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Kate Harris, Chair
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NAIC Health Care Affordability and Mitigation (B) Working Group
National Association of Insurance Commissioners
1101 K Street, N.W., Suite 650 Washington, DC 20005

Submitted via Email: Joe Touschner (jtouschner@naic.org)

RE: BCBSA Comments on Drafting Group 1: Standardize or limit utilization review to reduce administrative costs

Dear: Ms. Harris and Mr. Beagan

The Blue Cross Blue Shield Association (BCBSA) appreciates the opportunity to provide feedback on the Standardizing or Limiting Utilization Review to Reduce Administrative Costs Brief developed by the Health Care Affordability and Mitigation (B) Working Group Drafting Group #1.

BCBSA is a national federation of 31 independent, community-based and locally operated Blue Cross and Blue Shield companies (Plans) that collectively cover, serve, and support 1 in 3 Americans in every ZIP code across all 50 states and Puerto Rico. BCBS Plans contract with 95% of hospitals and 91% of doctors across the country and serve individuals covered through Medicare, Medicaid, employer-sponsored coverage, and the individual market.

BCBSA believes that everyone deserves peace of mind when it comes to their health care. As health care costs continue to rise, families, employers, and public programs are facing increasing financial pressure. Consumers are experiencing higher premiums, increased cost sharing, and rising out-of-pocket expenses, underscoring the need for solutions that address the underlying drivers of health care costs. BCBS companies are focused on addressing the root causes of rising costs and advancing a [roadmap](#) that could reduce health care costs by nearly \$1 trillion over 10 years through targeted reforms designed to improve affordability and promote a more sustainable health care system.

Given this commitment to improving health care affordability, BCBSA appreciates the Working Group's efforts to develop issue briefs that serve as educational resources for regulators and policymakers. These resources provide a valuable overview of policy approaches being considered and implemented across states and can help inform ongoing discussions regarding strategies to improve affordability and access to coverage. BCBSA believes the briefs will be a useful resource for regulators seeking to better understand the range of state policy options, as well as the opportunities and tradeoffs associated with different approaches. BCBSA looks forward to working with the Working Group as it continues its examination of policies that can support affordable, high-quality health coverage and care.

As the Working Group continues to refine these resources, BCBSA encourages the adoption and maintenance of a standardized format across the issue briefs. A consistent structure, including the presentation of state examples, discussion of policy considerations, evaluation of available evidence, and identification of legal, operational, and implementation considerations, would strengthen the briefs and make it easier for regulators and other stakeholders to compare approaches across topics. In addition, BCBSA agrees with recommendations offered by our consumer representative colleagues that each brief clearly articulate the affordability challenge it is intended to address and explain how the featured state approaches are designed to respond to that challenge. Providing this context would enhance the educational value of the briefs and help readers better understand the relationship between specific policy interventions and affordability objectives.

BCBSA also encourages the Working Group to maintain the briefs as neutral educational resources consistent with their stated purpose. The briefs are most effective when they provide an objective assessment of state approaches, including implementation experiences, operational considerations, potential benefits and drawbacks, and any available evidence regarding outcomes. Because states face differing market dynamics, regulatory frameworks, and affordability challenges, the briefs can serve as a particularly valuable resource when they present information in a balanced and non-prescriptive manner, enabling regulators and policymakers to evaluate policy options within the context of their own markets.

Finally, we recommend that the briefs consistently identify when a highlighted policy, law, or regulatory approach is subject to ongoing litigation, legal challenge, enforcement stays, or other significant legal uncertainty. Providing this context is particularly important where legal proceedings may affect implementation, enforceability, or the ultimate viability of a policy approach. Including such information would help ensure regulators receive a complete and balanced understanding of the policy landscape and avoid inadvertently presenting unsettled approaches as established best practices.

In addition to the overarching comments outlined above, BCBSA has provided attached redlines and document-specific comments for the Working Group's consideration. These recommendations are intended to improve consistency across the briefs, enhance contextual information, support the briefs'

educational purpose, and ensure that relevant implementation and legal considerations are presented in a balanced manner.

Thank you for the opportunity to provide feedback. We appreciate the Working Group's continued efforts to develop these resources and look forward to continued engagement as the briefs evolve. If you have any questions or would like additional information, please contact Randi Chapman at randi.chapman@bcbsa.com.

Sincerely,

A handwritten signature in dark ink, reading "Clay S. McClure". The signature is written in a cursive, flowing style.

Clay S. McClure, BCBSA
Senior Director, State Affairs

NAIC Health Care Affordability and Mitigation Working Group: Standardizing or Limiting Utilization Review to Reduce Administrative Costs

The Health Care Affordability and Mitigation Working Group Briefs are intended to be short, informative briefings for regulators and policymakers on various affordability efforts states have undertaken in recent years to help make health insurance more affordable. They are intended to be high-level and not an exhaustive resource on each issue. They also do not represent policy positions of the NAIC, a given state, author, or workgroup member.

Overview

Contributors

Contributor(s)	Title(s) of Contributor(s)	State(s) of Contributors
Kevin Beagan	Deputy Commissioner, Health Care Access Bureau	Massachusetts
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Executive Summary

This brief identifies three primary policy approaches states have adopted or considered for adoption:

- 1) **Prohibiting or limiting prior authorization for certain services, medications, or supplies.** It summarizes policies in numerous states that exempt services such as emergency care, behavioral health treatment, preventive services, medication-assisted treatment for opioid use disorder, cancer care, and other high-value services from prior authorization requirements.
- 2) **Standardizing prior authorization forms and required information.** It highlights states that require uniform prior authorization forms (often limited to two pages) and standardized data elements to reduce administrative burden and streamline communication between providers and insurers.
- 3) **Implementing electronic prior authorization (ePA) and interoperability requirements.** It explores the trend of adopting policies requiring or encouraging insurers to use electronic prior authorization systems and application programming interfaces (APIs) that integrate with electronic health records and conform to federal interoperability standards to automate and expedite the authorization process.

States with the Policy: *Prohibiting or limiting use of prior authorization for certain services, supplies and prescriptions*

Note: Under federal law (Consolidated Appropriations Act, 2021; 45 CFR Part 149), if a group health plan covers emergency services, it must do so without the use of prior authorization. This has also been adopted into many states’ laws.

State	Implementation Date	Key Variations/Notes
Colorado	August 7, 2024	Requires insurers to: Perform annual reviews of the list of health care services, including prescription drugs, that require prior authorization and eliminate requirements that do not “promote health care quality or equity” or “substantially reduce health care spending”

Commented [A1]: For all three tables, we recommend adding in-text citations to the specific statutes and regulations for each state entry so policymakers can read more. The tables reference specific bills, dates, and provisions, and sourcing each row would make the brief more useful.

State	Implementation Date	Key Variations/Notes
		Adopt programs to eliminate or substantially modify prior auth requirements to remove the administrative burden for qualified providers
Iowa	Prohibition on prior authorization: January 1, 2027; Annual review by insurers: 2025	Prohibits prior authorization for: cancer-related screenings recommended by the person's health care provider based on the most recently updated national comprehensive cancer network clinical practice guidelines in oncology which are designated as category 2A or lower; the diagnosis and treatment of an emergency medical conditions that develops or becomes evident while the person is in inpatient care that meets inpatient care standard, if the emergency medical condition is reasonably determined by a health care professional to be a life-threatening condition unless the covered person receives immediate assessment and treatment. Requires insurers to conduct an annual review and report on prior authorization, eliminate prior authorization requirements for services that are routinely approved and report on this, and justify any prior authorization that is in place where more than 80% were approved in the previous 12 months in their annual reporting.
Maine	2023	Prohibits prior authorization for: 12 visits of rehabilitative or habilitative services
Massachusetts	June 5, 2026	Prohibits prior authorization for: emergency services, inpatient acute care services (including inpatient acute mental health treatment), post-

State	Implementation Date	Key Variations/Notes
		acute care services provided on weekends or holidays, urgent care services, primary care services, preventive health services and vaccinations, abortion and abortion-related care, maternity services, physical therapy, occupational therapy, and speech therapy, outpatient substance use disorder services, medications for serious, persistent mental illness, specific chronic care medications identified (diabetes, heart disease, asthma, specific post-cancer diagnosis radiology imaging used to stage or determine treatment efficacy. Requires insurers to annually review their prior authorization lists and survey patients about their experiences, giving the DOI additional data to evaluate progress, reduce waste, and improve patient experience.
Michigan	July 1, 2016	Prohibits prior authorization for: pediatricians for general pediatric care services; emergency health services; Well woman visits.
Minnesota	January 1, 2026	Prohibits prior authorization for: outpatient mental health treatment or outpatient substance use disorder treatment, not including medications; antineoplastic cancer treatment consistent with National Comprehensive Cancer Network guidelines, not including medications; certain preventive services and immunizations; pediatric hospice services;

State	Implementation Date	Key Variations/Notes
		and treatment delivered through a neonatal abstinence program.
Missouri	2018	Prohibits prior authorization for: emergency services, stabilization services, medication-assisted treatments (including pharmacological therapies).
New Hampshire	SUD: January 1, 2017; Data: January 1, 2025	Prohibits prior authorization for: medically necessary interfacility transports for services related to the treatment and diagnosis of mental illnesses, treatment of an emergency medical condition as defined in RSA 420-J:3, XV, at least one medication-assisted treatment therapy for treatment of substance use disorders, the first 2 routine outpatient visits of an episode of care for assessment and care relating to a substance use disorder, the first 24 hours of short-term inpatient withdrawal management and clinical stabilization services. Collects prior authorization metrics and posts them publicly by insurer.
New Mexico	Medication treatment of an autoimmune disorder, cancer, a rare disease or condition, a serious mental illness or a substance use disorder, except in cases in which a biosimilar (2026); Gynecological and obstetric ultrasounds (2025); Mental health disorder and substance use disorder services, prescription drugs for SUD services (2023)	Prohibits prior authorization for: mental health and substance use disorder services, medication treatment of an autoimmune disorder, cancer, a rare disease or condition, a serious mental illness or a substance use disorder, except in cases in which a biosimilar, interchangeable biologic or generic version is available, emergency care, contraception,

State	Implementation Date	Key Variations/Notes
		coverage for individuals with diabetes, and gynecologic and obstetric ultrasounds.
Nebraska	January 1, 2026	Prohibits prior authorization for: emergency confinement; pre-hospital transport for emergency health services or transfers between facilities as required by federal EMTLA; or services that have an A or B rating from the US Preventive Task Force, immunizations recommended Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention, or preventive services and screening provided to women as required by 45 C.F.R. 147.130.
North Dakota	December 31, 2025	Prohibits prior authorization for: medication-assisted treatment of opioid use disorder; prehospital transportation or for the provision of emergency health care services for an emergency medical condition.
Oregon	January 1, 2018	Prohibits prior authorization for: the first 60 days of treatment for medication assisted treatment for opioid or opiate withdrawal, HIV treatment and prevention medications, FDA approved medications for substance use disorder, additional medically necessary procedures discovered during an already authorized surgery.
Washington	OUD: January 1, 2020; SUD: January 1, 2021; HIV: January 1, 2025	Prohibits the use of prior authorization for at least one federal food and drug administration approved product for the treatment of opioid use disorder in

State	Implementation Date	Key Variations/Notes
		the drug classes opioid agonists, opioid antagonists, and opioid partial agonists. Prohibits the use of prior authorization for withdrawal management services or inpatient or residential substance use disorder services in a behavioral health agency. Prohibits prior authorization for drugs that comprise at least one regimen recommended by the centers for disease control and prevention for human immunodeficiency virus postexposure prophylaxis.

States with the Policy: *Standardizing information collected to do prior authorization processing, including forms*

State	Implementation Date	Key Variations/Notes
Arizona	January 1, 2023	Requires DOI to approve a uniform request form for prescription drugs, devices or durable medical equipment and a uniform prior authorization request form for all other health care procedures, treatments and services. The forms must be 2 pages or less and meet the electronic submission and acceptance requirements prescribed under the law. Requires use by providers/plans.

Colorado	2013	Requires commissioner to develop, by rule, a standardized prior authorization form, not to exceed two pages in length, for use in submitting electronic and nonelectronic prior authorization requests. In developing the form, the commissioner shall take into consideration existing forms, including existing prior authorization forms established by CMS or the department of health care policy and financing.
Massachusetts	2012	Requires DOI to develop and implement uniform prior authorization forms for different health care services and benefits, including but not limited to post-acute care admissions and home health transitions. The forms must be 2 pages or less, be made electronically available and be capable of being electronically accepted by the insurer after being completed. Requires insurers to use and accept these forms.
Missouri	January 1, 2021	Requires insurers utilizing prior authorization to develop a single secure electronic PA cover page for all of their health benefit plans using prior authorization. The cover page must be used to accept and respond to requests, and providers must use such cover page for requests, and it must include, at a minimum, the statutory fields for information requested.
Nebraska	November 1, 2025	Required department to approve a single uniform prior authorization request form for prescription drugs, devices, and durable medical equipment and a single uniform prior authorization request form for all other health care services.

New Hampshire	2017	Requires insurers that require prior authorization for prescription drugs to use and accept the state's standard prior authorization forms (or the approved electronic standard).
New Mexico	2019	Requires DOI to adopt and insurers to use a streamlined and uniform prior authorization form for medical care, pharmaceutical benefits or related benefits.
Oregon	July 1, 2015	Requires DOI to develop by rule a uniform form that providers must use to request a prior authorization for a prescription drug benefit. The form must not exceed 2 pages and be electronically available and transmissible and include a provision under which additional information may be requested and provided.
Texas	2013; revised 2022	Requires DOI to prescribe a single, standard prior authorization request form and require issuers to accept and use this standard form.
Washington	2024	Requires Health Care Authority and OIC to develop a universal format accepted by all health insurers and Medicaid managed care organizations for behavioral health agencies to use for service authorization requests with common data requirements and a standardized form and simplified electronic process.

States with the Policy: Adopting requirements relating to electronic prior authorization and interoperability

Note: Federal requirements mandate the use of standardized application programming interfaces to support electronic prior authorization, particularly through the Centers for Medicare & Medicaid Services (CMS) Interoperability and Prior Authorization Final Rule (CMS-0057-F), which requires certain Medicare Advantage, Medicaid, CHIP, and ACA Marketplace plans to implement FHIR-based APIs for prior authorization requests for medical services, decisions, and related patient and provider data exchange. Many state policies align with these adopted standards. CMS has a proposed rule (CMS-0062-P) that considers adoption of similar standards for pharmacy services.

State	Implementation Date	Key Variations/Notes
Colorado	January 1, 2027	Requires insurers to establish, maintain and use an application programming interface (API) that automates the prior authorization request and approval process for providers. Requires the API to meet the most recent standards under US Health and Human Services.
Kansas	January 1, 2028	Requires utilization review entities to adopt and maintain a prior authorization API that aligns with the federal requirement at 45 C.F.R. 156.223 (b). Excludes drugs.
Massachusetts	June 5, 2026	Allows an insurer to implement and maintain an API for the automated processing of prior authorization requests. Allows for insurers to use financial incentives to require a provider to participate in use of an API.
Michigan	June 2023	Insurers of health benefits that require prior authorization are required to make available a standardized electronic prior authorization request transaction process that uses an electronic,

		internet, and web-based system that can transmit clinical information. Providers and insurers (or their utilization review organizations) must use this standard electronic PA transaction process unless the health professional is not able to because of a temporary technological or electrical failure.
Minnesota	January 1, 2027	Requires the use of an API for medical prior authorizations (i.e., does not apply to prescription drug PAs) that essentially mirrors the federal interoperability requirements. The API must allow providers to determine whether a prior authorization is required for health care services, identify prior authorization information and documentation requirements, and facilitate the exchange of prior authorization requests and determinations from provider electronic health records or practice management systems.
Missouri	Electronic PA: January 1, 2021; API: January 1, 2028	Requires utilization review entity to accept/respond to prior authorizations of drug benefits through electronic prior authorization. Proposed: By January 1, 2028, health insurers and utilization review entities shall implement and maintain a prior authorization API that conforms with federal law. If a health insurer cannot implement the prior authorization API by January 1, 2028, the health insurer shall provide written notice to the Department requesting an extension, accompanied by a documented plan to come into compliance. By January 1, 2028, an enrollee's health care provider may use the prior authorization API to

		submit requests for prior authorization of health care services, excluding prescription drugs. A health insurer shall accept prior authorization requests submitted through the API. (If legislation is signed into law, the single cover page requirement will be rescinded)
New Hampshire	January 1, 2027	Proposed: Requires all health insurers to implement and maintain prior authorization API in accordance with 45 CFR 156.222, beginning January 1, 2027.
Texas	January 1, 2027	Proposed: Requires issuer to maintain an electronic prior authorizations system that meets national standards no later than January 1, 2027.
Washington	January 1, 2027	Requires insurers to establish and maintain an interoperable electronic process or API that automates the process for in-network providers to determine whether a prior authorization is required for a covered prescription drug. The interoperable electronic process or API must support the exchange of prior authorization requests and determinations for prescription drugs, including information on covered alternative prescription drugs, beginning January 1, 2027.

Administrative Savings from Electronic Prior Authorization

According to the Council for Affordable Quality Healthcare (CAQH), there is about \$494 million per year in additional savings for the U.S. medical industry if prior authorization becomes fully electronic, according to the [2023 CAQH Index](#). Current evidence suggests that API-enabled electronic prior authorization generates meaningful administrative savings and workflow efficiencies. Any premium impact is expected to be modest and indirect, with the primary benefits accruing through reduced administrative burden, faster care, and improved interoperability.

Brief write up

Utilization review, particularly the use of prior authorization, has become a major focus of health care affordability efforts across the United States. While prior authorization is intended to ensure that medical services are appropriate and cost-effective, it is frequently criticized for creating administrative burdens, delaying patient care, and increasing costs for providers and insurers alike. At the same time, prior authorization remains a tool for promoting patient safety and evidence-based care, generally applied to services that are high-cost, high-risk, or subject to clinical variation, and the reforms described below refine that tool rather than remove it. Insurers maintain that prior authorization also guards against fraud, waste and unnecessary utilization that would otherwise raise costs for all beneficiaries. This Health Care Affordability and Mitigation Working Group brief examines how states are responding by adopting policies that simplify prior authorization processes while maintaining oversight of health care services. States pursuing these policies generally argue that a simpler, more automated process can lower administrative costs across the system and speed patient care. The brief identifies three primary policy approaches: limiting the use of prior authorization for certain services, standardizing prior authorization forms and information requirements, and adopting electronic prior authorization and interoperability systems.

The first policy approach limits or prohibits prior authorization requirements for selected medical services, medications, and treatments. Many states have focused these exemptions on services that are routinely approved or are essential to timely patient care, rather than on a judgment that prior authorization serves no purpose. Certain states have exempted emergency services, preventive care, behavioral health treatment, medication-assisted treatment for substance use disorders, cancer-related services, maternity care, rehabilitation therapies, and other high-value services from prior authorization requirements. Several states also require insurers to annually review their prior authorization requirements and eliminate those that are routinely approved or no

Commented [A2]: We recommend narrowing this heading to match the section's content or moving this content to paragraph 4 of the "Brief write up". The section addresses only the administrative savings from electronic prior authorization.

Commented [A3]: We recommend updating this with the more recent data in CAQH's 2025 index report which reports a \$461 million savings. We suggest linking to the full report, which is available here: <https://www.dataspring.com/advisory-services/index-report>. Slide 16 in the following PDF provides a summary: https://s3.amazonaws.com/amo_hub_content/Association361/files/CAQH_2026%20eSolutions%20Xchange%20Slides.pdf

Commented [A4]: We recommend noting prior authorization's ongoing value and clinical basis. The added language ensures the brief maintains a neutral and informative tone.

Commented [A5]: We recommend adding a sentence to connect PA reform with affordability. Making the link more explicit gives readers the through-line the brief's purpose implies and frames the three approaches that follow.

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longer improve quality or reduce costs. These reforms are intended to reduce unnecessary delays in treatment while improving patients' access to medically necessary care.

A second strategy focuses on reducing administrative complexity by standardizing prior authorization forms and required information. Historically, providers have had to complete different forms for each insurer, creating inefficiencies and increasing administrative costs. To address this issue, many states now require insurers to use uniform prior authorization forms that are typically limited to two pages and include standardized information fields. States such as Arizona, Colorado, Massachusetts, Missouri, Nebraska, New Hampshire, Oregon, Texas, and Washington have adopted standardized forms that providers can submit electronically or on paper. Uniform forms reduce paperwork, simplify communication between providers and insurers, decrease processing time, and allow medical staff to spend more time delivering patient care instead of completing administrative tasks. Standardized forms deliver the greatest efficiency when they are consistent across states and their data elements align with the federal electronic prior authorization standards, so that differing state forms do not reintroduce the complexity they are meant to reduce and the same information carries over as prior authorization moves electronic. For patients, the practical benefit of appropriately standardized forms is faster processing, which can shorten the time to a prior authorization decision and reduce delays in accessing care.

The third policy trend involves implementing electronic prior authorization (ePA) systems and improving interoperability between providers and insurers. Recent federal regulations require the adoption of application programming interfaces (APIs) for prior authorization for medical services as well as corresponding interoperability standards, to connect insurers, electronic health record systems, and providers to streamline these processes. Several states, including Colorado, Kansas, Massachusetts, Michigan, Minnesota, Missouri, Texas, Washington, and New Hampshire, have adopted or proposed requirements that health insurers establish electronic prior authorization systems consistent with federal interoperability standards. These systems enable providers to determine whether prior authorization is required, electronically submit requests, exchange clinical information, and receive decisions more quickly. By automating these processes, electronic prior authorization reduces administrative workload, minimizes delays in patient care, and improves communication throughout the health care system. These benefits depend on plans, providers and vendors building to the same standards. Aligning state requirements with the federal framework already in place, the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F) and its FHIR-based APIs, rather than divergent state forms, timelines, or API specifications, avoids fragmenting the interoperability these systems are meant to create. Realizing these benefits also depends on provider adoption, since electronic prior authorization delivers value only when providers implement and use these capabilities within their existing workflows. Supporting adoption, particularly among smaller practices that may face resource or system constraints, is essential to achieving the intended gains.

Commented [A7]: We recommend noting that the efficiency of standardized forms depends on cross-state consistency, alignment with the federal ePA standards and highlighting the patient perspective. Noting these conditions keeps this approach consistent with the interoperability points the brief makes for ePA in the next paragraph.

Commented [A8]: We recommend emphasizing alignment with the federal framework. The brief's third-approach table already observes that many state ePA policies track the CMS rule, so we suggest the paper state that convergence rather than leave it implicit.

Commented [A9]: We recommend noting that the benefits of electronic prior authorization depend on provider adoption, not just on plans and vendors building to the federal standards. Building to the standards creates only the potential for interoperability; it is providers using that capability in their workflows that produces the patient benefits.

The anticipated benefits of these reforms extend beyond administrative efficiency. According to the CAQH Index cited in the brief, the U.S. health care industry could realize approximately \$494 million in annual savings if prior authorization became fully electronic. Although premium reductions are expected to be modest, policymakers anticipate significant indirect benefits through lower administrative expenses, faster access to medically necessary treatment, improved provider workflow, and a better patient experience. Electronic systems also improve consistency and transparency by providing standardized requirements and faster communication between insurers and providers.

Commented [A10]: We recommend removing this paragraph as duplicative of the “Premium Impact and Savings Analysis” section above or removing the above section and only keeping this paragraph since it repeats much of the same information.

Overall, the policy trends outlined in the brief reflect a nationwide effort to modernize utilization review while preserving its role in promoting appropriate health care utilization. Rather than eliminating prior authorization entirely, states are focusing on targeted reforms that reduce unnecessary administrative burdens, streamline communication, and improve timely access to care. As more states adopt standardized forms, expand electronic prior authorization systems, and eliminate prior authorization for services, these reforms have the potential to improve both the efficiency and affordability of the health care system while maintaining appropriate oversight of health care spending.

Sources

Select statutes and regulations in states identified in the brief.

Further Reading

- For information relating to AHIP and Blue Cross Blue Shield Association’s multi-year commitments to streamline, simplify and reduce prior authorization, announced in June 2025. The commitments span reducing the volume of services requiring prior authorization (11%, or 6.5 million fewer, as of April 2026, and over 15% less in Medicare Advantage), honoring existing approvals for a 90-day transition when patients change plans, improving communications on determinations and appeals, standardizing electronic prior authorization submissions and 80% of approvals via electronic requests in real-time. <https://www.ahip.org/news/articles/health-plans-take-next-step-to-streamline-and-simplify-prior-authorization-for->

Commented [A11]: We recommend revising this summary to capture a broader scope of the initiative. As written, it describes only the standardized approach to electronic prior authorization submissions. Including the additional commitments would give readers a more accurate and complete picture and better match the sources cited.

patients-and-providers; <https://www.ahip.org/news/articles/health-plans-reduce-prior-authorization-support-continuity-of-care-and-enhanced-consumer-communications>

- For information relating to federal policies relating to APIs and relevant standards and implementation guides. <https://www.cms.gov/priorities/burden-reduction/overview/interoperability/implementation-guides-standards/application-programming-interfaces-apis-relevant-standards-implementation-guides-igs>