**South Carolina General Assembly**

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**S. 184**

**STATUS INFORMATION**

General Bill

Sponsors: Senator Rose

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Introduced in the Senate on January 11, 2011

Currently residing in the Senate Committee on **Banking and Insurance**

Summary: Mandated Benefits Review Act

**HISTORY OF LEGISLATIVE ACTIONS**

Date Body Action Description with journal page number

12/1/2010 Senate Prefiled

12/1/2010 Senate Referred to Committee on **Banking and Insurance**

1/11/2011 Senate Introduced and read first time ([Senate Journal‑page 87](file:///h:\sj%20archive\2011\01-11-11.docx))

1/11/2011 Senate Referred to Committee on **Banking and Insurance** ([Senate Journal‑page 87](file:///h:\sj%20archive\2011\01-11-11.docx))

2/4/2011 Scrivener's error corrected

**VERSIONS OF THIS BILL**

[12/1/2010](file:///p:\pprever\2011-12\184_20101201.docx)

[2/4/2011](file:///p:\pprever\2011-12\184_20110204.docx)

**A** **BILL**

TO AMEND TITLE 38 OF THE 1976 CODE, BY ADDING CHAPTER 105, TO ENACT THE “MANDATED BENEFITS REVIEW ACT”, TO PROVIDE DEFINITIONS, TO PROVIDE THAT PROPOSED AND EXISTING MANDATED HEALTH BENEFITS MUST BE REVIEWED BY THE DEPARTMENT OF INSURANCE, TO PROVIDE THE METHOD OF REVIEW, AND TO PROVIDE FOR THE EXPIRATION OF MANDATED HEALTH BENEFITS AFTER REVIEW UNLESS THE BENEFITS ARE REAUTHORIZED BY THE GENERAL ASSEMBLY.

Be it enacted by the General Assembly of the State of South Carolina:

SECTION 1. This act may be cited as the “Mandated Benefits Review Act”.

SECTION 2. Title 38 of the 1976 Code is amended by adding:

“Chapter 105

Mandated Benefits Review Act

Section 38‑105‑10. For purposes of this section:

(1) ‘Mandated benefits’ shall include:

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

(b) any mandated coverage of the services specific to health care practitioners;

(c) any mandate requiring an offering of specific services, treatments, practices; or an expansion of an existing coverage, and (d) any mandated reimbursement amount to specific health care practitioners.

(2) ‘Offering’ means that every carrier or health plan must offer the mandated benefit to prospective customers.

(3) ‘Report’ means an independent, actuarially‑based review.

Section 38‑105‑20. (A) A proposal or an amendment to an existing law or an amendment to a proposal for a new mandated health benefit shall be evaluated as to the proposal’s medical efficacy and financial impact. The General Assembly shall refer the proposal or any amendment to an existing law or any new amendment to a proposal to the South Carolina Department of Insurance for review.

(B) The department shall retain an independent actuary to review the proposal or amendment within forty‑five days after the proposal or amendment is submitted and assure that appropriate assumptions are used to accurately demonstrate the financial impact of the proposed health benefit mandate or amendment to a proposed mandate or an amendment to an existing law. The department shall include the results of this review in the report required by subsection (C).

(C) The department shall review the actuarial report and shall issue a report within forty‑five days as to whether:

(1) the information is complete;

(2) the research cited meets professional standards;

(3) all relevant research has been brought to light; and

(4) the conclusions and interpretations drawn from the evidence are consistent with the data presented. The department will provide the report to the General Assembly.

(D) In preparing the report required in subsection (C), the department shall assess the following in determining the adequacy of the information presented:

(1) the extent to which lack of coverage of the proposed benefit results in financial hardship;

(2) the demand for the proposed health care coverage from the public at large and in collective bargaining negotiations, and the extent to which voluntary coverage of the proposed benefit is available.;

(3) the department, in consultation with relevant medical experts, shall consider evidence of medical efficacy:

(a) if the legislation seeks to mandate coverage of a particular therapy:

(i) the results of at least one clinical trial demonstrating the medical consequences of that therapy compared to no therapy and to alternative therapies; and

(ii) the results of any other relevant clinical research;

(b) if the legislation seeks to mandate coverage of a specific class of practitioners or medical specialty:

(i) the results of at least one professionally acceptable, controlled trial demonstrating the medical results achieved by the specific class of practitioners or medical specialty relative to those already covered; and

(ii) the results of any relevant research.

(4) The department shall review evidence of financial impact including, but not limited to:

(a) the extent to which coverage will increase or decrease the cost of treatment or service;

(b) the extent to which the same or similar mandates have affected charges, costs, utilization and payments in other states;

(c) the extent to which the coverage will increase the appropriate use of the treatment or service;

(d) the extent to which the mandated treatment or service will be a substitute for more expensive or less expensive treatments or services;

(e) the extent to which the coverage will increase or decrease the administrative expenses of third party payers and the premium and administrative expenses of policyholders;

(f) the financial impact of the mandated benefit on small employers, medium sized employers, large employers and the state employees health benefit plan; and

(g) the financial impact of the mandated benefit purchasers of individual coverage, state high‑risk pools and the state retirement program.

(E)(1) Within ninety days of the effective date of this act, the Commissioner of Insurance shall prepare a list of all mandated benefits required to be included in health insurance policies issued in this State and transmit the list to the Code Commissioner. The Code Commissioner shall order the list based on the date of enactment of the mandated benefit from the oldest to most recent and beginning at the first item on the list divide the list into groups of four as nearly equally as possible. The Code Commissioner shall then provide the list to the President Pro Tempore of the Senate and the Speaker of the House of Representatives, and to any member of the General Assembly upon request. The list also must be published in the State Register in January annually for the duration of the applicable period that the benefits are considered pursuant to this subsection. On July first of the second year following the effective date of this act, the first group of benefits identified on the list shall expire unless reauthorized by the General Assembly. Every July first thereafter, the next group of benefits on the list that have not been considered shall expire unless reauthorized by the General Assembly, to continue each succeeding year until all the benefits have been considered. The Code Commissioner shall make an appropriate notation in the code that any mandated benefit that expires pursuant to this section is repealed.

(2) At least ninety days prior to the beginning of a Legislative Session in which a group of mandated health benefits will expire as provided in item (1), the Department of Insurance shall submit a report prepared according to subsections (C) and (D) to the President Pro Tempore of the Senate, the Speaker of the House of Representatives, and any member of the General Assembly upon request.”

SECTION 3. This act takes effect upon approval by the Governor.

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