BILL ANALYSIS

Senate Research Center

S.B. 989
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Health & Human Services
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Enrolled

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Biomarker testing allows doctors to use information about a person's specific genetic variations to better inform diagnosis, prognosis, and therapy selection for a cancer or rare disease patient. Insurance coverage of biomarker testing is not an across-the-board guarantee, nor is it being consistently reimbursed by the health plans in Texas.

S.B. 989 seeks to address this issue by amending the Insurance Code to include medically necessary coverage for biomarker testing of patients with cancer and other rare diseases. The bill establishes guidelines for health benefit plan issuers to provide coverage for biomarker testing when the test is supported by medical and scientific evidence and provides clinical utility, which means the use of the test for the condition is evidence-based, scientifically valid, outcome-focused, and predominately addresses the acute issue for which the test is being ordered. The bill also requires plans to provide coverage in a manner that limits disruptions in care, including minimizing the number of biopsies and biospecimen samples needed. The provisions of this bill apply to certain health care plans offered across the state, including those offered by the Employees Retirement System and Teacher Retirement System.

The committee substitute modifies the bill's applicability section by removing church benefit boards, three-share premium assistance programs, and Local Government Code benefit offerings.

S.B. 989 amends current law relating to health benefit plan coverage for certain biomarker testing.

RULEMAKING AUTHORITY

This bill does not expressly grant any additional rulemaking authority to a state officer, institution, or agency.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle E, Title 8, Insurance Code, by adding Chapter 1372, as follows:

CHAPTER 1372. COVERAGE FOR BIOMARKER TESTING

Sec. 1372.001. DEFINITIONS. Defines "biomarker," "biomarker testing," "consensus statements," and "nationally recognized clinical practice guidelines."

Sec. 1372.002. APPLICABILITY OF CHAPTER. (a) Provides that this chapter applies only to a health benefit plan that provides benefits for medical or surgical expenses incurred as a result of a health condition, accident, or sickness, including an individual, group, blanket, or franchise insurance policy or insurance agreement, a group hospital service contract, or an individual or group evidence of coverage or similar coverage document that is offered by:

(1) an insurance company;

(2) a group hospital service corporation operating under Chapter 842 (Group Hospital Service Corporations);

(3) a health maintenance organization operating under Chapter 843 (Health Maintenance Organizations);

(4) an approved nonprofit health corporation that holds a certificate of authority under Chapter 844 (Certification of Certain Nonprofit Health Corporations);

(5) a multiple employer welfare arrangement that holds a certificate of authority under Chapter 846 (Multiple Employer Welfare Arrangements);

(6) a stipulated premium company operating under Chapter 884 (Stipulated Premium Insurance Companies);

(7) a fraternal benefit society operating under Chapter 885 (Fraternal Benefit Societies);

(8) a Lloyd's plan operating under Chapter 941 (Lloyd's Plan); or

(9) an exchange operating under Chapter 942 (Reciprocal and Interinsurance Exchanges).

(b) Provides that this chapter, notwithstanding any other law, applies to:

(1) a small employer health benefit plan subject to Chapter 1501 (Health Insurance Portability and Availability Act), including coverage provided through a health group cooperative under Subchapter B (Coalitions and Cooperatives) of that chapter;

(2) a standard health benefit plan issued under Chapter 1507 (Consumer Choice of Benefits Plans);

(3) a basic coverage plan under Chapter 1551 (Texas Employees Group Benefits Act);

(4) a basic plan under Chapter 1575 (Texas Public School Employees Group Benefits Program);

(5) a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage);

(6) a plan providing basic coverage under Chapter 1601 (Uniform Insurance Benefits Act for Employees of The University of Texas System and the Texas A&M University System);

(7) the state Medicaid program, including the Medicaid managed care program operated under Chapter 533 (Medicaid Managed Care Program), Government Code;

(8) the child health plan program under Chapter 62 (Child Health Plan for Certain Low-Income Children), Health and Safety Code; and

(9) a self-funded health benefit plan sponsored by a professional employer organization under Chapter 91 (Professional Employer Organizations), Labor Code.

Sec. 1372.003. COVERAGE REQUIRED. (a) Requires that a health benefit plan, subject to Subsection (b), provide coverage for biomarker testing for the purpose of diagnosis, treatment, appropriate management, or ongoing monitoring of an enrollee's disease or

condition to guide treatment when the test is supported by the following kinds of medical and scientific evidence:

(1) a labeled indication for a test approved or cleared by the United States Food and Drug Administration;

(2) an indicated test for a drug approved by the United States Food and Drug Administration;

(3) a national coverage determination made by the Centers for Medicare and Medicaid Services or a local coverage determination made by a Medicare administrative contractor;

(4) nationally recognized clinical practice guidelines; or

(5) consensus statements.

(b) Requires a health benefit plan issuer to provide coverage under Subsection (a) only when use of biomarker testing provides clinical utility because use of the test for the condition:

(1) is evidence-based;

(2) is scientifically valid based on the medical and scientific evidence described by Subsection (a);

(3) informs a patient's outcome and a provider's clinical decision; and

(4) predominately addresses the acute or chronic issue for which the test is being ordered, except that a test is authorized to include some information that cannot be immediately used in the formulation of a clinical decision.

(c) Requires that a health benefit plan provide coverage under Subsection (a) in a manner that limits disruptions in care, including limiting the number of biopsies and biospecimen samples.

SECTION 2. Requires a state agency, if necessary for implementation of a provision of this Act, to request a waiver or authorization from a federal agency, and authorizes a delay of implementation until such a waiver or authorization is granted.

SECTION 3. Makes application of this Act prospective to January 1, 2024.

SECTION 4. Effective date: September 1, 2023.