

You are here: [Home](#) » [States](#) » [California](#) » [Laws](#) » [California State Laws](#)

California State Laws

- [Is Your Business Eligible for Group Coverage?](#)
- [Tax Benefits for Your Business](#)
- [California Small Group Law AB1672](#)
- [California Mental Health Parity Law AB 88](#)
- [San Francisco Health Care Security Ordinance \(HCSO\)](#)

Is Your Business Eligible for Group Coverage?

Under California law AB1672, small employers are guaranteed group coverage should they choose to purchase it, regardless of the employees' health status. A "small employer" is defined as a business with 2 to 50 full-time employees. In 2016, a small employer will be defined as a business with 2 to 50 full-time employees. Owners are generally counted as employees, so sole proprietorships with one employee fall into this category, as do partnerships without any employees (by definition partnerships have two or more partners).

California state law AB1672 says that small employers cannot be denied coverage as long as they:

- Pay their premiums.
- Have been in business longer than two months.
- Offer medical insurance coverage to all eligible full- and part-time employees.
- Comply with insurer requirements regarding employer contribution and employee participation.
- Have not committed fraud against the insurer.

See "[Laws Related to Health Insurance](#)" for more information, including specifics about California AB1672.

Tax Benefits for Your Business

Generally speaking, any expenses an employer incurs related to health insurance (for employees or for dependents) are 100% tax-deductible as ordinary business expenses, on both California and federal income taxes. Beyond this general rule, taxes get a bit more complicated. It is possible to set things up so that your employees save tax money. With just a little paperwork on your part, an employee can contribute to the cost of health insurance on a pre-tax basis. That means you deduct the cost of the premium from the employee's paycheck before state and federal taxes are calculated and deducted. This increases the employee's take-home pay and lowers the amount of the employee's taxable income.

California Small Group Law AB1672

Type of law: State.

Who's affected: "Small employers" in California, defined as businesses with 2 to 50 employees, the majority of whom work in California. (Technically the law applies not to employers themselves, but to the insurance carriers that sell small group health coverage.)

What it does: AB1672 gives small employers who meet certain requirements access to group medical coverage. An insurer cannot deny qualified small employers group medical coverage based on the health status of their employees, and premiums can only be slightly higher than average if employees have health problems. (Beginning in 2014 under the Affordable Care Act, qualified health plans will no longer be able to charge a different premium based on an employee's health problems or claims history.)

The key provisions of AB1652 are:

- Guaranteed issue and renewal of small group policies
- Rules on small group rates,
- Limitations on preexisting condition exclusions, and
- Requirement that plans and brokers provide fair information about all products.

The requirements apply whenever an employer pays directly for any portion, however small, of an employee's coverage.

Guaranteed Issue and Renewal

Every small employer has the right to buy any benefit plan design offered or sold by a health plan to other small employers in the same geographic region. This is known as "guaranteed issue."

"Guaranteed renewal" means that a health plan may not cancel a small employer's coverage just because one or more enrollees has a condition that generates high health plan costs. A plan may cancel coverage in the event of fraud, failure to pay premiums, or noncompliance with participation or contribution requirements.

Rating Protections

California does not set health plan rates or require rates to be approved by state regulators. State legislators are currently wrestling with the issue of requiring state approval of premium increases. California law does limit a health plan's ability to charge low rates to groups whose members are all in good health and high rates to groups that include sicker or riskier individuals. The rating protections operate by basing premium calculations on a "standard" rate that every health plan develops according to certain allowable factors. Plans must set actual premiums no more than 10 percent above or below the standard rate. This creates a "rate band" that allows the health plan to adjust employer rates for risk factors such as previous use of health services or industry type.

Limitations on Preexisting Condition Exclusions

- **Benefits for small employers.** AB1672 prevents insurers from denying coverage to a small employer on the basis of preexisting conditions. In addition, as described in the Rating Protections section above, an insurer may not charge a small employer more than 110% of its standard premium.
- **Benefits for employees.** Certain plans require new enrollees to be covered for a period of time before the plan will pay benefits for a preexisting condition. This period is called a "preexisting condition waiting period" and can extend up to 12 months. Under AB1672, enrollees whose medical coverage ends within 62 days of becoming eligible for a new medical plan can receive "credit" toward meeting the waiting period. This ability to apply "creditable coverage" from one plan to the next is often referred to as "portability." (In 2014 when the Affordable Care Act is fully implemented, waiting periods will be limited to 90 days and preexisting condition exclusions will no longer be permitted.)

Access to Information

Insurers—as well as agents and brokers—are required to follow certain rules designed to ensure that small employers have access to the whole range of an insurer's product offerings, with accurate and understandable information about their options and rights. To facilitate comparison-shopping, the law generally requires carriers to produce and provide various materials, including a summary brochure of all its benefit plan designs.

Small employers must be notified about standard employee risk rates and the impact of the risk adjustment factor in determining actual premiums. Once a premium is quoted, small employers will have 30 days to exercise the right to buy at the quoted rate.

Insurers, as well as agents and brokers, are prohibited from refusing or discouraging an application based on risk factors (such as health status, claims history, industry, occupation, or geographic location). Plans and agents are also prohibited from trying to steer "bad risks" to particular insurers or products.

California Mental Health Parity Law AB 88

Type of law: State.

Who's affected: All California employers who offer private medical insurance coverage.

What it does: For certain severe mental health conditions (including schizophrenia, bipolar disorder, major depressive disorders, and several others) or serious emotional disturbance of a child, health plans may not impose limitations or exclusions on mental health benefits that exceed those imposed on medical conditions in general. Plans may not impose higher copayments or deductibles for these conditions, nor may they impose different maximum lifetime benefits (caps) for these conditions. If the plan covers prescription drugs, prescription drugs for these conditions must also be covered.

What you need to do: There are no legal requirements for employers, but you may want to let your employees know that this law exists, and that they have the following rights:

- To a second opinion regarding diagnosis and treatment;
- To file a grievance through their health plan and then follow up through the Department of Managed Health Care if they believe that medically necessary care has been denied, delayed, or modified.

San Francisco Health Care Security Ordinance (HCSO)

Type of law: Local.

Who's affected: Firms with employees working in San Francisco.

What it does: The HCSO requires that "covered employers" make specified "health care expenditures" on behalf of "covered employees." Covered employers include for-profit companies with 20 or more employees and nonprofit companies with 50 or more employees. Covered employees include any employee working in San Francisco who has been employed for 90 days and who works ten or more hours per week (dropping to eight hours in 2009). In addition to requiring that health care expenditures be made, the HCSO mandates that covered employers maintain certain records, provide certain notice to employees, and report compliance to the city.

What you need to do: You will be considered a covered employer if you are a for-profit company with 20 or more employees or a nonprofit company with 50 or more employees regardless of where those employees work. If your company meets that standard, and any of your employees performs ten or more hours of work per week within the geographic boundaries of San Francisco, you will be required to make health care expenditures on behalf of the covered employee(s). Exemptions exist for certain employees, such as managers and supervisors.

Employers can meet their health care expenditure obligations in a number of ways:

- Payments to a health insurer to provide coverage for covered employees;
- Contributions on behalf of covered employees to a health spending account, such as a health reimbursement arrangement, a flexible spending account, or a medical/health savings account;
- Cash reimbursements to covered employees for expenses incurred in the purchase of health care services, such as doctor and pharmacy bills; and

Paying a health care provider directly for services rendered to covered employees.