2023 SENATE HUMAN SERVICES

SB 2389

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2389
2/15/2023

Relating to prior authorization for health insurance.

11:04 AM **Madam Chair Lee** called the hearing to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston, Hogan** are present.

Discussion Topics:

- Prior authorization delay
- Access to care
- Health care plan
- Provider care provider
- Cost shifting

11:05 AM **Senator Vedaa, District 6** introduced SB 2389 in favor and proposed an amendment 23.1108.01001 #20869.

11:07 AM **Andrew Askew, Vice President, Public Policy, Essentia Health,** testimony in favor #20858

11:15 AM **Tim Blasl, President ND Hospital Association**, in favor verbal introduced Lexie Huebner

11:17 AM **Lexie Huebner, Pre-Service Manager Ultru Health Systems**, testimony in favor #20889

11:30 AM **Donna Thronson, Communications Director, ND Medical Association** in favor verbal introduced Dr. Ana Tobiasz

11:31 AM **Ana Tobiasz, Maternal Fetal Medicine Physician on behalf of the North Dakota Medical Association,** testimony in favor #20842

11:36 AM **Tim Wahlin, Chief of Injury of Services, ND Workforce Safety and Insurance,** testimony in opposition #20606

11:39 AM **Dylan Wheeler, Head of Government Affairs, Sanford Health Plan**, testimony in opposition #20846

11:43 AM **Meghan Houn, Vice President of Public Policy and Government Affairs**, **ND Blue Cross Blue Shield** testimony in opposition #20887

11:51 AM **Jeff Ubben, Vice President of Compliance Regulatory Affairs and Special Investigation ND Blue Cross Blue Shield** verbally testified in opposition.

12:05 PM **Karlee Tebbut, Regional Director, State Affairs, AHIP-Guiding Greater Health** online testimony in opposition #20868

12:08 PM **Chrystal Bartuska, Life Health and Medicare Division Director, ND Insurance Department**, provided additional information neutral verbal

Additional written testimony:
Jonathan Haug, Medical Director of Surgical and Procedural Services, Altru in favor #20524
Sarah Lanford, Associate Director, State Advocacy, Association for Clinical Oncology in favor #20799
Michelle Mack, Senior Director, State Affairs, Pharmaceutical Care Management Association in opposition #20847

12:13 PM **Madam Chair Lee** closed the hearing.

Patricia Lahr, Committee Clerk

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2389
2/15/2023

Relating to prior authorization for health insurance.

3:47 PM **Madam Chair Lee** called the meeting to order. **Senators Lee, Cleary, Clemens, K. Roers, Weston** were present**. Senator Hogan** was absent.

Discussion Topics:

- Access to care
- Cost shifting

Senator Lee calls for discussion

Senator K. Roers moves **DO NOT PASS**.

Senator Weston seconded.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	N
Senator David A. Clemens	Y
Senator Kathy Hogan	AB
Senator Kristin Roers	Y
Senator Kent Weston	Y

Motion passed 4-1-1.

Senator Lee will carry SB 2389.

3:50 PM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

REPORT OF STANDING COMMITTEE

SB 2389: Human Services Committee (Sen. Lee, Chairman) recommends **DO NOT PASS** (4 YEAS, 1 NAY, 1 ABSENT AND NOT VOTING). SB 2389 was placed on the Eleventh order on the calendar. This bill does not affect workforce development.

2023 SENATE STANDING COMMITTEE MINUTES

Human Services Committee
Fort Lincoln Room, State Capitol

SB 2389
2/17/2023

Relating to prior authorization for health insurance.

8:30 AM **Madam Chair Lee** called the meeting to order.

Senators Lee, Cleary, Clemens, Weston, Hogan were present. **Senator Roers** was absent.

Discussion Topics:

- Amendments
- Committee action

Senator Cleary moves to reconsider amendment. **Senator Weston** seconded.
Voice vote. Motion passed.

Senator Cleary introduced an amendment that would hoghouse the bill and turn it into a study on prior authorization in commercial health insurance market place. #21065.

Senator Cleary moved amendment. #21065

Senator Weston seconded.

8:33 AM **Chrystal Bartuska, Life Health and Medicare Division Director, ND Insurance Department**, verbally provides additional information.

Senator Cleary moved to further amend by taking out the word 'commercial' and leave in the word health benefit plans. LC 23.1108.01004

Senator Weston seconded.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	AB
Senator Kent Weston	Y

Motion passed 5-0-1

Senator Cleary moves **DO PASS** as **AMENDED**.
Senator Weston seconded.

Roll call vote.

Senators	Vote
Senator Judy Lee	Y
Senator Sean Cleary	Y
Senator David A. Clemens	Y
Senator Kathy Hogan	Y
Senator Kristin Roers	AB
Senator Kent Weston	Y

Motion passed 5-0-1

Senator Lee will carry SB 2389.

8:40 AM **Madam Chair Lee** closed the meeting.

Patricia Lahr, Committee Clerk

Adopted by the Senate Human Services Committee

February 17, 2023

2-17-23

PROPOSED AMENDMENTS TO SENATE BILL NO. 2389

Page 1, line 1, after "A BILL" replace the remainder of the bill with "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. 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."

Renumber accordingly

REPORT OF STANDING COMMITTEE

SB 2389: Human Services Committee (Sen. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (5 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). SB 2389 was placed on the Sixth order on the calendar. This bill does not affect workforce development.

Page 1, line 1, after "A BILL" replace the remainder of the bill with "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. 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."

Renumber accordingly

2023 HOUSE INDUSTRY, BUSINESS AND LABOR

SB 2389

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2389
3/20/2023

A BILL for an Act to provide for a legislative management study of the prior authorization process for health insurance.

Chairman Louser called meeting to order 9:03 AM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representatives Boschee, Christy, Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

Discussion Topics:

- Waiting period
- Independent reviewer

In Favor:
Senator Shawn Vedaa, District 6, Velva, ND (no written testimony)
Tim Blasl, President, ND Hospital Association, #24837
Andrew Askew, VP of Public Policy, Essentia Health, #25846
Lexie Huebner, Present-Service Manager, Altru Health Systems, on behalf of the ND Hospital Association, #24766
Dylan Wheeler, Head of Government Affairs, Sanford Health Plan, #25797
Dr. Chad Carlson, ND Medical Association on behalf of Joan Connell, ND Medical Association, Physician Advisory Group, and lead physician, #24776
Gabriela Balf, Bismarck Psychiatrist, member of the ND Medical Association and ND Psychiatric Society, #25722
Megan Houn, Blue Cross and Blue Shield of ND (no written testimony)

Neutral:
Alex Kelsch, Kelsch Ruff Kranda Ludwig & Nagel representing Karlee Tebutt, Regional Director, Americans Health Insurance Plans, #25942

Additional written testimony:
Jonathan Haug, Physician, Anesthesiology at Altru, #24516

Chairman Louser adjourned the meeting 10:09 AM

Diane Lillis, Committee Clerk

2023 HOUSE STANDING COMMITTEE MINUTES

Industry, Business and Labor Committee
Room JW327C, State Capitol

SB 2389
3/28/2023

A BILL for an Act to provide for a legislative management study of the prior authorization process for health insurance.

Chairman Louser called meeting to order 11:12 AM

Members Present: Chairman Louser, Vice Chairman Ostlie, Representatives Boschee, Dakane, Johnson, Kasper, Koppelman, Ruby, Schauer, Thomas, Tveit, Wagner, Warrey.

Member absent: Representative Christy

Discussion Topics:

- Committee work

Representative Ruby moved a do pass.
Representative Boschee seconded.

Roll call vote:

Representatives	Vote
Representative Scott Louser	Y
Representative Mitch Ostlie	Y
Representative Josh Boschee	Y
Representative Josh Christy	AB
Representative Hamida Dakane	N
Representative Jorin Johnson	Y
Representative Jim Kasper	N
Representative Ben Koppelman	N
Representative Dan Ruby	Y
Representative Austen Schauer	Y
Representative Paul J. Thomas	Y
Representative Bill Tveit	Y
Representative Scott Wagner	Y
Representative Jonathan Warrey	Y

Motion passed 10-3-1

Representative Ostlie will carry the bill.

Chairman Louser adjourned the meeting 11:16 AM

Diane Lillis, Committee Clerk

REPORT OF STANDING COMMITTEE

SB 2389, as engrossed: Industry, Business and Labor Committee (Rep. Louser, Chairman) recommends **DO PASS** (10 YEAS, 3 NAYS, 1 ABSENT AND NOT VOTING). Engrossed SB 2389 was placed on the Fourteenth order on the calendar.

TESTIMONY

SB 2389

My name is Jonathan Haug, and I am a physician specializing in Anesthesiology at Altru, and I serve as the Medical Director of Surgery. I have been at Altru for 18 years, grew up in Grafton and Grand Forks, attended UND for college and Medical School. I am as local as you can get, and I am heavily invested in providing the best possible care to the patients of my hometown.

First I want to thank you for taking the time to read my story. I regret that I am not able to speak with you in person.

Over my 18 years in practice, I have unfortunately been a part of surgical cases where the patient had arrived for surgery, and we had to inform the patient that their insurance had not yet approved their surgery, so cancelled surgery. This is a big fail on the part of our health care system. The stress and anxiety of preparing for surgery takes a toll on not only the patient, but also family members.

Just recently I had the opportunity to experience this process with a family member. Last month my 76 year old mother had open heart surgery, replacing her aortic in addition to an ascending aortic aneurysm repair. I won't get into the details of her heart defects, but while this surgery is typically a very complicated operation, the heart defects that my mom has created even more challenges for our surgeon as the workup unfolded.

My mom had been monitoring her heart valve, and when she became symptomatic with shortness of breath and chest pain, we knew it was time to have it repaired. The preoperative workup by cardiology was extensive, and on November 29, she saw her surgeon and was scheduled for surgery. Surgery was set for January 9.

Because surgeries like this require an anesthesia team that is more specialized, we had ensured that our cardiac anesthesiologist would be available when we chose her surgery date. Everything was falling into place. My brother is also a physician, and he arranged his schedule so he could be in town for the week following her surgery.

The week prior to her surgery, we were informed that the insurance pre-approval process had not yet cleared, and there was a chance we would need to reschedule surgery. The Altru crew spent nearly an entire day on the phone

trying to sort things out with our insurance company. I spent an hour on the phone with the insurance company advocating both as a son and as the Medical Director, trying to get any unanswered questions resolved. My father also spent an hour on the phone with them. It was clearly a very inefficient process.

Ultimately, the Friday before her Monday surgery, we were told that my mom's insurance company had not yet pre-approved her case, and we would need to reschedule. This meant that my brother would not be able to be in town for her surgery, and we had to rearrange the schedule of our cardiac anesthesiologist. But not only that, in the back of our minds we were worried that something might happen to my mom while we waited. It is very possible that during that time her aneurysm could have ruptured, or her aortic valve could have led to sudden death. It was not a peaceful wait.

After 18 years of medical practice, and now as a family member, I can clearly state that our insurance pre-approval process is broken. Something needs to change. Thank you for your time and consideration.

Jonathan Haug, MD

2023 Senate Bill No. 2389
Testimony before the Senate Human Services Committee
Presented by Tim Wahlin
Workforce Safety and Insurance
Date: February 15, 2023

Mr. Chairman and Members of the Committee:

My name is Tim Wahlin, Chief of Injury Services at Workforce Safety & Insurance (WSI). I am here today to provide testimony regarding Senate Bill No. 2389. The WSI Board has taken a neutral position on this bill as amended. In the event the amendment fails, the WSI Board would oppose passage of this bill.

The proposed legislation appears to exclude the agency from its scope, but there exists some uncertainty. In an effort to clarify the agency's exclusion, we offer the attached amendment. The amendment would treat WSI like North Dakota State Medicaid.

Workforce Safety and Insurance is a state agency responsible for providing workers' compensation insurance to all North Dakota employers. Benefits paid include wage replacement, all related medical, including pharmacy benefits, for work related injuries. The agency maintains a managed care program which both lowers costs and targets better medical outcomes. The agency is statutorily mandated to operate in this manner. WSI contracts with managed care reviewers and utilizes published scientific based standards to assist in these reviews.

In the event the bill is not amended as we propose and it is later determined WSI is constrained by this legislation, it would pose meaningful and detrimental consequences for the organization and correspondingly raise medical costs.

For these reasons WSI's Board requests adoption of the clarifying amendment.

This concludes my testimony and I'd be happy to answer any questions you may have.

PROPOSED AMENDMENT TO SENATE BILL NO. 2389

Page 3, line 5, after "assistance" insert ",workforce safety and insurance"

Renumber accordingly

ASCO®
ASSOCIATION FOR CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

February 14, 2023

Senator Judy Lee, Chair
Senate Human Services Committee
North Dakota Senate
600 East Boulevard Avenue
Bismarck, ND 58505

Dear Chair Lee, Vice Chair Cleary, and Members of the Senate Human Services Committee,

The Association for Clinical Oncology (ASCO) is pleased to support **SB 2389**, which establishes guardrails around prior authorization processes in the state.

ASCO is a national organization representing physicians who care for people with cancer. With nearly 45,000 members, our core mission is to ensure that cancer patients have meaningful access to high quality, equitable 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 2389:

- **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

ASCO
ASSOCIATION FOR CLINICAL ONCOLOGY
KNOWLEDGE CONQUERS CANCER

decision and be available to discuss the basis for denial rather than deny care 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; and
- **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.

ASCO is encouraged by the steps SB 2389 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,

Lori J. Pierce, MD, FASTRO, FASCO
Chair of the Board
Association for Clinical Oncology

Senate Human Services Committee
SB 2389
February 15, 2023

Chair Lee and Committee Members, my name is Ana Tobiasz and I am a Maternal Fetal Medicine physician in Bismarck. I am a member of the North Dakota Medical Association Council and am presenting this testimony on its behalf. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA strongly supports SB 2389.

NDMA has long been concerned about the prior authorization process and its negative impact on patients, as we frequently hear from North Dakota physicians and patients about delays in care that result from these insurer protocols.

AMA survey data shows:

- 93% of physicians report care delays because of prior authorizations.
- 34% of physicians report that prior authorization has led to a serious adverse event for a patient in their care, such as hospitalization, permanent impairment, or death.
- 91% of physicians see prior authorization as having a negative effect on their patients' clinical outcomes.
- 82% of physicians indicated that patients abandon treatment due to authorization struggles with health insurers.

In addition to the harmful individual patient impact, there is no economic rationale for prior authorization. Costs to the health care system due to prior authorization are playing out in physician practices all over North Dakota.

For example, physician offices find themselves using inordinate amounts of staff time and resources submitting prior authorization paperwork to justify medically necessary care for their patients to health plans.

- According to American Medical Association (AMA) data, on average, physician practices complete 41 prior authorizations per physician per week.
- 40% of physicians report that there are staff members in their offices that exclusively work on prior authorizations.
- This adds up to nearly two business days, or 13 hours, each week – dedicated to completing prior authorizations.

It is also important to recognize that these prior authorization burdens continue to place administrative pressure on physician practices – as they face staff shortages and attempt to regain their footing following the COVID-19 pandemic.

Now more than ever, administrative burdens, such as prior authorization, weigh down physician practices and consume resources – leading to fewer resources being allocated to direct patient care.

Moreover, by delaying care, undercutting recovery, and reducing the stability of patients' health, prior authorization increases workforce costs as patients miss work or may not be as productive in their jobs.

- AMA survey data show that of physicians who treat patients between the ages of 18 and 65 currently in the workforce, more than half report that prior authorization has interfered with a patient's ability to perform their job responsibilities.

While health plans see prior authorization as a cost-saving tool used to reduce spending on medically necessary care, the costs to patients, physician practices, employers, and the health care system is unjustifiable.

In 2018, in what looked like progress, health plans recognized the need to reduce the burden of prior authorization and agreed in a joint consensus statement to make a series of improvements to the prior authorization process.

Despite increasing evidence of harm, however, most health plans have made no meaningful progress on reforms.

This means that passage of SB 2389 is necessary to improve access to care for patients in ND.

- This bill is a well-balanced approach to streamlining and right-sizing the prior authorization process.
- It brings ND in line with many states that have enacted similar reforms and sets an example for other policymakers to follow.
- It would reduce care delays from prior authorization requirements by mandating timely authorizations or denials from health plans.
- It also increases transparency in the process by requiring health plans to post the items and services subject to prior authorization restriction – allowing patients to make informed decisions about their health insurance and providers to access requirements easily.
- It reduces repeated prior authorizations, especially for those with chronic conditions.
- Requires that only qualified ND physicians be allowed to make an adverse determination.

I have several examples of patient's care in my own practice caring for high risk pregnancies that have been harmed or care delayed due to the burden of our current prior authorization processes:

- Patients on life saving medications in pregnancy such as blood thinners to treat blood clots in their legs or lungs frequently will require multiple different prior authorizations over the course of pregnancy even if this was completed months prior. I have patients who will present to the pharmacy after clinic hours to pick up a prescription they have been on for months only to find out a new prior authorization needs to be completed or the pharmacy will not dispense the medication. The cost of these medications is prohibitive for most patients to pay out of pocket therefore they can't just pay for it while waiting for the prior authorization to be completed. Because of

this I have had to admit patients to the hospital in order to continue their medications while waiting due to the harms caused if doses are missed. This only adds to the cost of healthcare on top of increasing risk to the patient and her pregnancy. Missing even one or two doses of a blood thinner in pregnancy can be catastrophic and lead to maternal death.

- I have had patients needing in utero fetal surgery for congenital anomalies such as spina bifida or a condition called twin to twin transfusion syndrome have their evaluation and care at a fetal care center out of state delayed while awaiting prior authorization to complete the necessary testing before this can be completed or to even be seen at these centers. Timing of these surgeries is critical and can only be done in a finite time frame to actually prove benefit and to be feasible to complete. In the case of twin-to-twin transfusion syndrome there is a matter of days or one or both fetuses can die or have long term brain damage as a result if not treated properly. I have had patients nearly miss the window to complete this solely because of delays in the prior authorization process.
- Multiple phone calls with inexperienced reviewers in order to get certain fetal genetic testing completed so a family can get a more accurate fetal diagnosis and start care planning. These are highly specialized discussions, and I sometimes will wait 45 minutes or more to speak to a nurse who then denies the request and then will transfer me for a “peer to peer” evaluation only to speak with a physician or advanced practice nurse that has no obstetric or fetal diagnosis experience and then still deny coverage so this family can plan for the care of their special needs infant appropriately before birth
- For diabetic women in pregnancy, certain types of insulin are more efficacious at keeping blood sugars controlled than others. I will have patients be denied the recommended treatments in pregnancy due to the burdensome prior authorization process and having a reviewer who has no obstetric or endocrinology experience to understand the importance of this to the management of her diabetes. Uncontrolled diabetes in pregnancy can lead to serious consequences for both

maternal and fetal health, including increasing the risk of stillbirth and can lead to severe maternal metabolic disturbances that can result in her requiring admission to the ICU. Delays in taking insulin are a direct result of this.

- Insulin frequently requires multiple prior authorization requests for the same medication over the course of pregnancy. This can lead to missed doses especially if the patient tries to pick up their insulin after clinic hours and doesn't have enough to get them through until the next day or to whenever the prior authorization approval is received. Again—this can lead to serious consequences both for maternal and fetal health. I have had to admit patients to the hospital due to these delays and the burdensome cost of insulin so as to make it prohibitive for most patients to just pay out of pocket.

These examples highlight how SB 2389 will improve the clinical outcomes of patients in ND, while also reducing wasted health care resources that are inherent in prior authorization programs. We look forward to supporting your efforts to enact this important legislation.

SANFORD HEALTH PLAN

February 15, 2023

Madam Chair and Member of the Senate Human Services Committee –

My name is Dylan Wheeler, Head of Government Affairs for Sanford Health Plan, respectfully submitting remarks in **opposition** to SB2389. To begin, as an integrated system and health plan, we openly welcome discussion around prior-authorization process because, ultimately, it leads to more efficient processes for our providers, and a more enjoyable plan experience for our members. However, we view SB2389 as a missed opportunity to dig in and find a unique North Dakota solution. SB2389 is modeled off a model law formulated by the American Medical Association and presents a one-size-fits-all proposed solution for North Dakota. As we recognize from working through a number of issues this session and those to come, North Dakota perceived problems deserve North Dakota solutions.

By way of example, this same legislation was introduced in Minnesota in 2020 and took many months of diligent negotiations between several stakeholders to come to compromise. On SB2389, while true that proponents have reached out and we have had preliminary discussions around the edges, there are and have been mixed messages on the perceived problem and whether SB2389 would remedy those issues. In order to advance purposeful, intentional, and meaningful dialogue around prior-authorization reform, we would encourage this committee to look at alternatives to scope and identify North Dakota issues in order to possibly develop North Dakota policy solutions.

In digging into the substance of the bill as it's currently broadly written, we are able to identify a handful of concerning sections that would require substantial investment to implement and comply with. For example, the bill would require a "same or similar" reviewer standard an initial denials and appeals. While on its face this may seem logical – the simple fact is health plans would not be able to staff such a requirement, and would be forced to externalize these prior-authorization processes. This would have cost impact and would have providers working with contracted entities, instead of local health plans. In addition, the bill also proposes significant adjustments for turnaround times of standard and urgent prior-authorizations. We agree that members and patients deserve timely responses to their requests; however, not all prior-authorizations are similar in terms of when that service would be provided (i.e. knee replacement 6 months out) v. a procedure schedule for the next week. In addition, the shrunken timelines will lead to missed opportunities for plans and providers to work through and collaborate on prior-authorization issues.

Finally, a very concerning section appears that would "auto-authorize" any prior-authorization that does not comply with the substance of the bill: turnaround times, same/similar specialist reviews, notification, contact physician, etc. We have concerns about member and patient safety in the event a procedure/service was to be provided without fully understanding the entirety of the patient record. In some cases, services that are subject to prior-authorization may be labeled "experimental and

investigational" – providing an "auto-authorization" process for these services should give the committee pause in examining that section. This requirement, again, will ultimately lead to higher denial rates.

I will end as I began and emphasize that as an integrated system – we welcome further discussion and debate around prior-authorization. However, SB2389 presents a one-size-fits-all national model law solution for North Dakota. Let's work together in the future and through the next interim to identify North Dakota issues and collaborate around potential North Dakota solutions.

Thank you for your time and diligent consideration.

Respectfully Submitted,

Dylan Wheeler, JD, MPA
Head of Government Affairs
Sanford Health Plan

February 15, 2023

The Honorable Judy Lee, Chair Senate Human Services Committee
The Honorable Sean Cleary, Vice Chair Senate Human Services Committee
North Dakota Senate Human Services Committee Members
State Capitol
600 East Boulevard
Bismarck, ND 58505-0360

Re: **SB 2389 – Relating to Prior Authorization for Health Insurance**
PCMA Testimony in Opposition to SB 2389

Dear Chair Lee, Vice Chair Cleary 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 2389 and respectfully is opposed. This bill is setting in statute the requirements and restrictions that include process, time frames, appeals, etc. for prior authorization.

Prior authorization is a requirement that a health plan pre-approves a prescription drug before a pharmacy can dispense it to an enrollee as a covered benefit. The major goals of prior authorization are to ensure appropriateness and suitability of the prescribed medication for the specific patient, safety, as well as to control costs. Health plans and PBMs rely on independent Pharmacy & Therapeutics Committees, comprised of experts that include 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 health plan has a prior authorization appeals process. According to the National Academies of Sciences, Engineering, and Medicine (NASEM), "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.

Some examples where health plans may require prior authorization for drug products in an effort to ensure appropriate use include:

[1] Making Medicines Affordable: A National Imperative," National Academies of Sciences, Engineering, and Medicine (NASEM), Nov. 2017.

- Growth Hormone and Testosterone prevents use for bodybuilding, anti-aging, and athletic performance while ensuring appropriate use for patients diagnosed with growth hormone deficiencies.
- Opioids: Ensures opioids are prescribed according to guidelines at the lowest dose possible for the shortest time possible, which helps prevent drug diversion and overuse.
- Transmucosal Immediate Release Fentanyl: Encourages appropriate use for the treatment of breakthrough pain in cancer patients who are opioid-tolerant.
- Hepatitis C Direct Acting Antivirals: Helps ensure patient appropriately selected and treated for an appropriate duration of therapy based on current standards of care to include making certain the patient is using the preferred medicine by genotype.
- Diabetes Drugs: Prevents inappropriate use for weight loss.
- Dementia Drugs: Prevents inappropriate use for autism.
- Anti-psychotic Drugs: Prevents inappropriate use for insomnia.
- Thrombopoietin Receptor Agonists: Encourages appropriate, approved use for the treatment of chronic immune (idiopathic) thrombocytopenic purpura in those who have had an insufficient response to corticosteroids, immunoglobulins or splenectomy.
- Biologic Immunomodulators: Encourages use of first-line agents prior to the use of biologic immunomodulators and use of biologic immunomodulators based on indication (i.e., used to treat a particular disease).

Inappropriate use of medicines can be dangerous for patients and result in unnecessary health care expenditures.

According to a study conducted by the Federal Trade Commission (FTC), upon a plan sponsor's request, "[l]arge PBMs and small or insurer-owned PBMs have used step-therapy and prior authorization programs to lower prescription drug costs and increase formulary compliance." The FTC also determined that "[p]rior authorization often involves a clinical justification for the use of drugs that are prone to misuse or are especially costly."[2]

Thank you again for the opportunity to comment on SB 2389 and we urge a "do not pass" vote.

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

Sincerely,

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[2] Federal Trade Commission, "Pharmacy Benefit Managers: Ownership of Mail-Order Pharmacies," August 2005. Available at http://ftc.gov/reports/index.htm#2005. [Emphasis added].

2022 Prior Authorization (PA) State Law Chart

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
AL Ala. Code 1975 § 27-3A-5		2 business days of receipt of request and all necessary info received. Plan must complete the adjudication of appeals in 30 days.							On appeal, all decisions must be made by physician in the same or similar general specialty as typically manages condition, procedure, or treatment.		When initial decision not to approve is made prior to/during an ongoing service requiring review, and physician believes warrants immediate appeal, can appeal via phone on expedited basis (48 hours).
AK 7 AAC 120.410 and Alaska Stat. § 21.07.020		Nonemergency:72 hours. For care following emergency services: 24 hours. Appeals: 18 working days after received. Expedited (jeopardize patient's health): 72 hours.		PA for a covered medical procedure on the basis of medical necessity may not be retroactively denied unless PA is based on materially incomplete or inaccurate information					Decisions to deny, reduce, or terminate a benefit or deny payment for service based on medically necessity must be made by employee or agent of plan who is a licensed health care provider. On appeal, same professional license as provider.		

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
AR AR Code § 23-99-11	Plan must strive to implement no later than July 1, 2018, mechanism by which providers may request PA through an automated electronic system as an alternative to telephone-based PA systems.	Nonurgent: 2 business days of obtaining all necessary info Urgent: 1 business day Emergency: a minimum of 24 hours following provision of emergency care for patient or provider to notify plan of admission or provision of care If occurs on holiday or weekend, plan cannot require notification until the next business day. If patient receives emergency care that requires immediate post-evaluation or post-stabilization service, a plan must make an authorization within 60 minutes of receiving a request.		Cannot rescind, limit, condition based on medical necessity unless provider notified 3 business days before scheduled date. Plan must pay for care that received PA for at least 90 days after PA granted unless never performed, claim was not timely, patient not eligible, fraud or misrepresentation. May rescind, limit, condition, or restrict PA based on eligibility at time of care if plan provided means to confirm whether patient is eligible up to the date of admission, service, procedure, or extension of stay.	Statistics must be available regarding PA approvals and denials on plan's website in a readily accessible format. Statistics must categorize approvals and denials by physician specialty; medication or diagnostic test or procedure; medical indication offered as justification for the PA request; and reason for denial.	Plans must disclose all PA requirements, including any written clinical criteria, in a publicly accessible manner on website. (If proprietary, can be available via secured link.) Adverse determination must be based on medical necessity or appropriateness of services and on written clinical criteria. "Medical necessity" includes "medical appropriateness," "primary coverage criteria," & any other terminology used by plan that refers to a "primary coverage criteria," and any other terminology used by plan that refers to a determination that is based in whole/in part on clinical justification for a service.	Cannot implement new/amended requirements before providing written 60-day notice.	A provider may submit a benefit inquiry to plan for service not yet provided to determine if service meets medical necessity/other requirements for payment PA decision must include determination as to whether patient is covered by a plan and eligible to receive the requested service.	Adverse determination must be made by a physician who possesses a current and unrestricted AR license. Physician may request that PA be reviewed by a physician in the same specialty as the physician making the request, by a physician in another appropriate specialty, or by pharmacologist.	If covered prescription pain medication requires PA, then PA can't be denied if patient has terminal illness.	provider may submit a benefit inquiry to plan for service not yet provided to determine whether service meets medical necessity and requirements for payment under a health benefit plan if service were to be provided to patient.
AZ A.R.S. §20-2803		For care provided after initial screening and immediately necessary to stabilize, PA is granted unless.		Plan cannot rescind or modify PA after the provider renders care in good faith and pursuant to the authorization.		Payer cannot request info that does not apply to the medical condition at issue for the purposes of determining whether to approve or deny a PA request.					.

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
CA 28 CCR § 1300.67.2 41	Use and accept only the PA form (Form No. 61-211). Accept through any reasonable means- paper, electronic, phone, web portal, or another mutually agreeable method. Notices to provider delivered in same manner or another mutually agreeable method.				Every plan using step therapy (ST) and PA must maintain, for at least 10 yrs. info to be made available to department upon request re: nonformulary drug requests, ST exceptions request and PA: (1) #of requests (2) Type of providers/ specialties submitting requests, specialties reviewing initial requests & internal appeals. (3) #of requests denied and reasons. (4) # of requests initially approved. (5) # of denials appealed internally and to external review, # upheld and reversed by internal appeal/ external review. (6) Time b/w request and approval (7) #of denials by type of provider and specialty.						

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
CO C.R.S. 10-16-124.5 C.R.S. 10-16-113	Electronically means when the provider submits request through a secure, web-based internet portal. Does not include e-mail. Standard form	For Rx: 2 business days (ePAs); 3 business days – non-urgent (oral, fax, email); 1 business day – urgent (oral, fax, email) For medical services: 15 days non-urgent, Urgent 72 hours. For concurrent review urgent care requests involving a request by the patient to extend the course of treatment beyond the initial period of time or the number of treatments authorized: if the request is made at least 24 hours prior to the expiration of the authorized period of time or authorized number of treatments, the plan shall make a determination w/ respect to the request w/in 24 hours. 1st level review – plan has 30 days				Must disclose list of drugs that require PA, written clinical criteria and criteria for reauth of previously approved drug after PA period expired. Require evidence-based guidelines.		Notice of right to appeal must be given to patient when PA is denied. 1st level review - reviewer must consider all comments, documents, records, and other info re: request submitted w/o regard to whether the info was submitted or considered in making the initial adverse determination.	All written adverse determinations must be signed by licensed physician familiar w/ standards of care in CO. 1st level review (appeal) must be evaluated by a physician who consults with an appropriate clinical peer unless reviewing physician is a clinical peer. The physician and clinical peer(s) cannot have been involved in initial determination but person that has involved w/denial may answer questions.		Can prospectively request peer-to-peer. Physician can request peer-to-peer re: adverse determination by reviewer making determination. Peer-to-peer must occur w/in 5 calendar days of request and be conducted b/w provider and reviewer who made determination or clinical peer if can't be available w/in 5 calendar days. Patient has right to a review meeting. Adverse determination, or w/ respect to voluntary 2nd level review of a 1st level review denial, must be reviewed by health care professional(s) w/ expertise in case.

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
CT											
DE HB 381 (2016)	NCPDP standards for ePA (no standards for medical services ePA)	Drugs: 2 business days from clean PA Medical services not through ePA, 8 business days; ePA: 5 business days	Plan cannot revoke, limit, condition or restrict a PA on ground of medical necessity after date health care provider received the PA. A proper notification of policy changes validly delivered may void a PA if received after PA but before delivery of the service.		Plans must report statistics on PA approvals, denials, appeals to the DHIN at least twice annually. Department may also request data at any time. Statistics must include: (1) For denials, aggregated reasons for denials; (2) For appeals: a. specialty; b. Medication, diagnostic test, or diagnostic procedure; c. Indication offered; d. Reason for underlying denial; and e. # of denials overturned upon appeal.	Clinical criteria must be described in language easily understandable by a provider practicing in the same clinical area	60-day notice of new PA requirements.	Must make any current PA requirements readily accessible on website and in written or electronic form upon request. Requirements must be described in detail and in clear, easily understandable language.			
FL Ch. 2016-224 (627.42392) and Ch. 16 – 222	A plan that does not use ePA must use the standard PA form approved by the FSC										

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
GA GA Code Ann. 33-64-8 SB 80 (2021) GA SB 341	NCPDP standard	1/1/22 – 12/31/22: response required w/in 15 calendar days of obtaining all necessary info. Beginning 1/1/23: Response requires w/in 7 calendar days of obtaining all necessary info. For urgent services no later than 72 hours after receiving all needed info.	If initial services performed w/in 45 business days of PA, the insurer may not revoke, limit, condition, or restrict authorization, except for a Schedule II controlled substance. When physician receives PA for drugs for patient w/ chronic condition who requires ongoing medication therapy, PA must: (1) Be valid for the lesser of: (A) 1 year from the date of PA or (B) until last day of coverage; and (2) cover changes in dosage prescribed		Insurers must make aggregate statistics available per insurer and per its plans regarding approvals and denials on its website in a readily accessible format. The Commissioner to determine the statistics required but must include, (1) Approved or denied on initial request; (2) Reason for denial; (3) Whether appealed; (4) Whether approved or denied on appeal; and (5) Time between submission and response.	Clinical criteria on which decision are made must be provided to provider at time of response. Change in coverage or approval criteria does not impact patient approval for remainder of plan year. Definition of medical necessity: services that prudent provider would provide for purpose of preventing, diagnosing, or treating illness, injury, or disease or its symptoms in manner that is: (a) In accordance w/ generally accepted standards of medical or other healthcare practice; (b) Clinically appropriate in terms of type, frequency, extent, site, and duration; (c) Not primarily for economic benefit of insurer or convenience of patient, treating physician, or other provider; and (d) Not primarily custodial care, unless custodial care is covered service.			Appeals must be review by provider who (1) Possesses a current and valid nonrestricted license or maintain other appropriate legal authorization; (2) Be currently in active practice in the same or similar specialty and who typically manages condition or disease; (3) Be knowledgeable of, and have experience providing, service under appeal; (4) Not have been directly involved in adverse determination; and (5) Consider all known clinical aspects of service under review, including, but not limited to, all pertinent medical or other records provided	PA cannot be required of unanticipated emergency services, urgent services, or covered services which are incidental to the primary covered service and determined by physician to be medically necessary	.

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
GA cont'd			during the period of authorization. New plan must honor old plan's PA for 30 days.						provider, relevant records, and medical or other literature from provider		
HI	General form used by some insurers										
ID Title 41, Ch. 39 (41-3930)		2 business days after complete member medical information is provided to plan, unless exceptional circumstances warrant a longer period.		Cannot rescind approval of provided service except for fraud/ misrep/non-payment of premium, benefit exhaustion, or eligibility.							
IL HB 711 (2021)		Nonurgent request in 5 calendar days and 48 hours for urgent care 15 days for appeal decisions.	90-day period of authorization when a patients change plans Requires approvals remain valid for six months, and 12 months for chronic conditions and long-term diseases, regardless of changes in dosage	Plans cannot deem as incidental or deny supplies or services that are routinely used as part of a health care service when: (1) an associated health care service has received PA; or (2) PA for the health care service is not required Payment (generally) if	Statistical reporting requirements include list of services/drugs subject to PA, total # of PA requests received, total # of denials and the top five reasons for denials, the # of denials appeals and whether they were upheld, and the average time between submission and response.	Clinical review criteria must (1) be based on nationally recognized, generally accepted standards except where IL law provides own standard; (2) be developed in accordance w/ current standards of a national medical accreditation entity; (3) ensure quality of care and access to needed health care services; (4)be evidence-based; (5) be sufficiently flexible to allow deviations from norms on a case-by-case basis; and (6) be	Notice of new requirements or changes 60 days in advance	Plan to make any PA requirements including the written clinical review criteria, readily accessible and conspicuously posted on website.	Physician reviewing appeal must: (1) possess a current and valid nonrestricted license to practice medicine; (2) be in the same or similar specialty as one who typically manages condition; (3) be knowledgeable of, and have experience providing, services; (4) not	An issuer must periodically review requirements and consider removal (1) where a drug/ procedure is customary and properly indicated or is a treatment for the clinical indication as supported by peer-reviewed medical publications;	Denials can be appealed/ reviewed by external independent review.

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
IL cont'd			Continued approval when plan's requirements change	service or drug is authorized		updated, if necessary, at least annually. "Medically necessary:" professional exercising prudent clinical judgment would provide care to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms and that are: (i) in accordance w/ generally accepted standards of medical practice; (ii) clinically appropriate in terms of type, frequency, extent, site, and duration and are considered effective for the patient's illness, injury, or disease; and (iii) not primarily for convenience of patient, treating physician/ professional, caregiver, family member, or other interested party, but focused on what is best for patient's health outcome.			have been directly involved in making adverse determination; (5) consider all known clinical aspects of service under review, including a review of all pertinent medical records and medical literature provided to plan.	or (2) for patients currently managed w/ established treatment regimen.	
IN SB 73 (2017) HR 1143 (2018)	NCPDP standard. Required of plan and physicians. Exemptions under certain	Urgent – 72 hours Nonurgent – 7 business days. If incomplete request, must respond w/in time period. (For ePA		If authorized, cannot retroactively deny, except if false or incorrect info provided or			Plans must disclose any new PA requirements 45 days before implemented (can be posted	List of PA requirements by CPT code on website or portal, including specific info that must be submitted.			

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
	circumstances & provider to use standard form	immediate electronic receipt required.)		noncoverage on day of service. Cannot deny claims for unanticipated medical service provided during another authorized service based solely on lack of PA.			conspicuously on plan's website).				
IA 191 IAC 79 IA HF2399 (2022)	Commissioner can consider NCPDP standards.	72 hours for urgent claims; 5 calendar days for non-urgent claims; 24 hours expedited If a request for a PA is incomplete or additional info is required, plan may request info w/in the applicable time periods. Once the info is submitted, the applicable time-period begins again. Payer must assign PA request a unique electronic ID number to track request.		Plan must pay provider at contracted rate for a service per the PA unless: 1. Waste, fraud or abuse 2. Provider/ patient provided inaccurate info that was relied upon to make the authorization 3. Service was no longer a benefit on the day it was provided 4. Care provided was no longer contracted with the plan on the date the care was provided 5. Provider failed to meet plan's timely filing requirements.				Plan must make available/ accessible on websites: a.) PA requirements, including list of drugs that require PA. b.) Clinical criteria that are easily understandable to providers, including clinical criteria for reauthorization of a previously approved drug after PA period has expired. c.) standards for submitting requests, including evidence-based guidelines.			

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
IA cont'd				6. Plan does not have liability for a claim (coordination of benefits) 7.Patient was no longer eligible							
KS											
KY KY Rev Stat § 217.211 SB 54 2019	ePA for drugs that meets the most recent NCPDP SCRIPT standard for ePA adopted by HHS. (Not fax, payer portals, electronic forms.)	Urgent: 24 hours after getting all necessary info. Nonurgent: 5 days after getting all necessary info. Necessary info is limited to results of any face-to-face clinical evaluation; any second opinion that may be required; and other info determined by the department to be necessary to making a determination. Plans must be available to conduct review during normal business hours and extended hours on Monday and Friday through 6:00 p.m., including federal holidays. Failure to make determination and provide written notice w/in time frames will be deemed to be a PA for the services or benefits.	PA is valid for lesser of 1 yr or last day of coverage when Rx is for patient w/ a condition requiring ongoing medication therapy, and the provider continues to prescribe the drug. Changes in doses do not require new PA. Does not include drugs for a non-maintenance condition; that have a typical treatment period <12 months; where there is evidence that	Unless otherwise specified by the provider's contract, an insurer cannot deem as incidental or deny supplies that are routinely used as part of a procedure when: (a) associated procedure has been preauthorized; or (b) PA for the procedure is not required. Plan cannot deny claim if PA not in effect on data of services on claim		"Medically necessary health care services:" Health care services that a provider would render to patient for the purpose of preventing, diagnosing, or treating an illness, injury, disease, or its symptoms in a manner that is: (a) In accordance w/ generally accepted standards of medical practice; and (b) Clinically appropriate in terms of type, frequency, extent, and duration.	Plan/UR entity must submit a copy of any changes to its utilization review policies or procedures to the DOI. No change to policies can take effect until after it has been filed with and approved by the commissioner.	Plans must make written procedures for determining whether requested care is covered, making utilization review determinations, and notifying patients and providers of determinations available on website to patients and providers. Plans must maintain info on publicly accessible website re: list of services/ codes for which PA is required including effective dates; date requirements listed; and date PA is removed if appliable. Also, must include services where PA	Only licensed physicians, who are of the same or similar specialty and subspecialty, when possible, as the ordering provider, can make a utilization review decision to deny, reduce, limit, or terminate a benefit or to deny, or reduce payment for a service because that service is not medically necessary, experimental, or investigational.	Cannot require PA for births or inception of neonatal intensive care services and notification cannot be required as a condition of payment.	

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
KY cont'd			does not support 12-month approval; or opioid analgesics/be-nzodiazepines					is performed by contracted entity.			
LA LSA-RS 22:1006.1 LSA-RS 46:460.33 ASB 348 (2022) LSA-R.S. 22:1139 SB 112 (2022)	Standard form must be accessible through multiple computer operating systems.							Plans must furnish in writing, w/in 24 hours of written/ oral request by provider or patient, medical criteria and other requirements for authorization. Upon denial, plan must provide written notification of denial and info on applicable law, regulation, policy, procedure, or medical criterion or guideline.		Plans must maintain program that allows for selective application of PA requirements based on stratification of providers' performance and adherence to plans' PA criteria. Criteria for participation and the services included to be at the sole discretion of the plan. (Cannot include Rx)	

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
ME Chapter 273 PL S.P. 218-L.D. 705 2019	Must accept/ respond through secure electronic transmission using NCPDP standards for eRx - fax, payer portal, or via electronic form is not electronic transmission	Nonemergency: Lesser of 72 hours or 2 business days (notify provider and patient). If additional information needed, lesser of 72 hours or 2 business days from receiving info. If outside consultation needed, 72 hours or 2 business days from plan's initial response.									
MD MD Code Ann. 19-108.2 MD Ins Code § 15-851 (2019)	Online process for accepting PA electronically. Plans must establish an online PA system for drugs & for step-therapy	Real time for ePA (drugs) that meets criteria, and no additional info is needed. 1 business day for non-urgent drug; 2 business days non-urgent services (electronically)						Online access for providers to health care services requiring PA and key criteria for making a determination. Unique electronic identifier that provider can use to track PA.			
MA MGL C. 1760, 25	Must be available electronically Standard form	2 business days after receiving completed PA request from a provider									
MI Section 500.2212c SB 247 (2022)	ePA requirements on plans and providers	9 days for nonurgent until May 31, 2024, and then drops to 7 days. 72 hours for urgent	PA is valid for not less than 60 calendar days or for clinically appropriate duration,		Every year, plan must report to department on department, aggregated trend data related to their PA practices and	PA requirements to be based on peer-reviewed clinical review criteria developed either by (1) entity that works directly w/ clinicians (in or outside plan) to develop clinical review	For drugs, plan must notify providers via plan's provider portal of new or amended PA requirements at least 45 days before implemented. For	Plan to make PA requirements, including written clinical review criteria, readily accessible and conspicuously posted on website.	Denial upon appeal must be reviewed by licensed physician, board certified or eligible in same	Plans must adopt a program that promotes the modification of PA requirements of certain	

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
MI cont'd			whichever is later.		experience for the prior year: (a) # of PA requests. (b) # of PAs denied. (c) # of appeals received. (d) # of adverse determinations reversed on appeal. (e) Total # PA requests, the # of requests that were not submitted electronically. (f) Top 10 services denied. (g) Top 10 reasons PA requests denied. On 10/1 every year, dept. aggregates data into report.	criteria, and does not receive direct payments based on outcome of clinical care decision; or (2)Medical specialty organization. Clinical review criteria must: - Consider needs of atypical populations/ diagnoses -Ensure quality of care & access -Be evidence-based -Sufficiently flexible for all deviations from norms (on case-by-case basis) -Be reevaluated & updated when needed/ at least annually.	services, must notify at least 60 days before implemented.		specialty as a provider who typically manages the medical condition or provides the service. If plan can't ID a licensed physician who meets requirements w/o exceeding time limits, plan may use licensed physician in similar specialty as considered appropriate, determined by plan.	prescription drugs, medical care, or related benefits, based on the performance of the providers w/ respect to adherence to nationally recognized evidence-based medical guidelines and other quality criteria.	
MN M.S.A. § 62M.05; M.S.A. § 62M.06 M.S.A. § 62M.07 SF 3204 2019	NCPDP standard mandated for prescribers and plans. If PA requirements for health care service, must allow providers to submit requests by telephone, fax, or voice mail or	Nonurgent: 5 business days after all info reasonably necessary to make decision is provided and must provide "audit trail" of notification. Expedited determination required if provider says warranted. No later than 48 hrs and must include at least 1 business day after the initial request. When expedited adverse determination is	When patient changes plans, PA good for 60 days - provider/ patient must submit documentation of previous PA to new plan.	May not revoke, limit, condition, or restrict a PA unless there is evidence that the PA was authorized based on fraud or misinformation or a previously approved PA conflicts w/ state or federal law.	Every April, plans must post: (1) # of PA requests for which an authorization was issued; (2) # of PA requests that adverse determination was issued and sorted by: (i) service; (ii) whether appealed; and (iii) whether upheld or reversed on appeal; (3) # of PA requests submitted		Electronic notice of new/amended requirement must be sent 45 days in advance to all MN-based, in-network attending providers who are subject to requirements. If, during plan year, coverage terms change or the clinical criteria used to conduct PA change, does not apply until the next	Upon request, plans must provide criteria used to determine necessity, appropriateness, and efficacy of service and identify the database, professional treatment parameter or other basis for the criteria.	In appeals to reverse an adverse determination for clinical reasons, the plan must ensure that a physician of plan's choice the same or a similar specialty as typically manages the medical condition, procedure, or treatment is		

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
MN cont'd	through an electronic mechanism 24 hours/day, 7 days/week Standard form: Sec. 4. MN Statutes 2018, section 62M.04, subdivision 3 limited	made, must also notify patient and provider of right to submit expedited appeal. Plan must notify in writing the patient, provider, claims administrator of determination on the appeal w/in 15 days after receipt of the notice of appeal. If plan entity can't make a determination w/in 15 days due to circumstances out of its control, may take up to 4 additional days. Any more and must inform parties of reason. Reviewer cannot be physician who made adverse determination.			electronically (4) reasons for denials including but not limited to: (i) patient did not meet PA criteria; (ii) incomplete info submitted; (iii) change in treatment program; (iv) patient no longer covered.		plan year for patients who received PA using former coverage terms or clinical criteria. Does not apply if deemed unsafe, if independent source of research/ clinical guidelines or evidenced-based standards changes for reasons related to patient harm; or if replaced w/ generic rated as equivalent or biologic rates as interchangeable and 60-day notice given.	Plan must post on its public website PA requirements of organization that performs UR review for the plan. Plan must have written standards: (1) procedures and criteria used to determine if care is appropriate, reasonable, or medically necessary; (2) system for providing prompt notification of determinations and appeal procedures; (3) compliance w/ time frames; (4) procedures to appeal adverse determinations; (5) procedures to ensure confidentiality of patient info.	reasonably available to review the case. No individual who is performing utilization review may receive any financial incentive based on the number of adverse determinations made provided that utilization review organizations may establish medically appropriate performance standards.		
MS MS Code 2015 83-9-63	Standard form – cannot exceed 2 pages and must be available electronically	2 business days of receiving completed request on standard form.									

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
MO Mo stat. 376.1350 -376.1389 SB 982 (2018)		2 business days after obtaining all necessary info. For concurrent review determinations, w/in 1 working day of obtaining all necessary info				All review programs must use documented clinical review criteria that are based on sound clinical evidence. Plan may develop its own clinical review criteria, or purchase or license clinical review criteria from qualified vendors. Plan must make available its clinical review criteria upon request by regulators.		Plan must implement a written utilization review program that describes all review activities and must file an annual report of its utilization review program activities w/ the DOI.	Any medical director who administers the UR program or oversees review decisions must be a qualified health care professional licensed in MO. A licensed clinical peer shall evaluate the clinical appropriateness of adverse determinations.		Appeals: - 1st level: insurer conducts investigation; -- 2nd level: submitted to an insurer-specific panel for review; -3rd level: insurance director hires appeals review organization.
MT § 33-36-205		Care for post-evaluation/ post-stabilization services required immediately after emergency services, plan must provide access to an authorized representative 24/7 to facilitate review.									
NE § 44-5426						Plans must use documented clinical criteria based on sound clinical evidence and evaluate periodically. Plan may develop its own clinical criteria or purchase/license criteria from qualified vendors. Plan must make criteria available to authorized government agencies.			A plan must ensure that a majority of the persons reviewing a grievance involving an adverse determination have appropriate expertise		

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
NH NHRSA 420-J;7-b	ePA w/ NCDPD standard permitted. Plan cannot use ePA when: pharmacist/ prescriber: (1) lacks internet access; (2) has low patient volume; (3) opted-out for certain medical condition or patient requests; (4) lacks EMR or when (5) ePA interface does not allow pre-population of prescriber & patient info; (6) ePA interface creates prescriber costs.	48 hours for medically necessary non formulary Rx drug Urgent care: 72 hours Urgent and relating to the extension of an ongoing course of treatment and involving a question of medical necessity: 24 hours 15 days for non-urgent				Clinical review criteria considered or utilized in making claim benefit determinations shall be: (a) Developed with input from appropriate actively practicing practitioners in the carrier or other licensed entity's service area; (b) Updated at least biennially and as new treatments, applications, and technologies emerge; (c) Developed in accordance with the standards of national accreditation entities: (d) Based on current, nationally accepted standards of medical practice; and (e) If practicable, evidence-based.					
NM NM Stat § 59A-22-52 (2013) SB 188 (2019)	Standard form- drugs and services Plans must establish electronic portal system	7 days Expedited: 24 hours (Reasonable medical probability, delay a in treatment could: (a) seriously jeopardize patient's			By every Sept., OSI to report to Governor/legislature minimum:(1) PA data for each plan individually and collectively; (2) the number and nature						

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
NM cont'd	for secure electronic transmission of PA requests 24/7	life or overall health; (b) affect patient's ability to regain maximum function; or (c) subject patient to severe and intolerable pain.)			of complaints against plan for failure to follow the Act; and (3) actions taken by the office, including fines, against plans to enforce compliance.						
NJ P.L. 2005, C. 352 www.state.nj.us/dobi/chap352/352uminitialqanda.html#q2		Generally, 15 days request. When patient receiving inpatient hospital services, plan respond w/in 24 hours.		If a plan grants PA for a service, or approves it upon concurrent review, plan cannot make a retrospective review and deny coverage based on medically necessity in the absence of fraud or misrepresentation		"Medically necessary" means a health care service that a health care provider, exercising his prudent clinical judgement, would provide.for the purpose of evaluating, diagnosing or treating an illness, injury, disease or its symptoms and that is: in accordance w/ the generally accepted standards of medical practice; clinically appropriate, in terms of type, frequency, extent site and duration, & considered effective for patient's illness, injury or disease; not primarily for convenience of patient or health care provider; and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results.	Changes in any UM standards must be posted on website at least 30 days prior to the change becoming effective.	Plan must identify the commercial company that produced clinical guidelines used in determining medical necessity. Plan must post a copy of all internally-produced clinical criteria used to determine medical necessity. All info must be posted in a clear and conspicuous manner.	Any denial of a request for authorization or limitation imposed by a payer on a requested service shall be made by a physician under the clinical direction of the medical director who shall be licensed in NJ.		Provider does not have independent right to appeal an adverse determination but plans may allow. In order to appeal to Stage 3 at the Independent Health Care Appeals Program (IHCAP), provider must have consent from the patient.

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
NY NY Ins L § 3238 (2012) SB 4721A (2016) https://www.nysenate.gov/legislation/laws/ISC/3238 (2020)	Standard form Take into account NCPDP standards	If request is complete, w/in 3 business days of receipt. If incomplete, w/in the earlier of 3 business days of receipt of necessary info, 15 days of partial, or 15 days of end of 45-day period if no additional info received. For urgent/ expedited: If request complete – w/in 72 hrs. If incomplete w/in 48 hrs. of earlier of receipt of necessary info or end of 48 period. Court ordered treatment – 72 hrs. Preferred drug program must make available a 24 hr per day, seven days per week telephone call center that includes a toll-free phone line and dedicated facsimile line to respond to PA requests		Plan must pay claims for service for which PA was received prior to care, unless patient was ineligible at time of care, claim was not timely, inaccurate info submitted, or fraud. When providing service, if provider determines additional/related service is immediately necessary, and in clinical judgment is a medically timely service and would not be advisable to interrupt provision of care for a PA, plan cannot deny payment unless service was (1) not covered benefit (2) not medically necessary; (3)investigational /experimental; (4) see above factors re: permitted denials.					For adverse determinations – a clinical peer. Appeals: Clinical Peer (who did not make initial decision and is not subordinate of clinical peer who made initial determination)		

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NC N.C. Gen. Stat. 58-50-61 N.C. Gen. Stat. 58-3-200(c).		3 business days after receipt of all necessary information.		Plan cannot retract determination after services, supplies, or items provided, or reduce payments when furnished in reliance on determination, unless it was based on material misrepresentation re: patient's condition that was knowingly made by patient/ provider.				Written notice of a non-certification must be submitted to provider and patient - include all reasons for denial. Notice must include instructions to pursue informal reconsideration, or appeal (either on expedited or non-expedited basis).	Qualified health care professional must administer UR program and oversee review decisions under direction of a physician. A physician licensed in NC must evaluate clinical appropriateness of all non-certifications.		Violations may subject plan to enforcement action by DOI which may include civil penalties, restitution, or licensure action.
ND ND Cent Code 23-01-38	Rx PA to be accessible electronically. Fax is not electronic.										
OH SB 129 (2016)	NCPDP standard for Rx and CAQH operating rules for info exchange in medical benefit. Electronic submission does not include fax or payer portal not using	48 hours for urgent 10 calendar days for non-urgent after receipt of all necessary info. Appeals: For urgent services – 48 hours. For other services – 10 calendar days.	For PAs related to drugs for chronic conditions, plan must honor PA for the lesser of 12 months from approval or the last day of eligibility. Plan may require a provider to submit info	No retroactive denials of a PA assuming medical necessity and eligibility requirement met. Upon written request, plan must permit a retrospective review for service where PA was required but not obtained if service was (i)			Disclose new requirements 30 days in advance via email or standard mail and must be entitled "Notice of Changes to Prior Authorization Requirements.	Plan must make available to all participating providers on its website or provider portal a listing of PA requirements, including info or documentation that a practitioner must submit in order for PA request to be considered complete.	Appeals must be between the provider and a clinical peer.		Enforcement: committing a series of violations that, taken together, constitute a practice or pattern shall be considered an unfair and deceptive practice. After appeal process, can go

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OH cont'd	NCPDP standard.		indicating that the patient's chronic condition has not changed not more than quarterly. (Provider must respond w/in 5 days.)	directly related to another service for which PA has been obtained and performed; (ii) service was not known to be needed when original service was performed and (iii) need for service was revealed when original service was performed. Plan cannot deny claim for such a service based solely on the fact that a PA approval was not received.				Plan must make available on website info about policies, contracts, or agreements offered by plan that clearly identifies specific services, drugs, or devices to which a PA requirement exists.			to external review. If unintentional error on claims results in a claim that does not match the info originally submitted in the approved PA, upon receiving a denial, practitioner may resubmit the claim.
OK 63 OK Stat 63-313B	Use a form for Rx (not standard)										
OR HB 2517 (2021)	Standard form for Rx. Must be electronically available Provider can make a secure electronic submission, meeting industry standards for	Nonemergency service: 2 business days. If additional information is request, decision must be made 2 business day after receipt of info, or 15 days after date of request.	Approved PA, (not Rx), is binding on plan for the later of: (A)reasonable duration of treatment based on clinical standards; or (B)60 days after the date	Except in the case of misrepresentation relevant to a request for PA, a PA determination is binding on the insurer of length of PA (see previous column)	Plans much provide to Department an annual summary of PA requests: (A) # of requests received; (B) # of requests denied and reasons including, lack of medical necessity or failure to provide additional clinical	May only require the minimum amount of material info necessary to approve/disapprove the Rx. Plan must use evidence-based clinical review criteria, continuously updated based on new evidence and research, and take into account new developments in	60-day notice of new requirements If change in formulary or coverage impacts coverage of treatment plan and patient has been stabilized for at least 90 days, plan must continue to	Plan to post on website requirements for requesting coverage of a treatment, drug, device, diagnostic or laboratory test subject to utilization review, including specific documentation	Plans must use OR-licensed physician to make all final recommendations regarding coverage for care subject to utilization review and to consult as needed.	A PA may be limited to the services of a specific provider or to services of a designated group of providers who contract with or are employed by the insurer	Any denial must be given timely appeal before appropriate medical consultant or peer review committee. Qualified health care personnel must be available for same-day

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
OR cont'd	privacy, along with needed documents, and receive an electronic acknowledge-ment of receipt of request.		that treatment begins following approval of PA. For Rx: 1 yr from date treatment begins following approval if drug: (A)is prescribed as maintenance therapy expected to last at least 12 months based on medical or scientific evidence; (B) prescribed throughout the 12-month period.		info requested by plans; (C) # of requests that were initially approved; and (D) # of denials that were reversed by internal appeals or external reviews.	treatment.	provide coverage of the treatment until utilization review, internal and external reviews are completed.	required, and a list of the treatments, drugs, devices or diagnostic or laboratory tests subject to utilization review. Notice of denial must be written in plain language, understandable to providers and patients, and include the specific reason for the denial based on evidence-based, peer reviewed literature. If based on terms in a policy or certificate of insurance, denial must cite the specific language.	For IRO, at least one reviewer must be a clinician in same or a similar specialty as the provider who prescribed the treatment.		telephone responses to inquiries concerning certification of continued length of stay.
PA Act 146 (2022)	Plans to have portals that allows for submission of PA request, access to the medical policies, info needed to request Peer-to-Peer, and contact info for clinical/ admin staff.	For Medicaid or CHIP managed care plan: 2 business days after receipt of all info. For urgent care under commercial plans: 72 hours For nonurgent under commercial plans: 15 days		Plan cannot deny a "closely related service" based on lack of prior auth if plan is notified of closely related service w/in 3 days and prior to the submission of the claim.		Medical policies to be reviewed at least annually. Clinical criteria must be based on applicable nationally recognized medical standards; be consistent w/ applicable governmental guidelines; provide for delivery of a service in a clinically appropriate type, frequency and	Notice to be provided 30 days in advance of new policy	Medical policies must be made available on website and through portal and include the clinical review criteria used to develop the policy. Plan must send a notice of denial to patient and must include statement	Licensed health care provider w/ appropriate training, knowledge or expertise in same/similar specialty or, licensed health care provider in consultation w/ appropriately qualified 3rd-party health care		Peer-to-peer review: plan to make available a licensed health care professional w/ authority to overturn or modify PA decisions. P2P available b/w denial and internal grievance process or

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PA cont'd	Plans have to offer training for providers. Providers must us portal to submit PA request (some exceptions).					setting and for a clinically appropriate duration; reflect current medical and scientific evidence on emerging procedures, clinical guidelines and best practices as articulated in independent, peer-reviewed medical literature.		specified in the law that outlines right to an appeal and external appeal.	provider, licensed in same/similar specialty or type of provider who manages condition. Internal and external grievance process for Medicaid/CHIP MCOs - licensed physician in same/similar specialty that typically manages or consults on service. IRO review for commercial plans-physician or appropriate provider w/ expertise in treatment of condition and has recent or current actual clinical experience.		internal adverse benefit determination process. Process for requesting P2P to be on plans' website and portal. Statute established state external review process. One level of internal review and then 1 level of external review by IRO (DOI oversees).
RI R23-17.12-UR § 27-18.9		15 business days for non-urgent, 72 hours for urgent/emergent. Allow for direct contact with peer reviewer.		A utilization review entity cannot retrospectively deny authorization for				A utilization review agent cannot conduct utilization review for services delivered or	All initial, prospective and concurrent adverse determinations and all first level		A first and second level appeal adverse determinations cannot be made until an

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
RI cont'd				services provided when PA was obtained unless approval was based on inaccurate info material to the review, or services were not provided consistent w/ submitted plan of care and/or any restrictions included in the PA granted by the review agent.				proposed to be delivered in RI unless the Department has granted the review agent a certificate. No reviewer will be compensated, paid a bonus, or given an incentive, based on making an adverse determination.	appeal adverse determinations shall be made, documented and signed by a licensed practitioner with the same licensure status as the ordering practitioner or a licensed physician		appropriately qualified and licensed review provider has spoken to, or otherwise provided for, an equivalent two-way direct communication with patient's attending physician unless physicians choose not to or is not available.
SC											
SD											
TN § 56-6-701 et. al.		2 business days within the receipt of request and receipt of all info necessary to complete review. Appeals: 30 days Expedited appeals: 48 hours Plans must make staff available by toll-free telephone at least 40 hours/week during normal business hours and have a telephone system capable of accepting or recording incoming telephone calls during other than							Physicians or psychologists making determinations must have current licenses from a state licensing agency in US. Appeals: adverse decisions must be made by physician in same or a similar general specialty as typically manages the		

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
TN cont'd		normal business hours and shall respond to these calls within 2 working days;							medical condition. For mental health and SUD care, person performing the review in appeal must be both licensed at independent practice level and in appropriate mental health or chemical dependency discipline like that of the requesting provider.		
TX TX Ins. Code 1369.304 and TX Admin Code 19.1820 SB1742 2019	Standard form for Rx, consider national standards. Must be available electronically (applies to all plans, Medicaid, CHIP) By the 2nd anniversary of adoption of national standards for ePA, a plan must respond	If noncompliance w/ respect to publication, notice, or response, must provide an expedited appeal under Section 4201.357 for any service affected.			Plan must post on website statistics on approval/denial rates for service in the preceding year, including statistics in the following categories:(i) physician or provider type and specialty; (ii)indication offered; (iii)reasons for denial; (iv)denials overturned on internal appeal; (v) denials overturned by an independent review org; (vi)		Insurer to provide 60-day notice of new or amended PA requirements (5 days if removing PA or making a change that reduces burden on patients/physicians.)	Plan must provide to any preferred provider a list of services that require PA and info on the PA process w/in 5 business days. Plan must post PA requirements on website (conspicuously, easily searchable, and w/o needing login) and include: the effective date of PA requirement; a list of any supporting	Plan's review plan, including reconsideration and appeal requirements, must be reviewed by a physician licensed to practice medicine in TX and conducted in accordance w/ standards developed w/ input from appropriate health care providers and approved by a	Gold carding: A physician or provider will receive an exemption from prior authorization for a service from a plan if, in a 6-month period, receive 90% approvals for prior auth requirements for that service.	Before adverse determination based on medically necessity, appropriateness or experimental or investigational nature of service, provider must be able to discuss w/ a physician licensed to practice medicine. If w/in 10 working days after date an appeal is requested or

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
TX Cont'd	via ePA when prescriber initiates a request electronically.				total annual PA requests, approvals, and denials for service			documentation required; screening criteria, which may include CPT/ICD codes. Insurer may, instead of making info publicly available on website that may violate copyright law or licensing agreement, supply summary of w/held info sufficient to allow provider to understand basis for determinations.	physician licensed to practice medicine in TX. A utilization review agent must conduct review under the direction of a physician licensed to practice medicine in the state.		denied, the provider requests a particular type of specialty provider review, a provider who is of the same or a similar specialty must review the denial or the decision denying appeal. Specialty review to be completed w/in 15 working days. Must have expediated appeal procedures for denial of emergency care, continued hospitalization, or other service if provided written statement and supporting documentation that necessary to treat life-threatening condition or prevent serious harm.

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
UT 31A-22-650				Plan cannot revoke PA if eligibility requirements met, accurate claim, and not based on fraud/materially incorrect info.	A plan using PA must report to department, for previous calendar year, the percentage of authorizations, not including a claim involving urgent care, for which the plan notified a provider of decision more than 1 week after the day on which the plan received the request.		Plan must notify on website, and if request by network provider via mail or email, 30 days before change takes effect.		Appeal of adverse PA determination request by physician based on clinical or medical necessity may only be reviewed by a physician currently licensed in state, district, or territory of US. Appeal of adverse determination based on clinical or medical necessity of a drug, may only be reviewed by individual currently licensed in a state, district, or territory US as a physician and surgeon; or pharmacist.		
VT 18 VSA 9418b.	PA form must include set of common data requirements for nonclinical info for PA included in the 278	Respond to completed prior auth in 48 hours for urgent care and 120 hours for non-urgent. The plan must notify the provider or make available to a health care provider a									

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
VT cont'd	standard transaction, national standards for PA, and e-prescribing. (Workgroup decided to move forward with medical services only.) Plan must accept the national standard transaction information, such as HIPAA 278 standards for sending or receiving PA electronically	receipt of the request for prior auth and any needed missing information within 24 hours of receipt.									
VA SB 1262 (2015) S1607 2019	ePA requirements using NCPDP standard	W/in 2 business days of submission of a fully completed PA request, plans must communicate to prescriber if request is approved, denied, or requires more info. Plan must notify the provider after submission of complete request w/in 24 hours (including weekend hours) for urgent, 2	PA granted by another plan be honored for at least initial 30 days of members' new Rx coverage. Must honor PA for a drug, other than an opioid, regardless of	If during a previously authorize invasive or surgical procedure the provider discovers clinical evidence to perform a less or more extensive or complicated procedure, then plan must pay claim if (i) not investigative in				Plan's formularies, PA requirements and request forms must be available on plan's website and updated w/in 7 days of changes.		Stakeholders to convene workgroup to look at common evidence-based parameters for carrier approval of 10 most frequently prescribed chronic disease	

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
VA cont'd		business days for non-urgent. Tracking system should be available.	changes in dosages. Must honor PA issued by the insurer regardless, if enrollee changes plans, with the same insurer and the drug is a covered benefit with the current health plan.	nature, but medically necessary as a covered service under plan; (ii) appropriately coded; and (iii) compliant with post-service claims process, including required timing for submission.						management drugs subject to PA, 10 most frequently prescribed mental health prescriptions subject to PA, and generic prescription drugs subject to PA.	
WA SB 5346 CR-103	Must have a secure online process and ability to upload documents.	Non-urgent: 5 days Expedited: 2 days Plans must allow a provider to submit a request for a PA for a service at all times, including outside normal business hours.	PA cannot expire sooner than 45 days from date of approval			Plan must maintain a documented PA program description and use evidence based clinical review criteria. Online process must allow provider access to clinical criteria. Plan must (a) Accept any evidence-based info from provider that will assist in the process; (b) Collect only the info necessary to authorize the service and maintain a process for the provider to submit records; (c), require only the section(s) of the medical record necessary to determine medical necessity or	Plans must give providers 60-days' notice before making any changes to its PA program, including addition of new PA requirements to services or changes to the clinical criteria used to consider PA requests.	Denial must include specific reason and if based on clinical review criteria, the criteria must be provided. Denial must include the department, credentials and phone # of individual who has the authorizing authority to approve or deny the request. A notice regarding an enrollee's appeal rights must also be included in the communication. Plans must have available a	Plans' PA programs must be staffed by health care professionals who are licensed, certified or registered, are in good standing, and must be in the same or related field as the provider who submitted the request, or of a specialty whose practice entails the same or similar covered health care service.	Plan must have extenuating circumstances policy that eliminates the requirement for PA when extenuating circumstance prevents a participating provider from obtaining a required PA before a service is delivered	Specialists must be permitted by insurance carriers and their TPAs to request a PA for a diagnostic or laboratory service based upon advanced review of the medical record.

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
WA cont'd						appropriateness of the service; and (d) base determinations on the medical info in the patient's records and obtained by plan at time of the review decisions. Requires workgroup to create standards on PA.		"current and accurate online PA process" that provides physicians w/ patient-specific info needed to determine if service is a benefit and info needed to submit request Online process must provide info required to determine if service is benefit, if PA is necessary, preservice requirements apply, if PA is required, clinical criteria, any required			
WV HB 2351 (2019)	Insurer to develop forms and portal. Insurer must accept electronic PA request and respond to requests through electronic means by 7/1/20. NCPDP SCRIPT	If physician submits request for PA electronically and all info is provided: 7 days. If delay could seriously jeopardize life, health or safety of patient or subject patient to adverse health consequence in opinion of provider: 2 days Insurer to inform provider of incompleteness in 2 business days. Provider				Standard for requiring PA must be science-based using nationally recognized standard. Must use national best practice guidelines to evaluate a PA		One PA per episode of care	Peer review must be w/ provider similar in specialty, education and background.	No PA on Rx at time of inpatient discharge - immediately approved for not less than 3 days (if cost < $5,000/day.) After 3 days, PA may be required. Gold Carding: If provider performed average of 30	Medical director has ultimate decision regarding appeal determination and provider can consult w/ medical director after peer-to-peer. Timeframes for appeal no longer than 30 days

State	ePA and question set	Response Times	PA length	Retrospective denials	Data reporting	Clinical criteria and medical necessity	Notice of new requirements	Transparency	Qualifications of reviewer	Exceptions/ gold carding	Peer-to-peer/appeal process/ other
WV cont'd	Standard for ePA.	must respond w/in 3 business day or care denied/new request required. Timeframes N/A to PA request submitted through telephone, mail, or fax.								procedures/yr in 6-mo period & received 100% approval rating, plan won't require PA for that procedure for 6 mo. Exemption is reviewed before renewal and is subject to internal auditing at any time. Plan may rescind if determines provider isn't performing procedure in conformity w/ requirements based on internal audit.	
WI		Plan receiving request for PA of experimental procedure that includes all required information upon which to make a decision must issue a decision within 5 working days.									
WY											

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February 15, 2023

Senator Judy Lee, Chairman
Senate Human Services Committee
North Dakota State Capitol, Pioneer Room
600 East Boulevard Avenue
Bismarck, North Dakota 58505

Senator Sean Cleary, Vice-Chairman
Senate Human Services Committee
North Dakota State Capitol, Pioneer Room
600 East Boulevard Avenue
Bismarck, North Dakota 58505

Re: AHIP Concerns on SB 2389, *Relating to Prior Authorization for Health Insurance*

Dear Chairman Lee, Vice-Chairman Cleary, Members of the Committee,

On behalf of AHIP, I am writing to express our concerns with SB 2389, *Relating to Prior Authorization for Health Insurance.* We appreciate the opportunity to provide feedback on the legislation and your consideration of our concerns.

Health insurance providers work diligently to ensure that enrollees are getting the right care, at the right time, from the right provider. Utilization management tools, like prior authorization, are critically important to ensure enrollees receive safe, evidence-based, timely, and high-quality care. These tools rely upon provider-developed clinical guidelines, consultation with specialists, input from medical associations, and nationally recognized care criteria to ensure consideration of the latest medical evidence based on the highest standards of care.

SB 2389 will increase health care costs and exacerbate inappropriate or unsafe treatments. As proposed, AHIP is concerned that SB 2389 is broadly written and could undermine the essential role of prior authorization in addressing the long-standing challenges to safe and affordable evidence-based health care. Under the supervision of medical professionals, prior authorization reduces inappropriate, unsafe and low value patient care and it helps to lower a patient's out-of-pocket costs, protect patients, prevent overuse, misuse or unnecessary (or potentially harmful) care, and ensure care is consistent with evidence-based practices.

Prior authorization is only used in limited circumstances and the percentage of services requiring prior authorization is relatively small (typically less than 15 percent). However, health plans report that up to 25 percent of prior authorization requests they receive from clinicians are for care that is not supported by medical evidence and 65% of physicians themselves have reported that at least 15-30 percent of medical care is unnecessary. A JAMA study estimates that waste in our health care system ranged from $760 billion to $935 billion, approximately 25 percent of total health care spending.

SB 2389 prioritizes provider payment over patient safety. AHIP is concerned that SB 2389 creates a review and appeals process that guarantees provider payments at the expense of patient safety. Numerous studies show that Americans frequently receive inappropriate care including overuse, misuse, or underuse of health care services. In fact, data shows that unnecessary treatments are associated with complications or adverse events, and billions of dollars are wasted annually on excessive testing and treatment. A recent study from Johns Hopkins suggests that doctor errors, including "unwarranted variation in physician practice patterns that lack accountability," were the third leading cause of death in the U.S. prior to COVID-19.

SB 2389 could exacerbate delays in patient care and increase administrative costs. AHIP is concerned that the proposed timelines in the legislation are arbitrary and could have the unintended consequences of increasing denials and unsafe treatments. We should instead be striving to achieve uniformity with existing standards so that

clinicians, patients, advocate organizations, and health insurance providers can have standard protocols for such reviews for most patients.

Health insurance providers already meet expedited and standard timeframes for prior authorization determinations for urgent and non-urgent care. AHIP is concerned that SB 2389 will lead to timeframes being arbitrarily rushed, which could lead to prior authorization requests being denied based on incomplete information from the patient's physician. Health care providers have a shared responsibility and delays in receiving the necessary information from providers hinder the ability of insurance providers to make determinations in a timely manner.

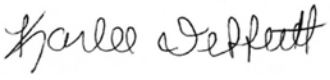
Moreover, the approach in SB 2389 could lead to inappropriate approvals that are not clinically justified and may result in patient harm, higher toxicity of treatment, or more invasive treatment for the patient than what may be medically necessary. There are many circumstances when a patient is on a treatment plan and health insurance providers need to check in with health care providers to see if the patient's treatment is effective and their goals are being achieved.

Health insurance providers are implementing innovative solutions to streamline processes, improve the quality of care, reduce costs, and enhance patients' overall care experience.
In 2018, AHIP and stakeholders representing providers and pharmacists developed a Consensus Statement recommending opportunities to improve the prior authorization process. Since then, health insurance providers have taken several extensive steps to improve the prior authorization for patients and providers alike, including increasing the adoption of electronic prior authorization (epic). In 2020, AHIP launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative in 2020 to better understand the impact of ePA on improving the PA process, making health care more efficient and effective.

Health care experts and clinical leaders have also called for wider adoption of evidence-based guidelines. The mission of the Choosing Wisely Initiative – which was founded by physicians and clinicians – is to help inform patients and ensure that any test, treatment, drug or procedure is "supported by evidence, not duplicative of other tests procedures, free from harm, and truly necessary." That is what prior authorization delivers.

For these reasons, AHIP respectfully requests that the Human Services Committee does not support SB 2389 because it undermines important patient protections and would increase the cost of health care for North Dakotans. We appreciate the opportunity to provide feedback on the legislation and your consideration of our concerns.

Sincerely,



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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. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.

23.1108.01001

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.

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~~prior authorization 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~~relating to an admission, extension of stay, or health care service which is partially or wholly adverse to the enrollee, including a decision to deny an admission, extension of stay, or health care services on the basis that 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 other health care service.
3. "Authorization" means a determination by a ~~utilization~~prior authorization review organization that a health care service has been reviewed and, based on the information provided, satisfies the ~~utilization~~prior authorization 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~~prior authorization 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, workers' compensation, 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~~prior authorization review organization.

13. "Prior authorization 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.

14. "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~~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. Requirements must be described in detail using plain and ordinary language comprehensible by a layperson.

2. If a ~~utilization~~prior authorization review organization intends to implement a new prior authorization requirement or restriction, or amend an existing requirement or restriction, the ~~utilization~~prior authorization review organization shall:

   a. Ensure the new or amended requirement is not implemented unless the ~~utilization~~prior authorization 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~~prior authorization 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~~prior authorization 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~~prior authorization review organization is questioning the medical necessity of a health care service, the ~~utilization~~prior authorization 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.

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

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

~~2.~~ b. 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.~~ c. Must be knowledgeable of, and have experience providing, the health care services under appeal;

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

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

~~6.~~ 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 ~~utilization~~prior authorization review organization by the enrollee's health care provider, any relevant records provided to the ~~utilization~~prior authorization review organization

by a health care facility, and any medical literature provided to the ~~utilization~~prior authorization review organization by the health care provider.

2. Notwithstanding subsection 1, 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.

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

1. If a ~~utilization~~prior authorization review organization requires prior authorization of a health care service, the ~~utilization~~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 prior authorization or adverse determination within ~~two~~seven 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~~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 medical condition for the enrollee or health care provider to notify the ~~utilization~~prior authorization 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~~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 not later than ~~twenty-four hours~~three business days 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~~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 ~~utilization~~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 ~~utilization~~prior authorization review organization of the admission or provision of health care services.

3. A ~~utilization~~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 ~~utilization~~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 ~~utilization~~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 ~~utilization~~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.

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

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

26.1-36.11-10. Retrospective denial.

A ~~utilization~~prior authorization 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~~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 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~~prior authorization review organization shall honor a prior authorization granted to an enrollee from a previous ~~utilization~~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 ~~utilization~~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 ~~utilization~~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.

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

If a ~~utilization~~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 ~~utilization~~prior authorization review organization.

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

1. A ~~utilization~~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.

~~**26.1-36.11-16. 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.~~

26.1-36.11-16. 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 change in clinical criteria do 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.

~~26.1-36.11-18~~26.1-36.11-17. Notification to claims administrator.

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

Good Morning, Madam Chair, and members of the Senate Human Services Committee.

My name is Megan Houn, with Blue Cross Blue Shield of North Dakota and I stand today in opposition of SB 2389 for a number of reasons we will share shortly, but primarily because 90-percent of this proposed legislation already exists in one form or another in the Century Code.

- 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 accreditation organization or state statute, typically provides 14 days for prior authorizations. BCBSND's average turnaround time is 2-4 business days, however most
    - BCBSND has not received any formal complaints about our prior authorization timeliness.
- There are several things our health care provider partners can do to ensure quick turnarounds for prior authorization requests:
    - Only submit requests on services that require prior authorization. Over 40% of the requests we receive do not require any prior authorization.
        - Of all the healthcare services available, BCBSND only requires prior authorization on about 50 services. We evaluate that list at least annually (removing and adding as needed).
        - To make it even easier to determine which services require prior auth, BCBSND is investing in an electronic tool that providers can use. Deployment of the tool is scheduled for mid-2023.
    - Submit requests electronically. Over 30% of the requests we receive are submitted on paper, which takes longer to process.
    - Submit all the necessary supporting documentation with the initial request.
- This bill not only feels unnecessary given our performance but would also introduce additional administrative costs.
    - The bill seeks to introduce a step prior to determination with the health plan offering a peer-to-peer conversation <u>prior</u> to issuing a denial.
        - With a proposed timeline of 2 days, it would be incredibly difficult to connect with the ordering physician for a phone call to discuss prior to issuing a denial.
        - BCBSND offers peer-to-peer conversations post decision. BCBSND works with providers to gain the necessary documentation needed to approve a service, if the documentation is not there, we will issue the denial, which can be appealed.
    - The bill's appeal language is broad and allows for a loose interpretation of "emergency". Expedited appeals should have more defined parameters to manage volume and avoid confusion.
    - The bill seeks to require one payer to honor another payer's prior authorization. This is unnecessary given the federal requirements around continuity of care, which is more generous than what is being proposed in this bill.
- BCBSND is exceeding well-established standards for prior authorizations, this bill is unnecessary, and we welcome health care providers to work with us to resolve any issues they have.
- SB 2389 proposes to add another chapter to the Century Code, chapter 26.1-36.11, N.D.C.C. This will result in at least four separate chapters in the Century Code that apply to claims and appeals requirements, grievances, utilization review and prior authorization requirements. This proposed legislation only serves to complicate an already complicated area of the law even further. It should be pointed out that these current laws not only cover prior

authorization (also described as preservice, precertification, prior approval) but comprehensively address concurrent claims and post service claims review and timeframes. This federal law that governs claims and appeals not only for post-service and concurrent claim reviews, includes as well and these will govern and preempt any conflicting provisions between current law and SB 2389.

- Just one example of this, which has already been pointed out, is the definition of "emergency medical condition". This term is defined in BCBSND benefit plan documents (and tracks the current statutory definition) but is also defined in Section 26.1-26.4-02(2), N.D.C.C., and in SB 2389. Does this not seem like overkill?

  With your permission, Madam Chair, I would like to introduce Jeff Ubben, our Vice President of Compliance Regulatory Affairs and Special Investigations.

- A major issue with the bill comes at page 6, lines 18-27. This provision essentially says that if a health care provider says a patient's condition requires emergency medical care for a condition, this creates a rebuttable presumption that the health care services provided are in fact medically necessary, unless the insurance company provides clear and convincing evidence that the services provided are not medically necessary. Our issues with this provisions are as follows:

    - The U.S. Department of Justice has estimated that up to 10% of the nation's healthcare spend is for services that are fraud, waste, and abuse.

    - BCBSND processed over 7 million claims last year. If we consider that up to 10% of services submitted to us for payment are fraud, waste, or abuse, it's not difficult to see that would could be required to submit rebuttal documentation on thousands of claims per month. This would create a large administrative burden and require us to hire numerous new positions to undertake this work. These extra administrative burdens will come back to your constituents in the form of higher health insurance premiums.

    - If we are unable to meet the large burden created by this provision, we would be forced to pay for a greatly increased amount of services that are fraud, waste, or abuse, the costs of which again will be passed on to your constituents in the form of higher health insurance premiums.

    - I oversee our provider audit team at BCBSND. We have found that providers routinely bill diagnosis such as runny noses, sore throats, and coughs as emergency medical services. Yes, we have the opportunity to rebut, but at what cost, and why should this be necessary under the law?

    - The bill does not identify who the arbitrator or decider is when the insurance company presents its rebuttal evidence to a provider's claim that a service is an emergency condition. Since this legislation is proposed to go into the Insurance Code, I presume the Insurance Commissioner will be the decider. The Insurance Commissioner and his staff would be put in the position of deciding thousands of medical disputes between emergency room doctors and health insurance company doctors. The Insurance Commissioner and his staff are not medical professionals, therefore, they would be

required to add costly medical doctor FTEs to their staff or add costly consultants to review thousands of claims every month.

The next concern is a general concern. In my position, I handle all of the complaints made by consumers and providers that are made to the Insurance Department. There has not been a single complaint to the Insurance Department to BCBSND regarding what this bill seeks to address, which is the process and timelines behind prior approvals. To be clear, this bill does nothing to address any provider or patient concerns about medical necessity standards, as prior authorization and medical necessity are two entirely different things. If this bill was really aimed at addressing patient care surrounding the prior authorization process, we would have seen complains from patients regarding what this bill seeks to address, which is the prior authorization process.

Finally, I've worked directly with providers to successfully address concerns numerous times in my role at BCBSND. There is no reason why we cannot work with Essentia and any other aggrieved providers to address their concerns here. I believe this is a much better approach, to sit down and work things out, than to draft problematic legislation for an entire state that seems to be limited to an issue a few providers are having.

2023 Senate Bill no. 2389
Senate Human Services Committee
Senator Judy Lee, Chairman
February 15, 2023

Good morning, Chairman Lee and members of the Senate Human Services Committee. I am Lexie Huebner. I serve as Altru Health System's Pre-Service Manager. I am testifying on behalf of the North Dakota Hospital Association (NDHA), which represents hospitals and health systems across the state. We ask that you give this bill a **Do Pass** recommendation.

I have a passion for helping patients understand the complexities of their chosen health care insurance in order to avoid costly surprise medical bills. That passion is the basis of my current position at Altru. It is my goal to improve price transparency within the health care industry and to reduce the burden that medical bills put on families.

Prior authorization processes are extremely complex and difficult to summarize. This is due to the lack of standardization between health care plans as no two are the same. Currently, there is not a universal standard for why a particular health care plan determines that a certain medical service requires prior authorization. Likewise, there is neither a standard communication process nor a standard explanation of what documentation needs to be included to support the prior authorization request. It's a "learn as you go", "trial and error" system that is full of inefficiencies, misdirection, and creates heavy workforce burdens. It is a process that has very little regulation and is controlled differently by each health care plan.

What exactly is prior authorization? It is a process that health plans use that requires health care providers to obtain prior approval before they can deliver specific health care services to a patient. If prior authorization is not given, the health insurance plan will not cover the services.

You may hear that prior authorization requirements are in place to reduce costs and ensure that health care providers are recommending medically necessary treatments. I have also heard it is so the patient can be sure of the medical appropriateness of the services a provider is recommending. Another health care plan's reasoning is to be sure of the "extent" of a patient's coverage. These reasons might have been true when prior authorization requirements first began. However, those statements are outdated, and I have witnessed prior authorization requirements doing the direct opposite of helping patients.

Prior authorizations do not reduce cost but, instead, contribute to the rise in health care prices. At Altru, our prior authorization workload increased 15% from 2021 to 2022. That increase adds an administrative burden not only on the health care facility but, also on the health care plan which now needs to review and approve more services than ever before. With each new prior authorization requirement comes more documentation, testing, and communication requirements on both the health care plan and the provider. Prior authorization requirements are not slowing down but constantly increasing. So far in 2023, we have seen even more of an increase in new health services that now require prior authorization. I can't see how prior authorization is reducing the cost of health care for patients.

When prior authorization is denied, cost is increased. A denial will be issued with a recommendation that the patient and provider try a different form of health care service or procedure and require proof that the substituted service failed before the health care plan will approve the initial requested service. This happened recently with a patient who needed spinal fusion surgery. The surgery was denied by the health care plan and, for it to be approved, the patient needed to complete a psychiatric evaluation and show that a handful of other treatment options failed. Meaning, the patient has to schedule multiple other doctor visits, pay more copayments, and contribute more to the patient's out-of-pocket max. All of that with no guarantee in the end that the patient can have the service that the neurosurgeon initially recommended to help eliminate crippling back pain. Again, this is not reducing cost for our patients but, instead, is adding more for the patient to pay.

Prior authorization does not ensure that health care professionals are recommending medically appropriate treatments. When a health care service requires prior authorization, there is no reasoning or explanation provided by the health plan for it. The health plans provide no data showing that that specific health care service was ordered inappropriately X amount of times, no committee validates the reasoning for why prior authorization improves the appropriateness of services, and no examples are shared to show that a health care provider is recommending health care services inappropriately. In fact, the only notification of a health care plan's policy change is when we suddenly begin receiving prior authorization denials for a medical service.

Each denial can be a teaching moment and Altru adjusts our processes as we learn what steps were needed and what procedures need updating for prior authorization to be approved going forward. Altru learns what requires prior authorization through the denial analysis and has started to see health plans require prior authorizations for services done while patients are in observation in the ER, for genetic testing for neonatal intensive care unit (NICU) treatments, cancerous biopsies, and medically necessary contraceptive treatments. In order to be more proactive and a better advocate for our patients, Altru has hired two additional team members to focus on overturning prior authorization denials and to gather a better understanding of denial reasoning.

This started two years ago and, while some healthcare plans don't even allow for an appeal of a denial, Altru tries to work with those plans that do.

The denials that we have been successful in overturning equate to over nine million dollars of health care services for which health care plans were otherwise not going to extend coverage. Nine million dollars that would have transferred from the health care plan to either the patient or the health care provider. This is not reducing cost but is allowing health care plans to avoid covering necessary health care services.

You may hear that prior authorization barriers are specific to non-North Dakota based health plans. In my experience, it is NOT unique to any particular health plans. We have seen patient delays for ANY health plan that requires prior authorization whether that is non-profit, for-profit, non-North Dakota, North Dakota, or federal plans. If a health plan requires prior authorization, it is a barrier to patients receiving health care timely.

The reasoning for prior authorizations is no longer aligned with today's health care industry. However, the ultimate reason I'm here in support of this bill is not because of the burden it puts on Altru or proving that Altru's health care providers are recommending medically appropriate services. I'm here because prior authorizations are delaying patient care and I see an opportunity for North Dakota to do better for our residents. At the heart of this bill is the patient. Prior authorization requirements delay patient care, period. Anytime a specific health care service requires prior authorization, a health plan has at least 15 business days to return a determination. That means, the patient is scheduled at least 15 business days out in order to ensure prior authorization is timely approved. That is 15 business days that a CT, MRI, X-Ray, cancer injection, spinal fusion, or heart valve replacement is delayed for North Dakota patients.

I can also let you know that the likelihood of that 15-business day turnaround timeframe being met by the health plan is low. The amount of work that is required of a physician and nurse to gather all the documentation that must be submitted with the prior authorization request takes time. The documentation needs are very specific to each health plan. There is not a standard of what should be submitted and there is variation on how prior authorizations and supporting documentation can be submitted. Furthermore, if the smallest of details is missing from the supporting documentation, the health plan then requests additional documentation and the 15-business day timeframe starts over. This means the patient's care is further delayed.

The rebuttal from the health plans to a delayed prior-authorization or a denied prior-authorization is always this: It doesn't mean that the patient can't move forward with the recommended services. They certainly can and that is true. However, if you were a patient waiting to hear if your health plan approved prior authorization for your spinal fusion surgery or for your mom's heart

valve replacement surgery and it was denied and won't be covered by your health plan but you can still move forward if you'd like to be self-pay, would you? Would you say yes to a surgery that costs thousands of dollars at 100% out of pocket even though you are insured? Would you go forward if we told you it might be approved if you have three other services first and they failed and you are still in pain, then we can try to resubmit prior authorization for your spinal surgery? Or, the other option you'll hear is that a health care provider can move forward with the recommended procedure without prior authorization but it won't be covered, so the only option for the provider is to write off the cost. Again, this is only saving the health plan money and moves the financial burden to the provider. How is that working together to help improve health care?

I want to leave you with one final patient story. This is a story of a North Dakota family who came to Altru to have a baby. What should have been a joyous time quickly turned into a scary time as the baby needed extra attention and was rushed to the NICU. The family and the new baby had a North Dakota insurance plan and both the mom and baby were admitted. Thankfully, the NICU doctors were successful in helping this baby and everyone was sent home. Fast forward a couple of weeks from discharge and Altru received a prior authorization denial for the genetic testing that was done on the baby. Because the genetic testing was not given prior authorization, the health plan denied coverage for the entirety of the stay. The bill was $540,000. That entire charge was denied because prior authorization was not received for an admitted NICU infant who needed genetic testing to identify underlying conditions that would help the surgeon have the most success with the medically needed surgery. Again, our friends, neighbors, family members deserve better than this.

Today, we have the opportunity to take a step in the right direction to help improve this process in North Dakota. We've compromised on the bill you see before you today, we've worked with the health plans in North Dakota to try and find a middle ground that helps to improve the patients' experiences, gets them the health care they need, and reduces cost.

Thank you, Chairman Lee and the members of the Committee, for giving me the opportunity to play a part in improving health care for North Dakotans. We ask that you give the bill a **Do Pass** recommendation. Thank you for your consideration. I would be happy to answer any questions.

Respectfully,

Lexie Huebner, Pre-Service Manager
Altru Health Systems

During the 2023-2024 interim, the legislative management shall consider studying prior authorization in the commercial health insurance marketplace. The study shall include:

- The extent to which prior authorization is used by health insurance companies in the state, including the types of services and procedures for which prior authorization is required
- The impact of prior authorization on patient care, including the effects on patient health outcomes, patient satisfaction, healthcare costs and patient access to care
- The impact of prior authorization on healthcare providers and insurers, including the administrative burden, time and cost associated with obtaining prior authorization, and the appropriate utilization of healthcare services
- State and federal laws and regulations that may impact prior authorization
- Input from stakeholders, including patients, providers, and commercial insurance plans

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

My name is Jonathan Haug, and I am a physician specializing in Anesthesiology at Altru, and I serve as the Medical Director of Surgery. I have been at Altru for 18 years, grew up in Grafton and Grand Forks, attended UND for college and Medical School. I am as local as you can get, and I am heavily invested in providing the best possible care to the patients of my hometown.

First I want to thank you for taking the time to read my story. I regret that I am not able to speak with you in person.

Over my 18 years in practice, I have unfortunately been a part of surgical cases where the patient had arrived for surgery, and we had to inform the patient that their insurance had not yet approved their surgery, so cancelled surgery. This is a big fail on the part of our health care system. The stress and anxiety of preparing for surgery takes a toll on not only the patient, but also family members.

Just recently I had the opportunity to experience this process with a family member. Last month my 76 year old mother had open heart surgery, replacing her aortic in addition to an ascending aortic aneurysm repair. I won't get into the details of her heart defects, but while this surgery is typically a very complicated operation, the heart defects that my mom has created even more challenges for our surgeon as the workup unfolded.

My mom had been monitoring her heart valve, and when she became symptomatic with shortness of breath and chest pain, we knew it was time to have it repaired. The preoperative workup by cardiology was extensive, and on November 29, she saw her surgeon and was scheduled for surgery. Surgery was set for January 9.

Because surgeries like this require an anesthesia team that is more specialized, we had ensured that our cardiac anesthesiologist would be available when we chose her surgery date. Everything was falling into place. My brother is also a physician, and he arranged his schedule so he could be in town for the week following her surgery.

The week prior to her surgery, we were informed that the insurance pre-approval process had not yet cleared, and there was a chance we would need to reschedule surgery. The Altru crew spent nearly an entire day on the phone

trying to sort things out with our insurance company. I spent an hour on the phone with the insurance company advocating both as a son and as the Medical Director, trying to get any unanswered questions resolved. My father also spent an hour on the phone with them. It was clearly a very inefficient process.

Ultimately, the Friday before her Monday surgery, we were told that my mom's insurance company had not yet pre-approved her case, and we would need to reschedule. This meant that my brother would not be able to be in town for her surgery, and we had to rearrange the schedule of our cardiac anesthesiologist. But not only that, in the back of our minds we were worried that something might happen to my mom while we waited. It is very possible that during that time her aneurysm could have ruptured, or her aortic valve could have led to sudden death. It was not a peaceful wait.

After 18 years of medical practice, and now as a family member, I can clearly state that our insurance pre-approval process is broken. Something needs to change. Thank you for your time and consideration.

Jonathan Haug, MD

2023 Senate Bill no. 2389

House Industry, Business and Labor Committee
Representative Scott Louser, Chairman
March 14, 2023

Good morning, Chairman Louser and members of the Industry, Business and Labor Committee. I am Lexie Huebner. I serve as Altru Health System's Pre-Service Manager. I am testifying on behalf of the North Dakota Hospital Association (NDHA), which represents hospitals and health systems across the state. We ask that you give this bill a Do Pass recommendation.

I have a passion for helping patients understand the complexities of their chosen health care insurance to avoid costly surprise medical bills. That passion is the basis of my current position at Altru. It is my goal to improve price transparency within the healthcare industry and to reduce the burden that medical bills put on families.

What exactly is prior authorization? It is a process that health plans use that requires healthcare providers to obtain prior approval before they can deliver specific healthcare services to a patient. If prior authorization is not given, the health insurance plan will not cover the cost of the services.

What does the prior authorization look like in the real world? If you have healthcare insurance, prior authorizations have likely played a part in your healthcare journey. But how? Let me tell a story of a North Dakota family who came to Altru to have a baby. What should have been a joyous time quickly turned scary as the baby needed extra attention and was rushed to the NICU. The family and the new baby had a North Dakota health insurance plan and both the mom and baby were admitted. Thankfully, the NICU doctors were successful in helping this baby and everyone was sent home. Fast forward a couple of weeks from discharge and Altru received a prior authorization denial for the genetic testing that was done on the baby. Because the genetic testing was not given prior authorization, the health plan denied coverage for the entirety of the stay. The bill was $540,000.

Another North Dakota resident had been diagnosed with an aggressive form of cancer and needed to start radiation oncology treatments immediately. Based on the North Dakota plan the patient had, radiology oncology required prior authorization before treatments could begin. Altru submitted the prior authorization request in January of 2022. Unfortunately, 10 business days later, the prior authorization came back as denied. The insurance plan had deemed radiation oncology as not medically appropriate. Altru oncologists disagreed with that determination and wanted to proceed with an appeal. The appeal was started in February of 2022 and Altru made the decision to have the patient move forward with radiation oncology treatments despite the denial. This was the patient's best shot at beating the cancer. Altru worked on this appeal from February 2022 to December 2022 and was successful in overturning the denial. On 1/23/2023, the patient's North Dakota insurance plan paid for the radiation oncology services they had proceeded with back in February of

2022. A whole year had gone by before it was determined that the radiation oncology treatments were, in fact, medically appropriate to begin with. Imagine if the patient had went by the prior authorization denial and did not move forward with the treatment. These are just two examples – as the Pre-Service Manager, I see these examples every day. If you read Jonathan Haug's testimony, you'll encounter another example.

Prior authorization processes are extremely complex and difficult to summarize. This is due to the lack of standardization between health care plans as no two are the same. It is a process that has very little regulation and is controlled differently by each health care plan. Because of this complexity, I would welcome any opportunity to study the process. It is my hope that a study would bring forth more information about:

- Ensuring prior-authorization lists are current and up to date with today's patients' needs and do not hinder patients getting access to timely care.
- Confirming prior authorizations work to reduce patient's medical costs and do not add to a patient's out of pocket costs.
- Reviewing the prior authorization denial process and validate the rate of prior authorization denial appeals that are overturned.
- Further understanding the prior-authorization approval process and who ultimately approves a prior authorization.
- Exploring how frequent prior authorization requirements are changing throughout a year and how are changes being communicated to both patients and the healthcare facilities.
- Discover if prior authorizations are delaying patients' ability to receive timely medical care.

It is the hope that this study could improve the prior authorizations process in North Dakota. It encourages a better understanding of the prior authorization process and how it not only affects the healthcare industry but, more importantly, how it affects patients' access to timely healthcare.

Thank you, Chairman Louser and the members of the Committee, for giving me the opportunity to play a part in improving healthcare for North Dakotans. We ask that you give the bill a Do Pass recommendation. Thank you for your consideration. I would be happy to answer any questions.

Respectfully,

Lexie Huebner, Pre-Service Manager
Altru Health Systems

House IBL Committee
SB 2389
March 14, 2023

Chairman Louser and Committee Members, my name is Joan Connell, and I am a physician in Bismarck. I am a member of the North Dakota Medical Association, NDMA 6th District President, and lead physician on the Physician Advisory Group. I am presenting this testimony on behalf of NDMA. The North Dakota Medical Association is the professional membership organization for North Dakota physicians, residents, and medical students. NDMA strongly supports SB 2389.

NDMA has long been concerned about the prior authorization process and its negative impact on patients, as we frequently hear from North Dakota physicians and patients about delays in care that result from these insurer protocols.

AMA survey data shows:

- 93% of physicians report care delays because of prior authorizations.
- 34% of physicians report that prior authorization has led to a serious adverse event for a patient in their care, such as hospitalization, permanent impairment, or death.
- 91% of physicians see prior authorization as having a negative effect on their patients' clinical outcomes.
- 82% of physicians indicated that patients abandon treatment due to authorization struggles with health insurers.

In addition to the harmful individual patient impact, there is no economic rationale for prior authorization. Costs to the health care system due to

prior authorization are playing out in physician practices all over North Dakota.

For example, physician offices find themselves using inordinate amounts of staff time and resources submitting prior authorization paperwork to justify medically necessary care for their patients to health plans.

- According to American Medical Association (AMA) data, on average, physician practices complete 41 prior authorizations per physician per week.
- 40% of physicians report that there are staff members in their offices that exclusively work on prior authorizations.
- This adds up to nearly two business days, or 13 hours, each week – dedicated to completing prior authorizations.

It is also important to recognize that these prior authorization burdens continue to place administrative pressure on physician practices – as they face staff shortages and attempt to regain their footing following the COVID-19 pandemic.

Now more than ever, administrative burdens, such as prior authorization, weigh down physician practices and consume resources – leading to fewer resources being allocated to direct patient care.

Moreover, by delaying care, undercutting recovery, and reducing the stability of patients' health, prior authorization increases workforce costs as patients miss work or may not be as productive in their jobs.

- AMA survey data show that of physicians who treat patients between the ages of 18 and 65 currently in the workforce, more than half report that prior authorization has interfered with a patient's ability to perform their job responsibilities.

While health plans see prior authorization as a cost-saving tool used to reduce spending on medically necessary care, the costs to patients, physician practices, employers, and the health care system is unjustifiable.

In 2018, in what looked like progress, health plans recognized the need to reduce the burden of prior authorization and agreed in a joint consensus

statement to make a series of improvements to the prior authorization process.

Despite increasing evidence of harm, however, most health plans have made no meaningful progress on reforms.

This means that passage of SB 2389 is necessary to improve access to care for patients in ND. Items that the study may cover include:

- Streamlining and right-sizing the prior authorization process.
- Reviewing the many states that have enacted similar reforms and sets an example for other policymakers to follow.
- How to reduce care delays from prior authorization requirements by requiring timely authorizations or denials from health plans.
- Increasing transparency in the process by requiring health plans to post the items and services subject to prior authorization restriction – allowing patients to make informed decisions about their health insurance and providers to access requirements easily.
- Reducing repeated prior authorizations, especially for those with chronic conditions.

I have several examples of patient's care in my own practice where patients have been harmed or care delayed due to the burden of our current prior authorization processes:

1. At every Children's Regional Asthma Clinic, we have 2-3 patients who are unable to access the recommended treatment that would be best for them due to prior authorization issues. This is so frustrating because the reason the insurance companies keep denying the prescriptions we write is because the insurance companies have not kept up to date with the most recent pediatric asthma guideline recommendations.
2. When prescribing anti-reflux medications, I need to consider the dosage form that will be best tolerated by my patient. Days will be wasted, in addition to manpower hours, going back and forth with the insurance company and the pharmacy to try to get the medication my patient needs.

3. I have some patients with diabetes who are started on insulin pumps with continuous glucose monitoring (CGM). Each brand of pumps and monitors has unique features that might make it a “best fit” for a given patient. These diabetes tools require prior approval, which sometimes results in a “less than best fit” pump or CGM for a patient. This situation can worsen if the patient switches insurance and the new insurance company does not accept the current insulin pump and CGM. The patient is stuck paying out of pocket for supplies for their current, still functional tools OR paying the deductible to replace their perfectly good pump and CGM for something that their new insurance covers. This can be a no win situation.

These examples highlight how a study of prior authorization is necessary. We look forward to supporting your efforts to enact this important legislation. Thank you and I would be happy to answer any questions.

2023 Senate Bill 2389

House Industry, Business and Labor Committee

Representative Scott Louser, Chairman

March 14, 2023

Chairman Louser and members of the House Industry, Business and Labor Committee, I am Tim Blasl, President of the North Dakota Hospital Association (NDHA). I testify in support of engrossed Senate Bill 2389 and ask that you give the bill a **Do Pass** recommendation.

I'm here today to introduce Senate Bill 2389, a bill that now seeks to study the value of standardizing the prior authorization process and aligning it with the best practices adopted throughout the country. 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 physicians 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 care providers.

I would now like to introduce Lexie Huebner from Altru Health. Ms. Huebner will be testifying on our behalf. She will be providing you more details regarding prior authorization and the impacts on their facility. Thank you.

Respectfully Submitted,

Tim Blasl, President
North Dakota Hospital Association

NORTH DAKOTA PSYCHIATRIC SOCIETY

A District Branch of the American Psychiatric Association

House Industry, Business and Labor Committee
Re: In Support of Senate Bill 2389
March 14th, 2023

Chairman Louser, esteemed Committee Members,

I am Gabriela Balf, a Bismarck psychiatrist and member of NDMA and of the ND Psychiatric Society. I testify on behalf of both NDPS and my own.

Over the years, NDMA and NDPS and their national-level organization AMA and APA, respectively, have expressed concern about the dangerous **gaps in patient care** that the Prior Authorization process has been proven to bring. I have many stories about people being discharged from the hospital where they were prescribed the only medication that stabilized them, the insurance did not approve or delayed the approval of that medication, and they ended up back in the hospital, or, like it has been documented, they died.

Sometimes, the preferred drug list and the Prior Authorization process ignore **several situations in real medical practice** that appear daily, at least in my experience as a specialist in treatment-refractory conditions like depression, bipolar disorder, schizophrenia, dementia with behavioral disturbances, personality disorders, etc. It is my daily reality as a psychiatrist, since psychotropic data in trials reflects the pharma's interests, and not the prevalence or importance of psychiatric conditions, and we have scarce means to treat our patients in a rural state. In psychiatry, it is a well-known fact that 85% of the prescribed medications are prescribed for an "off-label" use (Hefner et al., 2022). Conversely, **more than 80% of conditions in DSM do not have FDA approved medicines** (Rothschild, 2021), some with a huge societal prevalence and cost: Borderline Personality Disorder, Lewy Body Dementia, etc). Well-known databases like Cochrane or textbooks like Stephen Stahl's "Prescriber's Guide" delineate the uses and the studies published in peer-reviewed journals that support the use of those medications. Some psychiatric disorders have **gold-standard treatments that are not readily available in our state**: ECT (Electro Convulsive Treatment) or TMS (Transcranial Magnetic Stimulation) for treatment refractory depression, DBT (Dialectical Behavioral Therapy) for borderline personality disorder or CBT-I (Cognitive Behavioral Therapy for Insomnia), yet we psychiatrists still strive to bring relief and safety to our patients and their families.

A survey of American psychiatrists (Barnett & Bodkin, 2020) regarding prescription medications demonstrated that clinicians spent 38 minutes per PA phone call for patients of all ages and 60 minutes for pediatric patients. "Respondents predominantly believed the obligation to obtain PA reduces job satisfaction and negatively impacts patient care. A total of 59.9% of respondents reported employing either diagnosis modification or falsification of previous medication trials at least occasionally in order to obtain PA. A total of 66.6% refrained at least occasionally from prescribing preferred medications due to PA requirement or expectation of one."

At times, the prior authorization process includes discussions with unqualified gatekeepers, sometimes followed by blatant decline of a peer-to-peer discussion (drug classes, formulations, treatment options available in the region.)

Even when patients are extremely ill and, in our opinion, warrant **inpatient** level of care, a review (Barnett & Bodkin, 2019) found that: "However, 94% of private insurance plans still required PAs specifically for inpatient behavioral health care in 2014 – the average time spent average time spent per call was 59.6±30.3 minutes." In that review, **all** PA requests were approved.

In sum, we salute the strategy of studying these above dangerous or costly situations, and we propose the design includes a proposal from APA that is currently pursued in some versions of legislation in 25 states: APA's state model legislation on prior authorization reform. Briefly, the model would prohibit prior authorization in certain circumstances including for generic prescription drugs that are not on the controlled substances list, on any drugs that had been previously prescribed without interruption for six months, and on any long-acting injectable medication. There is also the provision that any denial of coverage be made by a board certified psychiatrist, requires that all denials be eligible for an expedited internal appeal process, and requires the insurer to render a decision within 48 hours of the requested expedited appeal process (relates to Section 1 point 2 of the Engrossed SB 2389.)

Thank you for working together with us for the safety and better health of our patients, our communities. I stand for questions.

Gabriela Balf, MD, MPH
Clin Assoc Prof – UND Dept of Psychiatry and Behavioral Science

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SANFORD HEALTH PLAN

March 20, 2023

Chairman Louser, Vice Chair Ostlie and Members of the House Industry, Business and Labor Committee –

My name is Dylan Wheeler, Head of Government Affairs for Sanford Health Plan, respectfully submitting remarks in **SUPPORT** to SB2389, as amended. To begin, as an integrated system and health plan, we openly welcome discussion around prior-authorization process because, ultimately, it leads to more efficient processes for our providers, and a more enjoyable plan experience for our members. We view SB2389 as an opportunity to dig in and find possible solutions to perceived problems – ideally looking towards a unique North Dakota solution.

Over the course of the last couple months we have engaged in discussions with bill proponents and initially took an opposition stance to the initial draft. This was due in large part to a handful of unresolved issues, broad scope, and operational/implementation impact it would have had. However, the amendment represents an initial compromise that we had brought forward to SB2389 prior to session and thus stand in support of an interim study looking to better understand prior-authorization processes. Looking forward, and as the study looks to address, it will take substantial input from all interested stakeholders to develop a potential North Dakota solution. Of note, in the near future, a Federal rule is likely to be published that may alleviate some concerns in the industry regarding flow and transparency of medical necessity information, patient prior-authorization history, and incorporating other best practices.

We appreciate the diligent consideration by the Senate Human Services committee, and Senator Cleary for bringing forth the amended version. We too, appreciate the consideration that this committee will bring as well.

Please let me know there may be any follow up questions that I can assist with.

Respectfully submitted,

Dylan Wheeler JD, MPA
Head of Government Affairs
Sanford Health Plan

Essentia Health

House Industry, Business, and Labor Committee
SB 2389
March 20, 2023

Chair Louser and committee members:

Thank you for the opportunity to be here today. My name is Andy Askew, and I serve as Essentia Health's Vice President of Public Policy.

Essentia Health is an integrated health system serving patients in North Dakota, Minnesota, and Wisconsin. Headquartered in Duluth, Minnesota, we roughly 15,000 employees who serve patients and communities through our 14 hospitals, 77 clinics, 6 long-term care facilities, 3 assisted living facilities, 3 independent living facilities, 6 ambulance services, 24 retail pharmacies, and 1 research institute. Essentia Health is an accredited accountable care organization by the National Committee for Quality Assurance and is focused on the triple aim of better health, improving patient experience, and lowering costs.

I'm here to introduce Senate Bill 2389, a bill that now seeks to study the value of standardizing the prior authorization process and aligning it with the best practices adopted throughout the country. 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. There's no doubt that prior authorization is an important tool in the day of rising health care costs, but the federal gov't and states have recognized that overly burdensome prior authorization requirements unnecessarily delay care for patients and drive administrative costs and provider burnout.

As a start to fixing prior authorization, states around the country have begun looking at how the volume of prior authorization is impacting patients, physicians and the health care system. While these programs may reduce the amount health insurers are paying on care in the short-term, delaying or denying medically necessary care is not an appropriate or effective long-term solution to reducing costs. Prior authorization must be used judiciously, efficiently, and in a manner that prevents cost-shifting onto patients, physicians, and other providers.

To ensure North Dakota strikes uses prior authorization as a tool to ensure patients are receiving the appropriate without unnecessarily delaying patient care or driving up administrative costs, the proponents of the bill, who you will hear from shortly, ask you to support studying how to align North Dakota's regulations of prior authorization with the best practices adopted throughout the country.

Thank you for your consideration.

Sincerely,

Andrew Askew
Vice President of Public Policy
Essentia Health

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Guiding Greater Health

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March 20, 2023

Chairman Scott Louser
House Industry, Business and Labor Committee
North Dakota State Capitol
600 East Boulevard Avenue
Bismarck, North Dakota 58505

Re: AHIP Concerns on SB 2389, *Relating to Prior Authorization for Health Insurance*

Dear Chairman Louser and Members of the Committee,

On behalf of AHIP, I am writing to express our concerns with SB 2389, *Relating to Prior Authorization for Health Insurance.* We appreciate the opportunity to provide feedback on the legislation and your consideration of our concerns.

Health insurance providers work diligently to ensure that enrollees are getting the right care, at the right time, from the right provider. Utilization management tools, like prior authorization, are critically important to ensure enrollees receive safe, evidence-based, timely, and high-quality care. These tools rely upon provider-developed clinical guidelines, consultation with specialists, input from medical associations, and nationally recognized care criteria to ensure consideration of the latest medical evidence based on the highest standards of care.

SB 2389 will increase health care costs and exacerbate inappropriate or unsafe treatments. As proposed, AHIP is concerned that SB 2389 is broadly written and could undermine the essential role of prior authorization in addressing the long-standing challenges to safe and affordable evidence-based health care. Under the supervision of medical professionals, prior authorization reduces inappropriate, unsafe and low value patient care and it helps to lower a patient's out-of-pocket costs, protect patients, prevent overuse, misuse or unnecessary (or potentially harmful) care, and ensure care is consistent with evidence-based practices.

Prior authorization is only used in limited circumstances and the percentage of services requiring prior authorization is relatively small (typically less than 15 percent). However, health plans report that up to 25 percent of prior authorization requests they receive from clinicians are for care that is not supported by medical evidence and 65% of physicians themselves have reported that at least 15-30 percent of medical care is unnecessary. A JAMA study estimates that waste in our health care system ranged from $760 billion to $935 billion, approximately 25 percent of total health care spending.

SB 2389 prioritizes provider payment over patient safety. AHIP is concerned that SB 2389 creates a review and appeals process that guarantees provider payments at the expense of patient safety. Numerous studies show that Americans frequently receive inappropriate care including overuse, misuse, or underuse of health care services. In fact, data shows that unnecessary treatments are associated with complications or adverse events, and billions of dollars are wasted annually on excessive testing and treatment. A recent study from Johns Hopkins suggests that doctor errors, including "unwarranted variation in physician practice patterns that lack accountability," were the third leading cause of death in the U.S. prior to COVID-19.

SB 2389 could exacerbate delays in patient care and increase administrative costs. AHIP is concerned that the proposed timelines in the legislation are arbitrary and could have the unintended consequences of increasing denials and unsafe treatments. We should instead be striving to achieve uniformity with existing

standards so that clinicians, patients, advocate organizations, and health insurance providers can have standard protocols for such reviews for most patients.

Health insurance providers already meet expedited and standard timeframes for prior authorization determinations for urgent and non-urgent care. AHIP is concerned that SB 2389 will lead to timeframes being arbitrarily rushed, which could lead to prior authorization requests being denied based on incomplete information from the patient's physician. Health care providers have a shared responsibility and delays in receiving the necessary information from providers hinder the ability of insurance providers to make determinations in a timely manner.

Moreover, the approach in SB 2389 could lead to inappropriate approvals that are not clinically justified and may result in patient harm, higher toxicity of treatment, or more invasive treatment for the patient than what may be medically necessary. There are many circumstances when a patient is on a treatment plan and health insurance providers need to check in with health care providers to see if the patient's treatment is effective and their goals are being achieved.

Health insurance providers are implementing innovative solutions to streamline processes, improve the quality of care, reduce costs, and enhance patients' overall care experience.
In 2018, AHIP and stakeholders representing providers and pharmacists developed a Consensus Statement recommending opportunities to improve the prior authorization process. Since then, health insurance providers have taken several extensive steps to improve the prior authorization for patients and providers alike, including increasing the adoption of electronic prior authorization (epic). In 2020, AHIP launched the Fast Prior Authorization Technology Highway (Fast PATH) initiative in 2020 to better understand the impact of ePA on improving the PA process, making health care more efficient and effective.

Health care experts and clinical leaders have also called for wider adoption of evidence-based guidelines. The mission of the Choosing Wisely Initiative – which was founded by physicians and clinicians – is to help inform patients and ensure that any test, treatment, drug or procedure is "supported by evidence, not duplicative of other tests procedures, free from harm, and truly necessary." That is what prior authorization delivers.

For these reasons, AHIP respectfully requests that the Industry Business and Labor Committee not support SB 2389 as introduced. We appreciate the opportunity to provide feedback on the legislation and your consideration of our concerns.

Sincerely,

Karlee Tebbutt

Karlee Tebbutt
Regional Director, State Affairs
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