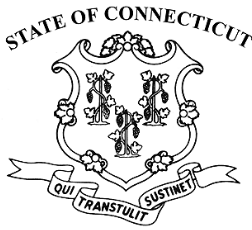

House of Representatives

General Assembly

File No. 331

January Session, 2023

Substitute House Bill No. 6711

House of Representatives, March 30, 2023

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 MANDATED HEALTH INSURANCE BENEFIT REVIEW.

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

1 Section 1. Section 38a-21 of the general statutes is repealed and the
2 following is substituted in lieu thereof (*Effective October 1, 2023*):

3 (a) As used in this section:

4 (1) "Commissioner" means the Insurance Commissioner.

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

6 (3) "Executive director" means the executive director of the Office of
7 Health Strategy.

8 (4) "Health carrier" has the same meaning as provided in section 38a-
9 1080.

10 **[**(2)**]** (5) "Mandated health benefit" means **[**an existing statutory

11 obligation of, or**]** proposed legislation that would require **[**,**]** an insurer,
12 health care center, hospital service corporation, medical service
13 corporation, fraternal benefit society or other entity that offers
14 individual or group health insurance or medical or health care benefits
15 plan in this state, a health carrier that offers a qualified health plan
16 through the exchange or the state employee plan to **[**: (A) Permit an
17 insured or enrollee to obtain health care treatment or services from a
18 particular type of health care provider; (B) offer or provide coverage for
19 the screening, diagnosis or treatment of a particular disease or
20 condition; or (C)**]** offer or provide coverage for a particular type of
21 health care treatment or service, or for medical equipment, medical
22 supplies or drugs used in connection with a health care treatment or
23 service. **[**"Mandated health benefit" includes any proposed legislation to
24 expand or repeal an existing statutory obligation relating to health
25 insurance coverage or medical benefits.**]**

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

28 (7) "State employee plan" means the group hospitalization, medical,
29 pharmacy and surgical insurance plan offered to state employees and
30 retirees pursuant to section 5-259.

31 (b) (1) There is established within the Insurance Department a health
32 benefit review program for the review and evaluation of any mandated
33 health benefit that **[**is requested**]** receives a public hearing by the joint
34 standing committee of the General Assembly having cognizance of
35 matters relating to insurance. Such program shall be funded by the
36 Insurance Fund established under section 38a-52a. The commissioner
37 shall be authorized to make assessments in a manner consistent with the
38 provisions of chapter 698 for the costs of carrying out the requirements
39 of this section. Such assessments shall be in addition to any other taxes,
40 fees and moneys otherwise payable to the state. The commissioner shall
41 deposit all payments made under this section with the State Treasurer.
42 The moneys deposited shall be credited to the Insurance Fund and shall
43 be accounted for as expenses recovered from insurance companies. Such

44 moneys shall be expended by the commissioner to carry out the
45 provisions of this section and section 2 of public act 09-179.

46 (2) The commissioner [shall] may contract with The University of
47 Connecticut Center for Public Health and Health Policy or an actuarial
48 accounting firm to conduct any mandated health benefit review
49 [requested] required pursuant to subsection [(c)] (d) of this section. The
50 director of said center may engage the services of an actuary, quality
51 improvement clearinghouse, health policy research organization or any
52 other independent expert, and may engage or consult with any dean,
53 faculty or other personnel said director deems appropriate within The
54 University of Connecticut schools and colleges, including, but not
55 limited to, The University of Connecticut (A) School of Business, (B)
56 School of Dental Medicine, (C) School of Law, (D) School of Medicine,
57 and (E) School of Pharmacy.

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

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

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

69 (c) Not later than seven days after each public hearing on any
70 mandated health benefit during a regular session of the General
71 Assembly, the joint standing committee of the General Assembly having
72 cognizance of matters relating to insurance shall submit to the
73 commissioner and the executive director a list that includes each
74 mandated health benefit that received a public hearing during the
75 current regular session.

76 (d) Not later than April 15, 2024, and each April fifteenth thereafter,
77 the commissioner, in consultation with the executive director, shall
78 submit a mandated health benefit review report, in accordance with
79 section 11-4a, to the joint standing committee of the General Assembly
80 having cognizance of matters relating to insurance. Such report shall
81 provide an assessment of each mandated health benefit included in the
82 list provided pursuant to subsection (c) of this section. Such report shall
83 include an evaluation of the quality and cost impacts of mandating each
84 health benefit, including:

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

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

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

96 [(D) If the coverage is not generally available, the extent to which
97 such lack of coverage results in persons being unable to obtain necessary
98 health care treatment;

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

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

105 (G) The level of public demand and the level of demand from
106 providers for insurance coverage for the treatment, service or

107 equipment, supplies or drugs, as applicable;

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

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

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

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

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

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

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

126 **[**(O)**]** <u>(4)</u> The impact of making the benefit applicable to the state
127 employee health insurance or health benefits plan; **[**and**]**

128 **[**(P)**]** <u>(5)</u> The extent to which credible scientific evidence published in
129 peer-reviewed medical literature generally recognized by the relevant
130 medical community determines the treatment, service or equipment,
131 supplies or drugs, as applicable, to be safe and effective; **[**and**]**

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

133 **[**(A)**]** <u>(6)</u> The extent to which the mandated health benefit may
134 increase or decrease the cost of the treatment, service or equipment,

135 supplies or drugs, as applicable, over the next five years;

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

139 [(C)] (8) The extent to which the mandated health benefit may serve
140 as an alternative for more expensive or less expensive treatment, service
141 or equipment, supplies or drugs, as applicable;

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

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

148 [(F)] (11) The extent to which the treatment, service or equipment,
149 supplies or drugs, as applicable, is more or less expensive than an
150 existing treatment, service or equipment, supplies or drugs, as
151 applicable, that is determined to be equally safe and effective by credible
152 scientific evidence published in peer-reviewed medical literature
153 generally recognized by the relevant medical community;

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

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

162 [(I)] (14) The impact of the mandated health benefit on cost-shifting
163 between private and public payors of health care coverage and on the
164 overall cost of the health care delivery system in the state; and

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

167 (e) The joint standing committee of the General Assembly having
168 cognizance of matters relating to insurance may conduct an
169 informational hearing following such committee's receipt of the
170 mandated health benefit review report submitted by the commissioner,
171 in consultation with the executive director, pursuant to subsection (d)
172 of this section. The commissioner and executive director shall attend
173 and be available for questions from the members of such committee at
174 such hearing.

This act shall take effect as follows and shall amend the following sections:		
Section 1	*October 1, 2023*	38a-21

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 24 $	FY 25 $
Insurance Dept.	IF - Revenue Gain	Same as Cost	Same as Cost
Insurance Dept.	IF - Cost	Same as Revenue	Same as Revenue

Note: IF=Insurance Fund

Municipal Impact: None

Explanation

The bill modifies the Health Benefit Review Program (HBRP), which is likely to result in an increase in costs and an equivalent increase in revenue to the Insurance Fund beginning in FY 24, and annually thereafter.

Under the program, the Insurance Department (DOI) contracts with outside entities to conduct reviews of proposed health insurance benefit mandates. These contract costs are paid for through an assessment on insurers, so the bill's changes to the program are not anticipated to result in a net fiscal impact to the state.

Costs (and offsetting revenue) under the bill are anticipated to range between $65,000 and $80,000 per health benefit mandate reviewed each fiscal year. The bill makes various changes that impact costs under the program that are discussed below.

First, the bill requires DOI to conduct reviews for every proposed mandate that receives a public hearing during a regular session. To the extent the Insurance and Real Estate Committee continues to hold public

hearings for numerous proposed health benefit mandates per year, the bill will result in more frequent use of the program. The last time the program reviewed mandates was in FY 15; however, more than 20 proposed mandates have had public hearings across the last three sessions.

Second, the bill requires DOI to submit a version of the currently required report on each mandate to the committee by April 15th of the same session, significantly shortening the time for review. Under current law, DOI must receive the list of mandates to study by August 1 and provide the report by January 1 of the following year. Because of the very short time to complete the reviews (as little as one month) that is allowed under the bill, DOI may incur higher contract costs for reviews.

Partially offsetting the above factors, the bill makes other changes that are likely to reduce costs, such as allowing DOI to contract directly with an actuarial accounting firm to conduct the reviews and reducing the criteria that must be included in the report for each benefit mandate.

The Out Years

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

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)