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

SPEAC®
STATE PATIENTS EQUAL ACCESS COALITION

Outdated coverage policies in Wisconsin *USED TO* limit cancer patients' access to life-saving drugs!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, Wisconsin passed legislation for health policies issued or renewed on or after January 1, 2015. This law requires any health benefit plan that provides coverage for cancer treatment to cover extend coverage for orally administered anticancer medication at a cost to equal to intravenously administered or injected cancer medications. A health benefit plan is also in compliance with the law if they charge no more than $100 per prescription for the orally administered anticancer treatment. Additionally, plans may not increase the out-of-pocket cost to patients to achieve compliance. **To view Wisconsin'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 intravenous chemotherapy, an FDA-approved, orally administered drug should be covered at a rate no less favorable than an intravenous drug. Pahave a maximum of $100 co-payment per prescription, per month. The $100 limit may be adjusted each year to keep pace with inflation.

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 with the Wisconsin Office of the Commissioner of Insurance's Consumer Complaints at http://oci.wi.gov/consinfo.htm or call the Insurance Consumer Hotline at (800) 236-8517. For information about our oral parity work in Washington, DC, please go to: peac.myeloma.org.

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Date of enactment: **April 3, 2014** Date of publication*: **April 4, 2014**
* Section 991.11, WISCONSIN STATUTES: Effective date of acts. "Every act and every portion of an act enacted by the legislature over the governor's partial veto which does not expressly prescribe the time when it takes effect shall take effect on the day after its date of publication."

2013 WISCONSIN ACT 186

AN ACT ***to amend*** 40.51 (8), 40.51 (8m), 66.0137 (4), 120.13 (2) (g) and 185.983 (1) (intro.); and ***to create*** 609.837 and 632.867 of the statutes; **relating to:** copayments, deductibles, or coinsurance for oral chemotherapy and injected or intravenous chemotherapy.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 40.51 (8) of the statutes is amended to read:

40.51 **(8)** Every health care coverage plan offered by the state under sub. (6) shall comply with ss. 631.89, 631.90, 631.93 (2), 631.95, 632.72 (2), 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.87 (3) to (6), 632.885, 632.89, 632.895 (5m) and (8) to (17), and 632.896.

SECTION 2. 40.51 (8m) of the statutes is amended to read:

40.51 **(8m)** Every health care coverage plan offered by the group insurance board under sub. (7) shall comply with ss. 631.95, 632.746 (1) to (8) and (10), 632.747, 632.748, 632.798, 632.83, 632.835, 632.85, 632.853, 632.855, 632.867, 632.885, 632.89, and 632.895 (11) to (17).

SECTION 3. 66.0137 (4) of the statutes is amended to read:

66.0137 **(4)** SELF-INSURED HEALTH PLANS. If a city, including a 1st class city, or a village provides health care benefits under its home rule power, or if a town provides health care benefits, to its officers and employees on a self-insured basis, the self-insured plan shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 4. 120.13 (2) (g) of the statutes is amended to read:

120.13 **(2)** (g) Every self-insured plan under par. (b) shall comply with ss. 49.493 (3) (d), 631.89, 631.90, 631.93 (2), 632.746 (10) (a) 2. and (b) 2., 632.747 (3), 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (4), (5), and (6), 632.885, 632.89, 632.895 (9) to (17), 632.896, and 767.513 (4).

SECTION 5. 185.983 (1) (intro.) of the statutes is amended to read:

185.983 **(1)** (intro.) Every voluntary nonprofit health care plan operated by a cooperative association organized under s. 185.981 shall be exempt from chs. 600 to 646, with the exception of ss. 601.04, 601.13, 601.31, 601.41, 601.42, 601.43, 601.44, 601.45, 611.26, 611.67, 619.04, 623.11, 623.12, 628.34 (10), 631.17, 631.89, 631.93, 631.95, 632.72 (2), 632.745 to 632.749, 632.775, 632.79, 632.795, 632.798, 632.85, 632.853, 632.855, 632.867, 632.87 (2), (2m), (3), (4), (5), and (6), 632.885, 632.89, 632.895 (5) and (8) to (17), 632.896, and 632.897 (10) and chs. 609, 620, 630, 635, 645, and 646, but the sponsoring association shall:

SECTION 6. 609.837 of the statutes is created to read:

609.837 Copayment equality for oral and injected chemotherapy. Limited service health organizations, preferred provider plans, and defined network plans are subject to s. 632.867.

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SECTION 7. 632.867 of the statutes is created to read:

632.867 Oral and injected chemotherapy. (1) DEFINITIONS. In this section:

(a) "Chemotherapy" means drugs and biologics that kill cancer cells directly, including antineoplastics, biologic response modifiers, hormone therapy, and monoclonal antibodies, and that are used to do any of the following:

1. Cure a specific cancer.
2. Control tumor growth when cure is not possible.
3. Shrink tumors before surgery or radiation therapy.
4. Destroy microscopic cancer cells that may be present after a tumor is removed by surgery to prevent a cancer recurrence.

(b) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(c) "Self-insured health plan" has the meaning given in s. 632.85 (1) (c).

(2) COPAYMENT, DEDUCTIBLE, OR COINSURANCE REQUIREMENTS; LIMITATIONS. (a) Except as provided in par. (am), a disability insurance policy that covers injected or intravenous chemotherapy and oral chemotherapy, or a self-insured health plan that covers injected or intravenous chemotherapy and oral chemotherapy, may not require a higher copayment, deductible, or coinsurance amount for oral chemotherapy than it requires for injected or intravenous chemotherapy, regardless of the formulation or benefit category determination by the policy or plan.

(am) A disability insurance policy or self-insured health plan that limits copayments paid by a covered individual to no more than $100 for a 30-day supply of oral chemotherapy medication is considered to comply with this section. On January 1, 2016, and on each January 1 annually thereafter, a disability insurance policy or self-insured health plan may adjust the $100 limit under this paragraph by an amount that does not exceed the percentage increase in the U.S. consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(b) A disability insurance policy or a self-insured health plan may not comply with par. (a) by increasing the copayment, deductible, or coinsurance amount required for injected or intravenous chemotherapy that is covered under the policy or plan.

(c) Notwithstanding par. (a), for a disability insurance policy, or self-insured health plan, that is a high deductible health plan, as defined in 26 USC 223 (c) (2), par. (a) applies only after the plan enrollee's deductible has been satisfied for the year.

SECTION 8. Initial applicability.

(1) This act first applies to all of the following:

(a) Except as provided in paragraphs (b) and (c), disability insurance policies that are issued or renewed, and governmental or school district self-insured health plans that are established, extended, modified, or renewed, on the effective date of this paragraph.

(b) Disability insurance policies covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are issued or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.
2. The day on which the collective bargaining agreement is extended, modified, or renewed.

(c) Governmental or school district self-insured health plans covering employees who are affected by a collective bargaining agreement containing provisions inconsistent with this act that are established, extended, modified, or renewed on the earlier of the following:

1. The day on which the collective bargaining agreement expires.
2. The day on which the collective bargaining agreement is extended, modified, or renewed.

SECTION 9. Effective dates. This act takes effect on the day after publication, except as follows:

(1) The treatment of section 632.867 (2) (a) of the statutes and SECTION 8 of this act take effect on January 1, 2015.