JOINT COMMITTEE ON FINANCIAL SERVICES
2025-2026 (194th) BILL SUMMARY

Bill No: H1227

Title: AN ACT RELATIVE TO CANCER PATIENT ACCESS TO BIOMARKER TESTING TO PROVIDE APPROPRIATE THERAPY

Sponsor: Rep. Meghan Kilcoyne (*Clinton*)

Hearing Date: April 29, 2025

Reporting Deadline: June 28, 2025

Prior History:
2023-24 (H1227): Referred favorably; Referred to Health Care Financing; Reported favorably; Referred to HWM
2012-22 (H1137): Referred favorably; Referred to Health Care Financing; Ordered to a House Study

Similar Matters: S809 (Oliveira – Identical)

CURRENT LAW:
M.G.L. c. 32A Contributory Group General or Blanket Insurance for Persons in the Service of the Commonwealth (Group Insurance Commission)

M.G.L. c. 118E Division of Medical Assistance (MassHealth)

M.G.L. c. 175 Insurance

M.G.L. c. 176A Non-Profit Hospital Service Corporations (Blue Cross of Massachusetts)

M.G.L. c. 176B Medical Service Corporations (Blue Shield of Massachusetts)

M.G.L. c. 176G Health Maintenance Organizations (HMOs)

SUMMARY:
This bill defines "Biomarker testing" as 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.

This bill would require the Group Insurance Commission, MassHealth, and commercial health insurers to provide coverage for biomarker testing.

Biomarker testing coverage would be provided for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured's disease or condition when the test is supported by medical and scientific evidence, including, but not limited to: labeled

indications for an FDA-approved or -cleared test or indicated tests for an FDA-approved drug; Warnings and precautions on FDA-approved drug labels; Centers for Medicare and Medicaid Services (CMS) National Coverage Determinations or Medicare Administrative Contractor (MAC) Local Coverage Determinations; or Nationally recognized clinical practice guidelines and consensus statements.

Prior authorization would be completed within 72 hours except where an insured's well being is at significant risk. In that case, the insured would complete prior authorization within 24 hours.

Coverage would be provided in a way that limits care disruptions, and both the insured, and the physician would have easy access to an exception process.