2025 SB 2280
House Industry, Business and Labor Committee
Representative Jonathan Warrey, Chairman
March 17, 2025

Chairman Warrey and members of the House Industry, Business and Labor Committee, I am Marcus Lewis, CEO of First Care Health Center in Park River. Thank you for the opportunity to testify in support of Senate Bill 2280, which addresses the burdens of prior authorization in healthcare. I am testifying on behalf of the North Dakota Hospital Association (NDHA), which represents hospitals and health systems across the state.

I previously testified on prior authorizations to the Senate Industry and Business Committee on February 5, 2025. During that testimony, I discussed the difference between the intention and the impact of prior authorizations in healthcare, especially for rural facilities like First Care. As stated in my previous testimony, prior authorization policies create direct negative impacts on patient care, such as delaying care and placing additional stress not only on the patient but also on the healthcare provider. These policies result in dangerous delays in care, contribute to clinician burnout, and drive up costs for the healthcare system. Furthermore, they impose bureaucratic obstacles that interfere with timely patient treatment, ultimately jeopardizing patient health.

At First Care, we have seen firsthand the consequences of these delays.

Prior authorization requirements have delayed critical diagnostic procedures like CTs and MRIs, forcing some patients to wait or travel over an hour for care despite our ability to provide timely services. These delays contradict evidence-based medical practice and harm patient outcomes.

Due to the increasing administrative burden of prior authorizations, First Care Health Center has now had to hire a dedicated pre-authorization specialist. This position is solely responsible for managing authorization requests, tracking approvals, and handling denials, diverting resources away from direct patient care. This additional staffing expense is yet another consequence of unnecessary bureaucratic hurdles imposed by insurers. Adding

the labor costs of a full-time equivalent is no easy decision, and isn't one made for an inconvenience.

In outpatient infusions, delays in authorization disrupt essential treatments that help keep patients out of acute and emergency care settings. These delays in care are not conducive to an effective primary care environment, population health management, and our Patient-Centered Medical Home model.

Prior authorization delays result in unnecessarily prolonged hospital stays. We have had multiple cases where we received authorization—whether approval or denial—three days after a patient had been discharged or transferred to swingbed care. Preauthorization requests for swingbed care before a final determination from acute are often automatically denied. This puts our organization in a predicament: keep the patient in acute while waiting for swingbed approval or take the risk of denial by transitioning the patient without approval.

In another example, we have patients ready for transfer, with an available bed at our facility and a tertiary hospital eager to free up space—yet the transfer is delayed for days due to preauthorization requirements. In some cases, insurers provide only a seven-day authorization for swingbed services. However, the approval process for extending the stay can take up to two weeks. This results in a significant gap in coverage for both patients and our organization.

For all of these authorizations, peer-to-peer requests are becoming more frequent. These peer-to-peer calls are not conducive to rural providers. They are usually required within 24 hours, with little to no notice, pulling our family practice providers away from primary care visits to address bureaucratic hurdles instead of treating patients.

When a denial is received, it is up to us as the provider to deliver this news to the patient, adding unnecessary stress and confusion. We are also responsible for executing the appeal process, with extremely limited and ambiguous time limitations. Providing the appropriate care for the patient should not put the financial health of the facility at risk.

Delayed treatments, increased patient travel burdens, prolonged hospital stays, and the need for additional staffing to manage authorizations are not mere inconveniences—they are systemic failures that harm patient care and strain healthcare facilities. The experiences of providers and patients alike demonstrate that prior authorization requirements create significant barriers to timely and effective medical treatment.

For me personally, it comes down to accountability and trust. When I go to see my primary care provider, I trust that they are ordering the appropriate diagnostic, treatment, and medications for my condition. Why does my insurer not have the same faith in our Board-Certified MDs, DOs, FNPs, and PAs? If there is an accountability concern, why isn't the issue addressed with those respective boards, versus the impact of patient care delivery?

As value-based care progresses throughout healthcare, the total risk factor of wellness moves from the payor to provider. This continues through full capitation payments to providers, based on clinical coding and documentation. Prior authorization requirements impede this transition, removing trust and stewardship from the care team and Primary Care Provider.

We urge you to support Senate Bill 2280, which takes necessary steps to remove unnecessary barriers to timely patient care, hold insurers accountable, and align policies with the realities of rural healthcare delivery. These guidelines will enhance accountability, improve patient care, and ensure that healthcare providers can focus on what truly matters—caring for their patients.

Thank you for your time and consideration.

Respectfully Submitted,

Marcus Lewis, CEO
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