



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



Outdated coverage policies in Florida USED TO limit cancer patients' access to life-saving drugs!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, Louisiana implemented a law, effective January 1, 2013 that directs health insurers who provide coverage for cancer treatment to extend coverage for prescribed orally administered anticancer medications at a cost to patients no less favorable than that of those receiving intravenously administered or injected anticancer therapies. Additionally, if a health plan limits the total amount paid for oral anticancer medications to \$100 per prescription, they are also in compliance with the law. However, high deductible health plans and plans purchased through the Exchange are excluded. Plans may not increase cost-sharing for IV medications or reclassify benefits to reach compliance, nor can plans apply prior authorization measures that don't also apply to IV medications. **To view Louisiana'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 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 \$100 co-payment per prescription.

What to do if an insurance plan doesn't comply & to find out if the law applies to your health plan:

Contact the Attorney General's Consumer Protection Division, Consumer Protection Hotline at 1-800-351-4889 or click <http://www.ag.state.la.us/Complaint.aspx?articleID=16&catID=15>. For information about our oral parity work in Washington, DC, please go to: peac.myeloma.org.



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LOUISIANA REVISED STATUTES
TITLE 22. INSURANCE
CHAPTER 4. INSURANCE AND INSURANCE CONTRACT REQUIREMENTS BY TYPE OF INSURANCE
PART 3. HEALTH AND ACCIDENT COVERAGE
SUBPART A. HEALTH AND ACCIDENT INSURANCE; STANDARDS AND CONTRACT REQUIREMENTS IN
GENERAL

La. R.S. 22:999.1 (2012)

§ 22:999.1. Parity for orally administered anti-cancer medications with intravenously administered or injected anti-cancer medications

A. It is hereby declared that the public policy of this state is that every person within this state with health insurance coverage that provides coverage for cancer treatment shall have access to the type of covered medication used to treat his cancer, as such a decision affects the person's overall, long-term health and quality of life. It is also declared that orally administered anti-cancer medications, although very effective in killing or slowing the growth of cancerous cells, have high out-of-pocket costs to the covered person, impacting the decision of physicians to prescribe such medications, thus restricting patient access to life-saving oral anti-cancer medications. It is further declared that physicians must be able to make the best choice for their patients, considering the unique aspects of each patient and the progress of the disease.

B. (1) A health insurance issuer that provides coverage for cancer treatment shall provide for coverage of prescribed orally administered anti-cancer medications on a basis no less favorable than intravenously administered or injected cancer medications.

(2) Health insurance coverage of orally administered anti-cancer medications shall not be subject to any prior authorization, dollar limit, copayment, deductible, or other out-of-pocket expense that does not apply to intravenously administered or injected cancer medications, regardless of formulation or benefit category determination by the health insurance issuer.

(3) A health insurance issuer shall not reclassify or increase any type of cost-sharing to the covered person for anti-cancer medications in order to achieve compliance with this Section. Any change in health insurance coverage that otherwise increases an out-of-pocket expense applied to anti-cancer medications shall also be applied to the majority of comparable medical or pharmaceutical benefits covered by the health insurance issuer.

(4) A health insurance issuer that limits the total amount paid by a covered person through all cost-sharing requirements to no more than one hundred dollars per filled prescription for any orally administered anti-cancer medication shall be considered in compliance with this Section. For purposes of this Paragraph, "cost-sharing requirements" shall include copayments, coinsurance, deductibles, and any other amounts paid by the covered person for that prescription.

C. As used in this Section:



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- (1) "Anti-cancer medications" means medications used to kill or slow the growth of cancer cells.
- (2) "Covered person" means a policyholder, subscriber, enrollee, or other individual enrolled in or insured by a health insurance issuer for health insurance coverage.
- (3) "Health insurance coverage" or "coverage" means benefits consisting of medical care provided or arranged for directly, through insurance or reimbursement, or through a network, and including services paid for as medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract, preferred provider organization agreement, or health maintenance organization contract offered by a health insurance issuer.
- (4) "Health insurance issuer" means any entity that offers health insurance coverage through a policy or certificate of insurance subject to state law that regulates the business of insurance. For purposes of this Section, a "health insurance issuer" shall include a health maintenance organization, as defined and licensed pursuant to Subpart I of Part I of Chapter 2 of this Title, nonfederal government plans subject to the provisions of Subpart B of this Part, and the Office of Group Benefits.
- (5) "Network of providers" or "network" means an entity other than a health insurance issuer that, through contracts with health care providers, provides or arranges for access by groups of covered persons to covered health care services by health care providers who are not otherwise or individually contracted directly with a health insurance issuer.

D. The provisions of this Section shall not apply to the following:

- (1) Limited benefit health insurance policies or contracts.
- (2) High deductible health plans or policies that are qualified to be used in conjunction with a health savings account, a medical savings account, or other similar program authorized by 26 U.S.C. 220 et seq.
- (3) Qualified health plans offered through a health benefit exchange.