Chairman Barta and Members of the Committee –

Good Afternoon – my name is Dylan Wheeler and I serve as Head of Government Affairs for Sanford Health Plan. I'm speaking today in opposition to SB2280. I would note that as an integrated health system and health plan, my position today is also demonstrative of Sanford Health – we do not take separate policy positions on legislation; meaning that Sanford Health opposes SB2280.

Introduction

We oppose the bill for many reasons. However, we also recognize and are mindful that there are growing concerns around the use and prevalence of prior-authorization by health plans; yet – it not clear if these issues are coming from state-regulated markets. State regulated markets include Medicaid, Medicaid Expansion, the fully-insured individual, small and large group; more generally the ACA markets. State regulated markets exclude Medicare Advantage and self-funded markets. With that in my mind – today, we would also propose an amendment that would bring this bill to the middle by weighing concerns of the health insurance industry with the proposed legislation, but also carefully balancing the requests of proponents well. A copy of the proposed amendment is attached to my testimony, which I can walk through.

Why is prior-authorization important? Proponents have shared a lot about what is wrong about prior-authorization, but we need to also recognize that the process serves a purpose. To be clear – prior-authorization does not serve as a barrier to accessing care. The process ensures patient and member safety by instilling a checks-and-balances approach while ensuring the services seeking to be authorized is covered under the enrollee's benefit policy. In addition, prior-authorization serves as a utilization management tool – what is that? In a time of heightened scrutiny on healthcare affordability, health plans are uniquely positioned to help members navigate the healthcare system. Utilization management helps guide members to less costly, clinically appropriate covered services. This helps reduce costs to individuals, families, small and large businesses. Particularly with prescription drugs – which continue to be on an upward cost trajectory – prior-authorization serves as another check prior to covering. To put another way – without prior-authorization all the requested services that would be delivered – those costs would be shifted onto the respective plan members. That is, without a moderated approach that to some extent allows prior authorization, premiums to North Dakotans will go up.

Extent of Prior Authorizations

Before getting into the substance of the bill, I wanted to share a bit about what prior-authorization looks like at Sanford Health Plan. At Sanford Health Plan, we have a highly qualified prior-authorization staff made up of physicians, pharmacists, pharmacy technicians, nurses, and other clinically trained personnel. For plan year 2024, in state-regulated markets, Sanford Health Plan processed around 20,000 prior-authorization requests – nearly 12,000 were approved, with some

of the difference being denials. However, what is notable is number of unnecessary prior-authorization requests submitted – during that same time period Sanford Health Plan had roughly 3,700 requests for prior authorization submitted that were unnecessary. This causes additional time and resources on both the plan and provider side. Our highest rate of submissions come for the prescription drugs, network exceptions, and outpatient surgery services. Finally, about 25%-30% of our prior-authorization requests come from non-electronic means – such as fax submissions. Moving away from faxes to electronic requests will certainly add efficiency of prior authorization requests.

Desire to Work Together with Providers

To the bill itself, I wanted to start off by sharing a few concerns with SB2280 as initially drafted. Similar to the position that Sanford Health took on SB2389 last session, we are concerned with SB2280 because it is a large one-sided and one-size fits all approach to a perceived North Dakota issue. To be clear – during the past interim period, the interim Health Care committee had ample time to discuss this issue, hear from many sides, and debate the policy – ultimately, the interim committee declined to put forward a bill recommendation. From the Sanford Health Plan perspective, we asked – and have never received – data from the proponents to suggest that 1) there is an issue with state-regulated North Dakota markets and 2) whether the proposed bill rectifies those perceived problems. We much prefer working with providers directly to address questions or concerns.

Instead, we were pointed towards proponent testimony during the interim in support of the legislation. Such anecdotal testimony during the interim, without specific data to support each section of the proposed legislation left us unable to understand what markets these issues were coming from and to what end, we as payers, can take that feedback and make the process better. Moreover, in speaking with our staff at Sanford Health Plan – they report no concerns with working with the health systems and providers in this state. Rather – our staff have glowing reviews of the hands-on partnership with providers, ensuring that our members and concerns of providers are heard. In addition, our Chief Medical Officer reached out to colleagues in North Dakota – the concerns that were shared back deal with electronic portal capabilities and ways we can internally make our own process better – none of which are addressed in this bill. To this day – we have yet to receive any data from the proponents that demonstrate the need for this bill.

Public Programs

Outside of the lack of data to support this bill, an additional concern lies with the purposeful exclusion of large markets of North Dakota – those being Medicaid, Medicaid Expansion, WSI, and the North Dakota Public Employees Retirement System or NDPERS. If this bill is good policy – why exclude other state regulated markets? This is to avoid a fiscal note and implications for the state budget. As this bill sits, it would affect about 20%-25% of North Dakota health insurance policies. We are grateful the chairman is looking into the potential state fiscal impacts of the bill

should it be applied to those state programs, as that could be an important measuring stick for this committee.

Requirement of Review by "Same or Similar" Specialist

As written – this bill would bring additional costs to individuals, families, and small business – at a time when health care affordability is a prime area of concern for businesses and those looking for health insurance. A primary driver of cost within this bill is the requirement that each health carrier have a "same or similar" specialist review each denial. Health plans do not employ specialty physicians of every area on staff to review these claims. Rather, health plans would be forced to contract with external entities to conduct these reviews – oftentimes at a cost of $1,500 per case. Imagine hundreds if not thousands of claims needed to be reviewed by external physician reviewers at such a high cost. Additionally, we also read the bill that we would either need to employ or contract with a dentist as we do have dental claims that are processed under a medical benefit. Those costs would be passed along to the consumer in the form of a higher premium and would jeopardize positive relationships that we have built with providers in North Dakota.

Proposed Amendments

Instead of focusing on the issues within the bill as currently written, I want to spend some time on our proposed amendment and a path ahead with this bill. To be clear – Sanford Health is open to seeking reasonable compromise to meet in the middle with the proponents. In addition to the amendment, we would also recommend a subcommittee be assigned to hash out details, concerns, or other perspectives—the state needs to get this right, and for the right reasons. This bill is a large reform effort in North Dakota and should not move quickly. Rather, we should take our time to deliberately work together. In advance of committee, we also shared the proposed amendment with the Insurance Department for their review – they responded that the amendment looks reasonable.

With that – lets walk through our proposed amendment. We are grateful for Senator Klein to have had these amendments drafted for the committee's consideration. If the bill is so amended, Sanford Health would move into a support position. The amendment makes several important changes:

1. Includes Medicaid, Medicaid Expansion, WSI and NDPERS within the scope of the bill and explicitly excludes self-funded plans that are governed by ERISA (federal law).
2. Removes the "same or similar" reviewer standard on the initial appeal phase and proposes a compromise to have this apply to appeals, with a few tweaks.
3. Amends the turn-around times to align with recently issued Federal rules.

4. In a number of areas, provides health plans the ability to adopt up-to-date clinical and medical criteria during a plan year to ensure member and patient safety.
5. Removes the auto-authorization section; and instead we would agree to make this an explicit section of North Dakota Insurance Department Market Conduct Exams, which major payers in the state are subject to each 5 years at a minimum.
6. Amends the report to include additional metrics that would be informative to policy makers.
7. Amends other sections that may lead to confusion in terms of enforcement or are ambiguous.

Conclusion

Again – we recognize the need and want for prior-authorization reform in North Dakota. We strongly disagree with the narrow application to certain markets. This bill as introduced goes too far. But we see a path ahead with amendments and stand ready to work with the committee and the bills proponents to that end.

Mr. Chairman – I thank you and the committee for the time and welcome any questions.

Thank you.

Dylan C. Wheeler
Head of Government Affairs
Sanford Health Plan