employer can help employees with health coverage. Depending on employer size and goals, a **Health Reimbursement Arrangement (HRA)** may allow an employer to reimburse eligible individual health insurance premiums and/or qualified medical expenses under federal rules.

Two arrangements commonly discussed are the **Qualified Small Employer HRA (QSEHRA)** for certain smaller employers that do not offer a traditional group plan and the **Individual Coverage HRA (ICHRA)**, which can be available to employers of different sizes. These arrangements have detailed eligibility, notice, affordability, and employee-class rules. (HealthCare.gov)

An HRA can increase employee choice, but it also shifts more of the shopping decision to each employee. Before choosing an HRA instead of group coverage, compare administrative complexity, employee experience, Marketplace subsidy interactions, and the local individual-market options available to your workforce.

Renewal strategy: do not just accept the new rate

A group health renewal should be treated as an annual planning exercise rather than an invoice to approve. Before renewing, compare the existing plan against current alternatives and look at both employer cost and employee impact.

- Review the renewal increase and how much of it will be absorbed by the employer versus employees.
- Compare alternative deductibles, copays, HSA-compatible plans, and multiple-plan strategies.
- Recheck provider networks and prescription coverage, especially if the carrier or network is changing.
- Review employee enrollment and waiver patterns. A plan employees cannot afford may create low participation even if the employer contribution appears reasonable.
- Consider whether dental and vision benefits still provide value relative to their cost.
- Communicate changes before enrollment so employees understand what is changing and why.

2027 Oregon small-group rate outlook

Updated August 2026

Oregon regulators are reviewing 2027 small-group rate filings. On July 30, 2026, the Division of Financial Regulation said it had reduced insurers' requested small-group increases from a weighted average of **17% to 15.5%** in its proposed revised rates. Final rates can differ, and a statewide average does not predict the renewal for a particular employer. (Oregon DFR)

Employers with late-2026 or 2027 renewals should compare the actual carrier renewal against current alternatives rather than relying on statewide averages.

A group benefits checklist for Eastern Oregon employers

Before requesting or reviewing quotes, gather the information that will actually drive the decision:

- Legal business name, address, industry, requested effective date, and current carrier if applicable.
- A complete employee and dependent census, including employees who may waive coverage.
- Current medical, dental, and vision plan summaries and the most recent renewal if coverage already exists.
- Current employer contribution strategy for employee and dependent premiums.
- Eligibility rules: minimum hours, waiting period, and eligible employee classes.
- Must-have local hospitals, clinics, physicians, specialists, pharmacies, or out-of-area referral centers.
- The employer's priorities: lower fixed cost, richer benefits, HSA strategy, multiple plan choices, employee recruitment/retention, or a specific budget target.

How Intermountain Insurance Can Help

Group insurance is not simply a question of finding the carrier with the lowest monthly premium.

At **Intermountain Insurance**, our goal is to help employers build benefits around the workforce they actually have. We can help organize the quote process, evaluate medical, dental, and vision options, compare employer contribution strategies, review provider networks, explain plan differences, and support enrollment and renewal decisions.

We understand that employers in Eastern Oregon often compete for employees across a large geographic area and that health care access can require travel between communities. Local network fit, affordability for employees, and practical access to care deserve attention alongside the employer budget.

Ready to review your group benefits?

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