2025 SB 2280
Senate Industry and Business
Senator Barta, Chairman
February 5, 2025

Chairman Barta and members of the Senate Industry and Business Committee. My name is Courtney McNamee, and I serve as the Director of Payer Revenue Management and Patient Financial Services at Altru Health System. I am honored to represent Altru Health System and share my passion for ensuring patients remain at the heart of everything we do in healthcare and proud to be part of improving healthcare for the communities we serve. I write in favor of Senate Bill 2280 and ask that you give this bill a **Do Pass** recommendation.

Navigating the complexities of health insurance and benefits can be a daunting task for patients, families, care takers and providers. As someone deeply committed to advocating for patient-centric solutions, I prioritize helping individuals and families understand and access the care they need while minimizing financial burdens.

One critical area of focus in my role is the prior authorization process, a procedure required by many insurance payers to approve specific medical services, medications, or treatments before they are delivered. While prior authorization is intended to ensure that care is medically necessary and cost-effective, it can often introduce challenges for both patients and providers. A few examples I would like to highlight that our patients have experienced through the prior authorization process is as follows:

1. Patient A initially presented with a 40% blockage and was deemed to need a cardiac catheterization. However, the plan denied the request for the procedure, and despite multiple appeals and subsequently we were required to wait three months for approval. By the time the surgery was finally authorized, the patient's condition had worsened significantly, with the blockage increasing to 80%. This delay in care posed a clinically dangerous and unacceptable risk to the patient, as an 80% blockage is critically severe and could have led to major complications, including heart attack or other life-threatening conditions. The prolonged approval process not only delayed necessary treatment but also highlighted the risks of waiting for insurance authorization when immediate intervention is required for optimal patient outcomes. The patient was fearful that they would end up with a large balance and would not be able to afford the service if their insurance company did not cover the procedure. From the start of the process to the approval it took approximately 90 days to get approval to move forward.

2. Patient B presented in March 2024 requiring back surgery. Our organization submitted an initial authorization request on April 1, 2024, which was denied on April 10, 2024. In response, our provider participated in a peer review with a physician from the insurance company on May 9, 2024. Following the peer review, the patient was seen in the office again on May 13, 2024, per the direction of the insurance company's physician. A second-level appeal was submitted the same day, and the payer began reviewing the appeal on May 16, 2024. However, the case did not proceed to a hearing until July 18, 2024, at which point we were informed that a decision would be made within 2-3 business days. After not receiving an update, we escalated the issue to the payer's leadership team on July 23, 2024, but were initially told that they did not have access to any information regarding the appeal. Finally, on July 25, 2024, we received an email notification confirming that the appeal had been overturned in the patient's favor, allowing the surgery to proceed. This is a testament to the delays we are experiencing and the inconsistency we encounter. From the start of the process to the final approval it took approximately 115 days.

The prior authorization process is a significant administrative burden for healthcare providers due to the inconsistency and lack of standardization among insurance companies. Each payer has different requirements, timelines, and documentation standards, making it difficult for providers to navigate approvals efficiently and difficult for patients to understand. These inconsistencies lead to delays in patient care, increased administrative workload, and frequent denials that require extensive appeals. The complexity of the process not only creates frustration for providers but can also result in negative health outcomes for patients who experience unnecessary delays in receiving critical care. It is important that the prior authorization study move forward in hopes for there to be a better understanding of the following:

1. Differences in each payers prior authorization lists, documentation requirements, timeline of approvals and processes.
2. Develop a better understanding of the prior authorization process as a whole and its impact on patients care.
3. Provides transparency on how each insurance company communicates prior authorization changes and the frequency of the changes.
4. Determine if the prior authorization processes hinders the ability for patients to receive timely care.

At Altru Health System, we are committed to working collaboratively with payers, providers, and patients to enhance transparency, reduce administrative barriers, and expedite access

to medically necessary care. This bill will be the start to improving the prior authorization process for healthcare organizations and most importantly our patients and communities we serve across North Dakota.

I appreciate the opportunity to be part of improving healthcare across the state of North Dakota. We ask that you give the bill a Do Pass recommendation. Thank you for your consideration. If you have any questions, please reach out.

Thank you,

Courtney McNamee