BILL ANALYSIS

C.S.H.B. 1647
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Insurance
Committee Report (Substituted)

BACKGROUND AND PURPOSE

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. C.S.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.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that this bill does not expressly grant any additional rulemaking authority to a state officer, department, agency, or institution.

ANALYSIS

C.S.H.B. 1647 amends the Insurance Code to prohibit certain health benefit plan issuers, for an enrollee with a chronic, complex, rare, or life-threatening medical condition, from doing the following:

- limiting where clinician-administered drugs may be dispensed to certain pharmacies or to in-network pharmacies;
- limiting or excluding coverage for such drugs, that are otherwise covered, based on the enrollee's choice of pharmacy or the pharmacy's participation in the plan issuer's network;
- requiring a physician or health care provider participating in the plan issuer's network to bill for or be reimbursed for the delivery and administration of such drugs under the pharmacy benefit instead of the medical benefit without the patient's informed written consent and written attestation by the patient's physician or provider that a delay in the drug's administration will not place the patient at an increased health risk; or
- 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 the pharmacy's participation in the plan issuer's network.

The prohibitions apply only if the patient's physician or provider determines that a delay of care would make disease progression probable or the use of a pharmacy within the plan issuer's network would make death or patient harm probable, potentially cause a barrier to the patient's adherence to or compliance with the plan of care, or, because of the timeliness of the delivery or dosage requirements, necessitate delivery by a different pharmacy.

C.S.H.B. 1647 defines "clinician-administered drug" as an outpatient prescription drug other than a vaccine that meets the following criteria:

- it cannot reasonably be self-administered by the patient or administered by an individual assisting the patient with self-administration; and
- it is typically administered in a physician's office by a physician or other health care provider authorized to administer the drug.

Nothing in the bill's provisions may be construed to authorize a person to administer a drug otherwise prohibited under Texas or federal law or modify drug administration requirements under Texas law, including any requirements related to the delegation and supervision of drug administration.

C.S.H.B. 1647 specifies the sources of coverage to which its provisions apply and establishes exceptions to that applicability. The bill applies only to a health benefit plan that is delivered, issued for delivery, or renewed on or after January 1, 2024.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 1647 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

The substitute revises the definition for "clinician-administered drug" in the introduced by removing that the drug is typically administered in a hospital outpatient infusion center or other clinical setting.

Both the introduced and the substitute prohibit certain limitations on the coverage of clinician-administered drugs. The introduced prohibited a health benefit plan issuer, for an enrollee with a chronic, complex, rare, or life-threatening medical condition, from reimbursing a clinician-administered drug at a lower amount based on an enrollee's choice of pharmacy or the pharmacy's participation in the plan issuer's network. The substitute does not include this prohibition and instead prohibits a plan issuer, for such an enrollee, from requiring a physician or health care provider participating in the issuer's network to bill for or be reimbursed for the delivery and administration of such drugs under the pharmacy benefit instead of the medical benefit without the patient's informed written consent and the physician's or provider's written attestation that a delay in the drug's administration will not place the patient at an increased health risk.

The substitute includes a provision absent from the introduced that clarifies the prohibitions against certain limitations on the coverage of clinician-administered drugs apply only under certain conditions relating to negative outcomes for patient care.

The substitute revises the provisions in the introduced specifying the sources of coverage to which the bill's provisions apply, and establishing exceptions to that applicability, by removing health benefits provided by or through a church benefits board among the sources to which the bill's provisions apply and by including a prescription drug administered in a hospital, hospital

facility-based practice setting, or hospital outpatient infusion center among the sources excepted from the bill's provisions.