Senate Bill 2280 – Support
February 5, 2025
Senate Industry, Business and Labor Committee
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Chairman Barta and Members of the Committee,

My name is Janelle Moos, Associate State Director of Advocacy with AARP North Dakota. AARP is a nonpartisan, nonprofit, nationwide organization with nearly 38 million members. Approximately 82,000 of those members live in North Dakota.

Prior authorization, as you may already know, is preapproval for medical services or prescription drugs that health insurance plans often require before they'll cover the cost. Plans put these requirements in place to avoid paying for unnecessary services or expensive procedures and drugs when a lower-cost version that's available could work just as well.

Prior authorization also lets patients know ahead of time if their plan will approve something that's not always covered rather than having to appeal a denial after the fact. But how often and under what circumstances prior authorization is required depends on the health plan. For example, while original Medicare has a few prior authorization requirements, private Medicare Advantage plans and Part D prescription drug plans use this procedure more often.

A new study by KFF, formerly the Kaiser Family Foundation, released in August 2024, found Medicare Advantage prior authorization requests increased significantly from 37 million in 2019 to more than 46 million in 2022. The share of denied prior authorization requests also increased after several years of being stable, from 5.8 percent in 2021 up to 7.4 percent in 2022. What's more, KFF uncovered that the majority of denials in Medicare Advantage plans were overturned on appeal.

Two important sections of SB 2280 that align with AARP policy pertains to transparency and putting guardrails in place for who conducts prior authorization reviews and the process by which they are conducted. Our policy that supports authorization/ utilization review relates primarily to Medicare Advantage, but can be applied to the broader health insurance market including:

- Adverse UR decisions must be made by clinically qualified personnel and reviewed by active practitioners in the same or similar specialty. Reviewing clinicians need not be residents of the state where the enrollee whose claim is being reviewed resides. Reviewers must not receive financial compensation based directly or indirectly on the number or volume of certification denials.
- Certification decisions must be made at least as rapidly as the medical situation requires to protect the beneficiary's health and permit a meaningful appeal. Denials must be accompanied by clear information on the reasons for denial as well as instructions on how to appeal the denial. https://policybook.aarp.org/policy-book/health/section-c-medicare/medicare-part-c-medicare-advantage-ma-private-plans/medicare-advantage-standards#node-18896

SB 2280 also prohibits prior authorization for emergency services, which also lines up with AARP policy:

- Patients should be covered for all necessary care associated with the emergency. Health plans should be prohibited from requiring prior authorization for emergency services. https://policybook.aarp.org/policy-book/health/section-c-medicare/medicare-part-c-medicare-advantage-ma-private-plans/medicare-advantage-standards#node-18896:

Inappropriate prior authorization denials can have serious health implications for MA enrollees, especially those with significant medical needs. By delaying or preventing access to medically necessary care, the often-lengthy pre-approval process can disrupt care delivery or lead people to abandon their treatment. It can also result in serious adverse events such as hospitalization or even death. In other cases, improper coverage denials create a significant financial barrier to accessing medical services ordered by a health care provider because, without insurance, therefore, we urge you to look favorably upon SB 2280.

Thank you.