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Title.

Prepared by the Legislative Council
staff for Representative Vollmer
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Sixty-ninth
Legislative Assembly
of North Dakota

**PROPOSED AMENDMENTS TO
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.

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

- 1 administration-approved medications used to treat opioid addiction include methadone
2 and buprenorphine, alone or in combination with naloxone and extended-release
3 injectable naltrexone. Types of behavioral therapies include individual therapy, group
4 counseling, family behavior therapy, motivational incentives, and other modalities.
- 5 11. "Policy" means a health benefit plan as defined in section 26.1-36.3-01 or a dental
6 benefit plan as defined in section 26.1-36.9-01. The term does not include medical
7 assistance or the public employees retirement system uniform group insurance
8 program plans under chapter 54-52.1.
- 9 12. "Prior authorization" means the review conducted before the delivery of a health care
10 service, including an outpatient health care service, to evaluate the necessity,
11 appropriateness, and efficacy of the use of health care services, procedures, and
12 facilities, by a person other than the attending health care professional, for the
13 purpose of determining the medical necessity of the health care services or admission.
14 The term includes a review conducted after the admission of the enrollee and in
15 situations in which the enrollee is unconscious or otherwise unable to provide advance
16 notification. The term does not include a referral or participation in a referral process
17 by a participating provider unless the provider is acting as a prior authorization review
18 organization.
- 19 13. "Prior authorization review organization" means a person that performs prior
20 authorization for:
- 21 a. An employer with employees in the state who are covered under a policy;
22 b. An insurer that writes policies;
23 c. A preferred provider organization or health maintenance organization; or
24 d. Any other person that provides, offers to provide, or administers hospital,
25 outpatient, medical, prescription drug, or other health benefits to an individual
26 treated by a health care professional in the state under a policy.
- 27 14. "Urgent health care service" means a health care service for which, in the opinion of a
28 health care professional with knowledge of the enrollee's medical condition, the
29 application of the time periods for making a non-expedited prior authorization might:
- 30 a. Jeopardize the life or health of the enrollee or the ability of the enrollee to regain
31 maximum function; or

- 1 **b.** Must be in active practice in the same or similar specialty as the physician or
2 dentist who typically manages the medical condition or disease for at least five
3 consecutive years.
- 4 **c.** Must be knowledgeable of, and have experience providing, the health care
5 services under appeal.
- 6 **d.** ~~May not be employed by a prior authorization review organization or be under~~
7 ~~contract with a prior authorization review organization other than to participate in~~
8 ~~one or more of the prior authorization review organization's health care provider~~
9 ~~networks or to perform reviews of appeals, or otherwise have any financial~~
10 ~~interest in the outcome of the appeal; receive any financial incentive based on the~~
11 number of adverse determinations made. This subdivision does not apply to
12 financial incentives established between health plan companies and health care
13 providers.
- 14 **e.** May not have been directly involved in making the adverse determination; and
- 15 **f.** Shall consider all known clinical aspects of the health care service under review,
16 including a review of all pertinent medical records provided to the prior
17 authorization review organization by the enrollee's health care provider, any
18 relevant records provided to the prior authorization review organization by a
19 health care facility, and any medical literature provided to the prior authorization
20 review organization by the health care provider.
- 21 **2.** A review of an adverse determination involving a prescription drug must be conducted
22 by a licensed pharmacist or physician who is competent to evaluate the specific
23 clinical issues presented in the review.
- 24 **3.** This section does not apply to reviews conducted under sections 26.1-36-44 and
25 26.1-36-46.
- 26 **26.1-36.12-05. Prior authorization - Nonurgent circumstances.**
- 27 **1.** If a prior authorization review organization requires prior authorization of a health care
28 service, the prior authorization review organization shall make a prior authorization or
29 adverse determination and notify the enrollee and the enrollee's health care provider
30 of the decision within seven calendar days of obtaining all necessary information to
31 make the decision. For purposes of this subsection, "necessary information"

1 includes the results of any face-to-face clinical evaluation or second opinion that may
2 be required.

3 2. A prior authorization review organization shall have written procedures to address the
4 failure of a health care provider or enrollee to provide the necessary information to
5 make a determination on the request. If the health care provider or enrollee fails to
6 provide the necessary information to the prior authorization review organization within
7 fourteen calendar days of a written request for all necessary information, the prior
8 authorization review organization may make an adverse determination.

9 3. A prior authorization review organization shall allow an enrollee and the enrollee's
10 health care provider at least fourteen business days to request an updated prior
11 authorization following an unforeseen change in the circumstances or care needs for
12 the enrollee following a nonurgent circumstance or provision of health care services
13 for the enrollee or health care provider to notify the prior authorization review
14 organization of the nonurgent circumstance or provision of health care services.

15 **26.1-36.12-06. Prior authorization - Urgent health care services.**

16 A prior authorization review organization shall render a prior authorization or adverse
17 determination concerning urgent health care services and notify the enrollee and the enrollee's
18 health care provider of that prior authorization or adverse determination within seventy-two
19 hours after receiving all information needed to complete the review of the requested health care
20 services.

21 **26.1-36.12-07. Prior authorization - Emergency medical condition.**

22 1. A prior authorization review organization may not require prior authorization for
23 prehospital transportation or for the provision of emergency health care services for an
24 emergency medical condition.

25 2. A prior authorization review organization shall allow an enrollee and the enrollee's
26 health care provider a minimum of two business days following an emergency
27 admission or provision of emergency health care services for an emergency medical
28 condition for the enrollee or health care provider to notify the prior authorization review
29 organization of the admission or provision of health care services.

1 3. The medical necessity or appropriateness of emergency health care services for an
2 emergency medical condition may not be based on whether those services were
3 provided by participating or nonparticipating providers.

4 4. If an enrollee receives an emergency health care service that requires immediate
5 postevaluation or poststabilization services, a prior authorization review organization
6 shall make an authorization determination within two business days of receiving a
7 request. If the authorization determination is not made within two business days, the
8 services must be deemed approved.

9 **26.1-36.12-08. No prior authorization for medication assisted treatment.**

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

12 **26.1-36.12-09. Retrospective denial.**

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

17 **26.1-36.12-10. Length of prior authorization.**

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

20 **26.1-36.12-11. Chronic or long-term care conditions.**

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

24 **26.1-36.12-12. Continuity of care for enrollees.**

25 1. On receipt of information documenting a prior authorization from the enrollee or from
26 the enrollee's health care provider, a prior authorization review organization shall
27 honor a prior authorization granted to an enrollee from a previous prior authorization
28 review organization for at least the initial sixty days of an enrollee's coverage under a
29 new policy. To obtain coverage, the enrollee or health care provider shall submit
30 documentation of the previous prior authorization in accordance with the procedures in
31 the enrollee's new policy.

- 1 2. During the time period described in subsection 1, a prior authorization review
2 organization may perform its review to grant a prior authorization.
- 3 3. If there is a change in coverage of, or approval criteria for, a previously authorized
4 health care service, the change in coverage or approval criteria does not affect an
5 enrollee who received prior authorization before the effective date of the change for
6 the remainder of the enrollee's plan year. This subsection does not apply if a prior
7 authorization review organization changes coverage terms for a drug or device that
8 has been:
- 9 a. Deemed unsafe by the United States food and drug administration; or
10 b. Withdrawn by the United States food and drug administration or product
11 manufacturer.
- 12 4. A prior authorization review organization shall continue to honor a prior authorization
13 the organization has granted to an enrollee if the enrollee changes products under the
14 same health insurance company provided the health care service for which the
15 enrollee has received prior authorization is covered under the new policy.

16 **26.1-36.12-13. Failure to comply - Services deemed authorized.**

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

20 **26.1-36.12-14. Procedures for appeals of adverse determinations.**

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

27 **26.1-36.12-15. Effect of change in prior authorization clinical criteria.**

- 28 1. If, during a plan year, a prior authorization review organization changes coverage
29 terms for a health care service or the clinical criteria used to conduct prior
30 authorizations for a health care service, the change in coverage terms or in clinical
31 criteria does not apply until the next plan year for any enrollee who received prior

1 authorization for a health care service using the coverage terms or clinical criteria in
2 effect before the effective date of the change.

3 2. This section does not apply if a prior authorization review organization changes
4 coverage terms for a drug or device that has been:
5 a. Deemed unsafe by the United States food and drug administration; or
6 b. Withdrawn by the United States food and drug administration or product
7 manufacturer.

8 **26.1-36.12-16. Notification to claims administrator.**

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

13 **26.1-36.12-17. Annual report to insurance commissioner.**

14 1. A prior authorization review organization shall report to the insurance commissioner by
15 September first of each year information regarding prior authorization requests for the
16 previous calendar year.
17 2. The report must be available online and in a form specified by the commissioner.
18 3. The report must include the:
19 a. Total number of prior authorization requests received;
20 b. Number of prior authorization requests for which an authorization was issued;
21 c. Number of prior authorization requests for which an adverse determination was
22 issued;
23 d. Number of adverse determinations reversed on appeal;
24 e. Reasons an adverse determination was issued, expressed as a percentage of all
25 adverse determinations, which must include:
26 (1) The patient did not meet prior authorization criteria;
27 (2) Incomplete information was submitted by the provider to the prior
28 authorization review organization;
29 (3) The treatment program changed; or
30 (4) The patient is no longer covered by the health benefit plan;
31 f. Number of prior authorization requests submitted but not necessary;

- 1 g. Number of prior authorization requests submitted by electronic means; and
2 h. Number of prior authorization requests submitted by nonelectronic means,
3 including mail and facsimile.

4 **SECTION 2. LEGISLATIVE MANAGEMENT STUDY - PRIOR AUTHORIZATION**
5 **REQUIREMENTS IMPOSED BY THE PUBLIC EMPLOYEES RETIREMENT SYSTEM**
6 **UNIFORM GROUP INSURANCE PROGRAM PLANS - INSURANCE COMMISSIONER DATA**
7 **COLLECTION AND REPORT TO LEGISLATIVE MANAGEMENT.**

- 8 1. During the 2025-26 interim, the legislative management shall consider studying prior
9 authorization requirements imposed by the public employees retirement system
10 uniform group insurance plans under chapter 54-52.1 and the impact on patient care
11 and health care costs.
- 12 2. The study must include input from stakeholders, including patients, providers, and
13 commercial insurance plans.
- 14 3. The study must require insurance plans to submit to the insurance commissioner by
15 July 1, 2025, for the immediately preceding calendar year for each commercial
16 product:
- 17 a. The number of prior authorization requests for which an authorization was
18 issued;
- 19 b. The number of prior authorization requests for which an adverse determination
20 was issued, sorted by health care service, whether the adverse determination
21 was appealed, or whether the adverse determination was upheld or reversed on
22 appeal;
- 23 c. The reasons for prior authorization denial, including the patient did not meet prior
24 authorization criteria, incomplete information was submitted by the provider to the
25 utilization review organization, a change in treatment program, or the patient is
26 no longer covered by the plan; and
- 27 d. The number of denials reversed by internal appeals or external reviews.
- 28 4. The insurance commissioner shall aggregate this data into a report and submit it to the
29 legislative management by November 1, 2025.

Sixty-ninth
Legislative Assembly

- 1 5. The legislative management shall report its findings and recommendations, together
2 with any legislation required to implement the recommendations, to the seventieth
3 legislative assembly.

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

