Senate Bill 2280
March 17, 2025

Good afternoon, Chairman Warrey and members of the House Industry, Business and Labor committee. My name is Megan Hruby and I am with Blue Cross Blue Shield of North Dakota.

I am here this afternoon to provide some important perspective on Senate bill 2280, the prior authorization bill. BCBSND respectfully opposes SB 2280 for a number of reasons not limited to:

- lack of standardization as the proponents intend
- increased health care costs for your constituents, North Dakota small businesses and taxpayers
- duplication
- elimination of innovative programs we have invested in
- inability to monitor for fraud, waste and abuse
- and frankly, a lack of collaboration on behalf of some of our provider partners, who are most interested in a blank check

The fact of the matter is prior authorization only impacts a small number of procedures and treatment plans.

I pose the question--what problem are we trying to solve with SB 2280? The North Dakota Insurance Department will tell you they have very few, if any complaints. After last session, the interim Health Care committee spent more than a year studying prior authorization and came up with no recommendations and no committee bill.

All this to be said, we will be the first to say prior authorization is an important tool in how we collaborate with our provider partners for the best outcomes for our over 450,000 North Dakota members. Think of it like being married. Both the husband and the wife need to work together to make the marriage successful and to have the best possible outcomes. Much like a marriage, the provider and the payer are in a partnership focused on the best possible outcome for the member. That is where I would like to focus my comments today. Prior authorization requires collaboration, transparency and a mutual understanding that this is a shared responsibility between payers and providers. Fulfilling that responsibility also requires an understanding of several important factors that contribute to prior authorization's effectiveness and efficiency.

The first of these factors is making sure we all have a shared understanding of prior authorization's intent.

For us on the payer side, our intent with prior authorization is to ensure members are getting the best, highest-quality care at the most appropriate cost. Prior authorization serves as an important safety check – confirming together with the provider that what they are recommending is safe, medically evidenced and not duplicative.

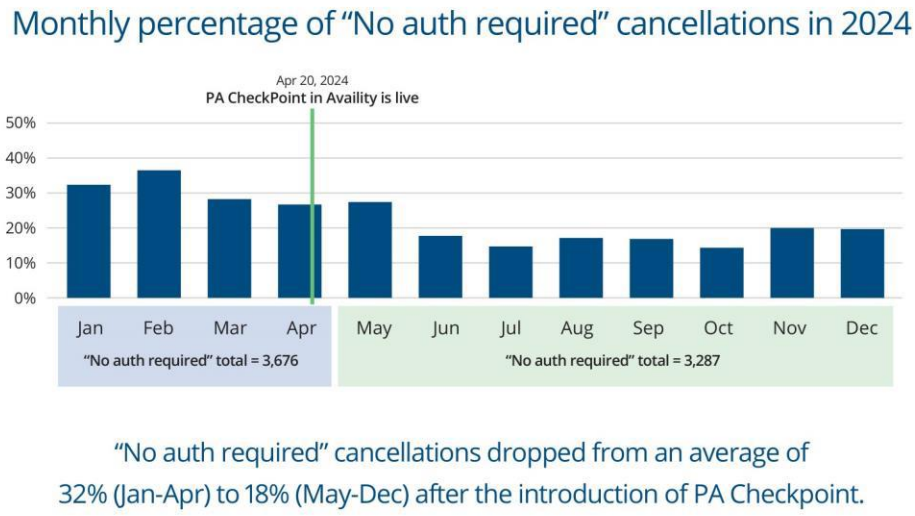
The intent is not to delay or interfere. It is to partner in and communicate around a care plan where, in some circumstances, there could be significant risk involved from a health, quality or cost perspective. When our teams review prior authorization requests, we are keeping three key things in mind:

- Safety and best care: We want to make sure what the doctor wants to do isn't experimental and won't unintentionally harm the patient and we want to make sure a member is getting the best kind of care for their condition.
- Cost: Some procedures, and especially pharmaceuticals, can be very expensive. Today, there are cell and gene therapies that cost over $4 million, oncology treatments that range from $5,000 to $150,000 monthly and Trikafta for cystic fibrosis averaging over $330,000 annually. We cover all those treatments and any subsequent care our members need. We want members to get the most out of every health care dollar they spend. If there are alternatives that can be applied with the same proven outcomes, those should be considered.
- Communication: Prior authorization encourages communication between a member's doctor and their insurance company. When done in a timely, transparent and efficient way the result is the best outcomes for the member's care.

The second important factor is a shared understanding of the prevalence and scope of prior authorization.

At BCBSND, we work hard to clearly and transparently communicate with our provider partners about requirements for prior authorization. BCBSND requires prior authorization for only 50 non-emergent services for which BCBSND requires prior authorization. That's 1.7%. And, all of those services are clearly posted on our website, www.bcbsnd.com/providers/policies-precertification/precertification-overview for providers to reference to reduce the effort spent on unnecessary submissions. We review our policies and national evidence standards at data at a minimum annually and we regularly add and remove anything that has changed. If a change is made, we communicate that to providers directly via our Health Care Newsletter which goes out weekly, on Thursdays. We can also send emergency communications out on the days

between. Providers can submit a prior authorization request on the same site. In 2024, to voluntarily assist with timely response and unwanted delays, BCBSND purchased and implemented a tool that immediately responds to providers who have submitted an unnecessary prior authorization. The tool informs the provider they can proceed with the patient's course of treatment immediately because the prior authorization was not needed. Prior to implementation of the tool, 32% of the PAs we received were not necessary, wasting resources on both the provider and carrier side. Since implementation of the tool, unnecessary prior authorizations for our members have dropped to 18%.



Furthermore, on average 90% of the prior authorizations that BCBSND receives are approved upon first review. Over a three-year period, not only did the number of services we require precertification for go down, but the 90% average approval rate remained consistent.

This is despite still receiving around 36% of requests via fax. And, we still receive handwritten prior authorizations.

A third factor is to have a shared understanding that providers play an important role in the efficiency of prior authorization reviews and responses.

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 industry accreditation organization or state statute, typically provides 14 days for prior authorizations. This bill would align with the new federal requirements that became effective on January 1, 2025. For urgent and expedited cases, the requirement is 72 hours and for non-urgent cases, the requirement is seven business days. We are happy to support those timelines. BCBSND's average turnaround time is 2-4 business days after all documentation is received, however most are complete around 24 hours, except for some medically complex cases. One thing this bill doesn't address is provider timelines. We would respectfully request that any timelines imposed on carriers be the same or similar for providers. Today, the law requires two to seven days for carriers but allows up to 90 days for providers to complete documentation. If we are all in agreement regarding the goals of providing timely care to patients, we should all be subject to the same standards.

Factor Four: The proposed legislation has very limited impact because of exempted parties and laws governing self-funded plans

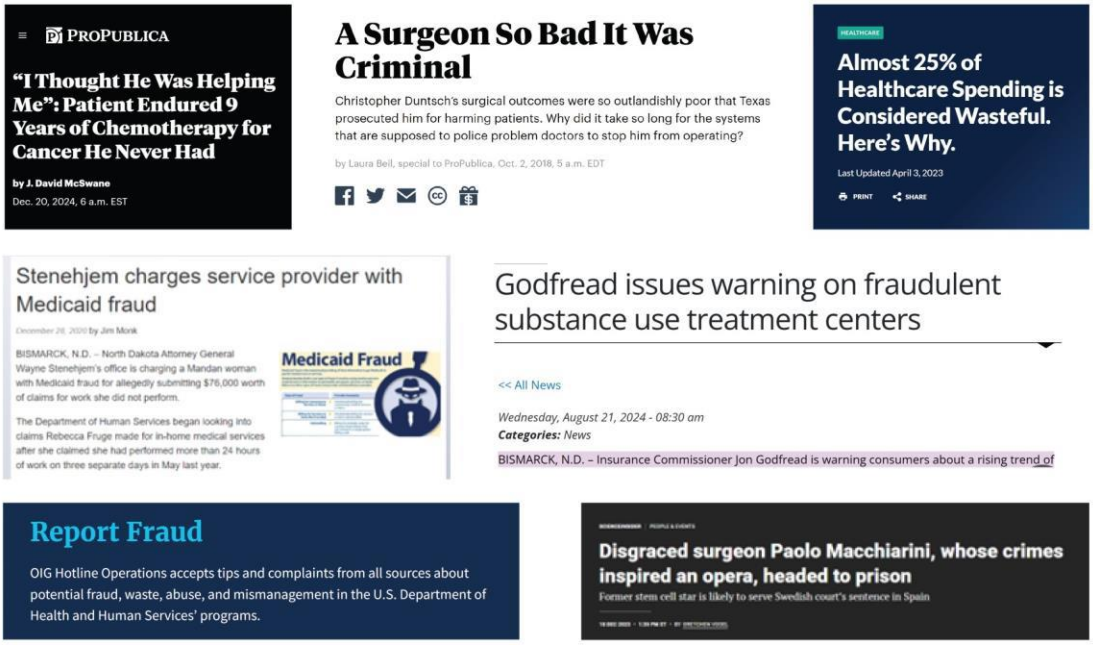
One of the themes we heard more than once from proponents of the bill during the interim Health Care Committee study on prior authorization was a lack of standardization among the many (some cited over 85!) payors with whom they work. Curiously, many of the major payors are missing from inclusion in this legislation, including Medicaid, Medicaid Expansion, Medicare Advantage, TriCare, PERS and WSI. Without including them, how is there standardization at all? BCBSND recommends amending the bill to include all major payors if the intent is truly standardization.

Additionally, I want to remind you that this would not apply to self-funded ERISA plans, because they are not subject to state law but are governed by ERISA. This bill would only apply to fully insured plans, which are approximately one-third of BCBSND's membership. It is my experience that most people do not know if they have a fully insured or self-funded plan, and the providers are also unlikely to know, so this bill will naturally create two different standards to be followed for prior authorizations based on which type of health plan a patient has.

Finally, it is important we have a shared understanding that a prior authorization denial does not always mean the final word.

If a prior authorization request is denied, our members have a few options. First, they, along with their provider, can appeal the decision. There are several reasons why a PA might deny, some are due to errors, some are due to coverage issues, and some are due to a failure to follow the steps required. The most prevalent issue we see is incomplete documentation (we have seen prior authorizations submitted without a patient name, or without the documentation to support the request being made.) If a request is denied, it might be reversed when we receive corrected or additional information or following a successful appeal. However, if the appeal is denied, our members then have the option to request an independent external review (IER.) IER's are performed by neutral third parties who review all the documentation and make a decision. We will then follow the decision of the independent external reviewer.

Factor Five: The role of prior authorization is a vitally important tool in the prevention of fraud, waste and abuse.



The most common types of benefits requiring prior authorization are not only high cost but also those with a high potential for misuse or inappropriate use. Again, not all benefits that fit into these categories require prior authorization. This bill prioritizes provider payment over patient safety and responsible stewardship of our state's health care dollars by limiting our ability to fight health care waste and abuse. According to the United States Department of Justice, health care fraud, waste and abuse imposes an enormous cost to the health care system and to our nation's economy as a whole. The U.S. General Accounting Office estimates that health care fraud, waste and abuse may account for as much as 10% of all health care expenditures. As health care expenditures now exceed one trillion dollars each year, that means more than $100 billion, or an average of $784 per family is being lost in health care fraud, waste and abuse annually.

https://www.justice.gov/archives/jm/criminal-resource-manual-976-health-care-fraud-generally#:~:text=976.,Health%20Care%20Fraud%E2%80%94Generally,just%20one%20health%20care%20system

The ability to have an effective prior authorization process is central to health insurance companies catching and eliminating these elevated levels of waste and abuse. This relieves your

constituents, North Dakota businesses and North Dakota taxpayers from paying increased costs for health insurance.

One recent example that has been in the headlines is the shortage of GLP-1 drugs caused by off-label use for weight loss.

GLP-1s are a class of drug utilized in the treatment of diabetes and obesity. In 2023, GLP-1s were the top selling drugs in the US at nearly $40 billion. In 2024, Medicaid programs spent over $3.5 billion dollars on these drugs. At BCBSND, GLP-1 drugs now account for more than 50% of the non-specialty drug spend.

Ozempic and Mounjaro are newer GLP-1 drugs with roughly $1,000+/month price tags. These drugs specifically are FDA approved for type II diabetic patients. Drugs in this category have shown effectiveness for chronic weight management; but in the example of Ozempic or Mounjaro, weight management would be considered an off-label use. The off-label use of this medication has caused a national shortage of the medication for diabetic patients and has significantly increased prescription drug health care spend. Making weight management medications available to all obese Americans at the current price point could cost over $1 trillion per year. Incorporating prior authorization programs aids in ensuring patient safety, medical necessity and appropriate utilization so these products can be utilized by the diabetic population it is intended to treat.

Another example is imaging. At BCBSND we regularly see a provider who will not accept imaging if it was not done at their facility. A patient might have had a CT scan, MRI or PET scan done previously, but the provider routinely orders the same test done again, this time at their own facility, subjecting our members not only to additional costs, but additional radiation.

Conclusion:

Prior to the 2023 legislative session, BCBSND was approached by a provider partner about potential prior authorization legislation. We came to the table, provided feedback and compromise language for almost three months, and zero compromises were made. As a result, during the 2023 legislative session, SB 2389, a prior authorization bill very similar to this, was introduced and subsequently received a four to one (with one absent) do not pass recommendation before it was pulled back into committee and made into a study. During the 23-24 interim, the Health Care committee studied prior authorization, taking testimony from

carriers, physicians, hospitals and their respective associations several times. At the conclusion of the interim study, no recommendation was made, nor was any committee bill drafted.

However, during both the time prior to the 2023 and 2025 Legislative sessions and continuing today, BCBSND has had an open door to visit with our provider partners, conducting one on one meetings with providers and policy stakeholder meetings to assess how we can improve the prior authorization (PA) process. Because of those meetings, BCBSND began implementation of a PA strategy a little over two years ago and that strategy is mid-implementation today. Over the course of several years, BCBSND will have spent $1,019,750 to assist with provider concerns and streamline our prior authorization process. Passage of this bill will derail that strategy and waste not only the dollars we have invested in it, but the staff time and dedication to improving the member and provider experience.

Prior Authorization is not a problem in North Dakota, it is an inconvenience. But, as you can see, it is a necessary inconvenience that has real purpose and very real impacts on North Dakotans and their health care choices. At Blue Cross, we are doing everything we can to minimize that inconvenience for our provider partners and our members through innovative tools, transparency and a keen eye toward flexibility. We value their input and are working with them on streamlining prior authorization as well as their gold carding goals, without legislative intervention.

Thank you, Chairman Warrey, with that I will stand for any questions.

Suggested Amendments necessary for BCBSND to move to a neutral position on the bill:

1. **Page 1, Lines 20-21**: Replace "drug formularies or lists of covered drugs" with "medical drugs"

BCBSND already posts our drug formularies and lists of covered drugs online. That won't change with this bill's passage or failure. Further, in discussion with proponents of the bill, and in their testimonies, they reference infusions, which are medical drugs covered under a medical benefit and medical necessity policies (which we also post online.)

We request that clarification be reflected in the legislation.

2. Page 5, Lines 3-7: Remove "~~May not be employed by a prior authorization review organization or be under contract with a prior authorization review organization other than to participate in one or more of the prior authorization review organization's health~~

~~care provider networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal~~;" (subsection D.) The definition of "prior authorization review organization" is so broad that it encompasses 3rd party appeal review organizations, meaning we would not have anyone available to review our appeals. We could either narrow the definition, or we must delete D. Our accreditation standards require the same or similar specialist review of appeals to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness. If our options to obtain this type of specialized review are eliminated or severely limited, it will jeopardize a plan's ability to obtain accreditation, which is required to sell insurance on the federal exchange. This also aligns with the intent of the providers who have spoken to wanting same or similar specialty review. We don't employ every specialty that a provider would, and having external reviewers is critical for us, and we think is also part of the Insurance Department's IER process.

3. **Page 7, Line 2**: Add "for non-emergent outpatient care". Inpatient hospital services currently do not require prior authorization at all in North Dakota. Inpatient emergent care should be received when authorized rather than anytime within the year, otherwise the patient is being put at risk. BCBSND currently gives a year approval for some outpatient services.
4. Page 7, Lines 5-6: Replace "a health care service" with "non-emergent outpatient care"
5. Page 7, Line 9: Add "For items and services covered by a patient's current health plan," This clarifies that this only applies to items covered by the member's current health plan. Meaning, you can't apply the law to things that are not covered by a policy. For example, if a patient is on a BCBS plan with infertility benefits but changes to a SHP plan with no infertility benefits, the patient would not have infertility benefits available under the current SHP policy even if they were approved under the previous BCBSND policy. Alternatively stated, if the patient's current policy doesn't cover vitamin D screenings, even if you performed a prior authorization, the benefits would still not be covered.

Suggested Amendments that would move BCBSND to a supporting position on the bill:

- Require providers to follow same/similar timelines as carriers to ensure the patient is the center of everyone's focus.
- Include requirements that transition providers away from handwritten and fax submissions and toward electronic prior authorization.