



California's Oral Anticancer Treatment Access Law: What Clinicians Need to Know



Outdated coverage policies in California changed to increase cancer patients' access to life-saving drugs!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, California recently passed a bill that sets a "cap" of \$200.00, per prescription, for patients receiving oral chemotherapy treatments. The law, which goes into effect on January 1, 2015, allows insurers to increase the cap annually based on the Consumer Price Index (CPI) and expires in 2019. Additionally, for consumers that purchase a high deductible health plan, the cap will only go into effect after the insured's deductible has been met. **To view California's 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 Medicare supplemental 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 or have a maximum of \$200 co-payment per prescription.

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

Please visit the CA Department of Insurance on the web at www.insurance.ca.gov or contact the Consumer Hotline at 800-927-HELP between 8:00am & 5:00pm, Pacific. For information about our oral parity work in Washington, DC, please go to: peac.myeloma.org.



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LEGISLATIVE COUNSEL'S DIGEST

AB 219, Perea. Health care coverage: cancer treatment.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime. Existing law also provides for the regulation of health insurers by the Department of Insurance. Existing law requires health care service plan contracts and health insurance policies to provide coverage for all generally medically accepted cancer screening tests and requires those contracts and policies to also provide coverage for the treatment of breast cancer. Existing law imposes various requirements on contracts and policies that cover prescription drug benefits.

This bill would prohibit an individual or group health care service plan contract or health insurance policy issued, amended, or renewed on or after January 1, 2015, that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells from requiring an enrollee or insured to pay, notwithstanding any deductible, a total amount of copayments and coinsurance that exceeds \$200 for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication. The bill would provide that for a health care service plan contract or health insurance policy that meets a specified federal definition of a high deductible health plan, this prohibition shall only apply once the enrollee's or insured's deductible has been satisfied for the year. The bill would authorize a health care service plan or health insurer, on January 1, 2016, and on January 1 of each year thereafter, to increase the \$200 limit by the percentage increase in the Consumer Price Index for that year. The bill would repeal these provisions on January 1, 2019.

Because a willful violation of the bill's requirements relative to health care service plans would be a crime, the bill would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

THE PEOPLE OF THE STATE OF CALIFORNIA DO ENACT AS FOLLOWS:

SECTION 1. (a) The Legislature finds and declares that the majority of prescriptions for oral anticancer medications are filled by cancer patients at reasonable cost due to effective health plan or health insurance coverage of the product or the low retail price of the drug.

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(b) It is the intent of the Legislature to help cancer patients who do not have access to the most appropriate treatment for their cancer because the terms of their health care service plan contract or health insurance policy do not make the covered treatment affordable.

(c) It is further the intent of the Legislature to set a maximum total copayment and coinsurance amount that health care service plans and health insurers can require patients to pay for a 30-day supply of oral anticancer medication. The Legislature does not intend health care service plans or health insurers to interpret that maximum to be a target or desirable patient cost.

SEC. 2. Section 1367.656 is added to the Health and Safety Code, to read:

1367.656. (a) Notwithstanding any other law, an individual or group health care service plan contract issued, amended, or renewed on or after January 1, 2015, that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells shall comply with all of the following:

(1) Notwithstanding any deductible, the total amount of copayments and coinsurance an enrollee is required to pay shall not exceed two hundred dollars (\$200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the contract.

(2) For a health care service plan contract that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an enrollee's deductible has been satisfied for the year.

(3) Paragraph (1) shall not apply to any coverage under a health care service plan contract for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) On January 1, 2016, and on January 1 of each year thereafter, health care service plans may adjust the two hundred dollar (\$200) limit described in paragraph (1). The adjustment shall not exceed the percentage increase in the Consumer Price Index for that year.

(5) A prescription for an orally administered anticancer medication shall be provided consistent with the appropriate standard of care for that medication.

(b) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 3. Section 10123.206 is added to the Insurance Code, to read:

10123.206. (a) Notwithstanding any other law, an individual or group health insurance policy issued, amended, or renewed on or after January 1, 2015, that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells shall comply with all of the following:

(1) Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred dollars (\$200) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.



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(2) For a health insurance policy that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an insured's deductible has been satisfied for the year.

(3) Paragraph (1) shall not apply to any coverage under a health insurance policy for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(4) On January 1, 2016, and on January 1 of each year thereafter, health insurers may adjust the two hundred dollar (\$200) limit described in paragraph (1). The adjustment shall not exceed the percentage increase in the Consumer Price Index for that year.

(5) A prescription for an orally administered anticancer medication shall be provided consistent with the appropriate standard of care for that medication.

(b) This section shall remain in effect only until January 1, 2019, and as of that date is repealed, unless a later enacted statute, that is enacted before January 1, 2019, deletes or extends that date.

SEC. 4. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.