California Health Benefits Review Program

Resource:

Health Insurance Benefit Mandates in California State and Federal Law

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CALIFORNIA
HEALTH BENEFITS REVIEW PROGRAM

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ABOUT THIS RESOURCE

The California Health Benefits Review Program (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.[1,2] This document has been prepared by CHBRP to inform interested parties of existing state and federal health insurance benefit mandate laws that may relate to the subject or purpose of a proposed state health insurance benefit mandate or repeal bill.

Benefit Mandates Listed

CHBRP defines health insurance benefit mandates through the lens of its authorizing statute.[3] Therefore, the listed mandates fall into one or more of the following categories: (a) offer or provide coverage for the screening, diagnosis, or treatment of specific diseases or conditions; (b) offer or provide coverage for types of health care treatments or services, including coverage of medical equipment, supplies, or drugs used in a treatment or service; (c) offer or provide coverage permitting treatment or services from a specific type of health care provider; and/or (d) specify terms (limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories. Table 1 includes California's state health insurance benefit mandate laws, and Table 2 includes federal health insurance benefit mandate laws.

Information Included for Listed Mandates

Table 1

Table 1 identifies relevant California statutes. The table specifies when the law mandates *an offer* of coverage for the benefit. The table also identifies which health insurance markets (group and/or individual) are subject to the mandate. Explanations of these terms are provided in Appendix A.

Table 2

Table 2 identifies relevant federal statutes, both those in existence prior to passage of the Affordable Care Act (ACA)[4] as well as federal mandates contained in the ACA. Like Table 1, Table 2 identifies the health insurance markets subject to the mandate. Because none of the federal mandates are mandates to *offer* coverage, this information is not included in Table 2.

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[1] Additional information about CHBRP is available at: www.chbrp.org.
[2] Although CHBRP assesses the impacts of bills, not existing laws, CHBRP's analysis of Assembly Bill 1904 (2010) required a review of mandate laws current at that time. That report and all other CHBRP analyses are available at: www.chbrp.org/completed_analyses/index.php.
[3] Available at: www.chbrp.org/documents/authorizing_statute.pdf.
[4] The federal "Patient Protection and Affordable Care Act" (P.L.111-148) and the "Health Care and Education Reconciliation Act" (P.L 111-152) were enacted in March 2010. Together, these laws are referred to as the Affordable Care Act (ACA).

Key Facts

- **Applicability of mandate laws:** Not all health insurance is subject to state health insurance benefit mandate laws. CHBRP annually posts estimates of Californians' sources of health insurance, including figures for the numbers of Californians with health insurance subject to state benefit mandates.[5]
- **California insurance regulation:** 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 and 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 benefit mandate laws, depending upon the exact wording of the law.
- **Federal-state mandate overlap:** DMHC-regulated plans and CDI-regulated policies may also be subject to federal benefit mandate laws. Federal benefit mandates may interact or overlap with state benefit mandates. Some known interactions are noted in the footnotes for Table 1.
- **Federal benefit mandates:** Federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates may apply to Medicare or to self-insured plans. Table 2 only lists federal benefit mandate laws that would be relevant to DMHC-regulated plans and CDI-regulated policies.
- **DMHC rules:** DMHC-regulated health plans are subject to "minimum benefit" laws and regulations, also known as "Basic Health Care Services," that 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.

[5] Available at: www.chbrp.org/other_publications/index.php.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
DMHC-Regulated Health Care Service Plan "Minimum Benefits"						
0	Health Plans regulated by the Department of Managed Health 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[8]		Group and Individual	Not a distinct mandate
Essential Health Benefits						
1	A federal mandate that requires some plans and policies to cover essential health benefits (EHBs) and places limits on cost sharing. The state statutes listed in this row define EHBs and cost sharing for California.[9,10]	1367.005 1367.006 1367.0065	10112.27 10112.28 10112.285		Small Group[11] and Individual[12] In 2017, Large Group sold via Covered California[13]	a, b, d
Cancer Benefit Mandates						
2	Breast cancer screening, diagnosis, and treatment	1367.6	10123.8		Not Specified[14]	a
3	Cancer screening tests	1367.665	10123.20		Group and Individual	b

[6] Defined per CHBRP's authorizing statute, available at: www.chbrp.org/documents/authorizing_statute.pdf. This list includes laws that meet that definition and are known to CHBRP.
[7] "Mandate to offer" indicates that all health care service plans and health insurers selling health insurance subject to the benefit mandate are required to *offer* coverage for the benefit. The health plan or insurer may comply (1) by including coverage for the benefit as standard in its health insurance products or (2) by offering coverage for the benefit separately and at an additional cost (e.g., a rider). See Appendix A.
[8] N/A indicates that the benefit mandate does not apply to products governed under the specified code.
[9] Affordable Care Act (ACA), Section 1301, 1302, and Section 1201 modifying Section 2707 of the Public Health Service Act (PHSA). See Table 2 below.
[10] For more information on essential health benefits (EHBs), see CHBRP's brief, *California's State Benefits Mandates and the Affordable Care Act's "Essential Health Benefits*, available at: www.chbrp.org/other_publications/index.php.
[11] The ACA defines a large group as >100 employees. California state law defines a large group as >50. However, the ACA [Section 1304(b)(3)] allows states to treat groups between 50 and 100 as large for plan years beginning before 2016.
[12] The EHB coverage requirement will apply to nongrandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.
[13] Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via an exchange [ACA Section 1312(f)(2)(B)]. Large group QHPs would be subject the EHB coverage requirement.
[14] "Not Specified" indicates that the benefit mandate does not specify which market or markets are subject.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
4	Cervical cancer screening	1367.66	10123.18		Group and Individual	a
5	Mammography	1367.65	10123.81		Not Specified	a, c
6	Mastectomy and lymph node dissection (length of stay, complications, prostheses, reconstructive surgery)	1367.635	10123.86		Not Specified	b, d
7	Oral anticancer medication cost-sharing limits	1367.656	10123.206		Group and Individual	d
8	Patient care related to clinical trials for cancer	1370.6	10145.4		Not Specified	d
9	Prostate cancer screening	1367.64	10123.835		Group and Individual	a
Chronic Conditions Benefit Mandates						
10	Diabetes education	N/A	10176.6	Offer	Not Specified (CDI)	a
11	Diabetes education, management, and treatment	1367.51	10176.61		Not Specified	a, b, d
12	HIV/AIDS, AIDS vaccine	1367.45	10145.2		Group and Individual (DMHC), Not Specified (CDI)	a
13	HIV/AIDS, HIV Testing	1367.46	10123.91		Group and Individual	a
14	HIV/AIDS, Transplantation services for persons with HIV	1374.17	10123.21(a)		Not Specified	d
15	Osteoporosis	1367.67	10123.185		Not Specified	a
16	Phenylketonuria	1374.56	10123.89		Not Specified	a
Hospice & Home Health Care Benefit Mandates						
17	Dementing illness exclusion prohibition	1373.14	10123.16		Group and Individual	a, d
18	Home health care	1374.10 (non-HMOs only)	10123.10	Offer	Group	b, d
19	Hospice care	1368.2	N/A		Group (DMHC)	b
Mental Health Benefit Mandates						
20	Alcohol and drug exclusion prohibition	N/A	10369.12		Group (CDI)	d
21	Alcoholism treatment	1367.2(a)	10123.6	Offer	Group	a
22	Behavioral health treatment for autism and related disorders	1374.73	10144.51 10144.52		Not Specified	b
23	Care provided by a psychiatric health facility	1373(h)(1)	N/A		Not Specified (DMHC)	b, d
24	Coverage and premiums for persons with physical or mental impairment	1367.8	10144		Group and Individual	a, d
25	Coverage for mental and nervous disorders, including care provided by a psychiatric health facility	N/A	10125	Offer	Group (CDI)	a
26	Coverage for persons with physical handicap	N/A	10122.1	Offer	Group (CDI)	a, d
27	Coverage for severe mental illnesses (in parity with coverage for other medical conditions)[15]	1374.72	10144.5 10123.15		Not Specified	a, b, d

[15] In addition to these state 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. See Table 2 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
28	Nicotine or chemical dependency treatment in licensed alcoholism or chemical dependency facilities	1367.2(b)	10123.6	Offer	Group	b, d
29	Prohibition of Lifetime Waiver for Mental Health Services	1374.5	10176(f)		Individual	a, d
30	Prohibition on Determining Reimbursement Eligibility from Inpatient Admission Status	1374.51	10144.6		Not Specified	d
Orthotics & Prosthetics Benefit Mandates						
31	Orthotic and prosthetic devices and services	1367.18	10123.7	Offer	Group	b
32	Prosthetic devices for laryngectomy	1367.61	10123.82		Not Specified	b
33	Special footwear for persons suffering from foot disfigurement	1367.19	10123.141	Offer	Group	b
Pain Management Benefit Mandates						
34	Acupuncture	1373.10 (non-HMOs only)	10127.3	Offer	Group	c, d
35	General anesthesia for dental procedures	1367.71	10119.9		Not Specified	b
36	Pain management medication for terminally ill	1367.215	N/A		Not Specified (DMHC)	b
Pediatric Care Benefit Mandates						
37	Asthma management	1367.06	N/A		Not Specified (DMHC)	a
38	Comprehensive preventive care for children aged 16 years or younger	1367.35	10123.5		Group	b
39	Comprehensive preventive care for children aged 17 or 18 years	1367.3	10123.55	Offer	Group	b
40	Coverage for the effects of diethylstilbestrol	1367.9	10119.7		Not Specified	a
41	Screening children for blood lead levels	1367.3(b)(2)(d)	10119.8	Offer	Group (DMHC), Group and Individual (CDI)	b
Provider Reimbursement Mandates						
42	Emergency 911 transportation[16]	1371.5	10126.6		Not Specified	d
43	Licensed or certified providers	1367(b)	N/A		Not Specified	c, d
44	Medical transportation services – direct reimbursement	1367.11	10126.6		Not Specified	d
45	OB-GYNs as primary care providers[17]	1367.69 1367.695	10123.83 10123.84		Not Specified	c, d
46	Pharmacists – compensation for services within their scope of practice	1368.5	10125.1	Offer	Not Specified	c, d

[16] The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a related requirement regarding coverage and cost-sharing for emergency services. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 2 below.

[17] The ACA (Section 1001 modifying Section 2719A of the PHSA) imposes a similar requirement prohibiting prior authorization for access to OB-GYNs. Grandfathered health plans (ACA Section 1251) are not subject to this requirement. See Table 2 below.

Table 1. California Health Insurance Benefit Mandates[6] (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Mandate to Offer?[7]	Markets (regulated by DMHC or CDI) Subject to the Mandate	Mandate Category
Reproduction Benefit Mandates						
47	Contraceptive devices and sterilization, and contraceptive education and counseling	1367.25	10123.196		Group and Individual	b
48	Contraceptive devices requiring a prescription	1367.25	10123.196		Group and Individual	b
49	Infertility treatments	1374.55	10119.6	Offer	Group	a, b, d
50	Maternity services	N/A	10123.865 10123.866		Group and Individual (CDI)	b
51	Maternity – amount of copayment or deductible for inpatient services	1373.4	10119.5		Not Specified	d
52	Maternity – minimum length of stay[18]	1367.62	10123.87		Not Specified (DMHC), Group and Individual (CDI)	d
53	Participation in the statewide prenatal testing Expanded Alpha Feto Protein (AFP) program	1367.54	10123.184		Group and Individual	b
54	Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group	b
Sterilization						
55	Sterilization rationale exclusion prohibition	1373	10120		Not Specified	d
Surgery Benefit Mandates						
56	Jawbone or associated bone joints	1367.68	10123.21		Not Specified (DMHC), Group and Individual (CDI)	a
57	Reconstructive surgery[19]	1367.63	10123.88		Not Specified	b
Other Benefit Mandates						
58	Authorization for nonformulary prescription drugs	1367.24	N/A		Not Specified (DMHC)	d
59	Blindness or partial blindness exclusion prohibition	1367.4	10145		Group and Individual	a, d
60	Prescription drugs: coverage for previously prescribed drugs	1367.22	N/A		Not Specified (DMHC)	d
61	Prescription drugs: coverage of “off-label” use	1367.21	10123.195		Not Specified (DMHC), Group and Individual (CDI)	d
62	Preventive services without cost sharing (in compliance with federal laws and regulations)[20]	1367.002	10112.2		Group and Individual	b, d
63	Second opinions	N/A	10123.68		Not Specified (CDI)	c

[18] 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. See Table 2 below.
[19] The federal Women’s Health and Cancer Rights Act of 1998 requires coverage for postmastectomy reconstructive surgery. See Table 2 below.
[20] ACA, Section 1001 modifying Section 2713 of the PHSA. See Table 2 below.

Table 2. Federal Health Insurance Benefit Mandates[21]

#	Federal Law	Topic Addressed by Benefit Coverage Mandate[22]	Markets Subject to the Mandate[23]	Mandate Category
Federal Mandates in Existence Prior to the Passage of the Affordable Care Act of 2010 (ACA)				
1	Pregnancy Discrimination Act of 1978 amending Title VII of the federal Civil Rights Act	Requires coverage for pregnancy and requires the coverage be in parity with other benefit coverage.	Group (15 or more)	d
2	Newborns' and Mothers' Health Protection Act of 1996	If maternity is covered, requires that coverage include at least a 48-hour hospital stay following childbirth (96-hour stay in the case of a cesarean section).	Group	d
3	Women's Health and Cancer Rights Act of 1998	If mastectomy is covered, requires coverage for certain reconstructive surgery and other postmastectomy treatments and services.	Group	b
4	Mental Health Parity and Addiction Equity Act of 2008, modified by the Affordable Care Act of 2010 [ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA)]	If mental health or substance use disorder (MH/SUD) services are covered, requires that cost-sharing terms and treatment limits be no more restrictive than the predominant terms or limits applied to medical/surgical benefits.	Group and Individual	d
Federal Mandates in the Affordable Care Act of 2010 (ACA)				
5	Section 1001 modifying Section 2711 of the PHSA	Prohibits lifetime and annual limits on the dollar value of benefits.[24]	Group and Individual	d
6	Section 1001 modifying Section 2713 of the PHSA	Preventive services without cost sharing.[25,26] As soon as 12 months after a recommendation appears in any of three sources, benefit coverage is required. The four sources are: • 'A' and 'B' rated recommendations of the United States Preventive Services Task Force (USPSTF)[27]; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)[28]; • For infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA)[29]; and • For women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA.[30]	Group and Individual	a, d

[21] CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: www.chbrp.org/docs/authorizing_statute.pdf. This list includes laws that meet that definition and are known to CHBRP.
[22] All listed federal health insurance benefit mandates are benefit coverage mandates. CHBRP is aware of no federal "mandates to offer."
[23] Unless otherwise noted, the federal mandates in the ACA do not apply to grandfathered health plans (Section 1251).
[24] Annual limits and lifetime limits apply to grandfathered plans, with the exception that grandfathered individual market plans are not subject to the prohibitions on annual limits [ACA Section 1251(a)(4)].

Table 2. Federal Health Insurance Benefit Mandates[21]

#	Federal Law	Topic Addressed by Benefit Coverage Mandate[22]	Markets Subject to the Mandate[23]	Mandate Category
7	Section 1001 modifying Section 2719A(b) of the PHSA	If emergency services are covered, requires coverage for these services regardless of whether the participating provider is in or out of network, with the same cost-sharing levels out of network as would be required in network, and without the need for prior authorization.	Group and Individual	d
8	Section 1001 modifying Section 2719A(d) of the PHSA	Prohibits requiring prior authorization or referral before covering services from a participating health care professional who specializes in obstetrics or gynecology.	Group and Individual	d
9	Section 1201 modifying Section 2704 of the PHSA	Prohibits "preexisting condition" benefit coverage denials.	Group and Individual[31]	d
10	Section 1301, 1302, and Section 1201 modifying Section 2707 of the PHSA	Requires coverage of essential health benefits (EHBs), and, for plans and policies that provide coverage for EHBs, and places limits on cost sharing. The 10 EHB categories are: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.[32]	Small Group[33] and Individual[34] In 2017, Large Group sold via Covered California[35]	a, b, d

[25] California law requires compliance with this mandate. See Table 1 above (categorized with "Other Benefit Mandates"). CHBRP has also produced a resource that examines the preventive services coverage requirement in the ACA, available here: www.chbrp.org/other_publications/index.php.
[26] For more information on the preventive services coverage requirement, see CHBRP's resource, *Federal Preventive Services Benefit Mandate and the California Benefit Mandates*, available at: www.chbrp.org/other_publications/index.php.
[27] Available at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
[28] Available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
[29] Regulations published in the Federal Register (Vol. 75, No 137, July 19, 2010) clarified which HRSA guidelines were applicable. The guidelines appear in two charts: Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care, available at: http://brightfutures.aap.org/clinical_practice.html; and Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children, available at: http://www.hrsa.gov/advisorycommittees/mchbadvisory/heritabledisorders/recommendedpanel/index.html.
[30] Available at: www.hrsa.gov/womensguidelines.
[31] Applies to grandfathered group market health plans and grandfathered individual market plans [ACA Section 1251(a)(4)].
[32] California has laws in place to define EHBs for the state. See Table 1 above (categorized with "Essential Health Benefits").
[33] The ACA defines a large group as >100 employees. California state law defines a large group as >50. However, the ACA [Section 1304(b)(3)] allows states to treat groups between 50 and 100 as large for plan years beginning before 2016.
[34] The EHB coverage requirement will apply to nongrandfathered plans and policies sold outside of the exchange as well as to qualified health plans (QHPs, see ACA Section 1301) certified by and sold via a health insurance exchange.
[35] Effective 2017, states may allow large-group market qualified health plans (QHPs, see ACA Section 1301) to be certified by and sold via a health insurance exchange [ACA Section 1312(f)(2)(B)]. Large group QHPs would be subject to the EHB coverage requirement.

Appendix A. Terms and Categories for Table 1 and Table 2

Code: A health insurance benefit mandate is a law requiring health insurance products (plans and policies) to provide, or in some 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.[36]
- 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.[37]

Mandated Benefit Coverage or Mandated Offer of Benefit 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 (1) by including the benefit as standard in its health insurance products, or (2) 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, the law may (or may not) specify which market(s) 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 their dependants.

Mandate Category: As per CHBRP's authorizing statute, 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.

[36] Available at: www.leginfo.ca.gov/cgi-bin/calawquery?codesection=hsc&codebody=&hits=20.
[37] Available at: www.leginfo.ca.gov/cgi-bin/calawquery?codesection=ins&codebody=&hits=20.

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 copayments, limits, etc.

Appendix B. Basic Health Care Services for DMHC-Regulated Health Care Service Plans[38]

The California Department of Managed Health Care (DMHC) regulates health care service plans, which are subject to the Knox-Keene Health Care Service Plan Act of 1975, as amended, which was codified in the Health and Safety Code.[39] The 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, as benefit mandates are defined by CHBRP's authorizing statute. 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 Title 28 of the California Code of Regulations.

In addition, subdivision (i) of Section 1367 of the Health and Safety Code provides the following: 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 Knox-Keene 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 Regulations, 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.

[38] The text in this appendix was adapted from a document prepared by the Department of Managed Health Care.
[39] Health and Safety Code Section 1340 et seq.

Appendix C. California Mandates (by Health and Safety Code Section)

The following table is presented to allow easy comparison of the mandates listed in Table 1. An N/A in either the Health and Safety Code column of the California Insurance Code column indicates that a mandate does not apply to products governed under that code.

#	Health and Safety Code (DMHC)	Insurance Code (CDI)
10	N/A	10176.6
20	N/A	10369.12
25	N/A	10125
26	N/A	10122.1
50	N/A	10123.865
50	N/A	10123.866
63	N/A	10123.68
62	1367.002	10112.2
1	1367.005	10112.27
1	1367.006	10112.28
1	1367.0065	10112.285
37	1367.06	N/A
44	1367.11	10126.6
31	1367.18	10123.7
33	1367.19	10123.141
61	1367.21	10123.195
36	1367.215	N/A
60	1367.22	N/A
58	1367.24	N/A
47	1367.25	10123.196
48	1367.25	10123.196
39	1367.3	10123.55
38	1367.35	10123.5
59	1367.4	10145
12	1367.45	10145.2
13	1367.46	10123.91
11	1367.51	10176.61
53	1367.54	10123.184
2	1367.6	10123.8
32	1367.61	10123.82
52	1367.62	10123.87
57	1367.63	10123.88
6	1367.635	10123.86
9	1367.64	10123.835
5	1367.65	10123.81
7	1367.656	10123.206
4	1367.66	10123.18
3	1367.665	10123.2
15	1367.67	10123.185
56	1367.68	10123.21
45	1367.69	10123.83
45	1367.695	10123.84
54	1367.7	10123.9
35	1367.71	10119.9
24	1367.8	10144
40	1367.9	10119.7
19	1368.2	N/A
46	1368.5	10125.1
8	1370.6	10145.4
42	1371.5	10126.6
55	1373	10120
17	1373.14	10123.16
51	1373.4	10119.5
14	1374.17	10123.21(a)
29	1374.5	10176(f)
30	1374.51	10144.6
49	1374.55	10119.6
16	1374.56	10123.89
27	1374.72	10144.5
27	1374.72	10123.15
22	1374.73	10144.51
22	1374.73	10144.52
43	1367(b)	N/A
21	1367.2(a)	10123.6
28	1367.2(b)	10123.6
41	1367.3(b)(2)(d)	10119.8
23	1373(h)(1)	N/A
34	1373.10 (non-HMOs only[1])	10127.3
18	1374.10 (non-HMOs only[1])	10123.1

Appendix D. California Mandates (by Insurance Code Section)

The following table is presented to allow easy comparison of the mandates listed in Table 1. An N/A in either the Health and Safety Code column of the California Insurance Code column indicates that a mandate does not apply to products governed under that code.

#	Health and Safety Code (DMHC)	Insurance Code (CDI)
19	1368.2	N/A
23	1373(h)(1)	N/A
36	1367.215	N/A
37	1367.06	N/A
43	1367(b)	N/A
58	1367.24	N/A
60	1367.22	N/A
62	1367.002	10112.2
1	1367.005	10112.27
1	1367.006	10112.28
1	1367.0065	10112.285
51	1373.4	10119.5
49	1374.55	10119.6
40	1367.9	10119.7
41	1367.3(b)(2)(d)	10119.8
35	1367.71	10119.9
55	1373	10120
26	N/A	10122.1
18	1374.10 (non-HMOs only[1])	10123.1
33	1367.19	10123.141
27	1374.72	10123.15
17	1373.14	10123.16
4	1367.66	10123.18
53	1367.54	10123.184
15	1367.67	10123.185
61	1367.21	10123.195
47	1367.25	10123.196
48	1367.25	10123.196
3	1367.665	10123.2
7	1367.656	10123.206
56	1367.68	10123.21
38	1367.35	10123.5
39	1367.3	10123.55
21	1367.2(a)	10123.6
28	1367.2(b)	10123.6

#	Health and Safety Code (DMHC)	Insurance Code (CDI)
63	N/A	10123.68
31	1367.18	10123.7
2	1367.6	10123.8
5	1367.65	10123.81
32	1367.61	10123.82
45	1367.69	10123.83
9	1367.64	10123.835
45	1367.695	10123.84
6	1367.635	10123.86
50	N/A	10123.865
50	N/A	10123.866
52	1367.62	10123.87
57	1367.63	10123.88
16	1374.56	10123.89
54	1367.7	10123.9
13	1367.46	10123.91
25	N/A	10125
46	1368.5	10125.1
42	1371.5	10126.6
44	1367.11	10126.6
34	1373.10 (non-HMOs only[1])	10127.3
24	1367.8	10144
27	1374.72	10144.5
22	1374.73	10144.51
22	1374.73	10144.52
30	1374.51	10144.6
59	1367.4	10145
12	1367.45	10145.2
8	1370.6	10145.4
10	N/A	10176.6
11	1367.51	10176.61
20	N/A	10369.12
14	1374.17	10123.21(a)
29	1374.5	10176(f)