2025 SENATE INDUSTRY AND BUSINESS

SB 2280

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

SB 2280
2/5/2025

A bill relating to prior authorization for health and dental insurance.

2:30 p.m. Chairman Barta opened the hearing.

Members present: Chairman Barta, Senator Klein, Senator Enget

Members absent: Vice-Chairman Boehm, Senator Kessel

Discussion Topics:

- Delay/denial of care
- Credentials of approvers
- Definition and intent of prior authorization
- Enforcement timeline and compliance clause
- Peer to peer approvals and specialists
- American Society for Radiology and Oncology
- American Healthcare systems
- Rural healthcare and Critical Access Hospitals
- Maintenance medications
- Online accessibility and transparency
- State regulated markets and definition
- Sanford Health Plan
- Electronic Health Portal (EMR)
- Increased premiums
- Fiscal note and piloting
- Denial options and appeal
- Independent External Reviewer (IER)
- Fraud, waste, and abuse
- GLP1 drugs and off label use
- ERISA Plans and exclusions

2:30 p.m. Senator Scott Meyer, District 18, testified in favor and introduced the bill.

2:34 p.m. Senator Brad Bekkedahl, District 1, testified in favor.

2:38 p.m. Andrew Askew, Vice President of Public Policy for Essentia Health, testified in favor and submitted testimony #35331.

2:47 p.m. Courtney Koeble, on behalf of the Executive Director of the ND Medical Association, introduced the following speaker.

2:47 p.m. Dr. J'Patrick Fahn, testified in favor and submitted testimony #34848.

3:04 p.m. Tim Blasl, President of the ND Hospital Association, testified in favor and submitted testimony #34868 and #34865.

3:17 p.m. Marcus Lewis - CEO of First Care Health Center in Park River, testified in favor.

3:19 p.m. Shane Goettle, Lobbyist representing the American Cancer Society's Cancer Action Network, testified in favor and submitted testimony #35022.

3:19 p.m. Carlotta McCleary, Executive Director of Mental Health America of ND and ND Families for Children's Mental Health, testified in favor and submitted testimony #35379.

3:24 p.m. Susan M. Finneman, resident of Bismarck, ND, testified in favor and submitted testimony #35373.

3:31 a.m. Dylan Wheeler, Head of Government Affairs for Sanford Health Plan, testified in opposition #37866, #37867.

4:00 p.m. Megan Hruby, Blue Cross Blue Shield of ND, testified in opposition #37488.

4:22 p.m. Michelle Mack, Senior Director, State Affairs of the Pharmaceutical Care Management Association (PCMA), testified in opposition and submitted testimony #35369.

4:25 p.m. Alexander Kelsch, lobbyist on behalf of AHIP, testified in opposition and submitted testimony #35356.

4:30 p.m. Chrystal Bartuska, ND Insurance Department, testified in neutral.

4:34 p.m. Mike Schwab, ND Pharmacist's Association, testified in neutral.

4:43 p.m. Chrystal Bartuska, ND Insurance Department, testified in neutral.

Additional written testimony:

Joan M. Connell, submitted testimony #35420 in favor.

Sarah Lanford, Associate Director of the Association for Clinical Oncology, submitted testimony #34513 in favor.

Kirsten Dvorak, Executive Director of Arc of ND, submitted testimony #34639 in favor.

Courtney McNamee, Altru Health System, submitted testimony #34651 in favor.

Cindy K. Flom-Meland, President APTA ND, submitted testimony #34816 in favor.

Todd Neiss, Business Manager of Bismarck Surgical Associates LLC, submitted testimony #34818 in favor.

Janelle Moos, Associate State Advocacy Director of AARP ND, submitted testimony #35041 in favor.

Shelly A. Ten Napel, CEO of Community Healthcare Association of the Dakotas (CHAD), submitted testimony #35269 and #35270 in favor.

Aaron Smith Heigaard, ACC North Dakota-Great Plains Chapter, submitted testimony # 35277 in favor.

Allen Hager, President of the ND Chiropractic Association, submitted testimony #35305.

Brenda Bosch, Clinic Manager of the Pain Treatment Center and Anesthesiologists PC, submitted testimony #35341 in favor.

Ben W. Hanson, Government Relations Director for the American Cancer Society Cancer Action Network, submitted testimony #35352 and #35353 in favor.

Bobbie Will, resident of Bismarck, ND, submitted testimony #35371 in favor.

Alex Young, Legislative Director for the American Council of Life Insurers, submitted testimony #34635 in opposition.

Marcus P. Caruso, Government Affairs Principal of Prime Therapeutics, submitted testimony #35358 in opposition.

4:44 p.m. Chairman Barta adjourned the meeting.

Audrey Oswald, Committee Clerk

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY
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February 4, 2025

Senator Jeff Barta, Chair
Senate Committee on Industry and Business
Fort Union Room, State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chair Barta and Members of the Senate Committee on Industry and Business,

The Association for Clinical Oncology (ASCO) is pleased to support **SB 2280**, which establishes guardrails around prior authorization processes in the state.

ASCO is the world's leading professional society representing physicians who care for people with cancer. With over 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality cancer care.

Prior authorization requires patients or their providers to secure pre-approval as a condition of payment or insurance coverage of services. In a recent ASCO survey, 80% of respondents said that a patient has experienced significant impacts on their health, such as disease progress, because of prior authorization processes. The most common harms to patients include delays in treatment (95%) and diagnostic imaging (94%), patients being forced onto second-choice therapy (93%) or denied therapy (87%) and increased out-of-pocket costs (88%). These survey results confirm that prior authorization results in unnecessary delays or denials of cancer care.

ASCO is committed to supporting policies that reduce cost while preserving quality of cancer care; however, it is critical that such policies be developed and implemented in a way that does not undermine patient access. Payer utilization management approaches like prior authorization are of particular concern because they represent greater likelihood of raising barriers to appropriate care for individuals with cancer.

ASCO is pleased that SB 2280:

- **Ensures timely access to care** by requiring insurers to respond to a prior authorization request within two working days for nonurgent circumstances and within 24 hours if the request is urgent;
- **Improves the review process** by requiring a physician who makes an adverse decision to notify the patient's physician before making an adverse decision and be available to discuss the basis for denial prior to a peer-to-peer conversation;

- **Accommodates the needs of specialized patient populations** by ensuring all adverse determination appeals are reviewed by a physician within the same relevant specialty as the prescribing physician;
- **Promotes continuity of care** by stipulating that prior authorization for a healthcare service for the treatment of chronic and long-term conditions, such as cancer, must remain valid for 12 months; and
- **Improves transparency** by implementing prior authorization statistic reporting.

ASCO is encouraged by the steps SB 2280 takes toward improving prior authorization in North Dakota, and we welcome the opportunity to be a resource for you. For a more detailed understanding of our policy recommendations on this issue, we invite you to read the ASCO Position Statement: Prior Authorization. Please contact Sarah Lanford at ASCO at Sarah.Lanford@asco.org if you have any questions or if we can be of assistance.

Sincerely,

Eric P. Winer, MD, FASCO
Chair of the Board
Association for Clinical Oncology

February 4, 2025

RE: SB 2280 – Oppose

To whom it may concern,

On behalf of the National Association of Dental Plans (NADP)[1] and the American Council of Life Insurers (ACLI)[2], 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 Is Different

Including dental plans in the prior authorization process would significantly disrupt how the dental market currently operates. Dental plans offer a wide variety of products and benefit designs compared with medical plans. Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventative services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. 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.

In dental, pre-treatment estimates are utilized to develop a treatment plan with a patient. For example, a patient needing multiple root canals could consult with their dentist on a timeline for care based on their dental needs. The dentist in turn could submit a pretreatment estimate to the patient's insurance plan to determine the coverage and medical necessity standards of their coverage. This healthy engagement through a pretreatment estimate allows a patient to receive care covered by their plan and develop a thorough care plan for the dentist.

The 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.[3] The prior authorization process can take as long as three weeks. In turn premiums and

[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

[2] 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.

[3] 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

cost of care may increase to meet the expanding administrative costs, feeding a cycle of cost increases that harms access to care and outcomes. For example, 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.

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 a 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,

Bianca Balale
Director of Government Relations
National Association of Dental Plans

Alex Young
Legislative Director
American Council of Life Insurers

The Arc
North Dakota

Industry and Business
SB 2280
February 5th, 2025

Chairman Barta and members of Industry and Business,

My name is Kirsten Dvorak, and I represent The Arc of North Dakota, an organization dedicated to promoting and protecting the human rights of individuals with intellectual and developmental disabilities (IDD). For 65 years, we have advocated for inclusive services that empower individuals with disabilities to lead meaningful, independent lives in their communities.

We are writing to express our support for Senate Bill No. 2280, which aims to enhance transparency, accountability, and timeliness in the prior authorization process for health and dental insurance. This legislation is crucial for individuals with IDD, who often face unnecessary delays and denials when seeking essential medical care.

Individuals with IDD rely on specialized therapies and ongoing medical treatments to maintain their health and independence. Delays in prior authorization can lead to serious consequences, including disruptions in treatment and worsening health outcomes. By mandating prior authorization decisions within two business days for non-urgent cases and within 24 hours for urgent cases, this bill helps prevent harmful delays for those requiring continuous and immediate care.

Additionally, Senate Bill 2280 ensures that prior authorizations for chronic conditions remain valid for 12 months. This change reduces the administrative burden on families and providers, who would otherwise have to reapply frequently. Many individuals with IDD need lifelong management for conditions such as epilepsy, cerebral palsy, and other complex medical issues. Disruptions in authorization can lead to severe setbacks, including hospitalizations, loss of function, increased pain, and a diminished quality of life. Caregivers and families already navigate a challenging healthcare system, and added administrative hurdles increase stress and financial strain, making it harder to provide consistent, high-quality care.

This bill creates essential safeguards against these disruptions by streamlining the prior authorization process and supporting long-term stability for individuals with IDD and their support networks.

In addition, the bill guarantees continuity of care by honoring prior authorizations for at least 60 days when an enrollee changes insurers. This provision prevents unnecessary service interruptions that could result in health deterioration. Additionally, protections against retrospective denials ensure that once approval is granted, it cannot be revoked for 45 business days, providing individuals and families with peace of mind and stability in their care.

Eliminating prior authorization for emergency medical services ensures individuals with IDD receive timely care without bureaucratic delays—the Arc of North Dakota advocates for equitable and accessible healthcare. Senate Bill 2280 reduces administrative barriers, simplifying access to essential services for individuals with IDD.

I urge the committee to support Senate Bill 2280 and prioritize the health and well-being of North Dakotans with disabilities.

Kirsten Dvorak
Executive Director
The Arc of North Dakota
701-222-1854

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

APTA North Dakota
A Chapter of the American Physical Therapy Association

February 4, 2025

Chairperson/Senator Barta and Members of the Committee,

I am a licensed physical therapist from Grand Forks. I am submitting this written testimony on behalf of APTA North Dakota, the membership association of physical therapists and physical therapist assistants in North Dakota. I currently serve as president for this association.

I appreciate the opportunity to submit this written testimony in support of Senate Bill 2280, which aims to improve the prior authorization process in healthcare. As a healthcare provider, I have witnessed firsthand how the current system creates unnecessary barriers to timely and effective patient care.

Prior authorization was originally intended as a cost-control measure for insurers, but over time, it has become an excessive administrative burden for providers and a significant obstacle for patients in need of essential treatments. On average, physicians and their staff spend nearly two full business days per week completing prior authorization requests, with 92% of providers reporting that the process results in care delays. Additionally, 33% have witnessed serious adverse events due to these delays, and 80% have seen patients abandon treatment altogether because of prior authorization hurdles.

Senate Bill 2280 proposes common-sense reforms to address these issues. By standardizing definitions, ensuring prior authorizations for maintenance medications remain valid for at least one year, and requiring timely insurer responses—24 hours for urgent care and two business days for non-urgent cases—this bill will improve patient outcomes and reduce administrative burdens on healthcare professionals. Furthermore, requiring licensed physicians of the same specialty to review requests will ensure more informed and fair decision-making.

Twenty-three states have enacted over 43 bills addressing prior authorization reform in recent years, signaling broad bipartisan recognition of the need for change. Senate Bill 2280 aligns with these efforts to ensure that patients receive timely, necessary care without undue delay. I urge you to vote YES on this critical piece of legislation.

Thank you for your time and consideration.

Sincerely,

Cindy Flom-Meland

Cindy Flom-Meland, PT, MPT, PhD
Board Certified Neurologic Specialist
President, APTA North Dakota

APTA North Dakota
1301 North Columbia Road, Stop 9037 / Grand Forks, ND 58202 / 701-777-3873 / info@aptand.com

Bismarck Surgical Associates

2025 Senate Bill No. 2280

Prior Authorization Legislation

Chairman Barta and Members of the Committee:

The Physician Owners of Bismarck Surgical Associates, LLC Same Day Surgery Center ask for your consideration and support of Prior Authorization Senate Bill 2280.

The purpose of Prior Authorizations, while initially making sense, has gone far beyond their initial intent and has become a tool for Insurance Companies and Third-Party Payers to deny care that many of North Dakota's Citizens need from a medically necessary standpoint. A more appropriate take on this is Payers deny payment for services that are already performed, meaning the Patient received the care that was needed, and the Providers don't get paid for those services because the Insurance Company has policies in place requiring prior authorization that allow them to deny payment.

The challenge with this, as is so often with surgery, is the Surgeon may find something during the surgery that needs to be fixed that wasn't prior authorized. They will fix it because that is the right thing to do versus performing only what was Authorized and having the patient come back to have the other issue fixed at a later date requiring additional recovery etc. just to meet the Insurance Companies requirements.

This Senate Bill forces the Insurance Companies to follow certain guidelines that will hopefully improve the prior authorization process and outline the process for appeal. Often the person behind the scenes who processed the denial in the first place is the same one who reviews an appeal and 9 times out of 10 will uphold their initial decision. Requiring someone new to review the appeal is a step in the right direction. Providers need regulations such as this to help stand up against the 800 Pound Gorilla that is the Insurance Industry.

Thank you for your time and consideration.

Respectfully,

Chad Carlson
President

Senate Industry Business & Labor
SB 2280
February 5, 2025

Chairman Barta and respected committee members,

I'm Dr. J'Patrick Fahn and have been practicing medicine for over 18 years.

It should be fairly evident that prior authorization is being recognized, across America, as a concern. Recent events have definitely shed light on this. People across the country, including here in North Dakota, are desperate for change in this area due to examples such as the summaries below:

1. **Delay in Cancer Treatment:** A woman with an aggressive form of breast cancer was prescribed a targeted therapy drug by her oncologist. However, her insurance company denied prior authorization, requiring her to try a less expensive, older chemotherapy regimen first. This delay allowed the cancer to progress, reducing the effectiveness of the targeted therapy when it was finally approved.

2. **Interruption of Mental Health Medication:** A young man with bipolar disorder found a medication that effectively managed his mood swings and allowed him to function normally. However, his insurance company denied prior authorization, insisting he try a series of older, less expensive medications first. This forced him to endure weeks of debilitating mood episodes, impacting his ability to work and maintain relationships.

3. **Denial of Physical Therapy:** A senior citizen recovering from a stroke was prescribed a course of intensive physical therapy to regain lost mobility. However, her insurance company denied prior authorization, citing cost concerns and a lack of "medical necessity." This denial hindered her recovery progress,

leaving her with limited mobility and decreased independence.

These are just a few examples of how prior authorization can fail patients. While intended to control costs and ensure appropriate care, the process often creates unnecessary barriers, delays critical treatments, and ultimately harms patients.

The American Society for Radiation Oncology (ASTRO) recently released a nationwide survey of more than 750 radiation oncologists, which confirms that prior authorization harms people with cancer by causing treatment delays, abandoned treatments, hospitalizations, and patient deaths.

https://www.astro.org/ASTRO/media/ASTRO/News%20and%20Publications/PDFs/PriorAuthSurvey_2024ExecutiveSummary.pdf

Prior authorization is a tool intended to control costs and ensure appropriate care. Just like any tool, safeguards are sometimes needed. Take a look at a table saw. Tables are an important piece of equipment for carpenters and both amateur and professional woodworkers. Table saw safeguards include SawStops, blade guards, and antikickback devices, to name a few. I don't need to tell you the risks of ignoring the safeguards.

I believe that prior authorizations were created with good intentions and as another layer to help prevent patients from receiving treatments they don't need. However, when this tool, just like any other tool, is put in the wrong hands, it can be used, potentially, for a purpose that deviates from its original intended purpose. So, we find ourselves here today.

This bill puts in place some safeguards to ensure that the tool will still function as intended but hopefully reduces the risk of hurting people. For example, you don't put a reciprocating saw blade on a table saw so why would an orthopedic surgeon do a peer to peer prior authorization for a gynecologist?

The recent public outcry should be indication enough that this tool is not working correctly. If prior authorization were a physical product that you could purchase for your home at a local small business, it would have already been recalled.

I implore you to listen to the testimony of the real people, country wide and right here at home, who have been affected by the delays and denials that the current prior authorization processes have caused. I think you would be hard-pressed to find a

patient who would insist that the current prior authorization process has saved their life or changed it in a meaningfully positive way.

To close, at least 23 states already have some form of prior authorization reform in place and many more are working on it. And, while I believe that this bill is not nearly comprehensive enough, this bill puts North Dakota at the forefront as a leader in prior authorization reform and you have my gratitude for that.

I kindly ask for your support for SB 2280.

With appreciation,

J'Patrick Fahn, DO

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

Chairman Barta and members of the Industry and Business Committee. I am Marcus Lewis, CEO of First Care Health Center in Park River. Thank you for the opportunity to testify in support of Senate Bill 2280, which addresses the burdens of prior authorization in healthcare. I am testifying on behalf of the North Dakota Hospital Association (NDHA), which represents hospitals and health systems across the state.

I previously testified on prior authorizations to the Interim Healthcare Committee in November 2023. During that testimony, I discussed the difference between the intention and the impact of prior authorizations in healthcare, especially for rural facilities like First Care. As stated in my previous testimony, prior authorization policies create direct negative impacts on patient care, such as delaying care and placing additional stress not only on the patient but also on the healthcare provider. These policies result in dangerous delays in care, contribute to clinician burnout, and drive-up costs for the healthcare system. Furthermore, they impose bureaucratic obstacles that interfere with timely patient treatment, ultimately jeopardizing patient health.

At First Care, we have seen firsthand the consequences of these delays.

For primary care and outpatient, these requirements have delayed critical diagnostic procedures, including CTs and MRIs. These delays further exacerbate conditions and postpone necessary treatment, contrary to evidence-based medical practice. Despite having the capability to provide timely care, we are seeing significant setbacks in medically necessary services.

We have also noticed an increase in third-party involvement in authorizations, particularly within narrow network plans. For example, one patient missed two weekly opportunities to complete an MRI onsite at our facility and was ultimately forced to drive over an hour for the procedure versus waiting for our Mobile Imaging next Monday.

In outpatient infusions, delays in authorization disrupt essential treatments that help keep patients out of acute and emergency care settings. These delays in care are not conducive to an effective primary care environment, population health management, and our Patient-Centered Medical Home model.

Prior authorization delays result in unnecessarily prolonged hospital stays. We have had multiple cases, received authorization – whether approval or denial - three days after a patient had been discharged or transferred to swingbed care. Preauthorization requests for swingbed care before a final determination from acute are often automatically denied. This puts our organization in a predicament: keep the patient in acute while waiting for swingbed approval, or we take the risk of denial by transitioning the patient without approval.

In another example, we have patients ready for transfer, with an available bed at our facility and a tertiary hospital eager to free up space - yet the transfer is delayed for days due to preauthorization requirements. In some cases, insurers provide only a seven-day authorization for swingbed services. However, the approval process for extending the stay can take up to two weeks. This results in a significant gap in coverage for both patients and our organization.

For all of these authorizations, peer-to-peer requests are becoming more frequent. These peer-to-peer calls are not conducive to rural providers. They are usually required within 24 hours, with little to no notice, pulling our family practice providers away from primary care visits to address bureaucratic hurdles instead of treating patients.

When a denial is received, it is up to us as the provider to deliver this news to the patient, adding unnecessary stress and confusion. We are also responsible for executing the appeal process, with extremely limited and ambiguous time limitations. Providing the appropriate care for the patient should not put the financial health of the facility at risk.

For me personally, it comes down to accountability and trust. When I go to see my primary care provider, I trust that they are ordering the appropriate diagnostic, treatment, and medications for my condition. Why does my insurer not have the same faith in our Board-Certified MDs, DOs, FNPs, and PAs? If there is an accountability concern, why isn't the issue addressed with those respective boards, versus the impact of patient care delivery?

As value-based care progresses throughout healthcare, the total risk factor of wellness moves from the payor to provider. This continues through full capitation payments to providers, based on clinical coding and documentation. Prior authorization requirements

impede this transition, removing trust and stewardship from the care team and Primary Care Provider.

We urge you to support Senate Bill 2280, which takes necessary steps to remove unnecessary barriers to timely patient care, hold insurers accountable, and align policies with the realities of rural healthcare delivery. These guidelines will enhance accountability, improve patient care, and ensure that healthcare providers can focus on what truly matters—caring for their patients.

Thank you for your time and consideration.

Respectfully Submitted,

Marcus Lewis, CEO
First Care Health Center

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

Chairman Barta and members of the Senate Industry and Business Committee, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I am here to testify in support of Senate Bill 2280. I ask that you give this bill a **Do Pass** recommendation.

The North Dakota Hospital Association represents 46 hospitals in the state. These members include large hospitals, critical access hospitals, and specialty hospitals. Our members appreciate the opportunity to speak to you about their concerns with the prior authorization process used by health plans. We support the goals of the bill which are to standardize the prior authorization process and align it with best practices.

Prior authorization is a cost-control measure that requires health care professionals to obtain health plan approval before delivery of the prescribed treatment, test, or medical service to qualify for payment. While prior authorization can play an important role in ensuring the necessity of a health care service or prescription and containing costs, overly burdensome requirements can prevent or delay patients' access to necessary care. Overly strict prior authorization requirements also require health care providers to spend inordinate amounts of time to comply with these requirements, which drives increased administrative costs and is rated as one of the top reasons for provider burnout. This is why states around the country have adopted reforms that ensure prior authorization is used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients and health care providers.

Prior authorization requires patients or their providers to secure pre-approval as a condition of payment or insurance coverage of services. Patients experience significant health impacts, such as delayed treatment, denied care, second-choice therapy, and disease progression, because of overly restrictive prior authorization processes. Hospitals

are committed to policies that reduce cost while preserving quality health care but they do not support practices that improperly delay or deny care and undermine patient access.

We support the bill's provisions to reduce overall healthcare provider and patient burden through improvement to prior authorization practices. The bill ensures timely access to care by requiring insurers to respond to a prior authorization request within two working days for nonurgent circumstances and within 24 hours for urgent health care services. It improves the process by requiring a physician who makes an adverse decision to notify the patient's physician before making an adverse decision and be available to discuss the basis for denial prior to a peer-to-peer review. It would ensure that adverse determination appeals are reviewed by a physician in the same specialty as the treating physician. We also support requiring prior authorization to remain valid for 12 months for patients with chronic and long-term conditions. It will also improve transparency by requiring data reporting annually, including the total number of prior authorization requests received; number of authorizations issued; number of adverse determinations issued; number of adverse determinations reversed on appeal; and the reasons an adverse determination was issued.

Thank you for your consideration of this bill. We ask that you give it a **Do Pass** recommendation.

To provide you with more information about how prior authorization practices affect hospitals in day to day care of patients, I would now like to introduce Marcus Lewis, CEO, of First Care Health Center in Park River, ND.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

Testimony of Shane Goettle
On Behalf of the American Cancer Society-Cancer Action Network
Senate Industry and Business Committee
Chairman Senator Jeff Barta

Senate Bill 2280

Chairman Barta, members of the Senate Industry and Business Committee, my name is Shane Goettle, and I am here today on behalf of the American Cancer Society-Cancer Action Network to testify in strong support of Senate Bill 2280.

This legislation is crucial in addressing the systemic barriers created by the current prior authorization process, which often delays access to medically necessary care for patients, including those battling cancer.

When prior authorization was first introduced, it was intended as a safeguard to ensure that high-cost medical procedures and treatments were necessary and appropriate. However, over time, this process has evolved into an overused bureaucratic hurdle that affects even the most routine treatments. According to a 2023 survey conducted by the American Medical Association:

- 92% of physicians report that prior authorization results in care delays, posing a significant risk to patient health.
- 33% report that delays in authorization have led to serious adverse events for their patients.
- 80% indicate that prior authorization requirements contribute to treatment abandonment.

For cancer patients, these statistics are not just numbers; they represent real people facing life-threatening illnesses who are being forced to wait for care while their insurance company reviews requests that should be standard.

For patients undergoing chemotherapy, radiation, or other critical treatments, timely access to care is not a luxury—it is a necessity. Prior authorization delays can mean the difference between a treatment being effective or ineffective, particularly in aggressive cancers where every day counts. Cancer patients cannot afford to wait days or weeks for an insurance company to determine whether their prescribed treatment is necessary.

Moreover, requiring re-authorization for medications that patients have already been using successfully for years adds unnecessary stress to individuals already dealing with the emotional and physical toll of a cancer diagnosis.

SB 2280 introduces several key reforms to address these issues:

1. **Standardized Definitions and Transparency** – The bill ensures uniformity in how "prior authorization" and "medical necessity" are defined, reducing ambiguity and streamlining the approval process.

2. **Extended Validity for Prior Authorizations** – A prior authorization for maintenance medications will be valid for at least one year, eliminating redundant paperwork and preventing unnecessary delays.
3. **Timely Decision-Making** – Insurers must respond to urgent prior authorization requests within 24 hours and non-urgent requests within two business days, ensuring that patients receive the care they need when they need it.
4. **Peer Review by Qualified Specialists** – The bill mandates that prior authorization denials must be reviewed by a physician within the same specialty or subspecialty as the treating provider, reducing the likelihood of inappropriate denials.
5. **Online Accessibility and Transparency** – Health insurers will be required to post all prior authorization procedures and lists of services subject to prior authorization on their websites to provide clear guidelines for patients and providers.

Reforming prior authorization is a national trend. According to the National Conference of State Legislatures, 23 states have enacted over 43 bills in recent years to address this issue, with 18 new laws passed in 2024 alone. North Dakota must act now to ensure that our patients receive timely, appropriate care without unnecessary bureaucratic obstacles.

Conclusion:

On behalf of the American Cancer Society-Cancer Action Network and the countless cancer patients affected by prior authorization delays, I urge you to support Senate Bill 2280. This legislation will not eliminate prior authorization, but it will ensure that the process is transparent, efficient, and, most importantly, does not put patients' health at risk.

I appreciate your time and consideration and respectfully ask for a Do Pass committee vote on SB 2280. Thank you, and I am happy to answer any questions.

Senate Bill 2280 – Support
February 5, 2025
Senate Industry, Business and Labor Committee
Janelle Moos, AARP ND jmoos@aarp.org

Chairman Barta and Members of the Committee,

My name is Janelle Moos, Associate State Director of Advocacy with AARP North Dakota. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. Approximately 82,000 of those members live in North Dakota.

Prior authorization, as you may already know, is preapproval for medical services or prescription drugs that health insurance plans often require before they'll cover the cost. Plans put these requirements in place to avoid paying for unnecessary services or expensive procedures and drugs when a lower-cost version that's available could work just as well.

Prior authorization also lets patients know ahead of time if their plan will approve something that's not always covered rather than having to appeal a denial after the fact. But how often and under what circumstances prior authorization is required depends on the health plan. For example, while original Medicare has a few prior authorization requirements, private Medicare Advantage plans and Part D prescription drug plans use this procedure more often.

A new study by KFF, formerly the Kaiser Family Foundation, released in August 2024, found Medicare Advantage prior authorization requests increased significantly from 37 million in 2019 to more than 46 million in 2022. The share of denied prior authorization requests also increased after several years of being stable, from 5.8 percent in 2021 up to 7.4 percent in 2022. What's more, KFF uncovered that the majority of denials in Medicare Advantage plans were overturned on appeal.

Two important sections of SB 2280 that align with AARP policy pertains to transparency and putting guardrails in place for who conducts prior authorization reviews and the process by which they are conducted. Our policy that supports authorization/ utilization review relates primarily to Medicare Advantage, but can be applied to the broader health insurance market including:

- Adverse UR decisions must be made by clinically qualified personnel and reviewed by active practitioners in the same or similar specialty. Reviewing clinicians need not be residents of the state where the enrollee whose claim is being reviewed resides. Reviewers must not receive financial compensation based directly or indirectly on the number or volume of certification denials.
- Certification decisions must be made at least as rapidly as the medical situation requires to protect the beneficiary's health and permit a meaningful appeal. Denials must be accompanied by clear information on the reasons for denial as well as instructions on how to appeal the denial. https://policybook.aarp.org/policy-book/health/section-c-medicare/medicare-part-c-medicare-advantage-ma-private-plans/medicare-advantage-standards#node-18896

SB 2280 also prohibits prior authorization for emergency services, which also lines up with AARP policy:

- Patients should be covered for all necessary care associated with the emergency. Health plans should be prohibited from requiring prior authorization for emergency services. https://policybook.aarp.org/policy-book/health/section-c-medicare/medicare-part-c-medicare-advantage-ma-private-plans/medicare-advantage-standards#node-18896:

Inappropriate prior authorization denials can have serious health implications for MA enrollees, especially those with significant medical needs. By delaying or preventing access to medically necessary care, the often-lengthy pre-approval process can disrupt care delivery or lead people to abandon their treatment. It can also result in serious adverse events such as hospitalization or even death. In other cases, improper coverage denials create a significant financial barrier to accessing medical services ordered by a health care provider because, without insurance, therefore, we urge you to look favorably upon SB 2280.

Thank you.

Community HealthCare Association of the Dakotas

Testimony:
Senate Bill 2280
Senate Industry and Business Committee
Senator Jeff Barta, Chair
February 5, 2025

Chairman Barta, Vice Chairman Boehm, and Members of the Committee:

I am Shelly Ten Napel and I am the CEO of Community HealthCare Association of the Dakotas (CHAD). On behalf of CHAD and our member health centers I am asking for your support of SB 2280 with a do pass recommendation.

CHAD is a non-profit membership organization that serves as the Primary Care Association for North Dakota and South Dakota, supporting community health centers across both states in their efforts to provide health care to underserved and low-income populations. The health centers we represent have locations in both urban and rural communities.

Community health centers (CHCs) are non-profit, community-driven primary care clinics that serve all individuals, regardless of their insurance status or ability to pay. The community health center integrated care model includes primary care, mental health and substance use treatment, dental care, pharmacy services, and a range of case management services that can include help with transportation, finding community resources, or assistance with insurance and financial enrollments.

North Dakota is home to five community health center organizations that provide comprehensive, integrated care to more than 36,000 individuals with over 126,000 visits at 22 locations in 20 communities across the state. Nearly 40% of those patients have Medicaid; 31% utilize private insurance; and 16% are uninsured; Over half earn incomes below the federal poverty level. I've included an attachment that indicates where health centers are located and what services they offer in North Dakota.

Our member health centers have expressed several concerns with the prior authorization process of commercial insurance plans and North Dakota Medicaid, including delays to urgently needed care and medications and a significant amount of staff time invested in securing authorizations that drive up the cost of health care and reduce staff satisfaction.

Delayed approval of prior authorization leads to delays in patient care. Patients being

treated for emergent health and mental health disorders typically need medications urgently and don't have time to wait for a lengthy prior authorization process. Health centers indicated that a reduction in the response time and a consistently applied time limit for the authorization process, as included in SB 2280, would help alleviate some of the barriers to care they are currently experiencing.

With the integrated care model health centers offer, they have many patients who need mental health and substance use treatment. For these patients, barriers to medication can sometimes be the difference between life and death. One health center specifically pointed to their patients experiencing distress such as those who are suicidal and postpartum patients with psychosis, and how delays in medication could be especially harmful or even fatal.

Health center providers indicate they spend a significant amount of time on the prior authorization process, which reduces the time they are able to spend in patient care. Kayla Abrahamson, DNP, FNP-C, a family practice nurse practitioner at Northland Health Centers in McClusky has this to say about prior authorization: "The time it takes to complete prior authorization for patients is significant, taking away from direct patient care and contributing to provider burnout." She continues "One of the major challenges we face today is the lack of staff available to assist with completing these prior authorization requests, which places an undue burden on providers whose time could be better spent focusing on treating patients. Urgent action is needed to streamline these processes, reduce administrative burdens, and prioritize patient care.".

On behalf of our member health centers, I ask for your support of Senate Bill 2280 to improve the prior authorization process.

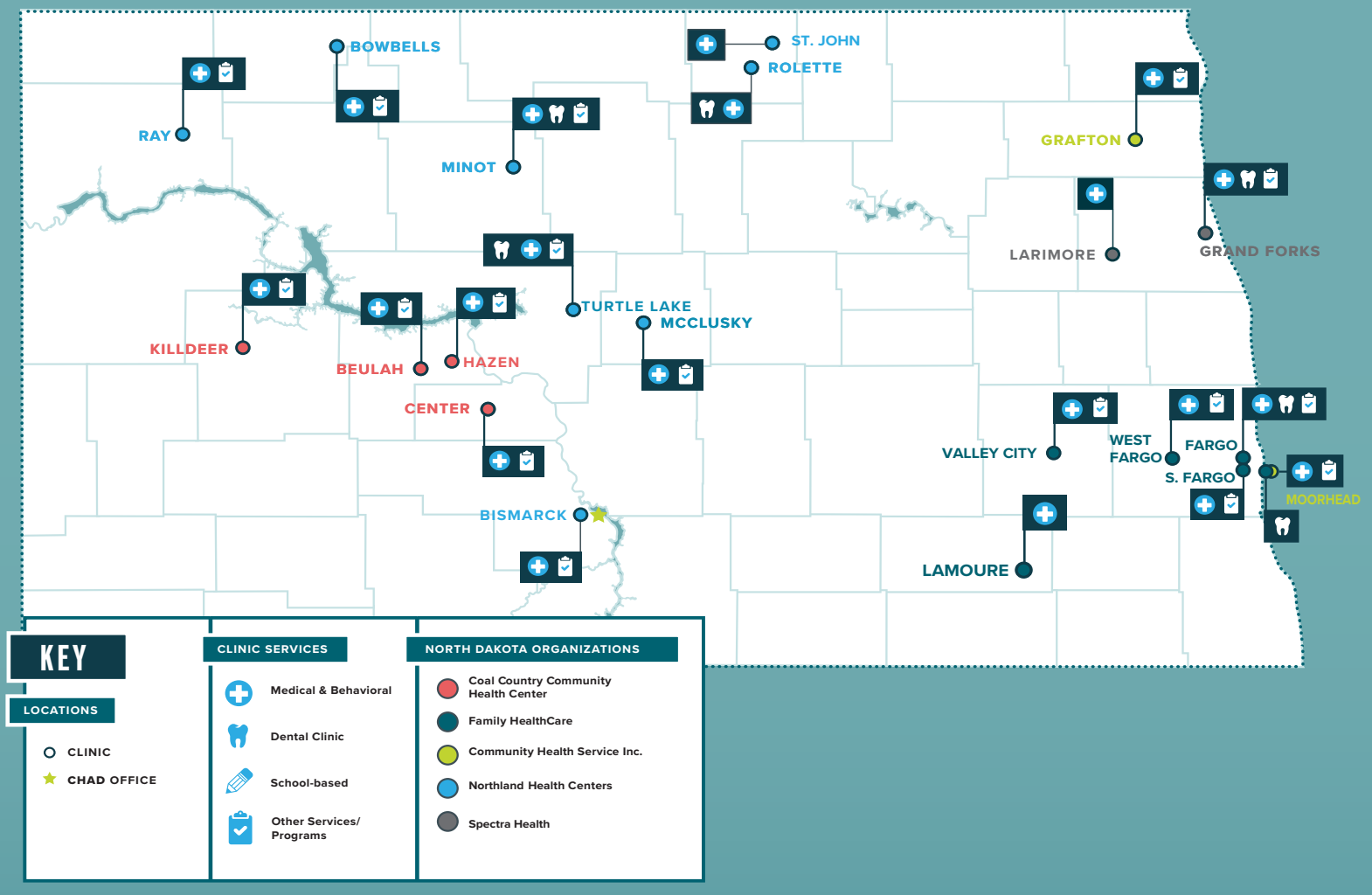
Respectfully submitted,

Shelly Ten Napel, CEO
Community HealthCare Association of the Dakotas

CHAD

WHAT IS A COMMUNITY HEALTH CENTER?

Community health centers (CHCs) are non-profit, community-driven primary care clinics that provide high-quality primary and preventive care to all individuals, regardless of their insurance status or ability to pay. Health centers are located in underserved and low-income urban and rural areas across North Dakota, providing access to affordable, quality health care for those who need it most. The centers serve as essential medical homes where patients can receive a wide array of services including medical, behavioral, and dental care along with help with transportation, interpretation, and other case management and care coordination services. In rural communities, health centers support a community's ability to retain local health care options, supporting access to health care where rural Dakotans live and work. North Dakota's network of five health center organizations provides care to over 36,000 patients each year at 22 locations in 20 communities across North Dakota.



NORTH DAKOTA PATIENTS

Source: 2023 UDS Preliminary Reports

PATIENTS BY POVERTY LEVEL

- < 100%: 42.4%
- 101%-150%: 13.6%
- 151%-200%: 8.4%
- > 200%: 35.6%

This represents a distribution of patients for whom income is known. Income is unknown for 47.0% of patients.

TOTAL PATIENTS 36,376

37.9% of total patients served are people of color

PATIENTS BY PAYOR SOURCE

- MEDICAID: 39.5%
- MEDICARE: 13.1%
- UNINSURED: 16.1%
- PRIVATE: 31.2%

ECONOMIC VIABLILITY

Source: Calculations based on 2023 UDS Reports

In addition to the actual dollars that flow to local communities through health centers, their role in maintaining access to health care can have an enormous impact on the long-term economic viability of rural and urban communities throughout North Dakota. For our smaller communities, access to local health care is crucial to a town's ability to recruit new companies and maintain a healthy workforce without long out-of-town trips to the doctors or to pick up prescriptions. When a small town is able to retain access to health care, it can serve as a main street anchor, keeping other small businesses viable. Across rural and urban communities, CHCs keep health care affordable by providing health care services regardless of ability to pay and by helping patients find health coverage options that are right for them.

STATEWIDE IMPACT

North Dakota CHCs had a total annual economic impact on the state of

$101,966,207 IN 2023

NORTH DAKOTA CHCs DIRECTLY GENERATED:

387 full-time jobs

AND SUPPORTED AN ADDITIONAL

229 jobs in other business

616 total jobs

This document is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $1,423,637, with 0 percent financed with non-governmental sources. The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS, or the U.S. Government. For more information, please visit HRSA.gov.

GREAT PLAINS CHAPTER
AMERICAN COLLEGE of CARDIOLOGY®

February 5, 2025

Dear Chair Barta and Members of the Senate Committee on Industry and Business,

Good afternoon, my name is Aaron Smith. I am a practicing cardiologist at Sanford Health in Fargo, as well as a member of the North Dakota-Great Plains Chapter of the American College of Cardiology (ACC). Today, I am testifying on behalf of the North Dakota-Great Plains Chapter to lend our full support to **Senate Bill 2280.**

Prior authorization is a utilization management process that requires healthcare providers to obtain approval from insurance companies before prescribing a specific medication or delivering certain types of care. Prior authorization is overused, and existing processes present significant administrative and clinical concerns. A study from the American College of Cardiology found that 77 percent of providers spent less time on patient care because they were dealing with the documentation involved in the prior authorization process. Senate Bill 2280 is a positive step to streamline prior authorization requirements so that patients can receive timely, quality, medical care.

One of the central provisions of Senate Bill 2280 is the modification of the timeframe in which an insurer must decide on a prior authorization request or an adverse determination (denial). Under Senate Bill 2280, insurers must make these decisions more promptly, aiming to reduce delays that could affect patient care. On several occasions, my patients have directly experienced hardship and frustration as a result of untimely decision-making with regard to prior authorization from insurers. I have patients who have been scheduled for cardiac stress testing only to find out that their test has been denied by insurance when they arrive. This puts patients in a position where they have to decide whether to pay for the test out-of-pocket, not knowing what the cost to them will be, or not undergo testing and potentially put their health at risk. Additionally, this legislation mandates that if a denial is made, the insurer must provide clear reasoning for the decision and inform patients about their right to appeal.

I urge the committee to pass Senate Bill 2280. The state's current prior authorization guidelines are contributing to greater physician burnout, reduced employee productivity, and significant costs incurred across the entire healthcare system. It is time to put patients first and ensure all North Dakotans receive the quality healthcare they deserve, without unnecessary obstacles.

Thank you.

Aaron Andrew Heigaard Smith, MD, FACC, FACP
ACC ND-Great Plains Member
Advanced Imaging Cardiologist
Sanford Health - Fargo
aaron.ah.smith@gmail.com

NORTH DAKOTA
Chiropractic Association

2025 Senate Bill 2280
Senate Industry and Business Committee
Senator Jeff Barta, Chairman
February 5, 2025

Chairman Barta and members of the Senate Industry and Business Committee, I am Dr. Allen Hager, a practicing chiropractor in Fargo. I am currently the President of the North Dakota Chiropractic Association (NDCA), and on behalf of the organization, I testify in support of Senate Bill 2280 and ask that you give the bill a **Do Pass** recommendation.

The NDCA represents chiropractors, who more commonly privately own and operate their clinical practices. Disjointed and changing prior authorization processes increase administrative waste and significantly burden small practices. Administrative waste is a significant driver of rising healthcare costs and increases provider burnout. These administrative hurdles have a negative impact on patient care, too, further establishing the need for industry standardization.

Healthcare providers utilize the standard of practice for healthcare services in any setting to identify a patient's condition and make an immediate plan of care that can be initiated as soon as possible, preferably during the initial encounter. Delaying implementation of the care with unnecessary reviews can adversely impact the patient's return to function and ultimately increase the overall cost of care. Delays in care associated with prior authorization have real consequences.

Performing utilization management, including prior authorization, should protect against fraud, waste, and abuse. They should not interrupt the flow of care. Providers need consistent processes, published rules, and predictable outcomes when engaging in necessary utilization management programs.

SB 2280 is a commonsense approach that allows chiropractors to continue to do what they do best. It's time to end the distractions and interference from disjointed and burdensome prior authorization processes. Please support SB 2280 with a **Do Pass** recommendation.

Respectfully,

Allen Hager, DC
President, North Dakota Chiropractic Association

Essentia Health

Senate Industry and Business Committee
SB 2280
February 5, 2025

Chairman Barta and committee members:

Essentia Health submits this testimony in strong support of SB 2280, a bill that creates a regulatory framework that ensures prior authorization is used consistently, efficiently, and in a manner that ensures access to timely care.

Essentia Health is an integrated health system serving patients in Minnesota, North Dakota, and Wisconsin. Headquartered in Duluth, Minnesota, Essentia Health combines the strengths and talents of more than 15,500 employees, including more than 2,350 physicians and advanced practitioners, who serve our patients and communities at our 14 hospitals, 80 clinics, six long-term care facilities, six assisted living and independent living facilities, 7 ambulance services, 29 retail pharmacies, and one research institute.

Prior authorization was originally created to ensure that medical treatments and medications are used appropriately and cost-effectively. By requiring approval before certain services are provided, the process aims to prevent unnecessary or potentially harmful treatments, promote the use of evidence-based care, and control healthcare costs, ultimately safeguarding patient health and ensuring the sustainability of healthcare resources.

While prior authorization was designed to ensure appropriate and cost-effective use of medical treatments, overly burdensome and unregulated prior authorization requirements delay necessary patient care and drive administrative costs and provider burnout. Unchecked prior authorization also allows critical medical decisions to be made by insurance company analysts or algorithms – not licensed medical professionals.

When care is delayed, patients need more aggressive, expensive treatments, longer hospitals stays, and emergency interventions – all of which drive up health care costs. Furthermore, the added administrative burden placed upon physicians by prior authorization is the leading cause of burnout, and it makes recruiting and retaining doctors more difficult, especially in our rural communities.

There are several ways that prior authorization can be improved to better support patient care while maintaining the integrity of the purpose to ensure the most effective treatments are provided at the best possible cost to the patient.

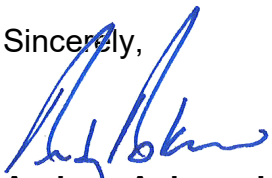
- Standardize and shorten the turnaround time for approvals of prior authorization to 2 business days for nonurgent care and 24 hours for urgent care requests

- Auto-authorize any request that has not had an authorization determination within expected timeframes
- Require same or similar specialty physician reviewers
- Require electronic submission of authorizations, preferably within national interoperability standards
- Require transparency through annual reporting requirements of timeliness of prior authorization decisions and the volumes and rates of authorization denials

Common sense prior authorization reforms will have a significant positive health outcome and financial impact for the citizens of North Dakota who seek healthcare across the state, which is why we strongly support SB 2280. We respectfully request you to join us in this support and to give SB 2280 a DO PASS recommendation.

Thank you for your time and consideration.

Sincerely,



Andrew Askew, J.D., MBA
Vice President, Public Policy
Essentia Health
andrew.askew@essentiahealth.org

PAIN TREATMENT CENTER
ANESTHESIOLOGISTS, P.C.

202 E. Greenfield LN Ste 100 • Bismarck, ND 58503-6597 • 701-223-7822 • Appointments 701-250-7822 • Fax 701-223-7844

Chairman Barta and Members of the Committee:

The physicians of The Pain Treatment Center Anesthesiologists are asking you to seriously consider supporting **2024 Senate Bill No 2280, Prior Authorization Legislation**. This bill will help to ensure healthcare can be provided to our patients and the citizens of North Dakota in the most cost effective and effective manner. The majority of the prior authorizations we perform are for imaging studies and interventional spinal injections and procedures. The volume of authorizations have increased significantly in the last few years as most all insurance payers have created their own set of requirements and limitations for many of these procedures. They have created individual processes that require access to their portals and completion of online questions and documentation uploads to determine if a procedure will be authorized. This process takes significant time and additional staff to complete and patient care can easily be compromised by having to wait several days at times for approval decisions to be made.

As a physician, it is both frustrating and discouraging to develop a treatment plan with a patient after evaluation to be told by an employee of an insurance company, someone that has not seen the patient, that our treatment plan is not authorized. Many times, we are informed the patient has not met the insurance guidelines or needs additional conservative treatments. In most cases, we have already considered this, and do not agree with the response but to challenge this process takes resources that we simply do not have. Many times, the insurance payers will offer a peer to peer phone call to discuss the denial. This takes physician time from the practice to discuss a treatment plan that we have clearly documented and is frustrating to be on a call with someone is usually unaware of the clinic indications for these specialty services. Although these calls can result in overturning the denial, they should not be necessary to begin with and take time away from the practice and our patients.

The American Medical Association has published comprehensive statistics related to care delays, cost, and the inefficiencies the prior authorization process has created within the healthcare system. The AMA statistics are real and part of our daily experience and The Pain Treatment Center Anesthesiologists, and we are submitting this testimony, and asking you to support this legislation to ensure appropriate controls are in place to manage the prior authorization process in North Dakota.

Respectfully,

Dustin Goetz MD Attas Boutrous MD Hugh Carlson MD

MEMORANDUM

TO: INTERESTED PARTIES
FROM: ELIZABETH HARRINGTON, PUBLIC OPINION STRATEGIES
JAY CAMPBELL, HART RESEARCH ASSOCIATES
DATE: MARCH 12, 2019
RE: KEY HIGHLIGHTS FROM NATIONAL SURVEYS OF CANCER PATIENTS/CAREGIVERS AND PHYSICIANS WHO TREAT CANCER PATIENTS

In January 2019, Public Opinion Strategies and Hart Research Associates conducted two national online surveys: one survey among cancer patients and family caregivers of cancer patients; and, one survey among physicians who treat cancer patients (both oncologists and primary care physicians).

The objectives of this research were to explore how existing utilization management (UM) techniques are impacting cancer patients and measure attitudes toward incorporating UM techniques into Medicare drug plans.

Key Highlights:

Experience and Impact of Utilization Management (UM) Techniques

- **One in three cancer patients and caregivers of cancer patients (34%) report experiencing delays in their or their loved one's cancer care because their physician was waiting on approval from their health insurance plan for a cancer treatment, test, or prescription medicine.** Younger cancer patients and caregivers are more likely to report they or their loved one have experienced delays in cancer care (58% among ages 18-44, 28% among ages 45-64, and 17% among ages 65+). Those with private health insurance coverage report much higher levels of delays in their or their loved one's cancer care today compared to those on Medicare (38% of those with private health coverage ages 18-64 and only 14% of those with Medicare ages 65+ report experiencing delays in cancer care due to their health plan).

- **Majorities of physicians' report delays in their patients' cancer care are happening frequently because of having to wait for approval from their patients' health insurance plans.** Physicians were asked how often, on average, they or their cancer patients experience six different situations where their cancer patients' care is impacted by decisions made by health insurance plans. The table on the following page shows the frequency of occurrence among all physicians interviewed.

Physicians Who Treat Cancer Patients (How Often Problems Occur On Average)	Very/Somewhat Frequently	Sometimes	Rarely/Never
You have to wait on the patient's health insurance plan to approve a cancer treatment, test or prescription medication which results in a delay of care for the patient	56%	31%	13%
Your cancer patients are NOT able to afford the prescription medicines for their cancer treatment or side effects because of a decision by their health insurance plan	43%	42%	15%
Your cancer patients are NOT able to get all of the prescription medicines that you or they believed were necessary because of a decision by their health insurance plan	34%	43%	23%
Your cancer patients are NOT able to get all of the tests that you or they believed were necessary because of a decision by their health insurance plan	34%	42%	24%
Your cancer patients are NOT able to get all of the medical care that you or they believed were necessary because of a decision by their health insurance plan	29%	43%	28%
Your cancer patients are NOT able to get all of the treatments that you or they believed were necessary because of a decision by their health insurance plan	26%	46%	28%

- In the survey we asked about four different UM techniques that could be used by health plans regarding prescription drug coverage of cancer prescription medicines. **Nearly all physicians report experiencing these UM techniques on a regular basis with their cancer patients' health insurance plans: requiring prior authorization of prescription medicines, mandatory generic substitution of prescription medicines, limitations on the total amount of a prescription medicine that can be dispensed at one time, and requiring patients to try a lower-cost medication first before the health plan would cover a higher-cost medication. Majorities of cancer patients and caregivers report experiencing prior authorization of Rx during their or their loved one's cancer.**

Experience with UM Techniques Patients/Caregivers: %Yes Physicians: %Very/Somewhat Frequently/Sometimes	All Cancer Patients/Caregivers	All PC/Onc Physicians
Prior authorization/preauthorization of Rx	54%	96%
Rx mandatory generic substitute	44%	90%
Limit amount of Rx dispensed	41%	89%
Try lower cost Rx first	28%	88%

- Younger cancer patients and caregivers are much more likely to report experiencing these UM Techniques than older cancer patients and caregivers.

All Cancer Patients/Caregivers

	Ages 18-44	Ages 45-64	Ages 65+
UM Techniques: Experienced None of the 4	8%	25%	45%
UM Techniques: Experienced 1-2 out of the 4	41%	52%	47%
UM Techniques: Experienced 3-4 out of the 4	51%	23%	8%

- Cancer patients and caregivers with private health insurance are much more likely to have experienced these UM techniques than those with Medicare.

Cancer Patients/Caregivers

	All	Private Health Insurance Coverage Ages 18-64	Medicare Coverage Ages 65+
UM Experience: None	25%	19%	45%
UM Experience: 1-2 out of 4	48%	52%	47%
UM Experience: 3-4 out of 4	27%	29%	8%

- **Physicians report UM techniques are negatively impacting themselves and their cancer patients.** We asked physicians to describe how these UM techniques impact them as physicians and their patients in an open-ended question. Shown below are the coded topic areas respondents in the survey mentioned in their verbatim comments.

How Are UM Techniques Impacting You As A Physician?

- They are very time consuming, frustrating, and mean physicians have less time to spend with cancer patients.
- They make it harder for doctors to treat patients, they cannot always give cancer patients the treatment they think is best.
- There is considerably more paperwork and administrative work that needs to be done and it takes up a lot of time.
- It puts insurance companies in charge of patient care decisions instead of doctors making decisions with their patients.
- They can delay treatment for cancer patients who desperately need time sensitive treatment.
- They limit the prescriptions and medications available to cancer patients.

How Are UM Techniques Impacting Your Cancer Patients?

- They can delay treatment for cancer patients and can temporarily or permanently suspend their care.
- Patients feel increased stress, frustration, and worry, which has a negative impact on their health.
- Because of UM techniques, cancer patients don't receive the best care possible and are forced to get less effective (even if more cost efficient) treatments.
- The UM techniques compound to create worse outcomes for cancer patients. These patients don't recover as quickly or at all when the UM techniques are used.
- Patients can end up paying more money out of pocket for their care.

- **Seven in ten physicians or more report that UM techniques are having a significant negative impact on their practice of medicine.** The table below details the percent of physicians who report UM techniques are having a negative impact on different aspects of their cancer patients' care and how physicians practice medicine.

%Total Negative Impact Ranked By All	All Primary Care/Oncologist Physicians
The amount of time and resources physicians spend on administrative tasks and paperwork	88%
Patients' ability to get timely access to medications or treatments	83%
Physicians' decision-making abilities regarding patient care	79%
The quality of care patients receive	76%
Clinical outcomes for patients	71%
Physicians' clinical recommendations	69%

Attitudes Toward Utilization Management (UM) Techniques

- **There is a majority of opposition among cancer patients, caregivers and physicians for each of the UM techniques we tested being adopted and used by health plans.** The table below shows support for and opposition to the adoption of each of the UM techniques by health plans among cancer patients/caregivers and all primary care physicians/oncologists.

All Cancer Patients/Caregivers				All Primary Care/Oncologist Physicians		
Favor	Oppose	Net Difference		Favor	Oppose	Net Difference
32%	60%	-28%	Prior authorization/ preauthorization of Rx	15%	84%	-69%
31%	61%	-30%	Limit amount of Rx dispensed	17%	78%	-61%
26%	68%	-42%	Try lower cost Rx first	20%	78%	-58%
39%	53%	-14%	Rx mandatory generic substitution	40%	56%	-16%

- **Pluralities to majorities of physicians, cancer patients and caregivers believe if these UM techniques were part of all health plans, it would negatively impact the treatment cancer patients receive.** The table below shows the percentages of respondents who believe each technique would have a positive impact, a negative impact, or would not make a difference in the treatment cancer patients receive.

All Cancer Patients/Caregivers				All Primary Care/Oncologist Physicians		
Positive	Negative	No Difference	*Ranked by Patients/Caregivers: % Negative Impact*	Positive	Negative	No Difference
14%	60%	17%	Try lower cost Rx first	5%	74%	15%
17%	55%	19%	Prior authorization/ preauthorization of Rx	4%	81%	11%
17%	47%	30%	Limit amount of Rx dispensed	5%	63%	25%
16%	44%	30%	Rx mandatory generic substitution	8%	49%	34%

Attitudes Toward Utilization Management (UM) Techniques Medicare Proposal

Respondents read the following information:

Let's imagine for a moment that ALL of these policies you just read were adopted by Medicare prescription drug plans. This means Medicare prescription drug plans would:

- *Require doctors to get approval for a cancer prescription medication before doctors would be allowed to prescribe it to patients*
- *Set a maximum limit on the total amount of a given cancer prescription medication that can be dispensed at one time*
- *Require patients to try a lower-cost cancer prescription medication first before providing coverage for a higher-cost cancer prescription medication*
- *Require mandatory generic substitution of cancer prescription medications*

Please record whether you strongly favor, somewhat favor, somewhat oppose, or strongly oppose Medicare prescription drug plans adopting ALL of these policies or if you have no opinion about it one way or the other.

- **There is overwhelming opposition among physicians (80% oppose) and among cancer patients and caregivers (63% oppose) to Medicare prescription drug plans adopting these UM techniques. Majorities of Democrats and Republicans agree in their opposition to Medicare prescription drug plans adopting these UM techniques.**

	Cancer Patients/Caregivers		Primary Care/Oncologist Physicians	
	Republicans	Democrats	Republicans	Democrats
Total Favor	35%	24%	20%	14%
Total Oppose	60%	72%	74%	85%

- **Large majorities of cancer patients and caregivers (66%), and physicians (79%) believe if these UM techniques are adopted in Medicare prescription drug plans that it will be more difficult for cancer patients on Medicare to get their prescription medications. Majorities of Democrats and Republicans agree with this premise.**

	Cancer Patients/Caregivers		Primary Care/Oncologist Physicians	
	Republicans	Democrats	Republicans	Democrats
Easier	23%	19%	13%	7%
More Difficult	63%	71%	76%	84%
No Impact	14%	10%	12%	9%

- **The belief among cancer patients, caregivers and physicians is if these UM techniques are adopted in Medicare drug plans it will have the following negative outcomes:**
  - **Create extra hurdles for cancer patients on Medicare to go through before they can get access to prescription medicines prescribed by their doctor (77% cancer patients/caregivers say it is likely to happen, 87% of physicians)**
  - **Result in treatment delays for cancer patients on Medicare (73% cancer patients/caregivers say it is likely to happen, 83% of physicians)**
  - **Result in cancer patients on Medicare not having access to new cutting-edge therapies or treatments (70% cancer patients/caregivers say it is likely to happen, 78% of physicians)**
  - **Result in cancer patients on Medicare getting less effective treatments (66% cancer patients/caregivers say it is likely to happen, 65% of physicians)**
  - **Prevent cancer patients on Medicare from getting access to lifesaving therapies or treatments (65% cancer patients/caregivers say it is likely to happen, 62% of physicians)**
  - **Increase out-of-pocket costs for prescription medicines for cancer patients on Medicare (62% cancer patients/caregivers say it is likely to happen, 61% of physicians)**

Methodology:

On behalf of the American Cancer Society Cancer Action Network (ACS CAN), Public Opinion Strategies and Hart Research Associates conducted two national online surveys in January 2019 as follows:

1. Cancer Patients/Caregivers (N=403) - January 16-25, 2019: N=256 cancer patients and N=147 family caregivers of cancer patients
   - Cancer patients were defined as patients in active treatment, those taking prescription medications to treat their cancer of keep it in remission, or those taking prescription medications to help manage the side effects of their cancer treatment.
   - Caregivers were defined as family members or friends who are currently caring for or in the past year or two have cared for a cancer patient. Respondents were not professional caregivers.
2. Physicians Who Currently Treat Cancer Patients (N=401) - January 18-28, 2019: N=200 primary care physicians (family/general or internal medicine) and N=201 oncologists

The confidence interval for each sample (N=403/N=401) is ±5.6%.

2023 AMA prior authorization physician survey

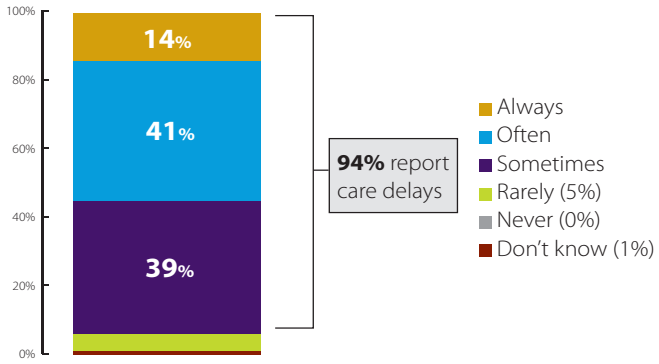
Prior authorization (PA) is a health plan cost-control process that requires health care professionals to obtain advance approval from the health plan *before* a prescription medication or medical service qualifies for payment and can be delivered to the patient. While health plans and benefit managers contend PA programs are necessary to control costs, physicians and other providers find these programs to be time-consuming barriers to the delivery of necessary treatment.

To assess the ongoing impact the PA process has on patients, physicians, employers and overall health care spending, the American Medical Association (AMA) annually conducts a nationwide survey of 1,000 practicing physicians (400 primary care/600 specialists) from a wide range of practice settings. As this year's findings demonstrate, the PA process continues to have a devastating effect on patient outcomes, physician burnout and employee productivity. In addition to negatively impacting care delivery and frustrating physicians, PA is also leading to unnecessary spending (e.g., additional office visits, unanticipated hospital stays and patients regularly paying out-of-pocket for care).

Patient impact

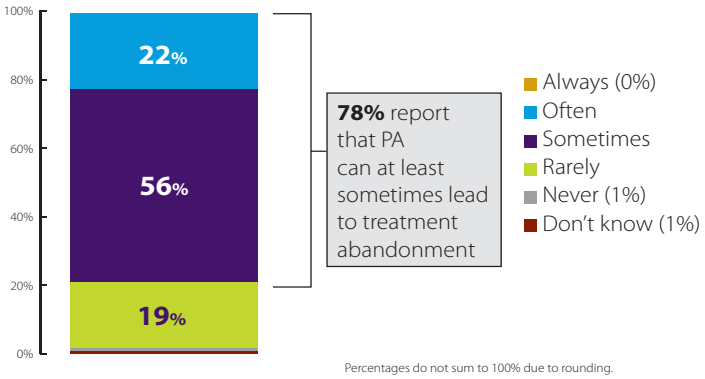
Care delays associated with PA

Q: For those patients whose treatment requires PA, how often does this process delay access to necessary care?



Treatment abandonment due to PA

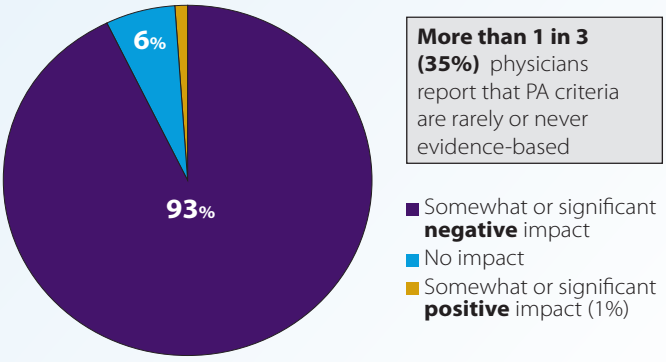
Q: How often do issues related to the PA process lead to patients abandoning their recommended course of treatment?



Percentages do not sum to 100% due to rounding.

Impact of PA on clinical outcomes

Q: For those patients whose treatment requires PA, what is your perception of the overall impact of this process on patient clinical outcomes?



Nearly 1 in 4 physicians (24%) report that PA has led to a **serious adverse event** for a patient in their care.

19% of physicians report that PA has led to a patient's hospitalization

13% of physicians report that PA has led to a life-threatening event or required intervention to prevent permanent impairment or damage

7% of physicians report that PA has led to a patient's disability/ permanent bodily damage, congenital anomaly/birth defect or death

Physician impact

PA leads to substantial administrative burdens for physicians, taking time away from direct patient care, costing practices money and significantly contributing to physician burnout. PA undercuts the financial stability of physician practices that are already struggling to stay solvent in this time of dwindling Medicare payments.

On average, practices complete

43

PAs per physician, per week

Physicians and their staff spend

12 HOURS

each week completing PAs

More than **1 in 3** or

35%

of physicians have staff who work exclusively on PA

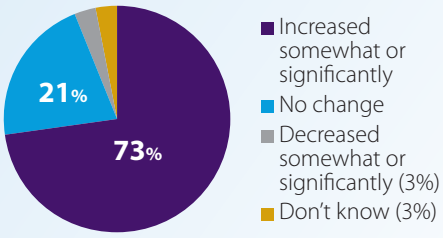
PA denials

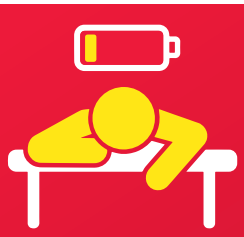
More than

1 in 4 (27%)

physicians report that PAs are **often** or **always** denied

Q: How has the number of PA denials changed over the last five years?





95%

of physicians report that PA **somewhat or significantly increases** physician burnout

PA appeals

Fewer than

1 in 5 (18%)

physicians report that they **always** appeal an adverse PA decision

Why don't physicians appeal?

62% report that they do not believe the appeal will be successful based on past experience

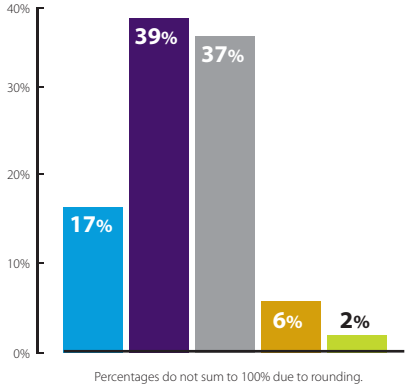
48% report that patient care cannot wait for the health plan to approve the PA

48% report that they have insufficient practice staff resources/time

When navigating the PA process, especially when appealing an adverse health plan PA decision, physicians are often required to participate in a "peer-to-peer (P2P) review" with a health plan representative. In fact, **almost two out of three physicians (61%)** report **at least sometimes** having to participate in P2P reviews.

P2P reviews require the physician to speak directly with a health plan representative, disrupting patient appointments and consuming significant physician time. As the findings demonstrate, the frequency of P2Ps is increasing, and physicians often do not speak to an appropriately qualified "peer."

Q: How has the frequency of peer-to-peer reviews during the PA process changed over the last five years?

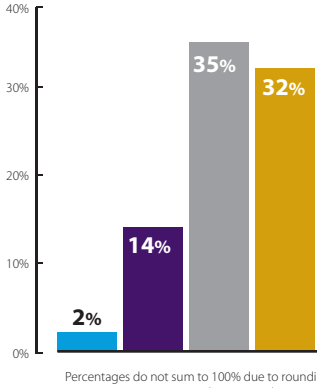


56% of physicians participating in P2Ps report P2P reviews have **increased** in the last five years

- Increased significantly
- Increased somewhat
- No change
- Decreased somewhat
- Decreased significantly

Percentages do not sum to 100% due to rounding.

Q: How often does the health plan's "peer" have the appropriate qualifications to assess and make a determination regarding the PA request?



Only 15%* of physicians participating in P2Ps report that the health plan's "peer" often or always has the appropriate qualifications

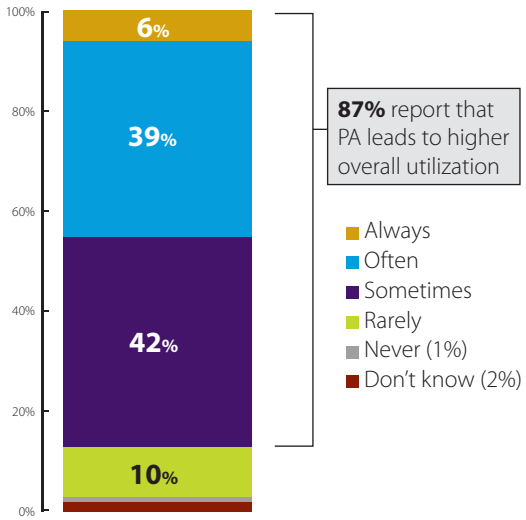
- Always
- Often
- Sometimes
- Rarely
- Never
- Don't know

Percentages do not sum to 100% due to rounding.
*Percentages sum to 15% due to rounding.

What is the cost of PA?

Not only does PA negatively impact patient care and significantly contribute to physician frustration and burnout, it also adds **significant costs to the entire health care system**. For example, patients are often forced to try ineffective treatments and/or schedule additional office visits because of PA requirements and delays. These delays inevitably lead patients to seek more expensive forms of care, including emergency room visits, and can even lead to unexpected hospitalization.

Q: Please consider how your patients' utilization of health care resources is impacted by the PA process. In your experience, how often does the PA process lead to higher overall utilization of health care resources?



Q: In which of the following ways has the PA process led to higher overall utilization of health care resources for patients in your care?

69% report ineffective initial treatment (e.g., due to step therapy requirements)

68% report additional office visits

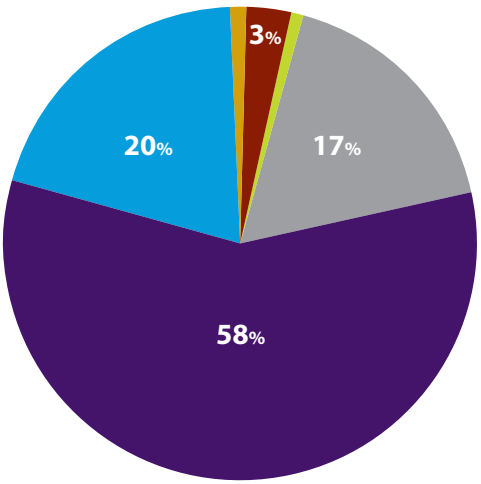
42% report immediate care/ER visits

29% report hospitalizations

In addition to higher health care resource utilization, PA can lead to other negative financial impacts for both employers and patients. Employers may face reduced productivity if PA causes employees to miss work due to rescheduled appointments or continued illness while waiting for care. In other situations, patients may pay out of pocket rather than endure PA-related care delays. Both scenarios raise serious questions about the overall value proposition of PA.

Patient out-of-pocket costs and PA

Q: How often does a PA delay or denial lead to a patient paying out of pocket for a medication that you prescribe (i.e., the health plan does not cover the prescription and the patient pays the full cost)?



Employer impact

53% of physicians with patients in the workforce report that PA has impacted patient job performance

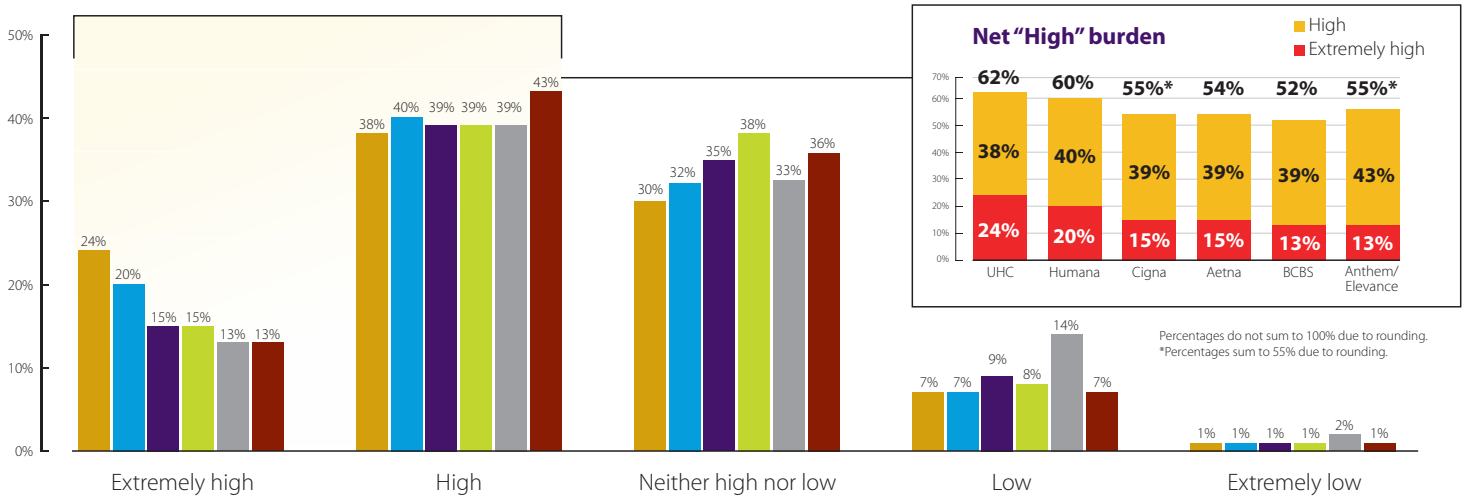
Health plan PA performance

To reduce administrative burdens and promote access to safe, timely care, the AMA, along with the American Hospital Association, American Pharmacists Association, Medical Group Management Association, America's Health Insurance Plans, and Blue Cross Blue Shield Association, released the "Consensus Statement on Improving the Prior Authorization Process" (CS) in January 2018.[1] Unfortunately, despite being released **nearly six years** before this survey was fielded, physicians report that health plans have made little progress honoring their commitments as outlined in the CS.

CS category	What do the numbers say?
Selective application of PA	• Only **8%** of physicians report contracting with health plans that offer programs that exempt providers from PA (e.g, gold card programs).
PA program review and volume adjustment	• A strong majority of physicians report that the number of PAs required for prescription medications **(83%)** and medical services **(82%)** has **increased** over the last five years. • **Over half (55%)** of physicians report that PA is **at least sometimes** required for a generic medication.
Transparency and communication regarding PA	• A majority of physicians report that it is **difficult to determine** whether a prescription medication **(63%)** or medical service **(59%)** requires PA. • Nearly **one in three (29%)** physicians report that the PA requirement information provided in their electronic health record (EHR)/e-prescribing system is **rarely or never** accurate.
Continuity of patient care	• An overwhelming majority **(88%)** of physicians report that PA interferes with continuity of care. • **Almost three out of five (59%)** physicians report that PA **at least sometimes** destabilizes a patient whose condition was previously stabilized on a specific treatment plan.
Automation to improve transparency and efficiency	• Physicians report **phone** as the most commonly used method for completing PAs. • **Only 23%** of physicians report that their EHR system offers electronic PA for prescription medications.

Several national insurers announced plans to voluntarily reduce the number of services that require PA in 2023.[2] However, despite these claims and the commitments made in the CS, physicians report consistently high PA burdens across major health plans.

Q: How would you describe the burden associated with PA in your practice for the following health plans?



Note: For each health plan, physicians who responded "don't know" or "I don't work with this health plan" were excluded from the analysis.

Survey methodology

- Forty-question, web-based survey administered in December 2023
- Sample of 1,000 practicing physicians drawn from Medscape panel
- Forty percent primary care physicians/60% specialists
- Sample screened to ensure that all participating physicians:
  - Are currently practicing in the United States
  - Provide 20+ hours of patient care per week
  - Complete PAs during a typical week of practice
- Complete survey questions can be found here https://www.ama-assn.org/system/files/2023-ama-prior-authorization-survey-question-list.pdf

References

1. "Consensus Statement on Improving the Prior Authorization Process" available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/arc-public/prior-authorization-consensus-statement.pdf
2. "2 big insurers take small steps to ease prior authorization burden" available at: https://www.ama-assn.org/practice-management/prior-authorization/2-big-insurers-take-small-steps-ease-prior-authorization

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Senate Bill 2280
North Dakota Senate Committee on Industry, Business, and Labor
February 5, 2025
AHIP Testimony

Thank you for the opportunity to speak before you today. My name is Alex Kelsch, and I am testifying today on behalf of America's Health Insurance Plans (AHIP). [1]

AHIP appreciates the opportunity to provide comments on SB 2288. Health plans share your commitment to ensuring patients have access to high-quality, affordable health care.

Unfortunately, SB 2288 would undermine patient safety and affordability. As a result, AHIP respectfully opposes this legislation in its current form because it could exacerbate delays in patient care and increase costs to the overall health care system.

Prior Authorization Protects Patient Safety. Prior authorization is a proven tool to ensure that patients receive safe, effective, and evidence-based care. Medical knowledge doubles every 73 days[2] and, to keep up with these changes, studies show that primary care providers would need to practice medicine nearly 27 hours per day.[3]

This is why it is so important that health plans, providers, and hospitals work together. Prior authorization serves as a critical safeguard to prevent unnecessary or inappropriate treatments that could result in patient harm. For example:

- ***Preventing unnecessary care.*** Patients with low-risk lower back pain frequently receive early imaging tests, which do not improve outcomes and can lead to unnecessary surgery and office visits, undue stress, excessive exposure to radiation, lost productivity, potential harms from prescription opioids, and avoidable costs.[4]
- ***Preventing dangerous drug interactions and ensuring drugs are used as clinically indicated.*** Prior authorization helps prevent dangerous drug interactions, ensures medications and treatments are safe, effective, and appropriate for a patient's specific condition, acts as a guardrail to ensure that medications are not used for clinical indications other than those approved by the Food and Drug Administration.

Prior Authorization Helps Reduce Patients' Health Care Costs. In addition, prior authorization helps ensure coverage is as affordable as possible. Experts agree that roughly a quarter of all medical spending is wasteful or low-value, costing the U.S. $340 billion annually.[5] 87% percent of doctors have reported negative impacts from low-value care[6] and an AHIP clinical appropriateness project with John Hopkins found that about 10% of physicians provided care inconsistent with consensus and evidence-based standards.[7]

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[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

[2] Densen, Peter. *Challenges and Opportunities Facing Medical Education*. Transactions of the American Clinical and Climatological Association 2011.

[3] Porter J, Boyd C, Skandari MR, Laiteerapong N. *Revisiting the Time Needed to Provide Adult Primary Care*. Journal of General Internal Medicine. January 2023.

[4] *Prior Authorization Promotes Evidence-Based Care That Is Safe and Affordable for Patients*. AHIP. November 2023.

[5] *Low-Value Care*. University of Michigan V-BID Center. February 2022.

[6] Ganguli, Ishani. *Characteristics of Low-Value Services Identified in US Choosing Wisely Recommendations*. JAMA Internal Medicine. February 1, 2022.

[7] *Clinical Appropriateness Measures Collaborative Project*. AHIP. December 2021.

Health Plans' Use of Prior Authorization is Targeted. Prior authorization is used sparingly and health plans continually seek to improve the efficiency and ease of use for providers including:

- *Significant investments in electronic prior authorization (ePA) adoption*. Despite health plans offering the capability for ePA, 60% of prior authorization requests for medical services are submitted manually (through phone or fax.)
- *Streamlining prior authorization for full treatment courses*. Health plans have streamlined prior authorization for common conditions like musculoskeletal disorders.
- *Waiving prior authorization for high-performing providers*. Health plans are implementing voluntary programs to waive prior authorization requirements for certain high-performing providers and for providers participating in risk-based payment contracts.

Industry Innovations and Upcoming Technology Requirements. In January 2024, the Centers for Medicare & Medicaid Services (CMS) released the Advancing Interoperability and Improving Prior Authorization Processes final rule.[8] The rule requires health plans to build and maintain four new application programming interfaces (APIs) that will:

1. Enable faster electronic prior authorization decisions.
2. Share large-scale population health data files with providers for value-based care.
3. Allow patients to access their claims and clinical data more easily.
4. Support care coordination when a patient transitions between payers.

The federal rule creates opportunities for states to align with federal requirements to improve care for patients, promote transparency, reduce burden, and improve care, promote transparency, efficiency, and improved care. To avoid conflicting requirements, AHIP recommends North Dakota lawmakers defer action on prior authorization while the new federal rules are being implemented.

For these reasons, we urge the Committee to vote no on SB 2288. Instead, we encourage policymakers to collaborate with health plans, providers, and hospitals on solutions that balance patient safety and affordability. Thank you for your time today.

[8] Advancing Interoperability and Improving Prior Authorization Processes. Centers for Medicare & Medicaid Services. 89 FR 8758. February 8, 2024.

February 5, 2025

The Honorable Jeff Barta
Committee on Industry and Business

Via Online Testimony Submission: https://ndlegis.gov/legend/committee/testimony/public-testimony/4377/?hearing=11467

RE: SB 2280: 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: Oppose

Dear Chair Barta and Members of the Committee on Industry and Business:

Thank you for the opportunity to comment on SB 2280. I represent Prime Therapeutics (Prime), a pharmacy benefit manager (PBM) owned by 19 not-for-profit Blue Cross and Blue Shield Insurers, subsidiaries, or affiliates of those Insurers, including Blue Cross & Blue Shield of North Dakota. SB 2280 seeks to apply the same Prior Authorization requirements for prescription drugs as it does medical care. These are two very different kinds of care and need to be treated as such. It is for this reason, among others that Prime opposes this legislation.

Prime helps people get the medicine they need to feel better and live well by managing pharmacy benefits for health plans, employers, and government programs including Medicare and Medicaid. Our company manages pharmacy claims for more than 30 million people nationally and offers clinical services for people with complex medical conditions. Our business model relies on transparency and advocating for simpler, lowest-net-cost pricing for drugs. Importantly, Prime is not focused on driving profit margins. To control costs, Prime's clients rely on our clinical expertise and drug management tools, such as Prior Authorization.

Prior Authorization programs consider safety and efficacy first
Prior authorization is an important tool that payers can use to direct patients to first-line, clinically preferred treatments while encouraging appropriate, label-compliant prescribing. These tools also help meet the payer's obligation to manage drug costs for the entire risk pool of members, which is why payers of all types, from Medicaid agencies to hospitals with their own employees, use prior authorization. However, physicians and drug manufacturers often advocate for policies that would severely limit these tools, and it is imperative for legislators and regulators to understand the value of prior authorization.

Providers and drug manufacturer advocates often claim that prior authorization criteria are arbitrary. In reality, payers and their administrators employ Pharmacy & Therapeutics (P&T) Committees made up of independent physicians and other healthcare professionals. P&T committees align their recommendations to multiple widely respected sources of clinical information about drug safety and efficacy when making recommendations about prior authorization programs, including but not limited to the American Society of Clinical Oncology (ASCO), FDA labeling, and peer-reviewed literature.

26.1-36.12-11 (Length of prior authorization) & 26.1-36.12-12 (Chronic or long-term care conditions)
The above sections completely undermine the clinical value of the Prior Authorization program. The first section relating to the length of prior authorization states, "A prior authorization is valid for six months after the date the health care provider receives the prior authorization;" this is usually justified by providers, because it is an "administrative burden for them." But from a safety and efficacy perspective, a lot can happen in six months. There are changes in a patient's health, the medication may not even be clinically recommended for a six month duration, the patient can get other prescriptions that may be contraindicated with the drug that required PA, and often, providers do not have visibility into those other drugs their patient may have been prescribed if done so by a different provider (but the PA entity does have that visibility). This is just as important for long-term

conditions, and the ask for in the chronic or long-term care condition section is for a 12-month PA approval! This is potentially dangerous to the patient and cannot be justified with alleviating the administrative burden of providers. This very same mindset is what led to the opioid epidemic.
Prime opposes this bill as written but would gladly sit down to speak on removing prescription drugs from this bill or discuss a separate process for them that keeps patient safety as the top priority.

Respectfully,

Marcus Caruso
Government Affairs, Prime Therapeutics
Cell: 612.845.9870 | Email marcus.caruso@primetherapeutics.com

February 5, 2025

The Honorable Jeff Barta, Chair Industry and Business Committee
The Honorable Keith Boehm, Vice Chair Senate Industry and Business Committee
North Dakota Senate Human Services Committee Members
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **SB 2280 – Relating to Prior Authorization for Health and Dental Insurance**
PCMA Testimony in Opposition to SB 2280

Dear Chair Barta, Vice Chair Boehm, and Committee Members:

My name is Michelle Mack, and I represent the Pharmaceutical Care Management Association, commonly referred to as PCMA. PCMA is the national trade association for pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 275 million Americans with health coverage provided by large and small employers, health insurers, labor unions, and federal and state-sponsored health programs.

At this time, PCMA appreciates the opportunity to provide comments on SB 2280 and respectfully opposes it. This bill establishes in statute the requirements and restrictions for prior authorization, including process, time frames, appeals, etc.

PBMs exist to make drug coverage more affordable by aggregating the buying power of millions of enrollees through their plan sponsor/payer clients. PBMs help consumers obtain lower prices for prescription drugs through price discounts from retail pharmacies, rebates from pharmaceutical manufacturers, and using lower-cost dispensing channels. Though employers, health plans, and public programs are not required to use PBMs, most choose to because PBMs help lower the costs of prescription drug coverage.

Prior Authorization Ensures Consistent, Guideline-Based Care While Reducing Costs for North Dakota Payers

Prior authorization is a form of utilization management where a health plan requires pre-approval of a prescription drug. The primary goals are 1) to ensure the appropriateness and suitability of the prescribed medication for the specific patient; 2) to ensure safety; and 3) to reduce costs.

The use of prior authorization in the medical benefit and drug benefit are different. Prior authorization in the medical benefit is for a service and prior authorization use in the drug benefit is for a product – a prescription drug. The difference is important because a drug is typically prescribed for use over a length of time, not just once. Ongoing use of a drug may require monitoring or testing to ensure the drug is safe and effective.

Prior authorization is a tool used for drugs with the following characteristics:

- Dangerous side effects
- Harmful when combined with other drugs
- Should only be used for specific health conditions
- Are often misused or abused
- Have equally, more effective, or more affordable drugs that would work for the majority of patients based on evidence-based drug therapy standards of care

According to the National Academy of Sciences, Engineering, and Medicine (NASEM), "Formularies are used to steer patients and prescribing clinicians toward generic substitutes, biosimilars, drugs with similar therapeutic efficacy for the same disease, or other therapeutic options." Without formulary controls, "insurance premiums would rise," notes NASEM. Prior authorization and step therapy are among the most effective formulary controls, thus prohibiting use of these programs would likely raise premiums. Increased premium costs are passed on directly to North Dakotans who are already feeling the strain from rising costs on their pocketbooks.

Prior Authorization Requirements are Developed by a Panel of Independent Experts.

Health plans and PBMs rely on independent Pharmacy and Therapeutics (P&T) Committees, comprised of independent experts including licensed physicians, pharmacists, and other medical professionals, to develop evidence-based guidelines used in drug management programs—including prior authorization—and to ensure that these management controls do not impair the quality of clinical care.

Every Plan has a Prior Authorization Exceptions Process to Safeguard Coverage of Non-Formulary Drugs when Appropriate.

According to the National Academies of Sciences, Engineering, and Medicines, "Every plan, whether Part D or an employer-sponsored pharmacy benefit, has an exception process that permits coverage of a drug not on formulary or reduces out-of-pocket cost if a prescriber provides information about side effects the patient has experienced from a lower-tiered drug or offers another medical reason for switching."[1] This process safeguards against the use of prior authorization being too restrictive.

Use of Real Time Benefits Tools and Electronic Prior Authorization Ease Provider Burden, Shorten Review Times, and Improve Transparency for Patients.

Any administrative complexities for providers can be minimized by using real time benefit tool technology, which allows prescribers to see the formulary, the patient's cost share, and other requirements at the time of prescribing. Electronic prior authorization (e-PA) is a useful tool that allows insurers and prescribers to communicate electronically instead of using antiquated fax machines and voice calls, which are expensive and time-consuming. According to the most recent data (2019), 75% of pharmacy prior authorizations are fully electronic and use the NCPDP SCRIPT electronic standard for PA.[2] 100% of prescribers should be using these tools.

[1] Making Medicines Affordable: A National Imperative," National Academies of Sciences, Engineering, and Medicine (NASEM), Nov. 2017.
[2] CAQH. 2020. "Issue Brief: The 2019 CAQH Pharmacy Services Index," pg. 2. https://www.caqh.org/hubfs/43908627/drupal/explorations/index/index-pharmacy-brief.pdf
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Industry Concerns with SB 2280

This bill, as drafted, puts all prior authorizations into the same bucket when there is a difference between medical benefits and prescription drug benefits. For example, on page 4, all "adverse determinations" need to be conducted by a licensed physician which would hinder real time benefit tools such as electronic prior authorization. Another example is the requirements for "Urgent" and "Emergency" on pages 6 - 7, as the requirements are geared to medical services. Also, on page 7, dealing with retrospective denial, a prescription drug prior authorization under the prescription drug benefit is never retrospectively denied.

We also have concerns with not being able to use prior authorization for medication assisted treatment on page 7. Drugs for the treatment of opioid use disorder can have dangerous side effects, can be harmful when combined with other drugs, or can be misused or abused, and there is a need for them to be reviewed for appropriate use.

Finally, we have concerns with the language dealing with chronic or long-term care conditions.

PCMA suggests that pharmacy or prescription drugs not be included in the bill. If that is not an option, we suggest creating a separate process for them and requiring mandatory electronic prior authorization use by providers. PCMA and its member companies would be happy to work with all the stakeholders on this matter to further discuss and reconcile the various issues.

Thank you again for the opportunity to comment on SB 2280. We urge a "do not pass" vote.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Michelle Mack
Senior Director, State Affairs
Phone: (202) 579-3190
Email: mmack@pcmanet.org

Senate Industry and Business
SB 2280
February 5th, 2025

Chairman Barta and members of the Senate Industry and Business Committee,

My name is Bobbie Will, and I support SB 2280. The passage of this bill will ensure timely access to care by requiring insurers to respond to a prior authorization request within specific timelines. I have personally watched friends and family decline in their health due to approval denials or delays. I am confident my loved ones' decline in health could have been avoided by a timely approval process.

This is lifesaving legislation! Our family dealt with prior authorization delays while waiting for approval for heart surgery for my 73-year-old mother. We feel very strongly the delay in the prior authorization approval process was a direct result of the rapid decline in her health and within a few months the loss of her life. We called a few times a week for a month before her procedure was approved by her insurance carrier. By the time the procedure was approved, her health had declined, and she ended up in the ICU. Within two weeks, she was moved to hospice and soon passed away. We will never know if the procedure would have saved her life, we didn't have the opportunity to find out. No family or healthcare provider should spend a month calling the insurer to receive approval for a life-saving heart procedure. This is only one example of a handful I could share from my personal experience.

The emotional toll prior authorization has on a patient and family is unnecessary. Life-saving treatments and procedures should have timely approval. Every day counts when you have heart failure and aggressive cancer.

I urge you to support Senate Bill 2280. This legislation will ensure timely approval and improve the health of North Dakotans. Timely care saves lives and costs!

Bobbie Will
District 35, Bismarck

Chairman Barta, Vice-Chairman Boehm, members of the Senate Industry and Business Committee:

My name is Susan Finneman. I live in Bismarck, ND. I was born and raised in North Dakota. My husband, Mike, was born and raised in Golva, ND. My mother was a nurse. I have two siblings and one brother-in-law that are physicians. I worked for 20 plus years as a Purchasing and Production Planning manager at a manufacturing firm.

My personal values regarding healthcare choice started when I was young. My first-grade teacher suspected that I had hearing issues. It was discovered that I had 0% hearing in one ear and

10% in the other. Our insurance allowed us to seek out and use specialists to identify and treat the problem. My parents did not have to jump through hoops to find and obtain the necessary care and restore my hearing to normal levels. I did not lose ground in school.

In March of 2015, I had surgery in Colorado to repair a disc in my spine. This surgery initially seemed to work but in April I started to have pain and numbness in my lower body. By the end of June, I was no longer able to get in and out of bed without assistance. I had to bend over a walker to get around and had to crawl up and down the steps of my home. My pain was usually 9 or 10 on a scale of

10. Throughout this period of time, my physician repeatedly asked for preauthorization for MRI and CAT scan imaging. The insurance company did not respond.

When I lost control of my bladder and bowel, I went to the ER. Due to the emergent situation, preauthorization was not required for the imaging. It was discovered that I had an infection in my spine. The infection had destroyed all the repaired disc, 50% of the vertebrae above it and 30% of the vertebrae below it. If I had fallen or moved incorrectly, my spinal cord could have been severed. Reconstruction surgery was now necessary.

Additionally, I began what would become a 6-month course of two IV antibiotics that needed to be infused twice a day. That course was followed by a year on oral antibiotics. I was on oxycodone and morphine to manage the pain. The consequences of use of these drugs are well known.

On October 30th, my reconstruction surgery was scheduled for Monday, November 16th. The surgeon's office immediately began working on obtaining authorization from the insurance company. On Friday, November 13th I received a call from the surgeon's office. They had still not received authorization from the insurance company. They were told that it was on the Medical Director's desk.

The surgery would need to be rescheduled. The next spot on the schedule was not until March of 2016.

I went to the insurance company's web site and found the name and phone for the highest-ranking MD on their executive staff. I made one phone call and had authorization within 30 minutes. I was able to do this because I have medical and system knowledge.

Within a day of the surgery, I was able to walk upright with little pain. Within a week, I no longer needed the walker. I firmly believe that had I not forced the issue, I would not be standing here today.

Senators: This happened ten years ago. Things are far worse today. Insurance companies have increased time delays and are requiring physicians to spend an increasing amount of time and energy on this type of problem. This becomes time that is not devoted to patient care and outcomes. I do not believe that a patient should have to go to these lengths to obtain necessary care. I wonder what happens to those who do not have the resources and background that I have.

As a manager in a manufacturing firm, I learned that having benchmarks and standards of performance are absolutely necessary to assure good outcomes.

It makes sense to hold insurance companies accountable for the timing of their decisions.

I encourage you to vote DO PASS on SB 2280 which allows me as a health care consumer to obtain care in a timely fashion from providers that I know and trust.

Thank you for your time.

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

Chairman Barta and members of the committee, my name is Carlotta McCleary. I am the Executive Director for both North Dakota Federation of Families for Children's Mental Health (NDFFCMH) and Mental Health America of North Dakota (MHAND). NDFFCMH is a parent run organization focused on the needs of children and youth with emotional, behavioral, or mental disorders and their families. MHAND's mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

We are here to support SB 2280. We believe SB 2280 is a patient-centric bill that will provide many substantial improvements to current practices. MHAND are NDFFCMH want to ensure North Dakotans can get timely access to services and supports that are recommended by their own physicians and specialists. Most importantly, prior authorizations are often burdensome to patients and can impact their health and quality of life if they are not receiving timely and necessary care recommended by their own physicians. Sometimes patients and their doctors have decided on a course of treatment only for it to be determined unauthorized by prior authorization. This often requires patients to set another appointment to discuss other options that likely will be approved. Additional time and expenses, including missed time at work, are burdens that the patients must endure. Prior authorizations are also often burdensome for medical professionals trying to deliver necessary and quality care for their patients, leading to substantial and harmful delays in treatment. For the patient, prior authorizations enter a

great deal of uncertainty, time and energy spent trying to get the care that they know they need. Prior authorizations add layers of distress to the lives of those already experiencing much distress from their medical conditions; layers of distress that we desperately wish we could erase from the minds of individuals and families we directly support, and those that we work alongside to help make North Dakota the healthiest state in the nation.

SB 2280 would provide standardized definitions for "prior authorization" and "medical necessity." Policies and procedures are to be put on the organization's website, written in ordinary language understandable by the average person. Additions or changes to the policies are required to be placed on their websites prior to enactment. Health care providers would be notified at least one hundred and twenty days before the change is implemented.

SB 2280 would ensure that physician and dentist recommendations would be reviewed by peers who at least have a similar specialty, with experience treating patients with the condition or illnesses that the service is being requested. Urgent healthcare requests will require a response within 24 hours, whereas non-urgent requests will be provided within two days. Furthermore, SB 2280 would allow an approved drug to be valid for a year (or at least through the last day of coverage) and cover any dosage change during the authorization period.

We believe that SB 2280 will make prior authorization policies more transparent and understandable for the general public and physicians, while simultaneously eliminating many of the barriers that currently exist for patients so that they can live healthier and more fulfilling lives. This bill would ensure that medical decisions could remain between the patient and their doctor.

Thank you for your time and I would be happy to respond to any questions.

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Senate Bill 2280
Industry and Business Committee
69th Legislative Assembly of North Dakota
February 5, 2025

Dear Chairman Barta and Committee Members,
My name is Joan Connell. As a pediatrician, parent, and North Dakota citizen, I am asking you to VOTE YES on SB 2280. The delay in receipt or lack of receipt of optimal medical care due to problems with prior authorization affects my patients every day.
This hits most frequently and hardest at the Children's Regional Asthma Clinic I hold in Bismarck. In spite of the national guidelines for pediatric asthma changing in late 2019, there are insurance companies that continue to deny medications that are recommended in the guidelines. Some insurance companies, including ND Medicaid, refuse to reimburse Symbicort, the only asthma combination inhaler that contains a low potency steroid, which I prefer to prescribe for patients due to adverse effects on growth that we have seen with high potency steroid inhalers. They tell me that the industry says this is not a concern, yet I have 5-10 patients in my clinic who would disagree because of their documented medication-associated drop off in height gain. Last month, we had a family ask for refills of epinephrine pens that two of their children need due to a history of severe allergic reaction/anaphylaxis. We refilled the script, which was denied. We then looked up the insurance company's listed formulary and prescribed the epinephrine pen that was listed. This too was denied. We then had to take more time to call the insurance company to ask exactly what they would like us to prescribe. While that was a complete waste of a lot of clinical time, the real disaster is that during that 2+ week interim, those kids did not have epinephrine pens. Thank God they did not have a severe allergic reaction during that time.
While I could continue with examples from each day, I think the benefit of this bill has been adequately illustrated with the above examples. Please VOTE YES on SB 2280 so patients can receive optimal therapy when they seek care.

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.

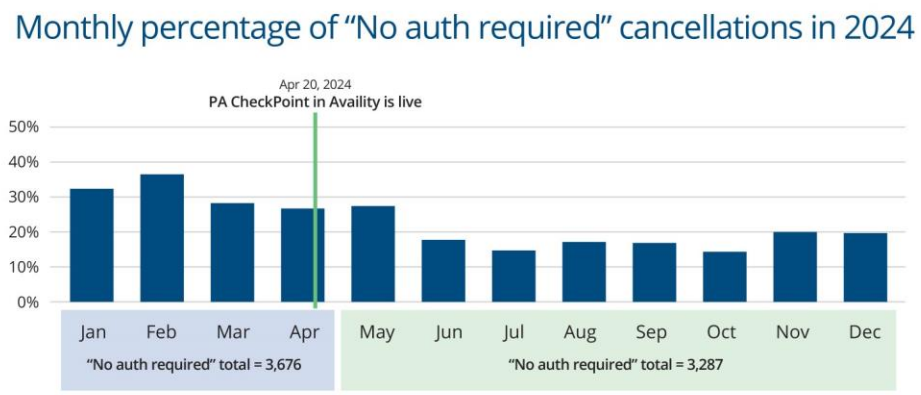
The intent is not to delay or interfere. It is to partner in and communicate around a care plan where, in some circumstances, there could be significant risk involved from a health, quality or cost perspective. When our teams review prior authorization requests, we are keeping three key things in mind:

- **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%.



"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.

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.

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.

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

25.1180.02001
Title.

Prepared by the Legislative Council staff for Senator Klein
January 31, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

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; and to provide for application.

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.

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 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~~self-funded health benefit plans subject to the federal Employee Retirement Income Security Act of 1974.

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.

3. This section may not be construed to prohibit a prior authorization review organization from amending existing prior authorization requirements to the benefit of an enrollee earlier than one hundred twenty days before the new amendment is implemented.

4. This section does not prohibit a prior authorization review organization from implementing a prior authorization requirement or restriction that aligns with medical guidelines and clinical criteria.

~~**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~~26.1-36.12-03. 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, or other health care personnel, 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~~26.1-36.12-04. 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~~of 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~~26.1-36.12-05. 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~~five 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~~26.1-36.12-06. 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~~three business days after receiving all information needed to complete the review of the requested health care services.

~~26.1-36.12-08~~26.1-36.12-07. 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~~three business days, the services must be deemed approved.

~~26.1-36.12-09~~26.1-36.12-08. 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~~26.1-36.12-09. Retrospective denial.

A prior authorization review organization may not revoke, limit, condition, or restrict a prior authorization if care is provided, as specified within the prior authorization request, within forty-five business days from the date the health care provider received the prior authorization unless there is evidence the prior authorization was based on fraud, misinformation, or a previously approved prior authorization conflicts with state or federal law.

~~26.1-36.12-11~~26.1-36.12-10. Length of prior authorization.

A prior authorization is valid for six months after the date the health care provider receives the prior authorization. This section does not limit a prior authorization review organization's ability to evaluate clinical criteria and medical guidelines during the six-month period. If clinical or medical guidelines change during the six-month period, the prior authorization review organization may adjust the prior authorized service.

~~26.1-36.12-12~~26.1-36.12-11. 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. This section does not limit a prior authorization review organization's ability to evaluate clinical criteria and medical guidelines during the twelve-month period. If clinical or medical guidelines change during the twelve-month period, the prior authorization review organization may adjust the prior authorized service.

~~26.1-36.12-13~~26.1-36.12-12. 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, unless a change in clinical or medical guidelines would negatively affect an enrollee, 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. This subsection does not apply if a prior authorization review organization changes coverage terms for a drug or device:

a. That has been deemed unsafe by the United States food and drug administration;

b. That has been withdrawn by the United States food and drug administration or the product manufacturer; or

c. After an independent source of research, clinical guidelines, or evidence-based standards issued drug-specific or device-specific warnings or recommendations changing the drug or device usage.

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~~26.1-36.12-13. 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~~26.1-36.12-14. Effect of change in prior authorization clinical criteria.

1. 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. This subsection does not apply if a prior authorization review organization changes coverage terms for a drug or device:

a. That has been deemed unsafe by the United States food and drug administration;

b. That has been withdrawn by the United States food and drug administration or the product manufacturer; or

c. After an independent source of research, clinical guidelines, or evidence-based standards issued drug-specific or device-specific warnings or recommendations changing the drug or device usage.

2. This section may not be construed to limit a prior authorization review organization's ability to implement prior authorization standards or restrictions before the next plan year which reflect updated medical and clinical guidelines that if not implemented would jeopardize the health of an enrollee.

~~26.1-36.12-17~~26.1-36.12-15. 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~~26.1-36.12-16. 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~~, which 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.;

f. Number of prior authorization requests submitted but not necessary;

g. Number of prior authorization requests submitted by electronic means; and

h. Number of prior authorization requests submitted by non-electronic means, including mail and facsimile.

SECTION 2. APPLICATION. This Act applies to health benefit plans offered or purchased after January 1, 2026.

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

SB 2280
2/11/2025

A bill relating to prior authorization for health and dental insurance.

10:00 a.m. Chairman Barta opened the hearing.

Members present: Chairman Barta, Vice-Chairman Boehm, Senator Klein, Senator Kessel, Senator Enget

Discussion Topics:

- Healthcare provider burnout
- State regulated market exclusion
- Auto-authorization provision
- Qualified licensed physician approval
- Market conduct exams and civil penalties
- Patient-centered timely care

10:00 a.m. Senator Scott Meyer, District 18, testified in neutral

10:13 a.m. Dylan Wheeler, Sanford Plan, testified in neutral.

10:20 a.m. Megan Hruby, Blue Cross Blue Shield, testified in neutral.

10:25 a.m. Chrystal Bartuska, ND Insurance Department, testified in neutral.

10:39 a.m. Chairman Barta closed the hearing.

Audrey Oswald, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

SB 2280
2/12/2025

A bill relating to prior authorization for health and dental insurance; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

10:07 a.m. Chairman Barta opened the hearing.

Members present: Chairman Barta, Vice-Chair Boehm, Senator Klein, Senator Kessel, Senator Enget

Discussion Topics:

- Clinical criteria definition

10:09 a.m. Megan Hruby, Blue Cross Blue Shield of ND, testified in neutral.

10:12 a.m. Chairman Barta closed the hearing.

Audrey Oswald, Committee Clerk

2025 SENATE STANDING COMMITTEE MINUTES

Industry and Business Committee
Fort Union Room, State Capitol

SB 2280
2/12/2025

A bill relating to prior authorization for health and dental insurance.

3:24 p.m. Chairman Barta opened the hearing.

Members present: Chairman Barta, Vice-Chairman Boehm, Senator Klein, Senator Kessel, Senator Enget

Discussion Topics:

- Pharmacists
- Personnel qualified
- ND PERS Program
- Legislative management study
- Auto-authorization

3:29 p.m. Senator Scott Meyer, District 18, testified in favor.

3:37 p.m. Nathan Svihovec, Director of ND Government Relations for Essentia Health testified in neutral.

3:40 p.m. Dylan Wheeler, Sanford Health Plan, testified in neutral.

3:40 p.m. Senator Kessel moved to adopt the amendment LC# 25.1180.02005.

3:41 p.m. Senator Boehm seconded the motion.

Senators	Vote
Senator Jeff Barta	Y
Senator Keith Boehm	Y
Senator Mark Enget	Y
Senator Greg Kessel	Y
Senator Jerry Klein	Y

Motion passed 5-0-0

3:41 p.m. Senator Klein moved a Do Pass As Amended.

3:42 p.m. Senator Kessel seconded the motion.

Senators	Vote
Senator Jeff Barta	Y
Senator Keith Boehm	Y
Senator Mark Enget	Y

Senator Greg Kessel	Y
Senator Jerry Klein	Y

Motion passed 5-0-0.

Senator Barta will carry the bill.

3:43 p.m. Chairman Barta adjourned the meeting.

Audrey Oswald, Committee Clerk

25.1180.02005
Title.03000

Adopted by the Industry and Business Committee

February 12, 2025

2-12-25

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO

JB 1 of 11

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; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

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.

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

JB 3-11

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 includes~~ a health benefit plan as defined in section 26.1-36.3-01 or 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 the public employees retirement system ~~health benefits~~uniform group insurance program plans under chapter 54-52.1.

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~~sixty 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~~an~~ adverse determinations are made~~determination made for a health benefit plan is reviewed~~ by a licensed physician ~~or~~, licensed dentist, or licensed pharmacist. 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.~~2. 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~~26.1-36.12-04. 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

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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~~26.1-36.12-05. 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~~seven calendar 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~~26.1-36.12-06. 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~~seventy-two hours after receiving all information needed to complete the review of the requested health care services.

~~26.1-36.12-08~~26.1-36.12-07. 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

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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.~~4. 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~~26.1-36.12-08. 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~~26.1-36.12-09. 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 unless there is evidence the prior authorization was based on fraud.

~~26.1-36.12-11~~26.1-36.12-10. **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~~26.1-36.12-11. **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~~26.1-36.12-12. **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. This subsection does not apply if a prior authorization review organization changes coverage terms for a drug or device that has been:
   a. Deemed unsafe by the United States food and drug administration; or
   b. Withdrawn by the United States food and drug administration or product manufacturer.
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~~26.1-36.12-13. 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~~26.1-36.12-14. 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~~26.1-36.12-15. Effect of change in prior authorization clinical criteria.

1. 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.
2. This section does not apply if a prior authorization review organization changes coverage terms for a drug or device that has been:
   a. Deemed unsafe by the United States food and drug administration; or
   b. Withdrawn by the United States food and drug administration or product manufacturer.

~~26.1-36.12-17~~26.1-36.12-16. 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~~26.1-36.12-17. 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 be available online and in a form specified by the commissioner.

3. 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~~, which must 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~~.~~;

   f. Number of prior authorization requests submitted but not necessary;

   g. Number of prior authorization requests submitted by electronic means; and

   h. Number of prior authorization requests submitted by nonelectronic means, including mail and facsimile.

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

1. During the 2025-26 interim, the legislative management shall consider studying prior authorization requirements imposed by the public employees retirement system uniform group insurance plans under chapter 54-52.1 and the impact on patient care and health care costs.
2. The study must include input from stakeholders, including patients, providers, and commercial insurance plans.

3. The study must require insurance plans to submit to the insurance commissioner by July 1, 2025, for the immediately preceding calendar year for each commercial product:
   a. The number of prior authorization requests for which an authorization was issued;
   b. The number of prior authorization requests for which an adverse determination was issued, sorted by health care service, whether the adverse determination was appealed, or whether the adverse determination was upheld or reversed on appeal;
   c. The reasons for prior authorization denial, including the patient did not meet prior authorization criteria, incomplete information was submitted by the provider to the utilization review organization, a change in treatment program, or the patient is no longer covered by the plan; and
   d. The number of denials reversed by internal appeals or external reviews.
4. The insurance commissioner shall aggregate this data into a report and submit it to the legislative management by November 1, 2025.
5. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

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

REPORT OF STANDING COMMITTEE
SB 2280

Industry and Business Committee (Sen. Barta, Chairman) recommends **AMENDMENTS (25.1180.02005)** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). SB 2280 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

2025 HOUSE INDUSTRY, BUSINESS AND LABOR

SB 2280

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2280
3/17/2025

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; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

2:31 p. m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, Brown, Christy, Finley-DeVille, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Discussion Topics:

- Standard definitions and process
- Safety and best care
- Doctor, insurance communications
- Fraud, waste & abuse
- Medical training reviews

2:31 p.m. Senator Scott Meyer, District 18, Grand Forks, ND, introduced, testified and submitted testimony #42490.

2:51 p.m. Susan M. Finneman, Bismarck, ND, testified in favor and submitted testimony #42367.

2:57 p.m. Emily A. Bakkum, Fargo, ND, testified in favor and submitted testimony #41924.

3:16 p.m. Andy Askew, Vice President, Public Policy, Essentia Health, testified in favor and submitted testimony #42553.

3:34 p.m. Dr. Duncan B. Ackerman, President, The Bone & Joint Center, testified in favor and submitted testimony #42428 and #42537.

3:48 p.m. Megan Hruby, Blue Cross and Blue Shield of North Dakota, testified in opposition and submitted testimony #42523.

4:19 p.m. Alexander Kelsch, Lobbyist, American's Health Insurance Plans (AHIP), testified in opposition and submitted testimony #42444.

4:22 p.m. Dylan Wheeler, Head of Government Affairs, Sanford Health Plan, testified as neutral and submitted testimony #42370.

4:26 p.m. Chrystal Bartuska, Division Director Life & Health, ND Insurance Department, testified as neutral.

Additional written testimony:
Courtney McNamee, Altru Health System, Grand Forks, ND, submitted testimony in favor #41505.
Erick P. Winer, MD, Board Chairman (by Sarah Lanford), Association for Clinical Oncology, Alexandria, VA, submitted testimony in favor #41563.
Bobbie L. Will, Susan G. Komen, Bismarck, ND, submitted testimony in favor #41642.
Carrie M. Varner, Harvey, ND, submitted testimony in favor #41794
Marcus Lewis, CEO, First Care Health Center, Park River, ND, submitted testimony in favor #41880.
Tim Blasl, President, North Dakota Hospital Association, submitted testimony in favor #41882.
Aaron Smith, Member, American College of Cardiology (ACC), North Dakota Great Plains Chapter, submitted testimony in favor #41921.
Bryan J. Seeley, Dentist, Elmwood Family Dentistry, submitted testimony in favor #41956.
Shelly Ten Napel, CEO, Community HealthCare Association of the Dakota, submitted testimony in favor #42057.
Kirsten Dvorak, Executive Director, The Arc of North Dakota, submitted testimony in favor #42136.
Brenda Ruehl, Director Program Services, Protection & Advocacy, submitted testimony in favor #42137.
Bianca Balale, Director of Government Relations, National Association of Dental Plans (NADP), submitted testimony in opposition #42163.
Joan M. Connell, Bismarck, ND, submitted testimony in favor #42167.
Janelle Moos, Associate State Director Advocacy, AARP ND, submitted testimony in favor #42231
Alex Young, Legislative Director, American Council of Life Insurers, submitted testimony in opposition #42291.
Carlotta McCleary, Executive Director, Mental Health American of North Dakota & ND Federation of Families for Children's Mental Health, submitted testimony in favor #42393.
Shane Goettle, Lobbyist, American Cancer society, Cancer Action Network, submitted testimony in favor #41899 and #42494.

4:30 p.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

2025 SB 2280
House Industry, Business and Labor
Representative Warrey, Chairman
March 17, 2025

Chairman Warrey and members of the House Industry, Business and Labor 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

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

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March 14, 2025

Representative Jonathan Warrey, Chair
Room JW327C, State Capitol
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chair Warrey and Members of the House Committee on Industry, Business and Labor,

The Association for Clinical Oncology (ASCO) is pleased to support **SB 2280**, which establishes guardrails around prior authorization processes in the state.

ASCO is the world's leading professional society representing physicians who care for people with cancer. With over 50,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality cancer care.

Prior authorization requires patients or their providers to secure pre-approval as a condition of payment or insurance coverage of services. In a recent ASCO survey, 80% of respondents said that a patient has experienced significant impacts on their health, such as disease progress, because of prior authorization processes. The most common harms to patients include delays in treatment (95%) and diagnostic imaging (94%), patients being forced onto second-choice therapy (93%) or denied therapy (87%) and increased out-of-pocket costs (88%). These survey results confirm that prior authorization results in unnecessary delays or denials of cancer care.

ASCO is committed to supporting policies that reduce cost while preserving quality of cancer care; however, it is critical that such policies be developed and implemented in a way that does not undermine patient access. Payer utilization management approaches like prior authorization are of particular concern because they represent greater likelihood of raising barriers to appropriate care for individuals with cancer.

ASCO is pleased that SB 2280:

- **Ensures timely access to care** by requiring insurers to respond to a prior authorization request within seven business days for nonurgent circumstances and within 72 hours if the request is urgent;
- **Accommodates the needs of specialized patient populations** by ensuring all adverse determination appeals are reviewed by a physician within the same relevant specialty as the prescribing physician;

- **Promotes continuity of care** by stipulating that prior authorization for a healthcare service for the treatment of chronic and long-term conditions, such as cancer, must remain valid for 12 months; and
- **Improves transparency** by implementing prior authorization statistic reporting.

ASCO is encouraged by the steps SB 2280 takes toward improving prior authorization in North Dakota, and we welcome the opportunity to be a resource for you. For a more detailed understanding of our policy recommendations on this issue, we invite you to read the ASCO Position Statement: Prior Authorization. Please contact Sarah Lanford at ASCO at Sarah.Lanford@asco.org if you have any questions or if we can be of assistance.

Sincerely,

Eric P. Winer, MD, FASCO
Chair of the Board
Association for Clinical Oncology

House Industry, Business and Labor
SB 2280
March 17th, 2025

Chairman Warrey and members of the House Industry, Business and Labor Committee,

My name is Bobbie Will, and I support SB 2280. The passage of this bill will ensure timely access to care by requiring insurers to respond to a prior authorization request within specific timelines. I have personally watched friends and family decline in their health due to approval denials or delays. I am confident my loved ones' decline in health could have been avoided by a timely approval process.

This is lifesaving legislation! Our family dealt with prior authorization delays while waiting for approval for heart surgery for my 73-year-old mother. We feel very strongly the delay in the prior authorization approval process was a direct result of the rapid decline in her health and the loss of her life. We called a few times a week for two months before her procedure was approved by her insurance carrier. By the time the procedure was approved, her health had declined, and she ended up in the ICU. Within two weeks, she was moved to hospice and soon passed away. We will never know if the procedure would have saved her life, we didn't have the opportunity to find out. No family or healthcare provider should spend two months calling the insurer to receive approval for a life-saving heart procedure. This is only one example of a handful I could share from my personal experience.

The emotional toll prior authorization has on a patient and family is unnecessary. Life-saving treatments and procedures should have timely approval. Every day counts when you have heart failure and aggressive cancer.

I urge you to support Senate Bill 2280. This legislation will ensure timely approval and improve the health of North Dakotans. Timely care saves lives and costs!

Bobbie Will
District 35, Bismarck

Hello, my name is Carrie Varner and I'm submitting my testimony in support of Senate Bill 2280. I found out in early 2023 that I have severe eosinophilic asthma, which is caused by a rare genetic disorder known as Job's Syndrome. Job's Syndrome affects my immune system, making me extremely susceptible to respiratory infections and complications from said infections. It also affects my skeletal system, which is why I stopped growing when I was 8 years old and why I still have most of my baby teeth. My type of asthma isn't able to be treated with traditional asthma medications and I was told about Xolair, an immunosuppressant medication for my type of asthma. I had to get prior authorization from my insurance in order to get the medication and it took 8 tries before I could get the medication. After I lost my extra help from my insurance because my income exceeded the limit for extra help in October 2024, I had to go through the process of getting prior authorization again in January.

My copay with the extra help was around 25 dollars a month; without it, it went up to 2,651.49 a month. I couldn't afford it during the prior authorization process and went without it for nearly two months; I had a significant decrease in my ability to control my asthma and essentially became homebound as a result. I even went to the media about the issue with my copay because no one should have to go through what I went through simply because of the prior authorization process. I got approved for Xolair to be given to me for free on March 4th due to a secondary application that my doctor filled out which was finally approved by insurance so I can get my medication again. I got my first shipment of Xolair again on March 13th and I was overjoyed that I can have control of my asthma again.

I'm one of the lucky ones who were to get through the seemingly endless prior authorization hoops that one must go through for medications, procedures, etc and if I didn't have my doctor & his team of nurses helping him along with self-advocates that I know in other states helping me with the process, I wouldn't have gotten my medication and I would be using a portable oxygen tank now; I'm 42 years old and I want to hold off on that for as long as possible so that I'm not forced into a more restrictive setting in order to control my asthma. I'm asking you to please consider approving 2280 and I'm available for questions if needed. Thank you for your time.

2025 SB 2280
House Industry, Business and Labor Committee
Representative Jonathan Warrey, Chairman
March 17, 2025

Chairman Warrey and members of the House Industry, Business and Labor Committee, I am Marcus Lewis, CEO of First Care Health Center in Park River. Thank you for the opportunity to testify in support of Senate Bill 2280, which addresses the burdens of prior authorization in healthcare. I am testifying on behalf of the North Dakota Hospital Association (NDHA), which represents hospitals and health systems across the state.

I previously testified on prior authorizations to the Senate Industry and Business Committee on February 5, 2025. During that testimony, I discussed the difference between the intention and the impact of prior authorizations in healthcare, especially for rural facilities like First Care. As stated in my previous testimony, prior authorization policies create direct negative impacts on patient care, such as delaying care and placing additional stress not only on the patient but also on the healthcare provider. These policies result in dangerous delays in care, contribute to clinician burnout, and drive up costs for the healthcare system. Furthermore, they impose bureaucratic obstacles that interfere with timely patient treatment, ultimately jeopardizing patient health.

At First Care, we have seen firsthand the consequences of these delays.

Prior authorization requirements have delayed critical diagnostic procedures like CTs and MRIs, forcing some patients to wait or travel over an hour for care despite our ability to provide timely services. These delays contradict evidence-based medical practice and harm patient outcomes.

Due to the increasing administrative burden of prior authorizations, First Care Health Center has now had to hire a dedicated pre-authorization specialist. This position is solely responsible for managing authorization requests, tracking approvals, and handling denials, diverting resources away from direct patient care. This additional staffing expense is yet another consequence of unnecessary bureaucratic hurdles imposed by insurers. Adding

the labor costs of a full-time equivalent is no easy decision, and isn't one made for an inconvenience.

In outpatient infusions, delays in authorization disrupt essential treatments that help keep patients out of acute and emergency care settings. These delays in care are not conducive to an effective primary care environment, population health management, and our Patient-Centered Medical Home model.

Prior authorization delays result in unnecessarily prolonged hospital stays. We have had multiple cases where we received authorization—whether approval or denial—three days after a patient had been discharged or transferred to swingbed care. Preauthorization requests for swingbed care before a final determination from acute are often automatically denied. This puts our organization in a predicament: keep the patient in acute while waiting for swingbed approval or take the risk of denial by transitioning the patient without approval.

In another example, we have patients ready for transfer, with an available bed at our facility and a tertiary hospital eager to free up space—yet the transfer is delayed for days due to preauthorization requirements. In some cases, insurers provide only a seven-day authorization for swingbed services. However, the approval process for extending the stay can take up to two weeks. This results in a significant gap in coverage for both patients and our organization.

For all of these authorizations, peer-to-peer requests are becoming more frequent. These peer-to-peer calls are not conducive to rural providers. They are usually required within 24 hours, with little to no notice, pulling our family practice providers away from primary care visits to address bureaucratic hurdles instead of treating patients.

When a denial is received, it is up to us as the provider to deliver this news to the patient, adding unnecessary stress and confusion. We are also responsible for executing the appeal process, with extremely limited and ambiguous time limitations. Providing the appropriate care for the patient should not put the financial health of the facility at risk.

Delayed treatments, increased patient travel burdens, prolonged hospital stays, and the need for additional staffing to manage authorizations are not mere inconveniences—they are systemic failures that harm patient care and strain healthcare facilities. The experiences of providers and patients alike demonstrate that prior authorization requirements create significant barriers to timely and effective medical treatment.

For me personally, it comes down to accountability and trust. When I go to see my primary care provider, I trust that they are ordering the appropriate diagnostic, treatment, and medications for my condition. Why does my insurer not have the same faith in our Board-Certified MDs, DOs, FNPs, and PAs? If there is an accountability concern, why isn't the issue addressed with those respective boards, versus the impact of patient care delivery?

As value-based care progresses throughout healthcare, the total risk factor of wellness moves from the payor to provider. This continues through full capitation payments to providers, based on clinical coding and documentation. Prior authorization requirements impede this transition, removing trust and stewardship from the care team and Primary Care Provider.

We urge you to support Senate Bill 2280, which takes necessary steps to remove unnecessary barriers to timely patient care, hold insurers accountable, and align policies with the realities of rural healthcare delivery. These guidelines will enhance accountability, improve patient care, and ensure that healthcare providers can focus on what truly matters—caring for their patients.

Thank you for your time and consideration.

Respectfully Submitted,

Marcus Lewis, CEO
First Care Health Center

2025 SB 2280
House Industry, Business and Labor Committee
Representative Jonathan Warrey, Chairman
March 17, 2025

Chairman Warrey and members of the House Industry, Business and Labor Committee, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I am here to testify in support of Senate Bill 2280. I ask that you give this bill a **Do Pass** recommendation.

The North Dakota Hospital Association represents 46 hospitals in the state. These members include large hospitals, critical access hospitals, and specialty hospitals. Our members appreciate the opportunity to speak to you about their concerns with the prior authorization process used by health plans. We support the goals of the bill which are to standardize the prior authorization process and align it with best practices.

Prior authorization is a cost-control measure that requires health care professionals to obtain health plan approval before delivery of the prescribed treatment, test, or medical service to qualify for payment. While prior authorization can play an important role in ensuring the necessity of a health care service or prescription and containing costs, overly burdensome requirements can prevent or delay patients' access to necessary care. Overly strict prior authorization requirements also require health care providers to spend inordinate amounts of time to comply with these requirements, which drives increased administrative costs and is rated as one of the top reasons for provider burnout. This is why states around the country have adopted reforms that ensure prior authorization is used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients and health care providers.

Prior authorization requires patients or their providers to secure pre-approval as a condition of payment or insurance coverage of services. Patients experience significant health impacts, such as delayed treatment, denied care, second-choice therapy, and disease progression, because of overly restrictive prior authorization processes. Hospitals

are committed to policies that reduce cost while preserving quality health care but they do not support practices that improperly delay or deny care and undermine patient access.

We support the bill's provisions to reduce overall healthcare provider and patient burden through improvement to prior authorization practices. The bill ensures timely access to care by requiring insurers to respond to a prior authorization request within seven working days for nonurgent circumstances and within 72 hours for urgent health care services. It would ensure that adverse determination appeals are reviewed by a physician, licensed dentist, or licensed pharmacist. We also support requiring prior authorization to remain valid for 12 months for patients with chronic and long-term conditions. It will also improve transparency by requiring data reporting annually, including the total number of prior authorization requests received; number of authorizations issued; number of adverse determinations issued; number of adverse determinations reversed on appeal; and the reasons an adverse determination was issued.

Thank you for your consideration of this bill. We ask that you give it a **Do Pass** recommendation.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

Testimony of Shane Goettle
On Behalf of the American Cancer Society-Cancer Action Network
House Industry, Business and Labor Committee
Chairman - Representative Jonathan Warrey

Senate Bill 2280

Chairman Warrey, members of the House Industry, Business and Labor Committee, my name is Shane Goettle, and I am here today on behalf of the American Cancer Society-Cancer Action Network to testify in strong support of Senate Bill 2280.

This legislation is crucial in addressing the systemic barriers created by the current prior authorization process, which often delays access to medically necessary care for patients, including those battling cancer.

When prior authorization was first introduced, it was intended as a safeguard to ensure that high-cost medical procedures and treatments were necessary and appropriate. However, over time, this process has evolved into an overused bureaucratic hurdle that affects even the most routine treatments. According to a 2023 survey conducted by the American Medical Association:

- 92% of physicians report that prior authorization results in care delays, posing a significant risk to patient health.
- 33% report that delays in authorization have led to serious adverse events for their patients.
- 80% indicate that prior authorization requirements contribute to treatment abandonment.

For cancer patients, these statistics are not just numbers; they represent real people facing life-threatening illnesses who are being forced to wait for care while their insurance company reviews requests that should be standard.

For patients undergoing chemotherapy, radiation, or other critical treatments, timely access to care is not a luxury—it is a necessity. Prior authorization delays can mean the difference between a treatment being effective or ineffective, particularly in aggressive cancers where every day counts. Cancer patients cannot afford to wait days or weeks for an insurance company to determine whether their prescribed treatment is necessary.

Moreover, requiring re-authorization for medications that patients have already been using successfully for years adds unnecessary stress to individuals already dealing with the emotional and physical toll of a cancer diagnosis.

SB 2280 introduces several key reforms to address these issues:

1. **Standardized Definitions and Transparency** – The bill ensures uniformity in how "prior authorization" and "medical necessity" are defined, reducing ambiguity and streamlining the approval process.

2. **Extended Validity for Prior Authorizations** – A prior authorization for maintenance medications will be valid for at least one year, eliminating redundant paperwork and preventing unnecessary delays.
3. **Timely Decision-Making** – Insurers must respond to urgent prior authorization requests within 72 hours and non-urgent requests within seven calendar days, ensuring that patients receive the care they need when they need it.
4. **Peer Review by Qualified Specialists** – The bill mandates that prior authorization denials must be reviewed by a physician. Licensed dentist, or licensed pharmacists with expertise in the specific medical condition, reducing the likelihood of inappropriate denials.
5. **Online Accessibility and Transparency** – Health insurers will be required to post all prior authorization procedures and lists of services subject to prior authorization on their websites to provide clear guidelines for patients and providers.
6. **Protection Against Retrospective Denials** – A prior authorization review organization may not revoke or limit a previously granted authorization if care is provided within 45 business days unless fraud is involved.
7. **Study on Prior Authorization's Impact** – The bill now includes a legislative management study to assess the effects of prior authorization on patient care and healthcare costs, ensuring accountability and improvement in future reforms.

Reforming prior authorization is a national trend. According to the National Conference of State Legislatures, 23 states have enacted over 43 bills in recent years to address this issue, with 18 new laws passed in 2024 alone. North Dakota must act now to ensure that our patients receive timely, appropriate care without unnecessary bureaucratic obstacles.

Conclusion:

On behalf of the American Cancer Society-Cancer Action Network and the countless cancer patients affected by prior authorization delays, I urge you to support Senate Bill 2280. This legislation will not eliminate prior authorization, but it will ensure that the process is transparent, efficient, and, most importantly, does not put patients' health at risk.

I appreciate your time and consideration and respectfully ask for a Do Pass committee vote on SB 2280. Thank you, and I am happy to answer any questions.

GREAT PLAINS CHAPTER
AMERICAN COLLEGE of CARDIOLOGY®

March 16, 2025

Dear Chair Warrey and Members of the House Committee on Industry, Business and Labor,

Good afternoon, my name is Aaron Smith. I am a practicing cardiologist at Sanford Health in Fargo, as well as a member of the North Dakota-Great Plains Chapter of the American College of Cardiology (ACC). Today, I am testifying on behalf of the North Dakota-Great Plains Chapter to lend our full support to **Senate Bill 2280.**

Prior authorization is a utilization management process that requires healthcare providers to obtain approval from insurance companies before prescribing a specific medication or delivering certain types of care. Prior authorization is overused, and existing processes present significant administrative and clinical concerns. A study from the American College of Cardiology found that 77 percent of providers spent less time on patient care because they were dealing with the documentation involved in the prior authorization process. Senate Bill 2280 is a positive step to streamline prior authorization requirements so that patients can receive timely, quality, medical care.

One of the central provisions of Senate Bill 2280 is the modification of the timeframe in which an insurer must decide on a prior authorization request or an adverse determination (denial). Under Senate Bill 2280, insurers must make these decisions more promptly, aiming to reduce delays that could affect patient care. On several occasions, my patients have directly experienced hardship and frustration as a result of untimely decision-making with regard to prior authorization from insurers. I have patients who have been scheduled for cardiac stress testing only to find out that their test has been denied by insurance when they arrive. This puts patients in a position where they have to decide whether to pay for the test out-of-pocket, not knowing what the cost to them will be, or not undergo testing and potentially put their health at risk. Additionally, this legislation mandates that if a denial is made, the insurer must provide clear reasoning for the decision and inform patients about their right to appeal.

I urge the committee to pass Senate Bill 2280. The state's current prior authorization guidelines are contributing to greater physician burnout, reduced employee productivity, and significant costs incurred across the entire healthcare system. It is time to put patients first and ensure all North Dakotans receive the quality healthcare they deserve, without unnecessary obstacles.

Thank you.

Aaron Andrew Heigaard Smith, MD, FACC, FACP
ACC ND-Great Plains Member
Advanced Imaging Cardiologist
Sanford Health - Fargo
aaron.ah.smith@gmail.com

Dear Chairman Warrey, Vice-Chairmen Ostlie and Johnson, and Members of the House IBL Committee,

My name is Emily Bakkum, and I would first like to thank you for giving me the opportunity to tell my family's story in support of SB2280. It truly demonstrates the importance of this bill and the consequences of our current system's lack of mandates.

I am honored to be the voice for my late cousin, Shanna Barone. The first thing that came to people's minds about Shanna was her smile. It was warm, inviting and just the right amount of mischievous.

Her immediate family didn't think much of her fall in September; they thought maybe she missed a step off the deck. She had a headache but nothing so bad that it needed medical treatment.

That changed on Sept. 19 when Shanna was life-flighted from Carrington to Fargo with stroke symptoms. After imaging, a neurosurgeon performed an emergency craniotomy, removing part of a tumor applying pressure to the brain. They saw three more inoperable spots. Initial reports determined it was likely lymphoma, but her care team was optimistic.

She was a healthy 40-year-old mother, and lymphoma is treatable. I finished my own cancer treatment a year prior. It was breast cancer spread to lymph nodes, so not the same certainly, but I became fiercely protective of my cousin. I was ready to be involved however she needed me to be.

We lost Shanna on Feb. 6, less than five months after the first sign of trouble. It was grueling and heartbreaking and perhaps there was nothing that could have been done to save her life, but dealing with

the insurance company's prior authorization requirements certainly cost us time in a process where – aside from cancer -- time was perhaps our greatest adversary.

Prior authorization was most likely born of necessity with good intentions. Insurers use this, in part, to contain costs. As its evolved, however, physicians report the process can lead to significant delays in care, contributing to negative outcomes in patients, including abandoned treatment. The process was once used sparingly to determine whether costly medical procedures or medications were needed but now providers often must get approval to prescribe even the most routine medications and procedures. As mentioned in discussions on the North Dakota Senate floor regarding North Dakota Senate Bill 2280, providers are now becoming "gun-shy" to any prescriptions and procedures being covered and submitting prior authorization requests for most services.

Her team of oncologists submitted prior authorization requests for aggressive chemotherapy and a PET scan upon admittance. She didn't get approval and receive those services until Oct. 3 – an 11-day wait. The PET scan determined a mass in her abdomen, so a prior authorization request was sent for another chemotherapy regimen that would address that as well. She wasn't approved until Oct. 11 – eight days.

Her oncologists remained vigilant and switched the plan on Nov. 18. They wanted a better response, so they switched to R-ICE, a combination of four chemotherapy drugs given over several days.

They would follow with CAR-T cell therapy, a process that usually takes between three and four weeks to complete.

By Jan. 2 or perhaps sometime sooner, Shanna's oncologists submitted the prior authorization request for CAR-T because they knew she would need it sooner than later. Her symptoms increased daily. She lost vision in her left eye, then movement and feeling on that side, then her speech. Her skull skin was so tight around the growing tumor it was shiny.

Radiation began Jan. 2 to buy time waiting for approval. By Jan. 5, she was admitted and would never leave.

On Friday, Jan. 10 -- Shanna got "soft approval" for CAR-T from the insurance company, but they "couldn't" sign off by the end of the business day and told us to wait until the next week. Formal approval was received on Jan. 14 . The lab expedited their turnaround to complete all processes by Jan. 29.

By then, she had declined, so she had to undergo another surgery to place a shunt in her skull to relieve pressure. We were so encouraged by her response -- she was responsive and spoke clearly for the first time in weeks. But two days later she declined again. Additional cancer cells had been allowed to grow during the period she waited for approval, and the pressure relieved by the fluid being drained had been replaced by the presence of more cancer.

Shanna passed away Feb. 7, 11 days after her 41st birthday.

Shanna knew her battle would be hard, but she went into it with fiery determination, an intelligent, compassionate care team and family support.

This is why placing limits on the amount of time insurers can take to make prior authorization decisions is vital. Such limits could have curtailed at least some of the delays faced by Shanna and possibly reduced her suffering, which was devastating to watch.

I am also in strong support of this bill's directive to require board-certified, licensed providers with relevant experience in the case's particular area of medicine to review prior authorizations. I have not met one oncologist between my own cancer journey or Shanna's who would have sat on their hands and let a patient struggle for this amount of time.

Her life depended on decisions she didn't get to make, ones that increased suffering and anxiety in the interim. If a simple set of laws can prevent this situation from happening to another North Dakotan, the decision to pass this bill is an easy one.

ELMWOOD FAMILY DENTISTRY

Dr. Bryan Seeley, D.D.S.
1213 Prairie Parkway
West Fargo ND 58078
(701) 282-5250

Dear Chairman Warrey, Vice-Chairmen Ostlie and Johnson, and Members of the House IBL Committee,

My name is Dr. Bryan Seeley, and I have been practicing dentistry in North Dakota for 21 years. It has been my privilege to contribute to my community and fellow North Dakotans in this capacity and watch how dentistry has evolved over the years to better serve our patients. I am writing in strong support of SB2280 because we are at a pivotal time in our industry where insurance reform is absolutely necessary for our patients.

While advancements in technology have certainly made many procedures and treatments more comfortable and efficient for our patients, we have seen a steady increase in insurance companies interfering with treatment plans. Outside of very basic procedures, prior authorization is being required for most treatment. This delays care for the patient and renders the provider helpless to provide quick relief. North Dakota dentists have also been experiencing issues with prior authorization being approved, but after the procedure has been completed, a reversal in the decision to pay on the claim – leaving thousands of dollars of unexpected costs on the patient.

These issues have resulted in many North Dakota practices terminating their contracts as participating providers for any insurance plans. The burden to file insurance then lands on the patients themselves, who must navigate a system of which they generally have no expertise.

Transparency is important for establishing trust. We are upfront with our fee schedules for each procedure or treatment at our practice and complete a financial consultation with each patient in our office. Similarly, SB2280 would guarantee the transparency of the claims filed with the insurance company, the number of approvals and denials, and the reason for the denials – all important data to determine that North Dakotans are getting fair coverage for their premiums.

SB2280 would help alleviate delays and interruptions in patient care for North Dakotans. With an enforced timeline for prior authorization, we can schedule patients for their follow-up care at the time of their initial appointment, instead of waiting for a longer period of time, then trying to find time in the schedule for them weeks down the road. This would drastically help with continuity of care.

Perhaps even more importantly, SB2280 would ensure a licensed dentist, educated in the field with ongoing continuing education to stay abreast of new dental development and treatment options would be making informed decisions on prior authorization. A provider who has experience with patients, materials and treatment modalities is far more adept to make decisions with the best interest of the patient at the forefront.

I appreciate your time and your consideration of my testimony in favor of SB2280. I respectfully ask for your support in passing SB2280 for a healthier North Dakota.

Dr. Bryan Seeley

Community HealthCare Association of the Dakotas

Testimony:
Senate Bill 2280
House Industry, Business and Labor Committee
Representative Jonathan Warrey, Chair
March 17, 2025

Chairman Warrey, Vice Chairman Johnson, and Members of the Committee:

I am Shelly Ten Napel, and I am CEO of Community HealthCare Association of the Dakotas (CHAD). On behalf of CHAD and our member health centers I am asking for your support of SB 2280 with a do pass recommendation.

CHAD is a non-profit membership organization that serves as the Primary Care Association for North Dakota and South Dakota, supporting community health centers across both states in their efforts to provide health care to underserved and low-income populations. The health centers we represent have locations in both urban and rural communities.

Community health centers (CHCs) are non-profit, community-driven primary care clinics that serve all individuals, regardless of their insurance status or ability to pay. The community health center integrated care model includes primary care, mental health and substance use treatment, dental care, pharmacy services, and a range of case management services that can include help with transportation, finding community resources, or assistance with insurance and financial enrollments.

North Dakota is home to five community health center organizations that provide comprehensive, integrated care to more than 36,000 individuals with over 126,000 visits at 22 locations in 20 communities across the state. Nearly 40% of those patients have Medicaid; 31% utilize private insurance; and 16% are uninsured; Over half earn incomes below the federal poverty level. I've included an attachment that indicates where health centers are located and what services they offer in North Dakota.

Our member health centers have expressed several concerns with the prior authorization process of commercial insurance plans and North Dakota Medicaid, including delays to urgently needed care and medications and a significant amount of staff time invested in securing authorizations that drive up the cost of health care and reduce staff satisfaction.

Delayed approval of prior authorization leads to delays in patient care. Patients being

treated for emergent health and mental health disorders typically need medications urgently and don't have time to wait for a lengthy prior authorization process. Health centers indicated that a reduction in the response time and a consistently applied time limit for the authorization process, as included in SB 2280, would help alleviate some of the barriers to care they are currently experiencing.

With the integrated care model health centers offer, they have many patients who need mental health and substance use treatment. For these patients, barriers to medication can sometimes be the difference between life and death. One health center specifically pointed to their patients experiencing distress such as those who are suicidal and postpartum patients with psychosis, and how delays in medication could be especially harmful or even fatal.

Health center providers indicate they spend a significant amount of time on the prior authorization process, which reduces the time they are able to spend in patient care. Kayla Abrahamson, DNP, FNP-C, a family practice nurse practitioner at Northland Health Centers in McClusky has this to say about prior authorization: "The time it takes to complete prior authorization for patients is significant, taking away from direct patient care and contributing to provider burnout." She continues "One of the major challenges we face today is the lack of staff available to assist with completing these prior authorization requests, which places an undue burden on providers whose time could be better spent focusing on treating patients. Urgent action is needed to streamline these processes, reduce administrative burdens, and prioritize patient care.".

On behalf of our member health centers, I ask for your support of Senate Bill 2280 to improve the prior authorization process.

Respectfully submitted,

Shelly Ten Napel, CEO
Community HealthCare Association of the Dakotas

The Arc
North Dakota

IBL
SB 2280
March 17, 2025

My name is Kirsten Dvorak, Executive Director of The Arc of North Dakota, an organization dedicated to promoting and protecting the human rights of individuals with intellectual and developmental disabilities (IDD). For 65 years, we have advocated for inclusive services that empower individuals with disabilities to lead meaningful, independent lives in their communities.

We support Senate Bill No. 2280, designed to improve transparency, accountability, and promptness in the health and dental insurance authorization process. This legislation is vital for individuals with IDD, who often face unwarranted delays and denials when seeking essential medical care.

People with IDD depend on specialized therapies and ongoing medical treatments to support their health and independence. Delays in obtaining prior authorization can lead to serious interruptions in treatment, adversely affecting health outcomes. By requiring prior authorization decisions to be made within seven calendar days for non-urgent cases and within 72 hours for urgent health care services, Senate Bill 2280 aims to eliminate detrimental delays for individuals needing continuous and prompt care.

Additionally, the legislation ensures that prior authorizations for chronic or long-term care conditions are valid for a full 12 months. This adjustment significantly alleviates the administrative burden on families and healthcare providers, who would otherwise have to reapply frequently. Many individuals with intellectual and developmental disabilities (IDD) need lifelong management for chronic conditions like epilepsy, cerebral palsy, and various complex medical issues. Interruptions in authorization can result in serious setbacks, such as hospitalizations, loss of function, heightened pain, and a reduced quality of life. Caregivers and families navigate a challenging healthcare environment, and additional administrative obstacles only increase stress and financial pressures, making it harder to maintain consistent, high-quality care.

This bill establishes essential protections against disruptions by simplifying the prior authorization process and enhancing long-term stability for individuals with IDD and their caregivers. Additionally, it ensures continuity of care by recognizing prior authorizations for a minimum of 60 days when an enrollee switches insurers, thus preventing unnecessary interruptions in services and potential health decline.

Safeguards against retrospective denials mean that once authorization is granted, it remains valid for 45 business days unless fraud is suspected, giving individuals and families reassurance and stability in their care. By removing prior authorization requirements for emergency medical services, Senate Bill No. 2280 guarantees that individuals with IDD can access timely medical care without bureaucratic hurdles. The Arc of North Dakota passionately supports equitable and accessible healthcare, believing this bill significantly lowers administrative barriers and streamlines access to necessary services for those with IDD.

We urge the committee to support Senate Bill No. 2280 and prioritize the health and well-being of North Dakotans with disabilities.

Kirsten Dvorak
Executive Director
The Arc of North Dakota
701-222-1854

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Industry, Business and Labor Committee
House Bill 2280 – March 17, 2025
Testimony of Brenda Ruehl, P&A Director Program Services

Greetings Chairman Warrey and members of the Industry, Business and Labor Committee. My name is Brenda Ruehl and I'm a Director of Program Services at the North Dakota Protection and Advocacy Project (P&A). P&A is an independent state agency established in 1977 to assert and advance the human, civil, and legal rights of people with disabilities. The agency's programs and services seek to make positive changes for people with disabilities where we live, learn, work and play.

P&A supports this bill as it supports individuals with disabilities as they seek medical services to maintain and/or regain their health. Many individuals with disabilities need lifelong health care for physical and behavioral health needs and for complex diseases including cancer, cardiac, metabolic, and respiratory diagnoses. This bill would ensure that medical decisions remain between individuals and their doctor, who best know and understand their medical needs.

Obtaining authorization for care and treatment can be complicated, confusing and burdensome to some individuals and they give up. This can seriously impact their current and future health. A delay in care can exacerbate their illness; requiring longer hospitalizations, more expensive treatment, and long-term outcomes that impact their health, employment and longevity. When emergency events can be treated timelier, the need for hospitalizations and serious complications due to delay in authorizing care are reduced. Eliminating prior authorization for emergency medical services ensures individuals receive timely care.

This bill would safeguard against delays and disruptions by streamlining the prior authorization process. It also guarantees continuity of care by honoring prior authorizations for at least 60 days when an enrollee changes insurers. It protects against retrospective denials once approval is granted, it cannot be revoked for 45 business days. This bill provides a regulatory framework that ensures prior authorization is efficient, consistent and in a manner that provides access to medical care in a timely manner.

P&A is in strong support of SB 2280 and request you give a Do Pass on this bill to protect the health of all North Dakota citizens.

Thank you for your time and consideration.

Brenda Ruehl
Director Program Services
bruehl@nd.gov

March 17, 2025

RE: SB 2280 – Oppose

Chair Warrey and Members of the Committee,

On behalf of the National Association of Dental Plans (NADP)[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 Is Different

Including dental plans in the prior authorization process would significantly disrupt how the dental market currently operates. Dental plans offer a wide variety of products and benefit designs compared with medical plans. Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventative services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. 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.

In dental, pre-treatment estimates are utilized to develop a treatment plan with a patient. For example, a patient needing multiple root canals could consult with their dentist on a timeline for care based on their dental needs. The dentist in turn could submit a pretreatment estimate to the patient's insurance plan to determine the coverage and medical necessity standards of their coverage. This healthy engagement through a pretreatment estimate allows a patient to receive care covered by their plan and develop a thorough care plan for the dentist.

The 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. In turn premiums and cost of care may increase to meet the expanding administrative costs, feeding a cycle of cost increases that harms access to care and outcomes. For example, 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.

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

[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

[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

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 a 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,

Bianca Balale
Director of Government Relations
National Association of Dental Plans

Senate Bill 2280
Industry and Business Committee
69th Legislative Assembly of North Dakota
February 5, 2025

Dear Chairman Warrey and Committee Members,
My name is Joan Connell. As a pediatrician, parent, and North Dakota citizen, I am asking you to VOTE YES on SB 2280. The delay in receipt or lack of receipt of optimal medical care due to problems with prior authorization affects my patients every day.
This hits most frequently and hardest at the Children's Regional Asthma Clinic I hold in Bismarck. In spite of the national guidelines for pediatric asthma changing in late 2019, there are insurance companies that continue to deny medications that are recommended in the guidelines. Some insurance companies, including ND Medicaid, refuse to reimburse Symbicort, the only asthma combination inhaler that contains a low potency steroid, which I prefer to prescribe for patients due to adverse effects on growth that we have seen with high potency steroid inhalers. They tell me that the industry says this is not a concern, yet I have 5-10 patients in my clinic who would disagree because of their documented medication-associated drop off in height gain. Last month, we had a family ask for refills of epinephrine pens that two of their children need due to a history of severe allergic reaction/anaphylaxis. We refilled the script, which was denied. We then looked up the insurance company's listed formulary and prescribed the epinephrine pen that was listed. This too was denied. We then had to take more time to call the insurance company to ask exactly what they would like us to prescribe. While that was a complete waste of a lot of clinical time, the real disaster is that during that 2+ week interim, those kids did not have epinephrine pens. Thank God they did not have a severe allergic reaction during that time.
While I could continue with examples from each day, I think the benefit of this bill has been adequately illustrated with the above examples. Please VOTE YES on SB 2280 so patients can receive optimal therapy when they seek care.

Senate Bill 2280 – Support
March 17, 2025
House Industry, Business and Labor Committee
Janelle Moos, AARP ND jmoos@aarp.org

Chairman Warrey and Members of the Committee,

My name is Janelle Moos, Associate State Director of Advocacy with AARP North Dakota. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. Approximately 82,000 of those members live in North Dakota.

Prior authorization, as you may already know, is preapproval for medical services or prescription drugs that health insurance plans often require before they'll cover the cost. Plans put these requirements in place to avoid paying for unnecessary services or expensive procedures and drugs when a lower-cost version that's available could work just as well.

Prior authorization also lets patients know ahead of time if their plan will approve something that's not always covered rather than having to appeal a denial after the fact. But how often and under what circumstances prior authorization is required depends on the health plan. For example, while original Medicare has a few prior authorization requirements, private Medicare Advantage plans and Part D prescription drug plans use this procedure more often.

A new study by KFF, formerly the Kaiser Family Foundation, released in August 2024, found Medicare Advantage prior authorization requests increased significantly from 37 million in 2019 to more than 46 million in 2022. The share of denied prior authorization requests also increased after several years of being stable, from 5.8 percent in 2021 up to 7.4 percent in 2022. What's more, KFF uncovered that the majority of denials in Medicare Advantage plans were overturned on appeal.

Two important sections of SB 2280 that align with AARP policy pertains to transparency and putting guardrails in place for who conducts prior authorization reviews and the process by which they are conducted. Our policy that supports authorization/ utilization review relates primarily to Medicare Advantage, but can be applied to the broader health insurance market including:

- Adverse UR decisions must be made by clinically qualified personnel and reviewed by active practitioners in the same or similar specialty. Reviewing clinicians need not be residents of the state where the enrollee whose claim is being reviewed resides. Reviewers must not receive financial compensation based directly or indirectly on the number or volume of certification denials.
- Certification decisions must be made at least as rapidly as the medical situation requires to protect the beneficiary's health and permit a meaningful appeal. Denials must be accompanied by clear information on the reasons for denial as well as instructions on how to appeal the denial. https://policybook.aarp.org/policy-book/health/section-c-medicare/medicare-part-c-medicare-advantage-ma-private-plans/medicare-advantage-standards#node-18896

SB 2280 also prohibits prior authorization for emergency services, which also lines up with AARP policy:

- Patients should be covered for all necessary care associated with the emergency. Health plans should be prohibited from requiring prior authorization for emergency services. https://policybook.aarp.org/policy-book/health/section-c-medicare/medicare-part-c-medicare-advantage-ma-private-plans/medicare-advantage-standards#node-18896:

Inappropriate prior authorization denials can have serious health implications for MA enrollees, especially those with significant medical needs. By delaying or preventing access to medically necessary care, the often-lengthy pre-approval process can disrupt care delivery or lead people to abandon their treatment. It can also result in serious adverse events such as hospitalization or even death. In other cases, improper coverage denials create a significant financial barrier to accessing medical services ordered by a health care provider because, without insurance, therefore, we urge you to look favorably upon SB 2280.

Thank you.

March 17, 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 Is Different

Including dental plans in the prior authorization process would significantly disrupt how the dental market currently operates. Dental plans offer a wide variety of products and benefit designs compared with medical plans. Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventative services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. 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.

In dental, pre-treatment estimates are utilized to develop a treatment plan with a patient. For example, a patient needing multiple root canals could consult with their dentist on a timeline for care based on their dental needs. The dentist in turn could submit a pretreatment estimate to the patient's insurance plan to determine the coverage and medical necessity standards of their coverage. This healthy engagement through a pretreatment estimate allows a patient to receive care covered by their plan and develop a thorough care plan for the dentist.

The 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. In turn premiums and cost of care may increase to meet the expanding administrative costs, feeding a cycle of cost increases that harms access to care and outcomes. For example, 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.

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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.

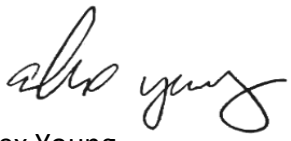
Prior authorization is most commonly used as a managed care tool to control costs and avoid unnecessary expensive procedures. A prior authorization requires advance approval for, usually higher cost services following a review to determine if the proposed service is medically necessary. Once issued, 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 a 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,



Alex Young
Legislative Director
American Council of Life Insurers

North Dakota 2025 Legislative Session
Senate Bill 2280 Regarding Prior Authorization

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

My name is Susan Finneman. I live in Bismarck, ND. I was born and raised in North Dakota. I worked for 20 plus years as a Purchasing and Production Planning manager at a multinational manufacturing firm. My mother was a nurse. I have two siblings and one brother-in-law that are physicians.

My personal values regarding healthcare choice started when I was young. My first-grade teacher suspected that I had hearing issues. It was discovered that I had 0% hearing in one ear and 10% in the other. Our insurance allowed us to seek out and use specialists to identify and treat the problem. My parents did not have to jump through hoops to find and obtain the necessary care and restore my hearing to normal levels. I did not lose ground in school.

In March of 2015, I had surgery in Colorado to repair a disc in my spine. This surgery initially seemed to work but in April I started to have pain and numbness in my lower body. By the end of June, I was no longer able to get in and out of bed without assistance. I had to bend over a walker to get around and had to crawl up and down the steps of my home. My pain was usually 9 or 10 on a scale of 10. Blood work repeatedly indicated a serious infection. Throughout this period of time, my physician repeatedly asked for preauthorization for MRI and CAT scan imaging. The insurance company did not respond.

When I lost control of my bladder and bowel, I went to the ER. Due to the emergent situation, preauthorization was not required for the imaging. It was discovered that I had an infection in my spine. The infection had destroyed all the repaired disc, 50% of the vertebrae above it and 30% of the vertebrae below it. If I had fallen or moved incorrectly, my spinal cord could have been severed. Reconstruction surgery was now necessary.

Additionally, I began what would become a 6-month course of two IV antibiotics that needed to be infused twice a day. That course was followed by a year on oral antibiotics. Oxycodone and morphine were prescribed to manage the pain. The consequences of use of these drugs are well known.

The long-term use of the antibiotics caused dental problems as well as intestinal issues that persisted for more than 5 years. The extended use of the narcotics caused me to understand addiction. I was physically addicted to the meds. I desperately wanted to be off the narcotics as they fogged my brain and prevented me from driving myself to appointments. This burdened my husband. It took an additional 2 months of work to fully discontinue their use.

On October 30th, my reconstruction surgery was scheduled for Monday, November 16th. The surgeon's office immediately began working on obtaining authorization from the insurance company. On Friday, November 13th I

received a call from the surgeon's office. They had still not received authorization from the insurance company. They were told that it was on the Medical Director's desk. The surgery would need to be rescheduled. The next spot on the schedule was not until March of 2016.

I went to the insurance company's web site and found the name and phone for the highest-ranking MD on their executive staff. I made one phone call and had authorization within 30 minutes.

I was able to do this because I have medical and system knowledge. It should be noted that many insurance companies have now made this information very difficult to find. This further degrades the ability of patient and provider to obtain authorization for needed care.

Within a day of the surgery, I was able to walk upright with little pain. Within a week, I no longer needed the walker. I firmly believe that had I not forced the issue, I would not be standing here today. Had the insurance company provided authorizations in a timely manner, I would have been spared months of ongoing pain and trauma.

Chairman Warrey and Committee members: This happened ten years ago. Things are far worse today. Insurance companies have increased time delays and are requiring physicians to spend an increasing amount of time and energy on this type of problem. This becomes time that is not devoted to patient care and outcomes. I do not believe that a patient should have to go to these lengths to obtain necessary care. I wonder what happens to those who do not have the resources and background that I have.

As a manager in a manufacturing firm, I learned that having benchmarks and standards of performance are absolutely necessary to assure good outcomes. It makes sense to hold insurance companies accountable for the timing of their decisions. Insurance companies can and should do better.

I encourage you to vote DO PASS on Senate Bill 2280 which allows me as a health care consumer to obtain care in a timely fashion from providers that I know and trust.

Thank you for your time.

SANFORD HEALTH PLAN

Chairman Warrey and Members of the House IBL 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 a neutral position on 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 is neutral on SB2280.

Sanford initially opposed SB2280 as drafted and presented in the Senate – this was for a number of reasons. Primarily – our opposition was premised on the bill being too one-sided and not demonstrative of a middle ground. As an integrated health system and health plan, we worked to share our concerns, drat an amendment, and work towards compromise. The bill, as amended and before you today, represents significant work with the proponents and other stakeholders to identify areas of opportunity to bring the bill more towards the middle. We believe the SB2280 – as now amended – represents that middle ground.

We want to thank Senator Meyer and the proponents for the receptiveness of hearing our concerns and also thank the proponents for largely taking Sanford Health amendments on the Senate side. We understand and acknowledge, too that concerns remain for opponents on other sections of the bill. To be clear on our position, if an amendment may shift the current version one way or the other, we may re-evaluate our position – as we would with any large reform legislation. Make no mistake, SB2280 is bringing substantial reform regarding prior-authorization and deserves thoughtful consideration.

Some may now ask – if it was Sanford's amendments that were mostly adopted in the Senate – why have they only moved to neutral and are not supporting SB2280? Simply put – this is due to the scope of the legislation. As we shared in the Senate, we have concerns with the bill not applying these reforms across all state-regulated markets. As written, the legislation precludes application to Medicaid, Medicaid Expansion, WSI and NDPERS. This exclusion prohibits application of the standards set forth SB2280 from applying to well over 100,000 North Dakotans. We acknowledge and appreciate the study language to NDPERS. Yet by not including these large markets of covered lives, the bill seemingly contradicts the proponents' argument that inconsistent prior authorization requirements are a barrier to providing care. This specific provision precludes Sanford from moving to support.

Again – we thank the hard work in the Senate from all parties, understand some concerns may remain from opponents and are still committed to working on SB2280 to ensure this meaningful reform is in the best form to benefit our providers and health system. Most importantly, that they can benefit the patients – the citizens of North Dakota.

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

SB 2280 Testimony
Senate Industry and Business Committee
Representative Jonathan Warrey, Chairman
March 17, 2025

Chairman Warrey and members of the committee, my name is Carlotta McCleary. I am the Executive Director for both North Dakota Federation of Families for Children's Mental Health (NDFFCMH) and Mental Health America of North Dakota (MHAND). NDFFCMH is a parent run organization focused on the needs of children and youth with emotional, behavioral, or mental disorders and their families. MHAND's mission is to promote mental health through education, advocacy, understanding and access to quality care for all individuals.

We are here to support SB 2280. We believe SB 2280 is a patient-centric bill that will provide many substantial improvements to current practices. MHAND are NDFFCMH want to ensure North Dakotans can get timely access to services and supports that are recommended by their own physicians and specialists. Prior authorizations do serve a purpose, one that can save money and produce effectiveness for the patient. However, there are well-known issues with the way many patients experience prior authorizations today. For many, the prior authorization process can introduce significant delays in treatment, treatment that the patient has been told are medically necessary by their own doctor. When this occurs, prior authorizations can be burdensome to patients and can impact their health and quality of life if they are not receiving timely and necessary care recommended by their own physicians. Prior authorizations can also be burdensome for medical professionals trying to deliver necessary and quality care for their patients, leading to substantial and harmful delays in treatment. For the patient, prior

authorizations enter a great deal of uncertainty, time and energy spent trying to get the care that they know they need. Prior authorizations add layers of distress to the lives of those already experiencing much distress from their medical conditions; layers of distress that we desperately wish we could erase from the minds of individuals and families we directly support, and those that we work alongside to help make North Dakota the healthiest state in the nation.

Again, the prior authorization process is a necessary component of the health care system, but there are reforms that can be beneficial and needed for all parties. SB 2280 would provide standardized definitions for "prior authorization" and "medical necessity." Policies and procedures are to be put on the organization's website, written in ordinary language understandable by the average person. Additions or changes to the policies are required to be placed on their websites prior to enactment. Health care providers would be notified at least one hundred and twenty days before the change is implemented.

SB 2280 would ensure that physician and dentist recommendations would be reviewed by peers who at least have a similar specialty, with experience treating patients with the condition or illnesses that the service is being requested. Urgent healthcare requests will require a response within 24 hours, whereas non-urgent requests would be provided within two days. Furthermore, SB 2280 would allow an approved drug to be valid for a year (or at least through the last day of coverage) and cover any dosage change during the authorization period.

We believe that SB 2280 will make prior authorization policies more transparent and understandable for the general public and physicians, while simultaneously eliminating

many of the barriers that currently exist for patients so that they can live healthier and more fulfilling lives.

Thank you for your time and I would be happy to respond to any questions.

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PRIOR AUTHORIZATION
SB 2280

HOUSE IBL COMMITTEE 3/17/25

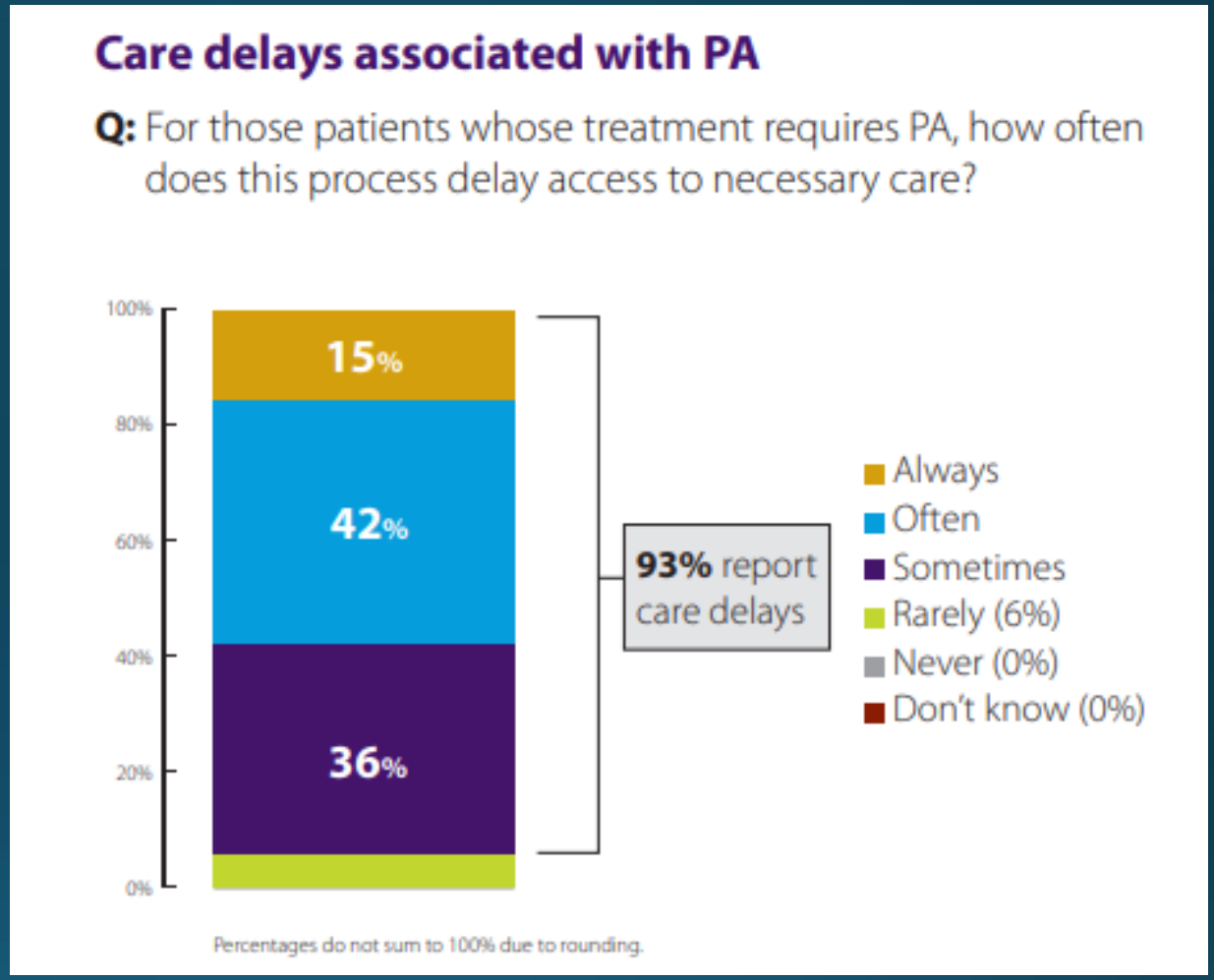
Duncan B. Ackerman, MD

- Orthopedic Surgeon
- President -- The Bone & Joint Center, North Dakotas largest independent orthopedic surgery practice
- Past Chair for State Legislative and Regulatory Issues Committee for The American Academy of Orthopedic Surgeons

Consensus in 2018 to make improvements in PA process….AMA physician survey results indicate failure of improvement

Prior Authorization Patient Impact

93% report care delays

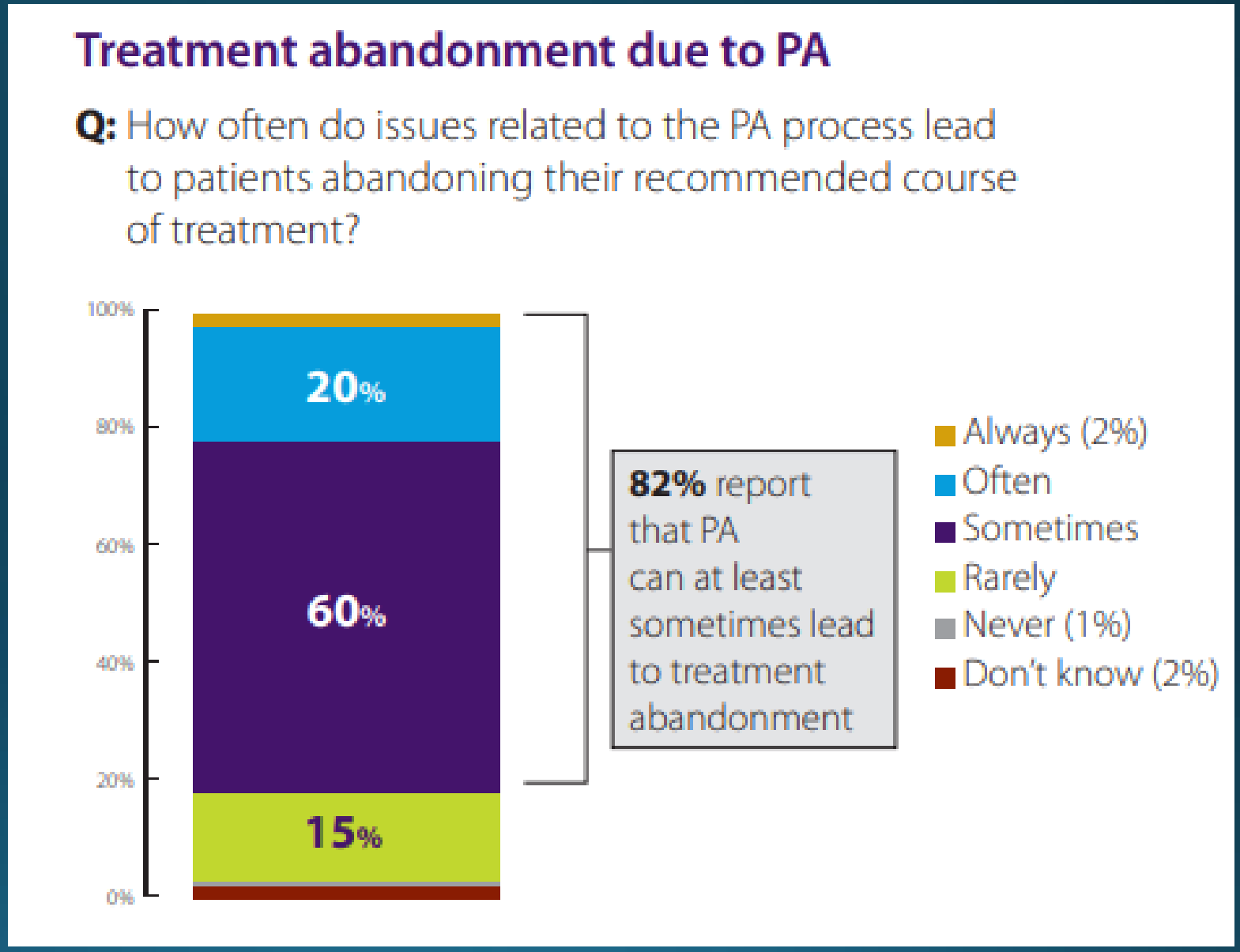


AMA
AMERICAN MEDICAL ASSOCIATION

2024 AMA prior authorization physician survey

Prior Authorization Patient Impact

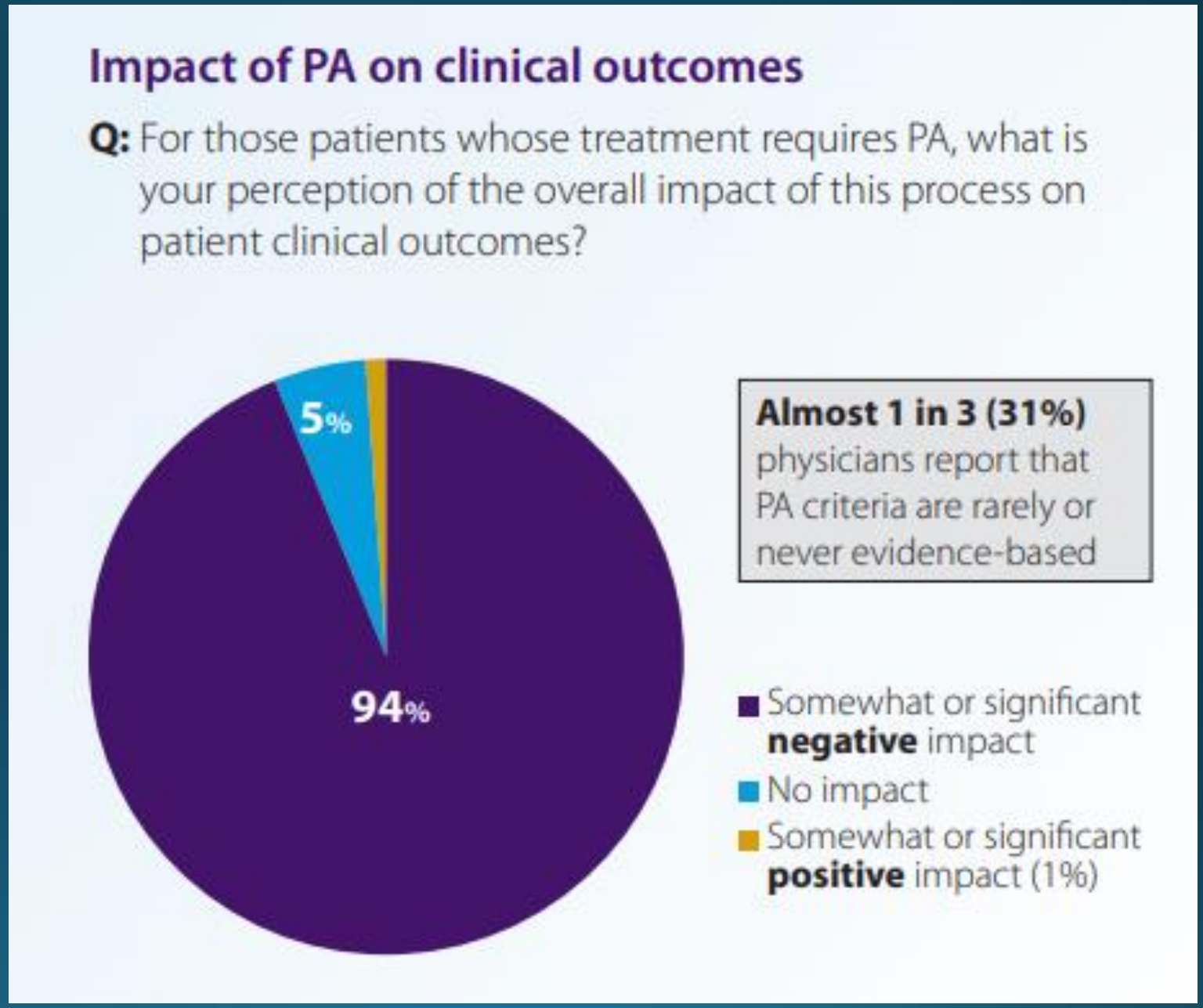
82% report PA can lead to treatment abandonment



AMA prior authorization (PA) physician survey | AMA

Prior Authorization Patient Impact

94% report somewhat or significant patient impact

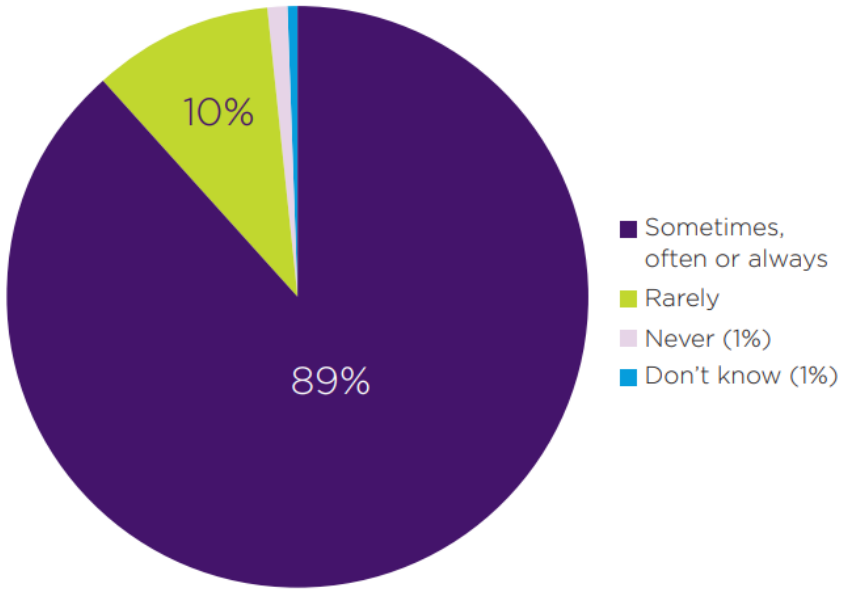


AMA prior authorization (PA) physician survey | AMA

Continuity of patient care

CS agreement Encourage sufficient protections for continuity of care during a transition period for patients undergoing an active course of treatment when there is a formulary or treatment coverage change or change of health plan that may disrupt their current course of treatment.

Survey An overwhelming majority (**89%**) of physicians report that PA interferes with continuity of care.



Percentages do not sum to 100% due to rounding.

Q: How often does the PA process interfere with the continuity of ongoing care (e.g., missed doses, interruptions in chronic treatment)?

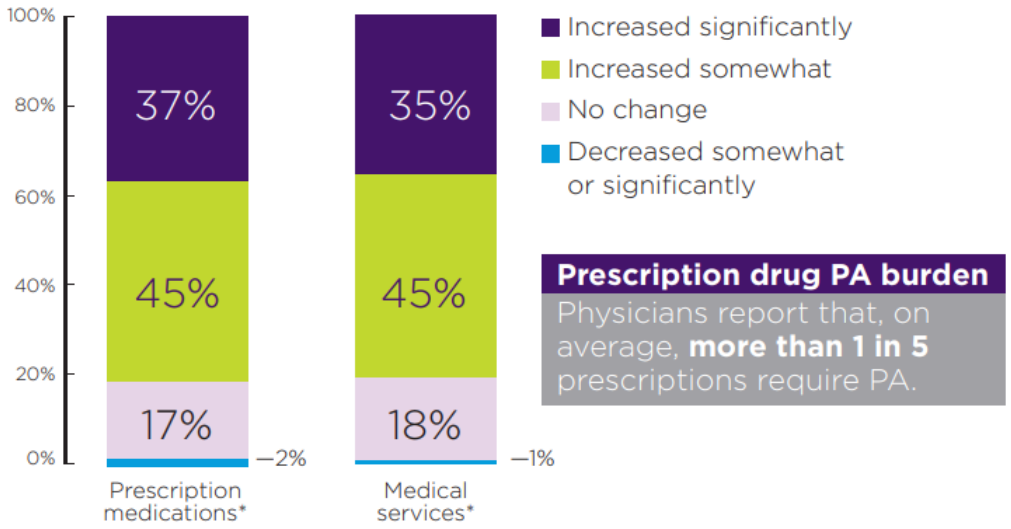
89% of physicians report that PA interferes with continuity of care

2023 AMA survey

PA program review and volume adjustment

CS agreement Encourage revision of PA requirements, including the list of services subject to PA, based on data analytics and up-to-date clinical criteria.

Survey A strong majority (**81%# and 80%**, respectively) of physicians report that the number of PAs required for prescription medications and medical services has increased over the last five years.



Prescription drug PA burden
Physicians report that, on average, **more than 1 in 5** prescriptions require PA.

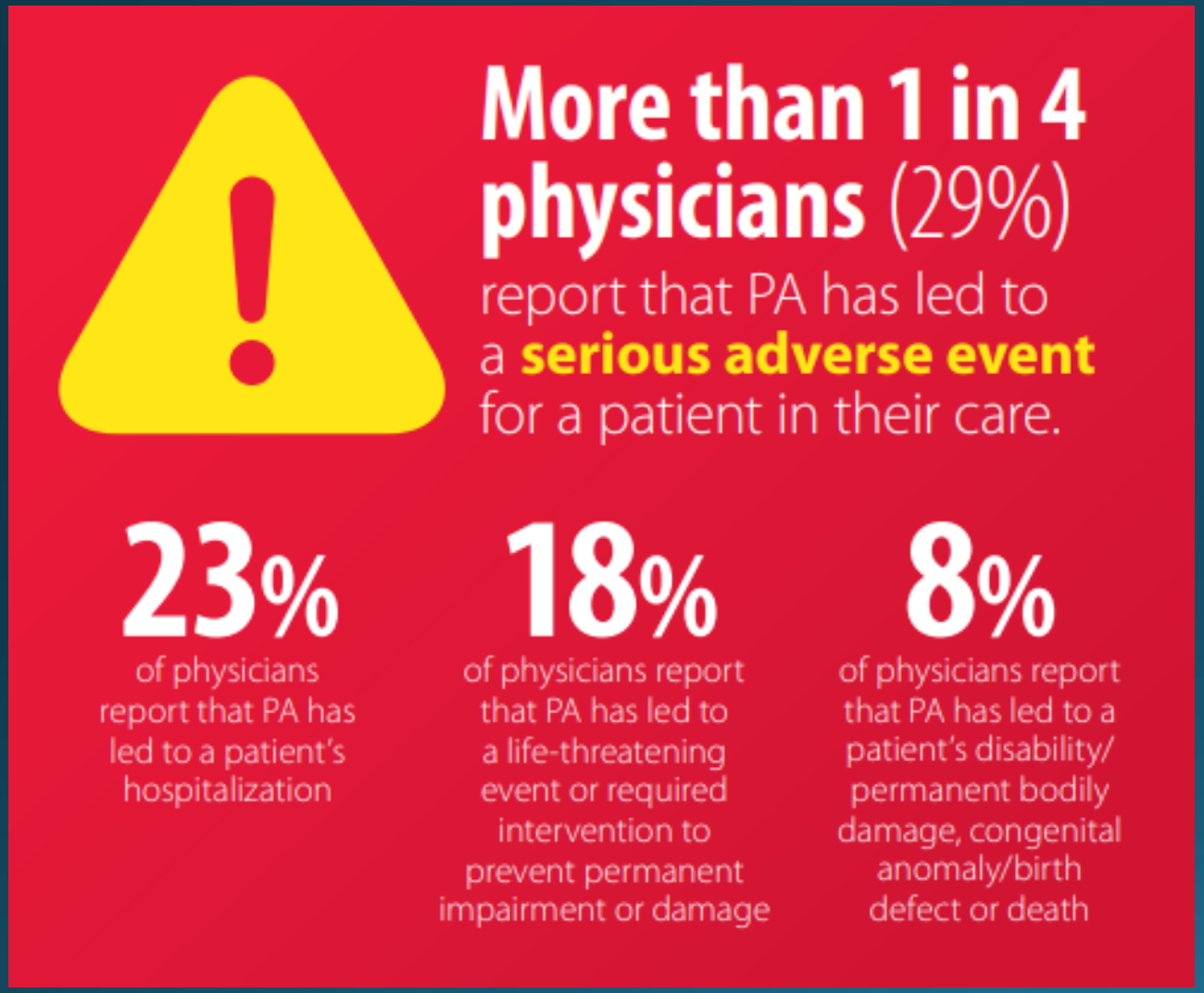
*Percentages do not sum to 100% due to rounding.
#Percentages do not sum to 81% due to rounding.

Q: How has the number of PAs required for prescription medications/medical services used in your patients' treatment changed over the last five years?

81% of physicians report number of PAs required for prescription medication and medicals services (80%) has increased over past 5 years

AMA Prior Authorization Survey Update | AMA (ama-assn.org)

Prior Authorization (PA) Patient Impact



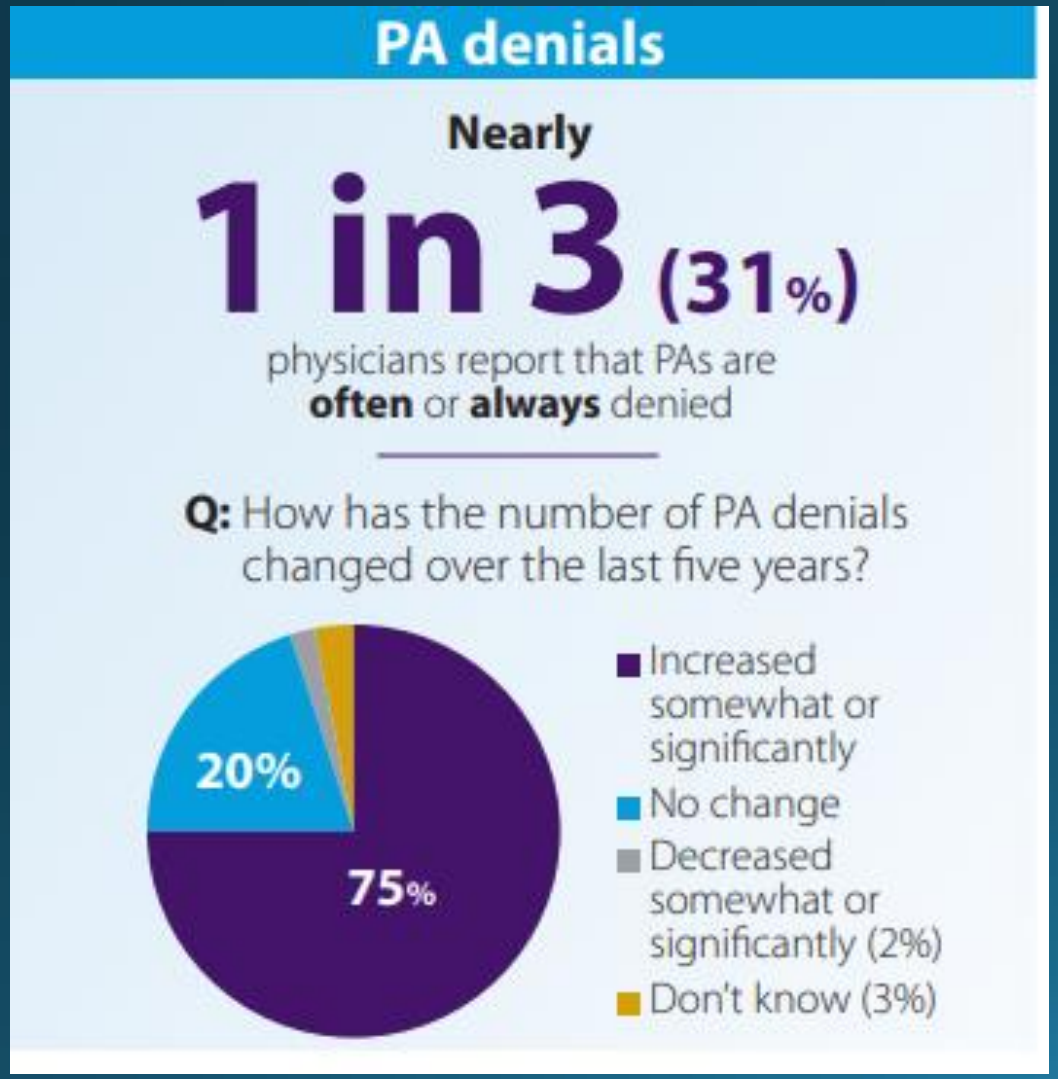
23% report PA led to hospitalization

18% report PA led to life threatening event, or required intervention to prevent permanent impairment

8% report PA to patient disability or permanent body damage

AMA prior authorization (PA) physician survey | AMA

Prior Authorization (PA) Patient Impact



BJC Patient impact

Huge Variability in Denial of Musculoskeletal Services

Many Carriers have fail 1st mechanisms requiring, potentially unnecessary treatment

Prior Authorization Physician Impact

AMA prior authorization (PA) physician survey | AMA

- The Bone & Joint Center Impact

- In 2024 BJC worked with 136 different insurance plans, each with different PA process and guidelines

AMA prior authorization (PA) physician survey | AMA

)

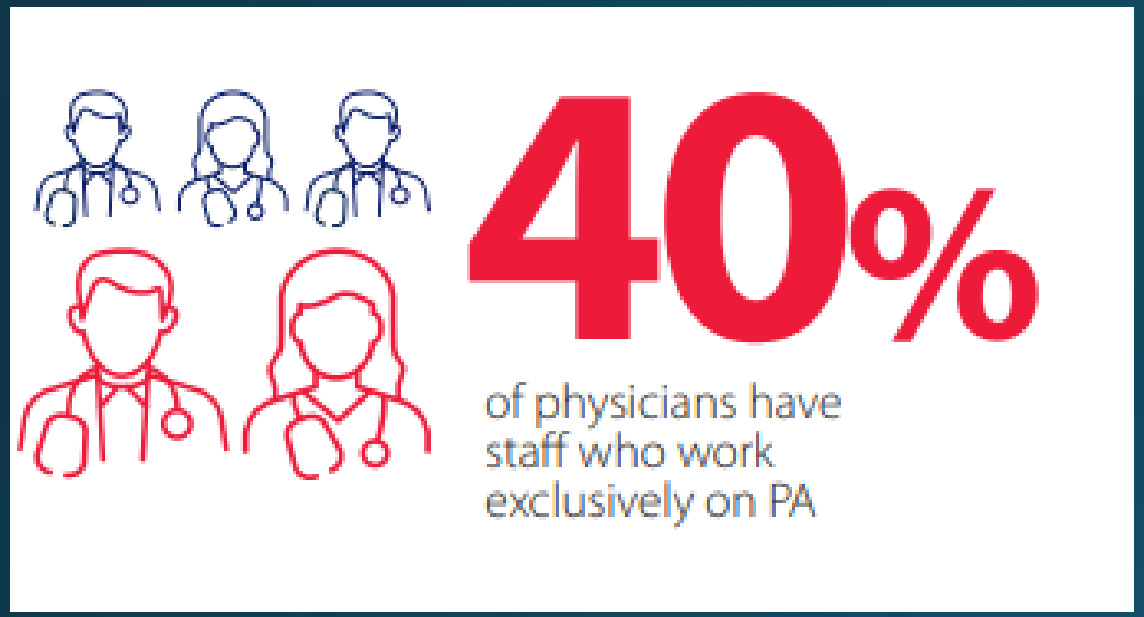
- The Bone & Joint Center Impact
- 13,438 requests in 2024
- 258/week
- 52.8/day (254.5 work days in 2024)

AMA prior authorization (PA) physician survey | AMA

- The Bone & Joint Center Impact

- 22 Clinicians x 13 hours/week = 286 hours

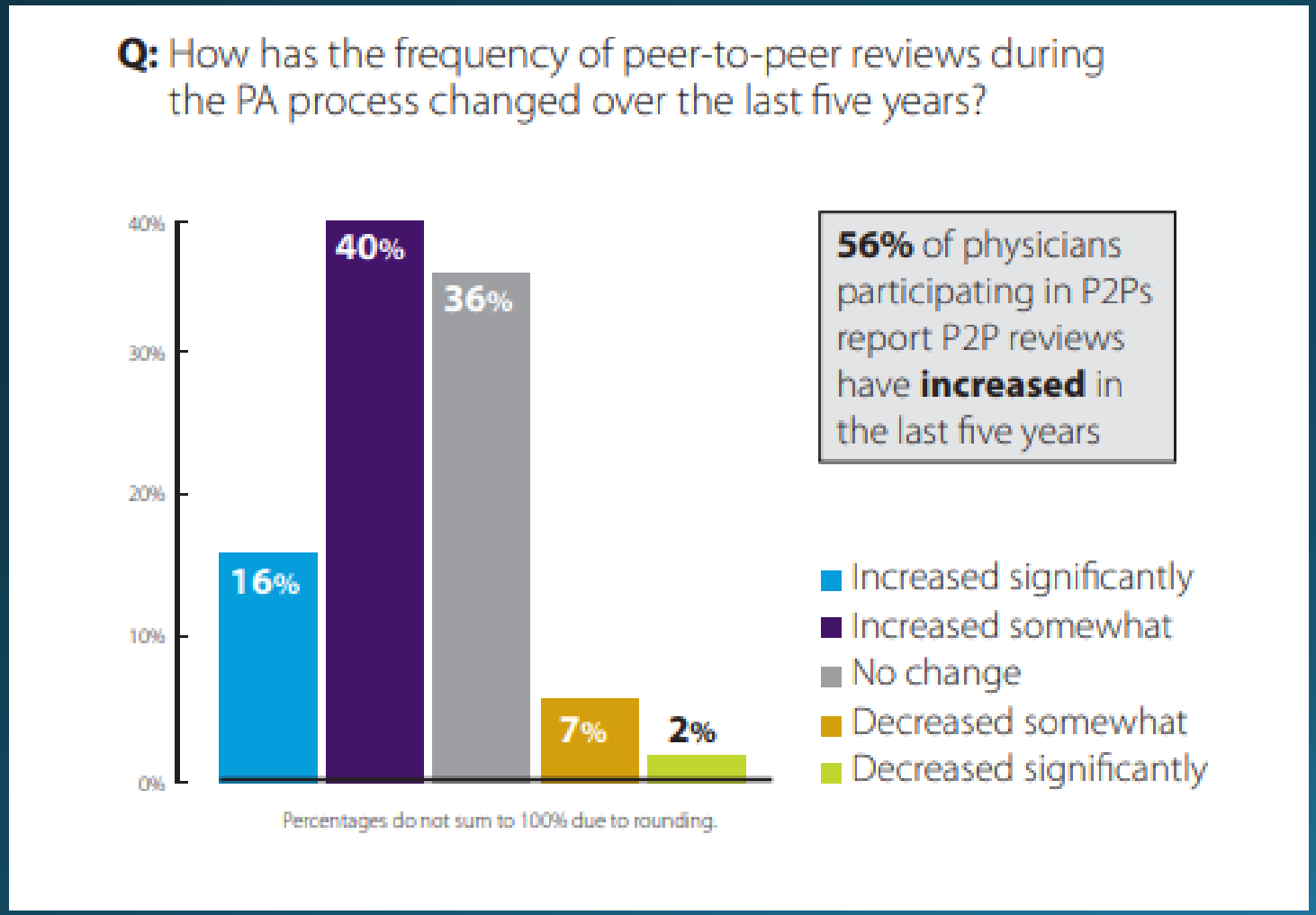
AMA prior authorization (PA) physician survey | AMA



- The Bone & Joint Center (BJC) Impact
- 8 FTEs to complete PAs/scheduling cost BJC $350,000/year.

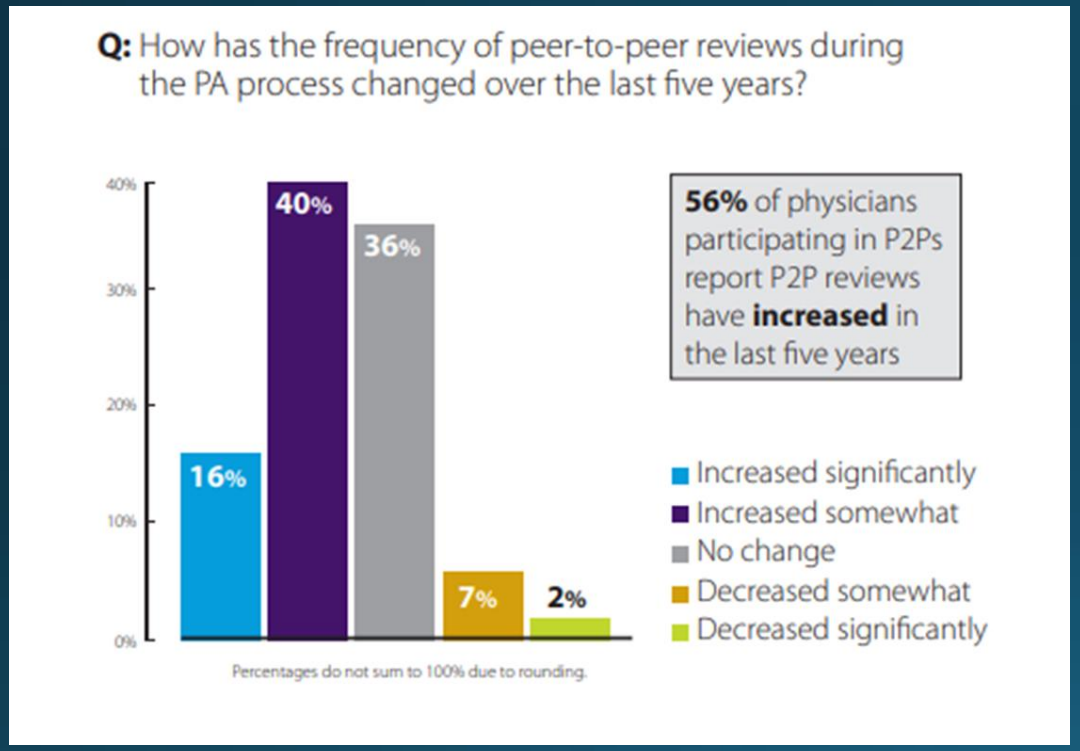
AMA prior authorization (PA) physician survey | AMA

Peer-to-Peer (P2P)



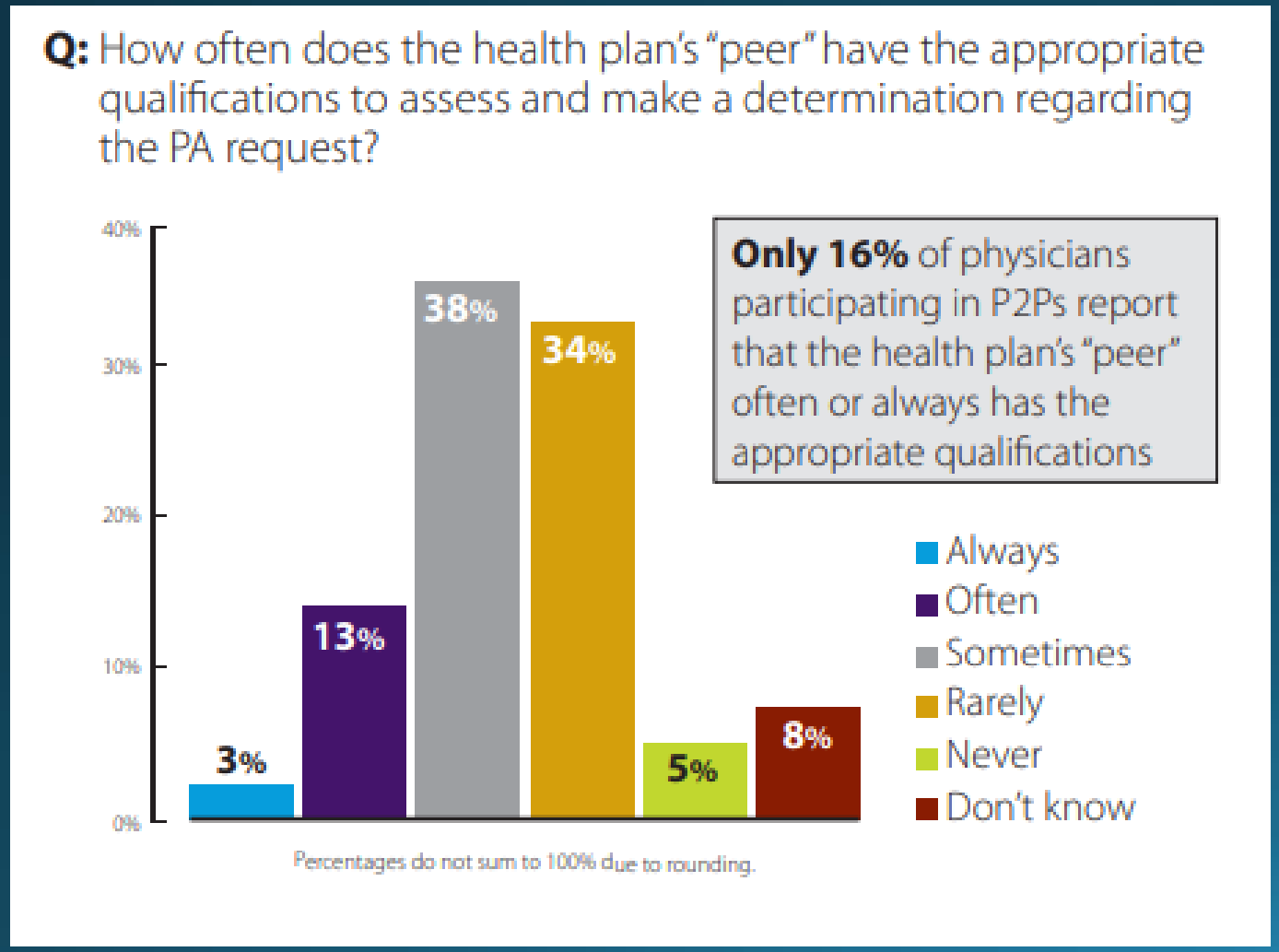
- The Bone & Joint Center (BJC) Impact
- $350,000 does not include loss of time from patient care required to perform Peer to Peer review.
- Approximately 25-30/month

Peer-to-Peer (P2P)



- 30 P2P/mo x 20 minutes minimum to complete Peer to Peer = 600 minutes
- 600 / 15 min avg patient appt time = 40 appointment slots lost to P2P process per month
- 480 patient appointment slots a year lost to Peer to Peer

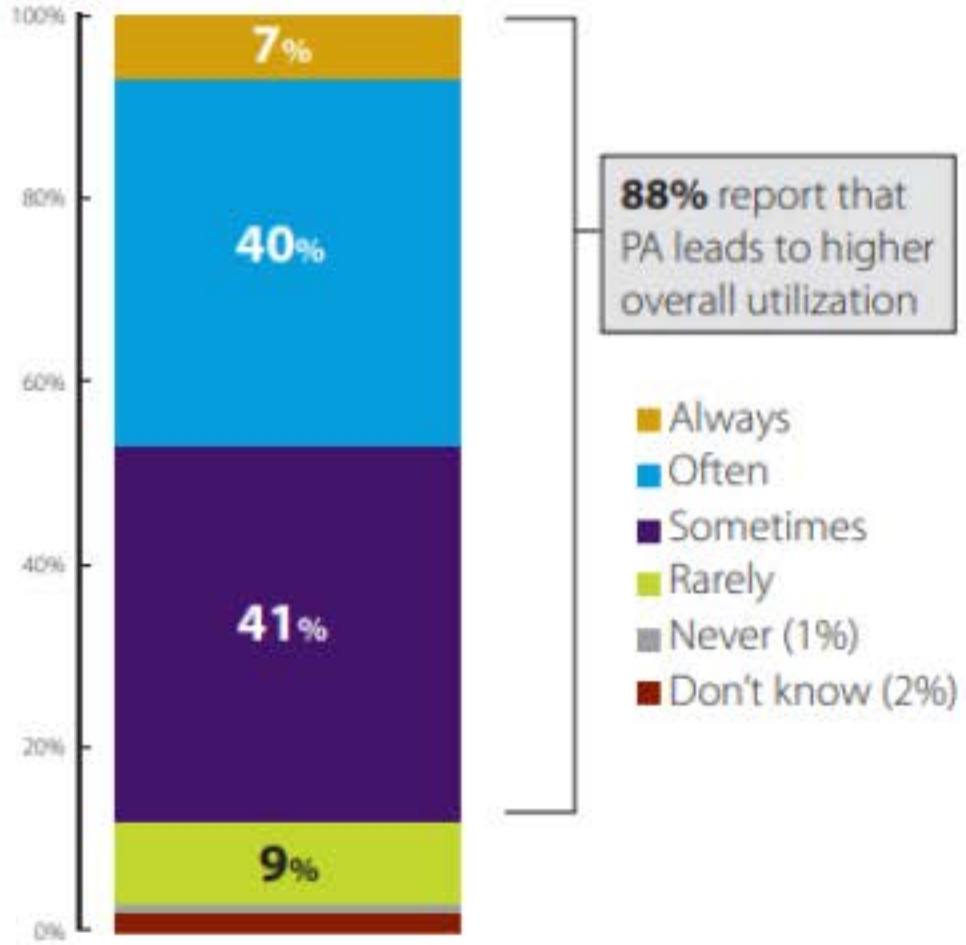
Peer-to-Peer (P2P)



BJC experience

Rarely does the "Peer" have appropriate qualifications to have an educated conversation about musculoskeletal care

Q: Please consider how your patients' utilization of health care resources is impacted by the PA process. In your experience, how often does the PA process lead to higher overall utilization of health care resources?



Q: In which of the following ways has the PA process led to higher overall utilization of health care resources for patients in your care?

77% report ineffective initial treatment (e.g., due to step therapy requirements)

73% report additional office visits

47% report immediate care/ER visits

33% report hospitalizations

Employer impact

58% of physicians with patients in the workforce report that PA has impacted patient job performance

AMA prior authorization (PA) physician survey | AMA

- Would also argue that PA can result in delayed return to work, and lost wages for patients injured off the job
- PA, step therapy (fail first) has potential to increase cost for WSI with delayed return to work

Real World implications of care delayed by PA

Real-world clinical and economic impacts of delayed rotator cuff repair surgery in Japan: analysis of a large claims database

Hiroyuki Sugaya, MD[a,*], Yuki Otaka, BS[b], Yuichi Shiotsuki, MS, MPH[b], Akie Seno, BSc, MBA[c]

[a]*Tokyo Sports & Orthopaedic Clinic (TSOC), Tokyo, Japan*
[b]*JMDC Inc, Tokyo, Japan*
[c]*Smith & Nephew, Asia Pacific, Singapore, Singapore*

Orthopedics

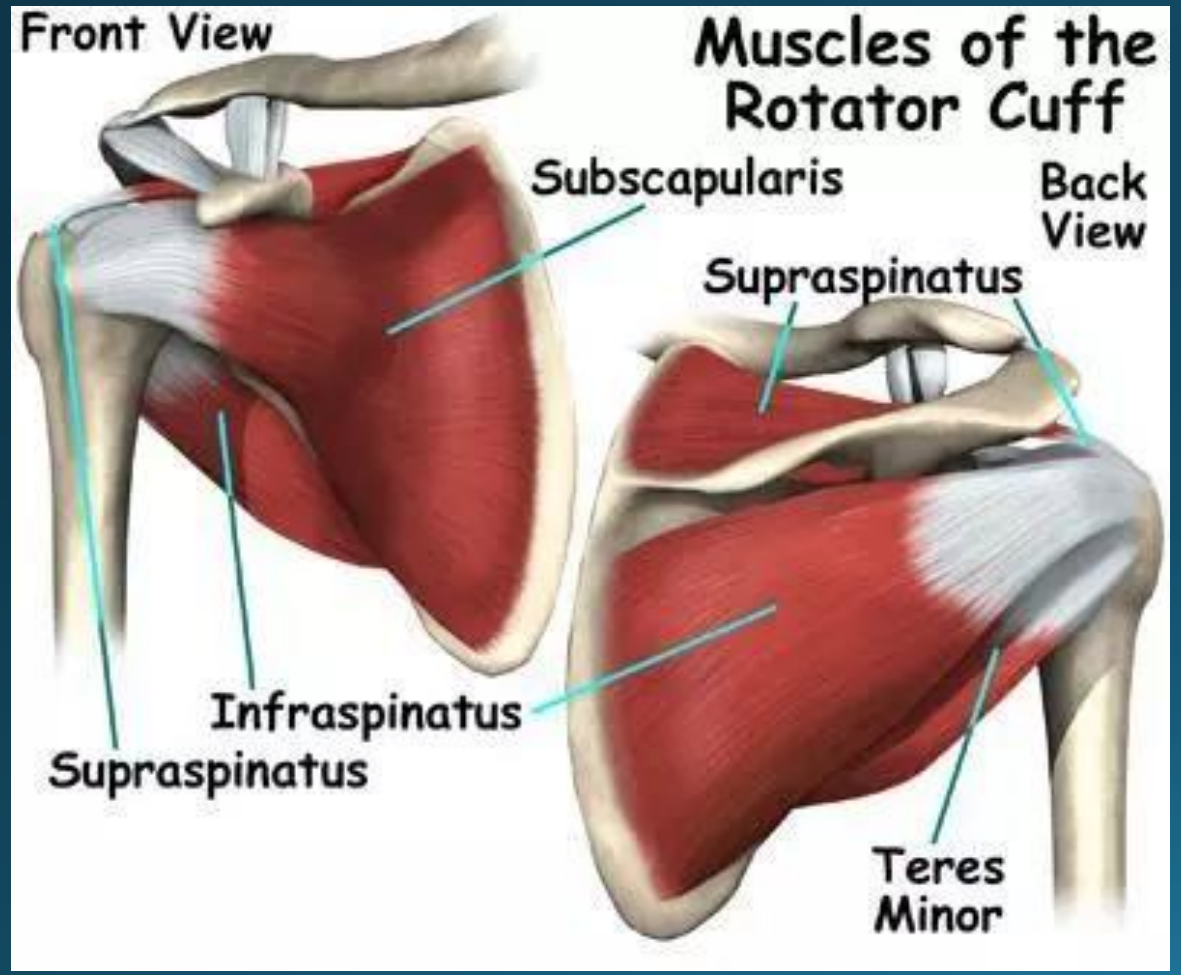
Direct and indirect economic burden associated with rotator cuff tears and repairs in the US

Niraj Parikh, Diane J. Martinez, Isabelle Winer, Laurie Costa, Deeksha Dua & Paul Trueman

Pages 1199-1211 | Received 19 Oct 2020, Accepted 11 Apr 2021, Published online: 19 May 2021

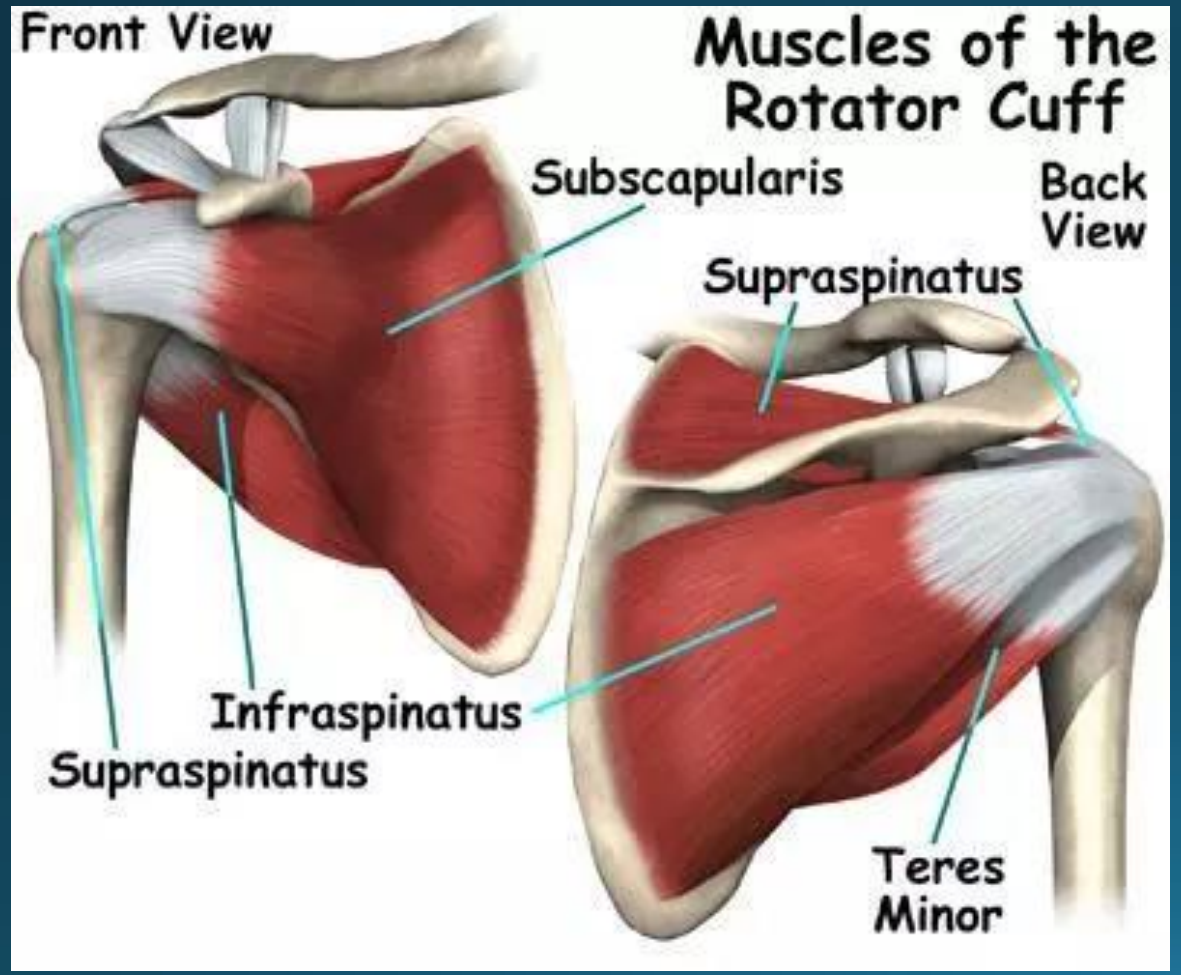
Cite this article https://doi.org/10.1080/03007995.2021.1918074 Check for updates

Delayed Rotator Cuff Surgery Implications



- Delayed rotator cuff surgery leads to:
- Increased overall cost (avg addition spend $8524 for delayed repair of full tear)
- Increase risk of repeat surgery
- Increase risk of complications
- Increase risk of revision surgery

Delayed Rotator Cuff Surgery Implications

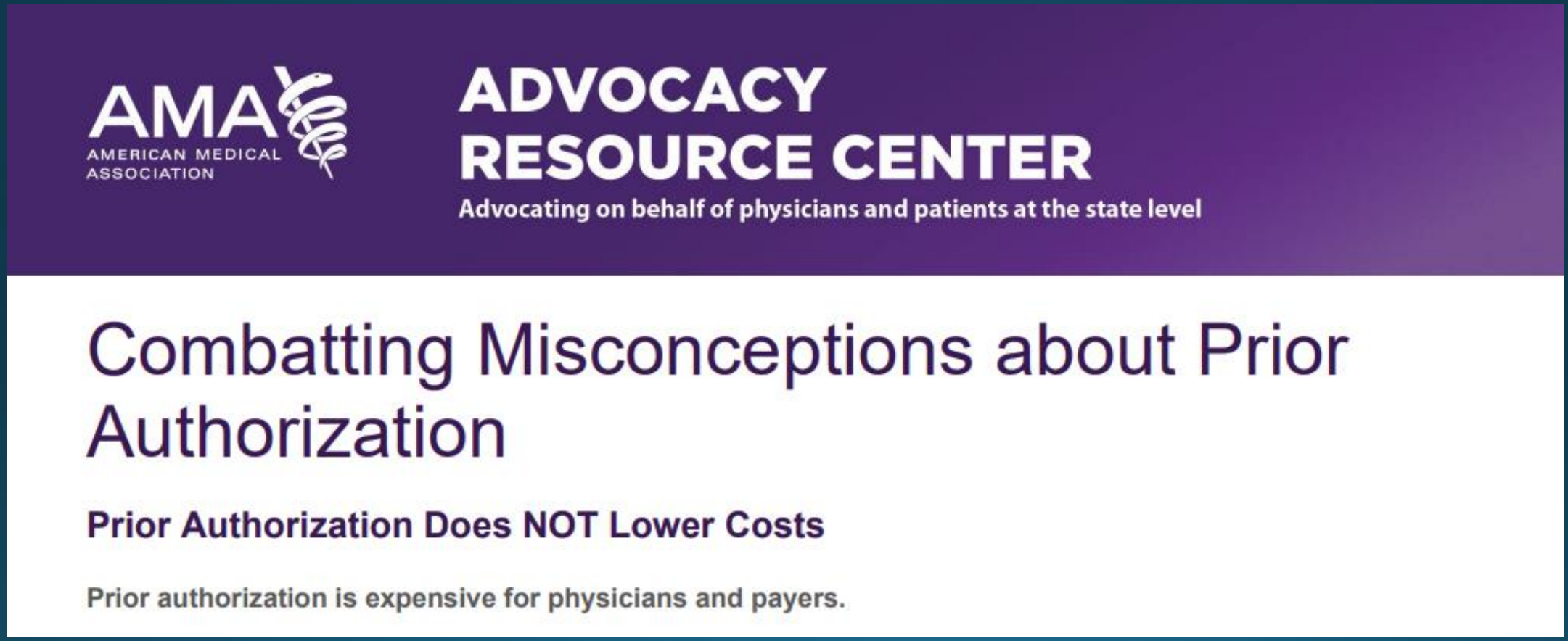


- Delayed rotator cuff surgery leads to:
- Loss of productivity and Income
- Financial Strain
- Job Security Risk
- Productivity Loss

Commentary on previous testimony

- Medical Knowledge doubles every 73 days – primary care providers would need to practice medicine nearly 27 hours per day.
- Question – how many physicians and health care professionals that deliver patient care are involved in PA decision making at the insurance company level??
- My opinion – the patient's physician is best suited to make clinical decision regarding care
- 10% of physicians provided care inconsistent with consensus and evidence-based standards.
- Which means…90% of physicians are practicing according to guidelines….
- Why do we have blanket PA rules?

Recommended Read



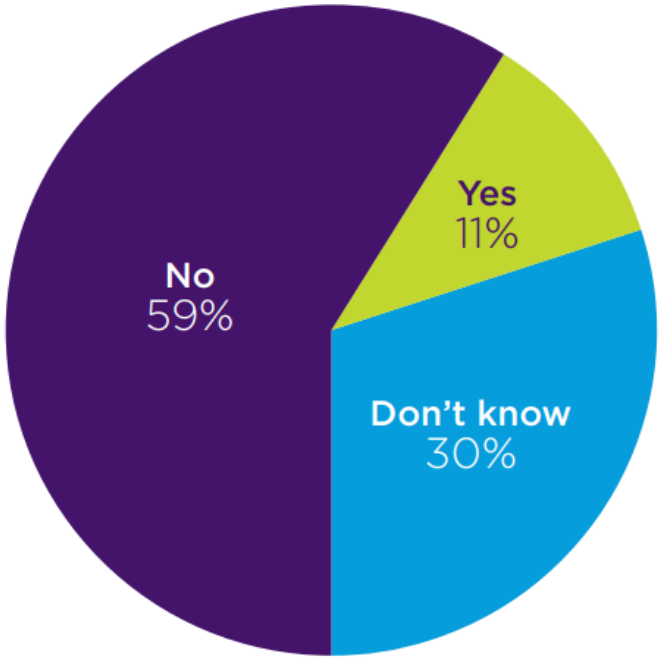
SB 2280

- Aligns standards seen in other states
- Improves timeline to decisions on Prior Authorization
- Improves Peer to Peer process by requiring same specialty review
- Encourages engagement about future improvements…

Selective application of PA

CS agreement Encourage the use of programs that selectively implement PA requirements based on stratification of health care providers' performance and adherence to evidence-based medicine.

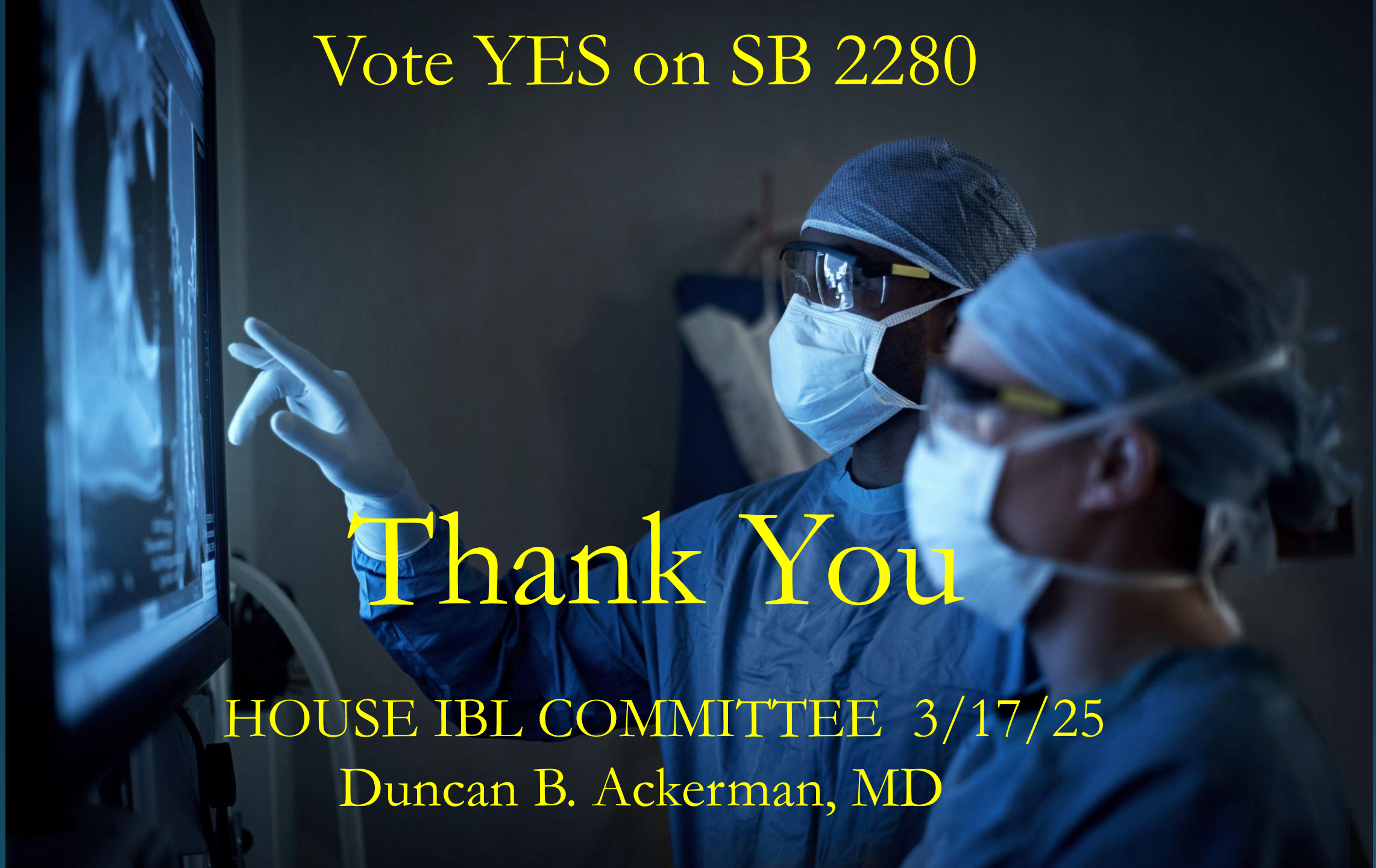
Survey Only **11%** of physicians report contracting with health plans that offer programs that exempt providers from PA.



Q: Do any of the health plans with which you contract offer programs that exempt physicians from PA requirements?

Future Improvements

"Gold Card" programs -- providers that are good stewards of health care dollars and consistently adhere to evidence-based guideline are subject to less PA requirements.



Vote YES on SB 2280

Thank You

HOUSE IBL COMMITTEE 3/17/25

Duncan B. Ackerman, MD

Senate Bill 2280
House Committee on Industry, Business, and Labor
March 17, 2025
AHIP Testimony

Thank you for the opportunity to speak before you today. My name is Alex Kelsch, and I am testifying today on behalf of America's Health Insurance Plans (AHIP). [1]

AHIP appreciates the opportunity to provide comments on SB 2280. Health plans share your commitment to ensuring patients have access to high-quality, affordable health care.

It is important to recognize that the prior authorization process serves an important purpose. Prior authorization is a critical tool used to prevent unnecessary or inappropriate treatments that could result in patient harm. For example patients with low-risk lower back pain frequently receive early imaging tests, which do not improve outcomes and can lead to unnecessary surgery and office visits, undue stress, excessive exposure to radiation, lost productivity, potential harms from prescription opioids, and avoidable costs.[2] This is why it is so important that health plans, providers, and hospitals work together to prevent unnecessary or inappropriate treatments that could result in patient harm.

Prior authorization also ensures that patients receive the most cost-effective care and do not receive unnecessary treatments. Experts agree that roughly a quarter of all medical spending is wasteful or low-value, costing the U.S. $340 billion annually[3] and 87% percent of doctors have reported negative impacts from low-value care.[4]

We appreciate the sponsors' efforts to work with health plans in the Senate on amendments to improve the bill. AHIP would like to make the following suggestions on additional amendments:

- **Include North Dakota public programs.** We understand the proponents desire for uniformity in the marketplaces with respect to prior authorization. It is important to note that the requirements in SB 2280 will not bring more uniformity to the market since it excludes large segments of the North Dakota regulated market - those being Medicaid, Medicaid Expansion, WSI, and the North Dakota Public Employees Retirement System or NDPERS. The current applicability would only impact about 20%-25% of North Dakota health insurance policies.
- **Remove the references to dental services**. Dental plans rarely utilize prior authorizations as described in the bill. They are structured as a limited scope excepted benefit, meaning there is a focus on preventive coverage, not complex procedures that would require prior authorization. Because dental plans have a limited benefit, they often utilize nonbinding pretreatment estimates, which are requested by the dentist, not required by the plan. These are used to develop treatment plans for a patient and can be adjusted based on the patient's needs. Therefore, limited scope dental plans should not be included in this bill.

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[1] AHIP is the national association whose members provide health care coverage, services, and solutions to hundreds of millions of Americans every day. We are committed to market-based solutions and public-private partnerships that make health care better and coverage more affordable and accessible for everyone.

[2] Prior Authorization Promotes Evidence-Based Care That Is Safe and Affordable for Patients. AHIP. November 2023.

[3] Low-Value Care. University of Michigan V-BID Center. February 2022.

[4] Ganguli, Ishani. Characteristics of Low-Value Services Identified in US Choosing Wisely Recommendations. JAMA Internal Medicine. February 1, 2022.

- **Provide a technical clarification to the continuity of care section.** AHIP requests the following clarifying langue to note the continuity of care section is for covered services and requesting providers submit the appropriate documentation.
    - 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, unless a change in clinical or medical guidelines would negatively affect an enrollee, 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 **for covered services under the new policy. The enrollee or the enrollee's health care provider must submit documentation of the previous prior authorization to the new policy company in accordance with the new policy company's procedures**.

Thank you for the opportunity to comments.

Chairman Warrey and members of the House Industry, Business, and Labor Committee, I am Senator Scott Meyer, representing District 18 in Grand Forks. I am honored to stand before you today to introduce engrossed Senate Bill 2280—a critical piece of legislation aimed at reforming the prior authorization process in North Dakota's health care system making it better for all patients.

For those unaware, prior authorization is the process where a patient needs a service or prescription and, due to constraints on the insurance policies, requires the patient – through their physician, pharmacist, or dentist – to get approval from the insurance company that it will be covered. This process requires significant time from providers and ultimately results in delayed care that is often critically needed in a timely manner. Moreover, this bill covers many of the reforms already in effect in republican and democrat states across this country, including Oklahoma, Louisiana, Wyoming, Kentucky, and Mississippi, to protect North Dakotans.

Many of you, your families, and your constituents have likely experienced the frustrations this bill seeks to address; delays in care when insurance companies' and PBM's bureaucratic administration interferes with patient care. What began as a tool to ensure the necessity of costly treatments has evolved into a bureaucratic nightmare, creating unnecessary roadblocks to timely medical care, and placing the decision of treatment in the hands of insurance companies rather than the patients and their providers. This bill is the product of over 18 months of rigorous study, collaboration, and compromise. Following a proposal last session, the interim Healthcare Committee engaged stakeholders—patients, providers, and insurers alike— identifying issues and solutions to the challenges in the current prior authorization process. This bill is the result of that work. This bill has brought consensus around this issue backed by 20 organizations representing over 100,000 North Dakotans. The coalition is comprised of the following reputable organizations:

- American Cancer Society - Cancer Action Network
- North Dakota Medical Association
- North Dakota Hospital Association
- CHI St. Alexius
- North Dakota Chiropractic Association
- Essentia Health
- Community Healthcare Association of the Dakotas
- Altru Health
- Susan G Komen

- Trinity Health
- AARP of North Dakota
- North Dakota Rural Health Association
- The Bone and Joint Center
- North Dakota Chapter of the American Physical Therapy Association
- North Dakota Dental Association
- North Dakota Association of Community Providers
- North Dakota Pharmacists Association
- The ARC of North Dakota
- The North Dakota chapter of the American Academy of Pediatrics

The common message from all these organizations is they want patients to receive decisions about their care in a timely fashion.

I knew that there were many legislators who were not on the interim committee who are passionate about this issue, that is why we brought forward this standalone bill. The only opposition to this legislation comes from the same organizations that consistently oppose patient-focused reforms: Insurance and their partners in the PBMs. Where you land on this bill ultimately comes down to whether you think insurance companies and their partners at the PMBs, or our local North Dakota providers have patients' timely care in mind.

That is why, following my testimony, you will hear from your constituents, the organizations and patients who are affected by this process every day. To date, at no point throughout this process and at no point today will you hear from a single patient who stands with the big insurance companies and their PBM's against this legislation.

Let me outline how SB 2280 proves patient outcomes. It brings by requiring insurers to publicly disclose their prior authorization policies. It establishes clear timelines—72 hours for urgent cases and 7 days for non-urgent ones—so patients aren't left waiting in limbo. If insurers fail to respond within these timeframes, the request is auto-authorized, ensuring accountability and that the patients get clarity and timely care. The bill also ensures that medical decisions are made by licensed medical professionals—not business analysts, algorithms, or AI—keeping care decisions in qualified hands. And once a service is approved, it cannot be arbitrarily revoked, offering certainty to patients and providers.

Chairman Warrey, this legislation reflects nearly 20 major concessions which were made on the Senate side to address concerns from insurers. We've aligned timelines with federal Medicaid and Medicare standards, worked with opponents of the legislation to create an

effective and workable standard for reviewers, and delayed the effective date to January 1, 2026, giving the industry ample time to prepare.

Additionally, this legislation includes a Legislative Management study, to explore in the future, prior authorization's impact on the North Dakota Public Employees Retirement System (PERS). This optional study ensures the same deliberate care applied to market insurance reforms can be extended to PERS, rather than applying a one size fits all approach.

Let me be clear: SB 2280 does not force insurers to approve claims. It simply requires a timely response—yes or no—so patients and providers can move forward. This bill is a comprehensive reform that places common-sense guardrails around prior authorization, ensuring it serves its original purpose without compromising patient care.

The support for this legislation is overwhelming. As I mentioned a coalition of 20 organizations—representing over 100,000 North Dakotans, including pharmacists, physicians, hospitals, and advocates for seniors, children, and those with chronic conditions—stand behind SB 2280. You'll hear from many of them today, sharing stories of delayed treatments and the real human cost of the current system. Their voices have shaped the bill you have before you.

The reality is that citizens throughout the nation and your constituents here in North Dakota are beyond frustrated and are reaching a fever pitch of outrage over the continuing practices of big insurance and PBMs. Unfortunately, we've seen some high profile situations where people took insurance issues into their own hands. However, the way we are supposed to resolve these issues is in committee rooms just like this one we are in today. As duly elected policy makers for this state the law is in our hands. It is time for us to exercise this responsibility.

Chairman Warrey and committee members, this is a balanced, collaborative approach to a problem that affects thousands of North Dakotans every year. The Senate Industry and Business Committee unanimously endorsed it, and the Senate passed it 43 - 4. Now it is your turn to act. I respectfully urge you to join with myself and fellow cosponsors Chairman Warrey, Chairman Nelson, Chairman Barta, Chairman Bekkedahl, and Senator Cleary and give SB 2280 a swift "Do Pass" recommendation. We've studied this issue long enough—patients shouldn't have to face costly delays in receiving prior authorization from big insurance and their PBM collaborators to get the care they deserve.

Thank you for your time and attention. I'm happy to answer any questions.

Scott Meyer

scottmeyer@ndlegis.gov

218.791.7655

Improve Prior Authorization – Support Senate Bill 2280

What is Prior Authorization?

When it began decades ago, prior authorization was used sparingly by insurers to determine whether costly medical procedures or medications were needed.

Today, for many insurers, prior authorization has deteriorated into a system that requires healthcare providers to get approval to prescribe even the most routine medications and procedures. It's often even required for medications that a patient has been using for years to manage an illness, including chemotherapy medications, in a situation when timely treatment is critical.

The process often leads to delays in patient treatment, administrative burdens for healthcare providers, and can prevent patients from receiving necessary care due to lengthy approval processes or denials.

A survey of physicians, conducted in 2023 by the American Medical Association, found that:

- On average, practices complete 45 prior authorization requests per physician per week.
- Physicians and their staff spend an average of 14 hours—almost two business days—completing those requests each week.
- 64% report that it is difficult to determine whether a prescription medication requires prior authorization.
- 92% report authorizations result in care delays – a barrier to providing timely patient care.
- 33% report the process led to a serious adverse event for a patient in their care.
- 80% report the process can lead to treatment abandonment.
- 62% report the process led to additional office visits.
- 80% report that the number of prior authorizations required for prescription medications and medical services has risen over the last five years.
- 58% report that prior authorization impacts the workforce by affecting the patient's job performance.

Vote YES on Senate Bill 2280

The Solution

According to a National Conference of State Legislatures database, 23 states enacted more than 43 bills related to prior authorization in the last few years, with 18 enacted in 2024 alone. SB 2280 proposes to:

- Provide uniformity by standardizing "prior authorization" and "medical necessity" definitions.
- Allow a prior authorized maintenance drug to be valid for one year or at least until the last day of coverage; and cover any dosage change during the authorization period.
- For insurers to post prior authorization procedures on their website and maintain a complete list of services for which prior authorization is required.
- Require licensed physicians, pharmacists, and dentists with experience treating the condition in question to review prior authorization requests.
- For urgent healthcare services, require a 72-hour response time; non-urgent would require a seven calendar-day response.

Altru

Essentia Health

NDMA
NORTH DAKOTA MEDICAL ASSOCIATION

TRINITY HEALTH

NDHA
North Dakota Hospital Association
Est. 1934

CHAD
Community HealthCare Association of the Dakotas

LEUKEMIA & LYMPHOMA SOCIETY®

American Cancer Society Cancer Action Network™

NDRHA
North Dakota Rural Health Association

The Bone & Joint Center

CHI St. Alexius Health
A member of CommonSpirit

NORTH DAKOTA
Chiropractic Association

The Arc
North Dakota

APTA
North Dakota
A Chapter of the American Physical Therapy Association

susan g. komen®

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

North Dakota Chapter
INCORPORATED IN NORTH DAKOTA
American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

North Dakota
DENTAL ASSOCIATION

Senate Bill 2280
March 17, 2025

Good afternoon, Chairman Warrey and members of the House Industry, Business and Labor 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
- 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, who are most interested in a blank check

The fact of the matter is prior authorization only impacts a small number of procedures and treatment plans.

I pose the question--what problem are we trying to solve with SB 2280? 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.

All this to be said, we will be the first to say 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.

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BND WD TEM • 6-19

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.

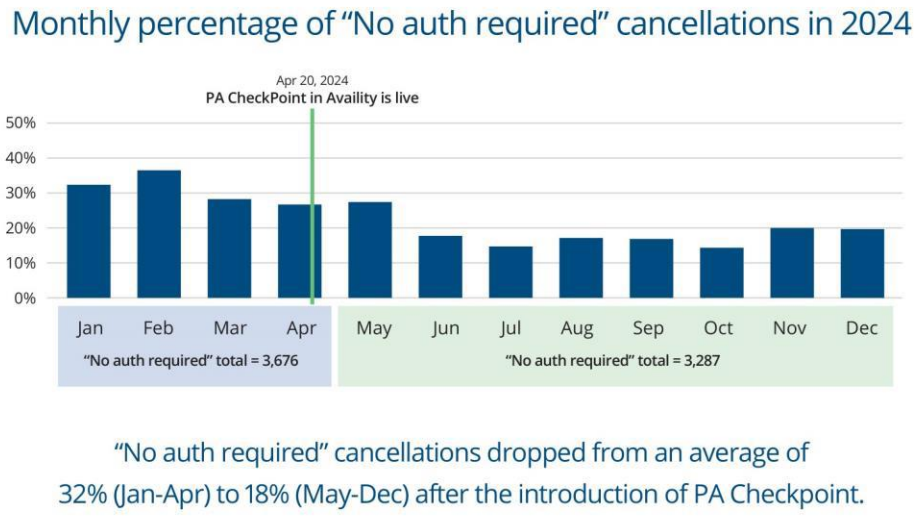
The intent is not to delay or interfere. It is to partner in and communicate around a care plan where, in some circumstances, there could be significant risk involved from a health, quality or cost perspective. When our teams review prior authorization requests, we are keeping three key things in mind:

- 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.

At BCBSND, we work hard to clearly and transparently communicate with our provider partners about requirements for prior authorization. BCBSND requires prior authorization for only 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 and national evidence standards at data at a minimum annually and we regularly add and remove anything that has changed. If a change is made, we communicate that to providers directly via our Health Care Newsletter which goes out weekly, on Thursdays. We can also send emergency communications out on the days

between. Providers can 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%.



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.

This is despite still receiving around 36% of requests via fax. And, we still receive handwritten prior authorizations.

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. This bill would align 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 are happy to support those timelines. 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. One thing this bill doesn't address is provider timelines. We would respectfully request that any timelines imposed on carriers be the same or similar 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

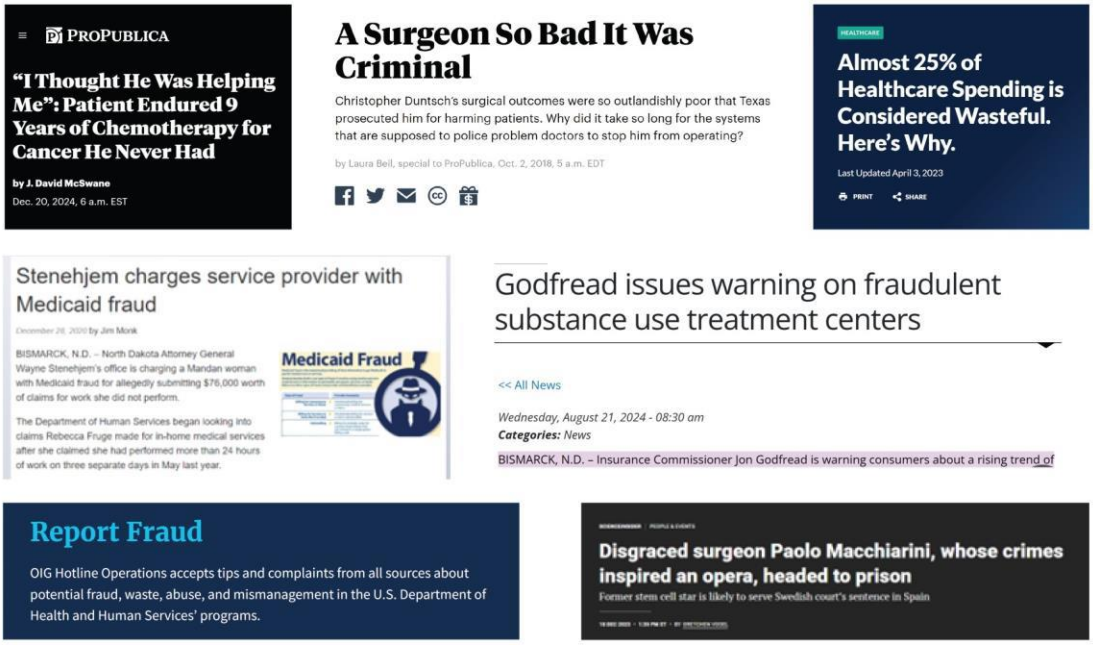
One of the themes we heard more than once from proponents of the bill during the interim Health Care Committee study on prior authorization was a lack of standardization among the many (some cited over 85!) payors with whom they work. Curiously, many of the major payors are missing from inclusion in 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.



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. Over the course of several years, BCBSND will have spent $1,019,750 to assist with provider concerns and streamline our prior authorization process. 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 choices. 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 Warrey, with that I will stand for any questions.

Suggested Amendments necessary for BCBSND to move to a neutral position on the bill:

1. **Page 1, Lines 20-21**: Replace "drug formularies or lists of covered drugs" with "medical drugs"

BCBSND already posts our drug formularies and lists of covered drugs online. That won't change with this bill's passage or failure. Further, in discussion with proponents of the bill, and in their testimonies, they reference infusions, which are medical drugs covered under a medical benefit and medical necessity policies (which we also post online.)

We request that clarification be reflected in the legislation.

2. Page 5, Lines 3-7: Remove "~~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~~;" (subsection D.) The definition of "prior authorization review organization" is so broad that it encompasses 3rd party appeal review organizations, meaning we would not have anyone available to review our appeals. We could either narrow the definition, or we must delete D. Our accreditation standards require the same or similar specialist review of appeals to apply specific clinical knowledge and experience when determining if an appeal meets criteria for medical necessity and clinical appropriateness. If our options to obtain this type of specialized review are eliminated or severely limited, it will jeopardize a plan's ability to obtain accreditation, which is required to sell insurance on the federal exchange. This also aligns with the intent of the providers who have spoken to wanting same or similar specialty review. We don't employ every specialty that a provider would, and having external reviewers is critical for us, and we think is also part of the Insurance Department's IER process.

3. **Page 7, Line 2**: Add "for non-emergent outpatient care". Inpatient hospital services currently do not require prior authorization at all in North Dakota. Inpatient emergent care should be received when authorized rather than anytime within the year, otherwise the patient is being put at risk. BCBSND currently gives a year approval for some outpatient services.
4. Page 7, Lines 5-6: Replace "a health care service" with "non-emergent outpatient care"
5. Page 7, Line 9: Add "For items and services covered by a patient's current health plan," This clarifies that this only applies to items covered by the member's current health plan. Meaning, you can't apply the law to things that are not covered by a policy. For example, if a patient is on a BCBS plan with infertility benefits but changes to a SHP plan with no infertility benefits, the patient would not have infertility benefits available under the current SHP policy even if they were approved under the previous BCBSND policy. Alternatively stated, if the patient's current policy doesn't cover vitamin D screenings, even if you performed a prior authorization, the benefits would still not be covered.

Suggested Amendments that would move BCBSND to a supporting position on the bill:

- Require providers to follow same/similar timelines as carriers to ensure the patient is the center of everyone's focus.
- Include requirements that transition providers away from handwritten and fax submissions and toward electronic prior authorization.

AMA AMERICAN MEDICAL ASSOCIATION

ADVOCACY RESOURCE CENTER

Advocating on behalf of physicians and patients at the state level

Combatting Misconceptions about Prior Authorization

Prior Authorization Does NOT Lower Costs

Prior authorization is expensive for physicians and payers.

- In primary care, data shows prior authorization costs a single physician between $2,161 to $3,430 annually.
- In a study of prior authorization at 11 dermatology clinics, researchers found that completing prior authorization for biologic drugs costs on average $15.80 per request, for a total of $3,454.15 in the month studied.
- A 2021 analysis conducted by the McKinsey Center for US Health System Reform found that Gold Carding, a process that allows approved physicians to avoid prior authorization for certain drugs or procedures, would lead to 5 to 10 percent savings in the prior authorization process for payers and physicians.
- In 2019, the Council for Affordable Quality Healthcare (CAQH) published a report showing that prior authorization is the most expensive manual administrative transaction in healthcare, with each transaction costing the plan $3 and the physician $11.
- CAQH's 2023 report found that administrative processes, including obtaining prior authorization, resulted in $89 billion of national healthcare expenditures.
- A study of type 2 Diabetes patients compared patients who requested a medication requiring prior authorization but were denied access to the medication with patients who requested the medication and received it. The patients who requested medication but were denied access had nearly $2000 higher in plan-paid health care costs, when compared to those patients who requested the same medication and were granted approval.
- In a Journal of the American Medical Association article, removing prior authorization for buprenorphine, a lifesaving medication for substance use disorder, was associated with nearly double the prescriptions for buprenorphine. The increase in prescriptions for buprenorphine was linked to statistically significant decreases in substance use related inpatient treatment and emergency department visits, meaning removal of prior authorization led to both improved patient outcomes and decreased economic healthcare costs.
- In a study of 24 state Medicaid programs, researchers found that restricting access to antidepressants increased emergency room visits and hospitalizations by 1.7 percentage points, increasing healthcare spending.
- Data from another study of 24 state Medicaid programs showed that formulary restrictions on antipsychotics increased the risk of hospitalization, inpatients costs, and total medical costs. The researchers estimated that formulary restrictions increased the number of incarcerated people by 9,920 and the costs associated with incarceration by $362 million nationwide.
- When comparing states where Medicaid requires prior authorization for atypical antipsychotics and states where Medicaid does not, a study published in the Journal of Managed Care found the likelihood of incarceration for patients with schizophrenia increased by 22 percent, suggesting the states that implemented prior authorization experience increased incarceration costs.
- In a study published in Health Affairs, researchers estimated that costs associated with "implementing, contesting, and navigating utilization management" were $6 billion, $24.8 billion, $26.7 billion, and $35.8 billion for payers, manufacturers, physicians, and patients, respectively. These findings indicate that prior authorization's total cost is $93.3 billion annually for all parties.

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Prior Authorization creates unnecessary administrative waste.

- One study of 11 dermatology clinics found that the prior authorization process for a dermatological procedure cost the clinics $1,456.00 in a single month, but approval was granted in 99.6 percent of dermatological procedure requests.
- A study of prior authorizations in pediatric oncology and hematology found that 98.5 percent of prior authorizations for medication were eventually approved.
- In a 2022 report, the U.S. Department of Health and Human Services found that 13 percent of prior authorizations denied by the Medicare Advantage Organization were for care that should have been covered by Medicare.
- A study published in the Journal of Clinical Oncology estimated that the annual cost of prior authorization for academic radiation oncology treatment was $40,125,848 USD, with 86 percent of these costs attributed to treatment plans that were approved.
- A cohort study found that although 96 percent of all prior authorizations on rheumatoid disease treatments were ultimately approved, prior authorization led to treatment delays and increased steroid use.

Prior Authorization Does NOT Improve Patient Outcomes

Prior authorization delays necessary patient care.

- Physicians responding to a survey conducted by the American Society for Clinical Oncology reported that prior authorization caused delays in treatment 96 percent of the time. This delay in treatment had real adverse effects, including disease progression (80 percent of respondents) and death of a patient (36 percent of respondents).
- In a survey of cancer patients, 69 percent of respondents reported their care was delayed as a result of prior authorization.
- In a study conducted in Canada, 20 percent of patients seeking a clopidogrel prescription deemed necessary by their health care team experienced delays or did not receive the prescription due to prior authorization denials. This delay or denial of treatment increased all-cause mortality for these patients.
- When prior authorization was removed for clopidogrel prescriptions in Canada, researchers found patients were able to access their medication quicker and experienced "improved cardiovascular outcomes."
- A study published in The American Journal of Managed Care found that restricted access (via prior authorization and step therapy) to novel anticoagulants led to reduced access to the drugs and higher risk of mortality, stroke, and transient ischemic attack.
- In a survey of radiation oncologists, 31 percent of respondents reported that prior authorization delayed their patient's treatment plan by one week, which is alarming as research associates "each week delay in starting cancer treatment with a 1.2 percent to 3.2 percent increased risk of death."
- When comparing patients with approved prior authorization requests and patients with denied prior authorization requests, a study published in the Journal of the American Academy of Dermatology found patients with approved prior authorization requests had an increased likelihood of disease improvement. Specifically, these patients had a 71.1 percent likelihood of disease improvement. In comparison, patients with denied prior authorization requests had a 58 percent likelihood of disease improvement.
- A study published in the Journal of the American Medical Association found that delays and payer-mandated treatment requirements in prior authorization for radiation treatment were associated with decreased radiation treatment effectiveness and, ultimately, hindered patient outcomes.

Prior authorization impedes evidence-based care.

- In a study analyzing access to PrEP, a medication that protects against contracting HIV, regions with high rates of prior authorization for PrEP had limited access to PrEP. Ultimately, these regions with high rates of prior authorization for PrEP also were associated with increased rates of HIV diagnosis.

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- In a survey of cancer patients, 22 percent of respondents did not receive the care "recommended by their treatment team" because of the denials or delays caused by prior authorization.
- In Maine, a prior authorization policy was implemented with the aim of encouraging the prescription of a less expensive medication for bipolar disorder. Only if the patient did not do well on the cheaper medication, could the patient be prescribed the second-generation antipsychotics. The institution of the prior authorization policy for medication for bipolar disorder led to an 8 percent decrease in use of the second-generation antipsychotics. This policy led to a decrease in the continuation of treatment for patients with bipolar disorder.
- Researchers found denial of irritable bowel disorder (IBD) medication through the prior authorization process was associated with a 9 times increased likelihood of IBD surgery for patients
- A study published in the Journal of Clinical Oncology found that introducing prior authorization requirements after a patient was on an established oral chemotherapy drug regimen was associated with reduced treatment adherence, delays in care, and discontinued treatment.
- A study published by IQVIA found 43% of commercial patients and 53% of Medicare patients did not begin the oncology treatment prescribed by their physician, following a payer rejection like prior authorization denials or step therapy requirements.

Prior authorization increases health inequities.

- A national survey of 1,340 US adults found that less affluent patients are less likely to appeal a prior authorization denial than wealthier patients. Moreover, Black Medicaid patients were significantly less likely to be successful in their efforts to appeal a prior authorization denial.
- In a 2023 report, the Office of the Inspector General for the U.S. Department of Health and Human Services found that Medicaid managed care patients may not be receiving covered health care services, as a result of high rates of prior authorization denials. Specifically, for Medicaid managed care recipients, one out of eight prior authorization requests were denied.

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SB 2280: Modernizing Prior Authorization in North Dakota

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What is Prior Authorization?

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Prior Authorization Defined

- A cost-control procedure used by insurance companies
- Requires a patient to get approval from the insurance company before receiving a health care procedure or filling a prescription

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PA's impact to patient care and experience

- When used properly, PA *can control costs* so that patients receive medically necessary care, but is *burdensome and overused*

Decreases overall health care costs

- Harmful impacts of PA
  - Delays in treatment
  - Negative patient experience
  - Potential for treatment abandonment
  - Barriers to value-based care models
  - Administrative burden on providers

Decreases health outcomes & patient experience

Negatively impacts well-being of providers

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PA's impact to Essentia Health

- Essentia complies with over **470 contracts**, dedicating **65 staff FTE** to PA activities
- Without standardized regulations on PA:

Payers require different definitions of "medically necessary care"
There are no consistent timelines for PA decision or recourse for delay (e.g., can range from 3 to 21 days)
No transparency requirements regarding PA denials or supporting documentation requirements
Many payors do not allow electronic PA submissions; instead, they require submissions to be made by phone or fax.

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Prior Authorization Reform Efforts

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The Need for PA Reform

Bills in 30 states show momentum to fix prior authorization

MAY 10, 2023 • 4 MIN READ By Kevin B. O'Reilly, N

REGULATORY

Legislators urge CMS to finalize prior authorization reforms—and go further

By **Paige Minemyer** · Jun 22, 2023 3:50pm

dicaid Services | Prior Authorization | Medicare Advantage

PAYERS

House passes bill to install electronic prior authorization in Medicare Advantage plans

By **Robert King** · Sep 14, 2022 1:27pm

Pennsylvania prior authorization reform bill signed into law

Andrew Cass - Monday, November 7th, 2022

r 07, 2023 05:00 AM

Why insurers are scaling back prior authorizations

NONA TEPPER

Congress' prior authorization power play

By **BEN LEONARD** and **ERIN SCHUMAKER** | 06/21/2023 02:00 PM EDT

Jan 27, 2023 - Health

States jump into fight over prior authorization requirements

Decem

Arielle Dreher

CMS proposes streamlining, automating prior authorizations

NONA TEPPER

PAYERS

CMS proposes certain payers implement electronic prior authorization systems by 2026

By **Robert King** · Dec 6, 2022 5:45pm

Prior Authorization | Medicare Advantage | Affordable Care Act (ACA) | Interoperability

UnitedHealthcare cutting 20% of prior authorizations

Andrew Cass - Thursday, March 30th, 2023

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States Continue to Tackle PA Reform

- There are roughly 40 states that have passed PA reform legislation, including:

Alabama	**Arkansas**
Georgia	**Mississippi**
Idaho	**Oklahoma**
Indiana	**Tennessee**
Iowa	**Texas**
Louisiana	**Virginia**
Kentucky	**Wyoming**

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2023 Proposed PA Reform in North Dakota

- ✓ Imposing PA decision timelines
  - 2 business days for nonurgent
  - 24 hours for urgent
- ✓ Auto-authorization for noncompliance of timelines
- ✓ Transparency & reporting requirements
- ✓ "Same or similar specialty" review requirement
- ✓ Implementation of e-PA process

Included in SB 2389 as originally introduced

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SB 2280

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SB 2280 Key Provisions

- Decision Timelines
- Auto-authorization for noncompliance
- Licensed physician review requirements
- Reporting requirements
- Standardized definitions and processes

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SB 2280 Key Compromises

Issue	As introduced	Engrossed version
Decision timelines	24 hours / 2 business days	72 hours/7 calendar days
Review standards	Licensed physician of “same or similar” training	Licensed physician w/ experience treating condition
Peer review requirements	Required consultation before denial	**REMOVED**
Reporting requirements	Annual reporting to NDIC	Enhanced reporting measures to NDIC

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Questions

Andy Askew
Vice President of Public Policy
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2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2280
3/24/2025

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; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

9:50 a. m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, C. Brown, T. Brown, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Members Absent: Representatives Finley-DeVille, Schatz

Discussion Topics:

- Pre-authorization & denial
- Delayed care treatment
- Timely decisions
- Transparency & communication
- National trend

9:50 a.m. Tim Blasl, President, ND Hospital Association, testified in favor.

9:51 a.m. Marcus Lewis, CEO, First Care Health Center in Park River, ND, testified in favor and submitted testimony #43446.

10:03 a.m. Shane Goettle, American Cancer Society, Cancer Action Network, testified in favor.

10:21 a.m. William R. Sherwin, Executive Director, The North Dakota Dental Association, testified in favor and submitted testimony #43500 and #43501.

10:29 a.m. Micah Olson, Attorney, North Dakota Protection & Advocacy Project, testified in favor and submitted testimony #43469.

10:32 a.m. Rikka Pelta, Associate General Counsel, American Council of Life Insurers, testified (online) in opposition and submitted testimony #43528.

10:38 a.m. Biana Balale, Director of Government Relations, National Association of Dental Plans (NADP), testified (online) in opposition and submitted testimony #43507.

10:53 a.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

2025 SB 2280
House Industry, Business and Labor Committee
Representative Jonathan Warrey, Chairman
March 24, 2025

Chairman Warrey and members of the House Industry, Business and Labor Committee, I am Marcus Lewis, CEO of First Care Health Center in Park River. Thank you for the opportunity to testify in support of Senate Bill 2280, which addresses the burdens of prior authorization in healthcare. I am testifying on behalf of the North Dakota Hospital Association (NDHA), which represents hospitals and health systems across the state.

I previously testified on prior authorizations to the Senate Industry and Business Committee on February 5, 2025. During that testimony, I discussed the difference between the intention and the impact of prior authorizations in healthcare, especially for rural facilities like First Care. As stated in my previous testimony, prior authorization policies create direct negative impacts on patient care, such as delaying care and placing additional stress not only on the patient but also on the healthcare provider. These policies result in dangerous delays in care, contribute to clinician burnout, and drive up costs for the healthcare system. Furthermore, they impose bureaucratic obstacles that interfere with timely patient treatment, ultimately jeopardizing patient health.

At First Care, we have seen firsthand the consequences of these delays.

Prior authorization requirements have delayed critical diagnostic procedures like CTs and MRIs, forcing some patients to wait or travel over an hour for care despite our ability to provide timely services. These delays contradict evidence-based medical practice and harm patient outcomes.

Due to the increasing administrative burden of prior authorizations, First Care Health Center has now had to hire a dedicated pre-authorization specialist. This position is solely responsible for managing authorization requests, tracking approvals, and handling denials, diverting resources away from direct patient care. This additional staffing expense is yet another consequence of unnecessary bureaucratic hurdles imposed by insurers. Adding

the labor costs of a full-time equivalent is no easy decision, and isn't one made for an inconvenience.

In outpatient infusions, delays in authorization disrupt essential treatments that help keep patients out of acute and emergency care settings. These delays in care are not conducive to an effective primary care environment, population health management, and our Patient-Centered Medical Home model.

Prior authorization delays result in unnecessarily prolonged hospital stays. We have had multiple cases where we received authorization—whether approval or denial—three days after a patient had been discharged or transferred to swingbed care. Preauthorization requests for swingbed care before a final determination from acute are often automatically denied. This puts our organization in a predicament: keep the patient in acute while waiting for swingbed approval or take the risk of denial by transitioning the patient without approval.

In another example, we have patients ready for transfer, with an available bed at our facility and a tertiary hospital eager to free up space—yet the transfer is delayed for days due to preauthorization requirements. In some cases, insurers provide only a seven-day authorization for swingbed services. However, the approval process for extending the stay can take up to two weeks. This results in a significant gap in coverage for both patients and our organization.

For all of these authorizations, peer-to-peer requests are becoming more frequent. These peer-to-peer calls are not conducive to rural providers. They are usually required within 24 hours, with little to no notice, pulling our family practice providers away from primary care visits to address bureaucratic hurdles instead of treating patients.

When a denial is received, it is up to us as the provider to deliver this news to the patient, adding unnecessary stress and confusion. We are also responsible for executing the appeal process, with extremely limited and ambiguous time limitations. Providing the appropriate care for the patient should not put the financial health of the facility at risk.

Delayed treatments, increased patient travel burdens, prolonged hospital stays, and the need for additional staffing to manage authorizations are not mere inconveniences—they are systemic failures that harm patient care and strain healthcare facilities. The experiences of providers and patients alike demonstrate that prior authorization requirements create significant barriers to timely and effective medical treatment.

For me personally, it comes down to accountability and trust. When I go to see my primary care provider, I trust that they are ordering the appropriate diagnostic, treatment, and medications for my condition. Why does my insurer not have the same faith in our Board-Certified MDs, DOs, FNPs, and PAs? If there is an accountability concern, why isn't the issue addressed with those respective boards, versus the impact of patient care delivery?

As value-based care progresses throughout healthcare, the total risk factor of wellness moves from the payor to provider. This continues through full capitation payments to providers, based on clinical coding and documentation. Prior authorization requirements impede this transition, removing trust and stewardship from the care team and Primary Care Provider.

We urge you to support Senate Bill 2280, which takes necessary steps to remove unnecessary barriers to timely patient care, hold insurers accountable, and align policies with the realities of rural healthcare delivery. These guidelines will enhance accountability, improve patient care, and ensure that healthcare providers can focus on what truly matters—caring for their patients.

Thank you for your time and consideration.

Respectfully Submitted,

Marcus Lewis, CEO
First Care Health Center

Protection & Advocacy Project
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Bismarck, ND 58501
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House Industry, Business and Labor Committee
Senate Bill 2280 – March 24, 2025
Testimony of Micah Olson, P&A Position-In Support

My name is Micah Olson. I am an attorney at North Dakota Protection & Advocacy.

P&A supports SB 2280, as it supports individuals with disabilities as they seek medical services to maintain and/or regain their health. Many individuals with disabilities need lifelong health care for physical and behavioral health needs and for complex medical conditions. This bill would ensure that medical decisions remain between individuals and their doctor, who best know and understand their medical needs.

Obtaining authorization for care and treatment can be complicated, confusing, and burdensome to some individuals. Difficulties in obtaining authorization can cause disabled individuals to not seek necessary medical care. This can seriously impact their current and future health. A delay in care can exacerbate illness; requiring longer hospitalizations, more expensive treatment, and long-term outcomes that impact health, employment and longevity. When emergency events can be timely treated, hospitalizations and complications can be reduced. Eliminating prior authorization for emergency medical services ensures individuals receive timely care.

This bill would safeguard against delays and disruptions by streamlining the prior authorization process. It guarantees continuity of care by honoring prior authorizations for at least 60 days when an enrollee changes insurers. It protects against retrospective denials once approval is granted. It cannot be revoked for 45 business days. This bill provides a regulatory framework that ensures prior authorization is efficient, consistent and in a manner that provides access to medical care in a timely manner.

P&A is in strong support of SB 2280 and requests a Do Pass on this bill to protect the health of all North Dakota citizens.

Sixty-seventh Legislative Assembly of North Dakota
In Regular Session Commencing Tuesday, January 5, 2021

HOUSE BILL NO. 1154
(Representative Keiser)
(Senators Klein, Vedaa)

AN ACT to create and enact chapter 26.1-36.9 and sections 26.1-47-02.2 and 26.1-47-02.3 of the North Dakota Century Code, relating to prior authorization of dental services, dental networks, and payment of dental claims.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

SECTION 1. Chapter 26.1-36.9 of the North Dakota Century Code is created and enacted as follows:

26.1-36.9-01. Definitions.

As used in this chapter:

1. "Dental benefit plan" means a benefits plan that pays or provides dental expense benefits for covered dental services and is delivered through a dental insurer.

2. "Dental insurer" means a dental insurance company, dental service corporation, or dental plan organization authorized to provide dental benefits.

3. "Dental provider" means a licensed provider of dental services in this state.

4. "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease.

5. "Prior authorization" means confirmation by the covered individual's dental benefit plan that the services sought to be provided by the dental provider meet the criteria for coverage under the covered individual's dental benefit plan as defined by the covered individual's dental benefit plan.

26.1-36.9-02. Dental benefit plans - Prior authorization.

A dental benefit plan may not deny a claim subsequently submitted by a dental provider for procedures specifically included in a prior authorization, unless at least one of the following circumstances applies for each procedure denied:

1. Benefit limitations, such as annual maximums and frequency limitations not applicable at the time of the prior authorization, are reached due to utilization after issuance of the prior authorization.

2. The documentation for the claim provided by the dental provider submitting the claim clearly fails to support the claim as originally authorized.

3. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the condition of the patient occurs such that the prior authorized procedure would no longer be considered medically necessary, based on the prevailing standard of care.

4. If, after the issuance of the prior authorization, new procedures are provided to the patient or a change in the patient's condition occurs such that the prior authorized procedure would at that time require disapproval pursuant to the terms and conditions for coverage under the patient's plan in effect at the time the prior authorization was used.

5. The denial of the payment was due to one of the following:

   a. Another payor is responsible for payment.

   b. The dental provider already has been paid for the procedures identified on the claim.

   c. The claim was submitted fraudulently.

   d. The individual receiving the procedure was not eligible to receive the procedure on the date of service.

SECTION 2. Section 26.1-47-02.2 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.2. Dental networks.

1. As used in this section:

   a. "Affiliate" means a person that directly or indirectly through one or more intermediaries controls, or is under the control of, or is under common control with, the person specified.

   b. "Contracting entity" means a person that enters a direct contract with a dental provider for the delivery of dental services.

   c. "Network" means a group of preferred dental providers providing services under a network plan.

   d. "Network plan" means a dental benefit plan that requires a covered individual to use, or creates incentives, including financial incentives, for a covered individual to use a dental provider managed by, owned by, under contract with, or employed by the dental insurer.

   e. "Third party" means an entity that is not a party to a contracting entity's dental provider network.

2. A contracting entity may grant a third party access to a dental provider network contract, or a provider's dental services or contractual discounts provided pursuant to a dental provider network contract, if all of the following are met:

   a. The contract specifically states the contracting entity may enter an agreement with a third party allowing the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity.

   b. If the contracting entity is a dental insurer, the dental provider may opt out of the third-party access at the time the dental provider network contract was entered or renewed.

   c. The contracting entity identifies, in writing or electronic form to the dental provider, all third parties in existence as of the date the contract is entered or renewed.

   d. The contracting entity notifies dental network providers that a new third party is leasing or purchasing the network at least thirty days in advance of the relationship taking effect.

   e. The contracting entity makes available a copy of the dental provider network contract relied on in the adjudication of a claim to a participating dental provider within thirty days of a request from the dental provider.

3. A dental provider's refusal to agree in writing to the third-party access to the dental provider network does not permit the contracting entity to end the contractual relationship with the dental provider.

4. The provisions of this section do not apply if access to a provider network contract is granted to a dental carrier or an entity operating in accordance with the same brand licensee program as the contracting entity or to an entity that is an affiliate of the contracting entity.

SECTION 3. Section 26.1-47-02.3 of the North Dakota Century Code is created and enacted as follows:

26.1-47-02.3. Postpayment of dental claims - Payment recovery limitations.

1. As used in this section, "dental care provider" means a licensed provider of dental care services in this state.

2. Other than recovery for duplicate payments, a dental insurer, if engaging in overpayment recovery efforts, shall provide written notice to the dental care provider which identifies the error made in the processing or payment of the claim and justifies the overpayment recovery.

3. A dental insurer shall provide a dental care provider with the opportunity to challenge an overpayment recovery, including the sharing of claims information, and shall establish written policies and procedures for a dental care provider to follow to challenge an overpayment recovery.

4. A dental insurer may not initiate overpayment recovery efforts more than twelve months after the original payment for the claim was made. This time limit does not apply to overpayment recovery efforts that are:

   a. Based on reasonable belief of fraud, abuse, or other intentional misconduct;

   b. Required by, or initiated at the request of, a self-insured plan; or

   c. Required by a state or federal government plan.

_____	_____
Speaker of the House	President of the Senate
_____	_____
Chief Clerk of the House	Secretary of the Senate

This certifies that the within bill originated in the House of Representatives of the Sixty-seventh Legislative Assembly of North Dakota and is known on the records of that body as House Bill No. 1154.

House Vote:	Yeas 60	Nays 34	Absent 0
Senate Vote:	Yeas 45	Nays 1	Absent 1

_____
Chief Clerk of the House

Received by the Governor at _____M. on _____, 2021.

Approved at _____M. on _____, 2021.

_____
Governor

Filed in this office this _____day of _____, 2021,

at _____ o'clock _____M.

_____
Secretary of State

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

The North Dakota Dental Association stands in strong support with the broader coalition on SB 2280. We were present at the hearing today but were unable to testify our support(and request to remain in the bill) due to time constraints. This bill has been worked on for well over a year between the proponents and opponents to land in its current form before your committee. There have been multiple concessions by the proponents, and we feel the bill before you is in its ideal form and would respectfully ask that you give it a DO PASS recommendation without amendments.

Prior Authorization is important. Universal and broad protections for consumers that are standardized across healthcare professionals is important. Consumers lack education and knowledge in the healthcare space, so in areas where standardization can be accomplished supports patient understanding and expectations when navigating health care delivery. The broad and universal protections in SB 2280 set a standard and "expectation" for consumers as they navigate the healthcare space regardless of the provider type, they are seeing. Dentistry is often different, and this is one area where we welcome the collaborative work and standardization across health care providers.

For dental care providers we did advocate for and pass a very specific and limited Prior Authorizations Bill(HB 1154 in 2021) with strong support from your committee and chamber. These limited protections from HB 1154 have worked wonderfully in our arena of dental care and have resulted in many positive outcomes for patients and dentist/patient relationships alike. The broader and more universal protections in SB 2280 are complimentary to our smaller and more limited protections we advocated for in HB 1154. We would respectfully request to remain included in the bill so our dentists can realize the valid and strong over-arching protections in SB 2280. Specifically, of most concern and value to us is the "Personnel Qualified" sections starting on Page 4 and running onto Page 5. These protections and requirements that both "adverse determinations" and "review appeals" be required to be done by a "licensed dentist" is of the highest merit and one area that we strongly advocate for. We do NOT have these protections or standards in our current prior authorization law. With the proliferation of "business analysts" and "algorithms" making standard of care, adverse determinations, claims reviews and appeals reviews; it is of the utmost importance that our member dentists can speak with an equally trained provider regarding oral health decisions for patients.

For the above reasons and many more not stated, we would respectfully ask the Committee to leave "dental in the bill" and extend the standards and protections to our member dentists that you extend to other healthcare professionals. Not only are these valid and broad protections, but by leaving dental in the bill you create a "standardization" across all healthcare professionals making it easier for consumers to understand and navigate this space.

Please give SB 2280 a DO PASS recommendation and it is our hope that you pass the bill in its current form.

William R. Sherwin, Executive Director, The North Dakota Dental Association

March 24, 2025

RE: SB 2280 – Oppose

Chair Warrey and Members of the Committee,

On behalf of the National Association of Dental Plans (NADP)[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 Is Different

Including dental plans in the prior authorization process would significantly disrupt how the dental market currently operates. Dental plans offer a wide variety of products and benefit designs compared with medical plans. Dental benefit plan design differs fundamentally from medical plan design. A dental plan generally manages costs by paying a greater share of preventative services to encourage regular dental visits that can reduce the need for more costly procedures in the future. Higher cost-sharing for certain procedures keeps dental premiums low and affordable. 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.

In dental, pre-treatment estimates are utilized to develop a treatment plan with a patient. For example, a patient needing multiple root canals could consult with their dentist on a timeline for care based on their dental needs. The dentist in turn could submit a pretreatment estimate to the patient's insurance plan to determine the coverage and medical necessity standards of their coverage. This healthy engagement through a pretreatment estimate allows a patient to receive care covered by their plan and develop a thorough care plan for the dentist.

The 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. In turn premiums and cost of care may increase to meet the expanding administrative costs, feeding a cycle of cost increases that harms access to care and outcomes. For example, 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.

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

[1] NADP is the largest non-profit trade association focused exclusively on the dental benefits industry. NADP's members provide dental HMO, dental PPO, dental indemnity and discount dental products to more than 200 million Americans with dental benefits. Our members include the entire spectrum of dental carriers: companies that provide both medical and dental coverage, companies that provide only dental coverage, major national carriers, regional, and single state companies, as well as companies organized as non-profit plans.

[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

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 a 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,

Bianca Balale
Director of Government Relations
National Association of Dental Plans

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.

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2280
3/26/2025

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; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

2:59 p. m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives Bahl, C. Brown, T. Brown, Finley-DeVille, Grindberg, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Discussion Topics:

- External review
- Time standard
- Move dental to proper section

3: 01 p.m. Representative Bahl moved to adopt the amendment #44226.

3:01 p.m. Representative Vollmer seconded the motion.

Voice vote.

Motion passed.

3:01 p.m. Chrystal Bartuska, Division Director Life & Health, ND Insurance Department, shared information with the committee.

3:18 p.m. Andrew Askew, Vice President Public Policy, Essentia Health, available to answer questions.

3:55 p.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

Bill further amended on 03/31/25.

SB2280 03/26/2025 Proposed amendment language

1. **SECTION 3. LEGISLATIVE MANAGEMENT STUDY – PRIOR AUTHORIZATION ELECTRONIC HEALTH RECORDS FOR NONURGENT, URGENT, AND EMERGENCY HEALTH CARE SERVICES.**

During the 2025-26 interim, the legislative management shall consider studying the ability for all health care systems and providers to submit prior authorization requests, including the necessary supporting medical records, to a prior authorization review organization by secure electronic means.

The study should seek solutions that are alternatives to transmitting the prior authorization requests and supporting medical records by facsimile or mail. The study must include input from stakeholders, including patients, providers, and commercial insurance plans.

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

2025 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2280
3/31/2025

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; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

3:35 p. m. Chairman Warrey opened the meeting.

Members Present: Chairman Warrey, Vice Chairman Ostlie, Vice Chairman Johnson, Representatives T. Brown, Finley-DeVille, Kasper, Koppelman, D. Ruby, Schatz, Schauer, Vollmer

Members Absent: Representatives Bahl, C. Brown, Grindberg, Kasper

Discussion Topics:

- Independent external appeal process
- Nationally accredited Independent Review Organization (IRO).
- Time standard
- Move dental to proper section
- Bio similar drugs

3:35 p.m. Chrystal Bartuska, Division Director, Live & Health, ND Insurance Department, available for additional information and discuss amendment language.

3:59 p.m. Andrew Askew, Vice President Public Policy, Essentia Health, available to answer questions.

4:01 p.m. Jeff Ubban, Deputy General Counsel, Blue Cross and Blue Shield, available to discuss the amendment.

4:28 a.m. Dennis Pathroff, Lobbyist, American Council of Life Insurers (ACLI), available to discuss the amendment.

4:30 p.m. Representative Koppelman moved to amend LC #25.1180.3001, #44501 by changing page 7, line 29 after new policy, to state; "provided the health care service for which the enrollee has received prior authorization is covered under the new policy. To obtain coverage, the enrollee or health care provider shall submit documentation of the previous prior authorization in accordance with the procedures in the enrollee's new policy". And to change page 7, line 18 by inserting the words "at least" before 6 months.

4:30 p.m. Representative Vollmer seconded the motion.

4:31 p.m. Representative Koppelman withdrew his motion.

4:32 p.m. Representative Koppelman moved to remove the previous amendment approved on 3/26/25.

4:32 p.m. Representative Schauer seconded them motion.

Voice vote.

Motion passed.

4:32 Representative Koppelman moved to amend LC #25.1180.3001, #44501 by changing page 7, line 29 after new policy, to state; "provided the health care service for which the enrollee has received prior authorization is covered under the new policy. To obtain coverage, the enrollee or health care provider shall submit documentation of the previous prior authorization in accordance with the procedures in the enrollee's new policy". And to change page 7, line 18 by inserting the words "at least" before 6 months.

4:33 Representative Schauer seconded the motion.

Voice vote.

Motion passed.

4:35 p.m. Representative Koppelman moved to further amend to include as Section 3; the 25-26 legislative interim shall consider studying language.

4:35 p.m. Representative Vollmer seconded the motion.

Voice vote.

Motion passed.

4:35 p.m. Representative Ruby moved to further amend by removing the Dental language.

4:36 p.m. Representative Schauer seconded the motion.

Representatives	Vote
Representative Jonathan Warrey	Y
Representative Mitch Ostlie	Y
Representative Jorin Johnson	Y
Representative Landon Bahl	AB
Representative Collette Brown	AB
Representative Timothy Brown	N
Representative Lisa Finley-DeVille	N
Representative Karen Grindberg	AB
Representative Jim Kasper	AB
Representative Ben Koppelman	N
Representative Dan Ruby	Y
Representative Mike Schatz	AB

Representative Austin Schauer	Y
Representative Daniel R. Vollmer	N

Motion passed 5-4-5.

4:41 p.m. Representative Ostlie moved Do Pass as amended.

4:41 p.m. Representative Vollmer seconded the motion.

Representatives	Vote
Representative Jonathan Warrey	Y
Representative Mitch Ostlie	Y
Representative Jorin Johnson	Y
Representative Landon Bahl	AB
Representative Collette Brown	AB
Representative Timothy Brown	Y
Representative Lisa Finley-DeVille	Y
Representative Karen Grindberg	AB
Representative Jim Kasper	AB
Representative Ben Koppelman	Y
Representative Dan Ruby	Y
Representative Mike Schatz	Y
Representative Austin Schauer	Y
Representative Daniel R. Vollmer	Y

Motion passed 10-0-4.

4:43 p.m. Representative Vollmer will carry the bill.

4:43 p.m. Chairman Warrey closed the meeting.

Diane Lillis, Committee Clerk

25.1180.03003
Title.04000

Adopted by the House Industry,
Business and Labor Committee
March 31, 2025

Sixty-ninth
Legislative Assembly
of North Dakota

PROPOSED AMENDMENTS TO
FIRST ENGROSSMENT

VG 3/31/25
1 of 11

ENGROSSED 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; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

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.

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 a health benefit plan as defined in section 26.1-36.3-01~~ or a dental benefit plan as defined in section 26.1-36.9-01~~. The term does not include medical assistance or the public employees retirement system uniform group insurance program plans under chapter 54-52.1.

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 sixty 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~~, licensed dentist,~~ or licensed pharmacist. The reviewing individual:

1. Must have experience treating patients with the condition or illness for which the health care service is being requested; and
2. 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. 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;~~receive any financial incentive based on the number of adverse determinations made. This subdivision does not apply to financial incentives established between health plan companies and health care providers.

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.

3. This section does not apply to reviews conducted under sections 26.1-36-44 and 26.1-36-46.

26.1-36.12-05. 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 seven calendar days of obtaining all necessary information to make the decision. For purposes of this ~~subsection~~section, "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 have written procedures to address the failure of a health care provider or enrollee to provide the necessary information to make a determination on the request. If the health care provider or enrollee fails to provide the necessary information to the prior authorization review organization within fourteen calendar days of a written request for all necessary information, the prior authorization review organization may make an adverse determination.

3. A prior authorization review organization shall allow an enrollee and the enrollee's health care provider at least fourteen business days to request an updated prior authorization following an unforeseen change in the circumstances or care needs for the enrollee 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~~.

26.1-36.12-06. 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 seventy-two hours after receiving all information needed to complete the review of the requested health care services.

26.1-36.12-07. 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. 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.

4. If an enrollee receives an emergency health care service that requires immediate postevaluation or poststabilization 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.

26.1-36.12-08. 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.

26.1-36.12-09. 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 unless there is evidence the prior authorization was based on fraud.

26.1-36.12-10. Length of prior authorization.

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

26.1-36.12-11. 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.

26.1-36.12-12. 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. provided the health care service for which the enrollee has received prior authorization is covered under the new policy. To obtain coverage, the enrollee or

health care provider shall submit documentation of the previous prior authorization in accordance with the procedures in the enrollee's 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. This subsection does not apply if a prior authorization review organization changes coverage terms for a drug or device that has been:

   a. Deemed unsafe by the United States food and drug administration; or

   b. Withdrawn by the United States food and drug administration or product manufacturer.

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 provided the health care service for which the enrollee has received prior authorization is covered under the new policy.

26.1-36.12-13. 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.

26.1-36.12-14. 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.

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

1. 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.

2. This section does not apply if a prior authorization review organization changes coverage terms for a drug or device that has been:

a. Deemed unsafe by the United States food and drug administration; or

b. Withdrawn by the United States food and drug administration or product manufacturer.

26.1-36.12-16. 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.

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

1. A prior authorization review organization shall report to the insurance commissioner by September first of each year information regarding prior authorization requests for the previous calendar year.

2. The report must be available online and in a form specified by the commissioner.

3. 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;

e. Reasons an adverse determination was issued, expressed as a percentage of all adverse determinations, which must 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;

f. Number of prior authorization requests submitted but not necessary;

g. Number of prior authorization requests submitted by electronic means; and

h. Number of prior authorization requests submitted by nonelectronic means, including mail and facsimile.

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

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

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

SECTION 3. LEGISLATIVE MANAGEMENT STUDY - PRIOR AUTHORIZATION ELECTRONIC HEALTH RECORDS FOR NONURGENT AND EMERGENCY HEALTH CARE SERVICES. During the 2025-26 interim, the legislative management shall consider studying the ability for health care systems and providers to submit prior authorization reviews for nonurgent and emergency health care services by secure electronic means. The study must analyze alternatives to facsimile or mail for transmitting prior authorization requests and the supporting medical records. The study must include input from stakeholders, including patients, providers, and commercial insurance plans. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the seventieth legislative assembly.

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

REPORT OF STANDING COMMITTEE
ENGROSSED SB 2280

Industry, Business and Labor Committee (Rep. Warrey, Chairman) recommends **AMENDMENTS (25.1180.03003)** and when so amended, recommends **DO PASS** (10 YEAS, 0 NAYS, 4 ABSENT OR EXCUSED AND NOT VOTING). Engrossed SB 2280 was placed on the Sixth order on the calendar.

25.1180.03001
Title.

Prepared by the Legislative Council
staff for Representative Vollmer
March 28, 2025

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

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; to provide for a legislative management study; to provide for a legislative management report; and to provide an effective date.

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.

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 a health benefit plan as defined in section 26.1-36.3-01 or a dental benefit plan as defined in section 26.1-36.9-01. The term does not include medical assistance or the public employees retirement system uniform group insurance program plans under chapter 54-52.1.

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 sixty 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, licensed dentist, or licensed pharmacist. The reviewing individual:

1. Must have experience treating patients with the condition or illness for which the health care service is being requested; and
2. 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. 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;~~receive any financial incentive based on the number of adverse determinations made. This subdivision does not apply to financial incentives established between health plan companies and health care providers.

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.

3. This section does not apply to reviews conducted under sections 26.1-36-44 and 26.1-36-46.

26.1-36.12-05. 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 seven calendar days of obtaining all necessary information to make the decision. For purposes of this ~~subsection~~section, "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 have written procedures to address the failure of a health care provider or enrollee to provide the necessary information to make a determination on the request. If the health care provider or enrollee fails to provide the necessary information to the prior authorization review organization within fourteen calendar days of a written request for all necessary information, the prior authorization review organization may make an adverse determination.

3. A prior authorization review organization shall allow an enrollee and the enrollee's health care provider at least fourteen business days to request an updated prior authorization following an unforeseen change in the circumstances or care needs for the enrollee 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~~.

26.1-36.12-06. 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 seventy-two hours after receiving all information needed to complete the review of the requested health care services.

26.1-36.12-07. 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. 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.

4. If an enrollee receives an emergency health care service that requires immediate postevaluation or poststabilization 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.

26.1-36.12-08. 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.

26.1-36.12-09. 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 unless there is evidence the prior authorization was based on fraud.

26.1-36.12-10. Length of prior authorization.

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

26.1-36.12-11. 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.

26.1-36.12-12. 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. To obtain coverage, the enrollee or health care provider shall submit documentation of the previous prior authorization in accordance with the procedures in the enrollee's 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. This subsection does not apply if a prior authorization review organization changes coverage terms for a drug or device that has been:

   a. Deemed unsafe by the United States food and drug administration; or

   b. Withdrawn by the United States food and drug administration or product manufacturer.

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 provided the health care service for which the enrollee has received prior authorization is covered under the new policy.

26.1-36.12-13. 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.

26.1-36.12-14. 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.

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

1. 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.

2. This section does not apply if a prior authorization review organization changes coverage terms for a drug or device that has been:

a. Deemed unsafe by the United States food and drug administration; or

b. Withdrawn by the United States food and drug administration or product manufacturer.

26.1-36.12-16. 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.

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

1. A prior authorization review organization shall report to the insurance commissioner by September first of each year information regarding prior authorization requests for the previous calendar year.

2. The report must be available online and in a form specified by the commissioner.

3. 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;

e. Reasons an adverse determination was issued, expressed as a percentage of all adverse determinations, which must 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;

f. Number of prior authorization requests submitted but not necessary;

g. Number of prior authorization requests submitted by electronic means; and

h. Number of prior authorization requests submitted by nonelectronic means, including mail and facsimile.

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

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

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

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