RESOURCE

Health Insurance Benefit Mandates in California State and Federal Law

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California Health Benefits Review Program (CHBRP)
University of California, Berkeley

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 (and other health-insurance related legislation).[1] 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.

This document includes the following:

- Table 1. California Health Insurance Benefit Mandates
- Table 2. California Mandates with Sunset or Contingency Language
- Table 3. Federal Health Insurance Benefit Mandates
- Appendix A. Explanation of Table Terms and Categories
- Appendix B. Discussion of Basic Health Care Services

Benefit Mandate Categories

CHBRP defines health insurance benefit mandates through the lens of its authorizing statute.[2] Therefore, the state mandates listed in Tables 1 and 2 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 (e.g. limits, timeframes, copayments, deductibles, coinsurance, etc.) for any of the other categories.

Information Included for Listed Mandates

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, explicitly includes Medi-Cal, Medi-Cal exempt, Medi-Cal excluded) are subject to the mandate. Explanations of these terms are provided in Appendix A. Table 1 organizes state health benefit mandates according to the following topics:

[1] Additional information about CHBRP is available at: www.chbrp.org.
[2] Available at: https://www.chbrp.org/about/faqs

- DMHC-regulated Basic Health Care Services
- Essential Health Benefits
- Behavioral Health
- Cancer
- Chronic Conditions
- Dental Care
- Hospice and Home Health Care
- Maternal and Reproductive Health
- Orthotics and Prosthetics
- Outpatient Prescription Drugs
- Pain Management
- Pediatric Care
- Provider Reimbursement
- Surgery
- Other

Table 2 lists California benefit mandate statutes that contain either a sunset clause or contingency language. Sunset clauses specify that the law will no longer be in effect after the listed date. Contingency language specifies that the state law is in effect only so long as a federal law is in effect, or only if federal rulings do not indicate that some or all of the state law would exceed essential health benefits (EHBs).

Table 3 identifies relevant federal statutes, both those in existence prior to passage of the Affordable Care Act (ACA)[3] as well as federal benefit mandates contained in the ACA. Like Table 1, Table 3 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 3.

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.[4]

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 benefit mandates: Federal benefit mandates can apply more broadly than state benefit mandates. For example, federal benefit mandates, unlike state mandates, may apply to Medicare or to self-insured plans. Table 3 only lists federal benefit mandate laws that are applicable to DMHC-regulated plans and CDI-regulated policies, which are also under the purview of state law.

Federal-state mandate overlap: DMHC-regulated plans and CDI-regulated policies may be subject to both state and federal benefit mandate laws. Federal benefit mandates may interact or overlap with state benefit mandates, as in the case of mammography benefits. In addition, state laws that duplicate federal laws allow state-level regulators explicit authority to implement them, as in the case of EHBs. Some known interactions are noted in the footnotes for Table 1.

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.

[3] 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).
[4] Available at: https://www.chbrp.org/other-publications/resources.

Table 1. California Health Insurance Benefit Mandates[5]

#	Topic	California Health and Safety Code[6] (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 "Basic Health Care Services" (BHCS)- Mix of law and regulation (see Appendix B)						
0	All DMHC-regulated health plans are required to cover medically necessary BHCS, 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. Large group health policies regulated by the California Department of Insurance (CDI) have similar requirements.	Multiple Sections - See Appendix B	10112.281		See Appendix B	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.[8,9] (also see Table 3)	1367.005 1367.006	10112.27 10112.28		Small Group and Individual[10] as well as Large Group if sold via Covered California[11] (Medi-Cal excluded)[12]	a, b, d

[5] Defined per CHBRP's authorizing statute, available at: https://www.chbrp.org/about/faqs

[6] DMHC regulates the portions of the health benefit mandate law related to the Health and Safety Code.

[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] Affordable Care Act (ACA), Section 1301, 1302, and Section 1201 modifying Section 2707 of the Public Health Service Act (PHSA). See Table 3 below.

[9] Review report: *Essential Health Benefits: An Overview of Benefits, Benchmark Plan Options, and EHBs in California*, available at: https://www.chbrp.org/other-publications/issue-briefs

[10] The EHB coverage requirement applies to non-grandfathered 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.

[11] 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.

[12] See Appendix A for explicitly includes Medi-Cal, Medi-Cal excluded, and Medi-Cal exempt language.

Behavioral Health							
2	Alcohol and drug exclusion prohibition		N/A	10369.12		Group (CDI) – not specified	d
3	Alcoholism treatment		1367.2(a)	10123.6	Offer	Group (Medi-Cal excluded)	a
4	Autism and related disorders: behavioral health treatment (also see Table 2)		1374.73	10144.51 10144.52		Not Specified (Medi-Cal exempt)	b
5	Care provided by a psychiatric health facility		1373(h)(1)	N/A		Not Specified (DMHC)	b, d
6	CARE Court evaluation development and health care services (in-network and out-of-network) required pursuant to court-approved CARE agreement or CARE plan		1374.723	10144.54		Not Specified (Medi-Cal exempt)	a
7	Medical necessity determination and utilization review (see also Table 3)		1374.72 1374.721	10144.5 10144.52		Not Specified (Medi-Cal excluded)	a, b, c, d
8	Mental and nervous disorders		N/A	10125	Offer	Group (CDI)	a
9	Nicotine or chemical dependency treatment		1367.2(b)	10123.6	Offer	Group (Medi-Cal excluded)	b, d
10	Parity (Mental Health and SUD)	With coverage for other medical conditions	1374.72	10144.5 10123.15		Not Specified (Medi-Cal exempt)	a, b, d
11		Compliance with federal law. [13]	1374.76	10144.4		Large Group and Individual (Medi-Cal excluded)	a, b, d
12	Physical handicaps		N/A	10122.1	Offer	Group (CDI)	a, d
13	Physical or mental impairment		1367.8	10144		Group and Individual (Medi-Cal excluded)	a, d
14	Prohibitions	Lifetime waiver for mental health services	1374.5	10176(f)		Individual (Medi-Cal excluded)	a, d
15		Determining reimbursement eligibility from inpatient admission status	1374.51	10144.6		Not Specified	d

[13] ACA Section 1311(j) and Section 1563(c)(4) modifying Section 2726 of the Public Health Services Act (PHSA). See Table 3 below.

Cancer – also see rows under "Outpatient Prescription Drug Benefit Mandates"							
16	Clinical trials		1370.6	10145.4		Group and Individual (Medi-Cal excluded)	b, d
17	HPV vaccine, coverage without cost sharing		1367.66	10123.18		Group and Individual (Medi-Cal excluded)	b, d
18	Mastectomy and lymph node dissection (length of stay, complications, prostheses, reconstructive surgery)		1367.635	10123.86		Not Specified	b, d
19	Screening	Breast cancer screening, diagnosis, and treatment	1367.6	10123.8		Not Specified	a
20		Cancer screening tests, with further requirements for biomarker tests	1367.665	10123.20		Not Specified (for biomarkers, explicitly includes Medi-Cal)	b, d
21		Cervical cancer screening	1367.66	10123.18		Group and Individual (Medi-Cal excluded)	a
22		Colorectal cancer, prohibits cost sharing	1367.668	10123.207			a,b,d
23		Mammography	1367.65(a)	10123.81		Not Specified (DMHC) Group and Individual (CDI)	a, c
24		Prostate cancer screening	1367.64	10123.835		Group and Individual (Medi-Cal excluded)	a
Chronic Conditions – also see rows under "Outpatient Prescription Drugs," which are often relevant to chronic condition treatment							
25	Diabetes	Education	N/A	10176.6	Offer	Not Specified (CDI)	a
26		Education, management, and treatment	1367.51	10176.61		Not Specified	a, b, d
27	HIV/AIDS	AIDS vaccine	1367.45	10145.2		Group and Individual (DMHC), Not Specified (CDI) (Medi-Cal excluded)	a
28		HIV Testing	1367.46	10123.91		Group and Individual (Medi-Cal excluded)	a

29		Transplantation services for persons with HIV	1374.17	10123.21		Group and individual (CDI) Not Specified (DMHC)	d
30	Osteoporosis		1367.67	10123.185		Not Specified	a
31	Phenylketonuria		1374.56	10123.89		Not Specified	a
Hospice & Home Health Care							
32	Dementing illness exclusion prohibition		1373.14	10123.16		Group and Individual (Medi-Cal excluded)	a, d
33	Home health care		1374.10 (non-HMOs only)	10123.10	Offer	Group (Medi-Cal excluded)	b, d
34	Hospice care		1368.2	N/A[14]		Group (DMHC) (Medi-Cal excluded)	b
Maternal and Reproductive Health							
35	Abortion services: cost sharing		1367.251	10123.1961		Not specified, Medi-Cal included (DMHC) Group and Individual (CDI)	d
36	Contraception	Annual supply of self-administered hormonal contraceptives	1367.25	10123.196		Group and Individual (Medi-Cal excluded)	d
37		Contraceptive devices (including devices requiring a prescription) and male/female sterilization, and related clinical services	1367.25	10123.196		Group and Individual (explicitly includes Medi-Cal)	b
38		Sterilization rationale exclusion prohibition	1373(b)	10120		Not Specified	d
39		Vasectomies: cost sharing	1367.255	10123.1945		Not specified	d
40	Fertility/ Infertility	Fertility preservation services	1374.551	N/A		Not specified (Medi-Cal exempt)	a, b
41		Infertility treatments	1374.55	10119.6	Offer	Group (Medi-Cal excluded)	a, b, d
42	Maternity	Copayment or deductible for inpatient services	1373.4	10119.5		Not Specified (Medi-Cal excluded)	d
43		Maternal mental health	1367.625	10123.867		Not Specified	a

[14] N/A indicates that the benefit mandate does not apply to products governed under the specified code.

44		Maternity services	N/A	10123.865 10123.866		Group and Individual (CDI)	b
45		Minimum length of stay[15]	1367.62	10123.87		Not Specified (DMHC) Group and Individual (CDI)	d
46	Prenatal	Participation in the statewide prenatal testing Expanded Alpha-fetoprotein (AFP)[16] program	1367.54	10123.184		Group and Individual (Medi-Cal excluded)	b
47		Prenatal diagnosis of genetic disorders	1367.7	10123.9	Offer	Group (Medi-Cal excluded)	b
48	Reproductive and sexual health care services		1367.31	10123.202		Not Specified (Medi-Cal exempt)	d
Orthotics & Prosthetics							
49	Orthotic and prosthetic devices and services		1367.18	10123.7	Offer	Group (Medi-Cal excluded)	b
50	Prosthetic devices for laryngectomy		1367.61	10123.82		Not Specified	b
51	Special footwear for persons suffering from foot disfigurement		1367.19	10123.141	Offer	Group (Medi-Cal excluded)	b
Outpatient Prescription Drugs							
52	Authorization for nonformulary prescription drugs		1367.24	N/A		Not Specified (DMHC) (Medi-Cal exempt)	d
53	HIV/AIDS, pre-exposure and post-exposure prophylaxis: prohibition of step therapy or prior authorization		1342.74	10123.1933		Not specified	d
54	Oral anticancer medication cost-sharing limits		1367.656	10123.206		Group and Individual (Medi-Cal excluded)	d
55	Biosimilar medication step therapy allowance		1367.206	10123.201		Not specified	d
56	Cost sharing, formularies, and utilization management protocols		1342.73 1367.205	10123.1932 10123.192		Varied: some Not Specified (some Medi-Cal exempt)	b, d

[15] 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 3 below.

			1367.41 1367.42 1367.47	10123.201 10123.193 10123.65		and some Small Group and Individual (Medi-Cal excluded)	
57	"Off-label" use		1367.21	10123.195		Not Specified (DMHC), Group and Individual (CDI)	d
58	Previously prescribed drugs		1367.22	N/A		Not Specified (DMHC)	d
59	Prior authorization requests		1367.241	10123.191		Not Specified (Medi-Cal exempt)	d
60	Prorating cost sharing for partial fill for Schedule II controlled substance		1367.43	10123.203		Not specified	d
61	Sexually transmitted diseases (STDs): at home tests, in network only		1367.34	10123.208		Not Specified (Medi-Cal exempt)	a, b
62	Step Therapy		1367.244 1367.206	10123.197 1367.241		Not Specified (Medi-Cal exempt)	d
Pain Management							
63	Acupuncture		1373.10 (non-HMOs only)	10127.3	Offer	Group (Medi-Cal excluded)	c, d
64	General anesthesia for dental procedures		1367.71	10119.9		Not Specified	b
65	Pain management medication for terminally ill		1367.215	N/A		Not Specified (DMHC)	b
Pediatric Care							
66	Asthma management		1367.06	N/A		Not Specified (DMHC)	a
67	Comprehensive preventive care	Children aged 16 years or younger	1367.35	10123.5		Group (Medi-Cal excluded)	b
68		Children aged 17 or 18 years	1367.3	10123.55	Offer	Group (Medi-Cal excluded)	b
69	Effects of diethylstilbestrol		1367.9	10119.7		Not Specified (DMHC) Group and Individual (CDI)	a
70	Screening	Children at risk for lead poisoning for blood lead levels	1367.3(b)(2)(D)	10123.5 10123.55		Group (DMHC), Group (CDI) (Medi-Cal excluded)	b

71		Children (and adults) for adverse childhood experiences (ACEs)	1367.34	10123.51		Not Specified	a, b
72		Children for blood lead levels	N/A	10119.8	Offer	Individual or Group (CDI)	b
Provider Reimbursement							
73	Licensed or certified providers		1367(b)	N/A		Not Specified	c, d
74	OB-GYNs as primary care providers[17]		1367.69 1367.695	10123.83 10123.84		Not Specified	c, d
75	Pharmacists – compensation for services within their scope of practice		1368.5	10125.1	Offer	Not Specified (DMHC) Group (CDI)	c, d
76	Telehealth		1374.13 1374.14	10123.85 10123.855		Not Specified (explicitly includes Medi-Cal)	c, d
Surgery							
77	Jawbone or associated bone joints		1367.68	10123.21		Not Specified (DMHC) Group and Individual (CDI)	a
78	Reconstructive surgery[18]		1367.63	10123.88		Not Specified (Medi-Cal exempt)	b
Other Benefits							
79	Blindness or partial blindness exclusion prohibition		1367.4	10145		Group and Individual (Medi-Cal excluded)	a, d
80	Biomarker testing		1367.667	10123.209		Not Specified	b
81	COVID-19 diagnostic and screening testing		1342.2	10110.7		Not Specified	a, b, d
82	Cost sharing limits	EHBs, prohibits lifetime and annual dollar coverage limits (also see Table 3)	1367.001	10112.1		Group and Individual (Medi-Cal excluded)	b, d
83		Emergency medical ground transportation	1371.56	10126.66		Not Specified	d

[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 3 below.
[18] The federal Women's Health and Cancer Rights Act of 1998 requires coverage for post mastectomy reconstructive surgery. See Table 3 below.

84	Family cost sharing limits (also see Table 3)	1367.006 1367.007	10112.28 10112.29	Varied: Large Group, Small Group, Individual (Medi-Cal excluded)	d
85	Federally recommended preventive services without cost sharing as soon as 12 months after a recommendation appears in any of these sources, benefit coverage is required. The sources are: • 'A' and 'B' rated recommendations of the United States Preventive Services Task Force (USPSTF)[19]; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC)[20]; • 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)[21]; and • For women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA. (See Table 3 for matching Federal mandate)	1367.002	10112.2	Group and Individual (Medi-Cal excluded)	b, d
86	Dental benefits – prohibition of waiting period and preexisting condition provision	1374.194 1385.02	10120.41 10181.2	Group and Individual (Medi-Cal excluded)	d
87	Emergency 911 transportation[22]	1371.5	10126.6	Not Specified	d
88	Public health emergency (CA governor declared) disease prevention/mitigation services	1342.3	10110.75	Not Specified	a, b, d
89	Second opinions	N/A	10123.68	Not Specified (CDI)	c

Source: California Health Benefits Review Program, 2023.

[19] Available at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
[20] Available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.
[21] 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.
[22] 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 3 below.

Table 2. California Mandates with a Sunset or Contingency Clause in Existing Code (by Topic)

#	Topic	California Health and Safety Code (DMHC)	California Insurance Code (CDI)	Disabling Clause (Type and Language)
Mental Health Benefit Mandates				
1	Behavioral health treatment for autism and related disorders	1374.73	10144.51 10144.52	CONTINGENCY – 1374.73(a)(2) and 10144.51(a)(2): "[This] section does not require any benefits to be provided that exceed the essential health benefits that all health insurers will be required by federal regulations to provide under Section 1302(b) of the federal Patient Protection and Affordable Care Act."
Other Benefit Mandates				
2	Family cost sharing limits	1367.006 1367.007	10112.28 10112.29	CONTINGENCY – 1367.006(c)(2) and 10112.28(c)(2): "The [annual out-of-pocket] limit shall result in a total maximum out-of-pocket limit for all covered essential health benefits equal to the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of [the federal Patient Protection and Affordable Care Act (PPACA)]." CONTINGENCY – 1367.007(a)(2) and 10112.29(a)(2): "The dollar amounts [of the small employer deductible] shall be indexed consistent with Section 1302(c)(4) of PPACA and any federal rules or guidance pursuant to that section."
3	Preventive services without cost sharing (in compliance with federal laws and regulations)[23]	1367.002	10112.2	CONTINGENCY - 1367.002 and 10112.2: "To the extent required by federal law, a group or individual [health plan shall] comply with Section 2713 of the federal Public Health Service Act [as added by] Section 1001 of the federal Patient Protection and Affordable Care Act."

Source: California Health Benefits Review Program, 2023.

[23]ACA, Section 1001 modifying Section 2713 of the PHSA.

Table 3. Federal Health Insurance Benefit Mandates[24]

#	Federal Law	Topic Addressed by Benefit Coverage Mandate[25]	Markets Subject to the Mandate[26]	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 post-mastectomy 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.[27]	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. [28]	Group and Individual	d
6	Section 1001 modifying Section 2713 of the PHSA	Federally recommended preventive services without cost sharing. [29,30] 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) [31]; • Immunizations recommended by the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) [32];		

[24] CHBRP defines health insurance benefit mandates as per its authorizing statute, available at: https://www.chbrp.org/about/faqs.
[25] All listed federal health insurance benefit mandates are benefit coverage mandates. CHBRP is aware of no federal "mandates to offer."
[26] Unless otherwise noted, the federal mandates in the ACA do not apply to grandfathered health plans (Section 1251).
[27] California law requires compliance with this mandate. See Table 1 above (categorized with "Mental Health Benefit Mandates").
[28] 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)].
[29] California law requires compliance with this mandate. See Table 1 above (categorized with "Other Benefit Mandates").
[30] For more information on the preventive services coverage requirement, see CHBRP's resource, *Federal Recommendations and the California and Federal Preventive Services Benefit Mandates*, available at: https://www.chbrp.org/other-publications/resources.
[31] Available at: http://www.uspreventiveservicestaskforce.org/Page/Name/uspstf-a-and-b-recommendations/.
[32] Available at: www.cdc.gov/vaccines/hcp/acip-recs/index.html.

		• 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)[33]; and • For women, preventive care and screenings provided for in comprehensive guidelines supported by HRSA.[34] (See Table 1 for matching California mandate)		
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[35]	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.[36]	Small Group and Individual[37] In 2017, Large Group sold via Covered California[38]	a, b, d

Source: California Health Benefits Review Program, 2023.

[33] 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.

[34] Available at: https://www.hrsa.gov/womens-guidelines/index.html

[35] Applies to grandfathered group market health plans and grandfathered individual market plans [ACA Section 1251(a)(4)].

[36] California has laws in place to define EHBs for the state. See Table 1 above (categorized with "Essential Health Benefits").

[37] 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.

[38] 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. Explanation of Table Terms and Categories

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 per the California Health and Safety Code.[39] In addition to commercial enrollees,[40] a majority of Medi-Cal beneficiaries are enrolled in DMHC-regulated plans.[41]

- 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.[42]

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 individual market includes health insurance products issued to an individual to provide coverage for a person and/or their dependents.

- The group markets include health insurance products issued to employers (or other entities) to provide coverage for employees (or other persons) and/or their dependents. The large group market includes plans or policies with 101 or more enrollees. The small group market includes plans and policies with 1-100 enrollees.

- Technically not in a "market," the majority of Medi-Cal beneficiaries are enrolled in a DMHC-regulated plan. These beneficiaries are not considered to be in "group" market plans. These beneficiaries' plans may or may not be subject to the mandates listed in this document. Where possible, notes have been added to Table 1 indicating whether or not these beneficiaries' plans are subject to the listed benefit mandate. The added notes are:

[39] Available at: http://leginfo.legislature.ca.gov/faces/home.xhtml
[40] This group includes enrollees in DMHC-regulated plans associated with the California Public Employees' Retirement System (CalPERS) but not persons enrolled in CalPERS' self-insured plan (which is subject only to federal law).
[41] See CHBRP's *Estimates of Sources of Health Insurance*, a resource available at https://www.chbrp.org/other-publications/resources
[42] Available at: http://leginfo.legislature.ca.gov/faces/home.xhtml

- Explicitly includes Medi-Cal: the law explicitly requires compliance from health insurance products enrolling Medi-Cal beneficiaries.

- Medi-Cal exempt: the law explicitly exempts from compliance health insurance products enrolling Medi-Cal beneficiaries.

- Medi-Cal excluded: the law specifies that it is applicable to group and/or individual market health insurance products – as Medi-Cal beneficiaries are enrolled in neither,[43] CHBRP assumes that health insurance products enrolling Medi-Cal beneficiaries are not required to comply.

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.

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.

[43] DMHC and healthcare.gov specify that individual health plans are plans that you buy on your own, for yourself, or for your family and group health plans are obtained through your job, union, or as a retiree for employees/retirees and their families (see https://www.dmhc.ca.gov/HealthCareinCalifornia/TypesofCoverage.aspx and https://www.healthcare.gov/glossary/group-health-plan/). Enrollment of Medi-Cal beneficiaries in DMHC-regulated plans seems to fit neither definition.

Appendix B. Discussion of Basic Health Care Services[44]

Health care service plans are regulated by the California Department of Managed Health Care (DMHC). They are subject to the Knox-Keene Health Care Service Plan Act of 1975 (Knox-Keene Act), as amended, under the Health and Safety Code.[45] 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 a single provision, and thus is not a health insurance benefit mandate as 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 Knox-Keene 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 place requirements on health care service plans regarding denial, delay, or modification of coverage based on a decision for medical necessity (Section 1367.01).[46] In addition, Section 1300.67 of Title 28 of the California Code of Regulations, which further defines "basic health care services," further clarifies 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 applicable regulations can be accessed online on the DMHC's website at www.dmhc.ca.gov.

[44] The text in this appendix was adapted from a document prepared by the Department of Managed Health Care.
[45] Health and Safety Code Section 1340 et seq.
[46] CHBRP's issue brief on the medical necessity determination process can be found at https://www.chbrp.org/other-publications/issue-briefs

About CHBRP

The California Health Benefits Review Program (CHBRP) was established in 2002. As per its authorizing statute, CHBRP provides the California Legislature with independent analysis of the medical, financial, and public health impacts of proposed health insurance benefit-related legislation. The state funds CHBRP through an annual assessment on health plans and insurers in California.

An analytic staff based at the University of California, Berkeley, supports a task force of faculty and research staff from multiple University of California campuses to complete each CHBRP analysis. A strict conflict-of-interest policy ensures that the analyses are undertaken without bias. A certified, independent actuary helps to estimate the financial impact. Content experts with comprehensive subject-matter expertise are consulted to provide essential background and input on the analytic approach for each report. Detailed information on CHBRP's analysis methodology, authorizing statute, as well as all CHBRP reports and other publications are available at http://www.chbrp.org/.

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