

October 2, 2026

Senate Finance Committee
Attn: Health Coverage Reforms Request for Information
219 Dirksen Senate Office Building
Washington, DC 20510

Comments submitted electronically via email to insurance@finance.senate.gov

Re: Request for Information on Health Coverage Reforms

Dear Ranking Member Wyden:

The Association for Molecular Pathology (AMP) appreciates the opportunity to provide comments in response to the Senate Finance Committee's Request for Information (RFI), *Health Coverage That Works for Everyone*. AMP is an international medical and professional association representing approximately 3,100 physicians, doctoral scientists, and medical technologists who perform or are involved with laboratory testing based on knowledge derived from molecular biology, genetics, and genomics. Our membership includes professionals from academic medicine, hospital-based and private clinical laboratories, government, and the in vitro diagnostics industry.

As policymakers contemplate opportunities to reform the private payer healthcare system, AMP urges Congress to meaningfully address the ongoing payer prior authorization practices that can delay patient access to medically necessary testing. To assist the Senate Finance Committee in these efforts, AMP developed a [position statement](#) outlining principles and recommendations to improve the prior authorization process, including reducing administrative burden, improving transparency, establishing more timely processes, and ensuring that prior authorization requirements do not interfere with appropriate patient care. Many of these recommendations were developed in the context of challenges laboratories face under Medicare Advantage, but as the Committee is aware, the underlying problems are not unique to Medicare. Clinical laboratories navigate prior authorization requirements across public and private payers, as well as through laboratory benefit managers (LBMs), and many of the same barriers arise across markets. Accordingly, AMP believes these principles can help inform the Committee's consideration of broader prior authorization reforms across private health insurance markets. Drawing on these principles, AMP offers the following comments on several of the approaches and concepts identified in the RFI.

Limitations or Bans

AMP supports limiting prior authorization requirements when delays could adversely affect patient care or compromise a laboratory specimen's viability. These concerns are particularly relevant for molecular diagnostic testing, which is routinely used to guide urgent treatment decisions for patients with advanced cancers, infectious diseases, transplant-related conditions,

and other serious illnesses. Many molecular tests rely on blood or tissue specimens that may lose viability if testing is delayed **post** sample collection. In these circumstances, laboratories may need to begin processing a specimen before a prior authorization determination is complete to avoid compromising patient care or specimen integrity, leaving laboratories in a difficult position. Delayed testing could adversely affect patient care but proceeding with testing could expose the laboratory to significant financial risk if authorization is denied and subsequent reimbursement is withheld. Despite the financial risk, laboratories routinely put patients first and proceed with medically necessary testing when a delay could compromise patient care or specimen integrity. Given these realities, AMP recommends, at a minimum, allowing concurrent prior authorization when a laboratory test must be performed immediately because of clinical circumstances or specimen viability and, in these situations, allowing for other aspects of the coverage determination process, including appeal, to take place regardless of the prior authorization determination outcome. To better improve patient care, AMP encourages policymakers to consider limiting or waiving prior authorization for certain time-sensitive laboratory tests where requiring advance approval could delay medically necessary care (e.g. when personalized therapy options depend on the results of the test, and when the viability of the sample requires running it within a specified timeframe).

Such examples are:

- Acute leukemia, where molecular findings such as FLT3 can determine targeted therapy
- Advanced cancer, where molecular testing of a limited or irreplaceable biopsy can determine treatment selection
- Suspected meningitis/encephalitis, where CSF requires rapid processing and results can immediately affect antimicrobial therapy
- Fresh bone marrow/blood specimens for hematologic malignancies, where delays may compromise cellular viability and diagnostic yield

These protections should apply universally to all public and private health insurance so that patient access to timely laboratory testing is not dependent on the type of coverage.

Reviewer requirements

AMP agrees that appropriate clinical expertise is essential when prior authorization decisions require clinical judgment. This is particularly important for molecular diagnostic testing, which is complex, rapidly evolving, and may require specialized knowledge of the test, its clinical application, current standards of care, and the relevant medical evidence. Payers and LBMs should ensure that individuals responsible for reviewing prior authorization requests have expertise appropriate to the service under consideration and are able to meaningfully evaluate the clinical information submitted by the ordering provider or laboratory. AMP also cautions against relying on artificial intelligence (AI), algorithms, or other automated tools as substitutes for appropriate clinical review. While technology can help streamline administrative aspects of prior authorization, automated tools should not independently make medical necessity determinations or deny access to medically necessary testing. When clinical judgment is required, decisions should involve an appropriately qualified clinician with relevant expertise who can consider the patient's individual circumstances and the applicable clinical evidence.

Shifting the Burden to Insurers

AMP supports the goals of the RFI's proposed approach to shifting the burden of prior authorization to insurers, particularly reducing the administrative burden placed on providers and patients and ensuring that prior authorization requirements do not unnecessarily delay access to medically necessary care. AMP believes that when a payer requires prior authorization, the payer should bear greater responsibility for making the process clear, accessible, and efficient for the providers required to navigate it.

Laboratory professionals should be permitted to initiate prior authorization requests for the testing services they furnish. Payers often require the ordering provider to submit the prior authorization request, even though the clinical laboratory is the provider that performs the service and is directly reimbursed. This inappropriate barrier requires the laboratory to re-engage the ordering provider to complete an administrative process for a service the laboratory itself will provide, wasting providers' time and potentially delaying patient care. AMP recommends establishing a consistent standard across payers that allows the laboratory, as a paid provider of services, to initiate and participate directly in the prior authorization process.

Payers should also bear responsibility for clearly communicating which services require prior authorization, which coverage criteria apply, and what information is necessary to obtain approval. Providers should not have to navigate opaque or hard-to-access payer policies to determine whether authorization is required or what information to submit. Prior authorization requirements, applicable coverage criteria, and documentation requirements should be readily available to providers so they can initiate and complete requests without unnecessary administrative back-and-forth.

Standardizing Prior Authorization

AMP strongly supports greater standardization of prior authorization across health insurance markets. Currently, clinical laboratories must navigate different payer requirements for prior authorization, including what information must be submitted, how that information must be documented, and how requests and supporting materials must be transmitted. Greater consistency across payers would reduce administrative burden and make the prior authorization process more predictable and efficient for providers and patients.

AMP also supports standardized electronic prior authorization processes that allow providers to readily determine which items and services require authorization, identify the documentation necessary for approval, electronically submit the required information, receive a response, and track the status of a request. All information necessary to initiate and complete a prior authorization request should be readily accessible in a single location. AMP also supports requirements for certain payers to implement and maintain application programming interfaces (APIs) that facilitate these functions and encourages policymakers to build on existing efforts by promoting consistent electronic prior authorization standards across private health insurance markets.

Standardization should also extend to documentation requirements. Under any new standard, payers should not be allowed to request duplicative documentation when existing medical records submitted to the payer already contain sufficient information to establish medical

necessity. Test requisition forms (TRFs), for example, typically contain the clinical information necessary to demonstrate that applicable coverage criteria for laboratory services are met. TRFs should be recognized as valid medical documentation and accepted as sufficient when they contain the information necessary to establish that a laboratory service is reasonable and necessary. Establishing consistent documentation standards, including broader acceptance of TRFs across payers, would reduce unnecessary administrative work and support more effective electronic prior authorization.

AMP also recognizes automation's potential to improve prior authorization by reducing manual data entry and duplicative submissions, shortening response timelines, and improving transparency around coverage requirements and authorization status. However, technology alone cannot address inappropriate denials, clinical urgency, retrospective payment denials, or the financial burden laboratories face when testing must proceed before a prior authorization determination is finalized. Standardization and automation should complement, rather than replace, protections that ensure patients have timely access to medically necessary testing.

Time Restrictions

AMP supports requiring prior authorization determinations within 24 hours for urgent requests and within 48 to 72 hours for nonurgent requests. Payers need clear, enforceable timeframes for prior authorization determinations. For laboratory testing, even commonly used expedited review timeframes may be too long in certain clinical circumstances. Patients with advanced cancers, suspected infectious diseases, transplant-related conditions, and other serious illnesses need molecular diagnostic results quickly to inform treatment decisions, and certain blood and tissue specimens can lose viability if testing is delayed. Advancements in electronic prior authorization should make these shorter timeframes increasingly achievable. When a laboratory test is clearly covered under existing coverage criteria, and the information needed to establish medical necessity has been submitted electronically, patients and providers should not have to wait days for a determination.

AMP also supports safeguards to ensure that required timeframes are meaningful and cannot be circumvented through requests for unnecessary or duplicative information. Patients and providers should not bear the consequences of a payer's failure to issue a timely determination, and policies should also permit concurrent authorization when laboratory testing must proceed immediately because of clinical circumstances or specimen viability.

Voluntary Commitments

AMP supports several of the principles reflected in the voluntary commitments made by several of the larger private payers in June 2025, including standardizing electronic prior authorization, reducing unnecessary use of prior authorization, improving transparency regarding decisions and appeals, and providing more timely responses. These principles align with AMP's longstanding recommendations for improving prior authorization for laboratory testing; however, AMP believes clear, consistent requirements across payers would provide greater certainty for patients and providers than relying solely on voluntary commitments. In particular, AMP supports standards that require payers to clearly communicate prior authorization and documentation requirements; establish timely, efficient electronic prior authorization processes; provide detailed

explanations for denials; and ensure that patients and providers can rely on a prior authorization once it has been granted.

AMP recommends prohibiting retrospective denial or recoupment of payment for properly authorized services except in limited circumstances involving materially false or fraudulent information. AMP members have encountered situations in which laboratories are denied payment even after obtaining prior authorization. Such retrospective denials undermine the purpose of prior authorization and create significant operational and financial uncertainty for laboratories. Transparency is also critical when authorization is denied. Payers should be required to provide detailed information regarding the specific rationale for a denial, including whether coding, documentation, medical necessity criteria, or another issue contributed to the decision. Payers and LBMs should also maintain transparent, timely processes for providers to provide feedback on coverage policies, particularly when those policies do not reflect current medical knowledge or evidence. AMP members have reported receiving vague or incomplete explanations that do not meaningfully identify the basis for an adverse determination.

Finally, AMP recommends establishing better mechanisms for providers to report patterns of problematic prior authorization practices to the appropriate regulator. Laboratory professionals are well positioned to identify improper denials, unnecessary or duplicative documentation requirements, failures to comply with required timelines, and other practices that interfere with access to medically necessary testing. Provider reporting, coupled with appropriate oversight and transparency regarding approval and denial rates, would help policymakers and regulators identify systemic problems and ensure compliance with prior authorization standards.

Additional Considerations for Laboratory Testing

As the Committee considers prior authorization reform across private markets, AMP encourages policymakers to recognize several laboratory-specific issues that the approaches identified above may not resolve. First, prior authorization policies should account for the relationship between specimen collection and laboratory testing. AMP maintains that the “date of service” for clinical laboratory tests should always be defined as when the test is run, not when the specimen is collected. As previously discussed, in molecular pathology and genetic testing, specimen collection occurs before a test is actually performed, and laboratories cannot always reasonably delay testing while awaiting authorization. Additionally, inpatient policy sometimes dictates that the specimen collection date is the “date of service”, which greatly complicates prior authorization requests that come from the laboratory afterward.¹ Unfortunately, using the specimen collection as the “date of service” results in unnecessary administrative denials. Payers should allow laboratories to submit prior authorization requests after specimen collection when clinically appropriate, and specimen collection before authorization should not automatically serve as the basis for denial when delaying testing could compromise patient care or specimen viability.

Second, policymakers should examine the role of LBMs in administering prior authorization for laboratory services and consider policy reforms to address challenges for patients and providers associated with these entities. AMP members have reported problems related to unclear prior authorization requirements, insufficient explanations for denials, outdated or inaccurate coverage

¹ <https://www.ecfr.gov/current/title-42/chapter-IV/subchapter-B/part-414/subpart-G/section-414.510>

policies, and limited opportunities for laboratories and clinicians to provide feedback or request updates. Prior authorization reforms should apply to LBMs and other entities conducting utilization management on behalf of health plans so that protections cannot vary based on whether an insurer administers prior authorization directly or contracts with another entity to do so.

Finally, prior authorization policies should not unnecessarily restrict where medically necessary laboratory testing can be performed. AMP members have encountered situations in which an LBM required sending a specimen to a large national reference laboratory for testing services even though the local ordering institution or an affiliated academic medical center laboratory could perform the test. Such requirements can delay testing, disrupt care coordination, and interfere with communication among treating clinicians and laboratory professionals. Prior authorization reforms should preserve appropriate access to specialized laboratories with relevant expertise while ensuring that utilization management policies reflect current clinical evidence and standards of care.

Conclusion

Taken together, these reforms would establish a more consistent prior authorization framework across health insurance markets, reduce unnecessary administrative burden, and help ensure that patients have timely access to medically necessary laboratory testing regardless of their source of coverage.

AMP appreciates the Committee's attention to the challenges associated with prior authorization and its consideration of opportunities to improve these processes across private health insurance markets. Continued progress in this area is essential to reducing administrative burden, supporting timely access to medically necessary molecular diagnostic testing, and improving patient care. AMP looks forward to working with the Committee as it considers policies to make prior authorization more efficient, transparent, and responsive to patients' and providers' needs.

Sincerely,

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President, Association for Molecular Pathology