Mandate Review: Summary of State Requirements

(as of October 10, 2019)

History: As the number of state mandates has increased over the years, many states have enacted laws requiring the systematic review of health mandates.

- To date, 28 states (AZ, CA, CT, FL, GA, HI, IN, KS, KY, LA, ME, MD, MA, MO, MN, MS, NY, NH, NJ, ND, OH, PA, RI, TN, UT, VA, WA, and WI) have enacted such laws.
- Nevada has included a provision in the General Assembly's joint rules which requires the review of any health insurance mandate requiring coverage for any treatment or service.

2019 Activity:
To date in 2019, the following have been enacted:

GA: HB 533 repealed Georgia's statutory provisions establishing a special advisory commission on mandated health insurance benefits.

HI: HR 88/SCR 171/ SR 138 directs the State Auditor to conduct an assessment of the social and financial effects of mandating health insurers to provide coverage for clinical victim support services for victims of sexual violence.

Approaches: The majority of state laws authorize formal benefit review panels or commissions to evaluate the financial and social (i.e., access to services) impacts of mandates under consideration. In addition, several states also require the evaluation of the medical impact (i.e., medical efficacy) of mandates under consideration. HI's law is restricted to the evaluation of mental health and substance abuse mandates.

- The state laws vary as to who conducts the reviews. In some states, reviews are conducted by the staff of state agencies, in other states, reviews are conducted by political appointees to a review commission or by private contractors.

Test track for mandates. DE, KS and ND laws require any new benefit mandate to be implemented on a pilot basis for one year in the state employee health benefits program.

- After one year, the state employee systems are required to make recommendations as to whether the mandate should be continued for the state's employee health benefit program.

Binding nature of reviews. No state makes recommendations made through the mandate review processes binding on the legislature.

Fiscal support. CA and CO supplement the funding of mandate review through an annual fee on health insurance plans.

Chart: The following chart summarizes enacted laws in the states as of October 10, 2019.

State	Key Provisions
Arizona *Ariz. Rev. Stat. §20-181, §20-182, and §20-183* Effective 2003 Amended 2010	**Mandate review.** Requires an organization or individual advocating a legislative proposal which would mandate health coverage or offering by an insurer, hospital, medical, dental, or optometric service corporation, health care services organization or any other health care service contractor to submit a report explaining the factors prescribed in section 20–182 to the Joint Legislative Audit Committee on or before September 1 before the start of the legislative session for which the legislation is proposed. **Mandate review criteria.** Requires the report to assess the social and financial impacts of such coverage, including the effectiveness of the treatment or service proposed. *Social impacts* include (to the extent the information is available) the: • extent to which the treatment or service is generally utilized by a significant portion of the population; • extent to which the insurance coverage is already generally available, and if coverage is not generally available, the extent to which the lack of coverage results in persons avoiding necessary health care treatments or unreasonable financial hardship to the patient; • level of public demand for the treatment or service; • level of public demand for insurance coverage of the treatment or service; and • level of interest of collective bargaining agents in negotiations privately for inclusion of this coverage in group contracts. *Financial impacts* include (to the extent the information is available) the: • extent to which the coverage will increase or decrease the cost of the treatment or service; • extent to which the coverage will increase the appropriate use of the treatment or service; • extent to which the mandated treatment or service will be a substitute for a more expensive treatment or service; • extent to which the coverage will increase or decrease the administrative expenses of insurers and the premium and administrative expenses of policyholders; and • impact of this coverage on the total cost of health care. **Reports.** The joint legislative audit committee shall assign the written report to the appropriate legislative committee of reference established pursuant to section 41–2954. The legislative committee of reference shall hold at least one hearing and take public testimony after receiving the report. The legislative committee of reference shall study the written report and deliver a report of its recommendations to the joint legislative audit committee, the speaker of the house of representatives, the president of the Senate, the governor and the director of the department of insurance on or before December 1 of the year in which the report is submitted.
California *Cal. Health & Safety Code*	**Mandate review.** Requests the University of California to establish the California Health Benefit Review Program to assess proposed mandated benefit, service, or provider legislation. Also requests that the program assess legislation that impacts health insurance benefit design, cost-sharing, premiums, and other health insurance topics.

State	Key Provisions
§127660 Effective 2003 Amended 2019 Sunsets 7/1/2020	• Requests may be made by committee chairs, the Speaker of the Assembly, or the President of the Senate before bill introduction. **Mandate evaluation criteria.** Requests that evaluations include public health, medical and financial impacts. *Public health impacts* include, but are not limited to the: • impact on the health of the community, including (1) reduction of communicable disease, (2) benefits of prevention, and (3) diseases and conditions where gender and racial disparity outcomes are established in peer-reviewed scientific and medical literature; and • extent to which the proposed services reduce premature death and the economic loss associated with disease. *Medical impacts* include, but are not limited to, the extent to which the proposed mandate: • is generally recognized in the medical community as effective in screening, diagnosis, or treatment of a condition or disease, as demonstrated by a review of scientific and peer-reviewed medical literature; • is generally available and utilized by treating physicians; • makes a contribution to the health status of the population (including alternatives or not providing the benefit or service); and • does not diminish or eliminate access to currently available health care services. *Financial impacts* include, but are not limited to, the extent to which: • coverage will increase or decrease the benefit or cost of the service; • coverage will increase utilization of the benefit or service, or will be a substitute for, or affect the cost of, alternative services; • coverage will increase or decrease plan administrative expenses and the premium and expenses of subscribers/enrollees/policyholders; • the coverage has an impact on the total cost of health care; • coverage or repeal of coverage will have on anticipated costs or savings estimated upon implementation for one subsequent calendar year, or, if applicable, two subsequent calendar years through a long-range estimate. • there is potential cost or savings to the private sector, including the impact on small employers; • costs resulting from lack of coverage are shifted to other payers, including both public and private entities; • the proposed mandate does not diminish or eliminate access to currently available health care services; • the benefit or service is generally utilized by a significant portion of the population; • coverage for the benefit or service is already generally available; and • there is a level of public demand for coverage of the benefit or service, including interest of collective bargaining agents negotiating privately for such coverage in group contracts, and the extent to which the proposed mandate is covered by self-funded employers. **Fiscal support.** Requires health care service plans and health insurers to be assessed an annual fee to be determined by the Department of Managed Health Care and the DOI to support the University in its work to implement this Act.

State	Key Provisions
	• Annual fees shall be set in consultation with the University and be limited to the amount necessary to "fund the actual and necessary expenses of the analysis." **Reports.** After a request for review, the University has 60 days to report its findings. The Legislature also requests that the university post every analysis on the Internet and make every analysis available to the public upon request. • Requests that the university use a certified actuary or other person with relevant knowledge and expertise when assessing and preparing a written analysis of the financial impact of legislation proposing to mandate a benefit or service and legislation proposing to repeal a mandated benefit or service. **Conflict of interest provisions.** Requires the University to implement conflict of interest provisions including reviewer material financial interest, including holding a consulting agreement with a person or organization that would be affected by the legislation.
Connecticut *Conn. Gen. Stat. §38a-21* Effective 2009	**Mandate review.** Establishes, within the insurance department, a Health Benefit Review Program for the review and evaluation of any mandated health benefit that is requested by the joint standing committee of the General Assembly relating to insurance. Requires the commissioner to contract with The University of Connecticut Center for Public Health and Health Policy to conduct any mandated health benefit review **Mandate evaluation criteria.** Requires the evaluation of the social, financial, impacts of requested mandates. *Social impacts* include (to the extent information is available): • the extent to which the treatment, service or equipment, supplies or drugs, as applicable, is utilized by a significant portion of the population; • the extent to which treatment, service or equipment, supplies or drugs, as applicable, is currently available to the population including, but not limited to, coverage under Medicare; • the extent to which insurance coverage is already available for the treatment, service or equipment, supplies or drugs; • if the coverage is not generally available, the extent to which such lack of coverage results in persons being unable to obtain necessary health care treatment or endure unreasonable financial hardships on those persons needing treatment; • the level of public demand and the level of demand from providers and insurers for the treatment, service, supplies or drugs, and coverage of such treatment, service, equipment, supplies or drugs; • the likelihood of achieving consumer need as experienced by other states; • whether the benefit is a medical or broader social need and whether it is consistent with the role of health insurance and the concept of managed care; • the impact of the benefit on the availability of other benefits currently offered; and • the extent to which credible scientific evidence published in peer0reviewed medical literature generally recognized by the relevant medical community determines the treatment, service or equipment, supplies or drugs, as applicable to be safe and effective.

State	Key Provisions
	Financial impacts include (to the extent information is available): • the extent to which the mandated health benefit may increase or decrease the cost of or the inappropriate use of the treatment, service or equipment, supplies or drugs, as applicable over the next five years; • the extent to which the mandated health benefit may serve as an alternative for more expensive or less expensive treatment, service or equipment, supplies or drugs as applicable; • the methods that will be implemented to manage the utilization and costs of the mandated health benefit; • the extent to which insurance coverage for the mandate may be reasonably expected to increase or decrease the insurance premiums and administrative expenses for policyholders; • the impact on the total cost of health care, including potential benefits or savings to insurers and employers; • the extent to which the treatment, service or equipment, supplies or drugs is more or less expensive than an existing treatment, service or equipment, supplies or drugs that is determined to be equally safe and effective by credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and • the impact the mandated benefit would have on cost-shifting between private and public payors. **Report.** Requires, by August 1 of each year, for the joint standing committee of the General Assembly having cognizance of matters relating to insurance to submit to the commissioner a list of any mandated health benefits for which review is requested. Requires, not later than January 1 of the succeeding year, requires the commissioner to submit a report of the findings of such review.
Florida *Fla. Stat. §624.215* Effective 2000	**Mandate review.** Requires anyone seeking consideration of a legislative proposal mandating health coverage or the offering of coverage in either the group or individual markets, to submit to the Agency for Health Care Administration and legislative committees with jurisdiction, a report assessing social and financial impacts of the proposed coverage. **Mandate evaluation criteria.** Requires legislative staff conducting a review to include in their impact assessment of proposed mandates: • the extent to which the treatment or service is generally used by a significant proportion of the population; • the extent to which insurance coverage is generally available, and if not available, the extent to which the lack of coverage would result in people avoiding necessary treatment; • the level of public demand for the treatment or service; • the level of public demand for insurance coverage of the treatment or service; • the level of interest of collective bargaining in negotiating for the inclusion of this coverage in group contracts; • the extent to which the coverage increases or decreases the cost of the treatment or service; • the extent to which the mandated treatment or service would be a substitute for a more expensive treatment or service; • the extent to which coverage increases or decreases administrative expenses of insurers and the premium and administration expenses of policyholders; and • the impact of this coverage on the total cost of health care.

State	Key Provisions
Georgia *GA Code Ann. §33-24-61 and §33-24-64* Effective 2000	**Mandate review.** Requires the General Assembly to develop (through the DOI) fiscal impact statements of proposed mandated or mandatorily offered health insurance benefits. • Such review will assist the General Assembly in determining whether mandating a certain health insurance benefit is in the public interest.
~~**Georgia**~~ ~~*GA Code Ann. §33-1-19*~~ ~~Effective 2012~~ Repealed 2019	~~**Mandate review.** Establishes the Special Advisory Commission on Mandated Health Insurance Benefits (Commission), effective February 1, 2012, to advise the governor and General Assembly on the social and financial impact and the medical efficacy of current and proposed mandated benefits and providers. Establishes membership criteria for the Commission, including the health insurance industry.~~ ~~**Mandate evaluation criteria.** Requires the Commission to develop and maintain, within the department of insurance, a system and program of data collection to assess the impact of mandated benefits and providers, including costs to employers and insurers, impact of treatment, cost savings in the health care system, number of providers, and other data as appropriate.~~ ~~**Reports.**~~ • ~~Requires the Commission to report annually (by December 1) on its activities to the joint standing committee of the General Assembly having jurisdiction.~~ • ~~Requires the Commission to assess the social and financial impact and the medical efficacy of existing mandated benefits and providers in effect as of January 1, 2012, to the standing committees of the General Assembly with jurisdiction by May 1, 2012.~~
Hawaii *Haw. Rev. Stat. § 23-51 and § 23-52* Effective 1990	**Mandate review.** Requires concurrent resolutions to be passed requesting the auditor to prepare and submit to the legislature a report that assesses both the social and financial effects of the proposed mandated coverage before any legislative measure that mandates health insurance coverage for specific health services, specific diseases, or certain providers of health care services as part of individual or group health insurance policies, can be considered. **Mandate evaluation criteria.** Requires the auditor's report to study the following: *Social impacts*: • The extent to which the treatment or service is generally utilized by a significant portion of the population; • The extent to which such insurance coverage is already generally available;

State	Key Provisions
	• If coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment or an unreasonable financial hardship on those persons needing treatment; • The level of public demand for the treatment or service; • The impact of providing coverage for the treatment or service (such as morbidity, mortality, quality of care, change in practice patterns, provider competition, or related items); and • The impact of any other indirect costs upon the costs and benefits of coverage as may be directed by the legislature or deemed necessary by the auditor in order to carry out the intent of this section. *Financial impacts:* • The extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service; • The extent to which the proposed coverage might increase the use of the treatment or service; • The extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service; • The extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and • The impact of this coverage on the total cost of health care.
Kansas *Kan. Stat. Ann. §40-2248 and §40-2249* Effective 1990	**Mandate review.** Provides that new mandated health insurance coverage for specific health services, diseases or providers approved by the Legislature apply only to the state health care benefits program for at least one year. • After the one-year period, requires the Kansas State Employees Health Care Commission to submit a report to the Legislature indicating the impact such mandate has had on the state's health care benefits program and making a recommendation whether such mandated coverage should continue or whether additional utilization and cost data is required. **Mandate evaluation criteria.** Requires the Commission to use the following social and financial evaluation criteria when assessing the impact of a mandate, to the extent such information is available. *Social impacts* include: • the extent to which the treatment or service is generally utilized by a significant portion of the population; • the extent to which such insurance coverage is already generally available, and if not available, the extent to which the lack of coverage results in people being unable to obtain necessary treatment; • the level of public demand for the treatment or service; • the level of public demand for individual or group insurance coverage of the treatment or service; • the level of interest of collective bargaining organizations in negotiating inclusion of such coverage in group contracts; and • the impact of indirect costs (costs other than premiums and administrative costs) on coverage.

State	Key Provisions
	Financial impacts include the extent to which: • insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service; • proposed coverage might increase the use of the treatment or service; • mandated treatment or service might serve as an alternative for more expensive treatment or service; • insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and • the coverage would impact the total cost of health care.
Kentucky *KY. Rev. Stat. Ann. §6.948* Effective 1998 Amended 2010	**Mandate review.** Requires a financial impact statement for any bill mandating health benefits. • Requires a sponsor of a mandated benefits bill and any member proposing an amendment to such a bill to submit to the standing committee to which the bill has been referred a financial impact statement on health insurance coverage rates before final consideration by the committee. • Until the time a financial impact statement is prepared and attached to a bill or amendment that contains a mandated health benefit, action on the proposed shall not be in order. • Requires the Department of Insurance to prepare the financial impact statement. **Mandate review criteria.** Requires the financial impact statement to analyze the extent to which the mandated health benefit will: • increase or decrease premiums and the administrative expenses of insurers; and • impact the total cost of health care in Kentucky, including any potential cost savings that may be realized. **Report.** The financial impact statement shall be in writing and signed by the commissioner of the Department of Insurance or the commissioner's designee and be completed as soon as possible, but no later than thirty (30) days after the request by the sponsor of a measure.
Louisiana *LA Rev. Stat §22:2187* Effective 2016	**Mandate review.** Creates the Louisiana Mandated Health Benefits Commission (Commission), within the department of insurance to review mandated benefit proposals. Establishes Commission membership criteria. **Mandate evaluation criteria.** Requires the Commission to evaluate proposed legislation in any session to determine if the legislation creates a mandated health benefit that would require the state to defray the costs of the mandate for QHPs in excess of EHBs pursuant federal law. If the Commission determines that a mandate for QHPs is in excess of EHBs, it shall, in consultation with the Department of Insurance, notify the House and Senate committees on insurance of its determination that a mandate has been proposed and shall provide an actuarial cost projection for the cost of the proposed mandate for QHPs and non-QHPs. If the legislature enacts a mandate that is in excess of EHBs, the Commission must determine what the cost of the enacted mandate is to all QHPs and shall, by majority vote in an open meeting, adopt an actuarially sound cost estimate for the first plan or policy year for the mandate in excess of EHBs for all QHPs in this state. Health insurers have the right to object to the adoption of the cost estimate by filing an appeal in the 19th Judicial District Court of the state of Louisiana within 30 days of the adoption of the cost

State	Key Provisions
	estimate in open meeting.
Maine *ME Rev. Ann. Tit. 24-A, §2752* Effective 2000 Amended 2011	**Mandate review.** Requires the Bureau of Insurance to review service, disease, or provider mandate proposals in the group and individual markets referred by legislative committees with jurisdiction. • Proposed mandates may not be enacted into law unless reviewed. • A mandated option/offer is not considered a mandated benefit. **Mandate evaluation criteria.** Requires the Bureau to, at a minimum and to extent that information is available, review and report on the social, financial, and medical impacts of a proposed mandate. *Social impacts* include, the extent to which: • the treatment or service is utilized by a significant portion of the population or is available to the population; • insurance coverage for treatment or service is already available, and if not, extent to which lack of coverage results in person being unable to obtain necessary treatment and results in unreasonable financial hardship on those persons needing treatment; • there is a level of public and provider demand for the treatment or service; • there is a level of public and provider demand for individual or group insurance coverage of the treatment or service; • there is a level of interest of collective bargaining organizations for inclusion of this coverage in group contracts; • there is a likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states; • there are relevant findings of the health system agency relating to social impact of the mandated benefit; • there are alternatives to meeting the identified need; • benefit is medical or broader social need and whether consistent with role of health insurance and concept of managed care; • there would be any social stigma attached to the benefit upon the market; • there is an availability of other benefits currently being offered; • the benefit would have an impact on self-insured plans; and • there would be an impact in making the benefit applicable to the state employee health insurance program. *Financial impacts* include: • the extent to which proposed mandate would increase or decrease the cost of the treatment or service over the next 5 years; • the extent to which proposed mandate may increase appropriate or inappropriate use of treatment/service over the next 5 years; • the extent to which proposed mandate might serve as an alternative for more expensive or less expensive treatment or service; • the extent to which coverage may affect number and types of providers of mandated treatment/service over the next 5 years; • the extent to which insurance coverage of the health care service or provider may be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders;

State	Key Provisions
	• the methods that will be instituted to manage the utilization and costs of the proposed mandate; • the impact of indirect costs (costs other than premiums and administrative costs) on coverage; • the mandate has an impact on the total cost of health care; and • the effects on the cost of health care to employers and employees, including the financial impact on all sized employers. Requires the financial impact assessment to include a comparison of the rate of increase in the CPI for medical care services for the current year to the rate of increase in the CPI for the previous year as reported by the Bureau of Labor Statistics. *Medical efficacy impacts* include: • the contribution of the benefit to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and • if the legislation seeks to mandate coverage of an additional class of practitioners, ▪ the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered, and ▪ the methods of the appropriate professional organization that assure clinical proficiency. *Balance between social, financial, and medical efficacy* includes the extent to which: • the need for coverage outweighs the costs of mandating the availability of the coverage as an option for policyholders; • the problem of coverage may be solved by mandating the availability of the coverage as an option for policyholders; and • there is a cumulative impact of mandating the benefit in conjunction with existing mandates on cost and availability.
Maryland *MD Code Ann. Ins. §§15-1501, 15-1502, and MD Code, Health - General, § 19-103* Effective 2000 Amended 2014	**Mandate review of existing mandates.** Requires the Maryland Health Care Commission to review the full cost of mandated health services in the state. • If the Commission determines such cost is equivalent to or exceeds 2.2% of the state's average annual wage, the Commission must make recommendations for reducing the number of mandates. **Mandate review criteria of existing mandates.** Requires evaluation criteria for existing mandates to include: • an assessment of the full cost of each existing mandated service as a percentage of the state's annual wage and of premiums: ▪ under a typical group and individual health benefit plan in the state; ▪ under the state employee health benefit plan for medical coverage, and; ▪ under the Comprehensive Standard Health Benefit Plan. • an assessment of the degree to which existing mandated services are covered in self-funded plans; and • a comparison of mandated health services provided by the state with those provided in DE, DC, PA, and VA; including: ▪ the number of mandated services; ▪ the type of mandated services;

State	Key Provisions
	▪ the level and extent of coverage for each mandated service; and ▪ the financial impact of differences in levels of coverage for each mandated health insurance service. **Report on existing mandates.** Requires the Commission, on or before January 1, 2004, and every 4 years after that, to submit a report of its findings to the General Assembly. **Mandate review of proposed mandates.** Requires the Maryland Health Care Commission review proposed mandated benefits. **Mandate evaluation criteria for proposed mandates.** Requires the Commission to assess social, medical and financial impacts of proposed mandates. *Social impacts* include: • the extent to which the service is generally utilized by a significant portion of the population; • the extent to which the insurance coverage is already generally available, and if coverage is not generally available, the extent to which the lack of coverage results in individuals avoiding necessary treatments and unreasonable financial hardship; • the level of public demand for the service; • the level of public demand for insurance coverage of the service; • the level of interest of collective bargaining agents in negotiating privately for inclusion of coverage in group contracts; and • the extent to which the mandated health insurance service is covered by large self-funded employers in the state. *Medical impacts* include the extent to which the service is: • generally recognized by the medical community as being effective and efficacious in the treatment of patients; • generally recognized by the medical community as demonstrated by a review of scientific and peer review literature; and • generally available and utilized by treating physicians. *Financial impacts* include the extent to which: • coverage will increase or decrease the cost of the service; • coverage will increase the appropriate use of the service; • the mandated service will be a substitute for a more expensive service; • coverage will increase or decrease administrative expenses of insurers and premium and admin expenses of policyholders; • there is an impact of this coverage on the total cost of health care; and • there is an impact of all mandated health services on employers' ability to purchase policies meeting their employees' needs. **Report on proposed mandates.** Requires the Commission to submit an annual report on its findings (with recommendations), including an evaluation of any mandated health insurance service enacted, proposed, or otherwise submitted to the Commission by a member of the General Assembly.

State	Key Provisions
Massachusetts *Mass. Gen. Laws* *Ch. 3 §38C* Effective 2002 Amended 2012	**Mandate review.** Requires the Center for Health Information and Analysis (Center) to evaluate any mandate favorably reported out of relevant legislative committees. • Applies this requirement to mandates for specific health services, diseases, or providers. • In addition, *permits* relevant committees to request an evaluation prior to making any decisions on the proposed mandate. **Mandate evaluation criteria.** Requires evaluations, in the case of a mandate to cover an additional class of practitioners, to include the results of research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered. • For all other mandates, evaluations must include the following. *Financial impacts* include the extent to which: • costs would be affected over the next 5 years; • inappropriate or appropriate care might increase over the next 5 years; • the mandate might serve as an alternative for a more or less expensive treatment; • the mandate might affect the number or type of provider of the mandated treatment over the next 5 years; • it has effects on premiums, administrative expenses, indirect costs of all sized employers, and individual purchasers; • the potential benefits and savings to large and small employers, employees, and individual purchasers; • the effect on cost-shifting between private and public payers; • the costs to consumers of *not* mandating the benefit; and • the effect on overall cost of the health care delivery system in the state. *Medical efficacy impacts* include the impact on quality, health status, and efficacy when compared to alternative treatments. **Report.** Requires the Center to issue a comprehensive report at least once every four years on the cost and public health impact of all existing mandated benefits. In conjunction with this review, requires the Center to consult with the department of public health and the University of Massachusetts Medical School in a clinical review of all mandated benefits to ensure that all mandated benefits continue to conform to existing standards of care in terms of clinical appropriateness or evidence-based medicine.
Minnesota *M.S.A. § 62J.26* Effective 2009	**Mandate review**. The commissioner, in consultation with the commissioners of health and management and budget, must evaluate mandated health benefit proposals to provide the legislature with a complete and timely analysis of all ramifications of any mandated health benefit proposal. **Mandate evaluation criteria.** The evaluation must include: • scientific and medical information on the proposed health benefit, on the potential for harm or benefit to the patient, and

State	Key Provisions
	on the comparative benefit or harm from alternative forms of treatment; • public health, economic, and fiscal impacts of the proposed mandate on persons receiving health services in Minnesota, on the relative cost-effectiveness of the benefit, and on the health care system in general; • the extent to which the service is generally utilized by a significant portion of the population; and • the extent to which insurance coverage for the proposed mandated benefit is already generally available. The commissioner may consider actuarial analysis done by health insurers in determining the cost of the proposed mandated benefit.
Mississippi *Miss. Code Ann. § 83-5-93 and § 83-5-95* Effective 1993	**Mandate review:** Requires a person or organization that seeks sponsorship of any bill that mandates health insurance coverage for specific health services, for specific diseases or for certain providers of health care services as part of any individual or group health insurance policy to submit to the legislative committees to which the proposal is assigned an impact report that assesses the social and financial effects and the medical efficacy of the proposed mandated coverage. **Mandate evaluation criteria.** The report must evaluate the following: *Social impact:* • the extent to which such insurance coverage is already generally available; • if coverage is not generally available, the extent to which the lack of coverage results in persons being unable to obtain necessary health care treatment; • if the coverage is not generally available, the extent to which the lack of coverage results in unreasonable financial hardship on those persons needing treatment; • the level of public demand for the treatment or service; • the level of public demand for individual or group insurance coverage of the treatment or service; • the level of interest of collective bargaining organizations in negotiating privately for inclusion of this coverage in group contracts; and • the impact of indirect costs which are costs other than premiums and administrative costs, on the question of the costs and benefits of coverage. *Financial impact:* • the extent to which insurance coverage of the kind proposed would increase or decrease the cost of the treatment or service; • the extent to which the proposed coverage might increase the use of the treatment or service; • the extent to which the mandated treatment or service might serve as an alternative for more expensive treatment or service; • the extent to which insurance coverage of the health care service or provider can be reasonably expected to increase or decrease the insurance premium and administrative expenses of policyholders; and • the impact of this coverage on the total cost of health care.

State	Key Provisions
	Medical efficacy: • the contribution of the insurance coverage to the quality of patient care and the health status of the population, including the results of any research demonstrating the medical efficacy of the treatment or service compared to alternatives or not providing the treatment or service; and • if the legislation seeks to mandate coverage of an additional class of practitioners: 1. the results of any professionally acceptable research demonstrating the medical results achieved by the additional class of practitioners relative to those already covered; and 2. the methods of the appropriate professional organization that assure clinical proficiency. *Effects of balancing the social, economic and medical efficacy considerations, including:* • the extent to which the need for coverage outweighs the cost of mandating the benefit for all insureds; and • the extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option for insureds.
Missouri *V. A. M. S. 376.1190* Effective 2011	**Mandate review.** Requires the oversight division of the joint committee on legislative research to perform an actuarial analysis of the cost impact to private and public payers of any new or revised mandated health care benefit proposed by the General Assembly after August 28, 2011. **Report.** A recommendation must be delivered to the Speaker and the President Pro Tem prior to mandate being enacted.
Nevada *Assembly Joint Standing Rule No. 18*	**Mandate review:** Requires any standing committee of the Senate or Assembly to which a bill is referred requiring a policy of health insurance delivered or issued for delivery in the state to provide coverage for any treatment or service shall review the bill giving consideration to: • the level of public demand for the treatment or service for which coverage is required and the extent to which such coverage is needed in the state; • the extent to which coverage for the treatment or service is currently available; • the extent to which the required coverage may increase or decrease the cost of the treatment or service; • the effect the required coverage will have on the cost of obtaining policies of health insurance in the state; • the effect the required coverage will have on the cost of health care provided in the state; and • such other considerations as are necessary to determine the fiscal and social impact of requiring coverage for the treatment or service.
New Hampshire	**Review of existing mandates.** Authorizes the Department of Insurance (Department) to contract for an external review and evaluation of any mandated benefit.

State	Key Provisions
N.H. Rev. Stat. § 400-A:39-b Effective 2010	**Mandate review.** Requires any legislative measure containing a mandated benefit to be sent to the Department by the standing committee of either the House or Senate having jurisdiction over the proposal for review. **Mandate evaluation criteria.** Requires the Department to review the social, financial, and medical efficacy of the proposed mandated benefit, as well as the effects of balancing the social, economic, and medical efficacy considerations. **Report.** Requires the Department to report to the appropriate legislative committee their review findings.
New Jersey *N.J. Stat. Ann. §17B:27D-1 - §17B:27D-9* Effective 2003 Amended 2013	**Mandate review.** Establishes the Mandated Health Benefits Advisory Commission to study the social, financial and medical impact of proposed mandated health benefits. • Establishes provisions with respect to Commission membership requirements, terms of service, and responsibilities. **Mandate review criteria.** Requires a review of legislation containing a proposed mandated health benefit to include social, financial, and medical impacts. *Social impacts* include: • the extent to which the proposed mandate are needed by, available to and utilized by the population of New Jersey; • the extent to which insurance coverage for the proposed mandate already exists or, if no coverage exists, the extent to which the lack of coverage results in inadequate health care or financial hardship for the affected population of New Jersey; • the demand for the proposed mandate from the public and the source and extent of opposition to mandating the health benefit; • relevant findings bearing on the social impact of the lack of the proposed mandate; and • other information the commission deems appropriate. *Financial impacts* include: • the extent to which the proposed mandate would increase or decrease the cost for treatment or service; • the extent to which similar mandated health benefits in other states have affected charges, costs, and payments for services; • the extent to which the proposed mandate would increase the appropriate use of the treatment or service; • the impact of the proposed mandate on total costs to carriers and on administrative costs; • the impact of the proposed mandate on total costs to purchasers and benefit costs; • the impact of the proposed mandate on the total cost of health care within New Jersey; and • other information the commission deems appropriate. *Medical efficacy impacts* include: • if the proposal mandates coverage of a particular treatment or therapy, the recommendation of a clinical study or review article in a major peer-reviewed professional journal;

State	Key Provisions
	• if the proposal mandates coverage of the services provided by an additional class of practitioners, the results of at least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and the practitioners already covered by benefits; • the results of other research; • the impact of the proposed benefit on the general availability of health benefits coverage in New Jersey; and • other information the commission deems appropriate. Requires the *balance of the social, economic and medical efficacy considerations*, to include but not be limited to, the extent to which the need for coverage outweighs the costs of mandating the health benefit; and the extent to which the problem of coverage may be solved by mandating the availability of the coverage as an option under a health benefits plan. **Development of data collection system.** Requires the Commission to: • develop criteria for a system and program of data collection (for use by the Departments of Health and Banking and Insurance) to assess the impact of mandated health benefits, including the cost to employers and carriers, impact of treatment, cost savings in the health care system, number of providers and other data as may be appropriate; and • review and comment to any State department, board, bureau, commission or agency, with respect to any order or regulations proposed or implemented that affect mandated health benefits. **Report.** Requires the Commission (three years after the effective date of this Act) summarize to the Governor and Legislature the bills reviewed by the Commission and the Commission's findings, and any recommendations the Commission may have regarding the required review process.
New York *NY INS § 213* Effective 2007	**Mandate Review.** Establishes the "New York State Health Care Quality and Cost Containment Commission" to analyze the impact on health insurance costs and quality of proposed legislation which would mandate that health benefits be offered or made available in individual and group health insurance policies, contracts and comprehensive health service plans, including legislation that affects the delivery of health benefits or services or the reimbursement of health care providers. The Commission is permitted to undertake an evaluation of a proposed mandated benefit upon the receipt on a written request made by the governor, the chair of the Senate insurance committee and the chair of the assembly insurance committee. **Mandate review criteria.** The Commission's evaluation must consider: • the current practices of health plans with regard to the proposed mandated benefit, and, to the extent possible, self-funded health benefit plans; • the potential premium impact of the proposed mandated benefits on all segments of the insurance market, as well as the potential for avoided costs through early detection and treatment of conditions, or more cost-effective delivery of medical services; and • the most current medical literature regarding the proposed mandated benefit to determine its impact on health care

State	Key Provisions
	quality. **Report.** The commission shall deliver a written report of its findings to the chair of the assembly insurance committee and the chair of the Senate insurance committee.
North Dakota *N.D. Cent. Code §54-03-28* Effective 2001 Amended 2003	**Mandate review.** Requires proposals for mandates for coverage of services or payment for specified providers of services to be accompanied by a cost-benefit analysis provided by legislative counsel before being acted on. • Legislative counsel must contract with a private entity (recommended by the Insurance Commissioner) to provide the cost-benefit analysis. • The Insurance Commissioner shall pay the cost of the contracted services to the entity providing the services. **Mandate review criteria.** Provides that factors to be considered in the cost-benefit analysis include the extent to which the proposed mandate would: • increase or decrease the cost of service; • increase the appropriate use of the service; • increase or decrease administrative expenses of insurers • increase or decrease premium and administrative expenses of insureds; • have an impact on the total cost of health care. **Limitations on proposals.** Requires mandates for coverage of services or payment for specified providers of services to be limited to the public employees' health insurance program and the public employee retiree health insurance program. • After a one year period, requires the public employees' retirement system to prepare a report on the utilization and costs relating to the mandated coverage or payment and make a recommendation on whether such coverage or payment should continue. • Requires the legislature to take into consideration such report and recommendations before applying such mandates more broadly. **Legislative counsel study.** Requires legislative counsel to consider studying during the 2001-2002 interim, existing mandated health insurance coverage of services and the feasibility and desirability of repealing state laws mandating health insurance coverage of services. • Required during the 2001-02 interim the Insurance Commissioner to evaluate, subject to receipt of funding, each existing health insurance coverage mandate on the basis of cost or effect on insurance premiums as these relate to the benefits and evaluate the benefits of reducing the need for future health care services due to early identification and treatment.
Ohio	**Mandate review.** Permits the Director of the Legislative Service Commission to request and arrange for an "independent

State	Key Provisions
Ohio Rev. Code Ann. §103.146 Effective 2001	healthcare actuarial review" of a mandated benefit proposal. • Defines "mandated benefit" as requiring coverage or the offering of coverage for services (specifically excludes providers). • Requires the Director to retain one or more independent actuaries on a consulting basis to determine the financial impact of the mandated benefit. Actuaries retained must be members in good standing of the AAA. **Mandate review criteria.** Requires actuaries, when reviewing a mandated benefit, to consider the results of any professionally acceptable controlled trial and any other relevant research specifically centered around the benefit and to determine the extent to which the mandated benefit will: • increase or decrease the administrative expenses of insurance companies and health insuring corporations; • increase or decrease premiums; • financially impact all sized employers, including public programs if applicable; • increase or decrease the number of insured individuals in this state; and • impact the total cost and quality of health care, including any potential cost savings that may be realized.
Pennsylvania *PA. Cons. Stat. 35P.S. §449.9* Effective 2000 Amended 2003	**Mandate review.** Does not require mandate proposals be reviewed; however, if reviewed, requires the Health Care Cost Containment Council to contract with individuals who will constitute an independent Mandated Benefits Review Panel to review mandated benefit review proposals. • Establishes requirements for review panel membership and administrative review procedures. **Mandate evaluation criteria.** Provides that the following documentation should be provided by persons seeking review as helpful to the review process: • the extent to which the proposed benefit and the services it would provide are needed by, available to, and utilized by the population in the state; • the extent to which insurance coverage for the proposed benefit already exists, or if no such coverage exists, the extent to which this lack of coverage results in inadequate health care or financial hardship for the population of the state; • the demand for the proposed benefit from the public and the source and extent of opposition to mandating the benefit; • all relevant findings bearing on the social impact of the lack of the proposed benefit; • where the proposed benefit would mandate coverage of a particular therapy, the results of at least one professionally accepted, controlled trial comparing the medical consequences of the proposed therapy, alternative therapies, and no therapy; • where the proposed benefit would mandate coverage of an additional class of practitioners, the results of a least one professionally accepted, controlled trial comparing the medical results achieved by the additional class of practitioners and those practitioners already covered by benefits; and • evidence of the financial impact of the proposed legislation including ▪ the extent to which the proposed benefit would increase or decrease cost for treatment, ▪ the extent to which similar mandated benefits in other states have affected charges, costs, and payments for services, ▪ the extent to which the proposed benefit would increase the appropriate use of the treatment or service,

State	Key Provisions
	▪ the impact of the proposed benefit on administrative expenses of insurers, ▪ the impact of the proposed benefit on benefits cost of purchasers, and ▪ the impact of the proposed benefits on the total cost of health care in the state.
Rhode Island *RI Gen. Laws §42-14.5-3* Enacted 2013 Amended 2018	**Mandate review.** Requires the health insurance commissioner to provide a report with findings and recommendations to the Rhode Island President of the Senate and Speaker of the House on: • the impact of the current mandated health benefits in the state; • current provider and insurer mandates that are unnecessary and/or duplicative due to the existing standards of care and/or delivery of services in the health care system; • a state-by-state comparison of health insurance mandates and the extent to which Rhode Island mandates exceed other states benefits; and • recommendations for amendments to existing mandated benefits based on the findings. • A specific report on the impact of mandated coverage for mental health and substance use disorders on health insurance premiums and access in Rhode Island and submit a report of its findings to the general assembly on or before June 1, 2023.
Tennessee *Tenn. Code Ann.* *§ 3-2-111* Effective 2015	**Mandate review.** Requires that legislation containing a mandated health benefit be referred to the fiscal review committee for evaluation regarding the legislation's potential impact on the cost of health insurance premiums. **Report.** The fiscal review committee is required to attach a statement on proposed legislation regarding the proposed mandated benefit's impact on the premiums for health insurance coverage in Tennessee, especially for employees of small businesses, no later than March 15 of the year in which the legislation is filed. If the impact cannot be reasonably determined without additional resources, a statement to that effect, including the amount of additional resources needed must be included.
Utah *Utah Code Ann. §31A-30-118* Effective 2014 Amended 2019	**Mandate review.** Requires the state to quantify the cost attributable to each additional mandated benefit that is in excess of the essential health benefits (EHB) required under the Affordable Care Act (ACA) based on a qualified health plan (QHP) issuer's calculation of the cost associated with the mandated benefit. **Mandate evaluation criteria.** Requires costs to be: • calculated in accordance with generally accepted actuarial principles and methodologies; • conducted by a member of the American Academy of Actuaries; and • reported to the commissioner of insurance and to the individual Exchange operating in the state. **Impact of cost analysis.** The commissioner may require a proponent of a new mandated benefit to an EHB to provide a cost

State	Key Provisions
	analysis of the estimated cost to the state of such additional mandate. If the state is required to defray the cost of additional required benefits the state shall make the required payments directly to the QHP issuer. • An issuer of a QHP that receives a payment shall reduce the premium charged to the individual on whose behalf the issuer will be paid in an amount equal to the amount of the payment; or provide a premium rebate to an individual on whose behalf the issuer received a payment in an amount equal to the amount of the payment; and a premium rebate made is not a prohibited inducement. • A payment required under the ACA shall be based on a statewide average of the cost of the additional benefit for all issuers who are entitled to payment; and be submitted to an issuer through a process established and administered by the federal marketplace Exchange for the state for individual health plans; or Avenue H small employer market exchange for QHPs offered on the Exchange.
Virginia VA Code Ann. § 30-58.1 Effective 2013	**Mandate review**. Requires the Joint Legislative Audit and Review Commission to assess, analyze, and evaluate the social and economic costs and benefits of any proposed mandated health insurance benefit or mandated provider that is not included in the essential health benefits required by federal law to be provided under a health care plan, including the mandate's predicted effect on health care coverage premiums and related costs, net costs or savings to the health care system, and other relevant issues, and report its findings with respect to the proposed mandate to the Health Insurance Reform Commission. **Reports**. Findings and recommendations must be reported in such time and in such manner as the Commission deems proper to the agencies concerned, to the Governor and to the General Assembly.
Virginia *VA Code §30-342* Effective 2013 *VA Code §30-343* Effective 2016 Amended 2017	**Mandate review.** Establishes the Health Insurance Reform Commission (Commission) as a legislative commission with duties to monitor the implementation of the ACA, and requires, among other things: • assessments of existing and proposed mandated health insurance benefits and providers, including assessments of whether such a mandate is included in the essential health benefits required by federal law; and should be provided under health care plans offered through a health benefit Exchange, outside a health benefit Exchange, neither or both; • other studies of mandated benefits and provider issues as requested by the General Assembly; and • development of such recommendations as may be appropriate for legislative and administrative consideration in order to increase access to health insurance coverage, ensure that the costs to business and individual purchasers of health insurance coverage are reasonable, and encourage a robust market for health insurance products in the Commonwealth. Whenever a legislative measure containing a mandated health insurance benefit or provider is proposed that is not identical or substantially similar to a legislative measure previously reviewed by the Commission within the three-year period immediately preceding the then-current session of the General Assembly, the Chairman of the House or Senate Committee on Commerce and Labor having jurisdiction over the proposal shall request that the Commission assess the proposal. A copy of this request must also be sent to the Bureau of Insurance of the State Corporation Commission.

State	Key Provisions
	• Upon receipt, the Commission must request that the Bureau of Insurance of the State Corporation Commission prepare a non-binding analysis of the extent to which the proposed mandate is currently available under qualified health plans in the Commonwealth and advise the Commission as to whether, on the basis of that analysis, the applicable agency has determined or would likely determine, in accordance with applicable federal rules, that the proposed mandate exceeds the scope of the essential health benefits. • The Commission will be given a period of 24 months to complete and submit its assessment.
Washington *Wash. Rev. Code §48.47.020 - §49.47.030.* Effective 1997	**Mandate review.** Requires a systematic review of proposed mandated benefits to assist the legislature in determining whether mandating a particular coverage or offering is in the public interest. • Defines mandated benefits to mean required coverage or offering of specific services, treatments or providers. **Mandate evaluation criteria.** Requires assessment of social and financial impacts, as well as evidence of health care service efficacy of the proposed benefit. *Social impacts* include: • to what extent the benefit is generally utilized by a significant portion of the population; • to what extent the benefit is already generally available and if not generally available, to what extent has its unavailability resulted in unreasonable financial hardship; • the level of public demand for the benefit; • the level of interest of collective bargaining agents in negotiating privately for inclusion of this benefit in group contracts. *Financial impacts* include: • to what extent the benefit will increase or decrease the cost of treatment or service; • to what extent the coverage will increase the appropriate use of the benefit; • to what extent the benefit will be a substitute for a more expensive benefit; • to what extent the benefit will increase or decrease the administrative expenses of health carriers and the premium and administrative expenses of policyholders; • what the impact of this benefit will be on the total cost of health care services and on premiums for health coverage; • what the impact of this benefit will be on costs for state-purchased health care; and • what the impact of this benefit will be on affordability and access to coverage. *Evidence of health care service efficacy* includes: • if a mandatory benefit of a specific service is sought, to what extent has there been conducted professionally accepted controlled trials demonstrating the health consequences of that service compared to no service or an alternative service; • if a mandated benefit of a category of health care provider is sought, to what extent has there been professionally accepted controlled trials demonstrating the health consequences achieved by the mandated benefit of this category of a health care

State	Key Provisions
	provider; and • to what extent the mandated benefit enhances the general health status of the state residents.
Wisconsin *Wis. Stat. §601.423* Effective 1987 Amended 2018	**Mandate review.** Requires the Commissioner to submit a report on the social and financial impacts of any health insurance mandate, contained in any bill or amendment affecting insurance to the presiding officer in the legislature within 10 working days after receiving the copy of the bill from the legislative reference bureau. The Commissioner is not required to prepare or submit a report or written statement for an amendment if, by the end of the next business day after receiving a copy of the amendment from the legislative reference bureau, the amendment has failed adoption or failed to be reported out of committee. If the Commissioner fails to do so, the Commissioner must prepare a written statement explaining the reason for not preparing the report. **Mandate review criteria.** Requires reviews to include social and financial impacts. *Social impacts* include: • the portion of the state's residents who use the treatment or services covered by the mandate; • the extent to which individuals use these treatments or services; • the availability of insurance coverage for these treatments or services; and • the number of persons who would be eligible for coverage under the mandate, and the availability of insurance coverage for these persons without the mandate. *Financial impacts* include: • whether the mandate may increase or decrease the costs of the treatments or services covered by the health insurance mandate; • whether the mandate would increase the use of the treatments or services covered by the health insurance mandate; • whether any increased use would substitute for more expensive treatments or services; • the impact of the mandate on total costs of health care in this state; and • whether the mandate may increase the administrative costs to insurance companies and the premium costs to policyholders.