

BILL ANALYSIS

Senate Research Center
88R7022 RDS-F

S.B. 989
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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 health plans in Texas.

S.B. 989 ensures medically necessary insurance coverage of biomarker testing for the testing of patients with cancer and other rare diseases. Specifically, S.B. 989 establishes definitions for "biomarker," "biomarker testing," "consensus statements," and "nationally recognized clinical practice guidelines." The bill lists all the public and private issuers of health benefit plans that must cover biomarker testing for a plan that is delivered, issued for delivery, or renewed on or after January 1, 2024. It also provides the requirements under which biomarker testing must be covered by a health benefit plan 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.

As proposed, 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) health benefits provided by or through a church benefits board under Subchapter I (Church Benefits Board), Chapter 22, Business Organizations Code;

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

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

(10) a regional or local health care program operated under Section 75.104 (Health Care Services), Health and Safety Code;

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

(12) county employee group health benefits provided under Chapter 157 (Assistance, Benefits, and Working Conditions of County Officers and Employees), Local Government Code; and

(13) health and accident coverage provided by a risk pool created under Chapter 172 (Texas Political Subdivisions Uniform Group Benefits Program), Local Government 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 medical and scientific evidence, including:

(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;

(3) is outcome focused; and

(4) predominately addresses the acute 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.