

BILL ANALYSIS

Senate Research Center
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H.B. 1647
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Health & Human Services
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Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Patient advocates have raised concerns over patient safety with regard to "whitebagging," the practice of delivering drugs, typically infusion drugs, from a pharmacy, physician's office, or other site of service where a provider can administer the drugs to the patient. According to community oncologists, the practice of whitebagging can cause delays that lead to disease progression and are not in the best interest of patient outcomes. In addition, concerns exist regarding the chain of custody of the drugs that, when being whitebagged, do not follow the typical model of delivery to which physicians are accustomed. H.B. 1647 seeks to protect patient choice and safety, and the patient-physician relationship, by prohibiting issuers of certain health plans from imposing certain limitations relating to coverage of clinician-administered drugs under certain circumstances for patients with chronic, complex, rare, and life-threatening medical conditions.

H.B. 1647 amends current law relating to health benefit plan coverage of clinician-administered drugs.

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 Chapter 1369, Insurance Code, by adding Subchapter Q, as follows:

SUBCHAPTER Q. CLINICIAN-ADMINISTERED DRUGS

Sec. 1369.761. DEFINITIONS. Defines "administer," "clinician-administered drug," "health care provider," and "physician."

Sec. 1369.762. APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter 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 subchapter, 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) group health coverage made available by a school district in accordance with Section 22.004 (Group Health Benefits for School Employees), Education Code;

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

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

Sec. 1369.763. EXCEPTIONS TO APPLICABILITY OF SUBCHAPTER. (a) Provides that this subchapter does not apply to an issuer or provider of health benefits under or a pharmacy benefit manager administering pharmacy benefits under:

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

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

(3) the TRICARE military health system; or

(4) a workers' compensation insurance policy or other form of providing medical benefits under Title 5 (Workers' Compensation), Labor Code.

(b) Provides that this subchapter does not apply to a prescription drug administered in a hospital, hospital facility-based practice setting, or hospital outpatient infusion center.

Sec. 1369.764. CERTAIN LIMITATIONS ON COVERAGE OF CLINICIAN-ADMINISTERED DRUGS PROHIBITED. (a) Prohibits a health benefit plan issuer, subject to Subsection (b), from, for an enrollee with a chronic, complex, rare, or life-threatening medical condition:

(1) requiring clinician-administered drugs to be dispensed only by certain pharmacies or only by pharmacies participating in the health benefit plan issuer's network;

(2) if a clinician-administered drug is otherwise covered, limiting or excluding coverage for such drugs based on the enrollee's choice of pharmacy, or because the drug was not dispensed by a pharmacy that participates in the health benefit plan issuer's network;

(3) requiring a physician or health care provider participating in the health benefit plan issuer's network to bill for or be reimbursed for the delivery and administration of clinician-administered drugs under the pharmacy benefit instead of the medical benefit without:

(A) informed written consent of the patient; and

(B) a written attestation by the patient's physician or health care provider that a delay in the drug's administration will not place the patient at an increased health risk; or

(4) requiring that an enrollee pay an additional fee, higher copay, higher coinsurance, second copay, second coinsurance, or any other price increase for clinician-administered drugs based on the enrollee's choice of pharmacy or because the drug was not dispensed by a pharmacy that participates in the health benefit plan issuer's network.

(b) Provides that Subsection (a) applies only if the patient's physician or health care provider determines that:

(1) a delay of care would make disease progression probable; or

(2) the use of a pharmacy within the health benefit plan issuer's network would:

(A) make death or patient harm probable;

(B) potentially cause a barrier to the patient's adherence to or compliance with the patient's plan of care; or

(C) because of the timeliness of the delivery or dosage requirements, necessitate delivery by a different pharmacy.

(c) Provides that nothing in in this section is authorized to be construed to:

(1) authorize a person to administer a drug when otherwise prohibited under the laws of this state or federal law; or

(2) modify drug administration requirements under the laws of this state, including any requirements related to delegation and supervision of drug administration.

SECTION 2. Makes application of Subchapter Q, Chapter 1369, Insurance Code, as added by this Act, prospective to January 1, 2024.

SECTION 3. Effective date: September 1, 2023.