OLR Bill Analysis

sHB 6771

AN ACT REQUIRING HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING.

SUMMARY

This bill requires certain individual and group health insurance policies to cover biomarker testing to diagnose, treat, manage, or monitor an insured's disease or condition, if medical and scientific evidence (e.g., federal Food and Drug Administration approval, Medicare coverage determinations, or nationally recognized clinical guidelines) shows the testing provides clinical utility. The policies must provide coverage in a way that limits any disruptions to the insured's care. The bill also (1) requires health carriers to establish a process for insureds to request an exception to a coverage policy or dispute an adverse utilization review determination (e.g., denial) related to the coverage and (2) sets specific requirements for prior authorization requests.

Under the bill, a "biomarker" is a physical characteristic, including a gene mutation or protein expression that can be objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention for a disease or condition. A biomarker test analyzes a patient's tissue, blood, or other biospecimen for a biomarker.

Lastly, the bill requires the insurance commissioner, with the public health commissioner, to study the bill's effects on health care services provided in Connecticut. The insurance commissioner must report the study results to the Insurance and Real Estate and Public Health committees annually beginning by January 1, 2027, until January 1, 2031.

EFFECTIVE DATE: January 1, 2026

PROCESS FOR POLICY EXCEPTIONS AND COVERAGE APPEALS

The bill requires each health carrier (e.g., insurer or HMO) to establish a clear, readily accessible, and convenient process through which an insured, or his or her health care provider, may request a coverage policy exception or dispute an adverse utilization review determination. Carriers must post these processes on their websites.

PRIOR AUTHORIZATION REQUESTS

Under the bill, if the health insurance policy requires an insured to receive prior authorization for biomarker testing, the health carrier, associated utilization review entity, or third party acting on the carrier's behalf must approve or deny the prior authorization request within specified deadlines. Specifically, it must notify the insured, his or her health care provider, or any entity requesting the prior authorization of the approval or denial (1) within seven days, if the prior authorization is not urgent, or (2) within 72 hours if it is urgent. Under the bill, the health care provider determines if the authorization is urgent or not.

BILL APPLICABILITY

The bill applies to individual and group health insurance policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including those provided under an HMO plan. Because of the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

COMMITTEE ACTION

Aging Committee

Joint Favorable Substitute
Yea 13 Nay 0 (03/04/2025)