North Dakota Legislative Council

Prepared for the Health Care Committee
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HEALTH INSURANCE PRIOR AUTHORIZATION STUDY - BACKGROUND MEMORANDUM

INTRODUCTION

Section 1 of Senate Bill No. 2389 (2023) (Appendix A) directs the Legislative Management to study prior authorization (PA) in health benefit plans. The study must include consideration of:

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

The study also 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.

BACKGROUND

As introduced, Senate Bill No. 2389 would have created new requirements, restrictions, and timelines to standardize the PA process, including mandating the disclosure of PA requirements and restrictions; required a licensed physician to make adverse determinations; prohibited the use of PA for emergency services and the institution of timelines for urgent and nonurgent circumstances; required typical PAs to be valid for 6 months, PAs for chronic conditions to be valid for 12 months, and prohibited the ability to revoke, limit, or condition an authorization within 45 days following the date of receipt; and standardized the timeline of PA appeals. The bill was amended by the Senate to provide for this study.

The American Medical Association (AMA) describes the PA process as a cost-control mechanism that requires health care providers to seek advanced approval from health insurers before the delivery of a service, device, supply, or medication to ensure cost coverage. As health expenditures increased throughout the 1960s, programs to review insurance claims for appropriateness also increased. By the mid-1970s, most hospitals and the federal government were applying mandated utilization review programs for health expenditures.[1] Utilization review that is conducted before the delivery of a health care service is known as PA. Purchasers of health care, including private payers and the government, have become more aggressive in detecting and eliminating the use of nonessential health goods and services through further expansion of PA.

Health care providers submit PA requests in response to patient needs and await approval or denial before the service or good is administered to the patient.[2] Providers must be aware of a patient's individual insurance plan and the plan's intricacies to know what is required with each PA request. A request for PA can be approved, approved or denied in part, or denied. If a request for PA is denied, a provider may appeal the denial through another administrative process, which varies by state and payer.

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[1] *The Evolution of Prior Authorizations*, Accreditation Council for Medical Affairs, December 28, 2021.

[2] https://www.aha.org/lettercomment/2021-10-18-aha-urges-cms-address-prior-authorization-issues-affecting-medicare, *AHA Urges CMS to Address Prior Authorization Issues Affecting Medicare Advantage Patients*, American Hospital Association, October 18, 2021.

Goals of Prior Authorization

The goal of PA is to ensure the prescribed service, device, supply, or medication is medically necessary, clinically appropriate, and evidenced based. Prior authorization also aims to shift utilization towards lower-cost alternatives, namely when there are no additional safety or efficacy benefits associated with the higher priced alternative. Requiring PA ensures prescribed treatments align with specific Food and Drug Administration-approved indications in which the benefits to the patient outweigh the potential risks.

Barriers Imposed by Prior Authorizations

While PA is intended to contain costs and ensure appropriate utilization, both patients and physicians have identified significant barriers associated with the PA process. Concerns include care delays, treatment abandonment, serious adverse events including loss of life, increased administrative burden, and high processing costs. The American Medical Association identifies the PA process as the most common barrier to accessing medically necessary patient care, with 93 percent of physicians experiencing delays and 91 percent reporting a negative effect on patients' clinical outcomes. Each provider completes an average of 41 PAs per week, and 40 percent indicate they have hired full-time staff solely to handle PAs. Physicians have asserted the PA practice allows an unlicensed entity to practice medicine with limited patient information. Further, health insurers making approval determinations have an economic interest in denying patient care.

A 2021 Kaiser Family Foundation Issue Brief found that almost 99 percent of Medicare Advantage enrollees are in plans that require PA for some services.[3] In addition, 84 percent of Medicare Advantage enrollees are in plans that apply PA to a mental health service. An April 2022 report from the United States Department of Health and Human Services Office of the Inspector General (OIG) found 13 percent of PA denials by Medicare Advantage plans were for benefits that should otherwise have been covered under Medicare. The OIG cited use of clinical guidelines not contained in Medicare coverage rules as one reason for the improper denials, as well as managed care plans requesting additional unnecessary documentation. The OIG recommended and the Department of Health and Human Services agreed that the Centers for Medicare and Medicaid Services (CMS) should take a closer look at the appropriateness of clinical criteria used by Medicare Advantage plans in making coverage determinations.[4]

Many states, including North Dakota, do not have clear timeline requirements that need to be met by the utilization review committee when responding to PA requests. This lack of standardization often leads to delays in care which increase burdens on the health care system as patients then may require additional or more intensive treatment methods. The PA process not only is burdensome to providers, but also to patients. Patients may choose to forgo or discontinue pertinent care in response to PA requirements. Data from AMA shows 82 percent of physicians indicated that patients abandon treatment due to authorization struggles with health insurers.

Providers also indicate frustration with unclear reasoning when a PA is denied by health insurers resulting in greater administrative burden. Providers and health insurers often use different sources of clinical information in their decision making process, leading to discrepancies. Many states do not require the utilization review entity to disclose the basis for its decisionmaking. North Dakota is one among several states that lack a standardized appeal process with timelines and transparency.

NORTH DAKOTA STATUTORY PROVISIONS

North Dakota has a patchwork of statutory provisions relating to PA usage and practice. North Dakota Century Code Section 23-01-38 requires PA requests for drugs to be accessible on the prescribing provider's electronic software system and to be accepted electronically by the applicable utilization review committee, payer, insurance company, or pharmacy benefit manager. Chapter 26.1-26.4 outlines requirements for health care service utilization review, requiring agents to follow minimum standards set by the federal government, and prohibiting utilization review denial of and PA usage for emergency services. Section 26.1-36-03.1 requires insurers to disclose a general description of any utilization review policies and procedures, including a description of any required PA requirements and appeal procedures. Also included within the Century Code are provisions:

- Prohibiting a dental benefit plan from retroactively denying coverage for services that previously have received prior authorization, unless certain conditions are met (Chapter 26.1-36.9);

[3] https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2023-premiums-out-of-pocket-limits-cost-sharing-supplemental-benefits-prior-authorization-and-star-ratings/, *Medicare Advantage in 2023: Premiums, Out-of-Pocket Limits, Cost Sharing, Supplemental Benefits, Prior Authorization, and Star Ratings*, Kaiser Family Foundation, August 9, 2023.

[4] https://oig.hhs.gov/oei/reports/OEI-09-18-00260.asp?hero=mao-report-04-28-2022, Some Medicare Advantage Organization Denials of Prior Authorization Requests Raise Concerns About Beneficiary Access to Medically Necessary Care, United States Department of Health and Human Services Office of the Inspector General, April 27, 2022.

- Requiring providers to obtain PA from Preferred Provider Organization health plans prior to obtaining air ambulance services (Section 26.1-47-10); and
- Creating a PA drug program for individuals on medical assistance which meets federal requirements (Chapter 50-24.6).

AMERICAN MEDICAL ASSOCIATION MODEL LAWS

The American Medical Association has identified 21 PA and Utilization Management Reform Principles (Appendix B) to reduce the negative impact on patients, providers, and the health care system. The principles identified were used to develop the AMA's model law (Appendix C), and many states have implemented a number of these guidelines into their respective PA policies. The principles address the following areas:

- Clinical validity;
- Continuity of care;
- Transparency and fairness;
- Timely access and administrative efficiency; and
- Alternatives and exemptions.

The goal of AMA in reforming the PA process is to ensure patient-centered care by decreasing the manual, time-consuming burden of PA on providers. The association also has compiled a chart (Appendix D) comparing how the laws governing the PA process differ from state-to-state.

PRIOR AUTHORIZATION IN OTHER STATES

Minnesota

Prior authorization processes in Minnesota were reformed in 2018 and modified in 2020. The Minnesota legislature adopted several changes aimed at improving the state's PA process including:

- Requiring health insurers to provide a platform for providers to submit electronic requests for PA 24/7;
- Mandating utilization review organizations to have written standards governing PA, including procedures to determine medical necessity, a system to promptly inform patients and providers of determinations, and appeal procedures;
- Prohibiting the use of PA for emergency services, and standardizing response times from 48 hours to 5 business days;
- Prohibiting the revocation, limiting, or conditioning of a PA;
- Requiring 45-day notice for any new or amended requirements; and
- Requiring statistics of PA approvals, denials, and appeals to be accessibly published on health insurers' websites.

Arkansas

In 2015, Arkansas passed the "Prior Authorization Transparency Act" to prevent the hinderance of patient care, protect the practice of medicine, and secure a fair PA review process. Many of the model laws and policies outlined by AMA were adopted including:

- Implementing an electronic PA program;
- Standardizing response times from 24 hours to 2 business days, depending on urgency;
- Prohibiting the ability to rescind, condition, or limit PA based upon medical necessity;
- Requiring statistics of PA approvals, denials, and appeals to be accessibly published on health insurance providers' websites;
- Requiring all PA requirements to be disclosed, including any written clinical criteria, and adverse determinations to be based upon medical necessity or appropriateness of services and informed by written clinical criteria;
- Requiring 60-day notice for any new or amended PA requirements;

- Allowing providers to submit benefit plan inquiries for services not yet provided to determine if the service meets requirements for payment;
- Requiring PA determinations to include coverage and eligibility; and
- Requiring adverse determinations to be made by an unrestricted Arkansas medical licensee and allowing a physician to request the PA be reviewed by a physician of the same specialty.

Texas

Texas is the first state to enact a certification process known as "gold carding" in which physicians who have a 90 percent or higher PA approval rate for certain services over a 6-month period are exempt from PA requirements for those services. This policy empowers physicians who are consistent with the prescribing guidelines utilized by health insurers and reduces the burden on providers.

STUDY APPROACH

In conducting this study, the committee may wish to receive testimony from:

- North Dakota patients and health care providers regarding concerns associated with PA;
- The Insurance Department regarding the use of PA in the state and concerns associated with PA;
- The state's health insurers regarding their PA processes, statistics, and practices in the state and other states;
- The National Conference of State Legislatures regarding what other states have done to reform PA processes and federal law impacts; and
- Stakeholders and commercial insurance plan providers.

ATTACH:4