Notice of Intent to Adopt Rules

Revised October 2014

1. General Information

a. Agency/Board Name: Insurance Department		
b. Agency/Board Address: 106 East 6th Avenue	c. City: Cheyenne	d. Zip Code: 82002
e. Name of Contact Person: Heather Canarecci	f. Contact Telephone Number: 307-777-6916	
g. Contact Email Address: heather.canarecci1@wyo.gov		
h. Date of Public Notice: June 26, 2015	i. Comment Period Ends: August 14, 2015	
j. Program: General Agency Board or Commission Rules		

2. Rule Type and Information: For each chapter listed, indicate if the rule is New, Amended, or Repealed.

a. If "New," provide the Enrolled Act numbers and years enacted:

b. Provide the Chapter Number, Short Title, and Rule Type of Each Chapter being Created/Amended/Repealed

Please use the Additional Rule Information form for more than 10 chapters, and attach it to this certification.

Chapter Number:	Chapter Name:	
49	Regulation to Implement The Small Employer Health Insurance Availability Act	☐ New ☒ Amended ☐ Repealed
63	Medical Necessity Review Rights	☐ New ☒ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed
		☐ New ☐ Amended ☐ Repealed

c. ☒ The Statement of Reasons is attached to this Notice and, in compliance with *Tri-State Generation and Transmission Association, Inc. v. Environmental Quality Council*, 590 P.2d 1324 (Wyo. 1979), includes a brief statement of the substance or terms of the rule and the basis and purpose of the rule.

Complete all that apply:

☐ The following chapters do not differ from the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j):

_____

(Provide chapter numbers)

☐ These chapters differ from the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j) (see Statement of Reasons).

_____

(Provide chapter numbers)

☐ N/A These rules are not impacted by the uniform rules identified in the Administrative Procedure Act, W.S. 16-3-103(j).

d. ☒ N/A ☐ In consultation with the Attorney General's Office, the Agency's Attorney General representative concurs that strike and underscore is not required as the proposed amendments are pervasive (Section 5 of the Rules on Rules).

e. A copy of the proposed rules* may be obtained:

☒ By contacting the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

* If Item "d" above is not checked, the proposed rules shall be in strike and underscore format.

3. Public Comments and Hearing Information

a. A public hearing on the proposed rules has been scheduled. ☐ Yes ☒ No

If "Yes:"	Date:	Time:	City:	Location:

b. What is the manner in which interested persons may present their views on the rulemaking action?

☒ By submitting written comments to the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

A public hearing will be held if requested by 25 persons, a government subdivision, or by an association having not less than 25 members. Requests for a public hearing may be submitted:

☒ To the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

c. Any person may urge the Agency not to adopt the rules and request the Agency to state its reasons for overruling the consideration urged against adoption. Requests for an agency response must be made prior to, or within thirty (30) days after adoption, of the rule, addressed to the Agency and Contact Person listed in Section 1 above.

4. Federal Law Requirements

a. These rules are created/amended/repealed to comply with federal law or regulatory requirements. ☒ Yes ☐ No

If "Yes:" Applicable Federal Law or Regulation Citation: Patient Protection and Affordable Care Act (PPACA), Public L. 111-148 and section 2719 of the Public Health Service Act (PHS Act)

Indicate one (1):

☒ The proposed rules meet, but do not exceed, minimum federal requirements.

☐ The proposed rules exceed minimum federal requirements.

Any person wishing to object to the accuracy of any information provided by the Agency under this item should submit their objections prior to final adoption to:

☒ To the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

5. State Statutory Requirements

a. Indicate one (1):

☒ The proposed rule change *MEETS* minimum substantive statutory requirements.

☐ The proposed rule change *EXCEEDS* minimum substantive statutory requirements. Please attach a statement explaining the reason that the rules exceed the requirements.

b. Indicate one (1):

☒ The Agency has complied with the requirements of W.S. 9-5-304. A copy of the assessment used to evaluate the proposed rules may be obtained:

☒ By contacting the Agency at the physical and/or email address listed in Section 1 above.

☐ At the following URL: _____

☐ Not Applicable.

6. Authorization

a. I certify that the foregoing information is correct.

Printed Name of Authorized Individual	Tom Glause
Title of Authorized Individual	Insurance Commissioner
Date of Authorization	June 17, 2015

Distribution List:

- Attorney General and LSO: Hard copy of Notice of Intent; Statement of Reasons; clean copy of the rules; and strike-through and underline version of rules (if applicable). Electronic copies (PDFs) of all items noted (in addition to hard copies) may be emailed to LSO at Criss.Carlson@wyoleg.gov.
- Secretary of State: Electronic version of Notice of Intent sent to Rules@wyo.gov.

DEPARTMENT OF INSURANCE

STATE OF WYOMING

IN THE MATTER OF THE AMENDMENT TO CHAPTER 49 OF THE WYOMING DEPARTMENT OF INSURANCE RULES AND REGULATIONS,	))))	Docket No. 15-20

STATEMENT OF PRINCIPAL REASONS

FOR

Amendment of Chapter 49 of Wyoming Insurance Department Regulation

Small Employer Health Insurance

Wyoming Statute § 26-19-301 *et seq*. was originally enacted in 1992 and is known as the "Small Employer Health Insurance Availability Act." On February 25, 2015, Governor Mead signed SF32, SEA No. 0006, which provided for changes to W.S. §26-19-306(c)(vi). In addition, on or about November 25, 2013 Governor Mead required all State Agencies to reduce their Rules both in number and in length. Finally, changes have been made to this regulation to bring it into compliance with the existing federal law.

This Regulation was originally promulgated to implement the Small Employer Health Insurance Availability Act, § 26-19-301 et seq. The general purposes of W.S. § 26-19-301 et seq. and the Regulation was to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates among health benefit plans; to ensure renewability of coverage; to provide for continuation of coverage in certain situations; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small group health insurance market. Wyoming Statute § 26-19-301 et seq. and this Regulation were intended to promote broader spreading of risk in the small employer marketplace. Further, Wyoming Statute § 26-19-301 *et seq*., and this Regulation were intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. The revisions to this Regulation are to make the Regulation consistent with the statutory changes to take effect July 1, 2015. In addition, changes have been made to bring the rule into

compliance with the current requirements of federal law. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of W.S. § 26-19-301 et seq., and this Regulation.

Finally, this Rule was amended to comply with the Governor's directive to reduce the size and number of State Agency Rules. The old Rule 49 contained approximately 10,040 word. The amended Rule 49 contains approximately 7,192 words, which represents a reduction in length of 28%.

DEPARTMENT OF INSURANCE

STATE OF WYOMING

IN THE MATTER OF THE AMENDMENT TO CHAPTER 63 OF THE WYOMING DEPARTMENT OF INSURANCE RULES AND REGULATIONS,	))))	Docket No. 15-30

STATEMENT OF PRINCIPAL REASONS

FOR

Amendment of Chapter 63 of Wyoming Insurance Department Regulation

Medical Necessity Review Rights

Wyoming Statute § 26-40-201 was originally signed into law by Governor Dave Freudenthal on March 2, 2009, and was effective July 1, 2010. This statute was designed to define what medical necessity was, and establish requirements for benefit payments and benefit denials under a medical necessity standard. Changes were made to W.S. §26-40-201 during the 2015 General Session by HB0057, HEA5, and the changes were signed into law by Governor Mead on February 25, 2015. The changes extend the period of time for a request for external review from sixty (60) to one hundred twenty (120) days after receiving notice of the denial, and requires the independent review organization assigned to review the claim to forward the submitted information to the opposing party within one day of receipt. The changes made by HB0057, HEA5 made it necessary to amend this Regulation to ensure consistency with the statutory language.

In addition, on or about November 25, 2013, Governor Mead required all State Agencies to reduce their Rules both in number and in length. Changes have been made to reduce, reorganize and clarify the existing rule to comply with the Governor's directive. Such changes include utilization of consistent language, removing unnecessary and duplicative language, and eliminating reiteration of statutory language in the rule. The old Rule 63 contained approximately 7,266 words. The amended Rule 63 contains approximately 6,612 words, which represents a reduction in length of 9%.

Finally, recent changes have been made to federal law applicable to the payment and denial of benefits on the basis of medical necessity. Changes have been made to this regulation to bring it into compliance with existing federal law.

CHAPTER 49
SMALL EMPLOYER HEALTH INSURANCE

Section 1. **Authority**

This Regulation is issued pursuant to the authority vested in the Commissioner under W.S. §§ 26-2-110, 26-19-304(a)(xii) and 26-19-310.

Section 2. **Definitions**

(a) For the purposes of this Regulation: "Associate member of an employee organization" means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. § 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. § 1002(37A)), other than the following:

(i) An individual, or the beneficiary of such individual, who is employed by a participating employer within a bargaining unit covered by at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

(ii) An individual who is a present or former employee, or a beneficiary of such employee, of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan or of a related plan.

(b) "New entrant" means an eligible employee, or the dependent of an eligible employee, if coverage is offered to the dependent, who becomes part of an employer group after the initial period for enrollment in a health benefit plan, and who enrolls on a timely basis within the prescribed enrollment period. If an eligible employee has continued coverage under the provisions of W.S. § 26-19-113, or under the provisions of applicable Federal law, and the continued coverage is voluntarily continued to, or is voluntarily terminated on, a date that is after the end of that person's prescribed initial enrollment period of a health benefit plan, that eligible employee and his or her dependents shall not be considered late enrollees, as defined in W.S. § 26-19-302(xv).

(c) "Qualifying previous coverage" and "qualifying existing coverage" means public or private benefits or coverage provided under:

(i) Medicare, Medicaid, the Wyoming Health Insurance Pool, or other health benefit programs or coverages operated or maintained by any governmental entity;

(ii) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health plan; or

(iii) An individual health benefit plan (including coverage issued by a health maintenance organization, prepaid hospital or medical care plan, or a fraternal benefit society) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan.

(d) "Risk characteristic" means the claims experience, duration of coverage, or any similar characteristic related to the experience of a small employer group or of any member of a small employer group.

(e) "Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

Section 3. **Applicability and Scope**

(a) This Regulation shall apply to any health benefit plan, whether provided on a group or individual basis, which:

(i) Meets one or more of the conditions set forth in W.S. § 26-19-303;

(ii) Provides coverage to two or more eligible employees of a small employer, without regard to whether the policy or certificate was issued in this state; and

(iii) Is in effect on or after the effective date of W.S. § 26-19-301 et seq.

(b) A carrier that provides an individual health benefit plan to two or more of the employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of W.S. § 26-19-301 et seq. and this Regulation with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contribution as is explained in W.S. § 26-19-303.

(c) In the case of a carrier that provides individual health benefit plans to two or more employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in W.S. § 26-19-302(a)(xxii) and the small employer carrier shall be subject to W.S. § 26-19- 306(a) (relating to guaranteed issue of coverage) if:

(i) The small employer has at least two (2) employees;

(ii) The small employer contributes directly or indirectly to the premiums charged by the carrier; and

(iii) The carrier is aware or should have been aware of the contribution by the employer.

(d) The provisions of W.S. § 26-19-301 et seq. and this Regulation shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

(e) An individual health insurance policy shall not be subject to the provisions of W.S. § 26-19-301 et seq. and this Regulation solely because the policyholder elects a deduction under Section 162(l) of the Internal Revenue Code.

(f) Change in Employer Status:

(i) If a small employer, as defined by applicable federal or state law, is issued a health benefit plan under the terms of W.S. § 26-19-301 et seq., the provisions of W.S. § 26-19-301 et seq. and this Regulation shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than the required number of eligible employees to be considered a small employer. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than the required number of eligible employees to be considered a small employer but no later than the anniversary date of the employer's health benefit plan, notify the employer that the protection provided under W.S. § 26-19-301 et seq. and this Regulation shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

(ii) If a health benefit plan is issued to an employer that is not a small employer as defined in W.S. § 26-19-302(a)(xxii) or as defined by applicable federal or state law, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more eligible employees), the terms of W.S. § 26-19-301 et seq. shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of W.S. § 26-19-301 et seq. solely because the carrier continues to provide coverage under the health benefit plan to the employer

(iii) A carrier providing coverage to an employer described in subparagraph (f)(ii) , who becomes aware that the employer meets the requirements to be a small employer, as defined by applicable federal or state law, shall notify the employer within sixty (60) days of the options and protections available to the employer under W.S. § 26-19-301 et seq., including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

(iv) If a small employer has employees in more than one state, the provisions of W.S. § 26-19-301 et seq. and this Regulation shall apply to a health benefit plan issued to the small employer if:

(A) The majority of eligible employees of such small employer are employed in this state, or are residents of Wyoming; or

(B) If no state contains a majority of the eligible employees of the small employer, the primary business location for plan determination of the small employer shall be Wyoming.

(v) In determining whether the laws of Wyoming or another state apply to a health benefit plan issued to a small employer, the provisions of subparagraph (iv) shall be applied as of the plan issuance date.

(vi) If a health benefit plan is subject to W.S. § 26-19-301 et seq. and this Regulation, these provisions shall apply to all individuals covered under the health benefit plan, whether they reside in Wyoming or in another state.

(g) A carrier that is not operating as a small employer carrier in Wyoming shall not become subject to these provisions solely because a small employer that was issued a health benefit plan in another state by that carrier moves to Wyoming.

Section 4. **Establishment of Classes of Business**

(a) A small employer carrier that establishes more than one class of business as defined in W.S. § 26-19-302(a)(vii) shall maintain on file for inspection by the Commissioner the following information:

(i) A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

(ii) A statement describing the justification for establishing a separate class of business, and documentation substantiating differences in expected claims experience or administrative costs; and

(iii) A statement disclosing which, if any, health benefit plans are available in the class and any significant limitations related to the purchase of such plans.

(b) A carrier may not use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business.

Section 5. **Transition for Assumptions of Business from Another Carrier**

(a) A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in Wyoming unless:

(i) The transaction has been approved by the Commissioner of the state of domicile of the assuming carrier;

(ii) The transaction has been approved by the Commissioner of the state of domicile of the ceding carrier; and

(iii) The transaction otherwise meets the requirements of this section.

(b) A carrier domiciled in Wyoming that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plans from another carrier shall make a filing for approval with the Commissioner at least sixty (60) days prior to the date of the proposed transaction. The Commissioner may approve the transaction if the Commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of W.S. § 26-19-301 et seq. and this Regulation. The Commissioner shall not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Commissioner may approve the transaction as soon as the Commissioner deems reasonable after the filing.

(c) The filing required under paragraph (b) above shall:

(i) Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded;

(ii) Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business, pursuant to subsection (k), or will incorporate them into an existing class of business, pursuant to subsection (l). If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business into which the health benefit plans will be incorporated;

(iii) Describe whether the health benefit plans being assumed are currently available for purchase by small employers;

(iv) Describe the potential effect of the assumption, if any, on the benefits provided by the health benefit plans to be assumed;

(v) Describe the potential effect of the assumption, if any, on the premiums for the health benefit plans to be assumed;

(vi) Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and

(vii) Include any other information required by the Commissioner.

(d) A small employer carrier required to make a filing under subparagraph (b) above shall also make an informational filing with the Commissioner of each state in which there are small employer health benefit plans that would be included in the transaction. The informational filing to each state shall be made concurrently with the filing made under subparagraph (b) and shall include at least the information specified in subparagraph (c) for the small employer health benefit plans in that state.

(e) A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in Wyoming unless:

(i) The carrier has provided notice to the Commissioner at least sixty (60) days prior to the date of the proposed assumption. The notice shall contain the information specified in subparagraph (c).

(f) If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in W.S. § 26-19-304(a)(i), the assuming carrier shall make a filing with the Commissioner pursuant to W.S. § 26-19- 304(c) seeking suspension of the application of W.S. § 26-19-304(a)(i).

(g) An assuming carrier seeking suspension of the application of W.S. § 26-19-304(a)(i) shall not complete the assumption of health benefit plans covering small employers in Wyoming unless the Commissioner grants the suspension requested pursuant to subparagraph (f).

(h) Unless a different period is approved by the Commissioner, a suspension of the application of W.S. § 26-19-304(a)(i) shall, with respect to an assumed class of business, be for no more than fifteen (15) months and, with respect to each individual small employer, shall last only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business).

(i) Except as provided in subparagraph (b), a small employer carrier shall not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

(j) A small employer carrier may cede less than an entire class of business to an assuming carrier if:

(i) One or more small employers in the class have exercised their right under contract or Wyoming law to reject (either directly or by implication) the ceding of their health benefit plans to another carrier. In that instance, the transaction shall include each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or

(ii) After a written request from the transferring carrier, the Commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business.

(k) Except as provided in subsection (l), a small employer carrier that assumes one or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business.

(l) A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in W.S. § 26-19-302(a)(vii) (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions:

(i) Upon assumption of the health benefit plans, such health benefit plans shall be maintained as a separate class of business. During the fifteen-month (15) period following the assumption, each of the assumed small employer health benefit plans shall be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans.

(ii) The transfers authorized in subparagraph (a) shall occur with respect to each small employer on the anniversary date of the small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business.

(iii) A small employer carrier making a transfer pursuant to subparagraph (i) may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred.

(iv) The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to subparagraph (i). Upon transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption.

(v) During the fifteen-month period provided in this subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection shall not be considered a violation of the first sentence of W.S. § 26-19-304(b).

(m) An assuming carrier may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

(n) The Commissioner may approve a longer period of transition upon application of a small employer carrier. The application shall be made within sixty (60) days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

(o) Nothing in this section or in W.S. § 26-19-301 et seq. is intended to:

(i) Reduce or diminish any legal or contractual obligation or requirement, including any obligation of the ceding or assuming carrier related to the transaction;

(ii) Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

(iii) Reduce or diminish the protection related to an assumption reinsurance transaction otherwise provided by law.

Section 6. **Restrictions Relating to Premium Rates**

(a) A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. The

carrier shall also provide the Commissioner, upon request, the rate manual and any additional information or documentation specified in this Section.

(i) A small employer carrier that modifies the rating method used in the rate manual for a class of business shall maintain with the rate manual for a period of six (6) years information and documentation containing the following:

(A) The reasons the change in rating method is being modified;

(B) A complete description of each of the proposed modifications to the rating method;

(C) A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan);

(D) A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(E) A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of W.S. § 26-19-304.

(ii) For the purpose of this section a change in rating method shall mean:

(A) A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(B) A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(C) A change in the method of allocating expenses among health benefit plans in a class of business; or

(D) A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). A change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the

carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test.

(b) The rate manual developed pursuant to subsection (a) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

(c) A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(d) The rate manual developed pursuant to subsection (a) shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(e) Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(f) Except as provided in subparagraph (g), a premium charged to a small employer for a health benefit plan shall not include a separate application fee, underwriting fee, or any other separate fee or charge.

(g) A carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than five dollars ($5.00) per month per employee and is applied in a uniform manner to each health benefit plan in a class of business, with such fee being included in determining the carrier's compliance with W.S. § 26-19-304.

(h) A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to subsection (a) shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(i) Each rate manual, updates, and changes developed pursuant to subsection (a) shall be maintained by the carrier for a period of six (6) years.

(j) The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Commissioner.

(k) If group size is used as a case characteristic, the highest rate factor associated with a group size shall not exceed the lowest rate factor by more than 20 percent (20%).

(l) A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

(m) A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(n) Changes in premium rates for a small employer shall be subject to the provisions in W.S. § 26-19-304.

Section 7. **Requirement to Insure Entire Groups**

(a) A small employer carrier:

(i) That offers coverage to a small employer shall offer to provide coverage to each eligible employee and may offer coverage to each dependent of an eligible employee. Except as provided in paragraph (ii), the small employer carrier shall provide the same health benefit plan to each employee and eligible dependent(s);

(ii) May offer the employees the option of choosing among one or more health benefit plans, provided that each employee may choose any of the offered plans. The choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the employees or their dependents, unless allowed by applicable federal or state law;

(iii) Shall require each small employer that applies for coverage, as part of the application process, to provide a complete list of eligible employees and dependents, if offered, as defined in applicable federal or state law. Employees who are listed as being in their waiting period, probationary period or other period with similar limitations of coverage must be identified, including the ending date for each employee's period of limitation. Any subsequent lists submitted to the carrier shall also contain the information required in this section. The carrier shall require the employer to provide appropriate supporting documentation to verify the information required under this paragraph;

(iv) Shall secure a waiver with respect to each eligible employee and eligible dependents if dependent coverage is offered who declines an offer of coverage. The waiver shall be signed by the eligible employee or by the employee on behalf of the eligible dependent(s). The waiver shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall include the reason for declining coverage ,a written warning of the penalties imposed on late enrollees and a statement informing of any special enrollment rights, as allowed by applicable federal or state law. Waivers shall be maintained by the carrier for a period of six (6) years;

(v) Shall not issue coverage to a small employer that refuses to provide the list required under subparagraph (iii) or a waiver required under subparagraph (iv);

(vi) Shall not issue coverage to a small employer if the carrier, or the carrier's producer, has reason to believe that the small employer has induced or pressured an eligible employee or eligible dependent, if dependent coverage is offered, to decline coverage due the individual's risk characteristics.

(vii) Shall offer new entrants to a small employer group an opportunity to enroll in the health benefit plan. A new entrant who does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to subsection (a)(ii), the new entrant shall be offered the same choice of health benefit plans as the other members of the group.

(viii) Shall not apply a waiting period, elimination period or other similar limitation of coverage unless allowed by applicable federal and state law.

(ix) Shall accept new entrants for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents if dependent coverage is offered, except that a carrier may exclude coverage for preexisting medical conditions, if allowed by applicable federal or state law.

(x) May assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of W.S. § 26-19-304. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant.

(b) A producer shall:

(i) Notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee or eligible

dependent, if dependent coverage is offered, to decline coverage due to the individual's risk characteristics.

Section 8. **Consideration of Industry**

(a) Except as provided in subsections (b) and (c), a small employer carrier may not consider the trade or occupation of the employees of a small employer or the industry or type of business in which the small employer is engaged in determining whether to issue or continue to provide coverage to the small employer.

(b) A small employer carrier may use industry as a case characteristic in establishing premium rates, subject to applicable federal and state law.

(c) A small employer carrier may consider trade, occupation or industry as part of the eligibility criteria for a class of business, subject to applicable federal and state law.

Section 9. **Application to Re-enter State**

(a) A carrier that has been prohibited from writing coverage for small employers in Wyoming pursuant to W.S. § 26-19-305(c) may not resume offering health benefit plans to small employers in Wyoming until the carrier has made a petition and has been approved by the Commissioner.

(b) In the case of a small employer carrier doing business in only one established geographic service area of Wyoming, if the small employer carrier elects to nonrenew a health benefit plan under W.S. § 26-19-305(a)(vi), the small employer carrier shall be prohibited from offering health benefit plans to small employers in any part of the service area for a period of five (5) years. In addition, the small employer carrier shall not offer health benefit plans to small employers in any other geographic area of the state without the prior approval of the Commissioner.

Section 10. **Qualifying Previous and Qualifying Existing Coverage**

(a) For the purposes of W.S. § 26-19-302(a)(xv) and 26-19-306(c)(ii), an individual will be considered to have previous or existing coverage if the previous or existing policy, certificate or other benefit arrangement met the relevant definition of Section 2(c) of this Regulation. The small employer carrier shall interpret W.S. § 26-19-301 et seq. and this Regulation no less favorably to an insured individual than the following:

(i) A health insurance policy, certificate or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement.

(ii) A health insurance policy, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the basic health benefit plan if it provides benefits that:

(A) Have an actuarial value as considered for a normal distribution of groups that is not substantially less than the actuarial value of the basic health benefit plan; or

(B) Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for such services in the basic health benefit plan.

(b) In making a determination under subsection (a), a small employer carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan.

(c) For the purposes of W.S. § 26-19-306(c)(ii), an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement met the definition in Section 2(c) of this Regulation and provided any benefit with respect to that service.

(d) A small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each eligible dependent(s) if dependent coverage is offered at the time such employee or dependent initially enrolls into the health benefit plan. The small employer carrier shall contact the source of such previous or existing coverage to determine the benefits or limitations of the previous or existing coverage.

Section 11. **Restrictive Riders and Rates**

(a) Except as permitted in applicable federal and state law, a small employer carrier shall not modify or restrict a basic or standard health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

(b) Except as permitted in applicable federal and state law, a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee if dependent coverage is offered, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent if dependent coverage is offered for specific diseases, medical conditions or services otherwise covered by the plan.

Section 12. **Rules Related to Fair Marketing**

(a) A small employer carrier shall actively market each of its health benefit plans in Wyoming. A small employer carrier may not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier has good cause and has received the prior approval of the Commissioner.

(b) In marketing the basic and standard health benefit plans, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans. Any producer authorized by a small employer carrier to market health benefit plans in Wyoming shall also be authorized to market the basic and standard health benefit plans.

(c) A small employer carrier shall actively offer all health benefit plans actively marketed in Wyoming to any small employer that applies for or makes an inquiry regarding health insurance coverage. The offer shall be in writing and the offer may be provided directly to the small employer or delivered through a producer and shall include at least the following information:

(i) A general description of the benefits contained in the basic and standard health benefit plans and any other health benefit plan being offered to the small employer; and

(ii) Information describing how the small employer may enroll in the plans.

(d) A small employer carrier shall provide a price quote to a small employer directly or through an authorized producer within fifteen (15) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer directly or through an authorized producer within ten (10) working days of receiving a request for a price quote of any additional information needed to provide the quote.

(e) A small employer carrier may not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than are applied for other health benefit plans.

(f) The small group carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage, unless, membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan.

(g) A small employer carrier shall not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

(h) Carriers offering individual and group health benefit plans in Wyoming shall be responsible for determining whether the plans are subject to the requirements of W.S. § 26-19-301 et seq. and this Regulation. Carriers shall elicit the following information from applicants for such plans at the time of application:

(i) Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(ii) Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.

(i) If a small employer carrier fails to comply with subparagraph (h), the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with subparagraph (h).

(j) A small employer carrier shall file annually on or before March 15, in a format prescribed by the Commissioner, the following information related to health benefit plans issued by the small employer carrier to small employers in Wyoming:

(i) The number of small employers that were issued health benefit plans in the previous calendar year, separated as to newly issued plans and renewals;

(ii) The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year, separated as to newly issued plans and renewals;

(iii) The number of small employer health benefit plans in force in each county, or by zip code, of the state as of December 31 of the previous calendar year;

(iv) The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

(v) The number of small employer health benefit plans that were terminated or non-renewed for reasons other than nonpayment of premium by the carrier in the previous calendar year; and

(vi) The number of small employer health benefit plans that were issued to small employers that were uninsured for at least the three (3) months prior to issue.

Section 13. **Effective Date**

(a) This regulation shall become effective upon filing with the Secretary of State.

CHAPTER 49

REGULATION TO IMPLEMENT THE REGARDING SMALL EMPLOYER HEALTH INSURANCE AVAILABILITY ACT

' 26-19-301 et seq.

Section 1. Statement of Purpose

This Regulation is intended to implement the provisions of the Small Employer Health Insurance Availability Act, ' 26-19-301 et seq. The general purposes of W.S. ' 26-19-301 et seq. and this Regulation are to provide for the availability of health insurance coverage to small employers, regardless of their health status or claims experience; to regulate insurer rating practices and establish limits on differences in rates between health benefit plans; to ensure renewability of coverage; to provide for continuation of coverage in certain situations; to establish limitations on underwriting practices, eligibility requirements and the use of preexisting condition exclusions; to provide for establishment of a reinsurance program; to direct the basis of market competition away from risk selection and toward the efficient management of health care; and to improve the overall fairness and efficiency of the small group health insurance market. Wyoming Statute ' 26-19-301 et seq. and this Regulation are intended to promote broader spreading of risk in the small employer marketplace. Wyoming Statute ' 26-19-301 et seq., and this Regulation are intended to regulate all health benefit plans sold to small employers, whether sold directly or through associations or other groupings of small employers. Carriers that provide health benefit plans to small employers are intended to be subject to all of the provisions of W.S. ' 26-19-301 et seq., and this Regulation.

Section 1. **Authority**

This Regulation is issued pursuant to the authority vested in the Commissioner under W.S. §§ ' ' 26-2-110, 26-19-304(a)(xii) and 26-19-310.

Section 2. **Definitions**

For the purposes of this Regulation:

(a) "Associate member of an employee organization" means any individual who participates in an employee benefit plan (as defined in 29 U.S.C. ' § 1002(1)) that is a multi-employer plan (as defined in 29 U.S.C. ' § 1002(37A)), other than the following:

(i) An individual, (or the beneficiary of such individual,) who is employed by a participating employer within a bargaining unit covered by at least one of the collective

bargaining agreements under or pursuant to which the employee benefit plan is established or maintained; or

(ii) An individual who is a present or former employee, ~~(~~or a beneficiary of such employee,~~)~~ of the sponsoring employee organization, of an employer who is or was a party to at least one of the collective bargaining agreements under or pursuant to which the employee benefit plan is established or maintained, or of the employee benefit plan ~~(~~or of a related plan~~)~~.

(b) "New entrant" means an eligible employee, or the dependent of an eligible employee, ~~(~~if coverage is offered to the dependent~~)~~, who becomes part of an employer group after the initial period for enrollment in a health benefit plan, and who enrolls on a timely basis within the prescribed enrollment period. If an eligible employee has continued coverage under the provisions of W.S. ~~'~~ § 26-19-113, or under the provisions of applicable Federal law~~the Consolidated Omnibus Budget Reconciliation Act of 1985, (P.L. 99-272 and as amended)~~, and the continued coverage is voluntarily continued to, or is voluntarily terminated on, a date that is after the end of that person's prescribed initial enrollment period of a health benefit plan, that eligible employee and his or her dependents shall not be considered late enrollees, as defined in W.S. ~~'~~ § 26-19-302(xv).

(c) "Qualifying previous coverage" and "qualifying existing coverage" means public or private benefits or coverage provided under:

(i) Medicare, Medicaid, the Wyoming Health Insurance Pool, or other health benefit programs or coverages operated or maintained by any governmental entity;

(ii) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health plan; or

(iii) An individual health benefit plan (including coverage issued by a health maintenance organization, prepaid hospital or medical care plan, or a fraternal benefit society) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan.

(d) "Risk characteristic" means the ~~health status,~~ claims experience, duration of coverage, or any similar characteristic related to the ~~health status or~~ experience of a small employer group or of any member of a small employer group.

(e) "Risk load" means the percentage above the applicable base premium rate that is charged by a small employer carrier to a small employer to reflect the risk characteristics of the small employer group.

Section 3. ~~Section 4.~~ **Applicability and Scope**

(a) This Regulation shall apply to any health benefit plan, whether provided on a group or individual basis, which:

(i) Meets one or more of the conditions set forth in W.S. ~~'~~ § 26-19-303;

(ii) Provides coverage to two or more eligible employees of a small employer ~~located in this state~~, without regard to whether the policy or certificate was issued in this state; and

(iii) Is in effect on or after the effective date of W.S. ~~'~~ § 26-19-301 et seq.

(b) A carrier that provides an individual health benefit plan to two or more of the employees of a small employer shall be considered a small employer carrier and shall be subject to the provisions of W.S. ~~'~~ § 26-19-301 et seq. and this Regulation with respect to such policies if the small employer contributes directly or indirectly to the premiums for the policies and the carrier is aware or should have been aware of such contribution as is explained in W.S. ~~'~~ § 26-19-303.

(c) In the case of a carrier that provides individual health benefit plans to two or more employees of a small employer, the small employer shall be considered to be an eligible small employer as defined in W.S. ~~'~~ § 26-19-302(a)(xxii) and the small employer carrier shall be subject to W.S. ~~'~~ § 26-19- 306(a) (relating to guaranteed issue of coverage) if:

(i) The small employer has at least two (2) employees;

(ii) The small employer contributes directly or indirectly to the premiums charged by the carrier; and

(iii) The carrier is aware or should have been aware of the contribution by the employer.

(d) The provisions of W.S. ~~'~~ § 26-19-301 et seq. and this Regulation shall apply to a health benefit plan provided to a small employer or to the employees of a small employer without regard to whether the health benefit plan is offered under or provided through a group policy or trust arrangement of any size sponsored by an association or discretionary group.

(e) An individual health insurance policy shall not be subject to the provisions of W.S. ~~'~~ § 26-19-301 et seq. and this Regulation solely because the policyholder elects a deduction under Section 162(l) of the Internal Revenue Code.

(f) Change in Employer Status:

(i) If a small employer, as defined by applicable federal or state law, is issued a health benefit plan under the terms of W.S. § 26-19-301 et seq., the provisions of W.S. § 26-19-301 et seq. and this Regulation shall continue to apply to the health benefit plan in the case that the small employer subsequently employs more than ~~fifty (50) eligible employees~~ the required number of eligible employees to be considered a small employer. A carrier providing coverage to such an employer shall, within sixty (60) days of becoming aware that the employer has more than ~~fifty (50) eligible employees~~ the required number of eligible employees to be considered a small employer but no later than the anniversary date of the employer's health benefit plan, notify the employer that the protection provided under W.S. § 26-19-301 et seq. and this Regulation shall cease to apply to the employer if such employer fails to renew its current health benefit plan or elects to enroll in a different health benefit plan.

(ii) If a health benefit plan is issued to an employer that is not a small employer as defined in W.S. ~~'~~ § 26-19-302(a)(xxii) or as defined by applicable federal or state law, but subsequently the employer becomes a small employer (due to the loss or change of work status of one or more eligible employees), the terms of W.S. ~~'~~ § 26-19-301 et seq. shall not apply to the health benefit plan. The carrier providing a health benefit plan to such an employer shall not become a small employer carrier under the terms of W.S. ~~'~~ § 26-19-301 et seq. solely because the carrier continues to provide coverage under the health benefit plan to the employer~~. If an employer, on the effective date of this regulation, becomes a small employer by virtue of having between twenty-six (26) and fifty (50) eligible employees, that small employer's health benefit plan must comply with the provisions of W.S. ' 26-19-301, et seq. and this regulation no later than July 1, 1996, with the exception of compliance with the rate restrictions found in W.S. ' 26-19-304 and section 7 of this regulation. Small employer group carriers who insure small employer groups that become subject to the act and this regulation solely because of having between twenty-six (26) and fifty (50) eligible employees shall have until August 1, 1998, to have the premium rates charged for groups of between twenty-six (26) and fifty (50) eligible employees comply with the provisions of W.S. ' 26-19-304 and Section 7 of this regulation.~~

(iii) ~~(B)~~ A carrier providing coverage to an employer described in ~~subparagraph (A)~~ subparagraph (f)(ii) ~~shall~~, ~~within sixty (60) days of~~ who ~~become~~s~~ing~~ aware that the employer ~~has fifty (50) or fewer eligible employees~~meets the requirements to be a small employer, as defined by applicable federal or state law, shall notify the employer within sixty (60) days of the options and protections available to the employer under W.S. ~~'~~ § 26-19-301 et seq., including the employer's option to purchase a small employer health benefit plan from any small employer carrier.

(iv) ~~(g) (i) (A)~~ If a small employer has employees in more than one state, the provisions of W.S. ~~'~~ § 26-19-301 et seq. and this Regulation shall apply to a health benefit plan issued to the small employer if:

(A) ~~(I)~~ The majority of eligible employees of such small employer are employed in this state, or ~~were~~ are residents of Wyoming; or

(B) ~~(II)~~ If no state contains a majority of the eligible employees of the small employer, the primary business location for plan determination of the small employer shall be ~~is in this state~~Wyoming.

(v) ~~(B)~~ In determining whether the laws of ~~this state~~Wyoming or another state apply to a health benefit plan issued to a small employer ~~described in subparagraph (A)~~, the provisions of ~~the paragraph~~subparagraph ~~(A)~~(iv) shall be applied as of the ~~date the health benefit plan was issued to the small employer~~plan issuance date.~~.~~

(vi) ~~(ii)~~ If a health benefit plan is subject to W.S. ~~'~~§ 26-19-301 et seq. and this Regulation, these~~the~~ provisions ~~of W.S. ' 26-19-301 et seq. and this Regulation~~ shall apply to all individuals covered under the health benefit plan, whether they reside in ~~this state~~Wyoming or in another state.

(g) ~~(h)~~ A carrier that is not operating as a small employer carrier in ~~this state~~Wyoming shall not become subject to these provisions ~~of W.S. ' 26-19-301 et seq. and this Regulation~~ solely because a small employer that was issued a health benefit plan in another state by that carrier moves to ~~this state~~Wyoming.

Section 4. ~~Section 5.~~ **Establishment of Classes of Business**

(a) A small employer carrier that establishes more than one class of business as defined in W.S. ~~'~~§ 26-19-302(a)(vii) shall maintain on file for inspection by the Commissioner the following information ~~with respect to each class of business so established~~:

(i) A description of each criterion employed by the carrier (or any of its agents) for determining membership in the class of business;

~~(i)~~ (ii) A statement describing the justification for establishing ~~the~~ a separate ~~class as a separate~~ class of business, and documentation substantiating differences ~~that the establishment of additional groupings within the class of business is intended to reflect substantial differences~~ in expected claims experience or administrative costs ~~related to the reasons set forth in W.S. ' 26-19-302(a)(vii)(B)~~; and

~~(ii)~~ (iii) A statement disclosing which, if any, health benefit plans are ~~currently~~ available ~~for purchase~~ in the class and any significant limitations related to the purchase of such plans.

(b) A carrier may not ~~directly or indirectly~~ use group size as a criterion for establishing eligibility for a health benefit plan or for a class of business.

~~(c) A carrier may establish a maximum of three (3) classes of business as set forth in W.S. ' 26-19-302 (a)(vii)(A) and (B), with no more than two (2) additional groups within each established class.~~

Section 5. ~~Section 6.~~ **Transition for Assumptions of Business from Another Carrier**

(a) ~~(a) (i)~~ A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in ~~this state~~ Wyoming unless:

(i) The transaction has ~~not been disapproved~~ been approved by the Commissioner of the state of domicile of the assuming carrier;

(ii) ~~(B)~~ The transaction has ~~not been disapproved~~been approved by the Commissioner of the state of domicile of the ceding carrier; and

(iii) ~~(C)~~ The transaction otherwise meets the requirements of this section.

(b) ~~(ii)~~ A carrier domiciled in ~~this st~~Wyoming~~ate~~ that proposes to assume or cede the entire insurance obligation and/or risk of one or more small employer health benefit plans from another carrier shall make a filing for approval with the Commissioner at least sixty (60) days prior to the date of the proposed transaction. The Commissioner may approve the transaction if the Commissioner finds that the transaction is in the best interests of the individuals insured under the health benefit plans to be transferred and is consistent with the purposes of W.S. ~~'~~ § 26-19-301 et seq. and this Regulation. The Commissioner shall not approve the transaction until at least thirty (30) days after the date of the filing; except that, if the ceding carrier is in hazardous financial condition, the Commissioner may approve the transaction as soon as the Commissioner deems reasonable after the filing.

(c) ~~(iii) (A)~~ The filing required under paragraph (~~ii~~b) above shall:

(i) ~~(I)~~ Describe the class of business (including any eligibility requirements) of the ceding carrier from which the health benefit plans will be ceded;

(ii) ~~(II)~~ Describe whether the assuming carrier will maintain the assumed health benefit plans as a separate class of business, pursuant to subsection (~~c~~k), or will incorporate them into an existing class of business, pursuant to subsection (~~d~~l). If the assumed health benefit plans will be incorporated into an existing class of business, the filing shall describe the class of business ~~of the assuming carrier~~ into which the health benefit plans will be incorporated;

(iii) ~~(III)~~ Describe whether the health benefit plans being assumed are currently available for purchase by small employers;

(iv) ~~(IV)~~ Describe the potential effect of the assumption, ~~(~~if any,~~)~~ on the benefits provided by the health benefit plans to be assumed;

(v) ~~(V)~~ Describe the potential effect of the assumption ~~(~~, if any~~)~~, on the premiums for the health benefit plans to be assumed;

(vi) ~~(VI)~~ Describe any other potential material effects of the assumption on the coverage provided to the small employers covered by the health benefit plans to be assumed; and

(vii) ~~(VII)~~ Include any other information required by the Commissioner.

(d) ~~(B)~~ A small employer carrier required to make a filing under subparagraph (b~~ii~~) above shall also make an informational filing with the Commissioner of each state in which there are small employer health benefit plans that would be included in the transaction. ~~.~~ The informational filing to each state shall be made concurrently with the filing made under subparagraph (b~~ii~~) and shall include at least the information specified in subparagraph (c~~A~~) for the small employer health benefit plans in that state.

(e) ~~(iv)~~ A small employer carrier shall not transfer or assume the entire insurance obligation and/or risk of a health benefit plan covering a small employer in ~~this state~~Wyoming unless: ~~it complies with the following provisions:~~

(i) ~~(A)~~ The carrier has provided notice to the Commissioner at least sixty (60) days prior to the date of the proposed assumption. The notice shall contain the information specified in subparagraph (~~iii~~c). ~~for the health benefit plans covering small employers in this state.~~

(f) ~~(B)~~ If the assumption of a class of business would result in the assuming small employer carrier being out of compliance with the limitations related to premium rates contained in W.S. ~~'~~§ 26-19-304(a)(i), the assuming carrier shall make a filing with the Commissioner pursuant to W.S. ~~'~~§ 26-19- 304(c) seeking suspension of the application of W.S. ~~'~~§ 26-19-304(a)(i).

(g) ~~(C)~~ An assuming carrier seeking suspension of the application of W.S. ~~'~~§ 26-19-304(a)(i) shall not complete the assumption of health benefit plans covering small employers in ~~this state~~ Wyoming unless the Commissioner grants the suspension requested pursuant to subparagraph (~~B~~f).

(h) ~~(D)~~ Unless a different period is approved by the Commissioner, a suspension of the application of W.S. ~~'~~§ 26-19-304(a)(i) shall, with respect to an assumed

class of business, be for no more than fifteen (15) months and, with respect to each individual small employer, shall last only until the anniversary date of such employer's coverage (except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business).

(i) ~~(b) (i)~~ Except as provided in subparagraph (~~ii~~b), a small employer carrier shall not cede or assume the entire insurance obligation and/or risk for a small employer health benefit plan unless the transaction includes the ceding to the assuming carrier of the entire class of business which includes such health benefit plan.

(j) ~~(ii)~~ A small employer carrier may cede less than an entire class of business to an assuming carrier if:

(i) ~~(A)~~ One or more small employers in the class have exercised their right under contract or ~~state~~ Wyoming law to reject (either directly or by implication) the ceding of their health benefit plans to another carrier. In that instance, the transaction shall include each health benefit plan in the class of business except those health benefit plans for which a small employer has rejected the proposed cession; or

(ii) ~~(B)~~ After a written request from the transferring carrier, the Commissioner determines that the transfer of less than the entire class of business is in the best interests of the small employers insured in that class of business.

(k) ~~(c)~~ Except as provided in subsection (~~d~~l), a small employer carrier that assumes one or more health benefit plans from another carrier shall maintain such health benefit plans as a separate class of business.

(l) ~~(d)~~ A small employer carrier that assumes one or more health benefit plans from another carrier may exceed the limitation contained in W.S. ~~'~~ § 26-19-302(a)(vii) (relating to the maximum number of classes of business a carrier may establish) due solely to such assumption for a period of up to fifteen (15) months after the date of the assumption, provided that the carrier complies with the following provisions:

(i) Upon assumption of the health benefit plans, such health benefit plans shall be maintained as a separate class of business. During the fifteen-month (15) period following the assumption, each of the assumed small employer health benefit plans shall be transferred by the assuming small employer carrier into a single class of business operated by the assuming small employer carrier. The assuming small employer carrier shall select the class of business into which the assumed health benefit plans will be transferred in a manner such that the transfer results in the least possible change to the benefits and rating method of the assumed health benefit plans.

(ii) The transfers authorized in subparagraph (a) shall occur with respect to each small employer on the anniversary date of the small employer's coverage, except that the period with respect to an individual small employer may be extended beyond its first anniversary date for a period of up to twelve (12) months if the anniversary date occurs within three (3) months of the date of assumption of the class of business.

(iii) A small employer carrier making a transfer pursuant to subparagraph (i) may alter the benefits of the assumed health benefit plans to conform to the benefits currently offered by the carrier in the class of business into which the health benefit plans have been transferred.

(iv) The premium rate for an assumed small employer health benefit plan shall not be modified by the assuming small employer carrier until the health benefit plan is transferred pursuant to subparagraph (i). Upon transfer, the assuming small employer carrier shall calculate a new premium rate for the health benefit plan from the rate manual established for the class of business into which the health benefit plan is transferred. In making such calculation, the risk load applied to the health benefit plan shall be no higher than the risk load applicable to such health benefit plan prior to the assumption.

(v) During the fifteen-month period provided in this subsection, the transfer of small employer health benefit plans from the assumed class of business in accordance with this subsection shall not be considered a violation of the first sentence of W.S. ~~'~~§ 26-19-304(b).

(m) ~~(e)~~ An assuming carrier may not apply eligibility requirements (including minimum participation and contribution requirements) with respect to an assumed health benefit plan (or with respect to any health benefit plan subsequently offered to a small employer covered by such an assumed health benefit plan) that are more stringent than the requirements applicable to such health benefit plan prior to the assumption.

(n) ~~(f)~~ The Commissioner may approve a longer period of transition upon application of a small employer carrier. The application shall be made within sixty (60) days after the date of assumption of the class of business and shall clearly state the justification for a longer transition period.

(o) ~~(g)~~ Nothing in this section or in W.S. ~~'~~§ 26-19-301 et seq. is intended to:

(i) Reduce or diminish any legal or contractual obligation or requirement, including any obligation of the ceding or assuming carrier related to the transaction;

(ii) Authorize a carrier that is not admitted to transact the business of insurance in this state to offer or insure health benefit plans in this state; or

(iii) Reduce or diminish the protection related to an assumption reinsurance transaction otherwise provided by law.

Section 6. ~~Section 7.~~ **Restrictions Relating to Premium Rates**

(a) ~~(a)~~ ~~(i)~~ A small employer carrier shall develop a separate rate manual for each class of business. Base premium rates and new business premium rates charged to small employers by the small employer carrier shall be computed solely from the applicable rate manual developed pursuant to this subsection. To the extent that a portion of the premium rates charged by a small employer carrier is based on the carrier's discretion, the manual shall specify the criteria and factors considered by the carrier in exercising such discretion. The carrier shall also provide the Commissioner, upon request, the rate manual and any additional information or documentation specified in this Section.

(i) ~~(ii)~~ ~~(A)~~ A small employer carrier that modifies the rating method used in the rate manual for a class of business shall maintain with the rate manual for a period of six (6) years information and documentation containing the following:

(A) ~~(I)~~ The reasons the change in rating method is being modified;

(B) ~~(II)~~ A complete description of each of the proposed modifications to the rating method;

(C) ~~(III)~~ A description of how the change in rating method would affect the premium rates currently charged to small employers in the class of business, including an estimate from a qualified actuary of the number of groups or individuals (and a description of the types of groups or individuals) whose premium rates may change by more than ten percent (10%) due to the proposed change in rating method (not generally including increases in premium rates applicable to all small employers in a health benefit plan);

(D) ~~(IV)~~ A certification from a qualified actuary that the new rating method would be based on objective and credible data and would be actuarially sound and appropriate; and

(E) ~~(V)~~ A certification from a qualified actuary that the proposed change in rating method would not produce premium rates for small employers that would be in violation of W.S. ~~'~~ § 26-19-304.

(ii) ~~(B)~~ For the purpose of this section a change in rating method shall mean:

(A) A change in the number of case characteristics used by a small employer carrier to determine premium rates for health benefit plans in a class of business;

(B) A change in the manner or procedures by which insureds are assigned into categories for the purpose of applying a case characteristic to determine premium rates for health benefit plans in a class of business;

(C) A change in the method of allocating expenses among health benefit plans in a class of business; or

(D) A change in a rating factor with respect to any case characteristic if the change would produce a change in premium for any small employer that exceeds ten percent (10%). A change in a rating factor shall mean the cumulative change with respect to such factor considered over a twelve (12) month period. If a small employer carrier changes rating factors with respect to more than one case characteristic in a twelve (12) month period, the carrier shall consider the cumulative effect of all such changes in applying the ten percent (10%) test.

(b) ~~(b) (i)~~ The rate manual developed pursuant to subsection (a) shall specify the case characteristics and rate factors to be applied by the small employer carrier in establishing premium rates for the class of business.

~~(ii) Pursuant to W.S. ' 26-19-304(a)(xi), a small employer carrier may not use case characteristics other than age, gender, industry, geographic area, family composition and group size without the prior approval of the Commissioner.~~

(c) ~~(iii)~~ A small employer carrier shall use the same case characteristics in establishing premium rates for each health benefit plan in a class of business and shall apply them in the same manner in establishing premium rates for each health benefit plan. Case characteristics shall be applied without regard to the risk characteristics of a small employer.

(d) ~~(iv)~~ The rate manual developed pursuant to subsection (a) shall clearly illustrate the relationship among the base premium rates charged for each health benefit plan in the class of business. If the new business premium rate is different than the base premium rate for a health benefit plan, the rate manual shall illustrate the difference.

(e) ~~(v)~~ Differences among base premium rates for health benefit plans shall be based solely on the reasonable and objective differences in the design and benefits of the health benefit plans and shall not be based in any way on the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan. A small employer carrier shall apply case characteristics and rate factors within a class of business in a manner that assures that premium differences among health benefit plans for identical small employer groups vary only due to reasonable and objective differences in the design and benefits of the health benefit plans and are not due to the actual or expected health status or claims experience of the small employer groups that choose or are expected to choose a particular health benefit plan.

(f) ~~(vi) (A)~~ Except as provided in subparagraph (~~B~~g), a premium charged to a small employer for a health benefit plan shall not include a separate application~~-~~ fee, underwriting fee, or any other separate fee or charge.

(g) ~~(B)~~ A carrier may charge a separate fee with respect to a health benefit plan (but only one fee with respect to such plan) provided the fee is no more than five dollars ($5.00) per month per employee and is applied in a uniform manner to each health benefit plan in a class of business, with such fee being included in determining the carrier's compliance with W.S. ~~'~~§ 26-19-304.

(h) ~~(vii)~~ A small employer carrier shall allocate administrative expenses to the basic and standard health benefit plans on no less favorable of a basis than expenses are allocated to other health benefit plans in the class of business. The rate manual developed pursuant to subsection (a) shall describe the method of allocating administrative expenses to the health benefit plans in the class of business for which the manual was developed.

(i) ~~(viii)~~ Each rate manual, updates, and changes developed pursuant to subsection (a) shall be maintained by the carrier for a period of six (6) years~~. Updates and changes to the manual shall be maintained with the manual~~.

(j) ~~(ix)~~ The rate manual and rating practices of a small employer carrier shall comply with any guidelines issued by the Commissioner.

(k) ~~(c)~~ If group size is used as a case characteristic~~ by a small employer carrier~~, the highest rate factor associated with a group size ~~classification~~ shall not exceed the lowest rate factor ~~associated with such a classification~~ by more than 20 percent (20%).

(l) ~~(d)~~ A small employer carrier shall revise its rate manual each rating period to reflect changes in base premium rates and changes in new business premium rates.

(m) ~~(e)~~ A small employer carrier shall keep on file for a period of at least six (6) years the calculations used to determine the change in base premium rates and new business premium rates for each health benefit plan for each rating period.

(n) ~~(f)~~ Changes in premium rates for a small employer shall be subject to the provisions in W.S. ~~'~~§ 26-19-304.

~~(g) (i) A representative of a Taft Hartley trust (including a carrier upon the written request of such a trust) may file in writing with the Commissioner a request for the waiver of application of the provisions of W.S. '§ 26-19-304(a) with respect to such trust.~~

~~(i) (ii) A request made under paragraph (i) shall identify the provisions for which the trust is seeking the waiver and shall describe, with respect to each provision, the extent to which application of such provision would:~~

~~(ii)~~

~~(iii) (A) Adversely affect the participants and beneficiaries of the trust; and~~

~~(iv)~~

~~(v) (B) Require modifications to one or more of the collective bargaining agreements under or pursuant to which the trust was or is established or maintained.~~

~~(iii) A waiver granted under W.S. ' § 26-19-303(c) shall not apply to an individual who participates in the trust because the individual is an associate member of an employee organization or the beneficiary of such an individual.~~

~~(vii)~~ (i) ~~(h) Pursuant to W.S. ' § 26-19-304(e)(ii), each small employer carrier shall file with the commissioner on or before March 15 an actuarial certification certifying that the carrier is in compliance with W.S. ' § 26-19-301 et seq. and this Regulation~~. ~~Such filing shall be in the format and, at a minimum, contain the information set forth in Appendix A.~~

~~(i) Small employer group carriers who insure small employer groups that become subject to this act solely because of having between twenty-six (26) and fifty (50) eligible employees shall have until August 1, 1998, to have the premium rates charged for groups of between twenty-six (26) and fifty (50) eligible employees comply with the provisions of W.S. ' 26-19-304.~~

Section 7. ~~Section 8.~~ **Requirement to Insure Entire Groups**

(a) A small employer carrier:

(i) ~~(i) A small employer carrier that~~ That offers coverage to a small employer shall offer to provide coverage to each eligible employee and may offer coverage to each dependent of an eligible employee. Except as provided in paragraph (ii), the small employer carrier shall provide the same health benefit plan to each ~~such~~ employee and eligible ~~to their~~ dependent~~(s) if dependent coverage is offered~~;~~.~~

(ii) ~~(ii) A small employer carrier~~ M~~m~~ay offer the employees ~~of a small employer~~ the option of choosing among one or more health benefit plans, provided that each employee may choose any of the offered plans. ~~Except as provided in W.S. ' 26-19-306(c) (with respect to exclusions for preexisting conditions),~~ T~~t~~he choice among benefit plans may not be limited, restricted or conditioned based upon the risk characteristics of the employees or their dependents, unless allowed by applicable federal or state law;~~.~~

(iii) ~~(b) (i) A small employer carrier~~ S~~s~~hall require each small employer that applies for coverage, as part of the application process, to provide a complete list of

eligible employees and dependents, if offered, ~~of eligible employees~~ as defined in ~~W.S. '~~ § ~~26-19-302(a)(ix) and (x)~~applicable federal or state law. ~~All full time employees who work at least thirty hours per week and are in their waiting period, probationary period or other similar limitation of coverage shall be listed.~~ Employees who are listed as being in their waiting period, probationary period or other period with similar limitations of coverage must be identified, including the ending date for each employee's period of limitation~~as such~~. ~~The list must include the date on which the full time employee who is in their waiting period, probationary period or other similar period of coverage limitation achieved full time employee status, and when the waiting period, probationary period or other similar period of limitation of coverage ends.~~ Any subsequent lists submitted to ~~a small employer~~the carrier shall also contain the information required in this section. The ~~small employer~~ carrier shall require the ~~small~~ employer to provide appropriate supporting documentation to verify the information required under this paragraph;~~.~~

(iv) ~~(ii) A small employer carrier shall~~ Shall secure a waiver with ~~-~~ respect to each eligible employee and ~~each~~ eligible dependents if dependent coverage is offered ~~of such an eligible employee~~ who declines an offer of coverage ~~under a health benefit plan provided to a small employer~~. The waiver shall be signed by the eligible employee or by the employee on behalf of the eligible dependent(s). ~~(on behalf of such employee or the dependent of such employee)~~ ~~and~~ The waiver shall certify that the individual who declined coverage was informed of the availability of coverage under the health benefit plan. The waiver form shall ~~require that~~ include the reason for declining coverage ~~be stated on the form and shall include~~, a written warning of the penalties imposed on late enrollees and a statement informing of any special enrollment rights, as allowed by applicable federal or state law.~~.~~ Waivers shall be maintained by the ~~small employer~~ carrier for a period of six (6) years;~~.~~

(v) ~~(iii) (A) A small employer carrier~~ S~~s~~hall not issue coverage to a small employer that refuses to provide the list required under subparagraph (iii) or a waiver required under subparagraph (iv~~i~~);~~.~~

(vi) ~~(B) (I) A small employer carrier s~~Shall not issue ~~-~~coverage to a small employer if the carrier, or ~~a~~ the carrier's producer ~~for such carrier~~, has reason to believe that the small employer has induced or pressured an eligible employee or eligible dependent, if dependent coverage is offered, ~~(or dependent of an eligible employee)~~ to decline coverage due the individual~~'~~'s risk characteristics.

~~(a) (II) A producer shall notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee (or dependent of an eligible employee or eligible dependent, if dependent coverage is offered,) to decline coverage due to the individual'' s risk characteristics. Failure to provide such notification to the carrier may subject the producer to administrative action by the Wyoming Department of Insurance.~~

~~(viii)~~ (vii) ~~(c) (i)~~ Shall offer ~~New~~ new entrants to a small employer group ~~shall be offered~~ an opportunity to enroll in the health benefit plan ~~currently held by such group~~. A new entrant who does not exercise the opportunity to enroll in the health benefit plan within the period provided by the small employer carrier may be treated as a late enrollee by the carrier, provided that the period provided to enroll in the health benefit plan extends at least thirty (30) days after the date the new entrant is notified of his or her opportunity to enroll. If a small employer carrier has offered more than one health benefit plan to a small employer group pursuant to subsection (a)(ii), the new entrant shall be offered the same choice of health benefit plans as the other members of the group.

~~(ix)~~ (viii) ~~(ii) A small employer carrier s~~Shall not apply a waiting period, elimination period or other similar limitation of coverage ~~(other than an exclusion for preexisting medical conditions or exclusion from coverage for late enrollees consistent with W.S'. ' 26~~ unless allowed by ~~19-306(c))~~applicable federal and state law ~~with respect to a new entrant that is longer than one hundred eighty (180) days~~.

~~(x)~~ (ix) ~~(iii) New entrants to a group shall~~Shall ~~be~~ accept new entrants~~ed~~ for coverage by the small employer carrier without any restrictions or limitations on coverage related to the risk characteristics of the employees or their dependents if dependent coverage is offered, except that a carrier may exclude coverage for preexisting medical conditions, ~~consistent with the provisions provided in W.S. ' 26-19-306(c).~~if allowed by applicable federal or state law.

(x) ~~(iv) A small employer carrier m~~May assess a risk load to the premium rate associated with a new entrant, consistent with the requirements of W.S. ~~'~~ § 26-19-304. The risk load shall be the same risk load charged to the small employer group immediately prior to acceptance of the new entrant ~~into the group~~.

(b) A producer shall:

~~(xi)~~ (i) Notify a small employer carrier, prior to submitting an application for coverage with the carrier on behalf of a small employer, of any circumstances that would indicate that the small employer has induced or pressured an eligible employee or eligible dependent, if dependent coverage is offered, to decline coverage due to the individual's risk characteristics.

~~(d) (i) (A) In the case of an eligible employee (or dependent of an eligible employee) who, prior to the effective dates of W.S. ' 26-19-306(a), W.S. ' 26-19-302(a)(xxii), and W.S. ' 26-19-306(e), was excluded from coverage or denied coverage by a small employer carrier in the process of providing a health benefit plan to an eligible small employer (as defined in W.S. ' 26-19-302(a)(xxii)), the small employer carrier shall provide an opportunity for the eligible employee (or dependent of such eligible employee) to enroll in the health benefit plan currently held by the small employer.~~

~~(B) A small employer carrier may require an individual who requests enrollment under this subsection to sign a statement indicating that such individual sought coverage under the group contract (other than as a late enrollee) and that the coverage was not offered to the individual.~~

~~(C) In the case of an eligible employee of an employer who becomes a small employer as defined in W.S. ' 26-19-302(a)(xxii) by virtue of having between twenty six (26) and fifty (50) eligible employees on the effective date of this regulation and was excluded from coverage because the employer was not classified as a small employer until July 1, 1996, that eligible employee shall be provided the opportunity to enroll in the health benefit plan. That employee shall be credited time towards the pre-existing condition period from the date of initial enrollment application in the health benefit plan until the effective date of that employee's coverage.~~

~~(ii) The opportunity to enroll shall meet the following requirements:~~

~~(A) The opportunity to enroll shall begin no later than October 1, 1995. The period of enrollment for individuals described in paragraph (i) (A) of this subsection shall last for at least 30 days.~~

~~(B) Unless the small employer carrier has documentation showing otherwise, eligible employees and dependents of eligible employees who are provided an opportunity to enroll pursuant to this subsection shall be treated as new entrants. Premium rates related to such individuals shall be set in accordance with subsection (c).~~

~~(C) The terms of coverage offered to an individual described in paragraph (d)(i)(A) may exclude coverage for preexisting medical conditions if the health benefit plan currently held by the small employer contains such an exclusion, provided that the exclusion period shall be reduced by the number of days between the date the individual was excluded or denied coverage and the date coverage is provided to the individual pursuant to this subsection.~~

~~(D) A small employer carrier shall provide written notice at least forty-five (45) days prior to the opportunity to enroll provided in paragraph (A) to each small employer insured under a health benefit plan that becomes subject to W.S. ' 26-19-301 et seq. after July 1, 1995, but was not subject to W.S. ' 26-19-301 et seq. Prior to July 1, 1995, solely due to the employer having between twenty-six (26) and fifty (50) eligible employees. The notice shall clearly describe the rights granted under this subsection to employees and dependents who were previously excluded from or denied coverage and the process for enrollment of such individuals in the employer's health benefit plan.~~

Section 8. ~~Section 9.~~ **Consideration of Industry**

(a) Except as provided in subsections (b) and (c), a small employer carrier may not consider the trade or occupation of the employees of a small employer or the industry or type of business in which the small employer is engaged in determining whether to issue or continue to provide coverage to the small employer.

(b) A small employer carrier may use industry as a case characteristic in establishing premium rates, subject to ~~W.S. ' 26-19-304(a)(vii)~~applicable federal and state law.

(c) A small employer carrier may consider trade, occupation or industry as part of the eligibility criteria for a class of business, ~~as defined in W.S. ' 26-19-302(a)(vii~~subject to applicable federal and state law~~)~~.

Section 9. ~~Section 10.~~ **Application to Re-enter State**

(a) A carrier that has been prohibited from writing coverage for small employers in ~~this state~~Wyoming ~~pursuant to W.S. ' § 26-19-305(c) may not resume offering health benefit plans to small employers in ~~this state~~Wyoming until the carrier has made a petition and has been approved by ~~to~~ the Commissioner ~~to be reinstated as a small employer carrier and the petition has been approved by the Commissioner~~. ~~In reviewing a petition, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.~~

(b) In the case of a small employer carrier doing business in only one established geographic service area of ~~the state~~Wyoming, if the small employer carrier elects to nonrenew a health benefit plan under W.S. ~~'~~§ 26-19-305(a)(vi), the small employer carrier shall be prohibited from offering health benefit plans to small employers in any part of the service area for a period of five (5) years. In addition, the small employer carrier shall not offer health benefit plans to small employers in any other geographic area of the state without the prior approval of the Commissioner. ~~In considering whether to grant approval, the Commissioner may ask for such information and assurances as the Commissioner finds reasonable and appropriate.~~

Section 10. ~~Section 11.~~ **Qualifying Previous and Qualifying Existing Coverage**

(a) For the purposes of W.S. ~~'~~§ 26-19-302(a)(xv) and 26-19-306(c)(ii), an individual will be considered to have previous or existing coverage if the previous or existing policy, certificate or other benefit arrangement ~~covering such individual~~ met the relevant definition of ~~qualifying previous coverage or qualifying existing coverage contained in~~ Section ~~3~~2(c) of this Regulation. The small employer carrier shall interpret W.S. ~~'~~§ 26-19-301 et seq. and this Regulation no less favorably to an insured individual than the following:

(i) A health insurance policy, certificate or other health benefit arrangement shall be considered employer-based if an employer sponsors the plan or arrangement or makes a contribution to the plan or arrangement.

(ii) A health insurance policy, certificate or other benefit arrangement shall be considered to provide benefits similar to or exceeding the benefits provided under the basic health benefit plan if ~~the policy, certificate or other benefit arrangement provides benefits~~ it provides benefits that:

(A) Have an actuarial value ~~(~~as considered for a normal distribution of groups~~)~~ that is not substantially less than the actuarial value of the basic health benefit plan; or

(B) Provides coverage for hospitalization and physician services that is substantially similar to or exceeds the coverage for such services in the basic health benefit plan.

(b) In making a determination under subsection (a), a small employer carrier shall evaluate the previous or existing policy, certificate or other benefit arrangement taken as a whole and shall not base its decision solely on the fact that one portion of the previous or existing policy, certificate or benefit arrangement provides less coverage than the comparable portion of the basic health benefit plan.

(c) For the purposes of W.S. ~~'~~ § 26-19-306(c)(ii), an individual will be considered to have qualifying previous coverage with respect to a particular service if the previous policy, certificate or other benefit arrangement ~~covering such individual~~ met the definition ~~of qualifying previous coverage contained~~ in Section ~~3~~ 2(c) of this Regulation and provided any benefit with respect to ~~the~~ that service.

(d) A small employer carrier shall ascertain the source of previous or existing coverage of each eligible employee and each eligible dependent(s) ~~of an eligible employee~~ if dependent coverage is offered at the time such employee or dependent initially enrolls into the health benefit plan ~~provided by the small employer carrier~~. The small employer carrier shall ~~have the responsibility to~~ contact the source of such previous or existing coverage to ~~resolve any questions about~~determine the benefits or limitations of the ~~related to such~~ previous or existing coverage.

~~Section 10. Section 12. **Rescission**~~

~~(d) (a) If a small employer carrier determines that rescission is authorized under W.S. § 26-15-109 the small employer carrier A small employer carrier may rescind coverage for any small employer group, or any eligible employee, or any dependent of an eligible employeedependent(s). Rescission must be based solely upon material misstatements made during the application process, and shall be subject to any applicable~~

~~time limits on certain defenses provisions. When such a rescission action is taken, premiums for the policy or certificates rescinded must be refunded less any claims paid prior to the date of rescission. At the small employer carrier's option, tThe small employer carrier may seek to recover any amounts of claims paid in excess of premiums paid. The rescinded coverage shall be considered null and void from the date of issuance or the effective date of the coverage. Rescissions of the coverage of for an entire small employer group, including employees and dependents, shall be limited to circumstances under which the application misstatements have been made by the small employer in its capacity as an employer. Whenever possible, rescission shall be limited to the coverages derived through a single employee.~~

~~(d) (b) A new entrant An individual who was not initially a late enrollee and whose coverage is subsequently rescinded shall be allowed to re-enroll in the health benefit plan as of the date the coverage was rescinded. The individual insured person shall be treated as a late enrollee if the rescission of coverage takes place on a date beyond the final date of enrollment he or she was last eligible to enroll in the health benefit plan as a new entrant. Coverage that was rescinded shall not be considered as qualifying previous coverage or qualifying existing coverage. On or after the effective date of such individual's re-enrollment in a health benefit plan, the small employer carrier may adjust the premium charge to the small employer group for future rating periods to be in accordance with permissible and applicable rating factors as though full, accurate and timely underwriting information had been supplied when the individual initially enrolled in the plan.~~

Section 11. ~~Section 13.~~ **Restrictive Riders and Rates**

~~(a) A restrictive rider, endorsement or other provision that would violate the provisions of W.S. ' 26-19-306(c)(vi) and that was in force on the effective date of this Regulation may not remain in force beyond the first anniversary date of the health benefit plan subject to the restrictive provision that follows the effective date of this Regulation. A small employer carrier shall provide written notice to those small employers whose coverage will be changed pursuant to this subsection at least thirty (30) days prior to the required change to the health benefit plan.~~

(a) ~~(b)~~ Except as permitted ~~in W.S. ' 26-19-306(c)(iii)~~in applicable federal and state law, a small employer carrier shall not modify or restrict a basic or standard health benefit plan in any manner for the purposes of restricting or excluding coverage or benefits for specific diseases, medical conditions or services otherwise covered by the plan.

(b) ~~(c)~~ Except as permitted in ~~W.S. ' 26-19-306(c)(iii)~~applicable federal and state law, a small employer carrier shall not modify or restrict any health benefit plan with respect to any eligible employee or dependent of an eligible employee if dependent coverage is offered, through riders, endorsements or otherwise, for the purpose of restricting or excluding the coverage or benefits provided to such employee or dependent if dependent

coverage is offered for specific diseases, medical conditions or services otherwise covered by the plan.

~~(d) Any rates or rating on individual employees or dependents of a small employer that would violate the provisions of W.S. ' 26-19-304(a)(iv) and that was in force on the effective date of this Regulation may not remain in force beyond the first anniversary date of the health benefit plan subject to such ratings that follow the effective date of this Regulation. Adjustments in rates for claims experience, health status and duration from issue shall be applied uniformly to the rates charged for all employees and dependents of the small employer.~~

Section 12. ~~Section 14.~~ **Rules Related to Fair Marketing**

(a) ~~(a) (i)~~ A small employer carrier shall actively market each of its health benefit plans ~~to small employers~~ in ~~this state~~Wyoming. A small employer carrier may not suspend the marketing or issuance of the basic and standard health benefit plans unless the carrier has good cause and has received the prior approval of the Commissioner.

(b) ~~(ii)~~ In marketing the basic and standard health benefit plans ~~to small employers~~, a small employer carrier shall use at least the same sources and methods of distribution that it uses to market other health benefit plans ~~to small employers~~. Any producer authorized by a small employer carrier to market health benefit plans ~~to small employers~~ in ~~the state~~Wyoming ~~-~~shall also be authorized to market the basic and standard health benefit plans.

(c) ~~(b) (i)~~ A small employer carrier shall actively offer ~~at least the~~all ~~basic and standard~~ health benefit plans actively marketed in Wyoming to any small employer that applies for or makes an inquiry regarding health insurance coverage ~~from the small employer carrier~~. The offer shall be in writing and the offer may be provided directly to the small employer or delivered through a producer and shall include at least the following information:

(i) ~~(A)~~ A general description of the benefits contained in the basic and standard health benefit plans and any other health benefit plan being offered to the small employer; and

(ii) ~~(B)~~ Information describing how the small employer may enroll in the plans.

(d) ~~(ii) (A)~~ A small employer carrier shall provide a price quote to a small employer ~~(~~directly or through an authorized producer~~)~~ within fifteen (15) working days of receiving a request for a quote and such information as is necessary to provide the quote. A small employer carrier shall notify a small employer ~~(~~directly or through an authorized

producer) within ten (10) working days of receiving a request for a price quote of any additional information needed by the small employer carrier to provide the quote.

(e) (B) A small employer carrier may not apply more stringent or detailed requirements related to the application process for the basic and standard health benefit plans than are applied for other health benefit plans offered by the carrier.

(I) (iii) (A) If a small employer carrier denies coverage under a health benefit plan to a small employer on the basis of a risk characteristic, the denial shall be in writing and shall state with specificity the reasons for the denial (subject to any restrictions related to confidentiality of medical information). The written denial shall be accompanied by a written explanation of the availability of the basic and standard health benefit plans from the small employer carrier. The explanation shall include at least the following:

(1.) (I) A general description of the benefits contained in each such plan;

(II) A price quote for each such plan; and

(2.) (III) Information describing how the small employer may enroll in such plans.

(A) (B) The written information described in subparagraph (A) may be provided within the time periods provided in paragraph (ii) directly to the small employer or delivered through an authorized producer.

( ) (C) The price quote required under subparagraph (A)(II) shall be for the lowest-priced basic and standard health benefit plan for which the small employer is eligible.

(g) (f) (c) The small group carrier shall not require a small employer to join or contribute to any association or group as a condition of being accepted for coverage by the small employer carrier, except thaunlesst, if membership in an association or other group is a requirement for accepting a small employer into a particular health benefit plan, a small employer carrier may apply such requirement.

(h) (g) (d) A small employer carrier may shall not require, as a condition to the offer or sale of a health benefit plan to a small employer, that the small employer purchase or qualify for any other insurance product or service.

(i) (h) (e) (i) Carriers offering individual and group health benefit plans in this stateWyoming shall be responsible for determining whether the plans are subject to the requirements of W.S. ' § 26-19-301 et seq. and this Regulation. Carriers shall elicit the following information from applicants for such plans at the time of application:

(i) ~~(A)~~ Whether or not any portion of the premium will be paid by or on behalf of a small employer, either directly or through wage adjustments or other means of reimbursement; and

(ii) ~~(B)~~ Whether or not the prospective policyholder, certificate holder or any prospective insured individual intends to treat the health benefit plan as part of a plan or program under Section 162 (other than Section 162(l)), Section 125 or Section 106 of the United States Internal Revenue Code.

~~(j)~~ (i) ~~(ii)~~ If a small employer carrier fails to comply with subparagraph (~~i~~h), the small employer carrier shall be deemed to be on notice of any information that could reasonably have been attained if the small employer carrier had complied with subparagraph (~~i~~h).

(j) ~~(f)~~ ~~(i)~~ A small employer carrier shall file annually on or before March 15, in a format prescribed by the Commissioner, the following information ~~with the Commissioner~~ related to health benefit plans issued by the small employer carrier to small employers in ~~this state~~Wyoming:

(i) The number of small employers that were issued health benefit plans in the previous calendar year, separated as to newly issued plans and renewals;

(ii) The number of small employers that were issued the basic health benefit plan and the standard health benefit plan in the previous calendar year, separated as to newly issued plans and renewals;

(iii) The number of small employer health benefit plans in force in each county, or by zip code, of the state as of December 31 of the previous calendar year;

(iv) The number of small employer health benefit plans that were voluntarily not renewed by small employers in the previous calendar year;

(v) The number of small employer health benefit plans that were terminated or non-renewed for reasons other than nonpayment of premium by the carrier in the previous calendar year; and

(vi) The number of small employer health benefit plans that were issued to small employers that were uninsured for at least the three (3) months prior to issue.

~~(k) (ii) The information in paragraph (i) shall be filed with the commissioner on or before March 15. Such filing shall be in the format and, at a minimum, contain the information the commissioner prescribes. Such filing shall be made in conjunction with the~~

information specified under Section 7 (g) of this Regulation. The format and required information may be obtained from the Wyoming Insurance Department.

( ) (g) (i) Failure of the small group carrier to comply with the provisions of this section may subject such carrier to administrative action by the Wyoming Department of Insurance.

Section 15. **Status of Carriers as Small Employer Carriers**

(a) (i) Within sixty (60) days after the effective date of this Regulation, each carrier providing health benefit plans in this state that has not filed with the commissioner the basic and standard plans pursuant to W.S. ' 26-19-306(b) shall make a filing with the Commissioner indicating whether the carrier intends to operate as a small employer carrier in this state under the terms of this Regulation.

(ii) Carriers that have filed with the commissioner the basic and standard plans pursuant to W.S. ' 26-19-306(b) shall be considered as operating as a small employer carrier in the state.

(b) Subject to subsection (c), a carrier shall not offer health benefit plans to small employers, or continue to provide coverage under health benefit plans previously issued to small employers in this state, unless the filing provided pursuant to subsection (a) indicates that the carrier intends to operate as a small employer carrier in this state.

(c) If the filing made pursuant subsection (a) indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier may continue to provide coverage under health benefit plans previously issued to small employers in this state only if the carrier complies with the following provisions:

(i) The carrier complies with the requirements W.S. ' 26-19-301 et seq. with respect to each of the health benefit plans previously issued to small employers by the carrier.

(ii) The carrier provides coverage to each new entrant to a health benefit plan previously issued to a small employer by the carrier. The provisions of W.S. ' 26-19-301 et seq. and this Regulation shall apply to the coverage issued to such new entrants.

(iii) The carrier complies with the requirements of Sections 7, 8, and 13 of this Regulation as they apply to eligible employees and dependents of small employers whose coverage has been denied, limited, or restricted by the carrier, or whose rates are in violation of W.S. ' 26-19-304(a)(iv).

(d) If the filing made pursuant subsection (a) indicates that a carrier does not intend to operate as a small employer carrier in this state, the carrier shall be precluded from

~~operating as a small employer carrier in this state, except as provided for in subsection (c), for a period of five (5) years from the date of the filing. Upon a written request from such a carrier, the Commissioner may reduce the period provided for in the previous sentence if the Commissioner finds that permitting the carrier to operate as a small employer carrier would be in the best interests of the small employers in the state.~~

Section 13. ~~Section 16. **Continuation**~~

~~(a) (a) Continuation of coverage shall be made available to any eligible employee or dependent of an eligible employee~~ if dependent coverage is offered ~~who has been continuously covered by the health benefit plan during the entire three (3) month period ending with the termination of eligibility. Continuation must be made available to the eligible employee regardless of whether or not the covered dependents elect to continue coverage under W.S. ' § 26-19-113 and this regulation. Continuation must be made available to dependents of eligible employees~~ if dependent coverage is offered ~~who terminate employment or membership or eligibility regardless of whether or not the eligible employee continues coverage as provided in W.S. ' § 26-19-113 and this regulation.~~

~~(b)~~

~~(c)~~ (a) ~~(b) Former eligible employees or their dependents of the group that are continuing their coverage are not to be counted towards fulfilling that group's minimum participation requirements~~.

~~(d)~~ (b) ~~(c) The small group employer solely shall designate to whom the payment of premiums are to be made. This designation shall be made at the time continuation of coverage is elected. This designation shall be done in writing and be delivered to the former eligible employee who is electing to continue coverage as set forth in W.S. ' § 26-19-113~~.

~~(e)~~ (c) ~~(d) The former eligible employee or the dependent of a former eligible employee must notify the small employer of his or her desire to continue coverage as set forth in W.S. ' § 26-19-113. The notification must be within thirty-one (31) days after the expiration of coverage. This notification shall also include the former eligible employee's and\or dependent's election to continue dental, vision or other benefits that are in addition to the hospital, surgical, or other major medical benefits that were in the small employer group policy. This election can be made only once, and the decision is irrevocable after the election.~~

~~(f) (e) Grace period provisions that apply to former eligible employees who are continuing their coverage shall not be more restrictive than the grace period provisions that apply to the small employer group policy in which they were previously enrolled.~~

~~(g)~~

(d) ~~(f) For the purposes of this section, "former eligible employees" shall be defined as an eligible employee or dependent~~ if dependent coverage was offered ~~who has lost coverage under the small employer health benefit plan and is eligible to enroll for~~

~~continuation of coverage, or who is currently continuing coverage as set forth in W.S. ' § 26-19-113~~.

Section 14. Effective Date

~~(h)~~ (a) This regulation shall become effective upon filing with the Secretary of State.

SMALL EMPLOYER HEALTH INSURANCE

APPENDIX A

ACTUARIAL CERTIFICATION

TO: SMALL EMPLOYER HEALTH INSURANCE COMPLIANCE DIVISION

FROM: (Please type or print)

NAME OF COMPANY: _____

NAIC NUMBER: _____

NAME OF CONTACT PERSON: _____

TITLE: _____

TELEPHONE NUMBER: _____

DATE: _____

ADDRESS: _____
_____
_____
_____

I. Actuarial Certification:

I hereby certify that the rates charged small groups in the state of Wyoming are:

Based on rating methods that are actuarially sound;
Such that the index rate for any class of business does not exceed the index rate for another class of business by more than twenty percent (20%);
Such that rates for small employers with similar characteristics within a class of business do not vary from the index rate by more than thirty-five percent (35%);
Such that the percentage increase in the premium rate for a renewal rating period does not exceed the sum of the following:
(a)The percentage change in the new business premium rate measured from the first day of the prior rating period to the first day of the new rating period, or the percentage change in the base premium rate in the case of a class of business for which the insurer is not issuing new policies,

(b)An adjustment of not more than fifteen (15%) annually, adjusted pro rata for shorter rating periods, for such rating factors as claim experience, health status, and duration of coverage, determined in accordance with the [name of small employer carrier] rate manual or renewal rating guidelines, and

(c)An adjustment for a change in case characteristics or in benefit design characteristics, determined in accordance with the [name of small employer carrier] rate manual and rating procedure.

5.Such that the rate factor associated with any industry classification does not vary from the arithmetic average of the rate factors associated with all industry classifications by greater than fifteen percent (15%) of such coverage; and

6.In compliance with all other facets of W.S. 26-19-301 through 310, based upon the examination of premium rates for applicable health benefit plans and the review of their underlying actuarial assumptions and methods.

I certify that sufficient documentation of compliance is on file with the [name of small employer carrier] and available upon request by the Commissioner of Insurance.

_____

Signature

_____ Name (Typed or printed)_____

_____ Title (Typed or Printed) _____

Chapter 63

Medical Necessity Review Rights

Section 1. Authority

(a) This regulation is promulgated pursuant to W.S. §§ 26-40-201 and 26-2-110 of the Wyoming Insurance Code and pursuant to the Wyoming Administrative Procedures Act, W.S. § 16-3-101, *et seq*.

Section 2. Purpose and Intent

(a) The purpose of this Rule is to provide uniform standards for giving notice to claimants of their right to an independent review of any denial of an insurance claim as not medically necessary or on a similar basis, and to establish internal and external review procedures to assure that claimants under any insurance policy have the opportunity for an independent review in accordance with W. S. § 26-40-201.

Section 3. Definitions

(a) For purposes of this Rule:

(b) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(c) "Authorized representative" means:

(i) A person to whom a claimant has given express written consent to represent the claimant in an external review;

(ii) A person authorized by law to provide substituted consent for a claimant; or

(iii) A family member of the claimant or the claimant's treating health care professional only when the claimant is unable to provide consent.

(d) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(e) "Certification" means a determination by an insurer or its designee utilization review organization, or the claimant's treating health care professional that medical service has been reviewed and, based on the information provided, satisfies the statutory requirements for medical necessity as defined by W.S. § 26-40-102.

(f) "Claimant" means a policyholder, subscriber, enrollee or other individual participating in an insurance policy.

(g) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by an insurer to determine the necessity and appropriateness of health care services.

(h) "Commissioner" means the Commissioner of Insurance.

(i) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

(j) "Denial of claim" means a determination by an insurer or its designee utilization review organization that a medical service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity or other similar basis, and the requested service or payment for the service is therefore denied, reduced or terminated..

(k) "Insurance carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that transacts the business of insurance as defined by W.S. §26-1-102(a)(xv).

(l) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

(m) "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

(n) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

(o) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

(p) "Facility" means an institution providing medical services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

(q) "Insurance policy" means any contract, certificate, agreement, clauses, riders, and endorsements, offered or issued by an insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(r) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

(s) "Health care provider" or "provider" means a health care professional or a facility.

(t) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(i) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(ii) The provision of health care services to an individual; or

(iii) Payment for the provision of health care services to an individual.

(u) "Independent review organization" means an entity that conducts independent external reviews of claim denials.

(v) "Medical services" or "health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease or an admission, availability of care, continued stay or other care provided by a facility.

(w) "Medically necessary" includes but is not limited to "medical necessity" as defined by W.S. § 26-40-102(a)(iii).

(x) "NAIC" means the National Association of Insurance Commissioners.

(y) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

(z) "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

(aa) "Protected health information" means health information:

(i) That identifies an individual who is the subject of the information; or

(ii) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

(bb) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

(cc) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

(dd) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

(ee) "Utilization review organization" means an entity that conducts utilization review, other than an insurance carrier performing a review for its own insurance policies.

Section 4. Applicability and Scope

(a) Except as provided in subsection (b), this Rule shall apply to all insurance carriers.

(b) The provisions of this Rule shall not apply to a policy or certificate that provides coverage for long-term care insurance, as defined by W. S. § 26-38-103, or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, Wyoming Workers' Compensation or automobile medical-payment insurance.

Section 5. Notice of Right to Review

(a) An insurance carrier shall notify the claimant in writing of the claimant's right to request a review of any claim denied on the basis of not being medically necessary or on a similar basis. The notice shall include the appropriate statement and information set forth in subsection (b). The notice shall be sent to the claimant each time and at the same time as an insurance carrier sends written notice of the denial of claim on the basis of medical necessity or other similar basis.

(b) The notice of right to review shall include:

(i) Notice of the right to an internal review by the insurer which shall include:

(A) That the request for an internal review must be filed within thirty (30) days of the date the claimant received the denial of claim;

(B) That the claimant may submit additional information that relates to the claim;

(C) That the claimant may request the signed opinion of at least one (1) health care professional who is not an employee of the insurer;

(D) The procedure for filing the request for internal review; and

(E) That the claimant may have the right to an expedited review under circumstances where a delayed review would adversely affect the claimant.

(ii) Notice of the right to an external review by an Independent Review Organization approved by the commissioner which shall include the following or substantially equivalent language:

(A) "We have denied your request for the provision of or payment for a health care service or course of treatment. After completion of an internal review, you may have the right to have our decision reviewed by health care professionals who have no association with us and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice."

(B) That the request must be made within one hundred twenty (120) days of the receipt of the notice of claim denial following the completion of the internal review;

(C) That the request for review shall be filed on a form approved by the commissioner and include a health care professional's certification as to medical necessity;

(D) That the request shall be made in duplicate and include a fee of fifteen dollars ($15.00) payable by check or money order to the Office of the Wyoming State Treasurer.

(I) The fee may be waived for a claimant whose income is at or below the current federal poverty level guidelines and who files a financial hardship application available upon request from the Wyoming Insurance Department.

(E) That the insurer shall be responsible for the costs of an external review by an independent review organization; and

(F) That the claimant may have the right to an expedited review under circumstances where a delayed review would adversely affect the claimant.

(iii) Notice of the right to an internal and external expedited review which shall include:

(A) A statement that the expedited review shall be completed as expeditiously as the claimant's medical condition or circumstances require, and in any event within seventy-two (72) hours, where:

(I) The timeframe for the completion of a normal review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(II) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a facility.

(B) That the request for internal expedited review shall be filed pursuant to the requirements of the insurer. A request for external expedited review must be filed on a form approved by the commissioner and include a health care professional's certification as to medical necessity and of the need for an expedited review.

(c) As part of any notice required by this Rule, the insurer shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the claimant, for purposes of conducting an external review under this Rule, authorizes the insurer and the claimant's treating health care provider to disclose protected health information, including medical records, concerning the claimant that are pertinent to the external review.

Section 6. Request for External Review

(a) All requests for external review shall be made in writing to the insurer, on a form approved by the commissioner, together with a copy and fee of fifteen dollars

($15.00) payable by check or money order to the Wyoming State Treasurer. For any single claimant, there is an annual limit on fees of seventy-five dollars ($75.00) per calendar year.

(b) A claimant or the claimant's authorized representative may make a request for an external review of a denied claim or final denied claim.

(c) A claimant or the claimant's authorized representative may submit additional new information with the request for external review for consideration during the external review process.

(d) The request for external review shall be accompanied by a health care professional certification of medical necessity.

(e) The request for an expedited review shall be accompanied by a health care professional certification of need for expedited review.

Section 7. Exhaustion of Internal Review Process

(a) Except as provided in subsection (d), a request for an external review pursuant to Section 6 of this Rule shall not be made until the claimant has exhausted the insurer's internal review process required by W.S. § 26-40-201(b)(iii).

(b) A claimant shall be considered to have exhausted the insurer's internal review process for purposes of this section, if the claimant or the claimant's authorized representative:

(i) Has filed a request for internal review involving a denied claim; and

(ii) Except to the extent the claimant or the claimant's authorized representative requested or agreed to a delay, has not received a written decision on the request for internal review from the insurer within forty five (45) days following the date the claimant or the claimant's authorized representative filed the request for internal review with the insurer.

(c) Notwithstanding paragraph (b), a claimant or the claimant's authorized representative may not make a request for an external review of a denied claim involving a retrospective review determination until the claimant has exhausted the insurance carrier's internal review process.

(d) At the same time a claimant or the claimant's authorized representative files a request for an expedited internal review of a denied claim, the claimant or the claimant's authorized representative may file a request for an expedited external review of the denied claim under Section 9 of this Rule if:

(i) the claimant has a medical condition where the timeframe for completion of an internal review of the denied claim would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(ii) the claimant's claim concerns a request for admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

(e) Upon receipt of a request for an expedited external review under subparagraph (d) of this section, the independent review organization conducting the external review in accordance with the provisions of Section 9 of this Rule shall determine whether the claimant shall be required to complete the expedited internal review process before it conducts the expedited external review.

(i) Upon a determination that the claimant must first complete the expedited internal review process the independent review organization immediately shall notify the claimant and, if applicable, the claimant's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Section 9 of this Rule until completion of the expedited internal review process and the expedited internal review process remains unresolved.

(f) A request for an external review of a denied claim may be made before the claimant has exhausted the health carrier's internal review procedures whenever the insurer agrees to waive the exhaustion requirement.

Section 8. Standard External Review

(a) Within one hundred twenty (120) days after the date of receipt of a notice of a denial of claim pursuant to Section 5 of this Rule, a claimant or the claimant's authorized representative may file a request for an external review with the insurer on a form approved by the commissioner.

(b) Within five (5) business days after the date of receipt of a request for external review pursuant to paragraph (a), the insurer shall send a copy of the request to the commissioner together with the fee.

(c) Within five (5) business days following the date of receipt of the external review request from the claimant, the insurer shall complete a preliminary review of the request to determine whether:

(i) The individual is or was a claimant in the insurance policy at the time the health care service was requested or, in the case of a retrospective review, was a claimant in the insurance policy at the time the health care service was provided;

(ii) The health care service that is the subject of the claim denial is a covered service under the claimant's insurance policy, but for a determination by the insurer that the health care service is not covered because it does not meet the requirements for medical necessity or other similar basis;

(iii) The claimant has exhausted the insurer's internal review process unless the claimant is not required to exhaust the insurer's internal review process pursuant to Section 7 of this Rule; and

(iv) The claimant has provided all the information, forms and fee required to process an external review, including the release form provided under Section 5(c) of this Rule.

(d) Within one (1) business day after completion of the preliminary review, the insurer shall notify the commissioner and claimant and, if applicable, the claimant's authorized representative in writing whether:

(i) The request is complete; and

(ii) The request is eligible for external review.

(e) If the request:

(i) Is not complete, the insurer shall inform the claimant and, if applicable, the claimant's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete; or

(ii) Is not eligible for external review, the insurer shall inform the claimant and, if applicable, the claimant's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

(A) The commissioner may specify the form for the insurer's notice of determination that the request for standard external review is ineligible for review.

(B) The notice of determination shall include a statement informing the claimant and, if applicable, the claimant's authorized representative of the insurer's determination that the external review request is ineligible for review and may be appealed to the commissioner.

(f) The commissioner may determine that a request is eligible for external review under Section 8 of this Rule notwithstanding a insurer's determination that the request is ineligible and require that it be referred for external review.

(g) In making a determination under subparagraph (f) of this section, the commissioner's decision shall be made in accordance with the terms of the claimant's insurance policy and shall be subject to all applicable provisions of W. S. §§ 26-40-102(a) and 26-40-201.

(h) Whenever the insurance carrier determines that a request is eligible for external review following the preliminary review conducted pursuant to subsection (c), or that the claimant has provided the information requested to make their submission complete as required by paragraph (e)(i) of this section, the carrier shall, within one (1) business day of making such determination:

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 11 of this Rule to conduct the external review and notify the commissioner of the name of the assigned independent review organization; and

(ii) Notify in writing the claimant and, if applicable, the claimant's authorized representative of the request's eligibility and acceptance for external review.

(i) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the insurer's review process as set forth in the internal review process.

(j) The insurance carrier shall include in the notice that the claimant or the claimant's authorized representative may submit in writing to the assigned independent review organization additional information for consideration by the independent review organization. Such information shall be submitted within five (5) business days following the date of receipt of the notice. Once the assigned independent review organization receives additional information from the claimant, the independent review organization will forward the information to the issuer within one (1) business day of receipt.

(k) Within five (5) business days after the determination by the insurer that the external review request is eligible for external review as identified in paragraph (h) of this section, , the insurance carrier or its designated utilization review organization shall provide to the assigned independent review organization the health information considered in making the claim denial.

(l) Except as provided in paragraph (e), failure by the insurer or its utilization review organization to provide the health information within the time specified in paragraph (k) shall not delay the conduct of the external review.

(m) The independent review organization shall within five (5) days of receipt of the external review request from the insurer determine whether the documentation is complete and immediately notify the claimant and the insurer in writing what information is missing, if any.

(n) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (k) and any other health information submitted in writing to the independent review organization by the claimant or the claimant's authorized representative pursuant to subsection (j).

(o) The insurance carrier may reconsider its denial of the claim at any point prior to the completion of the external review.

(p) Reconsideration by the insurer of its denial of claim determination pursuant to paragraph (o) shall not delay or terminate the external review.

(q) The external review may only be terminated if the insurance carrier decides, upon completion of its reconsideration, to reverse its denial of claim and provide coverage or payment for the health care service that is the subject of the denied claim.

(i) Within one (1) business day after making the decision to reverse its claim denial, as provided in paragraph (q), the insurer shall notify the claimant and, if applicable, the claimant's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(ii) The assigned independent review organization shall terminate the external review upon receipt of the notice from the insurance carrier that the claim denial has been reversed.

(r) In addition to the health information provided pursuant to subsection (k), the assigned independent review organization, to the extent the health information is

available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Consulting reports from appropriate health care professionals and other documents submitted by the insurer, claimant, the claimant's authorized representative, or the claimant's treating provider;

(iv) The terms of coverage under the claimant's insurance policy;

(v)The standards identified in W.S. § 26-40-102(a)(iii).

(vi) All evidence based research used in the insurer's denial of the claim.

(s) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the denial of claim as medically necessary, to:

(i) The claimant;

(ii) If applicable, the claimant's authorized representative;

(iii) The insurance carrier; and

(iv) The commissioner.

(t) The independent review organization shall include in the notice sent pursuant to paragraph (s):

(i) A general description of the reason for the request for external review;

(ii) The date the independent review organization received the assignment from the insurer to conduct the external review;

(iii) The date the external review was conducted;

(iv) The date of its decision;

(v)The principal reason or reasons for its decision;

(vi) The rationale for its decision; and

(vii) References to the evidence or health information that they considered in reaching their conclusion, including references to how W.S. § 26-40-102 applies to the information reviewed.

(u) Upon receipt of a notice of a decision pursuant to paragraph (s) reversing the denial of claim, the insurance carrier within five (5) business days shall approve the covered benefit that was the subject of the denied claim.

(v) Upon receipt of a notice of decision pursuant to paragraph (s) reversing the denial of a claim, the commissioner shall refund the fee to the claimant.

(w) The assignment by the insurer of an approved independent review organization shall be on a rotational basis established by the commissioner.

Section 9. Expedited External Review

(a) A claimant or the claimant's authorized representative may make a request for an expedited external review with the commissioner at the time the claimant receives:

(i) A denial of claim if:

(A) The denied claim involves a medical condition of the claimant for which the timeframe for completion of an expedited internal review of a claim denial, if a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(B) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility; and

(C) The claimant or the claimant's authorized representative has filed a request for an expedited review of a claim denial as not being medically necessary or on a similar basis.

(b) The request shall be made in duplicate and include a fee of fifteen dollars ($15.00) payable by check or money order to the Wyoming State Treasurer. For any single claimant, there is an annual limit on fees of seventy-five dollars ($75.00).

(i) Upon receipt of a request for an expedited external review, the insurer immediately shall send a copy of the request and the fee to the commissioner;

(ii) Immediately upon receipt of the request pursuant to paragraph (i), the insurance carrier shall determine whether the request meets the reviewability requirements set forth in Section 8(c)(i) through 8(c)(iv) of this Rule. The insurance carrier shall immediately notify the commissioner and the claimant and, if applicable, the claimant's authorized representative of its eligibility determination.

(c) The commissioner may specify the form for the insurer's notice of initial determination under this subsection and any supporting information to be included in the notice.

(i) The notice of initial determination shall include a statement informing the claimant and, if applicable, the claimant's authorized representative that a insurer's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

(d) The commissioner may determine that a request is eligible for expedited external review notwithstanding an insurance carrier's initial determination that the request is ineligible and require that it be referred for expedited external review.

(e) In making a determination under paragraph (d) of this section, the commissioner's decision shall be made in accordance with the terms of the claimant's insurance policy and shall be subject to all applicable provisions of this Rule.

(f) Upon determination that the request meets the reviewability requirements, the insurer immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 11 of this Rule. The insurer shall immediately notify the commissioner of the name of the assigned independent review organization.

(g) Upon receipt of the request for expedited external review, the insurance carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the denial of claim to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

(h) As expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in Section 8c)(i) through 8(c)(iv) of this Rule, the assigned independent review organization shall:

(i) Make a decision to uphold or reverse the denial of claim; and

(ii) Notify the claimant and, if applicable, the claimant's authorized representative, the insurance carrier, and the commissioner of the decision.

(iii) The assigned independent review organization is not bound by any decisions or conclusions reached during the insurance carrier's internal review process.

(i) If the notice provided pursuant to paragraph (h) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(i) Provide written confirmation of the decision to the claimant and, if applicable, the claimant's authorized representative, the insurer, and the commissioner; and

(ii) Include the information set forth in Section 8(t) of this Rule.

(j) Upon receipt of the notice of a decision pursuant to paragraph (i) reversing the denial of claim, the insurance carrier immediately shall approve the covered benefit that was the subject of the denied claim.

(k) An expedited external review may not be provided for retrospective claim denials.

(l) The assignment by the insurer of an approved independent review organization shall be on the same basis as provided in Section 8(w).

Section 10. Binding Nature of External Review Decision

(a) An external (or expedited) review decision is binding on the insurance carrier except to the extent the insurance carrier has other remedies available under applicable state law.

(b) An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.

(c) A claimant or the claimant's authorized representative may not file a subsequent request for external review involving the same denied claim for which the claimant has already received an external review decision pursuant to W.S. § 26-40-201.

Section 11. Approval of Independent Review Organizations

(a) The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under W.S. § 26-40-201.

(b) In order to be eligible for approval by the commissioner under this section to conduct external reviews an independent review organization:

(i) Shall be accredited by Utilization Review Accreditation Commission (URAC) or another nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under Section 12 of this Rule; and

(ii) Shall submit an application for approval in accordance with subsection (c).

(c) The commissioner shall develop an application form for initially approving and for re-approving independent review organizations to conduct external reviews.

(d) Any independent review organization wishing to be approved to conduct external reviews under this Rule shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 12 of this Rule.

(e) Subject to subparagraph (i) of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by URAC or another nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under Section 12 of this Rule.

(i) The commissioner may approve independent review organizations that are not accredited by URAC or another nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(ii) The independent review organization shall submit an application fee in the sum of one hundred dollars ($100.00) to the commissioner with an application for approval and re-approval.

(iii) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under Section 12 of this Rule.

(iv) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under Section 12 of this Rule, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Rule that is maintained by the commissioner pursuant to subsection (f).

(f) The commissioner shall maintain and update a list of approved independent review organizations within fifteen (15) days of approval or determination of eligibility.

Section 12. Minimum Qualifications for Independent Review Organizations

(a) To be approved under Section 11 of this Rule to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this Rule that include, at a minimum:

(i) A quality assurance mechanism in place that:

(A) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(D) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Rule;

(ii) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(iii) Agree to maintain and provide to the commissioner the information set out in Section 14 of this Rule.

(b) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be health care professionals or other appropriate health care providers who meet the following minimum qualifications:

(i) Be an expert in the treatment of the claimant’s medical condition that is the subject of the external review;

(ii) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the claimant;

(iii) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(iv) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

(c) In addition to the requirements set forth in paragraph (a) of this section an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a insurance policy, a national, state or local trade association of insurance policies, or a national, state or local trade association of health care providers.

(d) In addition to the requirements set forth in paragraph (a), (b) and (c) of this section, to be approved pursuant to Section 11 of this Rule to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(i) The insurer that is the subject of the external review;

(ii) The claimant whose treatment is the subject of the external review or the claimant's authorized representative;

(iii) Any officer, director or management employee of the insurer that is the subject of the external review;

(iv) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(v)The facility at which the recommended health care service or treatment would be provided; or

(vi) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the claimant whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph (d) of this section, the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical

reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(f) An independent review organization that is accredited by URAC or another nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Section 11 of this Rule.

(g) The commissioner shall initially review and periodically review the independent review organization accreditation standards of URAC and other nationally recognized private accrediting entities to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.

(h) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

(i) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Section 13. Hold Harmless for Independent Review Organizations

(a) No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Rule, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Section 14. External Review Reporting Requirements

(a) An independent review organization assigned pursuant to Section 8 or Section 9 of this Rule to conduct an external review shall maintain written records grouped by assigning insurer on all Wyoming requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under paragraph (b) of this section.

(b) Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph (a) of this section for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(c) The report shall include in the aggregate and for each insurance carrier:

(i) The total number of requests for external review;

(ii) The number of requests for external review resolved and, of those resolved, the number resolved upholding the denied claim or final denied claim and the number resolved reversing the denied claim or final denied claim;

(iii) The average length of time for resolution;

(iv) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(v)The number of external reviews pursuant to Section 8 of this Rule that were terminated as the result of a reconsideration by the insurer of its denied claim or final denied claim after the receipt of additional information from the claimant or the claimant's authorized representative; and

(vi) Any other information the commissioner may request or require.

(d) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

(e) Each insurer shall maintain written records in the aggregate, and for each type of insurance policy offered by the insurer on all requests for external review that the insurer receives notice of from the insurers pursuant to W.S. § 26-40-201.

(f) Each insurer required to maintain written records on all requests for external review pursuant to paragraph (a) of this section shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(i) The report shall include in the aggregate and by type of insurance policy:

(A) The total number of requests for external review;

(B) From the total number of requests for external review reported under subparagraph (A) of this paragraph, the number of requests determined eligible for a full external review; and

(C) Any other information the commissioner may request or require.

(g) The insurer shall retain the written records required pursuant to this subsection for at least five (5) years.

Section 15. Funding of External Review

(a) The insurance carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 16. Disclosure Requirements

(a) Each insurance carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to claimants.

(b) The description required under subsection (a) shall include a statement that informs the claimant of the right of the claimant to file a request for an internal or external review in compliance with W.S. § 26-40-201.

(c) In addition to subsection (b), the statement shall inform the claimant that, when filing a request for an external review, the claimant will be required to authorize the release of any medical records of the claimant that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 17. Severability

(a) If any provision of this Rule, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Rule, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 18. Enforceability

Section 19. Any violation of these regulations shall be enforceable pursuant to the provisions of W.S. §26-1-107, W.S. §26-3-116, W.S. §26-9-211, and any other applicable rule or statute.

Section 20. Effective Date

(a) This Rule shall become effective upon filing with the Secretary of State.

Chapter 63

Medical Necessity Review Rights

Section 1. Authority

This regulation is promulgated pursuant to Wyo. Stat. §§ 26-40-201 and 26-2-110 of the Wyoming Insurance Code and pursuant to the Wyoming Administrative Procedures Act, Wyo. Stat. § 16-3-101, *et seq*.

Section 2. Purpose and Intent

The purpose of this Rule is to provide uniform standards for giving notice to claimants of their right to an independent review of any denial of an insurance disability claim as not medically necessary or on a similar basis, and to establish internal and external review procedures to assure that claimants under any disability insurance policyinsurance policy as defined by Wyo. Stat. § 26-5-103 have the opportunity for an independent review in accordance with Wyo. Stat. § 26-40-201.

Section 3. Definitions

For purposes of this Rule:

(a) "Ambulatory review" means utilization review of health care services performed or provided in an outpatient setting.

(b) "Authorized representative" means:

(i) A person to whom a claimant has given express written consent to represent the claimant in an external review;

(ii) A person authorized by law to provide substituted consent for a claimant; or

(iii) A family member of the claimant or the claimant's treating health care professional only when the claimant is unable to provide consent.

(c) "Case management" means a coordinated set of activities conducted for individual patient management of serious, complicated, protracted or other health conditions.

(d) "Certification" means a determination by an disability insurerinsurer or its designee utilization review organization, or the claimant's treating health care professional that medical service has been reviewed and, based on the information provided, satisfies the statutory requirements for medical necessity as defined by Wyo. Stat. § 26-40-102.

(e) "Claimant" means a policyholder, subscriber, enrollee or other individual participating in an disability insurance planinsurance policy.

(f) "Clinical review criteria" means the written screening procedures, decision abstracts, clinical protocols and practice guidelines used by an disability insurerinsurer to determine the necessity and appropriateness of health care services.

(g) "Commissioner" means the Commissioner of Insurance.

(h) "Concurrent review" means utilization review conducted during a patient's hospital stay or course of treatment.

~~(i) "Covered benefits" or "benefits" means those health care services to which a claimant is entitled under the terms of an health benefit planhealth insurance planinsurance policy.~~

~~(j)~~ (i) "Denial of claim" means a determination by an ~~disability~~ insurer or its designee utilization review organization that a medical service that is a covered benefit has been reviewed and, based upon the information provided, does not meet the requirements for medical necessity or other similar basis, and the requested service or payment for the service is therefore denied, reduced or terminated..

~~(k)~~ (j) "~~Disability~~ Insurance carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that transacts the business of ~~disability~~ insurance as defined by ~~Wyo. Stat. §26-5-103~~ W.S. §26-1-102(a)(xv).

~~(l)~~ (k) "Discharge planning" means the formal process for determining, prior to discharge from a facility, the coordination and management of the care that a patient receives following discharge from a facility.

~~(m)~~ (l) "Disclose" means to release, transfer or otherwise divulge protected health information to any person other than the individual who is the subject of the protected health information.

~~(n)~~ (m) "Emergency medical condition" means the sudden and, at the time, unexpected onset of a health condition or illness that requires immediate medical attention, where failure to provide medical attention would result in a serious impairment to bodily functions, serious dysfunction of a bodily organ or part, or would place the person's health in serious jeopardy.

~~(o)~~ (n) "Emergency services" means health care items and services furnished or required to evaluate and treat an emergency medical condition.

~~(p) "Evidence-based medicine" means the conscientious, explicit and judicious use of the current best evidence based on the overall systematic review of the research in making decisions about the care of individual patients.~~

~~(q) "Expert opinion" means a belief or an interpretation by specialists with experience in a specific area about the scientific evidence pertaining to a particular service, intervention or therapy.~~

~~(r)~~ (o) "Facility" means an institution providing medical services or a health care setting, including but not limited to, hospitals and other licensed inpatient centers, ambulatory surgical or treatment centers, skilled nursing centers, residential treatment centers, diagnostic, laboratory and imaging centers, and rehabilitation and other therapeutic health settings.

~~(s)~~ (p) "~~Health benefit plan~~Insurance policy" means any contract, certificate, ~~or~~ agreement, clauses, riders, and endorsements, offered or issued by an ~~disability~~ insurance carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

~~(t)~~ (q) "Health care professional" means a physician or other health care practitioner licensed, accredited or certified to perform specified health care services consistent with state law.

~~(u)~~ (r) "Health care provider" or "provider" means a health care professional or a facility.

~~(v)~~ (s) "Health information" means information or data, whether oral or recorded in any form or medium, and personal facts or information about events or relationships that relates to:

(i) The past, present or future physical, mental, or behavioral health or condition of an individual or a member of the individual's family;

(ii) The provision of health care services to an individual; or

(iii) Payment for the provision of health care services to an individual.

~~(w)~~ (t) "Independent review organization" means an entity that conducts independent external reviews of claim denials.

~~(x)~~ (u) "Medical services" or "health care services" means services for the diagnosis, prevention, treatment, cure or relief of a health condition, illness, injury or disease or an admission, availability of care, continued stay or other care provided by a facility.

~~(y)~~ (v) "Medically necessary" ~~means~~ includes but is not limited to "medical necessity" as defined by W~~yo~~.S~~tat~~. § 26-40-102(a)(iii).

~~(z)~~ (w) "NAIC" means the National Association of Insurance Commissioners.

~~(aa)~~ (x) "Person" means an individual, a corporation, a partnership, an association, a joint venture, a joint stock company, a trust, an unincorporated organization, any similar entity or any combination of the foregoing.

~~(bb)~~ (y) "Prospective review" means utilization review conducted prior to an admission or a course of treatment.

~~(cc)~~ (z) "Protected health information" means health information:

(i) That identifies an individual who is the subject of the information; or

(ii) With respect to which there is a reasonable basis to believe that the information could be used to identify an individual.

~~(dd)~~ (aa) "Retrospective review" means a review of medical necessity conducted after services have been provided to a patient, but does not include the review of a claim that is limited to an evaluation of reimbursement levels, veracity of documentation, accuracy of coding or adjudication for payment.

~~(ee)~~ (bb) "Second opinion" means an opportunity or requirement to obtain a clinical evaluation by a provider other than the one originally making a recommendation for a proposed health care service to assess the clinical necessity and appropriateness of the initial proposed health care service.

~~(ff)~~ (cc) "Utilization review" means a set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management, discharge planning, or retrospective review.

~~(gg)~~ (dd) "Utilization review organization" means an entity that conducts utilization review, other than an ~~disability insurance~~ insurance carrier performing a review for its own ~~health benefit plan~~insurance policies.

Section 4. Applicability and Scope

(a) Except as provided in subsection (b), this Rule shall apply to all ~~disability insurance carrier~~insurance carriers.

(b) The provisions of this Rule shall not apply to a policy or certificate that provides coverage for long-term care insurance, as defined by W~~yo~~. S~~tat~~. § 26-38-103, or to a Medicare supplement policy of insurance, as defined by the commissioner by regulation, coverage under a plan through Medicare, Medicaid, or the federal employees health benefits program, any coverage issued under Chapter 55 of Title 10, U.S. Code and any coverage issued as supplement to that coverage, any coverage issued as supplemental to liability insurance, ~~-~~Wyoming Workers' Compensation or automobile medical-payment insurance.

Section 5. Notice of Right to Review

(a) An ~~disability insurance carrier~~insurance carrier shall notify the claimant in writing of the claimant's right to request a review of any claim denied on the basis of not being medically necessary or on a similar basis. The notice shall include the appropriate statement and information set forth in subsection (b). The notice shall be sent to the claimant each time and at the same time as an ~~disability insurance carrier~~insurance carrier sends written notice of the denial of claim on the basis of medical necessity or other similar basis.

(b) The notice of right to review shall include:

(i) Notice of the right to an ~~Internal~~ internal ~~Review~~ review by the insurer which shall include:

(A) That the ~~appeal~~ request for an internal review must be filed within thirty (30) days of the date the claimant received the denial of claim;

(B) That the claimant may submit additional information that relates to the claim;

(C) That the claimant may request the signed opinion of at least one (1) health care professional who is not an employee of the insurer;

(D) The procedure for filing the request for internal review; and

(E) That the claimant may have the right to an expedited review under circumstances where a delayed review would adversely affect the claimant.

(ii) Notice of the right to an ~~External~~ external ~~Review~~ review by an Independent Review Organization approved by the commissioner which shall include the following or substantially equivalent language:

(A) "We have denied your request for the provision of or payment for a health care service or course of treatment. After completion of an internal review, ~~You~~ you may have the right to have our decision reviewed by health care professionals who have no association with us and are not the attending health care professional or the health care professional's partner by following the procedures outlined in this notice."

(B) That the request must be made within ~~sixty~~ one hundred twenty (~~60~~120) days of the receipt of the notice of claim denial following the completion of the internal review;

(C) That the request for review shall be filed on a form approved by the commissioner and include a health care professional's certification as to medical necessity;

(D) That the request shall be made in duplicate and include a ~~filing~~ fee of fifteen dollars ($15.00) payable by check or money order to the Office of the Wyoming State Treasurer.

(I) The ~~filing~~ fee may be waived for a claimant whose income is at or below the current federal poverty level guidelines and who files a financial hardship application available upon request from the Wyoming Insurance Department.

(E) That the insurer shall be responsible for the costs of an external review by an independent review organization; and

(F) That the claimant may have the right to an expedited review under circumstances where a delayed review would adversely affect the claimant.

(iii) Notice of the right to an internal and external expedited review which shall include:

(A) A statement that the expedited review shall be completed as expeditiously as the claimant's medical condition or circumstances require, and in any event within seventy-two (72) hours, where:

(I) The timeframe for the completion of a normal review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(II) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a facility.

(B) That the request for internal expedited review shall be filed pursuant to the requirements of the insurer. ~~on a form approved by the~~ A request for external expedited review must be filed on a form approved by the commissioner and include a health care professional's certification as to medical necessity and of the need for an expedited review.

(c) As part of any notice required by this Rule, the insurer shall include an authorization form, or other document approved by the commissioner that complies with the requirements of 45 CFR Section 164.508, by which the claimant, for purposes of conducting an external review under this Rule, authorizes the insurer and the claimant's treating health care provider to disclose protected health information, including medical records, concerning the claimant that are pertinent to the external review.

Section 6. Request for External Review

(a) All requests for external review shall be made in writing to the insurer, on a form approved by the commissioner, together with a copy and fee of fifteen dollars ($15.00) payable by check or money order to the Wyoming State Treasurer. For any single claimant, there is an annual limit on ~~filing~~ fees of seventy-five dollars ($75.00) per calendar year.

(b) A claimant or the claimant's authorized representative may make a request for an external review of a denied claim or final denied claim.

(c) A claimant or the claimant's authorized representative may submit additional new information with the request for external review for consideration during the external review process.

(d) The request for external review shall be accompanied by a health care professional certification of medical necessity.

(e) The request for an expedited review shall be accompanied by a health care professional certification of need for expedited review.

Section 7. Exhaustion of Internal ~~Grievance~~ Review Process

(a) Except as provided in subsection (d), a request for an external review pursuant to Section 6 of this Rule shall not be made until the claimant has exhausted the ~~disability insurer~~insurer's internal ~~grievance~~ review process required by W~~yo~~. S~~tat~~. § 26-40-201(b)(iii).

(b) A claimant shall be considered to have exhausted the ~~disability insurer~~insurer's internal ~~grievance~~ review process for purposes of this section, if the claimant or the claimant's authorized representative:

(i) Has filed a ~~n appeal~~ request for internal review involving a denied claim; and

(ii) Except to the extent the claimant or the claimant's authorized representative requested or agreed to a delay, has not received a written decision on the ~~grievance~~ request for internal review from the ~~disability insurer~~insurer within ~~thirty~~ forty five

(~~30~~45) days following the date the claimant or the claimant's authorized representative filed the ~~grievance~~ request for internal review with the ~~disability insurer~~insurer.

(c) Notwithstanding paragraph (b), a claimant or the claimant's authorized representative may not make a request for an external review of a denied claim involving a retrospective review determination until the claimant has exhausted the ~~disability insurance carrier~~insurance carrier's internal ~~grievance~~ review process.

(d) At the same time a claimant or the claimant's authorized representative files a request for an expedited internal review of a ~~grievance involving a~~ denied claim, the claimant or the claimant's authorized representative may file a request for an expedited external review of the denied claim under Section 9 of this Rule if:

(i) the claimant has a medical condition where the timeframe for completion of an ~~expedited~~ internal review of the ~~grievance involving a~~ denied claim would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(ii) the claimant's claim concerns a request for admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

(e) Upon receipt of a request for an expedited external review under subparagraph (d) of this ~~paragraph~~section, the independent review organization conducting the external review in accordance with the provisions of Section 9 of this Rule shall determine whether the claimant shall be required to complete the expedited internal review process before it conducts the expedited external review.

(i) Upon a determination that the claimant must first complete the expedited internal review process the independent review organization immediately shall notify the claimant and, if applicable, the claimant's authorized representative of this determination and that it will not proceed with the expedited external review set forth in Section 9 of this Rule until completion of the expedited internal review process and ~~the claimant's grievance at the completion of~~ the expedited internal review process remains unresolved.

(f) A request for an external review of a denied claim may be made before the claimant has exhausted the health carrier's internal ~~grievance~~ review procedures whenever the ~~disability insurer~~insurer agrees to waive the exhaustion requirement.

Section 8. Standard External Review

(a) Within ~~sixty (60)~~ one hundred twenty (120) days after the date of receipt of a notice of a denial of claim pursuant to Section 5 of this Rule, a claimant or the claimant's authorized representative may file a request for an external review with the insurer on a form approved by the commissioner.

(b) Within five (5) business days after the date of receipt of a request for external review pursuant to paragraph (a), the insurer shall send a copy of the request to the commissioner together with the ~~filing~~ fee.

(c) Within five (5) business days following the date of receipt of the external review request from the claimant, the ~~disability insurer~~insurer shall complete a preliminary review of the request to determine whether:

(i) The individual is or was a claimant in the ~~health benefit plan~~health ~~insurance plan~~insurance policy at the time the health care service was requested or, in the case of a retrospective review, was a claimant in the ~~health benefit plan~~health insurance ~~plan~~insurance policy at the time the health care service was provided;

(ii) The health care service that is the subject of the claim denial is a covered service under the claimant's ~~health benefit plan~~health insurance ~~plan~~insurance policy, but for a determination by the ~~disability insurer~~insurer that the health care service is not covered because it does not meet the requirements for medical necessity or other similar basis;

(iii) The claimant has exhausted the ~~disability insurer~~insurer's internal review process unless the claimant is not required to exhaust the ~~disability insurer~~insurer's internal review process pursuant to Section 7 of this Rule; and

(iv) The claimant has provided all the information, forms and fee required to process an external review, including the release form provided under Section 5(c) of this Rule.

(d) Within one (1) business day after completion of the preliminary review, the ~~disability insurer~~insurer shall notify the commissioner and claimant and, if applicable, the claimant's authorized representative in writing whether:

(i) The request is complete; and

(ii) The request is eligible for external review.

(e) If the request:

(i) Is not complete, the ~~disability insurer~~insurer shall inform the claimant and, if applicable, the claimant's authorized representative and the commissioner in writing and include in the notice what information or materials are needed to make the request complete; or

(ii) Is not eligible for external review, the ~~disability insurer~~insurer shall inform the claimant and, if applicable, the claimant's authorized representative and the commissioner in writing and include in the notice the reasons for its ineligibility.

(A) The commissioner may specify the form for the ~~disability insurer~~insurer's notice of determination that the request for standard external review is ineligible for review.

(B) The notice of determination shall include a statement informing the claimant and, if applicable, the claimant's authorized representative of the ~~disability insurer~~insurer's determination that the external review request is ineligible for review and may be appealed to the commissioner.

(f) The commissioner may determine that a request is eligible for external review under Section 8 of this Rule notwithstanding a ~~disability insurer~~insurer's determination that the request is ineligible and require that it be referred for external review.

(g) In making a determination under subparagraph (f) of this section, the commissioner's decision shall be made in accordance with the terms of the claimant's ~~health insurance plan~~insurance policy and shall be subject to all applicable provisions of W~~yo~~. S~~tat~~. §§ 26-40-102(a) and 26-40-201.

(h) Whenever the ~~disability insurance carrier~~insurance carrier determines that a request is eligible for external review following the preliminary review conducted pursuant to subsection (c), or that the claimant has provided the information requested to make their submission complete as required by paragraph (e)(i) of this section, the carrier shall, within one (1) business day of making such determination:

(i) Assign an independent review organization from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 11 of this Rule to conduct the external review and notify the commissioner of the name of the assigned independent review organization; and

(ii) Notify in writing the claimant and, if applicable, the claimant's authorized representative of the request's eligibility and acceptance for external review.

(i) In reaching a decision, the assigned independent review organization is not bound by any decisions or conclusions reached during the ~~disability insurer~~insurer's review process as set forth in the internal review process.

(j) The ~~disability insurance carrier~~insurance carrier shall include in the notice that the claimant or the claimant's authorized representative may submit in writing to the assigned independent review organization additional information for consideration by the independent review organization. Such information shall be submitted within five (5) business days following the date of receipt of the notice. Once the assigned independent review organization receives additional information from the claimant, the independent review organization will forward the information to the issuer within one (1) business day of receipt.

(k) Within ~~ten~~ five (~~10~~5) business days after the determination by the insurer that the external review request is eligible for external review as identified in paragraph (h) of this section, ~~date of receipt of the request for external review~~, the ~~disability insurance carrier~~insurance carrier or its ~~designee~~ designated utilization review organization shall provide to the assigned independent review organization the health information considered in making the claim denial.

(l) Except as provided in paragraph (e), failure by the ~~disability insurer~~insurer or its utilization review organization to provide the health information within the time specified in paragraph (k) shall not delay the conduct of the external review.

(m) The independent review organization shall within five (5) days of receipt of the external review request from the insurer determine whether the documentation is

complete and immediately notify the claimant and the insurer in writing what information is missing, if any.

(n) The assigned independent review organization shall review all of the information and documents received pursuant to subsection (k) and any other health information submitted in writing to the independent review organization by the claimant or the claimant's authorized representative pursuant to subsection (j).

(o) ~~Upon receipt of the information, if any, required to be forwarded pursuant to subsection (k), the disability insurance carrier~~insurance carrier may reconsider its denial of claim that is the subject of the external review.~~The insurance carrier may reconsider its denial of the claim at any point prior to the completion of the external review.~~

(p) Reconsideration by the insurer of its denial of claim determination pursuant to paragraph (o) shall not delay or terminate the external review.

(q) The external review may only be terminated if the ~~disability insurance carrier~~insurance carrier decides, upon completion of its reconsideration, to reverse its denial of claim and provide coverage or payment for the health care service that is the subject of the denied claim.

(i) Within one (1) business day after making the decision to reverse its claim denial, as provided in paragraph (q), the insurer shall notify the claimant and, if applicable, the claimant's authorized representative, the assigned independent review organization, and the commissioner in writing of its decision.

(ii) The assigned independent review organization shall terminate the external review upon receipt of the notice from the ~~disability insurance carrier~~insurance carrier that the claim denial has been reversed. ~~sent pursuant to subparagraph (i) of this paragraph.~~

(r) In addition to the health information provided pursuant to subsection (k), the assigned independent review organization, to the extent the health information is available and the independent review organization considers them appropriate, shall consider the following in reaching a decision:

(i) The claimant's medical records;

(ii) The attending health care professional's recommendation;

(iii) Consulting reports from appropriate health care professionals and other documents submitted by the ~~disability insurer~~insurer, claimant, the claimant's authorized representative, or the claimant's treating provider;

(iv) The terms of coverage under the claimant's ~~disability insurance policy~~insurance policy;

(v) The standards identified in W~~yo~~.S~~tat~~. § 26-40-102(a)(iii).

(vi) All evidence based research used in the insurer's denial of the claim.

(s) Within forty-five (45) days after the date of receipt of the request for an external review, the assigned independent review organization shall provide written notice of its decision to uphold or reverse the denial of claim as medically necessary, to:

(i) The claimant;

(ii) If applicable, the claimant's authorized representative;

(iii) The ~~disability insurance carrier~~insurance carrier; and

(iv) The commissioner.

(t) The independent review organization shall include in the notice sent pursuant to paragraph (s):

(i) A general description of the reason for the request for external review;

(ii) The date the independent review organization received the assignment from the insurer to conduct the external review;

(iii) The date the external review was conducted;

(iv) The date of its decision;

(v) The principal reason or reasons for its decision;

(vi) The rationale for its decision; and

(vii) References to the evidence or health information that they considered in reaching their conclusion, including references to how W~~yo~~. S~~tat~~. § 26-40-102 applies to the information reviewed. ~~, considered in reaching its decision.~~

(u) Upon receipt of a notice of a decision pursuant to paragraph (s) reversing the denial of claim, the ~~disability insurance carrier~~insurance carrier within five (5) business days shall approve the covered benefit that was the subject of the denied claim.

(v) Upon receipt of a notice of decision pursuant to paragraph (s) reversing the denial of a claim, the commissioner shall refund the ~~filing~~ fee to the claimant.

~~(u)~~ (w) The assignment by the insurer of an approved independent review organization shall be on a rotational basis established by the commissioner. ~~if the total number of approved independent review organizations is five (5) or fewer.~~

~~(i) If the number of approved independent review organizations is greater than five (5) a disability insurance carrier~~insurance carrier ~~may make a request to the commissioner to use not less than four (4) independent review organizations in its selection of independent review organizations upon a rotation system. The commissioner shall assign to the disability insurance carrier~~insurance carrier ~~those independent review organizations to be used by the insurer on a random basis ensuring fairness and impartiality in the approval of such limited independent review organization assignments.~~

Section 9. Expedited External Review

(a) ~~Except as provided in Section 8(s), a~~ A claimant or the claimant's authorized representative may make a request for an expedited external review with the commissioner at the time the claimant receives:

(i) A denial of claim if:

(A) The denied claim involves a medical condition of the claimant for which the timeframe for completion of an expedited internal review of a claim denial, if a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

(B) The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility; and

(C) The claimant or the claimant's authorized representative has filed a request for an expedited review of a claim denial as not being medically necessary or on a similar basis.

(b) The request shall be made in duplicate and include a ~~filing~~ fee of fifteen dollars ($15.00) payable by check or money order to the Wyoming State Treasurer. For any single claimant, there is an annual limit on ~~filing~~ fees of seventy-five dollars ($75.00).

(i) Upon receipt of a request for an expedited external review, the insurer immediately shall send a copy of the request and the ~~filing~~ fee to the commissioner;

(ii) Immediately upon receipt of the request pursuant to paragraph (i), the ~~disability insurance carrier~~insurance carrier shall determine whether the request meets the reviewability requirements set forth in Section 8(c)(i) through 8(c)(iv) of this Rule. The ~~disability insurance carrier~~insurance carrier shall immediately notify the commissioner and the claimant and, if applicable, the claimant's authorized representative of its eligibility determination.

(c) The commissioner may specify the form for the ~~disability insurer~~insurer's notice of initial determination under this subsection and any supporting information to be included in the notice.

(i) The notice of initial determination shall include a statement informing the claimant and, if applicable, the claimant's authorized representative that a ~~disability insurer~~insurer's initial determination that an external review request is ineligible for review may be appealed to the commissioner.

(d) The commissioner may determine that a request is eligible for expedited external review ~~under Section 8 of this Rule~~ notwithstanding an ~~disability insurance carrier~~insurance carrier's initial determination that the request is ineligible and require that it be referred for expedited external review.

(e) In making a determination under ~~subparagraph~~ paragraph (~~c~~)(~~i~~d) of this ~~paragraph~~section, the commissioner's decision shall be made in accordance with the terms of the claimant's ~~health insurance plan~~insurance policy and shall be subject to all applicable provisions of this Rule.

(f) Upon determination that the request meets the reviewability requirements, the insurer immediately shall assign an independent review organization to conduct the expedited external review from the list of approved independent review organizations compiled and maintained by the commissioner pursuant to Section 11 of this Rule. The insurer shall immediately notify the commissioner of the name of the assigned independent review organization.

~~(g) In reaching a decision in accordance with subsection (i), the assigned independent review organization is not bound by any decisions or conclusions reached during the disability insurance carrier~~insurance carrier's ~~internal review process.~~

~~(h)~~ (g) Upon receipt of the request for expedited external review, the ~~disability insurance carrier~~insurance carrier or its designee utilization review organization shall provide or transmit all necessary documents and information considered in making the denial of claim to the assigned independent review organization electronically or by telephone or facsimile or any other available expeditious method.

~~(i)~~ (h) As expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review that meets the reviewability requirements set forth in Section 8~~(c~~c)(i) through 8(c)(iv) of this Rule, the assigned independent review organization shall:

(i) Make a decision to uphold or reverse the denial of claim; and

(ii) Notify the claimant and, if applicable, the claimant's authorized representative, the ~~disability insurance carrier~~insurance carrier, and the commissioner of the decision.

~~(ii)~~ (iii) The assigned independent review organization is not bound by any decisions or conclusions reached during the insurance carrier's internal review process.

~~(j)~~ (i) If the notice provided pursuant to paragraph (~~i~~h) was not in writing, within forty-eight (48) hours after the date of providing that notice, the assigned independent review organization shall:

(i) Provide written confirmation of the decision to the claimant and, if applicable, the claimant's authorized representative, the ~~disability insurer~~insurer, and the commissioner; and

(ii) Include the information set forth in Section 8(t) of this Rule.

~~(k)~~ (j) Upon receipt of the notice of a decision pursuant to paragraph (i) reversing the denial of claim, the ~~disability insurance carrier~~insurance carrier immediately shall approve the covered benefit that was the subject of the denied claim.

~~(l)~~ (k) An expedited external review may not be provided for retrospective claim denials.

~~(m)~~ (l) The assignment by the insurer of an approved independent review organization shall be on the same basis as provided in Section 8(~~v~~w).

Section 10. Binding Nature of External Review Decision

(a) An external (or expedited) review decision is binding on the ~~disability insurance carrier~~insurance carrier except to the extent the ~~disability insurance carrier~~insurance carrier has other remedies available under applicable state law.

(b) An external review decision is binding on the claimant except to the extent the claimant has other remedies available under applicable federal or state law.

(c) A claimant or the claimant's authorized representative may not file a subsequent request for external review involving the same denied claim for which the claimant has already received an external review decision pursuant to W~~yo~~. S~~tat~~. § 26-40-201.

Section 11. Approval of Independent Review Organizations

(a) The commissioner shall approve independent review organizations eligible to be assigned to conduct external reviews under W~~yo~~. S~~tat~~. § 26-40-201.

(b) In order to be eligible for approval by the commissioner under this section to conduct external reviews an independent review organization:

(i) Shall be accredited by Utilization Review Accreditation Commission (URAC) or another nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations established under Section 12 of this Rule; and

(ii) Shall submit an application for approval in accordance with subsection (c).

(c) The commissioner shall develop an application form for initially approving and for re-approving independent review organizations to conduct external reviews.

(d) Any independent review organization wishing to be approved to conduct external reviews under this Rule shall submit the application form and include with the form all documentation and information necessary for the commissioner to determine if the independent review organization satisfies the minimum qualifications established under Section 12 of this Rule.

(e) Subject to subparagraph (i) of this paragraph, an independent review organization is eligible for approval under this section only if it is accredited by URAC or another nationally recognized private accrediting entity that the commissioner has determined has independent review organization accreditation standards that are equivalent to or exceed the minimum qualifications for independent review organizations under Section 12 of this Rule.

(i) The commissioner may approve independent review organizations that are not accredited by URAC or another nationally recognized private accrediting entity if there are no acceptable nationally recognized private accrediting entities providing independent review organization accreditation.

(ii) The independent review organization shall submit an application fee in the sum of one hundred dollars ($100.00) to the commissioner with an application for approval and re-approval.

(iii) An approval is effective for two (2) years, unless the commissioner determines before its expiration that the independent review organization is not satisfying the minimum qualifications established under Section 12 of this Rule.

(iv) Whenever the commissioner determines that an independent review organization has lost its accreditation or no longer satisfies the minimum requirements established under Section 12 of this Rule, the commissioner shall terminate the approval of the independent review organization and remove the independent review organization from the list of independent review organizations approved to conduct external reviews under this Rule that is maintained by the commissioner pursuant to subsection (f).

(f) The commissioner shall maintain and update a list of approved independent review organizations within fifteen (15) days of approval or determination of eligibility.

Section 12. Minimum Qualifications for Independent Review Organizations

(a) To be approved under Section 11 of this Rule to conduct external reviews, an independent review organization shall have and maintain written policies and procedures that govern all aspects of both the standard external review process and the expedited external review process set forth in this Rule that include, at a minimum:

(i) A quality assurance mechanism in place that:

(A) Ensures that external reviews are conducted within the specified time frames and required notices are provided in a timely manner;

(B) Ensures the selection of qualified and impartial clinical reviewers to conduct external reviews on behalf of the independent review organization and suitable matching of reviewers to specific cases and that the independent review organization employs or contracts with an adequate number of clinical reviewers to meet this objective;

(C) Ensures the confidentiality of medical and treatment records and clinical review criteria; and

(D) Ensures that any person employed by or under contract with the independent review organization adheres to the requirements of this Rule;

(ii) A toll-free telephone service to receive information on a 24-hour-day, 7-day-a-week basis related to external reviews that is capable of accepting, recording or providing appropriate instruction to incoming telephone callers during other than normal business hours; and

(iii) Agree to maintain and provide to the commissioner the information set out in Section 14 of this Rule.

(b) All clinical reviewers assigned by an independent review organization to conduct external reviews shall be health care professionals or other appropriate health care providers who meet the following minimum qualifications:

(i) Be an expert in the treatment of the claimant’s medical condition that is the subject of the external review;

(ii) Be knowledgeable about the recommended health care service or treatment through recent or current actual clinical experience treating patients with the same or similar medical condition of the claimant;

(iii) Hold a non-restricted license in a state of the United States and, for physicians, a current certification by a recognized American medical specialty board in the area or areas appropriate to the subject of the external review; and

(iv) Have no history of disciplinary actions or sanctions, including loss of staff privileges or participation restrictions, that have been taken or are pending by any hospital, governmental agency or unit, or regulatory body that raise a substantial question as to the clinical reviewer's physical, mental or professional competence or moral character.

(c) In addition to the requirements set forth in ~~subsection~~ paragraph (a) of this section an independent review organization may not own or control, be a subsidiary of or in any way be owned or controlled by, or exercise control with a ~~health benefit plan~~insurance policy, a national, state or local trade association of ~~health benefit plan~~ insurance policies, or a national, state or local trade association of health care providers.

(d) In addition to the requirements set forth in ~~subsections~~ paragraph (a), (b) and (c) of this section, to be approved pursuant to Section 11 of this Rule to conduct an external review of a specified case, neither the independent review organization selected to conduct the external review nor any clinical reviewer assigned by the independent organization to conduct the external review may have a material professional, familial or financial conflict of interest with any of the following:

(i) The ~~disability insurer~~insurer that is the subject of the external review;

(ii) The claimant whose treatment is the subject of the external review or the claimant's authorized representative;

(iii) Any officer, director or management employee of the ~~disability insurer~~insurer that is the subject of the external review;

(iv) The health care provider, the health care provider's medical group or independent practice association recommending the health care service or treatment that is the subject of the external review;

(v) The facility at which the recommended health care service or treatment would be provided; or

(vi) The developer or manufacturer of the principal drug, device, procedure or other therapy being recommended for the claimant whose treatment is the subject of the external review.

(e) In determining whether an independent review organization or a clinical reviewer of the independent review organization has a material professional, familial or financial conflict of interest for purposes of paragraph (d) of this section, the commissioner shall take into consideration situations where the independent review organization to be assigned to conduct an external review of a specified case or a clinical

reviewer to be assigned by the independent review organization to conduct an external review of a specified case may have an apparent professional, familial or financial relationship or connection with a person described in paragraph (d) of this section, but that the characteristics of that relationship or connection are such that they are not a material professional, familial or financial conflict of interest that results in the disapproval of the independent review organization or the clinical reviewer from conducting the external review.

(f) An independent review organization that is accredited by URAC or another nationally recognized private accrediting entity that has independent review accreditation standards that the commissioner has determined are equivalent to or exceed the minimum qualifications of this section shall be presumed in compliance with this section to be eligible for approval under Section 11 of this Rule.

(g) The commissioner shall initially review and periodically review the independent review organization accreditation standards of URAC and other nationally recognized private accrediting entities to determine whether the entity's standards are, and continue to be, equivalent to or exceed the minimum qualifications established under this section. The commissioner may accept a review conducted by the NAIC for the purpose of the determination under this paragraph.

(h) Upon request, a nationally recognized private accrediting entity shall make its current independent review organization accreditation standards available to the commissioner or the NAIC in order for the commissioner to determine if the entity's standards are equivalent to or exceed the minimum qualifications established under this section. The commissioner may exclude any private accrediting entity that is not reviewed by the NAIC.

(i) An independent review organization shall be unbiased. An independent review organization shall establish and maintain written procedures to ensure that it is unbiased in addition to any other procedures required under this section.

Section 13. Hold Harmless for Independent Review Organizations

(a) No independent review organization or clinical reviewer working on behalf of an independent review organization or an employee, agent or contractor of an independent review organization shall be liable in damages to any person for any opinions rendered or acts or omissions performed within the scope of the organization's or person's duties under the law during or upon completion of an external review conducted pursuant to this Rule, unless the opinion was rendered or act or omission performed in bad faith or involved gross negligence.

Section 14. External Review Reporting Requirements

(a) An independent review organization assigned pursuant to Section 8 or Section 9 of this Rule to conduct an external review shall maintain written records ~~by~~ grouped by ~~disability insurer~~assigning insurer on all Wyoming requests for external review for which it conducted an external review during a calendar year and, upon request, submit a report to the commissioner, as required under paragraph (b) of this section.

(b) Each independent review organization required to maintain written records on all requests for external review pursuant to paragraph (a) of this section for which it was assigned to conduct an external review shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(c) The report shall include in the aggregate and for each ~~disability insurance carrier~~insurance carrier:

(i) The total number of requests for external review;

(ii) The number of requests for external review resolved and, of those resolved, the number resolved upholding the denied claim or final denied claim and the number resolved reversing the denied claim or final denied claim;

(iii) The average length of time for resolution;

(iv) A summary of the types of coverages or cases for which an external review was sought, as provided in the format required by the commissioner;

(v) The number of external reviews pursuant to Section 8 of this Rule that were terminated as the result of a reconsideration by the ~~disability insurer~~insurer of its denied claim or final denied claim after the receipt of additional information from the claimant or the claimant's authorized representative; and

(vi) Any other information the commissioner may request or require.

(d) The independent review organization shall retain the written records required pursuant to this subsection for at least three (3) years.

(e) Each ~~disability insurer~~insurer shall maintain written records in the aggregate, and for each type of ~~health benefit plan~~insurance policy offered by the ~~disability insurer~~insurer on all requests for external review that the ~~disability insurer~~insurer receives notice of from the insurers pursuant to W~~yo~~.S~~tat~~. § 26-40-201.

(f) Each ~~disability insurer~~insurer required to maintain written records on all requests for external review pursuant to paragraph (a) of this section shall submit to the commissioner, upon request, a report in the format specified by the commissioner.

(i) The report shall include in the aggregate and by type of ~~health benefit plan~~insurance policy:

(A) The total number of requests for external review;

(B) From the total number of requests for external review reported under subparagraph (A) of this paragraph, the number of requests determined eligible for a full external review; and

(C) Any other information the commissioner may request or require.

(g) The ~~disability insurer~~insurer shall retain the written records required pursuant to this subsection for at least five (5) years.

Section 15. Funding of External Review

(a) The ~~disability insurance carrier~~insurance carrier against which a request for a standard external review or an expedited external review is filed shall pay the cost of the independent review organization for conducting the external review.

Section 16. Disclosure Requirements

(a) Each ~~disability insurance carrier~~insurance carrier shall include a description of the external review procedures in or attached to the policy, certificate, membership booklet, outline of coverage or other evidence of coverage it provides to claimants.

(b) The description required under subsection (a) shall include a statement that informs the claimant of the right of the claimant to file a request for an internal or external review in compliance with W~~yo~~.~~-~~S~~tat~~. § 26-40-201.

(c) In addition to subsection (b), the statement shall inform the claimant that, when filing a request for an external review, the claimant will be required to authorize the release of any medical records of the claimant that may be required to be reviewed for the purpose of reaching a decision on the external review.

Section 17. Severability

(a) If any provision of this Rule, or the application of the provision to any person or circumstance shall be held invalid, the remainder of the Rule, and the application of the provision to persons or circumstances other than those to which it is held invalid, shall not be affected.

Section 18. Enforceability

Any violation of these regulations shall be enforceable pursuant to the provisions of W.S. §26-1-107, W.S. §26-3-116, W.S. §26-9-211, and any other applicable rule or statute.

~~(a)~~

~~Section 18.~~Section 19. Effective Date

This Rule shall become effective ~~July 1, 2010 or~~ upon filing with the Secretary of State.