23.1108.01004

Sixty-eighth
Legislative Assembly
of North Dakota

SENATE BILL NO. 2389

Introduced by

Senators Vedaa, J. Roers

Representative Nelson

A BILL ~~for an Act to create and enact chapter 26.1-36.11 of the North Dakota Century Code, relating to prior authorization for health insurance.~~for an Act to provide for a legislative management study of the prior authorization process for health insurance.

BE IT ENACTED BY THE LEGISLATIVE ASSEMBLY OF NORTH DAKOTA:

~~**SECTION 1.** Chapter 26.1-36.11 of the North Dakota Century Code is created and enacted as follows:~~

~~**26.1-36.11-01. Definitions.**~~

~~For the purpose of this chapter, unless the context otherwise requires:~~

~~1. "Adverse determination" means a decision by a utilization review organization that the health care services furnished or proposed to be furnished to an enrollee are not medically necessary or are experimental or investigational; and benefit coverage is therefore denied, reduced, or terminated. A decision to deny, reduce, or terminate a service not covered for reasons other than medical necessity or the experimental or investigational nature of the service is not an "adverse determination" for purposes of this chapter.~~

~~2. "Appeal" means a formal request, either orally or in writing, to reconsider an adverse determination regarding an admission, extension of stay, or other health care service.~~

~~3. "Authorization" means a determination by a utilization review organization that a health care service has been reviewed and, based on the information provided, satisfies the utilization review organization's requirements for medical necessity and appropriateness and that 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 utilization review organization to determine the necessity and appropriateness of health care services.~~

~~5. "Emergency medical condition" means a medical condition that manifests itself by symptoms of sufficient severity which may include severe 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, serious impairment of a bodily function, or serious dysfunction of any body part.~~

~~6. "Emergency health care services" means health care services, supplies, or treatments furnished or required to screen, evaluate, and treat an emergency medical condition.~~

~~7. "Enrollee" means an individual who has contracted for or who participates in coverage under a policy for that individual or the 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 or within the scope of practice for which a health care professional is licensed. The term also includes 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 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, 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 a medical services plan, or any other benefits program providing payment, reimbursement, or indemnification for health care costs. The term does not include medical assistance 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 utilization review organization.~~

~~13. "Urgent health care service" means a health care service for which, in the opinion of a physician with knowledge of the enrollee's medical condition, the application of the time periods for making a non-expedited prior authorization:~~

~~a. Could seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or~~

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

~~14. "Utilization review organization" means a person that performs prior authorization for one or more of the following entities:~~

~~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; and~~

~~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.~~

26.1-36.11-02. Disclosure and review of prior authorization requirements.

1. A utilization 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. Requirements must be described in detail using plain and ordinary language comprehensible by a layperson.
2. If a utilization review organization intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the utilization review organization shall:
   a. Ensure the new or amended requirement is not implemented unless the utilization review organization's website has been updated to reflect the new or amended requirement or restriction.
   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.

26.1-36.11-03. Personnel qualified to make adverse determinations.

A utilization review organization shall ensure all adverse determinations are made by a licensed physician. The physician:

1. Shall posses a valid nonrestricted license to practice medicine;
2. Must be of the same or similar specialty as the physician who typically manages the medical condition or illness or provides the health care service involved in the request;
3. Must have experience treating patients with the medical 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 utilization review organization's medical directors who is responsible for the health care services provided to enrollees.

26.1-36.11-04. Consultation before issuing an adverse determination.

If a utilization review organization is questioning the medical necessity of a health care service, the utilization review organization shall notify the enrollee's physician that medical necessity is being questioned. Before issuing an adverse determination, the enrollee's physician must have the opportunity to discuss the medical necessity of the health care service on the

~~telephone with the physician who will be responsible for determining authorization of the health care service under review.~~

~~**26.1-36.11-05. Requirements applicable to the physician who can review appeals.**~~

~~A utilization review organization shall ensure all appeals are reviewed by a physician. The reviewing physician:~~

~~1. Shall possess a valid nonrestricted license to practice medicine;~~

~~2. Must be in active practice in the same or similar specialty as the physician who typically manages the medical condition or disease for at least five consecutive years;~~

~~3. Must be knowledgeable of, and have experience providing, the health care services under appeal;~~

~~4. May not be employed by a utilization review organization or be under contract with a utilization review organization other than to participate in one or more of the utilization 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;~~

~~5. May not have been directly involved in making the adverse determination; and~~

~~6. Shall consider all known clinical aspects of the health care service under review, including a review of all pertinent medical records provided to the utilization review organization by the enrollee's health care provider, any relevant records provided to the utilization review organization by a health care facility, and any medical literature provided to the utilization review organization by the health care provider.~~

~~**26.1-36.11-06. Prior authorization - Nonurgent circumstances.**~~

~~1. If a utilization review organization requires prior authorization of a health care service, the utilization review organization shall make a prior authorization or adverse determination and notify the enrollee and the enrollee's health care provider of the prior authorization or adverse determination within two business days of obtaining all necessary information to make the prior authorization or adverse determination. 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 utilization review organization shall allow an enrollee and the enrollee's health care provider fourteen business days following a nonurgent circumstance or provision of~~

~~medical condition for the enrollee or health care provider to notify the utilization review organization of the nonurgent circumstance or provision of health care services.~~

~~**26.1-36.11-07. Prior authorization - Urgent health care services.**~~

~~A utilization 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 not later than twenty-four hours after receiving all information needed to complete the review of the requested health care services.~~

~~**26.1-36.11-08. Prior authorization - Emergency medical condition.**~~

~~1. A utilization 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 utilization 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 utilization review organization of the admission or provision of health care services.~~

~~3. A utilization 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 utilization 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 utilization 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 utilization 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.

26.1-36.11-09. No prior authorization for medication assisted treatment.

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

26.1-36.11-10. Retrospective denial.

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

26.1-36.11-11. Length of prior authorization.

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

26.1-36.11-12. Chronic or long-term care conditions.

If a utilization 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 must remain valid for twelve months.

26.1-36.11-13. 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 utilization review organization shall honor a prior authorization granted to an enrollee from a previous utilization 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 utilization 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 utilization 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.

26.1-36.11-14. Failure to comply - Services deemed authorized.

If a utilization 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 utilization review organization.

26.1-36.11-15. Procedures for appeals of adverse determinations.

1. A utilization 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.

26.1-36.11-16. Expedited appeal.

1. If an adverse determination for a health care service is made before or during an ongoing service requiring review and the attending health care professional believes the determination warrants an expedited appeal, the utilization review organization shall ensure the enrollee and attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization shall ensure reasonable access to the organization's consulting physician.

2. The utilization review organization shall notify the enrollee and attending health care professional by telephone of the organization's determination on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than seventy-two hours after receiving the expedited appeal.

3. If the adverse determination is not reversed through the expedited appeal, the utilization review organization shall include in the organization's notification the right to submit the appeal under the external appeal process referenced in section

~~26.1-36.11-17 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.~~

~~**26.1-36.11-17. Standard appeal.**~~

~~1. The utilization review organization shall establish procedures for appeals to be made either in writing or by telephone.~~

~~2. A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of the organization's determination on the appeal within fifteen days after receipt of the notice of appeal. If the utilization review organization is unable to make a determination within fifteen days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to four additional days to notify the enrollee, attending health care professional, and claims administrator of the organization's determination. If the utilization review organization takes any additional days beyond the fifteen-day period to make the organization's determination, in advance of the extension the organization shall inform the enrollee, attending health care professional, and claims administrator of the reasons for the extension.~~

~~3. The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.~~

~~4. Before upholding the adverse determination for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the adverse determination.~~

~~5. The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the adverse determination is made.~~

~~6. An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse an adverse determination must be provided the following:~~

~~a. A complete summary of the review findings;~~

~~b. Qualifications of the reviewers, including any license, certification, or specialty designation; and~~

~~c. The relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.~~

~~7. If the appeal is to reverse an adverse determination for clinical reasons, the utilization review organization shall ensure a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion reasonably is available to review the case.~~

~~**26.1-36.11-18. Notification to claims administrator.**~~

~~If the utilization review organization and the claims administrator are separate entities, the utilization 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.~~

SECTION 1. LEGISLATIVE MANAGEMENT STUDY - HEALTH INSURANCE PRIOR AUTHORIZATION.

1. During the 2023-24 interim, the legislative management shall consider studying prior authorization in health benefit plans. The study must include consideration of:
   a. The extent to which prior authorization is used by health insurance companies in this state, including the types of services and procedures for which prior authorization is required.
   b. The impact of prior authorization on patient care, including the effects on patient health outcomes, patient satisfaction, health care costs, and patient access to care.
   c. The impact of prior authorization on health care providers and insurers, including the administrative burden, time, and cost associated with obtaining prior authorization, and the appropriate utilization of health care services.
   d. State and federal laws and regulations that may impact prior authorization.
   e. Input from stakeholders, including patients, providers, and commercial insurance plans.

2. The study may include consideration of issues related to response times, retroactive denial, data reporting, clinical criteria and medical necessity, transparency, fraud and abuse, reviewer qualifications, exceptions, and an appeal process.
3. The legislative management shall report its findings and recommendations, together with any legislation required to implement the recommendations, to the sixty-ninth legislative assembly.