Legislative Council
600 East Boulevard Avenue, Bismarck, ND 58505

HEALTH CARE COMMITTEE

Tuesday, January 30, 2024
Roughrider Room, State Capitol
Bismarck, North Dakota

Senator Kyle Davison, Chairman, called the meeting to order at 9:00 a.m.

Members present: Senators Kyle Davison, Sean Cleary, Tim Mathern; Representatives Gretchen Dobervich*, Clayton Fegley, LaurieBeth Hager, Dawson Holle, Carrie McLeod, Jon O. Nelson, Emily O'Brien, Karen M. Rohr, Greg Stemen, Michelle Strinden

Members absent: Senator Kristin Roers; Representatives Mary Schneider, Robin Weisz

Others present: Margaret Reynolds, Cigna Healthcare; Megan Houn and Cindy Cameron, Blue Cross Blue Shield; Karlee Tebbutt, America's Health Insurance Plans; Nicholas Bradbury, CHI St. Alexius Health; Duncan Ackerman, The Bone and Joint Center; Matthew Schafer, Medica; Clint MacKinney, College of Public Health; and Jon Godfread, Insurance Commissioner

See Appendix A for additional persons present.

**Attended remotely*

It was moved by Representative Nelson, seconded by Representative O'Brien, and carried on a voice vote that the minutes of the November 1, 2023, meeting be approved as distributed.

PRIOR AUTHORIZATION STUDY

Ms. Margaret Reynolds, Senior Director, State Government Affairs Principal, Cigna Healthcare, provided testimony (Appendix B) relating to prescriptions and the committee's study of prior authorizations in health benefit plans. She noted:

- A licensed medical director approves all denial determinations at Cigna Healthcare.
- If the Legislative Assembly undertakes prior authorization reform to expedite patient care, establishing statutory deadlines and an electronic means to receive and process prior authorization requests should be considered.
- Gold card programs could put patients at risk because these programs require fewer checks.
- The Legislative Assembly is responsible for convening necessary stakeholders to address concerns with prior authorization.

Chairman Davison requested supplemental information from Ms. Reynolds relating to questions raised by the committee. Ms. Reynolds sent the committee a plan (Appendix C) commissioned by the Massachusetts Association of Health Plans and an email (Appendix D) responding to the committee's questions.

Ms. Megan Houn, Vice President of Government Affairs and Public Policy, Blue Cross Blue Shield of North Dakota, introduced Ms. Cindy Cameron, Manager of Medical Review and Utilization Management, Blue Cross Blue Shield of North Dakota, to the committee.

Ms. Cameron provided testimony (Appendix E) relating to the committee's study of prior authorizations in health benefit plans. She noted:

- Internal collaboration efforts of Blue Cross Blue Shield of North Dakota (BCBSND) include advisory committees, policy review, and outreach to community health care providers.

- Lack of behavioral health treatment access has resulted in BCBSND removing some behavioral health services from its prior authorization list.
- BCBSND has fewer services requiring prior authorization than most health insurers.
- Due to internal controls, it can take BCBSND up to 1 year to remove a service from its prior authorization list, but efforts are ongoing to make the process more efficient.
- Only 59 percent of all prior authorization requests are received electronically. To increase this number, BCBSND is facilitating and educating providers regarding electronic prior authorization capabilities.

Ms. Karlee Tebbutt, Regional Director, State Affairs, America's Health Insurance Plans, provided testimony (Appendix F) relating to the role of insurance providers and the committee's study of prior authorizations in health benefit plans. She noted:

- Health plans use evidence-based guidelines and the latest medical literature to stay informed about services and procedures that will cover certain members, subject to prior authorization.
- Prior authorization is not designed to dictate the type of care provided to the patient, but rather to provide a safety check based on the latest medical evidence, practices, and technology.
- America's Health Insurance Plans has five goals to improve the prior authorization process. These goals are selective application of prior authorization, program review and volume adjustment, transparency and communication, automation, and continuity of care.

Ms. Courtney Koebele, Executive Director, North Dakota Medical Foundation, introduced Dr. Nicholas Bradbury, Physician, CHI St. Alexius Health, Dr. J'Patrick Fahn, Chief Medical Officer, CHI St. Alexius Health, and Dr. Duncan Ackerman, Physician, The Bone and Joint Center, to the committee.

Dr. Bradbury provided testimony (Appendix G) relating to the committee's study of prior authorizations in health benefit plans. He noted:

- Insurance providers and physicians rarely communicate directly regarding prior authorization requests.
- About 90 percent of his recommended procedures are initially denied through the prior authorization process. Medical directors at certain insurance companies spend about 1.2 seconds reviewing a patient's claim.
- Vetted physicians within an insurance provider's network should be trusted to make the correct decisions.
- Prior authorizations should be reviewed by qualified specialists within the field of the proposed treatment.
- No penalties are in place for insurance providers that improperly deny valid prior authorization requests.

Dr. Fahn provided testimony (Appendix H) relating to the committee's study of prior authorizations in health benefit plans. He noted requiring insurance companies to implement a bona fide peer-to-peer mechanism would improve the prior authorization process.

Dr. Ackerman provided testimony (Appendix I) relating to the committee's study of prior authorizations in health benefit plans. He noted the lack of peer-to-peer collaboration is prevalent across all specialties in the prior authorization process.

Mr. Matthew Schafer, Director of Government Relations, Medica, provided testimony (Appendix J) relating to the committee's study of prior authorizations in health benefit plans.

Committee members expressed the desire to explore gold card programs, sensible prior authorization standards, accountability and transparency in the prior authorization process, increased peer-to-peer collaboration, and potential consequences for improper prior authorization denials.

VALUE-BASED CARE STUDY - RURAL HEALTH

Mr. Brad Gibbens, MPA, Acting Director, Center for Rural Health, and Assistant Professor, University of North Dakota School of Medicine and Health Sciences, provided testimony (Appendix K) relating to rural health care in North Dakota. He noted:

- 62 percent of rural hospitals in the state belong to an accountable care organization.

- Rural providers view value-based care as a model to deliver better health outcomes for patients and a feasible financial mechanism to continue providing care.
- Medicare must pay accountable care organizations to properly administer value-based care. Even with these payments, accountable care organizations have saved Medicare about $8 billion.

Dr. Clint MacKinney, Clinical Associate Professor, College of Public Health, provided testimony (Appendix L) relating to value-based care and payments in North Dakota and the United States. He noted:

- Maryland has an all-payer system in which commercial payers pay the same rates for the same services.
- For the past 35 years, Maryland has incrementally added value-based metrics to its health care payment systems.
- Value-based care focuses on metrics including clinical quality and patient experience.

Mr. Alfred Sams, President, Rough Rider High Value Network, provided testimony (Appendix M) relating to the Rough Rider High Value Network (RRHVN). He noted:

- When the RRHVN was formed, all independent critical access hospitals were invited to join the network and only one presently is not a member.
- The RRHVN is working to establish payer agnostic quality care metrics for network members to follow.
- To evaluate clinical quality, the RRHVN is interested in tracking breast cancer screening rates, colorectal cancer screening rates, cervical cancer screening rates, high blood pressure control, and diabetes control.
- Member dues, shared-savings from value programs, strategic partnerships, and sponsorships are revenue streams that will help sustain the RRHVN.

CONTRACT NURSING STUDY

Ms. Nikki Wegner, President, North Dakota Long Term Care Association, provided testimony (Appendix N) relating to minimum standards for businesses to provide contract nursing. She noted:

- The proposal for contract nursing applies to all health care facilities, not just nursing homes.
- The North Dakota Long Term Care Association is working with the Office of Legal Immigration to develop the nursing workforce.

At the request of the committee, Ms. Wegner provided additional information (Appendix O) related to questions posed by the committee.

Ms. Wendi Johnston, Staffing Manager, and Mr. Sheriff Sharma, Director of Business Development, DTN Staffing, provided testimony relating to experiences providing care and minimum standards for businesses to provide contract nursing. They noted:

- DTN Staffing has implemented several standards to prioritize patient and resident safety.
- DTN Staffing is 1 of 45 staffing agencies in the state and has a market share of about 40 percent for contract nurses.
- In general, nurses are becoming more selective regarding shifts and employment locations.
- DTN Staffing does not offer a different pay rate for different shifts.

REINSURANCE ASSOCIATION OF NORTH DAKOTA AND ESSENTIAL HEALTH BENEFITS

Mr. Jon Godfread, Insurance Commissioner, provided testimony (Appendix P) relating to updates to the Reinsurance Association of North Dakota (RAND). He noted:

- In the past, consumers paid premium taxes to insurance providers, and the insurance providers forwarded those taxes to the Insurance Department for deposit into the general fund. However, because of the RAND program, consumers will be able to keep the money previously paid in taxes, resulting in a $20 million to $25 million reduction in general fund revenues.
- It is essential to have insurance providers on the RAND board because insurance providers incur the tax assessments.
- If the RAND program is discontinued, insurance premiums for consumers could increase by 35 percent.

Mr. Godfread provided testimony (Appendix Q) relating to updates to essential health benefits. He noted:

- North Dakota is the first state to cover morbid obesity in its essential health benefits plan.
- The essential health benefits plan applies to individuals who purchase insurance through the individual marketplace.
- Under the Affordable Care Act and associated federal regulations, the state health insurance regulator determines coverage for a state's essential health benefit plan.

No further business appearing, Chairman Davison adjourned the meeting at 3:28 p.m.

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Dustin A. Richard
Counsel

ATTACH:17