Prior Authorization Testimony

Megan Hruby, Vice President of Public Policy and Government Affairs

Updated 2/5/2025

SB 2280: Prior Authorization

Good afternoon, Chairman Barta and members of the Senate Industry and Business 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
- inconsistency between state and federal law
- 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

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:

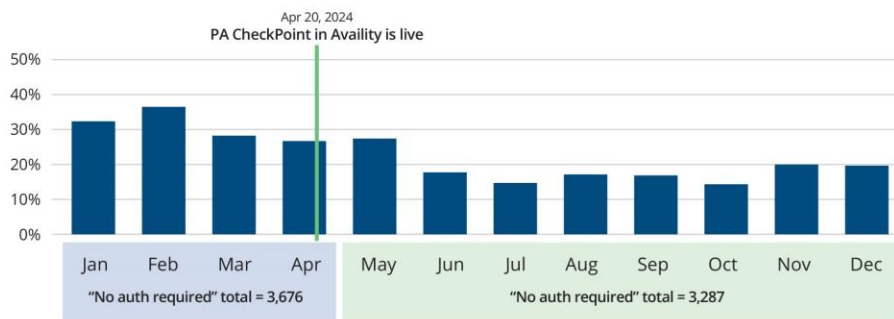
- **Safety and best care:** We want to make sure what the doctor wants to do isn't experimental and won't unintentionally harm the patient and we want to make sure a member is getting the best kind of care for their condition.
- **Cost:** Some procedures, and especially pharmaceuticals, can be very expensive. 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.

What problem are we trying to solve with SB 2280? The fact of the matter is prior authorization only impacts a small number of procedures and treatment plans. 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.

At BCBSND, we work hard to clearly and transparently communicate with our provider partners about requirements for prior authorization. Of the more than **71,920 procedure codes in ICD-10**, **there are only 1,224 codes, or 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 at a minimum annually and we regularly add and remove anything that has changed. Providers can even 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%.

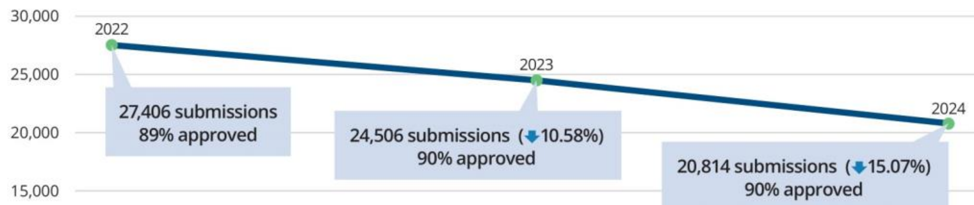
Monthly percentage of "No auth required" cancellations in 2024



"No auth required" cancellations dropped from an average of 32% (Jan-Apr) to 18% (May-Dec) after the introduction of PA Checkpoint.

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.

Total submitted prior authorizations 2022 to 2024



The number of prior authorizations being submitted each year has been declining significantly while we continue to maintain 89% – 90% approvals.

This is despite still receiving around 36% of requests via fax.

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. 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.

While we generally fall within the timelines laid out in SB 2280, we would recommend aligning state law 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 would also respectfully request that any timelines imposed on carriers be the exact same 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.

PROPUBLICA

"I Thought He Was Helping Me": Patient Endured 9 Years of Chemotherapy for Cancer He Never Had

by J. David McSwane

Dec. 20, 2024, 6 a.m. EST

A Surgeon So Bad It Was Criminal

Christopher Duntsch's surgical outcomes were so outlandishly poor that Texas prosecuted him for harming patients. Why did it take so long for the systems that are supposed to police problem doctors to stop him from operating?

by Laura Beil, special to ProPublica, Oct. 2, 2018, 5 a.m. EDT

HEALTHCARE

Almost 25% of Healthcare Spending is Considered Wasteful. Here's Why.

Last Updated April 3, 2023

PRINT SHARE

Stenehjem charges service provider with Medicaid fraud

by Jim Monk

BISMARCK, N.D. – North Dakota Attorney General Wayne Stenehjem's office is charging a Mandan woman with Medicaid fraud for allegedly submitting $76,000 worth of claims for work she did not perform.

The Department of Human Services began looking into claims Rebecca Fruge made for in-home medical services after she claimed she had performed more than 24 hours of work on three separate days in May last year.

Godfread issues warning on fraudulent substance use treatment centers

<< All News

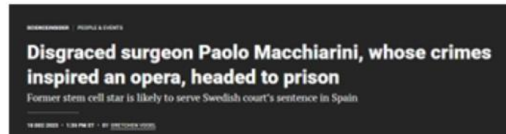
Wednesday, August 21, 2024 - 08:30 am

Categories: News

BISMARCK, N.D. – Insurance Commissioner Jon Godfread is warning consumers about a rising trend of

Report Fraud

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in the U.S. Department of Health and Human Services' programs.


Disgraced surgeon Paolo Macchiarini, whose crimes inspired an opera, headed to prison

Former stem cell star is likely to serve Swedish court's sentence in Spain

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. 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 spend (pocketbooks?). 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 Barta, with that I will stand for any questions.

Suggested Amendments:

- Remove dentists and all dental references as they have their own prior authorization law that was passed in 2021 in chapter 26.1-36.9. SB 2280 would create a conflict of law when it comes to prior authorization of dental plan benefits, as this bill has a different definition of "prior authorization" from current law and spells out different requirements for how to handle prior authorization of dental benefits from the current state law found at chapter 26.1-36.9.
- Align state and federal timelines.
- Require providers to follow same timelines to ensure patient is at the heart of the issue.
- Define emergency health care services for an emergency medical condition very specifically, especially as it relates to pre-hospital transportation for emergency health care services for an emergency medical condition.
- Eliminate the reporting section. BCBSND is happy to provide data, especially because it helps us see where there might be room for improvement. However, nearly if not all the requested reporting is required in the Market Conduct Annual Statement (MCAS) legislation, SB 2124, that this committee and the Senate passed earlier this session.