

2013 -- S 0428 SUBSTITUTE A

=====
LC01278/SUB A
=====

STATE OF RHODE ISLAND

IN GENERAL ASSEMBLY

JANUARY SESSION, A.D. 2013

—————
A N A C T

RELATING TO INSURANCE - ORALLY ADMINISTERED ANTICANCER MEDICATION

Introduced By: Senators Goldin, Ottiano, Jabour, Picard, and Cool Rumsey

Date Introduced: February 26, 2013

Referred To: Senate Health & Human Services

It is enacted by the General Assembly as follows:

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

3 **27-18-80. Orally administered anticancer medication - Cost-sharing requirement. –**

4 (a) Every individual or group hospital or medical expense, insurance policy or individual or group
5 hospital or medical services plan contract, plan or certificate of insurance delivered, issued for
6 delivery, or renewed in this state, on or after January 1, 2014, that offers both medical and
7 prescription drug coverage, and provides coverage for intravenously administered anticancer
8 medication, shall provide coverage for prescribed, orally administered anticancer medications
9 used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously
10 administered or injected cancer medications that are covered as medical benefits. An increase in
11 patient cost sharing for anticancer medications shall not be allowed to achieve compliance with
12 this section. Notwithstanding the above, the requirements shall not be construed to impose any
13 form of cap on cost-sharing.

14 (b) This section does not apply to insurance coverage providing benefits for: (1) Hospital
15 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
16 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
17 bodily injury or death by accident or both; and (9) Other limited benefit policies.

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

1 **27-19-71. Orally administered anticancer medication – Cost-sharing requirement. –**

2 (a) Every individual or group hospital or medical expense, insurance policy or individual or group
3 hospital or medical services plan contract, plan or certificate of insurance delivered, issued for
4 delivery, or renewed in this state, on or after January 1, 2014, that offers both medical and
5 prescription drug coverage, and provides coverage for intravenously administered anticancer
6 medication, shall provide coverage for prescribed, orally administered anticancer medications
7 used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously
8 administered or injected cancer medications that are covered as medical benefits. An increase in
9 patient cost sharing for anticancer medications shall not be allowed to achieve compliance with
10 this section. Notwithstanding the above, the requirements shall not be construed to impose any
11 form of cap on cost-sharing.

12 (b) This section does not apply to insurance coverage providing benefits for: (1) Hospital
13 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
14 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
15 bodily injury or death by accident or both; and (9) Other limited benefit policies.

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

18 **27-20-67. Orally administered anticancer medication – Cost-sharing requirement. –**

19 (a) Every individual or group hospital or medical expense, insurance policy or individual or group
20 hospital or medical services plan contract, plan or certificate of insurance delivered, issued for
21 delivery, or renewed in this state, on or after January 1, 2014, that offers both medical and
22 prescription drug coverage, and provides coverage for intravenously administered anticancer
23 medication, shall provide coverage for prescribed, orally administered anticancer medications
24 used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously
25 administered or injected cancer medications that are covered as medical benefits. An increase in
26 patient cost sharing for anticancer medications shall not be allowed to achieve compliance with
27 this section. Notwithstanding the above, the requirements shall not be construed to impose any
28 form of cap on cost-sharing.

29 (b) This section does not apply to insurance coverage providing benefits for: (1) Hospital
30 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
31 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
32 bodily injury or death by accident or both; and (9) Other limited benefit policies.

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

1 **27-41-84. Orally administered anticancer medication – Cost-sharing requirement. –**

2 (a) Every individual or group hospital or medical expense, insurance policy or individual or group
3 hospital or medical services plan contract, plan or certificate of insurance delivered, issued for
4 delivery, or renewed in this state, on or after January 1, 2014 ,that offers both medical and
5 prescription drug coverage, and provides coverage for intravenously administered anticancer
6 medication, shall provide coverage for prescribed, orally administered anticancer medications
7 used to kill or slow the growth of cancerous cells on a basis no less favorable than intravenously
8 administered or injected cancer medications that are covered as medical benefits. An increase in
9 patient cost sharing for anticancer medications shall not be allowed to achieve compliance with
10 this section. Notwithstanding the above, the requirements shall not be construed to impose any
11 form of cap on cost-sharing.

12 (b) This section does not apply to insurance coverage providing benefits for: (1) Hospital
13 confinement indemnity; (2) Disability income; (3) Accident only; (4) Long-term care; (5)
14 Medicare supplement; (6) Limited benefit health; (7) Specified disease indemnity; (8) Sickness or
15 bodily injury or death by accident or both; and (9) Other limited benefit policies.

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

19 **42-14.5-3. Powers and duties. [Contingent effective date; see effective dates under**
20 **this section.] --** The health insurance commissioner shall have the following powers and duties:

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

31 (b) To make recommendations to the governor and the house of representatives and
32 senate finance committees regarding health care insurance and the regulations, rates, services,
33 administrative expenses, reserve requirements, and operations of insurers providing health
34 insurance in the state, and to prepare or comment on, upon the request of the governor, or

1 chairpersons of the house or senate finance committees, draft legislation to improve the regulation
2 of health insurance. In making such recommendations, the commissioner shall recognize that it is
3 the intent of the legislature that the maximum disclosure be provided regarding the
4 reasonableness of individual administrative expenditures as well as total administrative costs. The
5 commissioner shall also make recommendations on the levels of reserves including consideration
6 of: targeted reserve levels; trends in the increase or decrease of reserve levels; and insurer plans
7 for distributing excess reserves.

8 (c) To establish a consumer/business/labor/medical advisory council to obtain
9 information and present concerns of consumers, business and medical providers affected by
10 health insurance decisions. The council shall develop proposals to allow the market for small
11 business health insurance to be affordable and fairer. The council shall be involved in the
12 planning and conduct of the quarterly public meetings in accordance with subsection (a) above.
13 The advisory council shall develop measures to inform small businesses of an insurance
14 complaint process to ensure that small businesses that experience rate increases in a given year
15 may request and receive a formal review by the department. The advisory council shall assess
16 views of the health provider community relative to insurance rates of reimbursement, billing and
17 reimbursement procedures, and the insurers' role in promoting efficient and high quality health
18 care. The advisory council shall issue an annual report of findings and recommendations to the
19 governor and the general assembly and present their findings at hearings before the house and
20 senate finance committees. The advisory council is to be diverse in interests and shall include
21 representatives of community consumer organizations; small businesses, other than those
22 involved in the sale of insurance products; and hospital, medical, and other health provider
23 organizations. Such representatives shall be nominated by their respective organizations. The
24 advisory council shall be co-chaired by the health insurance commissioner and a community
25 consumer organization or small business member to be elected by the full advisory council.

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

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

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

- 1 (iii) The uniform health plan claim form utilized by participating providers;
- 2 (iv) Methods for health maintenance organizations as defined by section 27-41-1, and
3 nonprofit hospital or medical service corporations as defined by chapters 27-19 and 27-20, to
4 make facility-specific data and other medical service-specific data available in reasonably
5 consistent formats to patients regarding quality and costs. This information would help consumers
6 make informed choices regarding the facilities and/or clinicians or physician practices at which to
7 seek care. Among the items considered would be the unique health services and other public
8 goods provided by facilities and/or clinicians or physician practices in establishing the most
9 appropriate cost comparisons.
- 10 (v) All activities related to contractual disclosure to participating providers of the
11 mechanisms for resolving health plan/provider disputes; and
- 12 (vi) The uniform process being utilized for confirming in real time patient insurance
13 enrollment status, benefits coverage, including co-pays and deductibles.
- 14 (vii) Information related to temporary credentialing of providers seeking to participate in
15 the plan's network and the impact of said activity on health plan accreditation;
- 16 (viii) The feasibility of regular contract renegotiations between plans and the providers
17 in their networks.
- 18 (ix) Efforts conducted related to reviewing impact of silent PPOs on physician practices.
- 19 (e) To enforce the provisions of Title 27 and Title 42 as set forth in section 42-14-5(d).
- 20 (f) To provide analysis of the Rhode Island Affordable Health Plan Reinsurance Fund.
21 The fund shall be used to effectuate the provisions of sections 27-18.5-8 and 27-50-17.
- 22 (g) To analyze the impact of changing the rating guidelines and/or merging the
23 individual health insurance market as defined in chapter 27-18.5 and the small employer health
24 insurance market as defined in chapter 27-50 in accordance with the following:
- 25 (i) The analysis shall forecast the likely rate increases required to effect the changes
26 recommended pursuant to the preceding subsection (g) in the direct pay market and small
27 employer health insurance market over the next five (5) years, based on the current rating
28 structure, and current products.
- 29 (ii) The analysis shall include examining the impact of merging the individual and small
30 employer markets on premiums charged to individuals and small employer groups.
- 31 (iii) The analysis shall include examining the impact on rates in each of the individual
32 and small employer health insurance markets and the number of insureds in the context of
33 possible changes to the rating guidelines used for small employer groups, including: community
34 rating principles; expanding small employer rate bonds beyond the current range; increasing the

1 employer group size in the small group market; and/or adding rating factors for broker and/or
2 tobacco use.

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

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

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

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

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

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

34 (1) Establishing a consistent standard for electronic eligibility and coverage verification.

1 Such standard shall:

2 (i) Include standards for eligibility inquiry and response and, wherever possible, be
3 consistent with the standards adopted by nationally recognized organizations, such as the centers
4 for Medicare and Medicaid services;

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

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

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

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

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

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

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

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

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

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

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

1 the application of such edits and that the provider have access to the payor's review and appeal
2 process to challenge the payor's adjudication decision.

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

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

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

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

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

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

23 (i) To issue an ANTI-CANCER MEDICATION REPORT. Not later than June 30, 2014
24 and annually thereafter, the office of the health insurance commissioner (OHIC) shall provide the
25 senate committee on health and human services, and the house committee on corporations, with:
26 (1) Information on the availability in the commercial market of coverage for anti-cancer
27 medication options; (2) For the state employee's health benefit plan, the costs of various cancer
28 treatment options; (3) The changes in drug prices over the prior thirty-six (36) months; and (4)
29 Member utilization and cost-sharing expense.

30 SECTION 6. This act shall take effect upon passage.

=====
LC01278/SUB A
=====

EXPLANATION
BY THE LEGISLATIVE COUNCIL
OF

A N A C T

RELATING TO INSURANCE - ORALLY ADMINISTERED ANTICANCER MEDICATION

1 This act would require insurance coverage for prescribed, orally administered anticancer
2 medication where there is coverage for intravenously administered or injected anticancer
3 medications.

4 This act would take effect upon passage.

=====
LC01278/SUB A
=====