HOUSE BILL NO. 622

INTRODUCED BY T. MCGILLVRAY

A BILL FOR AN ACT ENTITLED: "AN ACT PROVIDING FOR REVIEW OF A PROPOSED MANDATED BENEFIT, A PROPOSED CHANGE TO A MANDATED BENEFIT, AND EXISTING MANDATED BENEFITS BY THE COMMISSIONER OF INSURANCE."

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MONTANA:

NEW SECTION. **Section 1. Statement of purpose.** The purpose of [sections 1 through 4] is to provide for a review of mandated benefits. [Sections 1 through 4] require that a proposed mandated benefit or a proposed change to a mandated benefit be reviewed by the commissioner. The commissioner shall review 20% of the mandates annually as provided in [sections 1 through 4].

NEW SECTION. **Section 2. Definitions.** As used in [sections 1 through 4], the following definitions apply:

(1) "Health care provider" means a person licensed to provide any form of physical or mental health care under Title 37 or a health care facility licensed under Title 50, chapter 5.

(2) "Mandated benefit" includes:

(a) a mandated insurance coverage for specific medical or health-related services, treatments, medications, or practices;

(b) a mandated insurance coverage of the services specific to a health care provider;

(c) a mandate requiring an offering of specific services, treatments, medications, or practices to prospective customers by a health insurer;

(d) a mandated reimbursement amount to specific health care providers; or

(e) an expansion of a mandate described in subsections (2)(a) through (2)(d).

NEW SECTION. **Section 3. Mandated health benefit review.** (1) A proposal for a mandated benefit or a proposed change to an existing mandated benefit must be evaluated for medical efficacy and financial impact as provided in this section. Before a proposal may be introduced as legislation before the legislature, the proposal must be submitted for review to the commissioner by the party seeking the mandate or the legislator requesting

the legislation.

(2) The commissioner shall retain an independent actuary to review the proposal or amendment within 90 days after complete documentation is submitted and to ensure that appropriate assumptions are used to accurately demonstrate the financial impact of the proposal. The commissioner shall include the results of the review in a report.

(3) The report must accompany any proposed legislation at introduction and must include information as to whether:

(a) the information provided for in subsection (4) is complete;

(b) the research cited meets professional standards;

(c) all relevant research has been included; and

(d) the conclusions and interpretations that are drawn from the evidence are consistent with the data presented.

(4) The commissioner shall address the following concerns in determining the adequacy of the information presented in the report:

(a) if the insurance coverage is not generally in place, to what extent the lack of coverage results in financial hardship;

(b) what is the demand for the proposed mandated benefit from the public and in collective bargaining negotiations and to what extent is voluntary coverage available;

(c) the medical efficacy as demonstrated by the following evidence:

(i) for a particular service, treatment, medication, or practice, results of at least one clinical trial demonstrating the medical consequences of the service, treatment, medication, or practice compared to no therapy or to alternative therapies and any other relevant clinical research;

(ii) for a service of a particular health care provider, results of at least one professionally accepted, controlled trial demonstrating the medical effects achieved by the specific class of provider or medical specialty relative to the health care providers already covered and any other relevant clinical research;

(d) the financial impact as evidenced by the extent to which:

(i) insurance coverage of the mandated benefit will increase or decrease the cost of a service, treatment, medication, or practice;

(ii) the same or similar mandated benefits have affected costs, charges, use, and payments in other states;

(iii) the mandated benefit will increase the appropriate use of the service, treatment, medication, or

practice;

(iv) the mandated benefit will be a substitute for more or less expensive services, treatments, medications, or practices;

(v) the mandated benefit will increase or decrease the administrative expenses of third-party payors and the premium and administrative expenses of policyholders;

(vi) there will be a financial impact of the mandated benefit on small employers, medium-sized employers, large employers, the state employee health benefit plan, the comprehensive health association, the public employees' retirement system, and purchasers of individual coverage.

NEW SECTION. **Section 4. Review of existing mandated benefits.** The commissioner shall biennially review 20% of existing state-mandated benefits as provided in [section 1]. The commissioner shall report the findings to the economic affairs interim committee and the office of budget and program planning by September 15 of each even-numbered year.

NEW SECTION. **Section 5. Codification instruction.** [Sections 1 through 4] are intended to be codified as an integral part of Title 33, chapter 22, and the provisions of Title 33, chapter 22, apply to [sections 1 through 4].

NEW SECTION. **Section 6. Severability.** If a part of [this act] is invalid, all valid parts that are severable from the invalid part remain in effect. If a part of [this act] is invalid in one or more of its applications, the part remains in effect in all valid applications that are severable from the invalid applications.

- END -