
OLR Bill Analysis

sHB 6711

AN ACT CONCERNING MANDATED HEALTH INSURANCE BENEFIT REVIEW.

SUMMARY

This bill modifies the Insurance Department's mandated health benefit review program. It requires the Insurance and Real Estate Committee to give the insurance commissioner and the Office of Health Strategy (OHS) executive director a list of proposed mandated health benefits that received a public hearing during the regular legislative session for their review. The committee must do this within seven days after each public hearing on a mandated health benefit. Under current law, the committee may ask the commissioner to review existing or proposed benefits by August 1 of each year.

The bill requires the insurance commissioner, in consultation with the OHS executive director, to submit a mandated health benefit review report to the committee by April 15, 2024, and then annually, after they receive the list of mandated benefits that had a public hearing. The report must evaluate the quality and cost impacts of mandating each health benefit. The bill authorizes the committee to hold an informational hearing after it receives a report. The commissioner and executive director must 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 that each report must contain;
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.

By law, unchanged by the bill, the commissioner may assess health carriers (e.g., insurers and HMOs) for the costs of the mandated health benefit review program. Assessments are deposited in the Insurance Fund.

EFFECTIVE DATE: October 1, 2023

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 (1) health carrier offering health insurance policies or benefit plans in the state or a qualified health plan through the Connecticut Health Insurance Exchange (i.e., Access Health CT) or (2) the state employee health benefits 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. 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 Review Reports

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. The bill also newly requires each report to assess the mandated health benefit's impact on the cost of qualified health plans offered through the Connecticut Health Insurance Exchange.

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 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 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 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 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 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 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 Substitute

Yea 11 Nay 1 (03/14/2023)