North Dakota Legislative Council
Prepared for the Health Care Committee
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HISTORICAL HEALTH CARE MANDATES - BACKGROUND MEMORANDUM

INTRODUCTION

Section 1 of Senate Bill No. 2249 (2025) (appendix) provides for a study of historical health care mandates. The study must include:

- Analysis of current health care mandates, including when they were enacted, the purpose, effectiveness, and present applicability; and
- A history of health care mandates and step therapy protocol.

The study also must include input from the Department of Health and Human Services, the Insurance Department, the Public Employees Retirement System (PERS), insurance providers, and stakeholders.

NORTH DAKOTA HEALTH INSURANCE MANDATES

Application of State Health Insurance Mandates to Health Plans

State health insurance mandates only apply to certain state-regulated health plans, including plans sold on the Affordable Care Act's individual and small-group marketplaces and fully insured employer-sponsored plans.[1] The federal Employee Retirement Income Security Act of 1974 (ERISA)[2] generally pre-empts state health insurance mandates that otherwise would apply to self-insured employer-sponsored health plans.[3] Instead, mandates for self-insured employer-sponsored health plans are established under federal law and policy.

Cost-Benefit Analysis Requirements

North Dakota Century Code Section 54-03-28 outlines the procedural requirements for proposed measures and measures mandating health insurance coverage of services or payment for specified providers of services.

As originally enacted in 2001, Section 54-03-28 provided a legislative measure mandating health insurance coverage may not be acted on by any committee of the Legislative Assembly unless accompanied by a cost-benefit analysis. Additionally, before each legislative session, the Insurance Commissioner was to recommend a private entity for the Legislative Council to contract with to provide cost-benefit analyses services and pay the costs of all contracted services.

The 2003 Legislative Assembly amended Section 54-03-28 to include additional requirements for health insurance coverage mandates. Senate Bill No. 2029 (2003) required mandates be effective for the next biennium and be limited in application to the PERS health insurance programs. For the following Legislative Assembly, PERS was required to prepare and request introduction of a bill to repeal the expiration date and expand the mandated coverage to apply to accident and health insurance policies in the private market. In addition, PERS was required to prepare a report to attach to the bill regarding the

[1] North Dakota Century Code (NDCC) Section 26.1-36-01.1 provides a health insurance policy health coverage mandate does not apply to a policy that is a high-deductible health plan under federal law if the mandate would cause the policy to fail to qualify as a high-deductible health plan.
[2] 29 U.S.C. §§ 1001-1461.
[3] 29 U.S.C. § 1144.

effect of the mandated coverage or payment on the system's health insurance programs. The report was required to include information on the utilization and cost relating to the mandated coverage and a recommendation on whether the coverage should continue.

Senate Bill No. 2130 (2021) amended Section 54-03-28 to require the Legislative Management to adopt a procedure for identifying measures and proposed measures mandating health insurance coverage of services or payment for specified providers of services. The bill also amended the requirements for the cost-benefit analysis and required the analysis to be appended to a bill with a mandate before referral to a committee. If a cost-benefit analysis was not appended, the committee was to request the analysis from the Legislative Management.

The 2025 Legislative Assembly further amended Section 54-03-28 to remove certain responsibilities of the Insurance Commissioner and PERS in the health insurance mandate process. Specifically, House Bill No. 1248 (2025) removed the requirement that the Insurance Commissioner make a recommendation to the Legislative Council regarding a vendor to provide the cost-benefit analysis and pay for the services provided by the vendor. The bill also removed the requirement that PERS introduce a bill to continue the coverage under the PERS health insurance programs and extend the coverage to health insurance policies in the private market. The bill clarified that a cost-benefit analysis is necessary only if the measure mandating health insurance coverage has completed the 2-year period of limited application to the PERS health insurance programs.

Under Section 54-03-28, each cost-benefit analysis must include the:

1. Extent to which the proposed mandate would increase or decrease the cost of the service;
2. Extent to which the proposed mandate would increase the appropriate use of the service;
3. Extent to which the proposed mandate would increase or decrease the administrative expenses of insurers and the premium and administrative expenses of insureds; and
4. Impact of the proposed mandate on the total cost of health care.

Employee Benefits Programs Committee

Under Section 54-03-28, each health insurance mandate initially must be effective only for the next biennium and be limited in application to the PERS health insurance programs. The following legislative session, a legislative member or agency with bill introduction privilege has the option of introducing a measure to continue the coverage for the PERS health insurance programs and expand the coverage to health plans in the private market which are subject to state health insurance mandates. Due to these requirements, each health insurance mandate must be brought before the Employee Benefits Programs Committee for consideration and recommendation.[4]

If the committee determines a measure fiscally impacts the health and retiree health plans of state employees or employees of any political subdivision, the committee will take jurisdiction over the bill draft, which allows the insurance program affected by the measure, typically PERS or the Teachers' Fund for Retirement, to obtain an actuarial report from that program's actuary. The impacted program is required to pay for any actuarial reports required by the committee.

The committee, after obtaining actuarial information and receiving relevant testimony, must develop a report with respect to each legislative measure over which the committee takes jurisdiction. A copy of the report must be attached to each proposal if the proposal is introduced to the Legislative Assembly.[5]

[4] NDCC §§ 54-35-02.3 and 54-35-02.4.

[5] Legislation enacted in contravention of Section 54-35-02.4, which outlines the required procedures of the Employee Benefits Programs Committee, is invalid and any benefits provided under the legislation must be reduced to the level in place before the legislation was enacted.

Legislative Rule

Section 54-03-28(1) requires the Legislative Management to adopt a procedure for identifying measures and proposed measures mandating health insurance coverage of services or payment for specified providers of services. The procedure must include solicitation of draft measures and proposals during the interim between legislative sessions from legislators and agencies with bill introduction privileges and must include deadlines for identification of the measures or proposals. For the past two interims, this responsibility has been assigned to the Employee Benefits Programs Committee and the committee recommended to the Legislative Management the adoption of the deadline identified in North Dakota Legislative Manual Joint Rule 211. The rule requires a member planning to introduce a bill providing for a health insurance mandate to submit that proposal to the Legislative Council by the close of business on the second Friday following the adjournment of the organizational session.

ESSENTIAL HEALTH BENEFITS

In March 2010, the Affordable Care Act was signed into law. The Affordable Care Act required nongrandfathered health insurance coverage in the individual and small-group markets to cover essential health benefits, which include items and services in the following 10 benefit categories:

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.

Federal regulations define essential health benefits on state-specific benchmark plans.[6] A state benchmark plan is the standard selected to define the essential health benefits that private insurance plans (individual and small-group markets) must cover. The United States Department of Health and Human Services issued a bulletin providing each state could choose a benchmark plan from four types of benchmark plans:

1. The largest plan by enrollment in any of the three largest small-group insurance products in the state's small-group market;
2. Any of the largest three state employee health benefit plans by enrollment;
3. Any of the largest three national federal employees health benefits plan options by enrollment; or
4. The largest insured commercial non-Medicaid health maintenance organization operating in the state.

If a state chose a benchmark plan subject to state mandates, the mandates would be included in the state's essential health benefits plan. If a state failed to choose a benchmark plan by September 30, 2012, the default plan would be the nongrandfathered small-group plan with the largest enrollment in the state, which in North Dakota at the time was the Medica Choice Passport plan.

[6] 45 CFR 156.100 et seq.

During the 2011-12 interim, the Health Care Reform Committee selected Sanford Health Plan, the largest insured commercial non-Medicaid health maintenance organization operating in the state, as the essential health benefits benchmark plan for 2014 through 2016.[7] On September 28, 2012, the Insurance Commissioner submitted the selection to the Department of Health and Human Services. Beginning January 1, 2014, the Affordable Care Act required individual and small-group plans to include all essential health benefits, limit consumers' out-of-pocket costs, and meet coverage level standards. Large-group plans are required to comply with cost-sharing limits and coverage level standards, but are not required to cover the full scope of benefits in the essential health benefits package.

The 2015 Legislative Assembly established a process for an interim committee to study the state's options for plan years 2017 and beyond, have Legislative Management make a determination relating to the benchmark plan, and for the Governor to notify the federal government of the selection.[8] From 2017 through 2024, the state selected a Blue Cross Blue Shield of North Dakota small-group benchmark plan as the state's essential health benefits package.

In 2025, the federal Centers for Medicare and Medicaid Services approved changes to the North Dakota essential health benefits benchmark plan, which included enhanced coverage for certain services, including insulin cost-sharing limits.[9]

PREVIOUS STUDY

Section 2 of House Bill No. 1407 (2001) provided for a study of existing mandated health insurance coverage of services and the feasibility and desirability of repealing state laws mandating health insurance coverage of services. The bill also required the Legislative Council to receive a report from the Insurance Commissioner evaluating existing health insurance coverage mandates and the cost or effect on insurance premiums compared to the benefits. The study was assigned to the interim Budget Committee on Health Care. The committee received information from the Insurance Commissioner which categorized mandated health benefits into four categories:

1. **Service mandates** - Benefit or treatment mandates that require insurers to cover certain treatments, illnesses, services, or procedures. Examples include child immunization, well-child visits, and mammography.
2. **Beneficiary mandates** - Define the categories of individuals to receive benefits. Examples include newborns from birth, adopted children from the time of adoption, and handicapped dependents.
3. **Provider mandates** - Mandates that require insurers to pay for services provided by specific providers. Examples include nurse practitioners, optometrists, and psychologists.
4. **Administrative mandates** - Mandates that relate to certain insurance reform efforts that increase the administrative expenses of a specific health care plan. Examples include information disclosures, precluding companies from basing policy rates on gender, and precluding insurers from denying coverage from preauthorized services.

The Insurance Commissioner's analysis indicated there were 23 statutory specified mandates, which included 13 service mandates, 6 beneficiary mandates, 3 provider mandates, and 1 administrative mandate.[10]

[7] Memorandum, *Selection of Essential Health Benefits Under House Bill No. 1378*, Health Care Reform Committee (2015).
[8] House Bill No. 1378 (2015).
[9] Centers for Medicare & Medicaid Services, Information on Essential Health Benefits Benchmark Plans (2026).
[10] Section 26.1-36-09.11, relating to breast reconstruction surgery, was enacted in 2001 but was not included in the study. The section requires a health insurer to provide breast reconstructive surgery in accordance with the federal Women's Health and Cancer Rights Act of 1998. 42 U.S.C. 300gg-6.

Service Mandates

Optional Drugs and Chiropractic Care

Section 26.1-36-06 was enacted in 1985 and provides health insurers must make available, at the option of the policyholder, coverage for all drugs and medicines prescribed by a provider and coverage for services rendered and care administered by chiropractors. An additional premium may be charged for these coverages.

Off-Label Uses of Drugs

Section 26.1-36-06.1 was enacted in 1997 and provides health insurers may not exclude coverage for drugs that are not approved by the federal Food and Drug Administration for a particular indication if the drug is recognized for treatment of that indication in medical literature. The Insurance Commissioner may direct an insurer to make payments as required under the law. The law also allows the State Health Officer to create a panel to review off-label use to determine if payment is appropriate and make recommendations to the Insurance Commissioner.

Substance Abuse Treatment

Section 26.1-36-08 was originally enacted in 1985 and requires a group health insurer to cover health services for the diagnosis, evaluation, and treatment of alcoholism or drug addiction. The benefits must provide for inpatient treatment, treatment by partial hospitalization, and outpatient treatment. Inpatient treatment must be provided for a minimum of 60 days of services per year. Partial hospitalization must be provided for a minimum of 120 days of services per year. Benefits may be provided as a combination of inpatient and partial hospitalization. Outpatient treatment must be provided for a minimum of 20 visits for services and a deductible or copayment may not be established for the first 5 visits per year.

Mental Disorder Treatment

Section 26.1-36-09 was originally enacted in 1985 and requires a group health insurer to cover the diagnosis, evaluation, and treatment of a mental disorder. The benefits must provide for inpatient treatment, treatment by partial hospitalization, residential treatment, and outpatient treatment. Minimum coverage for days of services include 45 days for inpatient treatment, 120 days for partial hospitalization, 120 days of residential treatment, and 30 hours of outpatient treatment.

Mammogram Examination

Section 26.1-36-09.1 was enacted in 1989 and requires health insurers to cover one baseline mammogram for each woman who is at least 35 but less than 40 years of age and one mammogram examination every year or more frequently if ordered by a physician for women who are at least 40 years of age.

Involuntary Complications of Pregnancy

Section 26.1-36-09.2 was enacted in 1989 and prohibits health insurers from creating coverage exclusions, reductions, or limitations on coverage, deductibles, or coinsurance provisions for involuntary pregnancy complications unless the provisions apply to all benefits under the policy, including procedures of comparable difficulty and severity. A maternity deductible only may apply to expenses resulting from normal delivery and caesarean section delivery, with additional expenses for caesarean sections to be treated as any other illness under the policy.

Temporomandibular Joint Disorder

Section 26.1-36-09.3 was enacted in 1989 and provides a health insurer is required to cover surgical and nonsurgical treatment of temporomandibular joint disorder and craniomandibular disorder, the same as any other joint, whether treated by a physician or dentist. Benefits may be limited to a lifetime maximum of $10,000 per individual per surgery and $2,500 for nonsurgical treatment.

Preventative Health Care (Copayments)

Before Section 26.1-36-09.4 was repealed in 2013, it limited copayments to $5 for each prenatal care visit and $2 for each well-child or immunization visit.

Prostate-Specific Antigen Test

Section 26.1-36-09.6 was enacted in 1997 and provides a health insurer must cover an annual digital rectal examination and a prostate-specific antigen test for asymptomatic males age 50 and over, black males age 40 and over, and males age 40 and over with a history of prostate cancer.

Foods and Food Products for Inherited Metabolic Diseases

Section 26.1-36-09.7 was enacted in 1997 and requires a health insurer to cover medical foods and low-protein modified food products for the therapeutic treatment of an inherited metabolic disease, if the foods are determined to be medically necessary by a physician. Coverage may be limited to $3,000 per year for an individual with an inherited metabolic disease of amino acid or organic acid. Coverage is not required to the extent benefits are available through the Department of Health and Human Services.

Postdelivery Care for Mothers and Newborns

Section 26.1-36-09.8 was enacted in 1997 and requires health insurers to cover maternity benefits the same as illnesses. The section was amended once through Senate Bill No. 2072 (2021) to allow an insurer or provider to provide rebates to an insured to request less than the minimum coverage required under the section. This coverage must include 48 hours of inpatient care for a mother and newborn through a normal vaginal delivery, and 96 hours following a caesarean section. Inpatient care in excess of this time must be covered if it is reasonable and medically necessary. Deductibles, coinsurance, and other cost-sharing are permissible.

Dental Anesthesia

Section 26.1-36-09.9 was enacted in 1999 and requires a health insurance policy to provide benefits for anesthesia and hospitalization for dental care provided to a covered individual who is a child under the age of 9, is severely disabled, or who has a medical condition and requires hospitalization or general anesthesia for dental care treatment. A preauthorization may be required in the same manner required for hospitalization for other covered diseases or conditions.

Prehospital Emergency Medical Services

Section 26.1-36-09.10 was enacted in 1999 and requires a health insurer to provide prehospital emergency medical services benefits in the case of an emergency medical condition.

Beneficiary Mandates

Newborn and Adopted Children

Section 26.1-36-07 was enacted in 1985 and requires all individual and group health insurance policies to cover newborns from the moment of birth or the date of physical placement by a licensed child placement agency. Children placed for adoption must be covered by injury or sickness coverage, including congenital defects. If payment of a premium or subscription fee is required for coverage, the policy may require notification of the birth and payment be made within 31 days.

Incarcerated Juvenile

Section 26.1-36-20 was enacted in 1985 and continues the health insurance coverage of a juvenile if the juvenile has been given by a court to a public institution or agency for incarceration. A juvenile's incarceration may not be a basis for termination of the juvenile's health insurance.

Incarcerated Adult

Section 26.1-36-21 was enacted in 1985 and requires a health insurer to continue coverage of a prisoner under state supervision to the same extent as the general public, provided the prisoner meets all other qualifications and continues to pay the policy or premiums. A prisoner's incarceration may not be a basis for cancellation of the policy.

Covered Dependents

Section 26.1-36-22 was enacted in 1985 and provides an individual or group health insurance policy may be extended to insure family members or dependents. The premium must be paid by funds contributed by an employer or from funds contributed by the covered person. An insurer may exclude or

limit coverage when evidence of individual insurability is not satisfactory. Coverage of a dependent child of an employee must be provided until age 22 if the child physically resides with the covered member and is dependent upon the member for support and maintenance. The policy does not terminate when the child is a full-time student and has not yet reached age 26 or if the child is incapable of self-sustaining employment due to an intellectual or physical disability.

Continuation of Coverage After Termination of Employment

Section 26.1-36-23 was enacted in 1985 and provides employees whose insurance would otherwise terminate due to termination of employment are entitled to continue their hospital, surgical, and major medical insurance under the group policy under certain conditions, including continuous insurance under the policy for the previous 3 months. The continuation must be requested in writing within 10 days of the termination. The continuation is not available for anyone covered by Medicare or another insurance arrangement that provides hospital, surgical, or medical group coverage.

Continuation of Former Spouse's and Dependent Children's Coverage

Section 26.1-36-23.1 was enacted in 1987 and prohibits health insurers from discontinuing coverage of a spouse due to a result in any break of a marital relationship, except for a decree of annulment or divorce. The coverage must continue after entry of a decree if the decree requires the insured to provide continued coverage for the spouse or dependent children, but the coverage may not exceed 36 months.

Provider Mandates

Advanced Registered Nurse Practitioner

Section 26.1-36-09.5 was enacted in 1995 and requires health insurers to provide direct reimbursement to advanced registered nurse practitioners and registered nurse practitioners.

Freedom of Choice for Pharmacy Services

Section 26.1-36-12.2 was enacted in 1989 and prohibits third-party payers, including health insurers, from preventing a beneficiary from selecting a pharmacy of his or her choice or imposing fees or conditions for selecting particular providers.

Optometrist Services

Section 43-13-31 was enacted in 1979 and prohibits discrimination between licensed optometrists and physicians. The section also prohibits interference with the right to free choice of an ocular practitioner. Health insurers who cover payment of optometric services must cover the treatment whether performed by optometrists or physicians.

Administrative Mandates

Information Disclosure

Section 26.1-36-03.1 was enacted in 1999 and requires a health insurer to make available a written plan description with the terms and conditions of the policy or contract. The plan must disclose a general description of benefits and covered services, a description of the insured's financial responsibility for payment, an explanation of benefits and services obtained from nonparticipating providers, a description of the drug formulary, procedures and conditions covered, procedure for providing emergency services, utilization review policies, all complaint and grievance rights, and financial payment incentive methods. Written information must be provided, if requested, regarding a description of the process for credentialling, confidentiality procedures, a list of specialty preferred providers, and whether a specific drug is included in coverage.

HEALTH INSURANCE MANDATES ADOPTED AFTER 2001

Following the 2001 study through the 2025 legislative session, the Legislative Assembly adopted three health insurance mandates that were expanded to the private insurance market.

- Senate Bill No. 2252 (2007) requires an insurer to provide coverage, of the same type offered under a policy for illnesses, for health services to an individual covered under the policy for injury or illness resulting from suicide, attempted suicide, or self-inflicted injury. Although the bill was determined

to be a health insurance mandate, it was specifically exempted from the requirements of Section 54-03-28.[11]

- Senate Bill No. 2140 (2023) requires the PERS Board, and House Bill No. 1114 (2025) requires both the PERS Board and insurers, to provide health insurance benefits coverage that provides for insulin drug and medical supplies for insulin dosing and administration and limits out-of-pocket costs for a 30-day supply of covered insulin drugs and covered medical supplies for insulin dosing administration to $25 per pharmacy or distributor. The bill also prohibits a pharmacy benefits manager, pharmacy, or distributor to charge, collect, or require a covered individual to make a payment for more than the out-of-pocket limit and prohibits the imposition of a deductible, copayment, coinsurance, or other cost-sharing requirement that causes out-of-pocket costs for insulin or covered medical supplies to exceed the out-of-pocket limit.[12]
- House Bill No. 1038 (2015) required the PERS Board, and Senate Bill No. 2052 (2017) required both the PERS Board and insurers, to provide coverage for health services delivered by means of telehealth the same as coverage provided for services by in-person means. The coverage of telehealth services required to be provided by the PERS Board was repealed in 2019.[13] House Bill No. 1465 (2021) expanded the telehealth services coverage provided by insurers to include audio-only telephone for the purpose of an e-visit or a virtual check-in.

STEP THERAPY PROTOCOL

Step therapy is a utilization management practice that requires a patient to try a preferred medication or therapy and find it to be ineffective before a nonpreferred medication or therapy will be covered under the patient's prescription benefit plan. The protocol is typically used for therapeutic classes of drugs that include multiple medications with comparable efficacy or medications with generic alternatives.[14]

North Dakota state law places few limitations on step therapy protocols. Section 19-02.1-16.3 defines "step therapy protocol" as a protocol requiring an individual use a drug, or sequence of drugs, other than the prescription drug, or sequence of prescription drugs, the individual's health care provider recommends for the individual's treatment, before the pharmacy benefits manager or health plan allows coverage for the recommended prescription drug, or sequence of prescription drugs. The section prohibits a pharmacy benefits manager or health plan from requiring a step therapy protocol for coverage of a recommended prescription drug, or sequence of prescription drugs, if the recommended prescription drug is prescribed to treat the individual's diagnosis of metastatic cancer and the use of the recommended prescription drug is consistent with the federal Food and Drug Administration approved indications or is supported by medical literature.

A step therapy exception is a process by which a patient or provider requests coverage for a nonpreferred drug without fulfilling step therapy requirements. Step therapy exceptions commonly are referred to as step therapy exemptions, step therapy overrides, or medical exceptions. Many states, including Iowa, Minnesota, and South Dakota, have enacted legislation requiring that a step therapy exception process be available to patients whose medications are subject to step therapy.[15] Some states also indicate specific conditions under which a step therapy exception must be granted.

North Dakota law does not provide for a step therapy exception process. As introduced, Senate Bill No. 2249 (2025) would have created step therapy protocol exception requirements for PERS health benefit plans, with the potential for the exception requirements to be expanded to the private insurance market during the 2027 legislative session. Testimony from providers indicated step therapy necessitates drug therapy requirements in which patients are forced by insurers to try, and fail, with one or more

[11] NDCC § 26.1-36-09.12.
[12] NDCC §§ 26.1-36-09.16 and 54-52.1-04.18.
[13] NDCC §§ 26.1-36-09.15 and 54-52.1-04.13.
[14] Washington State Institute for Public Policy, *Step Therapy and Step Therapy Exceptions: A Review of the Research Evidence and State Policies* (June 2019).
[15] Iowa Code § 514F.7; Minn. Stat. § 62Q.184; S.D. Codified Laws § 58-17H-55.

medications before the cost of the medication originally prescribed will be covered, which wastes critical time in treatment that some patients cannot afford to lose. Testimony from providers also indicated the proposed legislation would remove unnecessary barriers and allow patients to gain access to the medication they need at a faster pace. Testimony from insurers indicated the need to review previous historical mandates to determine if there are mandates that are now duplicative or irrelevant due to medical evidence or marketplace changes. Testimony from business advocacy representatives indicated state health insurance mandates add cost to the small and large-group markets, impacting both employers and employees. The bill was amended by the Senate to provide for this study.

STUDY APPROACH

In conducting the study, the committee may wish to receive testimony from:

- Private insurance providers regarding perspectives on mandated coverage, including costs;
- The Insurance Department regarding historical cost-benefit analyses, federal regulations, and state mandates;
- PERS regarding the impact of mandates on the PERS health insurance programs;
- Medical professionals regarding current medical evidence and standards;
- The Department of Health and Human Services; and
- The National Conference of State Legislatures and other interested parties regarding actions taken by other states relating to state-regulated health plans, federal essential health benefits, and step therapy protocols.