A CALL TO ACTION: CANCER PATIENTS' TIMELY TREATMENT BILL OF RIGHTS

The Alliance is calling on state insurance commissioners to step up and enforce regulations already in place and adopt and enforce principles of the Cancer Patients' Timely Treatment Bill of Rights. By requiring insurance providers to adhere to common-sense practices and timelines and executing effective enforcement mechanisms to hold insurers accountable, state insurance commissioners can ensure cancer patients receive what they all deserve: fair, timely, and transparent access to cancer treatment.

CANCER PATIENTS' TIMELY TREATMENT BILL OF RIGHTS:

Principles to Ensure Fair, Timely, and Transparent Access to Cancer Treatment

Cancer patients and their doctors should be fighting *cancer*, not insurance companies. Unfortunately, too many cancer patients are battling restrictive, opaque, and unfair insurance review and appeal processes that drastically delay or make it impossible to receive treatments their doctors appropriately prescribe.

The Cancer Patients' Timely Treatment Bill of Rights: What All Cancer Patients Deserve

✔ **Fair, appropriate access to doctor-recommended treatment**, with approval/denial decisions made:

- in a transparent process
- based on accurate and up-to-date clinical criteria, and
- appeals handled by a medically qualified expert in the type of cancer the patient is facing, and the specific type of treatment recommended

✔ **Timely access to treatment** with initial approval/denial decisions made within **1 day** – and appeals settled no later than **5 days** – from the initial request. State insurance commissioners review final denials and hand down a decision within **15 days**

✔ **Enforcement mechanisms executed by insurance commissioners**, including:

- automatic approval if insurer fails to meet 5-day timeline for expedited appeal
- meaningful and substantial fines for repeated failure to provide fair, appropriate approvals

✔ **The same rights for cancer patients covered by employer self-funded plans**, which are not regulated by state insurance commissioners

FAIR ACCESS TO DOCTOR-RECOMMENDED TREATMENT

PRINCIPLE #1

Approval and denial determinations must be made in a transparent process and based on accurate and up-to-date clinical criteria, including current literature and recommendations of medical societies. Clinical information used for these determinations must be readily available to the prescribing physician, patient, and the public.

Because insurance companies often use third parties to help make approval or denial decisions, the relationship of these third parties, including the methodology used to select such vendors, payments made on a per case basis, the methodology used by the external vendor to review submitted case information, incentives for denial, if any, and the external reviewer's conflicts if any must be openly available for review in the public domain.

TIMELY ACCESS TO TREATMENT

PRINCIPLE #2

Cancer patients and their providers must be notified of a health plan's approval or denial determination within 24 hours after the initial request is made.

PRINCIPLE #3

If an insurer questions the medical necessity or the experimental or investigational nature of a health care service and is planning to issue a denial, the insurer must first provide the recommending physician (within the one-day requirement) a meaningful opportunity to discuss the patient's treatment plan and the clinical basis for the insurer's denial with a physician reviewer. A lack of reviewer familiarization with the relevant data cannot be a basis for denial.

FAIR AND TIMELY EXPEDITED APPEALS

PRINCIPLE #4

The patient or a person acting on the patient's behalf, or the patient's physician may appeal any denial decision by telephone or in writing and the insurance company has four working days to act on that appeal.

PRINCIPLE #5

The insurance company is required to use a board-certified medical oncologist, radiation oncologist, or surgical oncologist appropriately matched to the service being requested to make the decision on any expedited appeal.

PRINCIPLE #6

A final decision on any appeal must be made within four working days. If an approval or denial determination has not been made on an expedited appeal at the end of business on the fourth day, the requested treatment shall be deemed approved.

ENFORCEMENT

PRINCIPLE #7

If a cancer patient has received a denial determination from his or her insurer, the patient may file a complaint with the state insurance commissioner.

The State insurance commissioner shall complete an investigation of the cancer patient's complaint within 15 working days based upon information provided by the patient, their physician, and the health plan; the health plan's review process, confirmation of the specific documents reviewed, and written findings of the review will be considered required submissions and must be provided immediately. If a health plan is found in violation of not providing either the appropriate documentation in a timely manner, or appropriate approvals for services that are determined to be safe, effective and covered treatment by other health plans within the industry, the insurance commissioner may do any or all of the following things:

- Order the insurer to approve the treatment immediately;
- Require the health plan to update their coverage policy as it relates to such treatments so other patients do not experience the same problem;
- Order the insurer to pay a meaningful and substantial fine if it is determined that the insurer has a pattern of regularly denying access to services that are determined to be safe, effective and covered treatment by other health plans within the industry, including Medicare and Medicaid.

PRINCIPLE #8

While employer self-funded plans are not regulated by state insurance commissioners, we call upon these employers to adopt the Cancer Patients' Bill of Rights and enforce it with any insurer that administers their plan.