March 24, 2025

RE: SB 2280 – Oppose

Chairman Warrey and Members of the House Industry, Business and Labor Committee:

On behalf of the American Council of Life Insurers (ACLI)[1], we appreciate the opportunity to share our concerns with SB 2280 that would apply the medical prior authorization process to dental plans. We respectfully oppose the bill due to the inclusion of dental plans.

Dental Exemption Would Prevent Disruption of Market

Requiring dental plans to utilize the prior authorization process would greatly disrupt how the dental market currently operates. Currently, dental plans utilize the pretreatment estimate process described below. SB 2280, as currently drafted, would significantly alter the way dental claims are processed. North Dakota would be an outlier as no other state requires the prior authorization process to be utilized by dental plans.

This is because the prior authorization process is rigorous, necessitating a thorough review by an appropriately licensed dental consultant including review of documentation such as X-rays submitted by the treating dentist. For a low-premium, voluntary product like dental insurance, this rigorous process would add significant expense to the claims process, which would ultimately be reflected in premiums. Over the last five years, the industry has had negative price growth in some years and the highest yearly increase was only 2.5 percent.

The current pretreatment estimate process works in the dental market because the claims tend to be less complex than medical claims, which require a prior authorization process. The pretreatment estimate process allows patients to receive more timely care and reduces the administrative burden on both providers and carriers. Today, many medical providers report that they spend at least 16 hours a week on prior authorizations.[2] The prior authorization process can take as long as three weeks. Patient care would likely be delayed as carriers require prior authorization before many basic and major treatments can be provided so consumers, in addition to carriers and providers, would be negatively impacted.

Exempting dental insurance from SB 2280 would preserve the current claims process, keeping premiums stable and protecting access to care.

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[1] The American Council of Life Insurers (ACLI) is the leading trade association driving public policy and advocacy on behalf of the life insurance industry. 90 million American families rely on the life insurance industry for financial protection and retirement security. ACLI's member companies are dedicated to protecting consumers' financial wellbeing through life insurance, annuities, retirement plans, long- term care insurance, disability income insurance, reinsurance, and dental, vision and other supplemental benefits. ACLI's 280 member companies represent 94 percent of industry assets in the United States.

[2] American Medical Association. 2017. Prior Authorization Physician Survey. https://www.ama-assn.org/sites/default/files/media-browser/public/government/advocacy/2016-pa-survey-results.pdf

Pretreatment Estimates

The key distinguishing feature between prior authorizations and pretreatment estimates is that the latter is an optional process where providers and insureds can request information about benefit coverage and cost to receive an estimate. Requiring carriers to undertake the prior authorization process for proposed dental treatment not required as part of the plan will add tremendous expense to the claims process, which ultimately is reflected in premiums. It will also add to the amount of time it'll take for the patient to receive needed treatment.

Prior authorization is most commonly used as a managed care tool to control costs and avoid unnecessary expensive procedures. A prior authorization requires advance approval for, usually higher cost services following a review to determine if the proposed service is medically necessary. Once issued, a prior authorization is generally valid for a period of time and represents the carrier's promise not to subsequently deny payment for that service on the ground that it was not medically necessary.

However, in dental insurance, a pretreatment estimate is intended to serve as confirmation that the patient is covered by the dental plan as of the date of inquiry and that the proposed treatment is a covered benefit under the patient's dental plan. A pretreatment estimate is neither a guaranty of payment nor a determination of the necessity for the service. It is essentially an assurance to the dentist that the patient has insurance coverage as of that date, provides an estimate of the patient's likely out-of-pocket expense and, provided the patient has not used up all of their benefits when the claims is submitted, what the plan will pay.

Unlike the prior authorization, the dental plan makes no determination as to the medical/dental necessity for the procedure and the carrier has the right to determine retrospectively that the treatment was not required. Providers have a mechanism to appeal these decisions if they disagree. Because of the limited narrow scope of a pre-determination, it can be processed far more quickly than a prior authorization. This process helps keep dental premiums affordable.

Thank you for your consideration.

Respectfully submitted,

Rikki Pelta
AVP & Associate General Counsel
American Council of Life Insurers

25.1180.02000

Sixty-ninth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2280

Introduced by

Senators Meyer, Barta, Bekkedahl, Cleary

Representatives Nelson, Warrey

A BILL for an Act to create and enact chapter 26.1-36.12 of the North Dakota Century Code, relating to prior authorization for health ~~and dental~~ insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.12 of the North Dakota Century Code is created and enacted as follows:

26.1-36.12-01. Definitions.

As used in this chapter:

1. "Adverse determination" means a decision by a prior authorization review organization relating to an admission, extension of stay, or health care service that is partially or wholly adverse to the enrollee, including a decision to deny an admission, extension of stay, or health care service on the basis it is not medically necessary.
2. "Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination regarding an admission, extension of stay, or health care service.
3. "Authorization" means a determination by a prior authorization review organization that a health care service has been reviewed and, based on the information provided, satisfies the prior authorization review organization's requirements for medical necessity and appropriateness, and payment will be made for that health care service.
4. "Clinical criteria" means the written policies, written screening procedures, drug formularies or lists of covered drugs, determination rules, determination abstracts, clinical protocols, practice guidelines, medical protocols, and any other criteria or rationale used by the prior authorization review organization to determine the necessity and appropriateness of health care services.
5. "Emergency health care services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.

6. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity which may include pain and that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of medical attention to result in placing the individual's health in jeopardy, impairment of a bodily function, or dysfunction of any body part.

7. "Enrollee" means an individual who has contracted for or who participates in coverage under a policy for that individual or that individual's eligible dependents.

8. "Health care services" means health care procedures, treatments, or services provided by a licensed facility or provided by a licensed physician, ~~licensed dentist,~~ or within the scope of practice for which a health care professional is licensed. The term includes ~~dental services and~~ the provision of pharmaceutical products or services or durable medical equipment. This term does not include dental services.

9. "Medically necessary" as the term applies to health care services means health care services a prudent physician ~~or dentist~~ would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is:

   a. In accordance with generally accepted standards of medical practice;

   b. Clinically appropriate in terms of type, frequency, extent, site, and duration; and

   c. Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician, ~~treating dentist,~~ or other health care provider.

10. "Medication assisted treatment" means the use of medications, commonly in combination with counseling and behavioral therapies, to provide a comprehensive approach to the treatment of substance use disorders. United States food and drug administration-approved medications used to treat opioid addiction include methadone and buprenorphine, alone or in combination with naloxone and extended-release injectable naltrexone. Types of behavioral therapies include individual therapy, group counseling, family behavior therapy, motivational incentives, and other modalities.

11. "Policy" means an insurance policy, a health maintenance organization contract, a health service corporation contract, an employee welfare benefits plan, a hospital or medical services plan, or any other benefits program providing payment,

reimbursement, or indemnification for health care costs. The term does not includes a dental benefit plan as defined in section 26.1-36.9-01. The term does not include medical assistance, benefits under title 65, or public employees retirement system health benefits.

12. "Prior authorization" means the review conducted before the delivery of a health care service, including an outpatient health care service, to evaluate the necessity, appropriateness, and efficacy of the use of health care services, procedures, and facilities, by a person other than the attending health care professional, for the purpose of determining the medical necessity of the health care services or admission. The term includes a review conducted after the admission of the enrollee and in situations in which the enrollee is unconscious or otherwise unable to provide advance notification. The term does not include a referral or participation in a referral process by a participating provider unless the provider is acting as a prior authorization review organization.

13. "Prior authorization review organization" means a person that performs prior authorization for:

a. An employer with employees in the state who are covered under a policy;

b. An insurer that writes policies;

c. A preferred provider organization or health maintenance organization; or

d. Any other person that provides, offers to provide, or administers hospital, outpatient, medical, prescription drug, or other health benefits to an individual treated by a health care professional in the state under a policy.

14. "Urgent health care service" means a health care service for which, in the opinion of a health care professional with knowledge of the enrollee's medical condition, the application of the time periods for making a non-expedited prior authorization might:

a. Jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

b. Subject the enrollee to pain that cannot be managed adequately without the care or treatment that is the subject of the prior authorization review.

26.1-36.12-02. Disclosure and review of prior authorization requirements.

1. A prior authorization review organization shall make any prior authorization requirements and restrictions readily accessible on the organization's website to enrollees, health care professionals, and the general public. Requirements include the written clinical criteria and be described in detail using plain and ordinary language comprehensible by a layperson.
2. If a prior authorization review organization intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the prior authorization review organization shall:
   a. Ensure the new or amended requirement is not implemented unless the prior authorization review organization's website has been updated to reflect the new or amended requirement or restriction; and
   b. Provide contracted health care providers of enrollees written notice of the new or amended requirement or amendment no fewer than one hundred twenty days before the requirement or restriction is implemented.

26.1-36.12-03. Personnel qualified to make adverse determinations.

A prior authorization review organization shall ensure all adverse determinations are made by a licensed physician ~~or licensed dentist~~. The reviewing individual:

1. Shall posses a valid nonrestricted license to practice medicine ~~or dentistry~~;
2. Must be of the same or similar specialty as the physician ~~or dentist~~ who typically manages the condition or illness or provides the health care service involved in the request;
3. Must have experience treating patients with the condition or illness for which the health care service is being requested; and
4. Shall make the adverse determination under the clinical direction of one of the prior authorization review organization's medical directors who is responsible for the health care services provided to enrollees.

26.1-36.12-04. Consultation before issuing an adverse determination.

If a prior authorization review organization is questioning the medical necessity of a health care service, the prior authorization review organization shall notify the enrollee's physician ~~or dentist~~ that medical necessity is being questioned. Before issuing an adverse determination, the

prior authorization review organization shall allow the enrollee's physician ~~or dentist~~ the opportunity to discuss the medical necessity of the health care service on the telephone with the physician ~~or dentist~~ who will be responsible for determining authorization of the health care service under review.

26.1-36.12-05. Personnel qualified to review appeals.

1. A prior authorization review organization shall ensure all appeals are reviewed by a physician ~~or dentist~~. The reviewing individual:

   a. Shall possess a valid nonrestricted license to practice medicine ~~or dentistry~~;

   b. Must be in active practice in the same or similar specialty as the physician ~~or dentist~~ who typically manages the medical condition or disease for at least five consecutive years;

   c. Must be knowledgeable of, and have experience providing, the health care services under appeal;

   d. 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;

   e. May not have been directly involved in making the adverse determination; and

   f. Shall consider all known clinical aspects of the health care service under review, including a review of all pertinent medical records provided to the prior authorization review organization by the enrollee's health care provider, any relevant records provided to the prior authorization review organization by a health care facility, and any medical literature provided to the prior authorization review organization by the health care provider.

2. A review of an adverse determination involving a prescription drug must be conducted by a licensed pharmacist or physician who is competent to evaluate the specific clinical issues presented in the review.

26.1-36.12-06. Prior authorization - Nonurgent circumstances.

1. If a prior authorization review organization requires prior authorization of a health care service, the prior authorization review organization shall make a prior authorization or

adverse determination and notify the enrollee and the enrollee's health care provider of the decision within two business days of obtaining all necessary information to make the decision. For purposes of this subsection, "necessary information" includes the results of any face-to-face clinical evaluation or second opinion that may be required.

2. A prior authorization review organization shall allow an enrollee and the enrollee's health care provider fourteen business days following a nonurgent circumstance or provision of health care services for the enrollee or health care provider to notify the prior authorization review organization of the nonurgent circumstance or provision of health care services.

26.1-36.12-07. Prior authorization - Urgent health care services.

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

26.1-36.12-08. Prior authorization - Emergency medical condition.

1. A prior authorization review organization may not require prior authorization for prehospital transportation or for the provision of emergency health care services for an emergency medical condition.
2. A prior authorization review organization shall allow an enrollee and the enrollee's health care provider a minimum of two business days following an emergency admission or provision of emergency health care services for an emergency medical condition for the enrollee or health care provider to notify the prior authorization review organization of the admission or provision of health care services.
3. A prior authorization review organization shall cover emergency health care services for an emergency medical condition necessary to screen and stabilize an enrollee. If, within seventy-two hours of an enrollee's admission, a health care provider certifies in writing to a prior authorization review organization that the enrollee's condition required emergency health care services for an emergency medical condition, that certification will create a presumption the emergency health care services for the

emergency medical condition were medically necessary. The presumption may be rebutted only if the prior authorization review organization can establish, with clear and convincing evidence, that the emergency health care services for the emergency medical condition were not medically necessary.

4. The medical necessity or appropriateness of emergency health care services for an emergency medical condition may not be based on whether those services were provided by participating or nonparticipating providers. Restrictions on coverage of emergency health care services for an emergency medical condition provided by nonparticipating providers may not be greater than restrictions that apply when those services are provided by participating providers.

5. If an enrollee receives an emergency health care service that requires immediate post-evaluation or post-stabilization services, a prior authorization review organization shall make an authorization determination within two business days of receiving a request. If the authorization determination is not made within two business days, the services must be deemed approved.

26.1-36.12-09. No prior authorization for medication assisted treatment.

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

26.1-36.12-10. Retrospective denial.

A prior authorization review organization may not revoke, limit, condition, or restrict a prior authorization if care is provided within forty-five business days from the date the health care provider received the prior authorization.

26.1-36.12-11. Length of prior authorization.

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

26.1-36.12-12. Chronic or long-term care conditions.

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

26.1-36.12-13. Continuity of care for enrollees.

1. On receipt of information documenting a prior authorization from the enrollee or from the enrollee's health care provider, a prior authorization review organization shall honor a prior authorization granted to an enrollee from a previous prior authorization review organization for at least the initial sixty days of an enrollee's coverage under a new policy.
2. During the time period described in subsection 1, a prior authorization review organization may perform its review to grant a prior authorization.
3. If there is a change in coverage of, or approval criteria for, a previously authorized health care service, the change in coverage or approval criteria does not affect an enrollee who received prior authorization before the effective date of the change for the remainder of the enrollee's plan year.
4. A prior authorization review organization shall continue to honor a prior authorization the organization has granted to an enrollee if the enrollee changes products under the same health insurance company.

26.1-36.12-14. Failure to comply - Services deemed authorized.

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

26.1-36.12-15. Procedures for appeals of adverse determinations.

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

26.1-36.12-16. Effect of change in prior authorization clinical criteria.

If, during a plan year, a prior authorization review organization changes coverage terms for a health care service or the clinical criteria used to conduct prior authorizations for a health care service, the change in coverage terms or in clinical criteria does not apply until the next plan

year for any enrollee who received prior authorization for a health care service using the coverage terms or clinical criteria in effect before the effective date of the change.

26.1-36.12-17. Notification to claims administrator.

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

26.1-36.12-18. Annual report to insurance commissioner.

1. A prior authorization review organization shall report to the insurance commissioner by September first of each year, in a form and manner specified by the commissioner, information regarding prior authorization requests for the previous calendar year.
2. The report must include the:
   a. Total number of prior authorization requests received;
   b. Number of prior authorization requests for which an authorization was issued;
   c. Number of prior authorization requests for which an adverse determination was issued;
   d. Number of adverse determinations reversed on appeal; and
   e. Reasons an adverse determination was issued, expressed as a percentage of all adverse determinations. The reasons may include:
      (1) The patient did not meet prior authorization criteria;
      (2) Incomplete information was submitted by the provider to the prior authorization review organization;
      (3) The treatment program changed; or
      (4) The patient is no longer covered by the health benefit plan.