# Rhode Island's Oral Anticancer Treatment Access Law: What Clinicians Need to Know

International Myeloma Foundation

**Outdated coverage policies in Rhode Island *USED TO* limit cancer patients' access to life-saving drugs!**

Traditionally, IV chemotherapy treatments are covered under a health plan's medical benefit where the patient is required to pay an office visit copay, usually between $20 and $30. Conversely, oral anticancer medications are covered under a health plan's prescription benefit and, many times, patients are responsible for extremely high and unmanageable copays, creating an enormous barrier for patients to access orally administered drugs. According to a recent study published in the *Journal of Oncology Practice and American Journal of Managed Care*, ***10% of cancer patients failed to fill their initial prescriptions*** for oral anticancer medications due to high out-of-pocket costs.

**Legislative Solution**

In an effort to remove barriers to accessing life-saving treatments for cancer patients, Rhode Island passed a bill at the end of the 2013 legislative session, which became effective upon passage, that directs health benefit plans that provide coverage for cancer chemotherapy treatment to extend coverage for orally administered anticancer medication at a cost to patients no less favorable to intravenously administered or injected anticancer medications. Additionally, plans may not increase cost-sharing to achieve compliance. **To view Rhode Island's oral parity law, please see next page.**

**What Does This Mean for Patients?**

If a patient is ***privately insured (the law does not apply to Medicare or ERISA plans)***, and their plan covers chemotherapy, an FDA-approved, orally administered drug should have the same out-of-pocket costs for the patient as an intravenously administered drug.

**What to do if an insurance plan does not comply & to find out if the law applies to your health plan:**

Please visit the Office of the Rhode Island Health Insurance Commissioner by going to http://www.ohic.ri.gov, calling (401) 462-9517 or emailing HealthInsInquiry@ohic.ri.gov. For information about our oral parity work in Washington, DC, please go to: peac.myeloma.org.

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THE STATE OF RHODE ISLAND
BILL TEXT

RHODE ISLAND 2013-2014 LEGISLATIVE SESSION

HOUSE BILL 5354

CHAPTER 323
2013 -- H 5354 SUBSTITUTE A
ENACTED 07/15/13
INTRODUCED BY: REPRESENTATIVES AMORE, KAZARIAN, MELO, VALENCIA, AND ACKERMAN
DATE INTRODUCED: FEBRUARY 12, 2013

2013 Bill Text RI H.B. 5354

VERSION: Enacted - Public Law

VERSION-DATE: July 15, 2013

SYNOPSIS:

AN ACT

RELATING TO INSURANCE - ORALLY ADMINISTERED ANTICANCER MEDICATION

NOTICE:
[A> UPPERCASE TEXT WITHIN THESE SYMBOLS IS ADDED <A]

TEXT: It is enacted by the General Assembly as follows:

SECTION 1. Chapter 27-18 of the General Laws entitled "Accident and Sickness Insurance Policies" is hereby amended by adding thereto the following section:

[A> 27-18-79. ORALLY ADMINISTERED ANTICANCER MEDICATION - COST-SHARING REQUIREMENT. - <A] [A> (A) EVERY INDIVIDUAL OR

GROUP HOSPITAL OR MEDICAL EXPENSE, INSURANCE POLICY OR INDIVIDUAL OR GROUP HOSPITAL OR MEDICAL SERVICES PLAN CONTRACT, PLAN OR CERTIFICATE OF INSURANCE DELIVERED, ISSUED
FOR DELIVERY, OR RENEWED IN THIS STATE, ON OR AFTER JANUARY 1, 2014, THAT OFFERS BOTH MEDICAL AND PRESCRIPTION DRUG COVERAGE, AND PROVIDES COVERAGE FOR INTRAVENOUSLY ADMINISTERED ANTICANCER MEDICATION, SHALL

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PROVIDE COVERAGE FOR PRESCRIBED, ORALLY ADMINISTERED ANTICANCER MEDICATIONS USED TO KILL OR SLOW THE GROWTH OF CANCEROUS CELLS ON A BASIS NO LESS FAVORABLE THAN INTRAVENOUSLY ADMINISTERED OR INJECTED CANCER MEDICATIONS THAT ARE COVERED AS MEDICAL BENEFITS. AN INCREASE IN PATIENT COST SHARING FOR ANTICANCER MEDICATIONS SHALL NOT BE ALLOWED TO ACHIEVE COMPLIANCE WITH THIS SECTION. NOTWITHSTANDING THE ABOVE, THE REQUIREMENTS SHALL NOT BE CONSTRUED TO IMPOSE ANY FORM OF CAP ON COST-SHARING. <A]

[A> (B) THIS SECTION DOES NOT APPLY TO INSURANCE COVERAGE PROVIDING BENEFITS FOR: (1) HOSPITAL CONFINEMENT INDEMNITY; (2) DISABILITY INCOME; (3) ACCIDENT ONLY; (4) LONG-TERM CARE; (5) MEDICARE SUPPLEMENT; (6) LIMITED BENEFIT HEALTH; (7) SPECIFIED DISEASE INDEMNITY; (8) SICKNESS OR BODILY INJURY OR DEATH BY ACCIDENT OR BOTH; AND (9) OTHER LIMITED BENEFIT POLICIES. <A]

SECTION 2. Chapter 27-19 of the General Laws entitled "Nonprofit Hospital Service Corporations" is hereby amended by adding thereto the following section:

[A> 27-19-70. ORALLY ADMINISTERED ANTICANCER MEDICATION - COST-SHARING REQUIREMENT. - <A] [A> (A) EVERY INDIVIDUAL OR GROUP HOSPITAL OR MEDICAL EXPENSE, INSURANCE POLICY OR INDIVIDUAL OR GROUP HOSPITAL OR MEDICAL SERVICES PLAN CONTRACT, PLAN OR CERTIFICATE OF INSURANCE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE, ON OR AFTER JANUARY 1, 2014, THAT OFFERS BOTH MEDICAL AND PRESCRIPTION DRUG COVERAGE, AND PROVIDES COVERAGE FOR INTRAVENOUSLY ADMINISTERED ANTICANCER MEDICATION, SHALL PROVIDE COVERAGE FOR PRESCRIBED, ORALLY ADMINISTERED ANTICANCER MEDICATIONS USED TO KILL OR SLOW THE GROWTH OF CANCEROUS CELLS ON A BASIS NO LESS FAVORABLE THAN INTRAVENOUSLY ADMINISTERED OR INJECTED CANCER MEDICATIONS THAT ARE COVERED AS MEDICAL BENEFITS. AN INCREASE IN PATIENT COST SHARING FOR ANTICANCER MEDICATIONS SHALL NOT BE ALLOWED TO ACHIEVE

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SECTION 3. Chapter 27-20 of the General Laws entitled "Nonprofit Medical Service Corporations" is hereby amended by adding thereto the following section:

[A> 27-20-66. ORALLY ADMINISTERED ANTICANCER MEDICATION - COST-SHARING REQUIREMENT. - <A] [A> (A) EVERY INDIVIDUAL OR GROUP HOSPITAL OR MEDICAL EXPENSE, INSURANCE POLICY OR INDIVIDUAL OR GROUP HOSPITAL OR MEDICAL SERVICES PLAN CONTRACT, PLAN OR CERTIFICATE OF INSURANCE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE, ON OR AFTER JANUARY 1, 2014, THAT OFFERS BOTH MEDICAL AND PRESCRIPTION DRUG COVERAGE, AND PROVIDES COVERAGE FOR INTRAVENOUSLY ADMINISTERED ANTICANCER MEDICATION, SHALL PROVIDE COVERAGE FOR PRESCRIBED, ORALLY ADMINISTERED ANTICANCER MEDICATIONS USED TO KILL OR SLOW THE GROWTH OF CANCEROUS CELLS ON A BASIS NO LESS FAVORABLE THAN INTRAVENOUSLY ADMINISTERED OR INJECTED CANCER MEDICATIONS THAT ARE COVERED AS MEDICAL BENEFITS. AN INCREASE IN PATIENT COST SHARING FOR ANTICANCER MEDICATIONS SHALL NOT BE ALLOWED TO ACHIEVE COMPLIANCE WITH THIS SECTION. NOTWITHSTANDING THE ABOVE, THE REQUIREMENTS SHALL NOT BE CONSTRUED TO IMPOSE ANY FORM OF CAP ON COST-SHARING. <A]

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SECTION 4. Chapter 27-41 of the General Laws entitled "Health Maintenance Organizations" is hereby amended by adding thereto the following section:

[A> 27-41-83. ORALLY ADMINISTERED ANTICANCER MEDICATION - COST-SHARING REQUIREMENT. - <A] [A> (A) EVERY INDIVIDUAL OR GROUP HOSPITAL OR MEDICAL EXPENSE, INSURANCE POLICY OR INDIVIDUAL OR GROUP HOSPITAL OR MEDICAL SERVICES PLAN CONTRACT, PLAN OR CERTIFICATE OF INSURANCE DELIVERED, ISSUED FOR DELIVERY, OR RENEWED IN THIS STATE, ON OR AFTER JANUARY 1, 2014 ,THAT OFFERS BOTH MEDICAL AND PRESCRIPTION DRUG COVERAGE, AND PROVIDES COVERAGE FOR INTRAVENOUSLY ADMINISTERED ANTICANCER MEDICATION, SHALL PROVIDE COVERAGE FOR PRESCRIBED, ORALLY ADMINISTERED ANTICANCER MEDICATIONS USED TO KILL OR SLOW THE GROWTH OF CANCEROUS CELLS ON A BASIS NO LESS FAVORABLE THAN INTRAVENOUSLY ADMINISTERED OR INJECTED CANCER MEDICATIONS THAT ARE COVERED AS MEDICAL BENEFITS. AN INCREASE IN PATIENT COST SHARING FOR ANTICANCER MEDICATIONS SHALL NOT BE ALLOWED TO ACHIEVE COMPLIANCE WITH THIS SECTION. NOTWITHSTANDING THE ABOVE, THE REQUIREMENTS SHALL NOT BE CONSTRUED TO IMPOSE ANY FORM OF CAP ON COST-SHARING. <A]

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[A> (B) THIS SECTION DOES NOT APPLY TO INSURANCE COVERAGE PROVIDING BENEFITS FOR: (1) HOSPITAL CONFINEMENT INDEMNITY; (2) DISABILITY INCOME; (3) ACCIDENT ONLY; (4) LONG-TERM CARE; (5) MEDICARE SUPPLEMENT; (6) LIMITED BENEFIT HEALTH; (7) SPECIFIED DISEASE INDEMNITY; (8) SICKNESS OR BODILY INJURY OR DEATH BY ACCIDENT OR BOTH; AND (9) OTHER LIMITED BENEFIT POLICIES. <A]

SECTION 5. Section 42-14.5-3 of the General Laws in Chapter 42-14.5 entitled "The Rhode Island Health Care Reform Act of 2004 - Health Insurance Oversight" is hereby amended to read as follows:

42-14.5-3. Powers and duties. [Contingent effective date; see effective dates under this section.] -- The health insurance commissioner shall have the following powers and duties:

(a) To conduct quarterly public meetings throughout the state, separate and distinct from rate hearings pursuant to section 42-62-13, regarding the rates, services and operations of insurers licensed to provide health insurance in the state the effects of such rates, services and operations on consumers, medical care providers,
patients, and the market environment in which such insurers operate and efforts to bring new health insurers into the Rhode Island market. Notice of not less than ten (10) days of said hearing(s) shall go to the general assembly, the governor, the Rhode Island Medical Society, the Hospital Association of Rhode Island, the director of health, the attorney general and the chambers of commerce. Public notice shall be posted on the department's web site and given in the newspaper of general circulation, and to any entity in writing requesting notice.

(b) To make recommendations to the governor and the house of representatives and senate finance committees regarding health care insurance and the regulations, rates, services, administrative expenses, reserve requirements, and operations of insurers providing health insurance in the state, and to prepare or comment on, upon the request of the governor, or chairpersons of the house or senate finance committees, draft legislation to improve the regulation of health insurance. In making such recommendations, the commissioner shall recognize that it is the intent of the legislature that the maximum disclosure be provided regarding the reasonableness of individual administrative expenditures as well as total administrative costs. The commissioner shall also make recommendations on the levels of reserves including consideration of: targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans for distributing excess reserves.

(c) To establish a consumer/business/labor/medical advisory council to obtain information and present concerns of consumers, business and medical providers affected by health insurance decisions. The council shall develop proposals to allow the market for small business health insurance

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to be affordable and fairer. The council shall be involved in the planning and conduct of the quarterly public meetings in accordance with subsection (a) above. The advisory council shall develop measures

to inform small businesses of an insurance complaint process to ensure that small businesses that experience rate increases in a given year may request and receive a formal review by the department. The advisory council shall assess views of the health provider community relative to insurance rates of reimbursement, billing and reimbursement procedures, and the insurers' role in promoting efficient and high quality health care. The advisory council shall issue an annual report of findings and recommendations to the governor and the general assembly and present their findings at hearings before the house and senate finance committees. The advisory council is to be diverse in interests and shall include representatives of community consumer organizations; small businesses, other than those involved in the sale of insurance products; and hospital, medical, and other health provider organizations. Such representatives shall be nominated by their respective organizations. The advisory council shall be co-chaired by the health insurance commissioner and a community consumer organization or small business member to be elected by the full advisory council.

(d) To establish and provide guidance and assistance to a subcommittee ("The Professional Provider-Health Plan Work Group") of the advisory council created pursuant to subsection (c) above, composed of health care providers and Rhode Island licensed health plans. This subcommittee shall include in its annual report and presentation before the house and senate finance committees the following information:

(i) A method whereby health plans shall disclose to contracted providers the fee schedules used to provide payment to those providers for services rendered to covered patients;

(ii) A standardized provider application and credentials verification process, for the purpose of verifying professional qualifications of participating health care providers;

(iii) The uniform health plan claim form utilized by participating providers;

(iv) Methods for health maintenance organizations as defined by section 27-41-1, and nonprofit hospital or medical service corporations as defined by chapters 27-19 and 27-20, to make facility-specific data and other medical service-specific data available in reasonably consistent formats to patients regarding quality and costs. This information would help consumers make informed choices regarding the facilities and/or clinicians or physician practices at which to seek care. Among the items considered would be the unique health services and other public goods provided by facilities and/or clinicians or physician practices in establishing the most appropriate cost comparisons.

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(v) All activities related to contractual disclosure to participating providers of the mechanisms for resolving health plan/provider disputes; and

(vi) The uniform process being utilized for confirming in real time patient insurance enrollment status, benefits coverage, including co-pays and deductibles.

(vii) Information related to temporary credentialing of providers seeking to participate in the plan's network and the impact of said activity on health plan accreditation;

(viii) The feasibility of regular contract renegotiations between plans and the providers in their networks.

(ix) Efforts conducted related to reviewing impact of silent PPOs on physician practices.

(e) To enforce the provisions of Title 27 and Title 42 as set forth in section 42-14-5(d).

(f) To provide analysis of the Rhode Island Affordable Health Plan Reinsurance Fund. The fund shall be used to effectuate the provisions of sections 27-18.5-8 and 27-50-17.

(g) To analyze the impact of changing the rating guidelines and/or merging the individual health insurance market as defined in chapter 27-18.5 and the small employer health insurance market as defined in chapter 27-50 in accordance with the following:

(i) The analysis shall forecast the likely rate increases required to effect the changes recommended pursuant to the preceding subsection (g) in the direct pay market and small employer health insurance market over the next five (5) years, based on the current rating structure, and current products.

(ii) The analysis shall include examining the impact of merging the individual and small employer markets on premiums charged to individuals and small employer groups.

(iii) The analysis shall include examining the impact on rates in each of the individual and small employer health insurance markets and the number of insureds in the context of possible changes to the rating guidelines used for small employer groups, including: community rating principles; expanding small employer rate bonds beyond the current range; increasing the employer group size in the small group market; and/or adding rating factors for broker and/or tobacco use.

(iv) The analysis shall include examining the adequacy of current statutory and regulatory oversight of the rating process and factors employed by the participants in the proposed new merged market.

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(v) The analysis shall include assessment of possible reinsurance mechanisms and/or federal high-risk pool structures and funding to support the health insurance market in Rhode Island by reducing the risk of adverse selection and the incremental insurance premiums charged for this risk, and/or by making health insurance affordable for a selected at-risk population.

(vi) The health insurance commissioner shall work with an insurance market merger task force to assist with the analysis. The task force shall be chaired by the health insurance commissioner and shall include, but not be limited to, representatives of the general assembly, the business community, small employer carriers as defined in section 27-50-3, carriers offering coverage in the individual market in Rhode Island, health insurance brokers and members of the general public.

(vii) For the purposes of conducting this analysis, the commissioner may contract with an outside organization with expertise in fiscal analysis of the private insurance market. In conducting its study, the organization shall, to the extent possible, obtain and use actual health plan data. Said data shall be subject to state and federal laws and regulations governing confidentiality of health care and proprietary information.

(viii) The task force shall meet as necessary and include their findings in the annual report and the commissioner shall include the information in the annual presentation before the house and senate finance committees.

(h) To establish and convene a workgroup representing health care providers and health insurers for the purpose of coordinating the development of processes, guidelines, and standards to streamline health care administration that are to be adopted by payors and providers of health care services operating in the state. This workgroup shall include representatives with expertise that would contribute to the streamlining of health care administration and that are selected from hospitals, physician practices, community behavioral health organizations, each health insurer and other affected entities. The workgroup shall also include at least one designee each from the Rhode Island Medical Society, Rhode Island Council of Community Mental Health Organizations, the Rhode Island Health Center Association, and the Hospital Association of Rhode Island. The workgroup shall consider and make recommendations for:

(1) Establishing a consistent standard for electronic eligibility and coverage verification. Such standard shall:

(i) Include standards for eligibility inquiry and response and, wherever possible, be consistent with the standards adopted by nationally

recognized organizations, such as the centers for Medicare and Medicaid services;

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(ii) Enable providers and payors to exchange eligibility requests and responses on a system-to-system basis or using a payor supported web browser;

(iii) Provide reasonably detailed information on a consumer's eligibility for health care coverage, scope of benefits, limitations and exclusions provided under that coverage, cost-sharing requirements for specific services at the specific time of the inquiry, current deductible amounts, accumulated or limited benefits, out-of-pocket maximums, any maximum policy amounts, and other information required for the provider to collect the patient's portion of the bill;

(iv) Reflect the necessary limitations imposed on payors by the originator of the eligibility and benefits information;

(v) Recommend a standard or common process to protect all providers from the costs of services to patients who are ineligible for insurance coverage in circumstances where a payor provides eligibility verification based on best information available to the payor at the date of the request of eligibility.

(2) Developing implementation guidelines and promoting adoption of such guidelines for:

(i) The use of the national correct coding initiative code edit policy by payors and providers in the state;

(ii) Publishing any variations from codes and mutually exclusive codes by payors in a manner that makes for simple retrieval and implementation by providers;

(iii) Use of health insurance portability and accountability act standard group codes, reason codes, and remark codes by payors in electronic remittances sent to providers;

(iv) The processing of corrections to claims by providers and payors.

(v) A standard payor denial review process for providers when they request a reconsideration of a denial of a claim that results from differences in clinical edits where no single, common standards body or process exists and multiple conflicting sources are in use by payors and providers.

(vi) Nothing in this section or in the guidelines developed shall inhibit an individual payor's ability to employ, and not disclose to providers, temporary code edits for the purpose of detecting and deterring fraudulent billing activities. The guidelines shall require that each payor disclose to the provider its adjudication decision on a claim that was denied or adjusted based on the application of such edits and that the provider have access to the payor's review and appeal process to challenge the payor's adjudication decision.

(vii) Nothing in this subsection shall be construed to modify the rights or obligations of payors or providers with respect to procedures relating to the investigation, reporting, appeal, or prosecution under applicable law of potentially fraudulent billing activities.

(3) Developing and promoting widespread adoption by payors and providers of guidelines to:

(i) Ensure payors do not automatically deny claims for services when extenuating circumstances make it impossible for the provider to obtain a preauthorization before services are performed or notify a payor within an appropriate standardized timeline of a patient's admission;

(ii) Require payors to use common and consistent processes and time frames when responding to provider requests for medical management approvals. Whenever possible, such time frames shall be consistent with those established by leading national organizations and be based upon the acuity of the patient's need for care or treatment. For the purposes of this section, medical management includes prior authorization of services, preauthorization of services, precertification of services, post service review, medical necessity review, and benefits advisory;

(iii) Develop, maintain, and promote widespread adoption of a single common website where providers can obtain payors' preauthorization, benefits advisory, and preadmission requirements;

(iv) Establish guidelines for payors to develop and maintain a website that providers can use to request a preauthorization, including a prospective clinical necessity review; receive an authorization number; and transmit an admission notification.

[A> (I) TO ISSUE AN ANTI-CANCER MEDICATION REPORT. NOT LATER THAN JUNE 30, 2014 AND ANNUALLY THEREAFTER, THE OFFICE OF THE HEALTH INSURANCE COMMISSIONER (OHIC) SHALL PROVIDE THE SENATE COMMITTEE ON HEALTH AND HUMAN SERVICES, AND THE HOUSE COMMITTEE ON CORPORATIONS, WITH: (1) INFORMATION ON THE AVAILABILITY IN THE COMMERCIAL MARKET OF COVERAGE FOR ANTI-CANCER MEDICATION OPTIONS; (2) FOR THE STATE EMPLOYEE'S HEALTH BENEFIT PLAN, THE COSTS OF VARIOUS CANCER TREATMENT OPTIONS; (3) THE CHANGES IN DRUG PRICES OVER THE PRIOR THIRTY-SIX (36) MONTHS; AND (4) MEMBER UTILIZATION AND COST-SHARING EXPENSE. <A]

SECTION 6. This act shall take effect upon passage.