



North Dakota Legislative Council

Prepared for the Employee Benefits Programs Committee
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UNIFORM GROUP INSURANCE PROGRAM - PRIOR AUTHORIZATION REQUIREMENTS STUDY - BACKGROUND MEMORANDUM

Section 2 of Senate Bill No. 2280 (2025) ([appendix](#)) provides for a study of prior authorization requirements imposed by the Public Employees Retirement System (PERS) Uniform Group Insurance Program health plans under North Dakota Century Code Chapter 54-52.1 and the impact on patient care and health care costs.

The study requires PERS Uniform Group Insurance Program health plans to submit to the Insurance Commissioner by July 1, 2025, for the immediately preceding calendar year for each commercial product, the:

- Number of prior authorization requests for which an authorization was issued.
- 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.
- 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.
- Number of denials reversed by internal appeals or external reviews.

The Insurance Commissioner must aggregate the received data into a report and submit the report to the Legislative Management by November 1, 2025.

The study must include input from stakeholders, including patients, providers, and commercial insurance plans.

BACKGROUND

Prior authorization is the review conducted before the delivery of a 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.¹ Prior authorization 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.

2023-24 Interim

During the 2023-24 interim, the Health Care Committee studied the use of prior authorization in health benefit plans. The committee received testimony from representatives of the American Medical Association, health care providers, insurers, and other interested stakeholders.

¹NDCC § 26.1-36.12-01.

Testimony from the American Medical Association indicated 80 percent of physicians reported the number of medical services for which prior authorization is required by insurers has increased over the last 5 years, and 89 percent of physicians reported prior authorization interferes with the continuity of patient care.

Testimony from health care providers indicated when properly used, prior authorization can control costs to ensure patients receive medically necessary care. Testimony indicated harmful impacts of prior authorization include delays in treatment, negative patient experiences, potential for treatment abandonment, barriers to innovative care models, and additional administrative burdens on providers.

Testimony from physicians indicated insurers and physicians rarely communicate directly regarding prior authorization requests. Testimony indicated physicians feel medical directors at certain insurance companies do not spend adequate time reviewing a patient's claim, and vetted physicians within an insurance provider's network should be trusted to make the correct decisions. Testimony indicated prior authorizations should be reviewed by qualified specialists within the field of the proposed treatment.

Testimony received from insurers indicated prior authorization serves as an important safety check to confirm with the provider the care recommendation is safe, medically evidenced, and not duplicative. When reviewing prior authorization requests, a representative of one insurer testified it takes into consideration safety, best care, and cost, and encourages communication between a member's doctor and the member's insurance company. Testimony from insurers indicated there are several areas of opportunity to improve the prior authorization process, including ensuring providers submit requests only for services that require prior authorization, encouraging electronic submission of requests, and including all necessary supporting documentation with the initial request.

The committee made no recommendation to the Legislative Management regarding its study of the use of prior authorization in health benefit plans.

2025 Legislation

The 2025 Legislative Assembly passed Senate Bill No. 2280, which establishes requirements and procedures for prior authorization review organizations relating to the disclosure and review of prior authorization requests, decision deadlines, adverse determinations, appeal review, nonurgent circumstances, urgent health care services, and emergency medical conditions. The bill:

- Requires a prior authorization review organization to make prior authorization requirements and restrictions readily accessible on the organization's website.
- Requires a prior authorization review organization to provide notice of a new or amended prior authorization requirement or restriction 60 days before implementing the change.
- Requires all prior authorization adverse determinations to be made by a licensed physician who has experience treating patients with the condition or illness for which the health care service is being requested, or if involving a prescription drug, a licensed pharmacist or physician who is competent to evaluate the specific clinical issues presented in the review.
- Provides all prior authorization appeals are reviewed by a physician meeting certain requirements, including actively practicing in the same or similar specialty as the physician who typically manages the medical condition or disease for at least 5 consecutive years and is not directly involved in making the adverse determination.
- Requires a prior authorization review organization to make a prior authorization or adverse determination within 7 calendar days of obtaining all necessary information to make a decision under nonurgent circumstances. If a health care provider or enrollee fails to provide the necessary information to the prior authorization review organization within 14 calendar days of a written request, the prior authorization review organization may make an adverse determination.

- Requires a prior authorization review organization to make a prior authorization or adverse determination within 72 hours of obtaining all necessary information concerning urgent health care services.
- Prohibits a prior authorization review organization from requiring prior authorization for prehospital transportation or for the provision of emergency health care services for an emergency medical condition.
- Requires a prior authorization review organization to allow an enrollee or provider a minimum of 2 business days following an emergency admission or provision of emergency health care services for an emergency medical condition to notify the organization of the admission or provision of services.
- Requires a prior authorization review organization to make an authorization determination within 2 business days of receiving a request from an enrollee that received emergency health care services that require immediate post-evaluation or post-stabilization services. If the authorization determination is not made within 2 business days, the services must be deemed approved.
- Prohibits prior authorization for the provision of medication-assisted treatment for the treatment of opioid use disorder.
- Limits retrospective denial of prior authorization.
- Requires prior authorization to be valid for at least 6 months after the date the health care provider receives the prior authorization.
- Requires a prior authorization review organization to honor a prior authorization granted to an enrollee from a previous organization for at least the initial 60 days of an enrollee's coverage under a new policy.
- Requires a prior authorization review organization to report to the Insurance Commissioner by September 1 of each year information regarding prior authorization requests for the previous calendar year.

The bill excluded PERS Uniform Group Insurance Program health plans under Chapter 54-52.1, dental insurance plans, and medical assistance from being subject to the newly established prior authorization requirements and procedures. Testimony in support of the bill stressed the need for an interim study to determine whether the prior authorization provisions in the bill should be extended to PERS Uniform Group Insurance Program health plans. The bill becomes effective on January 1, 2026.

NORTH DAKOTA STATUTORY PROVISIONS

In addition to the newly established prior authorization requirements and procedures adopted in Senate Bill No. 2280 (2025) and codified in Chapter 26.1-36.12, other statutory provisions relating to prior authorization include:

- Providing a drug prior authorization request must be accessible to a health care provider with the provider's electronic prescribing software system and must be accepted electronically, through a secure electronic transmission, by the payer, the insurance company, or the pharmacy benefit manager responsible for implementing or adjudicating the authorization or denial of the prior authorization request (Section 23-01-38);
- Prohibiting a dental benefit plan from retroactively denying coverage for services that previously have received prior authorization, unless certain conditions are met (Chapter 26.1-36.9);
- Requiring providers to obtain prior authorization from Preferred Provider Organization health plans before obtaining air ambulance services (Section 26.1-47-10); and
- Creating a prior authorization drug program for individuals on medical assistance which meets federal requirements (Chapter 50-24.6).

INTEROPERABILITY AND PRIOR AUTHORIZATION FINAL RULE

In February 2024, the federal Centers for Medicare and Medicaid Services (CMS) issued the CMS interoperability and prior authorization final rule.² The final rule emphasizes the need to improve health information exchange to achieve appropriate access to health records and focuses on efforts to improve the prior authorization process through policies and technology. The final rule was effective in April 2024, with the initial requirements of the rule to be met by health insurance plans governed by CMS by January 1, 2026, and all remaining requirements to be met by January 1, 2027.

Although the final rule only impacts health insurance plans governed by CMS, many aspects of the rule align with recent reforms made in North Dakota through Senate Bill No. 2280 (2025). Those aspects include imposing prior authorization decision deadlines, auto-authorization when deadlines are not met, same or similar specialty review requirements, and transparency and reporting requirements.

UNIFORM GROUP INSURANCE PROGRAM

Background

The 1971 Legislative Assembly established the Uniform Group Insurance Program, codified as Chapter 54-52.1, which offers public employees health insurance benefits. Previously, the 1963 Legislative Assembly passed Senate Bill No. 176, formerly codified as Chapter 52-12, which authorized any department, board, or agency of the state to act on its own behalf or in conjunction with other agencies to enter a group hospitalization and medical care plan and group life insurance plan for state employees. The 1971 legislation establishing the Uniform Group Insurance Program repealed Chapter 52-12.

Section 54-52.1-02 provides the purpose of the Uniform Group Insurance Program is to promote the economy and efficiency of employment in the state's service, reduce personnel turnover, and offer an incentive to high-grade individuals to enter and remain in the service of state employment.³ The uniform group must be composed of eligible and retired employees and be formed to provide hospital benefits coverage, medical benefits coverage, and life insurance benefits coverage. Eligible employees include permanent employees who are employed by a governmental unit, members of the Legislative Assembly, judges of the Supreme Court, full-time employees of political subdivisions, elective state officers, disabled permanent employees who are receiving compensation from the North Dakota Workforce Safety and Insurance Fund, and paid members of state or political subdivision boards, commissions, or associations.

The Public Employees Retirement System Board (PERS Board) is responsible for administering the Uniform Group Insurance Program. The PERS Board must receive bids for the provision of hospital and medical benefits coverage and may receive bids separately for all or part of the prescription drug benefits coverage component of the medical benefits coverage. The board must contract with the carriers the board determines best serve the interests of the state and the state's eligible employees.

If the prescription drug coverage component of a health insurance benefits coverage contract uses the services of a pharmacy benefits manager, either contracted directly with a pharmacy benefits manager or indirectly through the health insurer, the PERS Board must give consideration and preference to an insurer's contract that meets certain criteria, including providing the board with monthly claims data and information on all programs being implemented or modified, such as prior authorization, step therapy, mandatory use of generic drugs, or quantity limits.⁴

²See 89 Fed. Reg. 8758 (February 8, 2024).

³The Legislative Assembly continued to provide funding for the cost of health insurance premiums for state employees for the 2025-27 biennium. The appropriations provide \$1,893 per month for employee health insurance, an increase of \$250, or 15.23 percent, compared to the 2023-25 biennium premium rate of \$1,643 per month.

⁴NDCC § 54-52.1-04.15.

Health Plans

Active Member Health Plans

The Public Employees Retirement System offers three health plans to active members: the preferred provider organization basic grandfathered plan, the preferred provider organization basic nongrandfathered plan, and the high-deductible health plan (HDHP). All three health plans are provided by the same insurance carrier, and all have the same prior authorization procedures and requirements.

The basic grandfathered plan is offered to individuals employed by a participating employer who are at least age 18, work at least 20 hours per week for 20 or more weeks per year, and whose positions are regularly funded and not of limited duration. Temporary employees may be eligible to participate as determined by their employer. The basic grandfathered plan is offered to all eligible state employees and eligible employees of participating political subdivisions.

The basic nongrandfathered plan is offered to individuals employed by a participating political subdivision who are at least age 18, work at least 20 hours per week for 20 or more weeks per year, and whose positions are regularly funded and not of limited duration. Temporary employees may be eligible to participate as determined by the participating employer. Only one political subdivision, Mercer County, participates in the basic nongrandfathered plan.

The HDHP with a health savings account is offered to eligible permanent state employees, university system employees, and district health unit employees. Temporary employees and employees of political subdivisions are not eligible to participate in the HDHP. The HDHP has higher annual deductibles and larger out-of-pocket costs for medical services. However, the higher initial out-of-pocket costs are partially offset by an employer contribution to a health savings account created in the member's name. A health savings account is a tax-advantaged member-owned account that allows a member to save pretax dollars for future qualified medical expenses.

Retired Member Health Plans

The Public Employees Retirement System offers two health plans to retired members: the Dakota Retiree Plan (Medicare) bundled with the Medicare Part D Prescription Drug Plan and the Dakota Retiree Plan (Non-Medicare).

The Dakota Retiree Plan (Medicare) bundled with the Medicare Part D Prescription Drug Plan is a supplemental plan to Medicare and requires any Medicare eligible individual to have both Medicare Parts A and B to participate.⁵ To be eligible, a retiree must be receiving a retirement allowance from an eligible retirement plan. The rate a member is charged for the supplemental plan is based on the enrollment date, Medicare eligibility, and the number of dependents, if any.

The Dakota Retiree Plan (Non-Medicare) is available to retirees before a retiree is eligible for Medicare. However, eligibility is determined based on when the retiree began receiving retirement benefits from an eligible retirement plan. The rate a member is charged for the plan is based on eligibility under the federal Consolidated Omnibus Budget Reconciliation Act, when the application for coverage is submitted to PERS, and the number of dependents, if any.

STUDY APPROACH

In conducting the study of the PERS Uniform Group Insurance Program prior authorization requirements, the committee may wish to receive input from insurers, health care providers, prior authorization review organizations, patients, and active and retired members.

ATTACH:1

⁵The Dakota Retiree Plan (Medicare) must be bundled with the Medicare Part D Prescription Drug Plan; it is not available as a stand-alone product.