SB 120-FN - AS INTRODUCED

2025 SESSION

25-0920
05/11

SENATE BILL ***120-FN***

AN ACT relative to insurance coverage for biomarker testing.

SPONSORS: Sen. Innis, Dist 7; Sen. Watters, Dist 4; Sen. Prentiss, Dist 5; Sen. Rosenwald, Dist 13; Rep. Potucek, Rock. 13; Rep. Wallner, Merr. 19

COMMITTEE: Health and Human Services

ANALYSIS

This bill requires health insurance coverage for biomarker testing. The bill also requires the state Medicaid plan to include coverage for biomarker testing.

- -

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

25-0920
05/11

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty Five

AN ACT relative to insurance coverage for biomarker testing.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Subdivision; Managed Care Law; Biomarker Testing. Amend RSA 420-J by inserting after section 19 the following new subdivision:

Biomarker Testing

420-J:20 Definitions. In this subdivision:

I. "Biomarker" means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacologic responses to a specific therapeutic intervention, including known gene-drug interactions for medications being considered for use or already being administered. Biomarkers include but are not limited to gene mutations, characteristics of genes, or protein expression.

II. "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes but is not limited to single-analyte tests, multi-plex panel tests, protein expression, and whole exome, whole genome, and whole transcriptome sequencing.

III. "Consensus statements" mean statements developed by an independent, multidisciplinary panel of experts utilizing a transparent methodology and reporting structure and with a conflict of interest policy. These statements are aimed at specific clinical circumstances and base the statements on the best available evidence for the purpose of optimizing the outcomes of clinical care.

IV. "Nationally recognized clinical practice guidelines" mean evidence-based clinical practice guidelines developed by independent organizations or medical professional societies utilizing a transparent methodology and reporting structure and with a conflict of interest policy. Clinical practice guidelines establish standards of care informed by a systematic review of evidence and an assessment of the benefits and risks of alternative care options and include recommendations intended to optimize patient care.

420-J: 21 Biomarker Testing; Health Benefit Plan Coverage Requirements.

I. Each health carrier issuing, amending, delivering or renewing a health benefit plan on or after January 1, 2026 shall include coverage for biomarker testing as defined in RSA 420-J:20, II, pursuant to the criteria established in this section.

II. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

(a) Labeled indications for an FDA-approved or -cleared test;

(b) Indicated tests for an FDA-approved drug;

(c) Warnings and precautions on FDA-approved drug labels;

(d) Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

(e) Nationally recognized clinical practice guidelines and consensus statements.

III. A health carrier shall ensure that coverage as defined in paragraph II is provided in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

IV. If utilization review, including but not limited to prior authorization, is required, the health carrier, utilization review entity, or any third party acting on behalf of an organization or entity subject to this subdivision shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider, and any entity requesting authorization of the service within 72 hours for non-urgent requests or within 24 hours for urgent requests.

V. The patient and prescribing practitioner shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy or an adverse utilization review determination of a health carrier. The process shall be made readily accessible on the health carrier's website.

2 New Section; Medicaid Coverage of Biomarker Testing. Amend RSA 167 by inserting after section 4-f the following new section:

167:4-g Biomarker Testing; Medicaid Coverage Requirements.

I. The state Medicaid plan shall cover biomarker testing as defined in RSA 420-J:20, II, in accordance with the requirements of this section.

II. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to:

(a) Labeled indications for an FDA-approved or -cleared test;

(b) Indicated tests for an FDA-approved drug;

(c) Warnings and precautions on FDA-approved drug labels;

(d) Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or

(e) Nationally recognized clinical practice guidelines and consensus statements.

III. Risk-bearing entities contracted under the state Medicaid plan to deliver services to beneficiaries shall provide biomarker testing at the same scope, duration and frequency as the Medicaid program otherwise provides to enrollees.

IV. The state Medicaid plan shall ensure coverage as defined in paragraph II is provided in a manner that limits disruptions in care including the need for multiple biopsies or biospecimen samples.

V. If utilization review, including but not limited to prior authorization, is required, the state Medicaid plan, utilization review entity, or any third party acting on behalf of an organization or entity subject to this section shall approve or deny a prior authorization request and notify the enrollee, the enrollee's health care provider, and any entity requesting authorization of the service within 72 hours for non-urgent requests or within 24 hours for urgent requests.

VI. The enrollee and participating provider shall have access to a clear, readily accessible, and convenient process to request an exception to a coverage policy of the state Medicaid plan or by risk-bearing entities contracted to the program. The process shall be made readily accessible to all participating providers and enrollees online.

VII. The department of health and human services shall submit to the Centers for Medicare and Medicaid Services any amendment to the state Medicaid plan required to provide coverage for biomarker testing in accordance with this section.

3 Effective Date. This act shall take effect July 1, 2025.

LBA
25-0920
Revised 2/4/25

SB 120-FN- FISCAL NOTE
AS INTRODUCED

AN ACT relative to insurance coverage for biomarker testing.

FISCAL IMPACT: This bill does not provide funding.

Estimated State Impact				
	FY 2025	**FY 2026**	**FY 2027**	**FY 2028**
Revenue	$0	Indeterminable	Indeterminable	Indeterminable
Revenue Fund(s)	General Fund			
Expenditures*	$0	Indeterminable	Indeterminable	Indeterminable
Funding Source(s)	General Fund, Highway Fund, and Various Agency Funds			
Appropriations*	$0	$0	$0	$0
Funding Source(s)	None			

***Expenditure = Cost of bill** ***Appropriation = Authorized funding to cover cost of bill**

METHODOLOGY:

This bill requires health insurers to pay for biomarker testing for diagnostic, treatment, appropriate management or ongoing monitoring of a disease or condition.

The Insurance Department states this bill amendments RSA 420-J requiring health carriers to cover biomarker testing. While some testing may already be included under the state Benchmark Plan when deemed medically necessary, any additional testing mandated by this law would constitute a new benefit requirement.

Section 420-J:21, IV introduces prior authorization timeframes (72 hours for non-urgent and 24 hours for urgent cases) that conflict with existing timeframes in 420-J:6 (7 calendar days for non-urgent and 72 hours for urgent cases).

The Department states the financial impact of requiring insurers to cover biomarker testing for diagnostic, treatment, management, or monitoring purposes is indeterminable. Costs depend on plan design, cost-sharing structures, and annual medical expenses. Increased utilization may raise initial expenses, but earlier detection and targeted treatments could offset costs through improved outcomes. The net fiscal is indeterminable.

If the mandated benefits exceed those covered under the Benchmark Plan, they would be classified as additional Essential Health Benefits requiring the state to cover associated costs for

Qualified Health Plan enrollees. This would result in an indeterminable expense to the State's expenditures starting in FY 2026.

The Department of Health and Human Services states this bill will not impact their department.

AGENCIES CONTACTED:

Insurance Department and Department of Health and Human Services