House IBL Committee
SB 2389
March 14, 2023

Chairman Louser and Committee Members, my name is Joan Connell, and I am a physician in Bismarck. I am a member of the North Dakota Medical Association, NDMA 6th District President, and lead physician on the Physician Advisory Group. I am presenting this testimony on behalf of NDMA. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA strongly supports SB 2389.

NDMA has long been concerned about the prior authorization process and its negative impact on patients, as we frequently hear from North Dakota physicians and patients about delays in care that result from these insurer protocols.

AMA survey data shows:

- 93% of physicians report care delays because of prior authorizations.
- 34% of physicians report that prior authorization has led to a serious adverse event for a patient in their care, such as hospitalization, permanent impairment, or death.
- 91% of physicians see prior authorization as having a negative effect on their patients' clinical outcomes.
- 82% of physicians indicated that patients abandon treatment due to authorization struggles with health insurers.

In addition to the harmful individual patient impact, there is no economic rationale for prior authorization. Costs to the health care system due to

prior authorization are playing out in physician practices all over North Dakota.

For example, physician offices find themselves using inordinate amounts of staff time and resources submitting prior authorization paperwork to justify medically necessary care for their patients to health plans.

- According to American Medical Association (AMA) data, on average, physician practices complete 41 prior authorizations per physician per week.
- 40% of physicians report that there are staff members in their offices that exclusively work on prior authorizations.
- This adds up to nearly two business days, or 13 hours, each week – dedicated to completing prior authorizations.

It is also important to recognize that these prior authorization burdens continue to place administrative pressure on physician practices – as they face staff shortages and attempt to regain their footing following the COVID-19 pandemic.

Now more than ever, administrative burdens, such as prior authorization, weigh down physician practices and consume resources – leading to fewer resources being allocated to direct patient care.

Moreover, by delaying care, undercutting recovery, and reducing the stability of patients' health, prior authorization increases workforce costs as patients miss work or may not be as productive in their jobs.

- AMA survey data show that of physicians who treat patients between the ages of 18 and 65 currently in the workforce, more than half report that prior authorization has interfered with a patient's ability to perform their job responsibilities.

While health plans see prior authorization as a cost-saving tool used to reduce spending on medically necessary care, the costs to patients, physician practices, employers, and the health care system is unjustifiable.

In 2018, in what looked like progress, health plans recognized the need to reduce the burden of prior authorization and agreed in a joint consensus

statement to make a series of improvements to the prior authorization process.

Despite increasing evidence of harm, however, most health plans have made no meaningful progress on reforms.

This means that passage of SB 2389 is necessary to improve access to care for patients in ND. Items that the study may cover include:

- Streamlining and right-sizing the prior authorization process.
- Reviewing the many states that have enacted similar reforms and sets an example for other policymakers to follow.
- How to reduce care delays from prior authorization requirements by requiring timely authorizations or denials from health plans.
- Increasing transparency in the process by requiring health plans to post the items and services subject to prior authorization restriction – allowing patients to make informed decisions about their health insurance and providers to access requirements easily.
- Reducing repeated prior authorizations, especially for those with chronic conditions.

I have several examples of patient's care in my own practice where patients have been harmed or care delayed due to the burden of our current prior authorization processes:

1. At every Children's Regional Asthma Clinic, we have 2-3 patients who are unable to access the recommended treatment that would be best for them due to prior authorization issues. This is so frustrating because the reason the insurance companies keep denying the prescriptions we write is because the insurance companies have not kept up to date with the most recent pediatric asthma guideline recommendations.
2. When prescribing anti-reflux medications, I need to consider the dosage form that will be best tolerated by my patient. Days will be wasted, in addition to manpower hours, going back and forth with the insurance company and the pharmacy to try to get the medication my patient needs.

3. I have some patients with diabetes who are started on insulin pumps with continuous glucose monitoring (CGM). Each brand of pumps and monitors has unique features that might make it a “best fit” for a given patient. These diabetes tools require prior approval, which sometimes results in a “less than best fit” pump or CGM for a patient. This situation can worsen if the patient switches insurance and the new insurance company does not accept the current insulin pump and CGM. The patient is stuck paying out of pocket for supplies for their current, still functional tools OR paying the deductible to replace their perfectly good pump and CGM for something that their new insurance covers. This can be a no win situation.

These examples highlight how a study of prior authorization is necessary. We look forward to supporting your efforts to enact this important legislation. Thank you and I would be happy to answer any questions.