OLR Bill Analysis

sHB 6895

AN ACT CONCERNING HEALTH BENEFIT REVIEW AND REQUIRING HEALTH INSURANCE COVERAGE FOR BIOMARKER TESTING.

SUMMARY

This bill requires that a mandated health insurance benefit enacted by the legislature on or after January 1, 2026, must sunset four years after its effective date, unless before that date the (1) Insurance and Real Estate Committee has received a mandated health benefit report on the benefit's quality and cost impacts from the insurance commissioner and (2) House and Senate each approve the benefit by a majority vote. (It is unclear whether this requirement is enforceable based on the principle of legislative entrenchment, under which one legislature generally cannot restrict a future legislature's ability to enact legislation.)

The bill modifies the Insurance Department's health benefit review program. It requires the insurance commissioner, within three years of a mandated health benefit's effective date, to submit a report to the Insurance and Real Estate Committee that evaluates the benefit's quality and cost impacts. (Under current law, the Insurance and Real Estate Committee may ask the insurance commissioner, by August 1 of each year, to review existing or proposed benefits. The bill eliminates this provision.) By law, unchanged by the bill, the insurance commissioner may assess health carriers (e.g., insurers and HMOs) for the costs of the health benefit review program. Assessments are deposited in the Insurance Fund.

The bill authorizes the Insurance and Real Estate committee to hold an informational public hearing after it receives a mandated health benefit report from the commissioner. It requires the insurance and Office of Health Strategy commissioners to attend each hearing to take members' questions.

The bill also does the following:

1. narrows the definition of "mandated health benefit";

2. generally reduces the amount of information that each report must contain;

3. eliminates a requirement that the insurance commissioner contract with the UConn Center for Public Health and Health Policy (which no longer exists) to conduct mandated health benefit reviews; and

4. requires him to contract with an actuary, actuarial firm, quality improvement clearinghouse, health policy research organization, or other independent expert necessary to conduct the reviews.

Next, the bill requires a legislative fiscal note for any bill that, if passed, would impact the premiums paid by enrollees of health benefit plans offered on the Connecticut Health Insurance Exchange (i.e. Access Health CT). These fiscal notes must include an enrollee impact statement. The Office of Fiscal Analysis must prepare the statement, which must assess if the bill will have a significant direct financial impact to the enrollees' premium costs (§§ 2 & 3). Beginning with the 2026 legislative session, the bill prohibits the legislature from acting on a bill without the required enrollee impact statement, unless two thirds of each chamber votes to dispense with the requirement (§ 3).

Lastly, the 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 demonstrates that the testing provides clinical utility. It (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.

EFFECTIVE DATE: January 1, 2026

§ 1 — HEALTH BENEFIT REVIEW PROGRAM

Mandated Health Benefit Definition

The bill narrows the definition of "mandated health benefit." Under the bill, the term means a statutory obligation that requires (1) a health carrier offering health insurance policies or benefit plans in the state or a qualified health plan through Access Health CT or (2) the state employee health plan, to offer or provide coverage for a particular type of health care treatment or service or medical equipment, supplies, or drugs used in connection with a health treatment or service.

Under current law, the term also includes the following, which the bill removes:

1. proposed legislation to expand or repeal an existing coverage obligation;
2. an existing obligation or proposed legislation allowing enrollees to obtain treatment or services from a particular type of health care provider; and
3. an existing obligation or proposed legislation to offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition.

Mandated Health Benefit Reports

The bill reduces the amount of information each report must contain. Under current law, a report must review certain social and financial impacts of mandating the benefit. The bill instead requires a report to evaluate certain quality and cost impacts of mandating it. The bill also newly requires each report to assess the mandated health benefit's impact on the cost of qualified health plans offered through Access Health CT.

Elements Required. As under existing law, each mandated health benefit report must include the following elements:

1. the extent to which a significant portion of the population uses the treatment, service, equipment, supplies, or drugs;

2. the extent to which they are available under Medicare or through other public programs;

3. the extent to which insurance policies already cover them;

4. the impact of applying the benefit to the state employees' health plan;

5. the extent to which credible scientific evidence published in peer-reviewed medical literature determines the treatment, service, equipment, supplies, or drugs are safe and effective;

6. the extent to which the benefit, over the next five years, may (a) increase or decrease the cost of the treatment, service, equipment, supplies, or drugs and (b) increase its appropriate or inappropriate use;

7. the extent to which the treatment, service, equipment, supplies, or drugs are more or less expensive than an existing one determined to be equally safe and effective by credible scientific evidence published in peer-reviewed medical literature;

8. the extent to which the benefit could be an alternative for more or less expensive treatment, service, equipment, supplies, or drugs;

9. the reasonably expected increase or decrease of a policyholder's insurance premiums and administrative expenses;

10. methods that will be implemented to manage the benefit's use and costs;

11. the impact on the (a) total cost of health care, including potential savings to insurers and employers from prevention or early detection of disease or illness and (b) cost of health care for small employers and other employers; and

12. the impact on (a) cost-shifting between private and public payors of health care coverage and (b) the overall cost of the state's

health care delivery system.

Elements No Longer Required. The bill eliminates the following elements from a mandated health benefit report:

1. if coverage of the benefit is not generally available, the extent to which this results in (a) people being unable to get necessary treatment and (b) unreasonable financial hardships on those needing treatment;

2. the level of demand from the public and health care providers for (a) the treatment, service, equipment, supplies, or drugs and (b) insurance coverage for these;

3. the likelihood of meeting a consumer need based on other states' experiences;

4. relevant findings of state agencies or other appropriate public organizations on the benefit's social impact;

5. alternatives to meeting the identified need, including other treatments, methods, or procedures;

6. whether the benefit is (a) a medical or broader social need and (b) consistent with the role of health insurance and managed care concepts;

7. potential social implications of the direct or specific creation of a comparable mandated benefit for similar diseases, illnesses, or conditions;

8. the benefit's impact on (a) the availability of other benefits already offered and (b) employers shifting to self-insured plans; and

9. the extent to which employers with self-insured plans offer the benefit.

§§ 4 & 5 — BIOMARKER TESTING COVERAGE

The 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 (FDA) approval, Medicare coverage determinations, or nationally recognized clinical guidelines) demonstrates that the testing has clinical utility.

The policies must provide coverage in a way that limits any disruptions to the insured's care. The policies also must require that biomarker testing be done at an in-network clinical lab facility that is federally certified or has been granted an FDA certification waiver.

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.

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 within (1) seven days, if the prior authorization is not urgent, or (2) 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 on or after January 1, 2026, 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.

BACKGROUND

Related Bills

sHB 6436 (File 53), favorably reported by the Insurance and Real Estate Committee, also eliminates a requirement that the insurance commissioner contract with the UConn Center for Public Health and Health Policy to conduct mandated health benefit reviews upon request of the Insurance and Real Estate Committee. Instead, it allows him to contract with any actuary, actuarial firm, quality improvement clearinghouse, health policy research organization, or other independent expert necessary to conduct the reviews.

sHB 6771 (File 107), favorably reported by the Aging Committee, similarly requires health insurance policies to cover certain biomarker testing.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable Substitute
Yea 12 Nay 1 (03/11/2025)