Senate Human Services Committee
SB 2389
February 15, 2023

Chair Lee and Committee Members, my name is Ana Tobiasz and I am a Maternal Fetal Medicine physician in Bismarck. I am a member of the North Dakota Medical Association Council and am presenting this testimony on its behalf. 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.

- This bill is a well-balanced approach to streamlining and right-sizing the prior authorization process.
- It brings ND in line with many states that have enacted similar reforms and sets an example for other policymakers to follow.
- It would reduce care delays from prior authorization requirements by mandating timely authorizations or denials from health plans.
- It also increases 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.
- It reduces repeated prior authorizations, especially for those with chronic conditions.
- Requires that only qualified ND physicians be allowed to make an adverse determination.

I have several examples of patient's care in my own practice caring for high risk pregnancies that have been harmed or care delayed due to the burden of our current prior authorization processes:

- Patients on life saving medications in pregnancy such as blood thinners to treat blood clots in their legs or lungs frequently will require multiple different prior authorizations over the course of pregnancy even if this was completed months prior. I have patients who will present to the pharmacy after clinic hours to pick up a prescription they have been on for months only to find out a new prior authorization needs to be completed or the pharmacy will not dispense the medication. The cost of these medications is prohibitive for most patients to pay out of pocket therefore they can't just pay for it while waiting for the prior authorization to be completed. Because of

this I have had to admit patients to the hospital in order to continue their medications while waiting due to the harms caused if doses are missed. This only adds to the cost of healthcare on top of increasing risk to the patient and her pregnancy. Missing even one or two doses of a blood thinner in pregnancy can be catastrophic and lead to maternal death.

- I have had patients needing in utero fetal surgery for congenital anomalies such as spina bifida or a condition called twin to twin transfusion syndrome have their evaluation and care at a fetal care center out of state delayed while awaiting prior authorization to complete the necessary testing before this can be completed or to even be seen at these centers. Timing of these surgeries is critical and can only be done in a finite time frame to actually prove benefit and to be feasible to complete. In the case of twin-to-twin transfusion syndrome there is a matter of days or one or both fetuses can die or have long term brain damage as a result if not treated properly. I have had patients nearly miss the window to complete this solely because of delays in the prior authorization process.
- Multiple phone calls with inexperienced reviewers in order to get certain fetal genetic testing completed so a family can get a more accurate fetal diagnosis and start care planning. These are highly specialized discussions, and I sometimes will wait 45 minutes or more to speak to a nurse who then denies the request and then will transfer me for a “peer to peer” evaluation only to speak with a physician or advanced practice nurse that has no obstetric or fetal diagnosis experience and then still deny coverage so this family can plan for the care of their special needs infant appropriately before birth
- For diabetic women in pregnancy, certain types of insulin are more efficacious at keeping blood sugars controlled than others. I will have patients be denied the recommended treatments in pregnancy due to the burdensome prior authorization process and having a reviewer who has no obstetric or endocrinology experience to understand the importance of this to the management of her diabetes. Uncontrolled diabetes in pregnancy can lead to serious consequences for both

maternal and fetal health, including increasing the risk of stillbirth and can lead to severe maternal metabolic disturbances that can result in her requiring admission to the ICU. Delays in taking insulin are a direct result of this.

- Insulin frequently requires multiple prior authorization requests for the same medication over the course of pregnancy. This can lead to missed doses especially if the patient tries to pick up their insulin after clinic hours and doesn't have enough to get them through until the next day or to whenever the prior authorization approval is received. Again—this can lead to serious consequences both for maternal and fetal health. I have had to admit patients to the hospital due to these delays and the burdensome cost of insulin so as to make it prohibitive for most patients to just pay out of pocket.

These examples highlight how SB 2389 will improve the clinical outcomes of patients in ND, while also reducing wasted health care resources that are inherent in prior authorization programs. We look forward to supporting your efforts to enact this important legislation.