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February 3, 2026

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Senate Committee on Financial Institutions and Insurance
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**AHIP Comments on Senate Bill (SB) 330: The Ensuring Transparency in Prior Authorization Act**

Dear Members of the Committee on Financial Institutions and Insurance,

AHIP appreciates the opportunity to provide comments on SB 330, which restricts the use of prior authorization.

> **As drafted, AHIP opposes SB 330 because it undermines health plans' ability to ensure patients have access to high-quality, affordable health care. Health plans have made voluntary commitments to streamline the prior authorization process for patients and providers and AHIP asks that you allow these initiatives to move forward without legislation such as SB 330, which could impede health plans' progress.**

Prior authorization is an important safeguard used by both public and private payers to help ensure patients receive care that is safe, evidence-based, and affordable. This safeguard helps hold down out-of-pocket costs for patients and premiums for everyone, ultimately helping ensure Americans' health care dollars are spent wisely. AHIP remains committed to working with you to improve the prior authorization process for Kansas residents while protecting patient safety and affordability.

## Health Plans Are Taking Action to Simplify Prior Authorization

In June 2025, health plans announced a series of multi-year voluntary commitments to streamline and simplify the prior authorization process for patients and providers.[1] These commitments are being implemented across insurance markets, including those with commercial coverage, Medicare Advantage, and Medicaid managed care, consistent with state and federal regulations. Health plans that serve nearly 270 million Americans are participating in this initiative.

Through these actions, health plans will deliver a more seamless patient experience and enable providers to focus on patient care, while also helping to modernize the system. For patients, these commitments will result in faster, more direct access to appropriate treatments and medical services. For providers, these commitments will streamline prior authorization workflows, allowing for a more efficient and transparent process, while promoting evidence-based care for their patients.

[1] *Health plans are making voluntary commitments to support patients and providers*. AHIP.

Since announcing the initiative in June, health plans have been working to implement the first series of commitments which took effect January 1, 2026. We expect to provide the first of regular updates on the industry-wide implementation of these commitments in the Spring of 2026:

- Reducing the Scope of Claims Subject to Prior Authorization
- Ensuring Continuity of Care When Patients Change Plans
- Enhancing Communication and Transparency on Determinations
- Ensuring Medical Review of Non-Approved Requests

The initiative also includes two interrelated and transformational commitments that have multi-year timelines and require substantial technical and operational work and collaboration among health plans and providers. These commitments will ultimately enable most prior authorizations to be routinely approved at the point of care, giving providers and patients a faster and more consistent experience.

- Expanding Real-Time Responses
- Standardizing Electronic Prior Authorization

More details on these voluntary commitments, as well as a 2024 prior authorization survey of AHIP's members, can be found here. AHIP members in Kansas have voluntarily agreed to these meaningful changes that will lead to a demonstrated improvement in the provider and member experience. We ask that you allow these initiatives to move forward without legislation such as SB 330, which could impede health plans' progress.

## Prior Authorization Protects Patient Safety

Prior authorization is a proven tool to ensure that patients receive safe, effective, and evidence-based care. It safeguards against unnecessary or inappropriate treatments that could result in harm. For example:

- ***Preventing low-value or inappropriate services.*** Prior authorization helps prevent unnecessary, potentially harmful, and costly services by ensuring care aligns with evidence-based guidelines and providers' own recommendations.[2]
- ***Preventing dangerous drug interactions.*** Prior authorization helps prevent harmful drug interactions and ensures care is safe, effective, and appropriate for each patient.
- ***Ensuring drugs are used as clinically indicated.*** Prior authorization ensures medications are used only for FDA-approved clinical indications.

Medical knowledge doubles every 73 days,[3] and to keep up with these changes, studies show that primary care providers would need to practice medicine nearly 27 hours per day.[4] This is why it is so important that health plans, providers, and hospitals work together to ensure treatment aligns with nationally recognized, evidence-based clinical criteria, protecting patients from unnecessary, and potentially harmful drugs and services.

## Prior Authorization Is Founded on Evidence-Based Criteria

Health plans employ doctors, nurses, and other clinicians to develop and regularly update their utilization (UM) programs using evidence-based criteria. UM programs are examined by health plan Pharmacy and Therapeutics (P&T) Committees, which are required for federal programs, and they must include clinicians that are independent and free of conflicts of interest.

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

[3] Densen, Peter. *Challenges and Opportunities Facing Medical Education*. Transactions of the American Clinical and Climatological Association 2011.

[4] Porter J, Boyd C, Skandari MR, Laiteerapong N. *Revisiting the Time Needed to Provide Adult Primary Care*. Journal of General Internal Medicine. January 2023.

A health plan's prior authorization process must meet stringent standards established by national health care accreditation agencies, such as the National Committee for Quality Assurance (NCQA) or Utilization Review Accreditation Commission (URAC). These accreditation standards address the clinical criteria used for decisions, regular review and availability of the criteria, practitioner involvement, qualifications or health professionals making prior authorization decisions, and timeframes for decisions.

Health plans also report their prior authorization statistics to the Kansas Department of Insurance through the National Association of Insurance Commissioners' Market Conduct Annual Statement.

### Prior Authorization Helps Reduce Patients' Health Care Costs

In addition to protecting patients from wasteful, low-value or inappropriate treatments or services that could result in harm, prior authorization helps ensure care is as affordable as possible. At a time when roughly a quarter of medical spending is considered wasteful of low-value, prior authorization is instrumental in reducing overuse and low-value care that cost Americans $340 billion annually.[5] Eighty-seven percent of doctors have reported negative impacts from low-value care[6] and an AHIP clinical appropriateness project with John Hopkins found that about 10% of physicians provided care inconsistent with consensus and evidence-based standards.[7]

By guiding patients to the right care, at the right time, in the right setting, prior authorization reduces wasteful spending and helps ensure health care dollars are used efficiently, while protecting patients from low-value care.

### Electronic Prior Authorization Provides Improved Experience

Health plans' targeted use of prior authorization, combined with electronic prior authorization, help streamline the process for providers, shorten decision times, and lower administrative burden. AHIP's 2020 Fast Prior Authorization Technology Highway (Fast PATH) initiative documents the value of electronic prior authorization[8], demonstrating that providers' increased adoption and use of electronic systems lead to:

- Faster Time to Patient Care
- Faster Time to Decisions
- Improved Information for Providers

This project showed that providers gain greater benefits as they use electronic prior authorization processes more often. *Yet nearly half of all prior authorization requests are still submitted manually (via phone, fax, or mail), making broader adoption of electronic prior authorization a major opportunity for improvement.*[9]

### Enhanced Federal Provider Authorization Oversight

In addition to the Industry Initiative to improve the prior authorization process, the Centers for Medicare and Medicaid Services (CMS) adopted new rules[10] in 2024 to implement several new and significant prior authorization requirements for health plans in federal programs.[11] Changes that must be adopted this year include:

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

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

[7] *Clinical Appropriateness Measures Collaborative Project*. AHIP. December 2021.

[8] *Prior Authorization: Helping Patients Receive Safe, Effective, and Appropriate Care*. AHIP.

[9] Busch, Fritz S., and Stacey V. Muller. *Potential Impacts on Commercial Costs and Premiums Related to the Elimination of Prior Authorization Requirements*. Milliman. March 30, 2023.

[10] *Advancing Interoperability and Improving Prior Authorization Processes*. Centers for Medicare & Medicaid Services. 89 FR 8758. February 8, 2024.

[11] *Impact of Federal Prior Authorization Requirements on States*. AHIP. February 20, 2024.

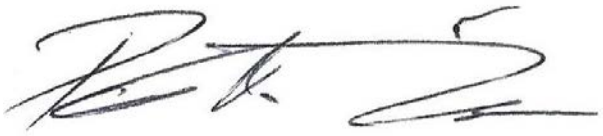
- *Prior Authorization Response Timeframes:* Impacted payers must send a prior authorization decision within 72 hours for expedited or urgent requests and 7 calendar days for standard or non-urgent requests.
- *Prior Authorization Reason for Denial:* Payers must specify a reason when they deny a prior authorization request in a standardized, interoperable format.
- *Electronic Process for Requests and Decisions:* Impacted plans must build a standardized electronic system to communicate to providers when prior authorization is needed, what documentation is necessary, and transmit both requests and decisions.
- *Prior Authorization Public Reporting:* Impacted payers must annually report prior authorization metrics on the plan's website, including:
    - a list of all items and services that require prior authorization.
    - the percentage of prior authorization requests approved, approved after appeals, and denied, aggregated for all items and services; and
    - the average timeframe between the submission of a prior authorization request and the decision made.

Once fully implemented, the federal rules and associated standards will provide consistency and uniformity to which states can align.

***AHIP Recommendation.*** AHIP urges you to vote "NO" on SB 330, which would enact onerous restrictions that could lead to patient harm and increased costs for Kansans. Health plans have made voluntary commitments to streamline the prior authorization process for patients and providers and AHIP asks that you allow these initiatives to move forward without legislation such as SB 330, which could impede health plans' progress.

AHIP stands ready to work with the Senate Committee on Financial Institutions and Insurance to advance innovative policy solutions that ensure consumers have access to high-quality and affordable health care.

Sincerely,



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*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. Visit www.ahip.org to learn how working together, we are Guiding Greater Health.*