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Small Employer Coverage Under the ACA: California vs. Federal Provisions

California HealthCare Foundation

Since passage of the federal Affordable Care Act (ACA) in 2010, California has enacted implementing state legislation in key areas, including establishment of a state-administered exchange, health insurance premium rate review, benefit standards and cost-sharing limits, and detailed rules for the offer and sale of private coverage to individual and small employer groups. These measures were taken in the context of pre-existing state laws and programs, requiring policymakers to analyze and reconcile state and federal standards.

Prior to passage of the ACA, California already had extensive state law requiring carriers in the state to guarantee availability of coverage for small employer groups of 2-50 employees. To implement the ACA, California retained, and as necessary revised, its existing statutory framework.

This overview compares California law and the ACA affecting the offer and sale of small employer health insurance **effective January 1, 2014**.[1]

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Application of Requirements	
Size of Small Employers	
For plan years from 1/1/14 until 12/31/15, "small employer"[2] means one who: ■ Is actively engaged in business or services on at least 50% of its working days during the preceding calendar year or quarter and was not formed primarily for purposes of buying health coverage. ■ Employed at least 1 but not more than 50 "eligible employees," the majority of whom were employed in this state, and for whom a bona fide employer-employee relationships exists. ■ Offers coverage to all eligible employees, as defined. Starting for plan years beginning 1/1/16, requirements apply to groups of up to 100 eligible employees. California retained existing elements of state law defining small employers for purposes of guaranteed issue, including the requirement that the majority of employees in the group must reside in the state. The new ACA-compliant provisions extend eligibility to groups of 1 instead of limiting eligibility to employers of 2–50 employees. California law requires that the definition of small employer be consistent with the ACA but is silent on the question of "owner-only" groups with no common law employees (such as sole proprietors, including those with a spouse active in the business). Consistent with federal law, owner-only groups are not eligible for guaranteed small group coverage. ✚ S [HSC §1357.500, §1357.503, §1357.600; CIC §10753, §10753.05, §10755]	"Small employer" means one who both: ■ Employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year. ■ Employs at least 1 employee on the first day of the plan year. Until 1/1/16, states may limit "small employers" to businesses with not more than 50 employees. Internal Revenue Service rules for determining what constitutes a single employer also apply. [42 USC §18024; ACA §1304] (45 CFR §155.20) The ACA and implementing federal rules base the definitions of "employer," "employee," "small employer," and "large employer" on the definitions in the PHSA, which predated the ACA. Section 2791 of the PHSA incorporates by reference the definition of employee in section 3(6) of ERISA, which also provides that an employer is defined by reference to section 3(5) of ERISA. To be an employer eligible to purchase guaranteed small group coverage, including coverage through the SHOP, the employer must employ at least one common law employee. For ACA purposes, therefore, an employee would not include a sole proprietor or spouse. (29 CFR §2510.3–3[c])

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Abbreviations, page 8. [ ] Denotes statutory citations. ( ) Denotes regulatory citations.

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Eligible Employees	
Eligible employees include: ■ Permanent employees actively engaged in the business of the employer for an average of 30 hours per week over the course of a month. ■ Permanent employees working 20–29 hours if they are otherwise eligible except for their hours and have worked at least 20 hours for 50% of the weeks in the previous calendar quarter. California retained the definition of eligible employee, amended to incorporate the IRC definition of a full-time employee, changing from employees who worked *at least* 30 hours in a normal workweek to employees with *an average* of 30 hours over the course of a month. ✚ S [HSC §1357.500, §1357.600; CIC §10753, §10755]	The ACA does not include a definition of employee specifically but relies on pre-existing definitions in the federal Employee Retirement Income Security Act of 1974 and the Public Health Services Act that define an employee as any individual employed by an employer. [PHSA §2791; 42 USC §300gg-91; 29 USC §1002] (See 45 CFR §155.20.) Internal Revenue Code §4980 defines which employees are treated as full-time employees for purposes of the federal shared employer responsibility provisions applicable to employers with more than 50 employees.
Guaranteed Associations	
California retained small group law defining "guaranteed associations" for purposes of guaranteed issue coverage. The California definition is similar to the federal definition but construes associations more narrowly, generally limiting guaranteed issue to those associations meeting specified criteria and which were already providing health insurance to their members prior to passage of California's small employer law in 1992. Health coverage through an association unrelated to employment is considered individual coverage pursuant to federal rules. ✚ S [HSC §1357.500, §1357.503, §1357.600; CIC §10753, §10753.05, §10755]	Federal law defines a "bona fide association," for purposes of health insurance coverage, so that an association must meet specific criteria, including that it exists for purposes other than obtaining insurance and that membership in the association is not based on an individual's health status. [PHSA §2791; 42 USC §300gg–91] Coverage provided to associations, but not related to employment, and sold to individuals, is not considered group coverage but is considered individual coverage. (45 CFR §144.102)
Guaranteed Issue and Renewal	
Guaranteed Availability (Guaranteed Issue) (Similar provisions as those applicable to individual coverage)[3]	
On and after October 1, 2013, health plans and health insurers (collectively, "issuers")[4] must fairly and affirmatively offer, market, *and sell*[5] all non-grandfathered[6] health benefit plans,[7] for policy years beginning on or after January 1, 2014, to all eligible small employers in the issuer's service area(s). Applies to issuers inside and outside of the exchange. ✚ S [HSC §1357.503; CIC §10753.05]	Issuers offering coverage in the group market must offer all products sold to groups and accept every employer that applies, except for grandfathered coverage. Issuers have the option to impose open enrollment periods with specific related requirements, as below. [ACA §1201; PHSA §2702; 42 USC §300gg-1] (45 CFR §147.140)
Issuers cannot have any conditions for eligibility or continued eligibility based on health status–related factors outlined in law. ☑ S [HSC §1357.52, §1357.503, §1357.604; CIC §10753.05, §10755.08, §10198.9]	Same prohibited health status factors. [ACA §1201; PHSA §2705; 42 USC §300gg-4]

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Exclusions and Exceptions	
Issuers can deny coverage to small employers if: ▪ Eligible employees and dependents don't live, work, or reside in the issuer's service area. ▪ Issuer demonstrates to the *satisfaction of regulators* that they do not have delivery system capacity in the service area (or portion of a service area) or financial capacity to underwrite new coverage, if applied uniformly to all groups. An issuer exercising an exception is unable to offer coverage to any small employer for at least 180 days, as specified, or until it notifies or demonstrates to regulators that it has addressed the capacity issues, as required. ▪ California regulators (California Department of Insurance [CDI] and Department of Managed Health Care [DMHC]) retain the authority to require issuers to discontinue offering new coverage if the regulators find the issuer does not have sufficient financial, organizational, or administrative capacity. ✚ S [HSC §1357.509, §1357.611; CIC §10753.11, §10753.12]	Similar federal exceptions apply to "network plans," defined as issuers who deliver and finance medical care, in whole or in part, through a defined set of contracted providers (45 CFR §144.103). [ACA §1201; PHSA §2705; 42 USC §300gg-1] (45 CFR §147.104)
Issuers may not impose any coverage exclusion or limitation because of a pre-existing condition. Applies to grandfathered and non-grandfathered coverage. ✚ S [HSC §1357.51, §1357.506, §1357.607; CIC §10753.08, §10755.08, §10198.7]	Same prohibition for all issuers of non-grandfathered group coverage. [ACA §1201; PHSA §2704; 42 USC §300gg-3] (45 CFR §147.108)
Issuers may not require an applicant or dependent to fill out a health assessment or questionnaire prior to enrollment, or acquire or request information that relates to a health status factor from any source prior to enrollment. ✚ S [HSC §1357.503; CIC §10753.05]	There is no similarly broad prohibition, though issuers of group coverage may not request, require, or purchase genetic information prior to enrollment or for underwriting purposes. [42 USC §300gg-53] (45 CFR §146.122)
Group Contribution and Participation Requirements	
Existing state law applies to non-grandfathered and grandfathered plans requiring issuers to file with regulators reasonable participation requirements (e.g., percentage of employees that must enroll in coverage with the issuer) and contribution requirements (employer contribution to employee premiums) and apply the requirements uniformly. Participation requirements may vary by group size but contribution requirements may not. ✚ S [HSC §1357.503, §1357.604; CIC §10753.05, §10755.06]	Issuers may refuse to renew coverage for a small employer that violates issuer participation or contribution requirements pursuant to applicable state law, as defined. (45 CFR §147.106)

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Guaranteed Renewability	
Issuers must renew coverage at the option of the small employer except when state and federal law and regulation permit cancellation, rescission, or non-renewal. Pursuant to already existing California law, grandfathered plans are also guaranteed renewable. [HSC §1365, §1357.03, §1357.604; CIC §10273.4, §10753.13, §10755.05, §10755.13] California revised state law and regulations to prohibit coverage rescissions, except in the case of fraud or misrepresentation of material fact, as specified, and to establish an appeals process with state regulators for when coverage is rescinded, cancelled, or not renewed. ✚ S [HSC §1365, §1368(a)(6), §1389.3, §1389.21; CIC §10273.7, §10384.17; 10 CCR 2270.50 et seq., 10 CCR 2270.70 et seq.]	Issuers must renew or maintain coverage at the option of the plan sponsor, except for one or more of the following: ▪ Nonpayment of premium. ▪ Fraud. ▪ Enrollee moving out of the service area of a network plan. ▪ Discontinuing a particular product, with a required 180-day notice and the offer to purchase any other group product on a guaranteed availability basis. Must be applied uniformly to all groups. ▪ Failure to comply with issuer participation or contribution requirements. ▪ Issuer ceasing to offer coverage to individuals (specific notices required, and issuer may not issue coverage to groups for five years). [ACA §1201; PHSA §2703; 42 USC §300gg-2] (45 CFR §147.106)
Enrollment and Coverage Periods	
Coverage Year	
California retained the ability of employers to purchase guaranteed coverage at any point during the year, and made ACA market and rating reforms applicable to the plan year, which for each employer begins the month that coverage begins for that employer. (By contrast, individual market coverage in the state is from January 1 to December 31.) ✚ S [HSC §1357.500; CIC §10753]	Issuer must allow an employer to purchase coverage at any point during the year. In the small group market, an issuer may limit the availability of coverage to an annual enrollment period that spans November 15 through December 15. (45 CFR §147.104[b][2])
Enrollment Periods	
Issuers inside and outside of the exchange must provide enrollment periods and special enrollment periods (for changes in coverage or life circumstances as described in 45 CFR §155.420) consistent with the ACA and federal rules, by reference to specific federal SHOP rules (45 CFR §155.725); however, certain events trigger special enrollment opportunities only in the exchange (e.g., change in an employee's citizenship or status as a legal resident). To gain guaranteed coverage, a small employer must agree to inform its employees of the availability of coverage and that those who do not elect coverage and later wish to do so must wait until the next open enrollment period or a special enrollment period. ☑ S [HSC §1357.503; CIC §10753.05]	Issuers *may* limit availability to open or special enrollment periods. If availability is limited to open enrollment periods, issuers must establish special enrollment periods for specified qualifying events. [ACA §1201; PHSA §2702; 42 USC §300gg-1] (45 CFR §147.104, §155.420, §155.725)

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Waiting Periods	
Continues the requirement in existing California law that HMOs (as defined in federal law) may impose an affiliation period of up to 60 days or issuers may impose a waiting period of up to 60 days as a condition of employment if the waiting period is applied equally to all eligible employees and dependents.[8] ✚ S [HSC §1357.506(b), §1357.607; CIC §10753.08(b), §10755.08]	Prohibits group health plans and issuers of group coverage from imposing any waiting period for coverage greater than 90 days. [ACA §1201; PSHA §2708; 42 USC §300gg-7]
Coverage Effective Dates	
Issuers must make coverage effective consistent with detailed timelines in state law, which generally mirror federal rules for exchanges and are the same as those for the individual market. Exchange effective dates may vary from the outside market as determined by the exchange. ☑ D [HSC §1357.504; CIC §10753.06.5] (10 CCR §6534, §6536)	Coverage effective dates outlined in federal rules apply to all issuers of small group non-grandfathered coverage and generally depend on the dates that premium payments are received. State-administered SHOP must establish effective dates of coverage for qualified employees. (45 CFR §155.720, §155.725)
Rates and Rating Factors	
Rating Factors	
As in federal law, issuers of non-grandfathered coverage inside and outside of the exchange may use only age, geography, and whether the coverage is for a family or individual in setting and adjusting premiums. However, state law does not allow for tobacco rating. California established 19 rating regions for non-grandfathered individual and small group coverage. Pre-ACA California law authorizing up to 9 issuer-determined geographic regions still applies to grandfathered small employer plans. The rating period (benefit year), during which issuers are prohibited from raising rates, for all small employer coverage is no less than 12 months from the date of issuance or renewal of the contract. Prior California law required rates to be in effect for only 6 months. Pre-ACA California law regarding rates and rate setting continues to apply to grandfathered small employer coverage. ✚ S [HSC §1357.512, §1357.600, §1357.612, §1357.613; CIC §10753.14, §10755.14, §10755.15]	Issuers may only vary rates based on: ■ Age, with no more than a 3:1 variation for adults. States may establish an age rating curve, or the federal default curve will apply.[9] ■ Geographic rating areas established by the state consistent with federal rules. ■ Whether coverage is for an individual or a family, with rules for family rating. ■ Tobacco use, except rates cannot vary by more than 1.5:1 for this factor. [ACA §1201; PHSA §2701; 42 USC §300gg] (45 CFR §147.102)

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Risk Pooling — Single Risk Pool	
Issuers inside and outside of the exchange must consider as one single risk pool for rating purposes the claims experience of all enrollees and insureds[10] in non-grandfathered coverage offered by an issuer in the small group market in the state. Rates may only be adjusted beyond the index rate for limited factors, which are generally the same as in federal law.[11] ☑ S [HSC §1357.503(i); CIC §10753.05(k)]	Issuers inside and outside of the exchange must consider as one single risk pool for rating purposes the claims experience of all enrollees in all non-grandfathered health plans offered by an issuer in the small group market in a state.[12] Federal rules outline the formula for issuers to develop an "index rate" based on claims costs for essential health benefits, adjusted for any payments or charges from risk adjustment and reinsurance. [ACA §1312; 42 USC §18032] (45 CFR §156.80)
Regulatory Rate Review	
All issuers must file a rate change for small group coverage, along with specified data and documentation, with the respective state regulator at least 60 days prior to implementing a rate change. Regulators review proposed changes to determine whether the rate increases are unreasonable as defined in state and federal law. California has a CMS-approved effective rate-review program. [HSC §1385.01–1385.13; CIC §10181–10181.13; SB 1163 Guidance] The California Health Benefit Exchange must require issuers to submit a justification for any rate increase and to post the information on their websites. The exchange's board must take into account the plan justifications and information provided to the board from CDI and DMHC about rate increases when determining whether to make the health plan available in the exchange. + S [GOV §100502]	Issuers in states with an effective rate-review program approved by CMS must submit rate increases above specified thresholds to the state and CMS along with a justification for the increase. CMS will adopt state determinations of unreasonableness in states with an effective rate review program, such as California. [ACA §1003; PHSA §2794; 42 USC §300gg-94] (45 CFR §154.200 et seq.) Exchanges must ensure that QHP issuers submit justification prior to a rate increase and post it on their website. The exchange must provide access to the issuer's justification through its website. (45 CFR §155.1020)
Notice of Coverage Options	
Issuers of group coverage must provide a notice to any enrollees or subscribers losing coverage informing them of the availability of coverage in the exchange, and that they may be eligible for reduced-cost coverage in Medi-Cal, as specified.[13] + S [HSC §1366.50; CIC §10786]	No specific similar provision.
California retained and revised prior requirements for issuer disclosures, which must be included as part of issuer solicitation and sales materials for small employers. + S [HSC §1357.514, §1357.614; CIC §10753.16, 10755.16]	Issuers must disclose to applicants the benefits and premiums available under all health insurance coverage for which the employer is qualified. [ACA §1001; PHSA §2709; 42 USC §300gg-9]

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Small Business Health Options Program (SHOP) (Selected provisions)	
Establishment of SHOP	
The California Health Benefit Exchange must establish a SHOP program consistent with federal ACA requirements. ☑ D [GOV §100502]	States that operate state-administered exchanges must provide for the establishment of a SHOP exchange to provide coverage for small employers, as specified. [ACA §1311; 42 USC §18031] (45 CFR §155.100)
SHOP Rules and Standards	
A qualified employer may participate in SHOP upon the submission of specific information. (10 CCR §6520) A qualified employee's initial employee open enrollment period must not exceed 30 days and begins the day the employer submits all of the required information and the SHOP has determined that the employer is qualified. The annual employee open enrollment period must not exceed 30 days and begins 45 days prior to the completion of the qualified employee's plan year and after the qualified employer's annual election period. (10 CCR §6528) A SHOP may initiate and allow an issuer to terminate a qualified employee's QHP coverage in specific circumstances — such as loss of eligibility or failure of the employee to pay premiums — so long as the issuer complies with the ACA and state and federal laws on cancellations, nonrenewals, and rescissions. ☑ D (10 CCR §6538)	The SHOP must permit qualified small employers to purchase coverage for qualified employees through the SHOP. (45 CFR §155.710) A SHOP must establish a uniform enrollment timeline and process for all QHP issuers and qualified employers to follow. (45 CFR §155.720) A SHOP must adhere to the initial open enrollment period set forth in 45 CFR §155.410 and allow a qualified employer to purchase coverage at any point during the year. Employers must also be provided with an annual election period of no less than 30 days prior to completion of the plan year. A SHOP must also establish a standardized annual open enrollment period of no less than 30 days. (45 CFR §155.725) The SHOP must determine the timing, form, and manner under which coverage in a QHP may be terminated. Termination of employer group health coverage may occur at the request of the employer, for nonpayment of premiums, lack of employee or dependent eligibility, rescission (in accordance with 45 CFR §147.128), or employee choice. (45 CFR §155.735)
Employee Choice of Plan	
To purchase coverage in the SHOP, an employer must submit, among other things, the health premium contribution amount for employees and dependents, the employer plan selection for a tier of coverage (bronze, silver, gold, or platinum), and the reference plan. The employee must submit, among other things, the name of the QHP selected by the employee and dependents. ☑ D (10 CCR §6520)	Employers may select any level of coverage made available to employees through an exchange. If an employer selects a level of coverage, employees can choose to enroll in any qualified health plan that offers the level of coverage. [ACA §1312; 42 USC §18032] (45 CFR §155.705)

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Market Study	
The California exchange must report to the Legislature no later than December 1, 2018, on whether to merge the individual and small group markets in the state. ☑ D [GOV §100503]	States may require the individual and small group markets to be merged. [ACA §1312; 42 USC 18032]

Abbreviations

ACA – Affordable Care Act

CCR – California Code of Regulations

CFR – Code of Federal Regulations

CIC – California Insurance Code

GOV – California Government Code

HSC – California Health and Safety Code

PHSA – Public Health Service Act

QHP – Qualified Health Plan

SHOP – Small Employer Health Options Program

USC – United States Code

Endnotes

1. The ACA and related federal rules requiring health insurance issuers to guarantee availability of, and renew coverage at the option of the individual or group, apply to issuers of individual, small group, and large group coverage. This chart focuses specifically on the small group market as defined in state and federal law. Additional details on provisions affecting individual coverage can be found by reviewing CHCF's *Individual Coverage Under the ACA: California vs. Federal Provisions.*
2. The California definition of "small employer" applies to any "person, firm, proprietary or nonprofit corporation, partnership, public agency, or association" meeting the specified criteria.
3. Where the provisions applicable to small employer groups are the same as or very similar to those that apply to individual coverage, this chart includes a general overview and the relevant statutory and regulatory citations.
4. California issuers, sometimes referred to collectively in California law as "carriers," include health care service plans licensed by the California Department of Managed Health Care (DMHC) and health insurers subject to the jurisdiction of the California Department of Insurance (CDI).
5. This wording in California law predates the ACA and was used to impose guaranteed availability requirements on issuers selling coverage to small employers pursuant to AB 1672, Chapter 1128, and Statutes of 1992. The 1992 language was intended to require that issuers *actively market* to all small employer groups regardless of the group health status or claims history, in addition to guaranteeing availability to applicant groups. Separate provisions prohibited using health status or claims experience as eligibility factors for small employer groups. California maintained a similar structure in enacting ACA individual market reforms, continuing the higher legal standard in California law.
6. Individual and small group coverage in effect as of March 23, 2010, that continues to meet federal requirements limiting benefit and coverage changes are considered "grandfathered plans" and are exempt from many of the ACA requirements that generally apply to issuers and coverage in the individual and small group markets. Issuers of grandfathered small employer coverage continue to be subject to the provisions governing small employer coverage that were in effect in California prior to 2014.
7. "Health benefit plan" refers collectively to health care service plan contracts under the HSC and health insurance policies under the CIC.
8. As of this writing, reconciliation of state and federal provisions relating to affiliation and waiting periods is under legislative review.

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Endnotes (Continued)

9. Age rating curves are outlined in federal guidance from the Center for Consumer Information and Insurance Oversight (CCIIO) dated February 25, 2013, available at www.cms.gov/CCIIO/Resources/Files/Downloads/market-reforms-guidance-2-25-2013.pdf.

10. Generally, in the HSC the term for persons enrolled is "enrollees," and in the CIC the term most often used is "insureds."

11. Federal rules require issuers who participate in exchanges to make a market-wide adjustment to the index rate for exchange fees they pay. California implementing law omits that requirement, but issuers would still be required to comply with the federal rule. As of this writing, conformance with federal law regarding the user fees is under legislative review.

12. In comments on the final federal health insurance market rules issued February 27, 2013, CCIIO noted in response to requests for clarification of whether the single risk pool is to be maintained at the holding company level or the individual licensee level that the single risk pool is to be maintained at the licensed entity level (78 Fed. Reg. 13422 [Feb. 27, 2013]). California law includes language that could reflect legislative intent to impose one single risk pool for issuers with enrollees in individual coverage under both DMHC and CDI, but because the California changes are in two separate codes with different terminology, further interpretation by state and federal regulators or legislative clarification may be needed.

13. CDI model notice can be found at: www.insurance.ca.gov/0250-insurers/0300-insurers/0200-bulletins/bulletin-notices-commiss-opinion/upload/ModelNoticesAB.pdf. DMHC model notice can be found at: www.dmhc.ca.gov/library/reports/news/dl14a.pdf.

About the Author

This table was prepared by the Kelch Policy Group, which administers the CHCF-funded Health Insurance Alignment Project.

About the Foundation

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