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## **OLR Bill Analysis**

### **HB 5013**

#### ***AN ACT CONCERNING MANDATED HEALTH INSURANCE BENEFIT REVIEW.***

#### **SUMMARY**

This bill modifies the Insurance Department's mandated health benefit review program. Beginning January 1, 2022, it also prohibits the General Assembly from enacting legislation establishing a mandated health benefit unless (1) the benefit has gone through the review program and a legislative hearing or (2) two-thirds of the Insurance and Real Estate Committee votes for it. (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 authorizes the Insurance and Real Estate Committee, during a regular legislative session and by a majority vote of its members, to require the insurance commissioner to review and report on up to five proposed mandated health benefits by the next January 1. Under current law, the committee may request a review of any number of existing or proposed benefits by August 1 of each year. 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.

The bill requires the commissioner to submit the mandated health benefit reports to the Insurance and Real Estate and Public Health committees, which must hold a joint informational hearing on each report. It requires him to attend each hearing to take members' questions.

The bill also does the following:

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

2. reduces the amount of information the commissioner's reports must include on each benefit;
3. allows, rather than requires, the commissioner to contract with the UConn Center for Public Health and Health Policy to conduct a review; and
4. allows him to contract with an actuarial accounting firm to conduct a review.

EFFECTIVE DATE: July 1, 2021

## **MANDATED HEALTH BENEFIT REVIEW PROGRAM**

### ***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 (e.g., insurer or HMO) offering health insurance policies or benefit plans in the state to offer or provide coverage for (1) a particular type of health care treatment or service or (2) 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 eliminates:

1. an existing statutory obligation of the carrier to offer or provide coverage;
2. proposed legislation to expand or repeal an existing coverage obligation;
3. an existing obligation or proposed legislation allowing enrollees to obtain treatment or services from a particular type of health care provider; and
4. 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***

Under the bill, the commissioner must report to the Insurance and Real Estate and Public Health committees on the proposed mandated health benefits by January 1 following a request. Current law requires him to submit reports only to the Insurance and Real Estate Committee.

The bill reduces the amount of information each report must contain. Under current law, a report must review specified social and financial impacts of mandating the benefit. The bill instead requires a report to evaluate the specified quality and cost impacts of mandating it.

***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 the treatment, service, equipment, supplies, or drugs are available under Medicare or through other public programs;
3. the extent to which insurance policies already cover the treatment, service, equipment, supplies, or drugs;
4. the effect 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 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 the appropriate or inappropriate use of the benefit;
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 effect 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 effect 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 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 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.

**COMMITTEE ACTION**

Insurance and Real Estate Committee

Joint Favorable

Yea 17 Nay 1 (03/22/2021)