House of Representatives

General Assembly

File No. 226

January Session, 2017

House Bill No. 7042

House of Representatives, March 27, 2017

The Committee on Insurance and Real Estate reported through REP. SCANLON of the 98th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONTROLLING CONSUMER HEALTH CARE COSTS.

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 Section 38a-21 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective July 1, 2017*):

(a) As used in this section:

(1) "Commissioner" means the Insurance Commissioner.

(2) "Mandated health benefit" means **[**an existing 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 a medical or health care benefits plan in this state 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.**]**

(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 the General Assembly having cognizance of matters relating to insurance. 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**]** may contract with The University of Connecticut Center for Public Health and Health Policy or an actuarial accounting firm to conduct any mandated health benefit review requested pursuant to subsection (c) of 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) During a regular session of the General Assembly, the joint standing committee of the General Assembly having cognizance of matters relating to insurance may, upon a majority vote of its members, require the commissioner to conduct one review of not more than five mandated health benefits. The committee shall submit to the commissioner a list of the mandated health benefits to be reviewed.

(d) Not later than January first of the first calendar year following a request for review made under subsection (c) of this section, the commissioner shall submit a mandated health benefit review report, in accordance with section 11-4a, to the joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health. Such report shall include an evaluation of the quality and cost impacts of mandating the 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 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:**]**

[(F)**]** (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;

[(G)] (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;

[(H)**]** (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;

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

[(J)**]** (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;

[(K)**]** (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;

[(L)**]** (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;

[(M)**]** (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

[(N)**]** (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.

(e) The joint standing committees of the General Assembly having cognizance of matters relating to insurance and public health shall conduct a joint informational hearing following their receipt of a mandated health benefit review report submitted by the commissioner pursuant to subsection (d) of this section. The commissioner shall attend and be available for questions from the members of the committees at such hearing. On and after February 1, 2018, the General Assembly shall not enact legislation to establish mandated health benefit unless such benefit has been the subject of a report and an informational hearing as provided in this section.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*July 1, 2017*	38a-21

INS *Joint Favorable*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 18 $	FY 19 $
Insurance Dept.	IF - Potential Cost	See Below	See Below

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

This bill prohibits the General Assembly from enacting any legislation mandating insurers to cover a new health benefit without a health benefit review report from the Department of Insurance (DOI). To the extent that this results in additional reviews, there could be additional costs to the Insurance Fund. The potential costs would vary based on the requirements of each review.

The DOI can contract with The University of Connecticut Center for Public Health and Health Policy or an actuarial firm to complete the health benefit review report.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to inflation.

OLR Bill Analysis

HB 7042

AN ACT CONTROLLING CONSUMER HEALTH CARE COSTS.

SUMMARY

This bill modifies the Insurance Department's mandated health benefit review program. It prohibits the General Assembly, beginning February 1, 2018, from enacting any legislation mandating insurers to cover a new health benefit unless the benefit has been the subject of (1) a health benefit review report by the department and (2) an informational hearing before the Insurance and Real Estate and Public Health committees at which the commissioner is present and available for questions.

The bill authorizes the Insurance and Real Estate Committee, during a regular legislative session and by a majority vote of the committee members, to require the insurance commissioner to review and report on up to five proposed mandated health benefits. Under current law, the committee may request a review from the commissioner by August 1 of each year.

As under current law, the bill requires the commissioner to submit the report by the next January 1. Under the bill, the report must be submitted to the Insurance and Real Estate and Public Health committees. Under current law, she submits it only to the Insurance and Real Estate Committee.

The bill allows, rather than requires, the commissioner to contract with the UConn Center for Public Health and Health Policy to conduct the reviews. Under the bill, she may also contract with an actuarial accounting firm for the reviews.

The bill reduces the amount of information that each report must contain. Under current law, a report must review specified social and

financial impacts of mandating the benefit. The bill instead requires the report to evaluate specified quality and cost impacts of mandating it.

By law, unchanged by the bill, the 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.

EFFECTIVE DATE: July 1, 2017

MANDATED HEALTH BENEFIT DEFINITION

The bill narrows the definition of "mandated health benefit." Under the bill, the term means proposed legislation that requires a health carrier offering health insurance policies or benefit plans in Connecticut to offer or provide coverage for (1) a particular health care treatment or service or (2) medical equipment, supplies, or drugs used in connection with a treatment or service.

Current law defines the term to also include (1) an existing statutory obligation of the carrier; (2) a provision allowing enrollees to obtain treatment or services from a particular type of health care provider; and (3) a provision to offer or provide coverage for the screening, diagnosis, or treatment of a particular disease or condition.

QUALITY AND COST IMPACTS MUST BE EVALUATED

Under the bill, a mandated benefit review report must evaluate the quality and cost impacts of mandating the benefit, and, as under existing law, must include:

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

2. the extent to which the treatment, service, or equipment is, or supplies and drugs are, available under Medicare or through public programs that charities, public schools, the Department of Public Health, municipal health departments or districts, or the Department of Social Services administer;

3. the extent to which insurance policies already cover the

treatment, service, equipment, supplies, or drugs;

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

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

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

7. the extent to which the treatment, service, or equipment is, or 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 that the relevant medical community generally recognizes;

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

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 utilization and costs;

11. the impact on the (a) total cost of health care, including potential savings to insurers and employers resulting 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 benefit review report:

1. if coverage of the benefit is not generally available, the extent to which this results in (a) people being unable to obtain 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 relating to 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 regarding the direct or specific creation of a comparable mandated benefit for similar diseases, illnesses, or conditions;

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

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

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 18 Nay 2 (03/09/2017)