BILL ANALYSIS

Senate Research Center
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S.B. 674
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AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

Currently, patients with a life-threatening disease or condition, such as cancer, who make the treatment decision to participate in a clinical trial are not covered by their insurance, even for routine medical care that would be covered by insurance if the patient was not participating in a clinical trial. The goal of clinical trials are to find better ways to treat cancer and other diseases. However, fewer than three percent of potentially eligible cancer patients enroll in clinical trials partly because insurance companies will not provide coverage for these patients.

From 1995 to 2006, 23 states passed legislation requiring health plans to pay routine medical care costs for clinical trial participants. In 2000, Medicare began to provide coverage for routine care costs for beneficiaries who decide to participate in clinical trials. There is no state regulation in Texas requiring insurance companies to cover routine medical care for patients participating in clinical trials.

As proposed, S.B. 674 requires insurance coverage of routine medical care for patients with a life-threatening disease or condition who have elected to participate in a clinical trial.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the commissioner of insurance in SECTION 1 (Section 1379.005, Insurance Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subtitle E, Title 8, Insurance Code, by adding Chapter 1379, as follows:

CHAPTER 1379. COVERAGE FOR ROUTINE PATIENT CARE COSTS FOR ENROLLEES PARTICIPATING IN CERTAIN CLINICAL TRIALS

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 1379.001. DEFINITIONS. Defines "enrollee," "life-threatening disease or condition," and "research institution."

Sec. 1379.002. APPLICABILITY OF CHAPTER. (a) Provides that this chapter applies only to a health benefit plan that provide benefits for certain medical or surgical expenses, or a 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 certain providers.

(b) Provides that this chapter applies to group health coverage made available by a school district in accordance with Section 22.004 (Group Health Benefits for School Employees), Education Code.

(c) Provides that this chapter applies to health and accident coverage provided by a risk pool created under Chapter 172 (Texas Political Subdivisions Uniform Group Benefits Program), Local Government Code, notwithstanding Section 172.014 (Application of Certain Laws), Local Government Code, or any other law.

(d) Provides this chapter applies to a basic coverage plan under Chapter 1551 (Texas Employees Group Benefits Act); a basic plan under Chapter 1575 (Texas Public School Employees Group Benefit Program); a primary care coverage plan under Chapter 1579 (Texas School Employees Uniform Group Health Coverage); and basic coverage under Chapter 1601 (Uniform Insurance Benefits Act for Employees of the University of Texas System and the A&M University System), notwithstanding any provision in Chapter 1551, 1575, 1579, or 1601 or any other law.

(e) Requires a standard health benefit plan provided under Chapter 1507 (Consumer Choice of Benefits Plans) to provide the coverage required by this chapter, notwithstanding any other law.

(f) Provides this chapter applies to coverage under a small employer health benefit plan subject to Chapter 1501 (Health Insurance Portability and Availability Act), notwithstanding Section 1501.251(Exception from Certain Mandated Benefit Requirements) or any other law.

Sec. 1379.003. APPLICABILITY TO CERTAIN GOVERNMENT PROGRAMS. Requires the state Medicaid program, to the extent allowed by federal law, and a managed care organization that contracts with the Health and Human Services Commission to provide health care services to Medicaid recipients through a managed care plan, provide the benefits required under this chapter to a Medicaid recipient.

Sec. 1379.004. EXCEPTION. Sets forth specific plans and policies to which this chapter does not apply.

Sec. 1379.005. RULES. Authorizes the commissioner of insurance, in accordance with Subchapter A, Chapter 36, to implement this chapter.

[Reserves Sections 1379.006-1379.050 for expansion.]

SUBCHAPTER B. COVERAGE FOR ROUTINE PATIENT CARE COSTS

Sec. 1379.051. ROUTINE PATIENT CARE COSTS. Sets forth specific items that do and do not constitute routine patient care costs.

Sec. 1379.052. COVERAGE REQUIRED. Requires a health benefit plan issuer (issuer) to provide benefits for routine patient care costs to an enrollee in connection with a phase I, phase II, phase III, or phase IV clinical trial, if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is approved by certain entities.

Sec. 1379.053. RESEARCH INSTITUTION. (a) Provides that an issuer is not required to reimburse the research institution conducting the clinical trial for the cost of routine patient care provided through the research institution unless the research institution, and each health care professional providing routing patient care through the research institution, agrees to accept reimbursement under the health benefit plan, at the rates that are established under the plan, as payment in full for the routine patient care provided in connection with the clinical trial.

(b) Provides that an issuer is not required to provide benefits under this section for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

Sec. 1379.054. LIMITATIONS ON COVERAGE. (a) Provides that this chapter does not require an issuer to provide benefits for routine patient care services provided outside of the plan's health care provider network unless out-of-network benefits are otherwise provided under the plan, notwithstanding Section 1379.053.

(b) Provides that this chapter does not require an issuer to provide benefits for health care services provided outside this state unless the health benefit plan otherwise provides benefits for health care services provided outside this state.

Sec. 1379.055. DEDUCTIBLE, COINSURANCE, AND COPAYMENT REQUIREMENTS. Authorizes benefits required under this chapter to be made subject to a deductible, coinsurance, or copayment requirement comparable to other deductible, coinsurance, or copayment requirements applicable under the health benefit plan.

SECTION 2. Amends Section 1506.151 (Minimum Pool Coverage), Insurance Code, by adding Subsection (d) to provide that coverage provided by the pool is subject to Chapter 1379 (Coverage for Routine Patient Care Costs for Enrollees Participating in Certain Clinical Trials).

SECTION 3. Makes application of this Act prospective to January 1, 2008.

SECTION 4. Effective date: September 1, 2007.