

AN ACT

relating to health benefit plan coverage for certain biomarker testing.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Subtitle E, Title 8, Insurance Code, is amended by adding Chapter 1372 to read as follows:

CHAPTER 1372. COVERAGE FOR BIOMARKER TESTING

Sec. 1372.001. DEFINITIONS. In this chapter:

(1) "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. The term includes:

(A) gene mutations; and

(B) protein expression.

(2) "Biomarker testing" means the analysis of a patient's tissue, blood, or other biospecimen for the presence of a biomarker. The term includes:

(A) single-analyte tests;

(B) multiplex panel tests; and

(C) whole genome sequencing.

(3) "Consensus statements" means statements that:

(A) address specific clinical circumstances based on the best available evidence for the purpose of optimizing

1 clinical care outcomes; and

2 (B) are developed by an independent,  
3 multidisciplinary panel of experts that uses a transparent  
4 methodology and reporting structure and is subject to a conflict of  
5 interest policy.

6 (4) "Nationally recognized clinical practice  
7 guidelines" means evidence-based clinical practice guidelines  
8 that:

9 (A) establish a standard of care informed by a  
10 systematic review of evidence and an assessment of the benefits and  
11 costs of alternative care options;

12 (B) include recommendations intended to optimize  
13 patient care; and

14 (C) are developed by an independent organization  
15 or medical professional society that uses a transparent methodology  
16 and reporting structure and is subject to a conflict of interest  
17 policy.

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

25 (1) an insurance company;

26 (2) a group hospital service corporation operating  
27 under Chapter 842;

- 1           (3) a health maintenance organization operating under  
2 Chapter 843;
- 3           (4) an approved nonprofit health corporation that  
4 holds a certificate of authority under Chapter 844;
- 5           (5) a multiple employer welfare arrangement that holds  
6 a certificate of authority under Chapter 846;
- 7           (6) a stipulated premium company operating under  
8 Chapter 884;
- 9           (7) a fraternal benefit society operating under  
10 Chapter 885;
- 11           (8) a Lloyd's plan operating under Chapter 941; or  
12           (9) an exchange operating under Chapter 942.
- 13           (b) Notwithstanding any other law, this chapter applies to:
- 14           (1) a small employer health benefit plan subject to  
15 Chapter 1501, including coverage provided through a health group  
16 cooperative under Subchapter B of that chapter;
- 17           (2) a standard health benefit plan issued under  
18 Chapter 1507;
- 19           (3) a basic coverage plan under Chapter 1551;  
20           (4) a basic plan under Chapter 1575;  
21           (5) a primary care coverage plan under Chapter 1579;  
22           (6) a plan providing basic coverage under Chapter  
23 1601;
- 24           (7) the state Medicaid program, including the Medicaid  
25 managed care program operated under Chapter 533, Government Code;  
26           (8) the child health plan program under Chapter 62,  
27 Health and Safety Code; and

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

3           Sec. 1372.003. COVERAGE REQUIRED. (a) Subject to  
4 Subsection (b), a health benefit plan must provide coverage for  
5 biomarker testing for the purpose of diagnosis, treatment,  
6 appropriate management, or ongoing monitoring of an enrollee's  
7 disease or condition to guide treatment when the test is supported  
8 by the following kinds of medical and scientific evidence:

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

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

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

16           (4) nationally recognized clinical practice  
17 guidelines; or

18           (5) consensus statements.

19           (b) A health benefit plan issuer must provide coverage under  
20 Subsection (a) only when use of biomarker testing provides clinical  
21 utility because use of the test for the condition:

22           (1) is evidence-based;

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

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

27           (4) predominately addresses the acute or chronic issue

1 for which the test is being ordered, except that a test may include  
2 some information that cannot be immediately used in the formulation  
3 of a clinical decision.

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

7 SECTION 2. If before implementing any provision of this Act  
8 a state agency determines that a waiver or authorization from a  
9 federal agency is necessary for implementation of that provision,  
10 the agency affected by the provision shall request the waiver or  
11 authorization and may delay implementing that provision until the  
12 waiver or authorization is granted.

13 SECTION 3. The change in law made by this Act applies only  
14 to a health benefit plan that is delivered, issued for delivery, or  
15 renewed on or after January 1, 2024.

16 SECTION 4. This Act takes effect September 1, 2023.

S.B. No. 989

\_\_\_\_\_  
President of the Senate

\_\_\_\_\_  
Speaker of the House

I hereby certify that S.B. No. 989 passed the Senate on April 12, 2023, by the following vote: Yeas 26, Nays 4.

\_\_\_\_\_  
Secretary of the Senate

I hereby certify that S.B. No. 989 passed the House on May 16, 2023, by the following vote: Yeas 114, Nays 24, two present not voting.

\_\_\_\_\_  
Chief Clerk of the House

Approved:

\_\_\_\_\_  
Date

\_\_\_\_\_  
Governor