Senate Bill 2280
House Committee on Industry, Business, and Labor
March 17, 2025
AHIP Testimony

Thank you for the opportunity to speak before you today. My name is Alex Kelsch, and I am testifying today on behalf of America's Health Insurance Plans (AHIP). [1]

AHIP appreciates the opportunity to provide comments on SB 2280. Health plans share your commitment to ensuring patients have access to high-quality, affordable health care.

It is important to recognize that the prior authorization process serves an important purpose. Prior authorization is a critical tool used to prevent unnecessary or inappropriate treatments that could result in patient harm. For example patients with low-risk lower back pain frequently receive early imaging tests, which do not improve outcomes and can lead to unnecessary surgery and office visits, undue stress, excessive exposure to radiation, lost productivity, potential harms from prescription opioids, and avoidable costs.[2] This is why it is so important that health plans, providers, and hospitals work together to prevent unnecessary or inappropriate treatments that could result in patient harm.

Prior authorization also ensures that patients receive the most cost-effective care and do not receive unnecessary treatments. Experts agree that roughly a quarter of all medical spending is wasteful or low-value, costing the U.S. $340 billion annually[3] and 87% percent of doctors have reported negative impacts from low-value care.[4]

We appreciate the sponsors' efforts to work with health plans in the Senate on amendments to improve the bill. AHIP would like to make the following suggestions on additional amendments:

- **Include North Dakota public programs.** We understand the proponents desire for uniformity in the marketplaces with respect to prior authorization. It is important to note that the requirements in SB 2280 will not bring more uniformity to the market since it excludes large segments of the North Dakota regulated market - those being Medicaid, Medicaid Expansion, WSI, and the North Dakota Public Employees Retirement System or NDPERS. The current applicability would only impact about 20%-25% of North Dakota health insurance policies.
- **Remove the references to dental services**. Dental plans rarely utilize prior authorizations as described in the bill. They are structured as a limited scope excepted benefit, meaning there is a focus on preventive coverage, not complex procedures that would require prior authorization. Because dental plans have a limited benefit, they often utilize nonbinding pretreatment estimates, which are requested by the dentist, not required by the plan. These are used to develop treatment plans for a patient and can be adjusted based on the patient's needs. Therefore, limited scope dental plans should not be included in this bill.

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[1] 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.

[2] Prior Authorization Promotes Evidence-Based Care That Is Safe and Affordable for Patients. AHIP. November 2023.

[3] Low-Value Care. University of Michigan V-BID Center. February 2022.

[4] Ganguli, Ishani. Characteristics of Low-Value Services Identified in US Choosing Wisely Recommendations. JAMA Internal Medicine. February 1, 2022.

- **Provide a technical clarification to the continuity of care section.** AHIP requests the following clarifying langue to note the continuity of care section is for covered services and requesting providers submit the appropriate documentation.
    - 26.1-36.12-13. 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, unless a change in clinical or medical guidelines would negatively affect an enrollee, a prior authorization review organization shall honor a prior authorization granted to an enrollee from a previous prior authorization review organization for at least the initial sixty days of an enrollee's coverage under a new policy **for covered services under the new policy. The enrollee or the enrollee's health care provider must submit documentation of the previous prior authorization to the new policy company in accordance with the new policy company's procedures**.

Thank you for the opportunity to comments.