Good Morning, Madam Chair, and members of the Senate Human Services Committee.

My name is Megan Houn, with Blue Cross Blue Shield of North Dakota and I stand today in opposition of SB 2389 for a number of reasons we will share shortly, but primarily because 90-percent of this proposed legislation already exists in one form or another in the Century Code.

- BCBSND believes providing timely care to patients is important, and we perform well in the prior authorization space, far exceeding the requirements laid out in state statute.
    - The standard, whether from CMS, our accreditation organization or state statute, typically provides 14 days for prior authorizations. BCBSND's average turnaround time is 2-4 business days, however most
    - BCBSND has not received any formal complaints about our prior authorization timeliness.
- There are several things our health care provider partners can do to ensure quick turnarounds for prior authorization requests:
    - Only submit requests on services that require prior authorization. Over 40% of the requests we receive do not require any prior authorization.
        - Of all the healthcare services available, BCBSND only requires prior authorization on about 50 services. We evaluate that list at least annually (removing and adding as needed).
        - To make it even easier to determine which services require prior auth, BCBSND is investing in an electronic tool that providers can use. Deployment of the tool is scheduled for mid-2023.
    - Submit requests electronically. Over 30% of the requests we receive are submitted on paper, which takes longer to process.
    - Submit all the necessary supporting documentation with the initial request.
- This bill not only feels unnecessary given our performance but would also introduce additional administrative costs.
    - The bill seeks to introduce a step prior to determination with the health plan offering a peer-to-peer conversation <u>prior</u> to issuing a denial.
        - With a proposed timeline of 2 days, it would be incredibly difficult to connect with the ordering physician for a phone call to discuss prior to issuing a denial.
        - BCBSND offers peer-to-peer conversations post decision. BCBSND works with providers to gain the necessary documentation needed to approve a service, if the documentation is not there, we will issue the denial, which can be appealed.
    - The bill's appeal language is broad and allows for a loose interpretation of "emergency". Expedited appeals should have more defined parameters to manage volume and avoid confusion.
    - The bill seeks to require one payer to honor another payer's prior authorization. This is unnecessary given the federal requirements around continuity of care, which is more generous than what is being proposed in this bill.
- BCBSND is exceeding well-established standards for prior authorizations, this bill is unnecessary, and we welcome health care providers to work with us to resolve any issues they have.
- SB 2389 proposes to add another chapter to the Century Code, chapter 26.1-36.11, N.D.C.C. This will result in at least four separate chapters in the Century Code that apply to claims and appeals requirements, grievances, utilization review and prior authorization requirements. This proposed legislation only serves to complicate an already complicated area of the law even further. It should be pointed out that these current laws not only cover prior

authorization (also described as preservice, precertification, prior approval) but comprehensively address concurrent claims and post service claims review and timeframes. This federal law that governs claims and appeals not only for post-service and concurrent claim reviews, includes as well and these will govern and preempt any conflicting provisions between current law and SB 2389.

- Just one example of this, which has already been pointed out, is the definition of "emergency medical condition". This term is defined in BCBSND benefit plan documents (and tracks the current statutory definition) but is also defined in Section 26.1-26.4-02(2), N.D.C.C., and in SB 2389. Does this not seem like overkill?

  With your permission, Madam Chair, I would like to introduce Jeff Ubben, our Vice President of Compliance Regulatory Affairs and Special Investigations.

- A major issue with the bill comes at page 6, lines 18-27. This provision essentially says that if a health care provider says a patient's condition requires emergency medical care for a condition, this creates a rebuttable presumption that the health care services provided are in fact medically necessary, unless the insurance company provides clear and convincing evidence that the services provided are not medically necessary. Our issues with this provisions are as follows:

    - The U.S. Department of Justice has estimated that up to 10% of the nation's healthcare spend is for services that are fraud, waste, and abuse.

    - BCBSND processed over 7 million claims last year. If we consider that up to 10% of services submitted to us for payment are fraud, waste, or abuse, it's not difficult to see that would could be required to submit rebuttal documentation on thousands of claims per month. This would create a large administrative burden and require us to hire numerous new positions to undertake this work. These extra administrative burdens will come back to your constituents in the form of higher health insurance premiums.

    - If we are unable to meet the large burden created by this provision, we would be forced to pay for a greatly increased amount of services that are fraud, waste, or abuse, the costs of which again will be passed on to your constituents in the form of higher health insurance premiums.

    - I oversee our provider audit team at BCBSND. We have found that providers routinely bill diagnosis such as runny noses, sore throats, and coughs as emergency medical services. Yes, we have the opportunity to rebut, but at what cost, and why should this be necessary under the law?

    - The bill does not identify who the arbitrator or decider is when the insurance company presents its rebuttal evidence to a provider's claim that a service is an emergency condition. Since this legislation is proposed to go into the Insurance Code, I presume the Insurance Commissioner will be the decider. The Insurance Commissioner and his staff would be put in the position of deciding thousands of medical disputes between emergency room doctors and health insurance company doctors. The Insurance Commissioner and his staff are not medical professionals, therefore, they would be

required to add costly medical doctor FTEs to their staff or add costly consultants to review thousands of claims every month.

The next concern is a general concern. In my position, I handle all of the complaints made by consumers and providers that are made to the Insurance Department. There has not been a single complaint to the Insurance Department to BCBSND regarding what this bill seeks to address, which is the process and timelines behind prior approvals. To be clear, this bill does nothing to address any provider or patient concerns about medical necessity standards, as prior authorization and medical necessity are two entirely different things. If this bill was really aimed at addressing patient care surrounding the prior authorization process, we would have seen complains from patients regarding what this bill seeks to address, which is the prior authorization process.

Finally, I've worked directly with providers to successfully address concerns numerous times in my role at BCBSND. There is no reason why we cannot work with Essentia and any other aggrieved providers to address their concerns here. I believe this is a much better approach, to sit down and work things out, than to draft problematic legislation for an entire state that seems to be limited to an issue a few providers are having.