

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



Outdated coverage policies in Nevada USED TO limit cancer patients' access to life-saving drugs!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

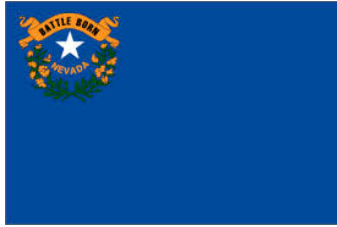
In an effort to remove barriers to accessing life-saving treatments for cancer patients, Nevada implemented legislation for health policies issued or renewed on or after January 1, 2015. This law requires health policies that provide coverage for the treatment of cancer through chemotherapy must not require a co-payment, co-insurance or deductible of more than \$100 per prescription for orally administered anticancer treatment. Additionally, plans may not increase the out-of-pocket cost for IV chemotherapy treatments to over \$100 to achieve compliance. **To view Nevada'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 ERISA, Medicare or Medicare supplemental plans)***, and their plan covers chemotherapy, an FDA-approved, orally administered drug should have a maximum of \$100 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:

You can file a complaint to the Consumer Services Section of the Nevada Division of Insurance at <http://doi.nv.gov/Consumers/File-A-Complaint/> or call (888) 872-3234. For information about our oral parity work in Washington, DC, please go to: peac.myeloma.org.



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NEVADA ADVANCE LEGISLATIVE SERVICE
NEVADA 77TH REGULAR SESSION

CHAPTER 375
SENATE BILL 266

2013 Nev. ALS 375; 2013 Nev. Stat. 375; 2013 Nev. Ch. 375; 2013 Nev. SB 266

SYNOPSIS: AN ACT relating to insurance; prohibiting certain policies of health insurance and health care plans from making monetary limits of coverage for certain orally administered chemotherapy less favorable to the insured than other forms of chemotherapy; limiting the total combined amount of any copayment, deductible or coinsurance for chemotherapy administered orally; and providing other matters properly relating thereto.

NOTICE:

[A> Text within these symbols is added <A]

[D> Text within these symbols is deleted <D]

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY,
DO ENACT AS FOLLOWS:

[*1] Section 1. Chapter 689A of NRS is hereby amended by adding thereto a new section to read as follows:

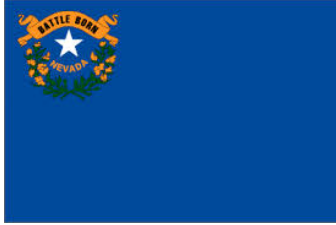
[A> 1. An insurer that offers or issues a policy of health insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not: <A]

[A> (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than \$ 100 per prescription. <A]

[A> (b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously. <A]

[A> (c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section. <A]

[A> 2. A policy subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void. <A]



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[A> 3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug. <A]

[*2] Sec. 2. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive [D> . <D] [A> , and section 1 of this act. <A]

[*3] Sec. 3. Chapter 689B of NRS is hereby amended by adding thereto a new section to read as follows:

[A> 1. An insurer that offers or issues a policy of group health insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not: <A]

[A> (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than \$ 100 per prescription. <A]

[A> (b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously. <A]

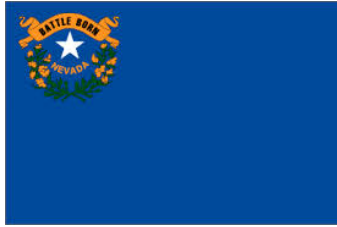
[A> (c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section. <A]

[A> 2. A policy subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the policy or renewal which is in conflict with this section is void. <A]

[A> 3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug. <A]

[*4] Sec. 4. Chapter 695B of NRS is hereby amended by adding thereto a new section to read as follows:

[A> 1. An insurer that offers or issues a contract for hospital or medical service which provides coverage for the treatment of cancer through the use of chemotherapy shall not: <A]



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[A> (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than \$ 100 per prescription. <A]

[A> (b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously. <A]

[A> (c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section. <A]

[A> 2. A contract subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the contract or renewal which is in conflict with this section is void. <A]

[A> 3. Nothing in this section shall be construed as requiring an insurer to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug. <A]

[*5] Sec. 5. Chapter 695C of NRS is hereby amended by adding thereto a new section to read as follows:

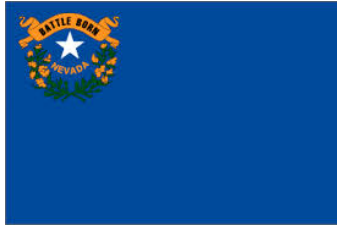
[A> 1. A health maintenance organization that offers or issues a health care plan which provides coverage for the treatment of cancer through the use of chemotherapy shall not: <A]

[A> (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than \$ 100 per prescription. <A]

[A> (b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously. <A]

[A> (c) Decrease the monetary limits applicable to such chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section. <A]

[A> 2. Evidence of coverage subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage



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subject to the requirements of this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void. <A]

[A] 3. Nothing in this section shall be construed as requiring a health maintenance organization to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug. <A]

[*6] Sec. 6. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

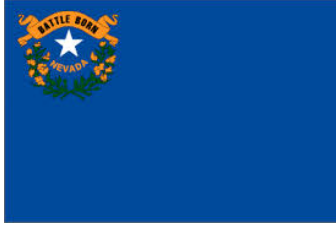
4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170 to 695C.173, inclusive, 695C.1733 to 695C.200, inclusive, [A] and section 5 of this act, <A] 695C.250 and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695 and 695C.1731 apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

[*7] Sec. 7. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070



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and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, [A] and section 5 of this act <A> or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The State Board of Health certifies to the Commissioner that the health maintenance organization:

(1) Does not meet the requirements of subsection 2 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

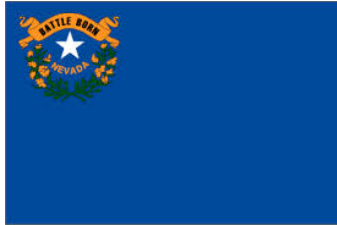
(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or



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(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

[*8] Sec. 8. Chapter 695G of NRS is hereby amended by adding thereto a new section to read as follows:

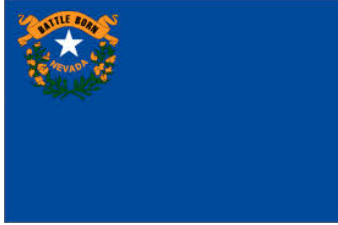
[A> 1. A managed care organization that offers or issues a health care plan which provides coverage for the treatment of cancer through the use of chemotherapy shall not: <A]

[A> (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than \$ 100 per prescription. <A]

[A> (b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously. <A]

[A> (c) Decrease the monetary limits applicable to chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section. <A]

[A> 2. An evidence of coverage for a health care plan subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void. <A]



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[A> 3. Nothing in this section shall be construed as requiring a managed care organization to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug. <A]

[*8x5] Sec. 8.5. NRS 695G.090 is hereby amended to read as follows:

695G.090 1. Except as otherwise provided in subsection 3, the provisions of this chapter apply to each organization and insurer that operates as a managed care organization and may include, without limitation, an insurer that issues a policy of health insurance, an insurer that issues a policy of individual or group health insurance, a carrier serving small employers, a fraternal benefit society, a hospital or medical service corporation and a health maintenance organization.

2. In addition to the provisions of this chapter, each managed care organization shall comply with:

(a) The provisions of chapter 686A of NRS, including all obligations and remedies set forth therein; and

(b) Any other applicable provision of this title.

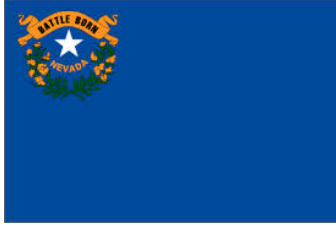
3. The provisions of NRS 695G.164, 695G.1645, 695G.200 to 695G.230, inclusive, and 695G.430 [A> and section 8 of this act, <A] do not apply to a managed care organization that provides health care services to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a managed care organization from any provision of this chapter for services provided pursuant to any other contract.

[*9] Sec. 9. Chapter 287 of NRS is hereby amended by adding thereto a new section to read as follows:

[A> 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental entity of the State of Nevada that provides health insurance through a plan of self-insurance which provides coverage for the treatment of cancer through the use of chemotherapy shall not: <A]

[A> (a) Require a copayment, deductible or coinsurance amount for chemotherapy administered orally by means of a prescription drug in a combined amount that is more than \$ 100 per prescription. <A]

[A> (b) Make the coverage subject to monetary limits that are less favorable for chemotherapy administered orally by means of a prescription drug than the monetary limits applicable to chemotherapy which is administered by injection or intravenously. <A]



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[A> (c) Decrease the monetary limits applicable to such chemotherapy administered orally by means of a prescription drug or to chemotherapy which is administered by injection or intravenously to meet the requirements of this section. <A]

[A> 2. A plan of self-insurance subject to the provisions of this chapter which provides coverage for the treatment of cancer through the use of chemotherapy and that is delivered, issued for delivery or renewed on or after January 1, 2015, has the legal effect of providing that coverage subject to the requirements of this section, and any provision of the plan or the renewal which is in conflict with this section is void. <A]

[A> 3. Nothing in this section shall be construed as requiring the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental entity of the State of Nevada that provides health insurance through a plan of self-insurance to provide coverage for the treatment of cancer through the use of chemotherapy administered by injection or intravenously or administered orally by means of a prescription drug. <A]

[*9x5] Sec. 9.5. NRS 287.015 is hereby amended to read as follows:

287.015 1. A local government employer and any employee organization that is recognized by the employer pursuant to chapter 288 of NRS may, by written agreement between themselves or with other local government employers and employee organizations, establish a trust fund to provide health and welfare benefits to active and retired employees of the participating employers and the dependents of those employees.

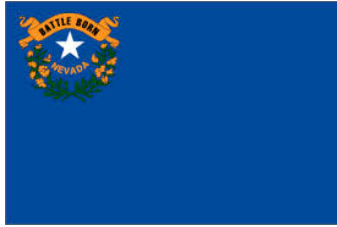
2. All contributions made to a trust fund established pursuant to this section must be held in trust and used:

(a) To provide, from principal or income, or both, for the benefit of the participating employees and their dependents, medical, hospital, dental, vision, death, disability or accident benefits, or any combination thereof, and any other benefit appropriate for an entity that qualifies as a voluntary employees' beneficiary association under Section 501(c)(9) of the Internal Revenue Code of 1986, 26 U.S.C. Section 501(c)(9), as amended; and

(b) To pay any reasonable administrative expenses incident to the provision of these benefits and the administration of the trust.

3. The basis on which contributions are to be made to the trust must be specified in a collective bargaining agreement between each participating local government employer and employee organization or in a written participation agreement between the employer and employee organization, jointly, and the trust.

4. The trust must be administered by a board of trustees on which participating local government employers and employee organizations are equally represented. The agreement that establishes the trust must:



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(a) Set forth the powers and duties of the board of trustees, which must not be inconsistent with the provisions of this section;

(b) Establish a procedure for resolving expeditiously any deadlock that arises among the members of the board of trustees; and

(c) Provide for an audit of the trust, at least annually, the results of which must be reported to each participating employer and employee organization.

5. The provisions of paragraphs (b) and (c) of subsection 2 of NRS 287.029 apply to a trust fund established pursuant to this section by the governing body of a school district.

6. [A> The provisions of section 9 of this act do not apply to a trust fund established pursuant to this section before October 1, 2013. <A]

[A> 7. <A] As used in this section:

(a) "Employee organization" has the meaning ascribed to it in NRS 288.040.

(b) "Local government employer" has the meaning ascribed to it in NRS 288.060.

[*10] Sec. 10. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.164, 695G.1645, 695G.170, 695G.171, 695G.173, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, [A> and section 8 of this act <A] in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

[*11] Sec. 11. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

HISTORY:

Approved by the Governor June 2, 2013