# House of Representatives

General Assembly

**File No. 310**

*January Session, 2025*

Substitute House Bill No. 6895

*House of Representatives, March 27, 2025*

The Committee on Insurance and Real Estate reported through REP. WOOD of the 29th Dist., Chairperson of the Committee on the part of the House, that the substitute bill ought to pass.

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

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-21 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Exchange" has the same meaning as provided in section 38a-1080.

(3) "Health carrier" has the same meaning as provided in section 38a-1080.

**[**(2)**]** (4) "Mandated health benefit" means **[**an existing**]** any statutory obligation **[**of, or proposed legislation**]** that would require **[**,**]** an insurer, health care center, hospital service corporation, medical service corporation, fraternal benefit society or other entity that offers

individual or group health insurance or medical or health care benefits plan in this state or a health carrier that offers a qualified health plan through the exchange or the state employee plan to [: (A) Permit an insured or enrollee to obtain health care treatment or services from a particular type of health care provider; (B) offer or provide coverage for the screening, diagnosis or treatment of a particular disease or condition; or (C)] offer or provide coverage for a particular type of health care treatment or service, or for medical equipment, medical supplies or drugs used in connection with a health care treatment or service. ["Mandated health benefit" includes any proposed legislation to expand or repeal an existing statutory obligation relating to health insurance coverage or medical benefits.]

(5) "Qualified health plan" has the same meaning as provided in section 38a-1080.

(6) "State employee plan" has the same meaning as provided in section 3-123rrr.

(b) (1) There is established 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] passed by the General Assembly [having cognizance of matters relating to insurance] on or after January 1, 2026. Such program shall be funded by the Insurance Fund established under section 38a-52a. The commissioner shall be authorized to make assessments in a manner consistent with the provisions of chapter 698 for the costs of carrying out the requirements of this section. Such assessments shall be in addition to any other taxes, fees and moneys otherwise payable to the state. The commissioner shall deposit all payments made under this section with the State Treasurer. The moneys deposited shall be credited to the Insurance Fund and shall be accounted for as expenses recovered from insurance companies. Such moneys shall be expended by the commissioner to carry out the provisions of this section and section 2 of public act 09-179.

(2) The commissioner shall [contract with The University of

Connecticut Center for Public Health and Health Policy to conduct**]** engage the services of any actuary, actuarial firm, quality improvement clearinghouse, health policy research organization or any other independent expert as the commissioner deems necessary to assist said commissioner in the review and evaluation of any mandated health benefit review **[**requested pursuant to subsection (c) of**]** required pursuant to this section. **[**The director of said center may engage the services of an actuary, quality improvement clearinghouse, health policy research organization or any other independent expert, and may engage or consult with any dean, faculty or other personnel said director deems appropriate within The University of Connecticut schools and colleges, including, but not limited to, The University of Connecticut (A) School of Business, (B) School of Dental Medicine, (C) School of Law, (D) School of Medicine, and (E) School of Pharmacy.

(c) Not later than August first of each year, the joint standing committee of the General Assembly having cognizance of matters relating to insurance shall submit to the commissioner a list of any mandated health benefits for which said committee is requesting a review. Not later than January first of the succeeding year, the commissioner shall submit a report, in accordance with section 11-4a, of the findings of such review and the information set forth in subsection (d) of this section.

(d) The review report shall include at least the following, to the extent information is available:

(1) The social impact of mandating the benefit, including:**]**

(c) Any mandated health benefit passed by the General Assembly on or after January 1, 2026, shall be terminated for all individual and group health insurance policies delivered, issued for delivery, renewed, amended or continued in this state four years after the effective date of such mandated health benefit, unless, prior to such termination and after the joint standing committee of the General Assembly having cognizance of matters relating to insurance receives a mandated health benefit review report pursuant to the provisions of subsection (d) of this

section, the General Assembly approves such mandated health benefit by a majority vote of both houses.

(d) Not later than three years after the effective date of any mandated health benefit, the commissioner shall submit a mandated health benefit review report, in accordance with the provisions of section 11-4a, to the joint standing committee of the General Assembly having cognizance of matters relating to insurance. Such report shall provide an assessment of each mandated health benefit passed by the General Assembly on or after January 1, 2026. Such report shall include an evaluation of the quality and cost impacts of mandating each such health benefit, including:

**[**(A)**]** (1) The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is utilized by a significant portion of the population;

**[**(B)**]** (2) The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is currently available to the population, including, but not limited to, coverage under Medicare, or through public programs administered by charities, public schools, the Department of Public Health, municipal health departments or health districts or the Department of Social Services;

**[**(C)**]** (3) The extent to which insurance coverage is already available for the treatment, service or equipment, supplies or drugs, as applicable;

**[**(D) 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;

(E) If the coverage is not generally available, the extent to which such lack of coverage results in unreasonable financial hardships on those persons needing treatment;

(F) The level of public demand and the level of demand from providers for the treatment, service or equipment, supplies or drugs, as applicable;

(G) The level of public demand and the level of demand from providers for insurance coverage for the treatment, service or equipment, supplies or drugs, as applicable;

(H) The likelihood of achieving the objectives of meeting a consumer need as evidenced by the experience of other states;

(I) The relevant findings of state agencies or other appropriate public organizations relating to the social impact of the mandated health benefit;

(J) The alternatives to meeting the identified need, including, but not limited to, other treatments, methods or procedures;

(K) Whether the benefit is a medical or a broader social need and whether it is consistent with the role of health insurance and the concept of managed care;

(L) The potential social implications of the coverage with respect to the direct or specific creation of a comparable mandated benefit for similar diseases, illnesses or conditions;

(M) The impact of the benefit on the availability of other benefits currently offered;

(N) The impact of the benefit as it relates to employers shifting to self-insured plans and the extent to which the benefit is currently being offered by employers with self-insured plans;**]**

**[**(O)**]** (4) The impact of making the mandated health benefit applicable to the state employee **[**health insurance or health benefits**]** plan; **[**and**]**

**[**(P)**]** (5) The extent to which credible scientific evidence published in peer-reviewed 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; **[**and

(2) The financial impact of mandating the benefit, including:**]**

**[**(A)**]** (6) The extent to which the mandated health benefit may increase or decrease the cost of the treatment, service or equipment, supplies or drugs, as applicable, over the next five years;

**[**(B)**]** (7) The extent to which the mandated health benefit may increase the appropriate or inappropriate use of the treatment, service or equipment, supplies or drugs, as applicable, over the next five years;

**[**(C)**]** (8) 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;

**[**(D)**]** (9) The methods that will be implemented to manage the utilization and costs of the mandated health benefit;

**[**(E)**]** (10) The extent to which insurance coverage for the treatment, service or equipment, supplies or drugs, as applicable, may be reasonably expected to increase or decrease the insurance premiums and administrative expenses for policyholders;

**[**(F)**]** (11) The extent to which the treatment, service or equipment, supplies or drugs, as applicable, is more or less expensive than an existing treatment, service or equipment, supplies or drugs, as applicable, 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;

**[**(G)**]** (12) The impact of insurance coverage for the treatment, service or equipment, supplies or drugs, as applicable, on the total cost of health care, including potential benefits or savings to insurers and employers resulting from prevention or early detection of disease or illness related to such coverage;

**[**(H)**]** (13) The impact of the mandated health care benefit on the cost of health care for small employers, as defined in section 38a-564, and for employers other than small employers; **[**and**]**

**[**(I)**]** (14) The impact of the mandated health benefit on cost-shifting

between private and public payors of health care coverage and on the overall cost of the health care delivery system in the state; and

(15) The impact of the mandated health benefit on the cost of qualified health plans offered through the exchange.

(e) The joint standing committee of the General Assembly having cognizance of matters relating to insurance may conduct an informational public hearing following such committee's receipt of the mandated health benefit review report provided pursuant to the provisions of subsection (d) of this section. The commissioner and the Commissioner of Health Strategy shall attend any such public hearing and be available for questions from the members of such committee at such public hearing.

Sec. 2. Section 2-24 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

The words "State of Connecticut" shall be printed at the head of each bill and document printed by order of the General Assembly, or either house thereof, and on its title page or cover, if any. Before printed, electronic or photographic copies of an original bill are made, the bill shall be endorsed with (1) the date of its introduction; (2) its number; (3) the name of the member or committee introducing it; and (4) the name of the committee to which it was referred. Copies of bills or resolutions printed or produced electronically after favorable report by a committee or reprinted or produced electronically after amendment on the third reading, i.e., files, shall bear the file number of such bill or resolution, placed conspicuously at the head of the same, which file number shall be assigned by the Legislative Commissioners' Office in the order printed or produced, the number and title of the bill, the name of the committee to which it was referred, the date and nature of the committee's report, in any case where the bill, if passed, would (A) require the expenditure of state or municipal funds, **[**or**]** (B) affect state or municipal revenue, or (C) impact the premiums paid by enrollees of health benefit plans offered through the exchange, as provided in section 38a-1080, a fiscal note, including an estimate of the cost or of the

revenue impact shall be appended thereto, **[**and,**]** in any case where the bill, if passed, would have a financial impact on electric ratepayers, a ratepayer impact statement, as described in subsection (b) of section 2-24a, as amended by this act, and, in any case where the bill, if passed, would have a financial impact on the premiums paid by enrollees of health benefit plans offered through the exchange, an enrollee impact statement, as described in subsection (b) of section 2-24a, as amended by this act. When a bill or resolution is accompanied with a report of a committee, other than a recommendation that it ought or ought not to pass, it shall then have an additional endorsement, as follows: "Accompanied by special report, No.**-**". Bills shall be designated in the calendar of each house by their file numbers, as well as by the titles and numbers of the bills.

Sec. 3. Section 2-24a of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2026*):

(a) No bill without a fiscal note appended thereto which, if passed, would require the expenditure of state or municipal funds or affect state or municipal revenue in the current fiscal year or any of the next ensuing five fiscal years shall be acted upon by either house of the General Assembly unless said requirement of a fiscal note is dispensed with by a vote of at least two-thirds of such house. Such fiscal note shall clearly identify the cost and revenue impact to the state and municipalities in the current fiscal year and in each of the next ensuing five fiscal years.

(b) Beginning with the session of the General Assembly commencing on January 9, 2019, no bill without a ratepayer impact statement appended thereto which, if passed, would have a financial impact on electric ratepayers, shall be acted upon by either house of the General Assembly unless said requirement of a ratepayer impact statement is dispensed with by a vote of at least two-thirds of such house. Such statement shall (1) be prepared by the Office of Fiscal Analysis; and (2) provide an assessment as to whether such bill will have a significant direct financial impact on the cost of electricity to the majority of Connecticut electric ratepayers.

(c) Beginning with the session of the General Assembly commencing on February 4, 2026, no bill without an enrollee impact statement appended thereto which, if passed, would have a financial impact on the premiums paid by enrollees of health benefit plans offered through the exchange, shall be acted upon by either house of the General Assembly, unless said requirement of an enrollee impact statement is dispensed with by a vote of at least two-thirds of such house. Such statement shall (1) be prepared by the Office of Fiscal Analysis, and (2) provide an assessment as to whether such bill will have a significant direct financial impact on the cost of premiums paid by enrollees of health benefit plans offered through the exchange. For the purposes of this section, "health benefit plan" has the same meaning as provided in section 38a-591a.

Sec. 4. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "Biomarker" means a characteristic, including, but not limited to, 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.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, tests for a single substance, tests for multiple substances and diseases or conditions. "Biomarker testing" does not include an evaluation of how a patient feels, functions or survives.

(3) "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.

(4) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing

transparent methodologies and reporting structures and conflict-of-interest policies.

(b) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an insured's disease or condition, provided such biomarker testing provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to, one or more of the following: (1) Approval or clearance of such test by the federal Food and Drug Administration or recommendations on labels of drugs approved by the federal Food and Drug Administration to conduct such test, (2) national coverage determinations or local coverage determinations for Medicare Administrative Contractors by the Centers for Medicare and Medicaid Services, or (3) nationally recognized clinical practice guidelines. Such policy shall provide such coverage in a manner that limits disruptions in care, including, but not limited to, the need for multiple biopsies or biospecimen samples. Such policy shall require that biomarker testing be performed at an in-network clinical laboratory facility certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time, or any such in-network clinical laboratory facility that has been granted a Clinical Laboratory Amendments of 1988 waiver by the federal Food and Drug Administration to perform such biomarker testing.

(c) Each entity providing such coverage shall establish a clear, readily accessible and convenient process through which an insured or an insured's health care provider may (1) request an exception to a coverage policy, or (2) dispute an adverse utilization review determination relating to such coverage. Each such entity shall post such process on the Internet web site maintained by such entity.

(d) If prior authorization is required before providing such coverage,

each entity providing such coverage or each utilization review entity or other third party acting on behalf of such entity shall approve or deny such prior authorization and notify the insured, the insured's health care provider and any other entity requesting such prior authorization of such approval or denial (1) if the prior authorization is not urgent, as determined by the insured's health care provider, not later than seven days after receiving a prior authorization request, or (2) if the prior authorization is urgent, as determined by the insured's health care provider, not later than seventy-two hours after receiving a prior authorization request.

Sec. 5. (NEW) (*Effective January 1, 2026*) (a) As used in this section:

(1) "Biomarker" means a characteristic, including, but not limited to, 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.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood or other biospecimen for the presence of a biomarker, including, but not limited to, tests for a single substance, tests for multiple substances and diseases or conditions. "Biomarker testing" does not include an evaluation of how a patient feels, functions or survives.

(3) "Clinical utility" means the test result provides information that is used in the formulation of a treatment or monitoring strategy that informs a patient's outcome and impacts the clinical decision.

(4) "Nationally recognized clinical practice guidelines" means evidence-based clinical practice guidelines informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options intended to optimize patient care developed by independent organizations or medical professional societies utilizing transparent methodologies and reporting structures and conflict-of-interest policies.

(b) Each group health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 of the general statutes delivered, issued for delivery, renewed, amended or continued in this state on or after January 1, 2026, shall provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management or ongoing monitoring of an insured's disease or condition, provided such biomarker testing provides clinical utility as demonstrated by medical and scientific evidence, including, but not limited to, one or more of the following: (1) Approval or clearance of such test by the federal Food and Drug Administration or recommendations on labels of drugs approved by the federal Food and Drug Administration to conduct such test, (2) national coverage determinations or local coverage determinations for Medicare Administrative Contractors by the Centers for Medicare and Medicaid Services, or (3) nationally recognized clinical practice guidelines. Such policy shall provide such coverage in a manner that limits disruptions in care, including, but not limited to, the need for multiple biopsies or biospecimen samples. Such policy shall require that biomarker testing be performed at an in-network clinical laboratory facility certified under the Clinical Laboratory Improvement Act of 1967, 42 USC Section 263a, as amended from time to time, or any such in-network clinical laboratory facility that has been granted a Clinical Laboratory Amendments of 1988 waiver by the federal Food and Drug Administration to perform such biomarker testing.

(c) Each entity providing such coverage shall establish a clear, readily accessible and convenient process through which an insured or an insured's health care provider may (1) request an exception to a coverage policy, or (2) dispute an adverse utilization review determination relating to such coverage. Each such entity shall post such process on the Internet web site maintained by such entity.

(d) If prior authorization is required before providing such coverage, each entity providing such coverage or each utilization review entity or other third party acting on behalf of such entity shall approve or deny such prior authorization and notify the insured, the insured's health care

provider and any other entity requesting such prior authorization of such approval or denial (1) if the prior authorization is not urgent, as determined by the insured's health care provider, not later than seven days after receiving a prior authorization request, or (2) if the prior authorization is urgent, as determined by the insured's health care provider, not later than seventy-two hours after receiving a prior authorization request.

| This act shall take effect as follows and shall amend the following sections: | | |
|---|---|---|
| Section 1 | *January 1, 2026* | 38a-21 |
| Sec. 2 | *January 1, 2026* | 2-24 |
| Sec. 3 | *January 1, 2026* | 2-24a |
| Sec. 4 | *January 1, 2026* | New section |
| Sec. 5 | *January 1, 2026* | New section |

***INS*** *Joint Favorable Subst.*

*The following Fiscal Impact Statement and Bill Analysis are prepared for the benefit of the members of the General Assembly, solely for purposes of information, summarization and explanation and do not represent the intent of the General Assembly or either chamber thereof for any purpose. In general, fiscal impacts are based upon a variety of informational sources, including the analyst's professional knowledge. Whenever applicable, agency data is consulted as part of the analysis, however final products do not necessarily reflect an assessment from any specific department.*

## OFA Fiscal Note

### State Impact:

| Agency Affected | Fund-Effect | FY 26 $ | FY 27 $ |
|---|---|---|---|
| Insurance Dept. | IF - Cost | See Below | See Below |
| Legislative Mgmt. | GF - Cost | See Below | See Below |
| Resources of the General Fund | GF - Potential Cost | Up to 92,000 | Up to 184,000 |
| Social Services, Dept. | GF - Potential Cost | See Below | See Below |
| State Comptroller - Fringe Benefits | GF - Potential Savings | See Below | See Below |
| State Comptroller - Fringe Benefits | GF - Potential Cost | Less than 100,000 | Less than 200,000 |

Note: IF=Insurance Fund; GF=General Fund

### Municipal Impact:

| Municipalities | Effect | FY 26 $ | FY 27 $ |
|---|---|---|---|
| Various Municipalities | Potential Savings | See Below | See Below |
| Various Municipalities | STATE MANDATE[1] - Potential Cost | Less than 34,000 | Less than 69,000 |

### Explanation

The bill does the following: (1) requires the Insurance Department to engage the services of a consultant to conduct health benefit reviews; (2) requires legislative fiscal notes prepared by the Office of Fiscal Analysis

[1] State mandate is defined in Sec. 2-32b(2) of the Connecticut General Statutes, "state mandate" means any state initiated constitutional, statutory or executive action that requires a local government to establish, expand or modify its activities in such a way as to necessitate additional expenditures from local revenues.

(OFA) for any bill that will impact the Exchange; and (3) mandates biomarker coverage. These result the fiscal impacts described below.

**Mandated Health Benefit Review.** Section 1 results in costs to the Insurance Fund of $65,000 to $80,000 per health benefit mandate reviewed each fiscal year starting in FY 26. These costs are associated with the Insurance Department hiring a consultant to complete the review. Section 1 also results in potential savings to the state for sunsetting health insurance mandates to the extent any such terminated mandate reduces premiums to the state employee health plan. These potential savings also apply to fully insured municipalities and those participating in the state partnership plan.

**Legislative Fiscal Notes.** Sections 2 and 3 require legislative fiscal notes prepared by OFA to include an enrollee impact statement for any bill that will impact premiums paid by enrollees of health benefit plans offered on the Connecticut Health Insurance Exchange resulting in a cost to OFA (within the Office of Legislative Management). OFA does not have the required expertise to produce these statements and will have to contract with an actuarial healthcare consultant. The final cost will depend on the number of enrollee impact statements required each year and the consultant's hourly rate.

**State Employee Health Plan.** Sections 4 and 5 of the bill result in a potential cost less than $100,000 for the partial year coverage in FY 26 and less than $200,000 annually thereafter to the State Comptroller – Fringe Benefits for the anticipated per member per month increase to the state employee health plan (SEHP) associated with the mandated coverage of biomarker testing. The SEHP currently covers biomarker testing. Premiums for the SEHP are anticipated to increase by $0.10 per member per month, assuming a 5% utilization rate increase.

**Municipalities.** Costs related to the mandated coverage may also be incurred by fully insured municipalities and those participating in the State Partnership Plan (SPP). The mandated coverage of biomarker testing results in a potential cost less than $34,000 for the partial year coverage in FY 26 and less than $69,000 annually thereafter shared

proportionately amongst municipalities in the SPP based on enrollment. The SPP currently covers biomarker testing. The potential cost accounts for an increase in utilization, and broader coverage for biomarker tests, which may impact plan premiums.

These estimates neglect any future cost saving offsets, and actual fiscal impacts will be realized in future premiums. Actual costs are dependent on the level of coverage, utilization, and number of those enrolled in each plan. Due to federal law, the coverage requirements will not apply to self-insured municipalities, as they are exempt under Employee Retirement Income Security Act (ERISA).

**Exchange and Covered Connecticut.** Sections 4 and 5 also result in a potential cost to the state of up to $92,000 for the partial year coverage in FY 26 and up to $184,000 annually thereafter to defray additional premium costs for enrollees purchasing health insurance on the state's exchange. This cost is potential as it is incurred to the extent the new coverage requirements for biomarker testing are determined to increase premiums and constitute new state benefit mandates under the federal Affordable Care Act (ACA). Currently, the different plans in the exchange cover biomarker testing. The potential cost accounts for an increase in utilization, and broader coverage for biomarker tests, which may impact plan premiums.

Under the ACA, states are allowed to mandate benefits beyond the federally-defined Essential Health Benefits (EHB) but must pay for that excess coverage. Federal regulations require the state to defray the cost of additional benefits related specific care, treatment or services mandated by state action after December 31, 2011 (except to comply with federal requirements) for all plans sold on the exchange.[2] There are currently 152,042 enrollees in qualified health plans on the exchange, including approximately 42,000 in Covered Connecticut.

To the extent the bill is determined to include a new state benefit mandate that requires defrayal, there would be a cost to the state

[2] 45 CFR 155.170

beginning January 1, 2026.[3] Full year costs would begin in FY 27 and continue annually.

Defrayal costs for Covered Connecticut enrollees would be incurred by the Department of Social Services (DSS), to the extent the bill raises premiums for those enrollees.

Federal regulations allow states to update their EHB benchmark plans, potentially incorporating new benefit mandates without the need for defrayal for plan years beginning on January 1, 2020.[4] If the state integrates biomarker testing into its EHB benchmark and obtains federal approval, these benefits become part of the EHB. As a result, the state would not be required to defray the costs of biomarker testing.

### *The Out Years*

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation, cost of biomarker tests, utilization of biomarker testing, and federal regulations regarding defrayal requirements.

[3] After determining if the mandate is subject to defrayal, states must reimburse the carriers or the insureds for the excess coverage. The premium costs are to be quantified by each insurer on the exchange and reported to the state.
[4] 45 CFR 156.111

**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)