2023 Senate Bill no. 2389
Senate Human Services Committee
Senator Judy Lee, Chairman
February 15, 2023

Good morning, Chairman Lee and members of the Senate Human Services Committee. I am Lexie Huebner. I serve as Altru Health System's Pre-Service Manager. I am testifying on behalf of the North Dakota Hospital Association (NDHA), which represents hospitals and health systems across the state. We ask that you give this bill a **Do Pass** recommendation.

I have a passion for helping patients understand the complexities of their chosen health care insurance in order to avoid costly surprise medical bills. That passion is the basis of my current position at Altru. It is my goal to improve price transparency within the health care industry and to reduce the burden that medical bills put on families.

Prior authorization processes are extremely complex and difficult to summarize. This is due to the lack of standardization between health care plans as no two are the same. Currently, there is not a universal standard for why a particular health care plan determines that a certain medical service requires prior authorization. Likewise, there is neither a standard communication process nor a standard explanation of what documentation needs to be included to support the prior authorization request. It's a "learn as you go", "trial and error" system that is full of inefficiencies, misdirection, and creates heavy workforce burdens. It is a process that has very little regulation and is controlled differently by each health care plan.

What exactly is prior authorization? It is a process that health plans use that requires health care providers to obtain prior approval <u>before</u> they can deliver specific health care services to a patient. If prior authorization is not given, the health insurance plan will not cover the services.

You may hear that prior authorization requirements are in place to reduce costs and ensure that health care providers are recommending medically necessary treatments. I have also heard it is so the patient can be sure of the medical appropriateness of the services a provider is recommending. Another health care plan's reasoning is to be sure of the "extent" of a patient's coverage. These reasons might have been true when prior authorization requirements first began. However, those statements are outdated, and I have witnessed prior authorization requirements doing the direct opposite of helping patients.

Prior authorizations do not reduce cost but, instead, contribute to the rise in health care prices. At Altru, our prior authorization workload increased 15% from 2021 to 2022. That increase adds an administrative burden not only on the health care facility but, also on the health care plan which now needs to review and approve more services than ever before. With each new prior authorization requirement comes more documentation, testing, and communication requirements on both the health care plan and the provider. Prior authorization requirements are not slowing down but constantly increasing. So far in 2023, we have seen even more of an increase in new health services that now require prior authorization. I can't see how prior authorization is reducing the cost of health care for patients.

When prior authorization is denied, cost is increased. A denial will be issued with a recommendation that the patient and provider try a different form of health care service or procedure and require proof that the substituted service failed before the health care plan will approve the initial requested service. This happened recently with a patient who needed spinal fusion surgery. The surgery was denied by the health care plan and, for it to be approved, the patient needed to complete a psychiatric evaluation and show that a handful of other treatment options failed. Meaning, the patient has to schedule multiple other doctor visits, pay more copayments, and contribute more to the patient's out-of-pocket max. All of that with no guarantee in the end that the patient can have the service that the neurosurgeon initially recommended to help eliminate crippling back pain. Again, this is not reducing cost for our patients but, instead, is adding more for the patient to pay.

Prior authorization does not ensure that health care professionals are recommending medically appropriate treatments. When a health care service requires prior authorization, there is no reasoning or explanation provided by the health plan for it. The health plans provide no data showing that that specific health care service was ordered inappropriately X amount of times, no committee validates the reasoning for why prior authorization improves the appropriateness of services, and no examples are shared to show that a health care provider is recommending health care services inappropriately. In fact, the only notification of a health care plan's policy change is when we suddenly begin receiving prior authorization denials for a medical service.

Each denial can be a teaching moment and Altru adjusts our processes as we learn what steps were needed and what procedures need updating for prior authorization to be approved going forward. Altru learns what requires prior authorization through the denial analysis and has started to see health plans require prior authorizations for services done while patients are in observation in the ER, for genetic testing for neonatal intensive care unit (NICU) treatments, cancerous biopsies, and medically necessary contraceptive treatments. In order to be more proactive and a better advocate for our patients, Altru has hired two additional team members to focus on overturning prior authorization denials and to gather a better understanding of denial reasoning.

This started two years ago and, while some healthcare plans don't even allow for an appeal of a denial, Altru tries to work with those plans that do.

The denials that we have been successful in overturning equate to over nine million dollars of health care services for which health care plans were otherwise not going to extend coverage. Nine million dollars that would have transferred from the health care plan to either the patient or the health care provider. This is not reducing cost but is allowing health care plans to avoid covering necessary health care services.

You may hear that prior authorization barriers are specific to non-North Dakota based health plans. In my experience, it is NOT unique to any particular health plans. We have seen patient delays for ANY health plan that requires prior authorization whether that is non-profit, for-profit, non-North Dakota, North Dakota, or federal plans. If a health plan requires prior authorization, it is a barrier to patients receiving health care timely.

The reasoning for prior authorizations is no longer aligned with today's health care industry. However, the ultimate reason I'm here in support of this bill is not because of the burden it puts on Altru or proving that Altru's health care providers are recommending medically appropriate services. I'm here because prior authorizations are delaying patient care and I see an opportunity for North Dakota to do better for our residents. At the heart of this bill is the patient. Prior authorization requirements delay patient care, period. Anytime a specific health care service requires prior authorization, a health plan has at least 15 business days to return a determination. That means, the patient is scheduled at least 15 business days out in order to ensure prior authorization is timely approved. That is 15 business days that a CT, MRI, X-Ray, cancer injection, spinal fusion, or heart valve replacement is delayed for North Dakota patients.

I can also let you know that the likelihood of that 15-business day turnaround timeframe being met by the health plan is low. The amount of work that is required of a physician and nurse to gather all the documentation that must be submitted with the prior authorization request takes time. The documentation needs are very specific to each health plan. There is not a standard of what should be submitted and there is variation on how prior authorizations and supporting documentation can be submitted. Furthermore, if the smallest of details is missing from the supporting documentation, the health plan then requests additional documentation and the 15-business day timeframe starts over. This means the patient's care is further delayed.

The rebuttal from the health plans to a delayed prior-authorization or a denied prior-authorization is always this: It doesn't mean that the patient can't move forward with the recommended services. They certainly can and that is true. However, if you were a patient waiting to hear if your health plan approved prior authorization for your spinal fusion surgery or for your mom's heart

valve replacement surgery and it was denied and won't be covered by your health plan but you can still move forward if you'd like to be self-pay, would you? Would you say yes to a surgery that costs thousands of dollars at 100% out of pocket even though you are insured? Would you go forward if we told you it might be approved if you have three other services first and they failed and you are still in pain, then we can try to resubmit prior authorization for your spinal surgery? Or, the other option you'll hear is that a health care provider can move forward with the recommended procedure without prior authorization but it won't be covered, so the only option for the provider is to write off the cost. Again, this is only saving the health plan money and moves the financial burden to the provider. How is that working together to help improve health care?

I want to leave you with one final patient story. This is a story of a North Dakota family who came to Altru to have a baby. What should have been a joyous time quickly turned into a scary time as the baby needed extra attention and was rushed to the NICU. The family and the new baby had a North Dakota insurance plan and both the mom and baby were admitted. Thankfully, the NICU doctors were successful in helping this baby and everyone was sent home. Fast forward a couple of weeks from discharge and Altru received a prior authorization denial for the genetic testing that was done on the baby. Because the genetic testing was not given prior authorization, the health plan denied coverage for the entirety of the stay. The bill was $540,000. That entire charge was denied because prior authorization was not received for an admitted NICU infant who needed genetic testing to identify underlying conditions that would help the surgeon have the most success with the medically needed surgery. Again, our friends, neighbors, family members deserve better than this.

Today, we have the opportunity to take a step in the right direction to help improve this process in North Dakota. We've compromised on the bill you see before you today, we've worked with the health plans in North Dakota to try and find a middle ground that helps to improve the patients' experiences, gets them the health care they need, and reduces cost.

Thank you, Chairman Lee and the members of the Committee, for giving me the opportunity to play a part in improving health care for North Dakotans. We ask that you give the bill a **Do Pass** recommendation. Thank you for your consideration. I would be happy to answer any questions.

Respectfully,

Lexie Huebner, Pre-Service Manager
Altru Health Systems