

FIRST ENGROSSMENT

ENGROSSED SENATE BILL NO. 2280

Introduced by

Senators Meyer, Barta, Bekkedahl, Cleary

Representatives Nelson, Warrey

1 A BILL for an Act to create and enact chapter 26.1-36.12 of the North Dakota Century Code,
2 relating to prior authorization for health and dental insurance; to provide for a legislative
3 management study; to provide for a legislative management report; and to provide an effective
4 date.

5 **BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:**

6 **SECTION 1.** Chapter 26.1-36.12 of the North Dakota Century Code is created and enacted
7 as follows:

8 **26.1-36.12-01. Definitions.**

9 As used in this chapter:

- 10 1. "Adverse determination" means a decision by a prior authorization review organization
11 relating to an admission, extension of stay, or health care service that is partially or
12 wholly adverse to the enrollee, including a decision to deny an admission, extension of
13 stay, or health care service on the basis it is not medically necessary.
- 14 2. "Appeal" means a formal request, either orally or in writing, to reconsider an adverse
15 determination regarding an admission, extension of stay, or health care service.
- 16 3. "Authorization" means a determination by a prior authorization review organization that
17 a health care service has been reviewed and, based on the information provided,
18 satisfies the prior authorization review organization's requirements for medical
19 necessity and appropriateness, and payment will be made for that health care service.
- 20 4. "Clinical criteria" means the written policies, written screening procedures, drug
21 formularies or lists of covered drugs, determination rules, determination abstracts,
22 clinical protocols, practice guidelines, medical protocols, and any other criteria or

- 1 rationale used by the prior authorization review organization to determine the
2 necessity and appropriateness of health care services.
- 3 5. "Emergency health care services" means health care services, supplies, or treatments
4 furnished or required to screen, evaluate, and treat an emergency medical condition.
- 5 6. "Emergency medical condition" means a medical condition that manifests itself by
6 symptoms of sufficient severity which may include pain and that a prudent layperson
7 who possesses an average knowledge of health and medicine could reasonably
8 expect the absence of medical attention to result in placing the individual's health in
9 jeopardy, impairment of a bodily function, or dysfunction of any body part.
- 10 7. "Enrollee" means an individual who has contracted for or who participates in coverage
11 under a policy for that individual or that individual's eligible dependents.
- 12 8. "Health care services" means health care procedures, treatments, or services
13 provided by a licensed facility or provided by a licensed physician, licensed dentist, or
14 within the scope of practice for which a health care professional is licensed. The term
15 includes dental services and the provision of pharmaceutical products or services or
16 durable medical equipment.
- 17 9. "Medically necessary" as the term applies to health care services means health care
18 services a prudent physician or dentist would provide to a patient for the purpose of
19 preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a
20 manner that is:
- 21 a. In accordance with generally accepted standards of medical practice;
22 b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and
23 c. Not primarily for the economic benefit of the health plans and purchasers or for
24 the convenience of the patient, treating physician, treating dentist, or other health
25 care provider.
- 26 10. "Medication assisted treatment" means the use of medications, commonly in
27 combination with counseling and behavioral therapies, to provide a comprehensive
28 approach to the treatment of substance use disorders. United States food and drug
29 administration-approved medications used to treat opioid addiction include methadone
30 and buprenorphine, alone or in combination with naloxone and extended-release

- 1 injectable naltrexone. Types of behavioral therapies include individual therapy, group
2 counseling, family behavior therapy, motivational incentives, and other modalities.
- 3 11. "Policy" means a health benefit plan as defined in section 26.1-36.3-01 or a dental
4 benefit plan as defined in section 26.1-36.9-01. The term does not include medical
5 assistance or the public employees retirement system uniform group insurance
6 program plans under chapter 54-52.1.
- 7 12. "Prior authorization" means the review conducted before the delivery of a health care
8 service, including an outpatient health care service, to evaluate the necessity,
9 appropriateness, and efficacy of the use of health care services, procedures, and
10 facilities, by a person other than the attending health care professional, for the
11 purpose of determining the medical necessity of the health care services or admission.
12 The term includes a review conducted after the admission of the enrollee and in
13 situations in which the enrollee is unconscious or otherwise unable to provide advance
14 notification. The term does not include a referral or participation in a referral process
15 by a participating provider unless the provider is acting as a prior authorization review
16 organization.
- 17 13. "Prior authorization review organization" means a person that performs prior
18 authorization for:
- 19 a. An employer with employees in the state who are covered under a policy;
20 b. An insurer that writes policies;
21 c. A preferred provider organization or health maintenance organization; or
22 d. Any other person that provides, offers to provide, or administers hospital,
23 outpatient, medical, prescription drug, or other health benefits to an individual
24 treated by a health care professional in the state under a policy.
- 25 14. "Urgent health care service" means a health care service for which, in the opinion of a
26 health care professional with knowledge of the enrollee's medical condition, the
27 application of the time periods for making a non-expedited prior authorization might:
- 28 a. Jeopardize the life or health of the enrollee or the ability of the enrollee to regain
29 maximum function; or
- 30 b. Subject the enrollee to pain that cannot be managed adequately without the care
31 or treatment that is the subject of the prior authorization review.

1 **26.1-36.12-02. Disclosure and review of prior authorization requirements.**

2 1. A prior authorization review organization shall make any prior authorization
3 requirements and restrictions readily accessible on the organization's website to
4 enrollees, health care professionals, and the general public. Requirements include the
5 written clinical criteria and be described in detail using plain and ordinary language
6 comprehensible by a layperson.

7 2. If a prior authorization review organization intends to implement a new prior
8 authorization requirement or restriction, or amend an existing requirement or
9 restriction, the prior authorization review organization shall:

- 10 a. Ensure the new or amended requirement is not implemented unless the prior
11 authorization review organization's website has been updated to reflect the new
12 or amended requirement or restriction; and
13 b. Provide contracted health care providers of enrollees written notice of the new or
14 amended requirement or amendment no fewer than sixty days before the
15 requirement or restriction is implemented.

16 **26.1-36.12-03. Personnel qualified to make adverse determinations.**

17 A prior authorization review organization shall ensure all adverse determinations are made
18 by a licensed physician, licensed dentist, or licensed pharmacist. The reviewing individual:

- 19 1. Must have experience treating patients with the condition or illness for which the
20 health care service is being requested; and
21 2. Shall make the adverse determination under the clinical direction of one of the prior
22 authorization review organization's medical directors who is responsible for the health
23 care services provided to enrollees.

24 **26.1-36.12-04. Personnel qualified to review appeals.**

25 1. A prior authorization review organization shall ensure all appeals are reviewed by a
26 physician or dentist. The reviewing individual:

- 27 a. Shall possess a valid nonrestricted license to practice medicine or dentistry;
28 b. Must be in active practice in the same or similar specialty as the physician or
29 dentist who typically manages the medical condition or disease for at least five
30 consecutive years;

- 1 c. Must be knowledgeable of, and have experience providing, the health care
2 services under appeal;
- 3 d. May not be employed by a prior authorization review organization or be under
4 contract with a prior authorization review organization other than to participate in
5 one or more of the prior authorization review organization's health care provider
6 networks or to perform reviews of appeals, or otherwise have any financial
7 interest in the outcome of the appeal;
- 8 e. May not have been directly involved in making the adverse determination; and
- 9 f. Shall consider all known clinical aspects of the health care service under review,
10 including a review of all pertinent medical records provided to the prior
11 authorization review organization by the enrollee's health care provider, any
12 relevant records provided to the prior authorization review organization by a
13 health care facility, and any medical literature provided to the prior authorization
14 review organization by the health care provider.
- 15 2. A review of an adverse determination involving a prescription drug must be conducted
16 by a licensed pharmacist or physician who is competent to evaluate the specific
17 clinical issues presented in the review.

18 **26.1-36.12-05. Prior authorization - Nonurgent circumstances.**

- 19 1. If a prior authorization review organization requires prior authorization of a health care
20 service, the prior authorization review organization shall make a prior authorization or
21 adverse determination and notify the enrollee and the enrollee's health care provider
22 of the decision within seven calendar days of obtaining all necessary information to
23 make the decision. For purposes of this subsection, "necessary information" includes
24 the results of any face-to-face clinical evaluation or second opinion that may be
25 required.
- 26 2. A prior authorization review organization shall allow an enrollee and the enrollee's
27 health care provider fourteen business days following a nonurgent circumstance or
28 provision of health care services for the enrollee or health care provider to notify the
29 prior authorization review organization of the nonurgent circumstance or provision of
30 health care services.

1 **26.1-36.12-06. Prior authorization - Urgent health care services.**

2 A prior authorization review organization shall render a prior authorization or adverse
3 determination concerning urgent health care services and notify the enrollee and the enrollee's
4 health care provider of that prior authorization or adverse determination within seventy-two
5 hours after receiving all information needed to complete the review of the requested health care
6 services.

7 **26.1-36.12-07. Prior authorization - Emergency medical condition.**

- 8 1. A prior authorization review organization may not require prior authorization for
9 prehospital transportation or for the provision of emergency health care services for an
10 emergency medical condition.
- 11 2. A prior authorization review organization shall allow an enrollee and the enrollee's
12 health care provider a minimum of two business days following an emergency
13 admission or provision of emergency health care services for an emergency medical
14 condition for the enrollee or health care provider to notify the prior authorization review
15 organization of the admission or provision of health care services.
- 16 3. The medical necessity or appropriateness of emergency health care services for an
17 emergency medical condition may not be based on whether those services were
18 provided by participating or nonparticipating providers.
- 19 4. If an enrollee receives an emergency health care service that requires immediate
20 postevaluation or poststabilization services, a prior authorization review organization
21 shall make an authorization determination within two business days of receiving a
22 request. If the authorization determination is not made within two business days, the
23 services must be deemed approved.

24 **26.1-36.12-08. No prior authorization for medication assisted treatment.**

25 A prior authorization review organization may not require prior authorization for the
26 provision of medication assisted treatment for the treatment of opioid use disorder.

27 **26.1-36.12-09. Retrospective denial.**

28 A prior authorization review organization may not revoke, limit, condition, or restrict a prior
29 authorization if care is provided within forty-five business days from the date the health care
30 provider received the prior authorization unless there is evidence the prior authorization was
31 based on fraud.

1 **26.1-36.12-10. Length of prior authorization.**

2 A prior authorization is valid for six months after the date the health care provider receives
3 the prior authorization.

4 **26.1-36.12-11. Chronic or long-term care conditions.**

5 If a prior authorization review organization requires a prior authorization for a health care
6 service for the treatment of a chronic or long-term care condition, the prior authorization
7 remains valid for twelve months.

8 **26.1-36.12-12. Continuity of care for enrollees.**

9 1. On receipt of information documenting a prior authorization from the enrollee or from
10 the enrollee's health care provider, a prior authorization review organization shall
11 honor a prior authorization granted to an enrollee from a previous prior authorization
12 review organization for at least the initial sixty days of an enrollee's coverage under a
13 new policy.

14 2. During the time period described in subsection 1, a prior authorization review
15 organization may perform its review to grant a prior authorization.

16 3. If there is a change in coverage of, or approval criteria for, a previously authorized
17 health care service, the change in coverage or approval criteria does not affect an
18 enrollee who received prior authorization before the effective date of the change for
19 the remainder of the enrollee's plan year. This subsection does not apply if a prior
20 authorization review organization changes coverage terms for a drug or device that
21 has been:

22 a. Deemed unsafe by the United States food and drug administration; or

23 b. Withdrawn by the United States food and drug administration or product
24 manufacturer.

25 4. A prior authorization review organization shall continue to honor a prior authorization
26 the organization has granted to an enrollee if the enrollee changes products under the
27 same health insurance company.

28 **26.1-36.12-13. Failure to comply - Services deemed authorized.**

29 If a prior authorization review organization fails to comply with the deadlines and other
30 requirements in this chapter, any health care services subject to review automatically are
31 deemed authorized by the prior authorization review organization.

1 **26.1-36.12-14. Procedures for appeals of adverse determinations.**

- 2 1. A prior authorization review organization shall have written procedures for appeals of
3 adverse determinations. The right to appeal must be available to the enrollee and the
4 attending health care professional.
- 5 2. The enrollee may review the information relied on in the course of the appeal, present
6 evidence and testimony as part of the appeals process, and receive continued
7 coverage pending the outcome of the appeals process.

8 **26.1-36.12-15. Effect of change in prior authorization clinical criteria.**

- 9 1. If, during a plan year, a prior authorization review organization changes coverage
10 terms for a health care service or the clinical criteria used to conduct prior
11 authorizations for a health care service, the change in coverage terms or in clinical
12 criteria does not apply until the next plan year for any enrollee who received prior
13 authorization for a health care service using the coverage terms or clinical criteria in
14 effect before the effective date of the change.
- 15 2. This section does not apply if a prior authorization review organization changes
16 coverage terms for a drug or device that has been:
- 17 a. Deemed unsafe by the United States food and drug administration; or
18 b. Withdrawn by the United States food and drug administration or product
19 manufacturer.

20 **26.1-36.12-16. Notification to claims administrator.**

21 If the prior authorization review organization and the claims administrator are separate
22 entities, the prior authorization review organization shall notify, either electronically or in writing,
23 the appropriate claims administrator for the health benefit plan of any adverse determination
24 that is reversed on appeal.

25 **26.1-36.12-17. Annual report to insurance commissioner.**

- 26 1. A prior authorization review organization shall report to the insurance commissioner by
27 September first of each year information regarding prior authorization requests for the
28 previous calendar year.
- 29 2. The report must be available online and in a form specified by the commissioner.
- 30 3. The report must include the:
- 31 a. Total number of prior authorization requests received;

- 1 b. Number of prior authorization requests for which an authorization was issued;
- 2 c. Number of prior authorization requests for which an adverse determination was
- 3 issued;
- 4 d. Number of adverse determinations reversed on appeal;
- 5 e. Reasons an adverse determination was issued, expressed as a percentage of all
- 6 adverse determinations, which must include:
 - 7 (1) The patient did not meet prior authorization criteria;
 - 8 (2) Incomplete information was submitted by the provider to the prior
 - 9 authorization review organization;
 - 10 (3) The treatment program changed; or
 - 11 (4) The patient is no longer covered by the health benefit plan;
- 12 f. Number of prior authorization requests submitted but not necessary;
- 13 g. Number of prior authorization requests submitted by electronic means; and
- 14 h. Number of prior authorization requests submitted by nonelectronic means,
- 15 including mail and facsimile.

16 **SECTION 2. LEGISLATIVE MANAGEMENT STUDY - PRIOR AUTHORIZATION**
17 **REQUIREMENTS IMPOSED BY THE PUBLIC EMPLOYEES RETIREMENT SYSTEM**
18 **UNIFORM GROUP INSURANCE PROGRAM PLANS - INSURANCE COMMISSIONER DATA**
19 **COLLECTION AND REPORT TO LEGISLATIVE MANAGEMENT.**

- 20 1. During the 2025-26 interim, the legislative management shall consider studying prior
- 21 authorization requirements imposed by the public employees retirement system
- 22 uniform group insurance plans under chapter 54-52.1 and the impact on patient care
- 23 and health care costs.
- 24 2. The study must include input from stakeholders, including patients, providers, and
- 25 commercial insurance plans.
- 26 3. The study must require insurance plans to submit to the insurance commissioner by
- 27 July 1, 2025, for the immediately preceding calendar year for each commercial
- 28 product:
 - 29 a. The number of prior authorization requests for which an authorization was
 - 30 issued;

- 1 b. The number of prior authorization requests for which an adverse determination
2 was issued, sorted by health care service, whether the adverse determination
3 was appealed, or whether the adverse determination was upheld or reversed on
4 appeal;
- 5 c. The reasons for prior authorization denial, including the patient did not meet prior
6 authorization criteria, incomplete information was submitted by the provider to the
7 utilization review organization, a change in treatment program, or the patient is
8 no longer covered by the plan; and
- 9 d. The number of denials reversed by internal appeals or external reviews.
- 10 4. The insurance commissioner shall aggregate this data into a report and submit it to the
11 legislative management by November 1, 2025.
- 12 5. The legislative management shall report its findings and recommendations, together
13 with any legislation required to implement the recommendations, to the seventieth
14 legislative assembly.

15 **SECTION 3. EFFECTIVE DATE.** This Act becomes effective on January 1, 2026.