ISSUE BRIEF: California's State Benefit Mandates and the Affordable Care Act's "Essential Health Benefits"

As of January, 2011

In March, 2010, federal government passed the federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (H.R.4872) enacting health care reform laws that dramatically affect the California health insurance market and its regulatory environment. These laws, referred to here as the Affordable Care Act (ACA), enact a number of provisions that would affect benefits covered by California health insurance plans and policies.

There remains considerable uncertainty around the impacts of the ACA on privately purchased health insurance in California, particularly with the establishment of an Exchange by 2014. Some basic details are specified in the ACA itself that suggest its potential impact, such as the introduction of subsidies and an individual tax penalty for non-coverage in 2014, but forthcoming federal regulations will further clarify the shape of Exchanges. At the state level, recently enacted state legislation (Assembly Bill (AB) 1602 and Senate Bill (SB) 900) to establish a structure for the Exchange provides an initial contour, but further decisions remain. The eventual impact of the Exchange (and the ACA more generally) will depend on many factors that are currently unknown and decisions currently pending.

The focus of this issue brief, however, is on a specific benefit-related provision of the ACA that requires coverage of "Essential Health Benefits" (EHB) for most plans and policies sold in the individual and small group markets, including those that will be provided through the Exchange. The California Health Benefits Review Program (CHBRP) focused on this specific ACA provision because of the Program's statutory charge to analyze proposed legislation that would newly mandate or repeal existing mandates of health insurance benefits.[1] Since the federal EHB requirements would interact with California's existing laws and proposed mandate (or repeal) legislation, CHBRP has produced this issue brief to provide background on what is currently known about the new federal EHB requirements, and thereby provide context for potential interaction effects between these federal requirements and the state bills CHBRP is charged with analyzing. **Because federal regulations defining these categories of benefits have not yet been promulgated, this is a preliminary analysis to highlight issues for consideration.**

Specifically, this brief provides:

- A description of the ACA provisions requiring coverage of "Essential Health Benefits" (EHB) by qualified health plans offered in the Exchange and by certain plans and policies offered outside the Exchange in the small group and individual markets.

[1] The statute that authorizes CHBRP, (Health & Safety Code Section 127660-127665) defines a benefit mandate or repeal bill as proposal that would mandate or repeal, a requirement on a health care service plan or a health insurer to do any of the following: "(1) Permit a person insured or covered under the policy or contract to obtain health care treatment or services from a particular type of health care provider. (2) Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition. (3) Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service." For more information regarding CHBRP, please see www.chbrp.org.

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- A description of state mandated benefits that apply to health care service plans licensed by the Department of Managed Health Care (DMHC) and to health insurance policies regulated by the California Department of Insurance (CDI).
- A discussion of the potential interactions between federal EHB requirements and existing state benefit mandate laws and resulting complexity in implementing related provisions of the ACA.

Essential Health Benefits

Section 1302(b) of the ACA requires some health insurance to cover specified categories of benefits. The EHB categories are:

A. Ambulatory patient services
B. Emergency services
C. Hospitalization
D. Maternity and newborn care
E. Mental health and substance use disorder services, including behavioral health treatment
F. Prescription drugs
G. Rehabilitative and habilitative services and devices
H. Laboratory services
I. Preventive and wellness services and chronic disease management
J. Pediatric services, including oral and vision care

The Secretary of Health and Human Services (HSS) is charged with defining these categories through regulation, ensuring that the EHB floor "is equal to the scope of benefits provided under a typical employer plan." To inform this determination, the Secretary of Labor will conduct a survey of employer-sponsored coverage and will provide a report to the Secretary of Health and Human Services, though the ACA does not specify the timetable of this survey.

In addition, the Secretary of HHS has requested that the Institute of Medicine (IOM) conduct a study that will ultimately make recommendations on the criteria for determining the EHBs. The IOM study will not make recommendations on the specific benefits to be included in the EHB package. Instead, the study will "review how insurers determine covered benefits and medical necessity and will provide guidance on the policy principles and criteria for the Secretary to take into account when examining QHPs for appropriate balance among categories of care; the health care needs of diverse segments of the population; and nondiscrimination based on age, disability, or expected length of life."[2]

The Secretary expects to publish the Notice of Proposed Rulemaking for matters related to the Exchange in the spring of 2011 and will publish further guidance later in 2011 and 2012.[3]

Health Plans and Polices Required to Cover EHBs

Section 1301(a) requires that "qualified health plans" (QHPs)—the health insurance plans that may be offered to the small group and individual group market through the Exchange—cover EHBs by 2014.

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[2] IOM. *Activity: Determining Essential Health Benefits*. Available at: http://www.iom.edu/Activities/HealthServices/EssentialHealthBenefits.aspx. Accessed on December 6, 2010.

[3] According to recent guidance published by the federal DHHS, it is a state's decision to require QHPs to provide benefits in the Exchange that go beyond the Essential Health Benefits. However, the federal government may offer recommendations and technical assistance (www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html. Accessed December 21, 2010).

In addition, Section 2707 of the ACA requires health insurance plans offered in the small group and individual markets *outside of* the Exchange to also cover EHBs as defined under Section 1302(b).

Large groups and self-insured plans will not be required to provide EHBs (Monahan, 2010). As mentioned, the EHB categories will be defined to mirror those benefits offered by a "typical" employer plan. Thus, the definition of the EHB categories will depend on how the Secretary of Labor interprets "typical" employer plan when designing and implementing the survey. If the survey is designed to represent the most number of enrollees, then the results will reflect the experience and benefit designs of large-size firms. If the survey is designed to represent the most number of employers, then the results will reflect the experience and benefit designs of mid- and small- size firms. Whether large group health plans' benefit package will align with EHB will depend on the results of the DOL survey and which plans are defined as "typical."

In summary, effective 2014, the following market segments will be subject to EHB requirements (unless otherwise specified):

Large Group Market, including self-insured plans
- Not subject to the EHB requirements[4]

Small Group Market
- QHPs purchased by small groups in the Exchange
- Insurance plans and policies purchased outside the Exchange in the small group market
- It is possible that "grandfathered" small group plans that continue to exist in 2014 may be exempt for EHB requirements, however this is not explicitly discussed in the federal Interim Final Rule (IFR) related to grandfathering status[5]. The same IFR projects that by 2013, approximately 50%-80% of small groups would have relinquished their grandfathering status.

Individual Market
- QHPs purchased by individuals in the Exchange, including catastrophic plans for eligible individuals
- Insurance plans and policies purchased outside the Exchange in the individual market
- For the individual market, under Section 2016, states have the option of entering into an Interstate Health Care Choice Compact. Plans offered through a Compact must cover EHBs.
- It is possible that "grandfathered" individual plans would continue to exist in 2014 and therefore will be exempt from EHB requirements. This is not explicitly discussed in the IFR clarifying grandfathering status. But the same IFR projects that every year, 40-67% of individual plans would relinquish their grandfathering status, and therefore most of the individual market would be comprised of "new plans" by 2013—which will be subject to the EHB requirements.

Other
- CO-OP plans[6]
- Multi-State Plans, offered by the federal Office of Personnel Management (OPM)[7]

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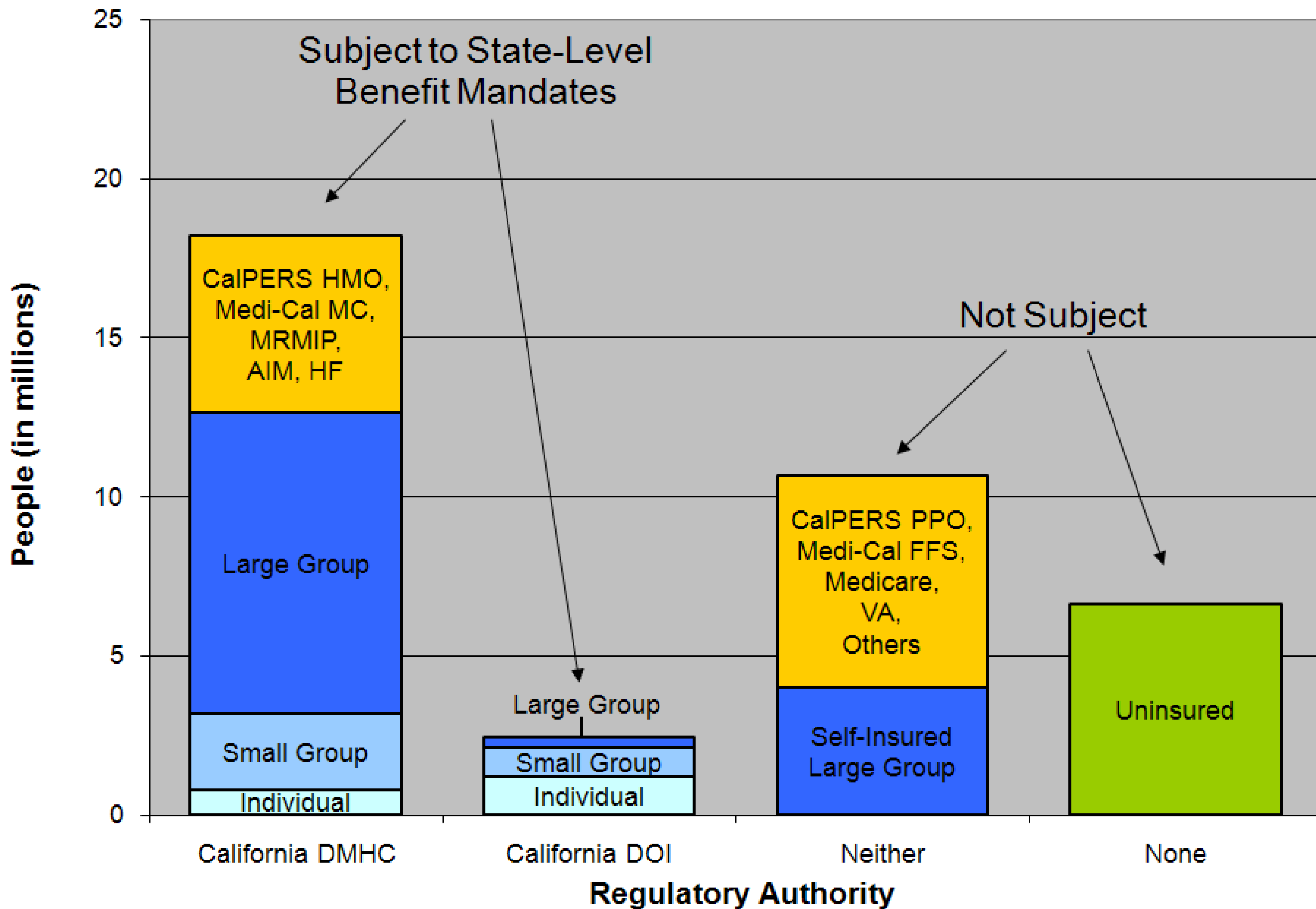
[4] Effective 2017, states may allow large group purchasing through the Exchange, which would subject large group plans and policies to EHB requirements (ACA Section 1312(f)(2)(B)).
[5] Department of the Treasury, Department of Labor, and Department of Health and Human Services. *Group Health Plans and Health Insurance Coverage Relating to Status as a Grandfathered Health Plan Under the Patient Protection and Affordable Care Act; Interim Final Rule and Proposed Rule*, Federal Register: 75: 116: pages 34538-34570, June 17, 2010.
[6] ACA Section 1322 defines and appropriates funding for the establishment of "CO-OP" plans: nonprofit, member-run health insurance issuers offering qualified health plans in the individual and small group markets.
[7] ACA Section 1334 directs OPM to offer at least two qualified health plans (defined as covering EHBs) in each state Exchange.

State Benefit Mandates in California

Health Plan and Polices Required to Cover State Benefit Mandates
State benefit mandates only apply to health insurance regulated at the state-level by either the California Department of Insurance (CDI) or the Department of Managed Health Care (DMHC). Thus, about 51% of Californians currently have health insurance subject to state benefit mandates. Figure 1 provides an illustration of the relative enrollment sizes of health insurance subject to state benefit mandates (DMHC- and CDI-regulated) and that which is not.

Figure 1: Estimated Sources of Health Insurance in California by Regulatory Authority, 2010



Source: CHBRP, *California Health Benefits Review Program: Estimates of Sources of Health Insurance in California, 2010*.
Note: These figures are CHBRP's estimates as of December, 2009. These estimates will be updated in January, 2011.

As the figure illustrates, two significant populations *do not* have health insurance subject to state benefit mandates:

- the uninsured (an estimated 17% in 2010)
- enrollees with insurance not regulated at the state level (an estimated 32% in 2010), including self-insured large groups plans and a variety of publicly funded health insurance

The outline below explains the types of health insurance subject to state benefit mandates.

<u>Large Group Market</u>

- DMHC-regulated and CDI-regulated large group plans and policies
  (Self-insured health insurance plans, regulated under ERISA, are *not* subject)

Small Group Market

- Qualified Health Plans (QHPs) sold within the Exchange. These will presumably be licensed by the DMHC or the CDI.[8]
- All plans and policies sold outside the Exchange

Individual Market

- Qualified Health Plans (QHPs) sold within the Exchange. These will presumably be licensed by the DMHC or the CDI.
- All plans and policies sold outside the Exchange

Publicly-funded insurance[9]

- DMHC-regulated publicly funded health care service plans, including
    - Medi-Cal Managed Care plans
    - CalPERS HMO plans
    - MRMIB-administered plans regulated by DMHC, including
        - Healthy Families Program,
        - Access for Infants and Mothers (AIM), and
        - MRMIP (Major Risk Medical Insurance Program)

Characteristics of DMHC-Regulated Health Insurance

As illustrated in Figure 1, about 45% of Californians have health insurance regulated at the state-level by DMHC and subject to state benefit mandates contained in the Health & Safety (H&S) Code.

- DMHC-regulated health insurance includes HMO, POS, and some PPO plans.
- This includes privately purchased insurance (large group, small group, and individual markets[10]) as well as some publicly funded insurance (CalPERS HMO, Medi-Cal Managed Care, Healthy Families, AIM, and MRMIP).
- DMHC oversees the majority of state-regulated group health insurance (90% of state-regulated, privately purchased group insurance in 2010).

Characteristics of CDI-Regulated Health Insurance

About 6% of Californians have health insurance regulated at the state-level by CDI and subject to state benefit mandates contained in the Insurance Code.

- CDI-regulated policies include some PPO plans and indemnity insurance.
- All policies regulated by CDI are privately purchased (through either the large group, small group, or individual markets).
- While DMHC regulates the majority of health insurance subject to state mandates (by virtue of the small and large group markets' enrollment size), CDI regulates about 60% of the individual market.

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[8] AB 1602 (Perez, 2010) and SB 900 (Alquist, 2010) established the California Health Benefit Exchange. This newly enacted state law require that carriers contracting with the Exchange be licensed and in good standing with either DMHC or CDI. (California Government Code, Section 100507(b))

[9] Publicly funded insurance that is not subject to state benefit mandates includes CalPERS PPO, Medi-Cal FFS, the Pre-Existing Condition Insurance Plan (PCIP) administered by MRMIB, and federal public health insurance programs (Medicare, TriCare, VA).

[10] The ACA defines a large group as >100 employees, whereas state law currently defines it as >50. However, ACA Section 1304(b)(3) allows states to treat groups between 50 and 100 as small for plan years beginning before 2016.

Current California Benefit Mandates

There are 42 benefit mandates within California's Insurance Code, applying to health insurance policies regulated by CDI. There are 45 benefit mandates currently in the Health & Safety Code, applying to health care service plans regulated by DMHC. Additionally, all DMHC-regulated health plans are required to cover a floor of medically necessary "basic health care services."[11]

Attachment A includes a list of current mandates in the California Health & Safety and Insurance Codes, sorted into the EHB category framework. This is provided primarily as a point of reference to discuss the potential interaction of state benefit mandates and EHBs as well as highlight outstanding issues which will need to be clarified as state policymakers and regulators pursue implementation efforts. Attachment A is organized as follows:

1. The first column provides the name of the EHB category, BHCS category, or a description of the mandate.
2. The second to fifth columns describe to which types of health insurance a mandate applies (e.g., DMHC-regulated group plans).
3. The sixth column describes whether the mandate requires a plan or policy to cover the benefit, or to *offer* coverage for the benefit.
4. The seventh column shows other potential EHB categories under which the mandated benefit may fall.
5. The eighth column provides a cross-reference to CHBRP's more detailed listing of current mandates (Attachment B).

Potential Interaction: EHB Requirements and Existing State Benefit Mandates

Given the various markets to which state benefit mandates and EHB requirements will apply, and given the range of affected health benefits, there is a complex range of issues for policymakers and regulators to consider as 2014 nears. In addition, it would be important to consider what benefits the marketplace would cover without an explicit mandate. So while both state benefit mandates and the EHB require coverage of certain benefits, some benefits are likely to be covered by the marketplace absent the legal requirement due to demand.[12] Thus, to understand the effective "marginal impact" of a benefit mandate requires understanding what portion of the marketplace would have covered the benefit or service without the legal requirement to do so.

Adding to the complexity is the provision of the ACA related to fiscal costs for state benefit mandates. Beginning in 2014, enrollees in the individual or small-group markets who purchase health insurance through the Exchange will qualify for federal tax subsidies. The ACA requires that states bear the additional cost for any state-level benefit requirements that go beyond the defined EHBs. Section 1311(d)(3)(B) states:

> *…a State may require that a qualified health plan offered in such State offer benefits in addition to the essential health benefits specified under section 1302(b).*
> *(ii) STATE MUST ASSUME COST- A State shall make payments—*

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[11] "Basic health care services" is delineated in California Health & Safety Code, Section 1345, and California Code of Regulations, Section 1300.67. Further explanation of BHCS is included in Attachment B.

[12] For one recent discussion of the marginal cost of benefit mandates, see pages 8-10 of CHBRP's Issue Analysis, *Assembly Bill 2587: Benefit Mandates*. Available online at: http://www.chbrp.org/docs/index.php?action=read&bill_id=106&doc_type=4

(I) to an individual enrolled in a qualified health plan offered in such State; or
(II) on behalf of an individual described in subclause (I) directly to the qualified health plan in which such individual is enrolled;
to defray the cost of any additional benefits described in clause (i).

There remains ambiguity about this provision, which is expected to be clarified further in forthcoming federal regulations. Assessing the potential for state costs will require understanding

- the number of enrollees in QHPs,
- what populations will be enrolled in plans and policies subject to EHB and state mandated benefits,
- which benefits will be considered part of the EHBs and which benefits are considered as being "in addition to" the EHB,
- how "costs" and "payments" for additional benefits are defined. For example, would definitions include
    - marginal premiums associated with the *mandate* (i.e. the requirement to cover the benefit); or marginal premiums associated with the full benefit.
    - out-of-pocket costs (i.e. copayments, co-insurance, deductibles)
    - for small group enrollees, the costs borne by the employer versus the enrollee?
- the specific formula that will be used to calculate a state's liability.

The National Association for Insurance Commissioners issued model language for establishing the Exchange. They propose states that require additional benefits measure associated costs on a net-cost basis, "considering both the costs of the service and any associated savings, based on an evidence-based methodology to determine the net cost, if any, of each additional benefit, and the value of the benefit to the State's residents. States also should be aware of the potential conflicts and opportunities for adverse selection created by having inconsistent benefits inside an Exchange and outside an Exchange."[13]

Differences in affected populations between the EHB and state benefit mandates
The types of plans and policies and market segments affected by state benefit mandates and the EHB requirements overlap in some areas, but are distinct. For example, a large group DMHC-regulated plan will be subject to state benefit mandates but not the EHB requirements. As mentioned, the EHB categories will be defined to mirror those benefits offered by a "typical" employer plan. Whether large group health plans' benefit package will align with EHB will depend on the results of the DOL survey and which plans are defined as "typical", as well as subsequent regulations yet to be promulgated.

Basic Health Care Services
Beyond differences in specific state benefits mandates, DMHC-regulated health plans are required to cover a floor of medically necessary "basic health care services", whereas CDI-regulated policies do not have these requirements.[14] In addition, the categories of benefits specified under the BHCS requirements do not align neatly with the EHB requirements. Table 1 below illustrates the differences.

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[13] NAIC. American Health Benefit Exchange Model Act. Available at: http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf. Accessed on December 23, 2010.

[14] Although the Knox-Keene Act governing DMHC-regulated plans does not explicitly state that "basic health care services" means all "medically necessary" basic health care services, there are numerous provisions within the act that reference "medical necessity" and that place requirements on plans in terms of what they must do when denying, delaying or modifying coverage based on a decision for medical necessity.

Table 1: Basic Health Care Services Categories and EHB Categories

EHB Categories (ACA, Section 1302(b))	**BHCS Categories** (Health and Safety Code, Section 1345)
Ambulatory patient services	Ambulatory care services Physician services, including consultation and referral
Emergency services	Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.
Hospitalization	Hospital inpatient services
Maternity and newborn care	N/A
Mental health and substance use disorder services, including behavioral health treatment	N/A
Prescription drugs	N/A
Rehabilitative and habilitative services and devices	Home health services Hospice care
Laboratory services	Diagnostic laboratory and diagnostic and therapeutic radiologic services
Preventive and wellness services and chronic disease management	Preventive health services
Pediatric services, including oral and vision care	N/A

There are five seeming discrepancies noted in Table 1 for the EHB categories of maternity and newborn care, mental health services, substance use disorder services, prescription drugs, and pediatric services, including oral and vision care. These are worth discussing in further detail.

Maternity and newborn care

While the California statute related to BHCS does not explicitly mention maternity and newborn care, DMHC-regulated plans are required to cover maternity and pregnancy-related care under laws governing emergency and urgent care (H&S, Section 1317.1) In addition, regulations defining basic health care services specifically include coverage for medically necessary services such as physician services, ambulatory and hospital services and prenatal care as preventive care (California Code of Regulations, Title 28, Section 1300.67). Therefore, coverage for maternity and newborn care would be considered currently required for DMHC-regulated group and individual plans.

Under Title VII of the federal Civil Rights Act, employers may not discriminate on the "basis of pregnancy, childbirth, or related medical conditions." Employers that offer health insurance and have 15 or more employees must cover maternity services benefits at the same level as other health care benefits. Thus, under federal law members obtaining health insurance in group market have coverage for maternity services.[15]

CDI-regulated policies are not explicitly required to cover maternity services. CHBRP estimates approximately 18% of the CDI-regulated individual market have coverage for maternity services. Therefore this EHB requirement would require a substantial portion of the CDI-regulated individual

[15] The Pregnancy Discrimination Act under Title VII of the Civil Rights Act of 1964

market (which represents about 60% of the *total* CDI- and DMHC- regulated individual market) to make changes by 2014 (CHBRP, 2010a).

Mental Health Services

Under current state law, DMHC-regulated plans and CDI-regulated policies are required to cover the diagnosis and medically necessary treatment of conditions specified as severe mental illnesses (SMI)[16] of a person of any age, and of serious emotional disturbances (SED) of a child. Coverage is required to be at "parity," that is, under the same terms and conditions applied to other medical conditions (e.g. cost-sharing, limitations). California's mandate applies to the large group, small groups, and individual markets.

Under California state law, DMHC- and CDI-regulated plans are required to cover mental health services for SMI/SED conditions. Other conditions are not explicitly required and may be excluded by plan contracts or policies. Based on an analysis of AB 1600 (a proposal to expand the current mental health mandate to all mental health conditions and substance use disorders at parity levels) CHBRP found that approximately 32% of the population enrolled in CDI-regulated and DMHC-regulated plans had coverage for mental health services but with some limitations. In addition, about 1.4% of enrollees had no coverage for mental health services, other than for those already mandated. Therefore, these plans may have to expand coverage depending on the scope of mental health benefits that will be required under the essential health benefits.

In addition, under the recently enacted federal Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008, health plans that cover mental health or substance use disorders to groups must provide coverage that is no more restrictive than coverage for other medical/surgical benefits. This parity provision applies to financial requirements (e.g., deductibles and copayments) and treatment limitations. The law applies to all group plans with greater than 50 employees. Section 1311 of the ACA specifies that the MHPAEA parity law applies to the new qualified health plans (that is, all plans sold in the Exchange) "in the same manner and to the same extent as such section applies to health insurance issuers and group health plans." This clause may be interpreted to mean that the MHPAEA exemption for small groups would *not* apply to qualified health plans that will be sold to small groups and individuals through the Exchange. However, there remains some ambiguity and this interaction between the MHPAEA and the ACA will need to be clarified.

Substance Use Disorders

There is no explicit requirement for DMHC- or CDI-regulated plans to cover substance use disorders. Under the federal MHPAEA, *if* substance use disorders are covered, they must be covered at parity. In addition, California law requires insurers to offer group purchasers coverage for the treatment of alcoholism.[17] CHBRP's analysis of AB 1600 found that approximately 35% of enrollees in CDI-regulated and DMHC-regulated plans had coverage for substance use disorders but with some limitations (CHBRP, 2010b). About 10% of enrollees had no coverage for substance use disorders. Therefore certain plans and polices will have to expand coverage for substance use disorders, but again, the scope of this required coverage will need to be clarified by forthcoming regulations.

Prescription Drugs

While there is no explicit requirement for DMHC- or CDI-regulated plans to cover prescription drugs, approximately 97% of enrollees in these markets have coverage for outpatient prescription drug

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[16] H&S Code Section 1374.72 specifies the SMI conditions as: Schizophrenia, Schizoaffective disorder, Bipolar disorder (manic-depressive illness), Major depressive disorders, Panic disorder, Obsessive-compulsive disorder, Pervasive developmental disorder or autism, Anorexia nervosa, and Bulimia nervosa.

[17] H&S Code Section 1367.2(a); Insurance Code Section 10123.6

benefits (CHBRP, 2010c). Under existing regulations that apply to DMHC-regulated plans, "Every health care service plan that provides coverage for outpatient prescription drug benefits shall provide coverage for all medically necessary outpatient prescription drugs" with certain exceptions as clarified in regulations.[18]

The EHB requirement to cover "prescription drugs" does not explicitly state that this requirement is for *outpatient* prescription drugs (e.g. drugs obtained at a pharmacy), though it may a reasonable interpretation.

Pediatric Services, including Oral and Vision Care

A number of California-specific benefits mandates may overlap or fall into the category of "pediatric services." Take the example of the requirements in state law to cover preventive services for children. DMHC- and CDI- regulated group plans are required to cover comprehensive preventive benefits for children under age 16, including, recommended immunizations, periodic health evaluations, and laboratory services in connection with periodic health evaluations.[19] For children aged 17-18, preventive benefits are required to be *offered* to groups for purchase.[20] DMHC-regulated group and individual plans are required to cover preventive services (such as recommended immunizations).[21] Current coverage for preventive services for children is estimated to be approximately 100% in the group market and 88% in the individual market and the gaps in coverage for preventive services fall in the CDI-regulated individual market (CHBRP, 2010d).

There are no current California mandates applying broadly to "oral care" or "vision care" for children. However, there are specific mandates that may fall into these categories such as the requirement to cover visions screenings up to age 16[22] and cleft palate repair surgery.[23] It is unclear whether this EHB category is intended to expand coverage for basic eyewear or dental care.

"Offer" mandates

A remaining legal ambiguity is that of "offer" mandates. Current state law requires that insurers and plans subject to state regulation "offer" coverage for a certain benefit. This means plans and insurers would allow the purchaser, such as an employer group, the option to buy a specific benefit (e.g., as a "rider"). Mandates to "offer" coverage do not require the plans and insurers to cover the benefit, but leave the option to the purchaser. It is unclear how these types of mandates would interact with the provision requiring states to assume the cost of benefit requirements extending beyond the EHB floor.

Condition coverage mandates

Another remaining legal ambiguity is how state mandates requiring the coverage of the treatment for a specific condition or disease will interact with federal law. These mandates often extend across multiple benefit categories. For example, California's mandate to cover breast cancer treatment implicitly requires coverage for screening and testing, medically necessary physician services, ambulatory services, prescription drugs, hospitalization, and surgery. For California benefit mandates that span across several EHB categories, it is unclear how these mandates would be evaluated in relation to the EHB.

[18] California Code of Regulations, Title 28, Section 1300.67.24
[19] H&S Code Section 1367.35; Insurance Code Section 10123.5
[20] H&S Code Section 1367.3; Insurance Code Section 10123.55
[21] California Code of Regulations, Title 28, Section 1300.67.24
[22] Required for DMHC-regulated plans under the BHCS regulations, California Code of Regulations, Title 28, Section 1300.67.24
[23] H&S Code Section 1367.63; Insurance Code Section 10123.88

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The contents of this issue brief do not constitute a legal opinion and should not be construed as such. This brief is provided for general informational purposes and represents CHBRP's analysis at the time of release. CHBRP welcomes input on these issues.

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Attachment A: Current California Benefit Mandates and Essential Health Benefits

This document provides a list of current health insurance benefit mandates in the California Health & Safety and Insurance Codes, sorted into the EHB category framework. This is provided primarily as a point of reference to discuss the potential interaction of state benefit mandates and EHBs as well as highlight outstanding issues which will need to be clarified as state policymakers and regulators pursue implementation efforts. This document is organized as follows:

- The first column provides the name of the EHB category, BHCS category, or a description of the mandate.
- The second to fifth columns describe to which types of health insurance a mandate applies (e.g., DMHC-regulated group plans).
- The sixth column describes whether the mandate requires a plan or policies to cover the benefit, or to *offer* coverage for the benefit.
- The seventh column shows other potential EHB categories under which the mandated benefit may fall.
- The eighth column provides a cross-reference to CHBRP's more detailed listing of current mandates (Attachment B).

EHB Categories/Mandate Topic	DMHC Group	DMHC Individual	CDI Group	CDI Individual	Mandate to Cover or Offer Coverage	Potential Other EHB Category Interactions	# in CHBRP Grid
(A) Ambulatory patient services							
Physician services	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-1*
Ambulatory care	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-2*
Breast cancer testing and treatment	Yes*	Yes*	Yes*	Yes*	Coverage	C, G, I	1
Patient care related to clinical trials for cancer	Yes*	Yes*	Yes*	Yes*	Coverage	C, F, G, H	6
Acupuncture	No	No	Yes	No	Offer		25
General anesthesia for dental procedures	Yes*	Yes*	Yes*	Yes*	Coverage	C	26
Coverage for the effects of diethylstilbestrol	Yes*	Yes*	Yes*	Yes*	Coverage	D, J	31
OB-GYNs as primary care providers [1]	Yes*	Yes*	Yes*	Yes*	Coverage	D	35
Infertility treatments	Yes	No	Yes	No	Offer	D	39
Jawbone or associated bone joints	Yes*	Yes*	Yes	Yes	Coverage		43
(B) Emergency services							
Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage and ambulance transport services provided through the "911" emergency response system	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-6*
Emergency 911 transportation [2]	Yes*	Yes*	Yes*	Yes*	Coverage		33

EHB Categories/Mandate Topic	DMHC Group	DMHC Individual	CDI Group	CDI Individual	Mandate to Cover or Offer Coverage	Potential Other EHB Category Interactions	# in CHBRP Grid
(C) Hospitalization							
Hospital inpatient services	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-2*
Mastectomy and lymph node dissection – length of stay	Yes*	Yes*	Yes*	Yes*	Coverage		5
Reconstructive surgery [3]	Yes*	Yes*	Yes*	Yes*	Coverage	A	44
(D) Maternity and newborn care							
Participation in the statewide prenatal testing Expanded Alpha Feto Protein (AFP) program	Yes	Yes	Yes	Yes	Coverage		38
Maternity – minimum length of stay [4]	Yes*	Yes*	Yes	Yes	Coverage	C	40
Maternity – amount of copayment or deductible for inpatient services	Yes*	Yes*	Yes*	Yes*	Coverage	C	41
Prenatal diagnosis of genetic disorders	Yes	No	Yes	No	Offer	A	42
(E) Mental health and substance use disorder services, including behavioral health treatment							
Alcoholism treatment	Yes	No	Yes	No	Offer	A, C, F	17
Coverage for mental and nervous disorders	No	No	Yes	No	Offer	A, C, F	19
Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities	Yes	No	Yes	No	Coverage	A	20
Coverage for severe mental illnesses (in parity with coverage for other medical conditions) [5]	Yes*	Yes*	Yes*	Yes*	Coverage	A, C, F	21
(F) Prescription drugs							
Pain management medication for terminally ill	Yes*	Yes*	No	No	Coverage	G	27
Contraceptive devices requiring a prescription	Yes	Yes	Yes	Yes	Coverage		37
Authorization for nonformulary prescription drugs	Yes*	Yes*	No	No	Coverage		45
Prescription drugs: coverage for previously prescribed drugs	Yes*	Yes*	No	No	Coverage		47
Prescription drugs: coverage of "off-label" use	Yes*	Yes*	Yes	Yes	Coverage		48
(G) Rehabilitative and habilitative services and devices							
Home health services	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-4*
Hospice care	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-7*
Home health care	No	No	Yes	No	Offer		14

EHB Categories/Mandate Topic	DMHC Group	DMHC Individual	CDI Group	CDI Individual	Mandate to Cover or Offer Coverage	Potential Other EHB Category Interactions	# in CHBRP Grid
Hospice care	Yes	No	No	No	Coverage		15
Orthotic and prosthetic devices and services	Yes	No	Yes	No	Offer		22
Prosthetic devices for laryngectomy	Yes*	Yes*	Yes*	Yes*	Coverage		23
Special footwear for persons suffering from foot disfigurement	Yes	No	Yes	No	Offer		24
(H) Laboratory services							
Diagnostic laboratory and diagnostic and therapeutic radiologic services	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-3*
(I) Preventive and wellness services and chronic disease management							
Preventive health services	*Yes*	*Yes*	*No*	*No*	*Coverage*		*BHCS-5*
Cancer screening tests	Yes	Yes	Yes	Yes	Coverage		2
Cervical cancer screening	Yes	Yes	Yes	Yes	Coverage		3
Mammography	Yes*	Yes*	Yes*	Yes*	Coverage		4
Prostate cancer screening	Yes	Yes	Yes	Yes	Coverage		7
Diabetes management and treatment	Yes*	Yes*	Yes*	Yes*	Coverage		8
HIV/AIDS, AIDS vaccine	Yes	Yes	Yes*	Yes*	Coverage		9
HIV/AIDS, HIV Testing	Yes	Yes	Yes	Yes	Coverage		10
HIV/AIDS, Transplantation services for persons with HIV	Yes*	Yes*	Yes*	Yes*	Coverage		11
Osteoporosis	Yes*	Yes*	Yes*	Yes*	Coverage		12
Preventive services coverage without cost-sharing	Yes**	Yes**	Yes**	Yes**	Coverage		49
(J) Pediatric services, including oral and vision care							
Phenylketonuria	Yes*	Yes*	Yes*	Yes*	Coverage	H	13
Asthma management	Yes*	Yes*	No	No	Coverage	I	28
Comprehensive preventive care for children aged 16 years or younger	Yes	No	Yes	No	Coverage	H, I	29
Comprehensive preventive care for children aged 17 or 18 years	Yes	No	Yes	No	Offer	H, I	30
Screening children for blood lead levels	Yes	No	Yes	Yes	Offer	D	32

EHB Categories/Mandate Topic	DMHC Group	DMHC Individual	CDI Group	CDI Individual	Mandate to Cover or Offer Coverage	Potential Other EHB Category Interactions	# in CHBRP Grid
Other							
Pharmacists -- compensation for services within their scope of practice	Yes*	Yes*	No	No	Coverage		36
Alcohol and drug exclusion	No	No	Yes	No	Coverage	A, B	16
Coverage and premiums for persons with physical or mental impairment	Yes	Yes	Yes	No	Coverage		18
Blindness or partial blindness	Yes	Yes	No	No	Coverage		46
Medical transportation services – direct reimbursement	Yes*	Yes*	Yes*	Yes*	Coverage		34

Key:
BHCS = Basic Health Care Services; these categories are denoted in italics.
* Code does not specify explicitly if the mandate applies to exclusively group or individual health insurance, and therefore applies to both.
** The preventive services at no-cost sharing mandate does not apply to health care service plans or health insurance policies with grandfather status per Section 1251 of the ACA (and subsequent regulation).
Notes:
[1] The federal Affordable Care Act (ACA) of 2010 (Section 2719A) imposes a similar requirement prohibiting prior authorization for access to OB-GYNs. Grandfathered health plans (ACA Section 1251) are not subject to this requirement.
[2] ACA Section 2719A imposes a related requirement regarding coverage and cost-sharing for emergency services. Grandfathered health plans (ACA Section 1251) are not subject to this requirement.
[3] The federal Women's Health and Cancer Rights Act of1998 requires coverage for post-mastectomy reconstructive surgery.
[4] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay in a hospital after delivery if the plan covers maternity services.
[5] In addition to these state-level benefit mandates, the federal Mental Health Parity and Addition Equity Act of 2008 requires that if a group plan or policy covers mental health, it must do so at parity with coverage for medical and surgical benefits.

Attachment B: Health Insurance Benefit Mandates in California State Law

December 1, 2010

This document has been prepared by the California Health Benefits Review Program (CHBRP). CHBRP responds to requests from the California Legislature to provide independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit mandates and repeals. Annual updates of this list, as well as additional information about CHBRP, can be found at www.chbrp.org.

Purpose of this list: This list is intended to alert interested parties of existing state legislation that may relate to the subject or purpose of a health insurance benefit mandate or repeal bill.

Benefit Mandates listed: Listed in Table 1 are "health insurance benefit mandates," as defined by CHBRP's enabling legislation (California Health and Safety Code Section 127660 et seq.) current in California law. The listed mandates fall into "categories of mandates" that (a) affect coverage for the screening, diagnosis, or treatment of specific diseases or conditions; (b) affect coverage for types of health care treatments or services, including coverage of medical equipment, supplies, or drugs used in a treatment or service; (c) affect coverage permitting treatment or services from a specific type of health care provider. The list also includes mandates that (d) specify terms (limits, timeframes, co-payments, deductibles, co-insurance, etc.) for any of the other categories.

Information included for listed mandates: Table 1 identifies relevant statutes and specifies whether the law mandates *coverage* for the benefit or mandates *an offer* of coverage for the benefit. The table also identifies which portions of the insurance market are impacted. Explanations of these terms are provided in Appendix A.

Other important information:

- Not all health insurance is subject to state-level health insurance benefit mandate law.
- California has a bifurcated legal and regulatory system for health insurance products. The Department of Managed Health Care (DMHC) regulates health care service plan contracts, which are subject to the Health & Safety Code. The California Department of Insurance (CDI) regulates health insurance policies, which are subject to the California Insurance Code. DMHC-regulated plan contracts and CDI-regulated policies may be subject to state-level benefit mandate laws, depending upon the exact wording of the law.
- Federal benefit mandate laws may interact or overlap with state benefit mandate laws. Some relevant federal laws are noted in the footnotes for Table 1.
- DMHC-regulated health plans are subject to "minimum benefit" laws and regulations, which may interact or overlap with state benefit mandate laws. The Basic Health Care Services requirement for DMHC-regulated Health Plans is noted in Table 1 and further explained in Appendix B.
- Although CHBRP assesses the impacts of bills, not existing laws, CHBRP's analysis of Assembly Bill 1214 (2007) required a review of mandate laws current at that time. That report and all other CHBRP analyses may be accessed at http://chbrp.org/analyses.html.

TABLE 1 – California Health Insurance Benefit Mandates (by Topic)

#	Topic	Health & Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Cover or Mandate to Offer	Markets Subject to the Mandate	Mandate Category
DMHC-Regulated Health Care Service Plan "Minimum Benefits"						
0	Health Plans regulated by the Department of Managed Care (DMHC) are required to cover medically necessary basic health care services, including: (1) Physician services; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services, out-of-area coverage and ambulance transport services provided through the "911" emergency response system; (7) Hospice care. See Appendix B for further details.	Multiple Sections -- See Appendix B	N/A[1]	Coverage	Group and Individual	*Not a distinct mandate*
Cancer Benefit Mandates						
1	Breast cancer testing and treatment	1367.6	10123.8	Coverage	N/S[2]	a
2	Cancer screening tests	1367.665	10123.20	Coverage	Group and Individual	b
3	Cervical cancer screening	1367.66	10123.18	Coverage	Group and Individual	a
4	Mammography	1367.65	10123.81	Coverage	N/S	a
5	Mastectomy and lymph node dissection – length of stay	1367.635	10123.86	Coverage	N/S	d
6	Patient care related to clinical trials for cancer	1370.6	10145.4	Coverage	N/S	d
7	Prostate cancer screening	1367.64	10123.835	Coverage	Group and Individual	a
Chronic Conditions Benefit Mandates						
8	Diabetes management and treatment	1367.51	10176.61	Coverage	N/S	a
9	HIV/AIDS, AIDS vaccine	1367.45	10145.2	Coverage	Group and Individual (DMHC), N/S (CDI)	a
10	HIV/AIDS, HIV Testing	1367.46	10123.91	Coverage	Group and Individual	a
11	HIV/AIDS, Transplantation services for persons with HIV	1374.17	10123.21(a)	Coverage	N/S	d
12	Osteoporosis	1367.67	10123.185	Coverage	N/S	a
13	Phenylketonuria	1374.56	10123.89	Coverage	N/S	a

[1] N/A indicates that mandate does not apply to products governed under that code.
[2] An N/S indicates that the language of the law does not specify which market is affected.

#	Topic	Health & Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Cover or Mandate to Offer	Markets Subject to the Mandate	Mandate Category
Hospice & Home Health Care Benefit Mandates						
14	Home health care	N/A	10123.10	Offer	Group	b
15	Hospice care	1368.2	N/A	Coverage	Group	b
Mental Health Benefit Mandates						
16	Alcohol and drug exclusion	N/A	10369.12	Coverage	Group	d
17	Alcoholism treatment	1367.2(a)	10123.6	Offer	Group	a
18	Coverage and premiums for persons with physical or mental impairment	1367.8	10122.1	Coverage	Group and Individual (DMHC), Group (CDI)	d
19	Coverage for mental and nervous disorders	N/A	10125	Offer	Group	a
20	Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities	1367.2(b)	10123.6	Coverage	Group	b
21	Coverage for severe mental illnesses (in parity with coverage for other medical conditions)[3]	1374.72	10123.15 (10144.5)	Coverage	N/S	a
Orthotics & Prosthetics Benefit Mandates						
22	Orthotic and prosthetic devices and services	1367.18	10123.7	Offer	Group	b
23	Prosthetic devices for laryngectomy	1367.61	10123.82	Coverage	N/S	b
24	Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Offer	Group	b
Pain Management Benefit Mandates						
25	Acupuncture	N/A	10127.3	Offer	Group	c
26	General anesthesia for dental procedures	1367.71	10119.9	Coverage	N/S	b
27	Pain management medication for terminally ill	1367.215	N/A	Coverage	N/S	b
Pediatric Care Benefit Mandates						
28	Asthma management	1367.06	N/A	Coverage	N/S	a
29	Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5	Coverage	Group	b
30	Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Offer	Group	b
31	Coverage for the effects of diethylstilbestrol	1367.9	10119.7	Coverage	N/S	a
32	Screening children for blood lead levels	1367.3(b)(2)(D)	10119.8	Offer	Group (DMHC), Group and Individual (CDI)	b

[3] In addition to these state-level benefit mandates, the federal Mental Health Parity and Addition Equity Act of 2008 requires that *if* a group plan or policy covers mental health, it must do so at parity with coverage for medical and surgical benefits.

#	Topic	Health & Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Cover or Mandate to Offer	Markets Subject to the Mandate	Mandate Category
Provider Reimbursement Mandates						
33	Emergency 911 transportation[4]	1371.5	10126.6	Coverage	N/S	d
34	Medical transportation services – direct reimbursement	1367.11	10126.6	Coverage	N/S	d
35	OB-GYNs as primary care providers[5]	1367.69	10123.83	Coverage	N/S	d
36	Pharmacists -- compensation for services within their scope of practice	1368.5	N/A	Coverage	N/S	c
Reproduction Benefit Mandates						
37	Contraceptive devices requiring a prescription	1367.25	10123.196	Coverage	Group and Individual	b
38	Participation in the statewide prenatal testing Expanded Alpha Feto Protein (AFP) program	1367.54	10123.184	Coverage	Group and Individual	b
39	Infertility treatments	1374.55	10119.6	Offer	Group	a
40	Maternity – minimum length of stay[6]	1367.62	10123.87	Coverage	N/S (DMHC), Group and Individual (CDI)	d
41	Maternity – amount of copayment or deductible for inpatient services	1373.4	10119.5	Coverage	N/S	d
42	Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group	b
Surgery Benefit Mandates						
43	Jawbone or associated bone joints	1367.68	10123.21	Coverage	N/S (DMHC), Group and Individual (CDI)	a
44	Reconstructive surgery[7]	1367.63	10123.88	Coverage	N/S	b
Terms & Conditions of Coverage Benefit Mandates						
45	Authorization for nonformulary prescription drugs	1367.24	N/A	Coverage	N/S	d
46	Blindness or partial blindness	1367.4	N/A	Coverage	Group and Individual	d
47	Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A	Coverage	N/S	d
48	Prescription drugs: coverage of "off-label" use	1367.21	10123.195	Coverage	N/S (DMHC), Group and Individual (CDI)	d
49	Preventive services coverage without cost-sharing	1367.002	10112.2	Coverage	Group and Individual	d

[4] The federal Affordable Care Act (ACA) of 2010 (Section 2719A) imposes a related requirement regarding coverage and cost-sharing for emergency services. Grandfathered health plans (ACA Section 1251) are not subject to this requirement.
[5] The federal Affordable Care Act (ACA) of 2010 (Section 2719A) imposes a similar requirement prohibiting prior authorization for access to OB-GYNs. Grandfathered health plans (ACA Section 1251) are not subject to this requirement.
[6] The federal Newborns' and Mothers' Health Protection Act of 1996 requires coverage for a minimum length of stay in a hospital after delivery *if* the plan covers maternity services.
[7] The federal Women's Health and Cancer Rights Act of 1998 requires coverage for post-mastectomy reconstructive surgery.

APPENDIX A: Terms and Categories for Table 1

Code -- A health insurance benefit mandate is a law requiring health insurance products (plans and policies) to provide, or in specified cases simply to offer, coverage for specified benefits or services. Because California has a bifurcated regulatory system for health insurance products, a benefit mandate law may appear in either of two codes or in both:

- Health & Safety Code: The California Department of Managed Health Care (DMHC) regulates and licenses health care services plans as per the California Health and Safety Code.
- Insurance Code: The California Department of Insurance (CDI) licenses disability insurance carriers and regulates disability insurance, which includes health insurance policies, per the California Insurance Code.

Mandated Coverage or Mandated Offer of Coverage -- In the language of either code section, the law may mandate coverage of benefits or may mandate that coverage for the benefits be offered.

- "Mandate to cover" means that all health insurance subject to the law must cover the benefit.
  "Mandate to offer" means all health care service plans and health insurers selling health insurance subject to the mandate are required to offer coverage for the benefit for purchase. The health plan or insurer may comply with the mandate either by including the benefit as standard in its health insurance products, or by offering coverage for the benefit separately at an additional cost (e.g. a rider).

Markets Subject to the Mandate – In the language of either code section, the law may (or may not) specify which market or markets are subject to the mandate.

- The "group" market includes health insurance products issued to employers (or other entities) to provide coverage for employees (or other persons) and/or their dependents.
- The "individual" market includes health insurance products issued to an individual to provide coverage for a person and/or his/her dependants.

Mandate Category – As per CHBRP's enabling legislation (California Health and Safety Code Section 127660 et seq.), the listed mandates fall into one or more types. A particular mandate law can require that subject health insurance do one or more of the following:

a. Offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition. An example would be a mandate that requires coverage for all health care services related to the screening and treatment of breast cancer.
b. Offer or provide coverage of a particular type of health care treatment or service, or of medical equipment, medical supplies, or drugs used in connection with a health care treatment or service. An example would be a mandate to cover reconstructive surgery.
c. Offer or provide coverage for services from a specified type of health provider that fall within the provider's scope of practice. An example would be a mandate that requires coverage for services provided by a licensed acupuncturist.
d. Offer or provide any of the forms of coverage listed above per specific terms and conditions. For example, the mental health parity law requires coverage for serious mental health conditions to be *on par* with other medical conditions, so that mental health benefits and other benefits are subject to the same co-payments, limits, etc.

APPENDIX B: Basic Health Care Services for DMHC-Regulated Health Care Service Plans*

The California Department of Managed Health Care (DMHC) regulates health care service plans, which are subject to the California Health & Safety Code. The Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act) requires all health care service plans, except specialized health care service plans, to provide coverage for all medically necessary basic health care services.

This requirement is based on several sections of the Knox-Keene Act rather than one straightforward provision, and so is not technically a Health Insurance Benefit Mandate. Specifically, subdivision (b) of Section 1345 defines the term "basic health care services" to mean all of the following: (1) Physician services, including consultation and referral; (2) Hospital inpatient services and ambulatory care services; (3) Diagnostic laboratory and diagnostic and therapeutic radiologic services; (4) Home health services; (5) Preventive health services; (6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage and ambulance transport services provided through the "911" emergency response system; (7) Hospice care pursuant to Section 1368.2. "Basic health care services" are also further defined in Section 1300.67 of the California Code of Regulations.

In addition, subdivision (i) of Section 1367 of the Health and Safety Code provides the following: (i) A health care service plan contract shall provide to subscribers and enrollees all of the basic health care services included in subdivision (b) of Section 1345, except that the director may, for good cause, by rule or order exempt a plan contract or any class of plan contracts from that requirement. The director shall by rule define the scope of each basic health care service that health care service plans are required to provide as a minimum for licensure under this chapter. Nothing in this chapter shall prohibit a health care service plan from charging subscribers or enrollees a copayment or a deductible for a basic health care service or from setting forth, by contract, limitations on maximum coverage of basic health care services, provided that the copayments, deductibles, or limitations are reported to, and held unobjectionable by, the director and set forth to the subscriber or enrollee pursuant to the disclosure provisions of Section 1363.

Although the Act does not explicitly state that "basic health care services" means all "medically necessary" basic health care services, there are numerous provisions within the act that reference "medical necessity" and that place requirements on plans in terms of what they must do when denying, delaying or modifying coverage based on a decision for medical necessity (Section 1367.01). In addition, Section 1300.67 of Title 28 of the California Code of Regulation, which further defines "basic health care services" does further clarify that "the basic health care services required to be provided by a health care service plan to its enrollees shall include, where medically necessary, subject to any co-payment, deductible, or limitation of which the Director may approve…"

The entire Knox-Keene Act and the applicable regulations can be accessed online on the DMHC's website at www.dmhc.ca.gov.

* The text in this appendix was adapted from a document prepared by a representative of the Department of Managed Health Care (S. Lowenstein).

APPENDIX C – California Mandates (by Health & Safety Code Section)

The following table is presented to allow easy comparison with other lists of mandates.

# of Mandate in Table 1	Health & Safety Code (DMHC)	California Insurance Code (CDI)
14	N/A[8]	10123.10
16	N/A	10369.12
19	N/A	10125
25	N/A	10127.3
49	1367.002	10112.2
28	1367.06	N/A
34	1367.11	10126.6
22	1367.18	10123.7
24	1367.19	10123.141
17	1367.2(a)	10123.6
20	1367.2(b)	10123.6
48	1367.21	10123.195
27	1367.215	N/A
47	1367.22	N/A
45	1367.24	N/A
37	1367.25	10123.196
30	1367.3	10123.55
32	1367.3 (b)(2)(D)	10119.8
29	1367.35	10123.5
46	1367.4	N/A
9	1367.45	10145.2
10	1367.46	10123.91
8	1367.51	10176.61
38	1367.54	10123.184
1	1367.6	10123.8
23	1367.61	10123.82
40	1367.62	10123.87
44	1367.63	10123.88
5	1367.635	10123.86
7	1367.64	10123.835

# of Mandate in Table 1	Health & Safety Code (DMHC)	California Insurance Code (CDI)
4	1367.65	10123.81
3	1367.66	10123.18
2	1367.665	10123.20
12	1367.67	10123.185
43	1367.68	10123.21
35	1367.69	10123.83
42	1367.7	10123.9
26	1367.71	10119.9
18	1367.8	10122.1
31	1367.9	10119.7
15	1368.2	N/A
36	1368.5	N/A
6	1370.6	10145.4
33	1371.5	10126.6
41	1373.4	10119.5
11	1374.17	10123.21(a)
39	1374.55	10119.6
13	1374.56	10123.89
21	1374.72	10123.15 (10144.5)

[8] An N/A in either the Health & Safety Code column or the California Insurance Code column indicates that a mandate does not apply to products covered under that code.

APPENDIX D – California Mandates (by Insurance Code Section)
The following table is presented to allow easy comparison with other lists of mandates.

# of Mandate in Table 1	Health & Safety Code (DMHC)	California Insurance Code (CDI)
15	1368.2	N/A[9]
27	1367.215	N/A
28	1367.06	N/A
36	1368.5	N/A
45	1367.24	N/A
46	1367.4	N/A
47	1367.22	N/A
49	1367.002	10112.2
41	1373.4	10119.5
39	1374.55	10119.6
31	1367.9	10119.7
32	1367.3(b)(2)(D)	10119.8
26	1367.71	10119.9
18	1367.8	10122.1
14	N/A	10123.10
24	1367.19	10123.141
21	1374.72	10123.15 (10144.5)
3	1367.66	10123.18
38	1367.54	10123.184
12	1367.67	10123.185
48	1367.21	10123.195
37	1367.25	10123.196
2	1367.665	10123.20
43	1367.68	10123.21
11	1374.17	10123.21(a)
29	1367.35	10123.5

# of Mandate in Table 1	Health & Safety Code (DMHC)	California Insurance Code (CDI)
30	1367.3	10123.55
17	1367.2(a)	10123.6
20	1367.2(b)	10123.6
22	1367.18	10123.7
1	1367.6	10123.8
4	1367.65	10123.81
23	1367.61	10123.82
35	1367.69	10123.83
7	1367.64	10123.835
5	1367.635	10123.86
40	1367.62	10123.87
44	1367.63	10123.88
13	1374.56	10123.89
42	1367.7	10123.9
10	1367.46	10123.91
19	N/A	10125
33	1371.5	10126.6
34	1367.11	10126.6
25	N/A	10127.3
9	1367.45	10145.2
6	1370.6	10145.4
8	1367.51	10176.61
16	N/A	10369.12

[9] An N/A in either the Health & Safety Code column or the California Insurance Code column indicates that a mandate does not apply to products covered under that code.

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