DRAFT ONLY
NOT APPROVED FOR INTRODUCTION

HOUSE BILL NO.

Prior authorization regulations.

Sponsored by: Joint Labor, Health & Social Services Interim Committee

A BILL

for

AN ACT relating to the insurance code; requiring health insurers and contracted utilization review entities to follow prior authorization regulations as specified; providing legislative findings; providing definitions; requiring rulemaking; making conforming amendments; and providing for effective dates.

Be It Enacted by the Legislature of the State of Wyoming:

Section 1. W.S. 26-55-101 through 26-55-113 are created to read:

CHAPTER 55 – ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION ACT

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STAFF COMMENT

For the Committee's information, the Centers for Medicare and Medicaid Services is in the process of creating a new rule regarding prior authorization. The rule should become effective January 1, 2026. It is unclear at this time what the new rule will entail.

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26-55-101. Short title.

This act shall be known and may be cited as the "Ensuring Transparency in Prior Authorization Act."

26-55-102. Legislative findings.

(a) The legislature finds and declares that:

(i) The patient-physician relationship is paramount and should not be subject to third party intrusion;

(ii) Prior authorization programs place cost savings ahead of optimal patient care;

(iii) Prior authorization programs shall not be permitted to hinder patient care or intrude on the practice of medicine.

26-55-103. Definitions.

(a) As used in this act:

(i) "Adverse determination" means a decision by a health insurer or contracted utilization review entity to deny, reduce or terminate benefit coverage for health care services furnished or proposed to be furnished because the services are not medically necessary or are experimental or investigational. A decision to deny, reduce or terminate health care services that are not covered for reasons other than their medical necessity or experimental or investigational nature is not an "adverse determination" for purposes of this act;

(ii) "Authorization" means an approved prior authorization request;

(iii) "Chronic or long term care condition" means a condition that lasts not less than three (3) months and requires ongoing medical attention, limits activities of daily living or both;

(iv) "Enrollee" means a person eligible to receive health care benefits by a health insurer pursuant to a health plan or other health insurance coverage. The term "enrollee" includes an enrollee's legally authorized representative;

(v) "Health care service" means health care procedures, treatments or services provided by a licensed health care facility or provided by a licensed physician. The term "health care service" also includes the provision of pharmaceutical products or services and durable medical equipment.

(vi) "Health insurer or contracted utilization review entity" means a person or entity that performs prior

authorization for one (1) or more of the following entities:

(A) An employer with employees in Wyoming who are covered under a health benefit plan, disability insurance as defined by W.S. 26-5-103 or a health insurance policy;

(B) An insurer that writes health insurance policies;

(C) A preferred provider organization or health maintenance organization.

(vii) "Medically necessary health care services" means health care services that a reasonable physician would provide to a patient for the purpose of preventing, diagnosing or treating an illness, injury, disease or its symptoms in a manner that is:

(A) In accordance with generally accepted standards of medical practice;

(B) Clinically appropriate in terms of type, frequency, extent, site and duration;

(C) Not primarily for the economic benefit of the health plans and purchasers or for the convenience of the patient, treating physician or other health care provider.

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STAFF COMMENT

The Committee may wish to consider using the definition of "medical necessity" under W.S. 26-40-102(a)(iii) to avoid confusion between the two definitions. It reads:

(iii) "Medical necessity" means:

(A) A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

(I) Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;

(II) Provides for the diagnosis, direct care and treatment of the patient's condition, illness, disease or injury;

(III) Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and

(IV) Is not primarily for the convenience of the patient, physician or other health care provider.

(B) A medical service, procedure or supply shall not be excluded from being a medical necessity under this section solely because the service, procedure or supply is not in common use if the safety and effectiveness of the service, procedure or supply is supported by:

(I) Peer reviewed medical literature, including literature relating to therapies reviewed and approved by a qualified institutional review board, biomedical compendia and other medical literature that meet the criteria of the National Institutes of Health's Library of Medicine for indexing in Index Medicus (Medline) and Elsevier Science Ltd. for indexing in Excerpta Medicus (EMBASE); or

(II) Medical journals recognized by the Secretary of Health and Human Services under Section 1861(t)(2) of the federal Social Security Act.

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(viii) "Medications for opioid use disorder" means the use of medications to provide a comprehensive approach to the treatment of opioid use disorder. Food and drug administration-approved medications used to treat opioid addiction include methadone, buprenorphine, alone or in combination with naloxone, and extended-release injectable naltrexone;

(ix) "Prior authorization" means the process by which health insurers or contracted utilization review entities determine the medical necessity or medical

appropriateness of otherwise covered health care services prior to rendering such health care services. "Prior authorization" also includes any health insurer or contracted utilization review entity's requirement that an enrollee or health care provider notify the health insurer or contracted utilization review entity prior to providing a health care service;

(x) "Urgent health care service" means a health care service for which the application of the time periods for making a non-expedited prior authorization decision could, in the opinion of a physician with knowledge of the enrollee's medical condition:

(A) Seriously jeopardize the life or health of the enrollee or the ability of the enrollee to regain maximum function; or

(B) Could subject the enrollee to severe pain that cannot be adequately managed without the care or treatment that is the subject of the review. For purposes of this act, urgent health care service shall include mental and behavioral health care services.

(xi) "This act" means W.S. 26-55-101 through 26-55-113.

26-55-104. Disclosure and review of prior authorization requirements.

(a) Each health insurer or contracted utilization review entity shall make any current prior authorization requirements and restrictions easily accessible on its website to enrollees, health care professionals and the general public. Each health insurer or contracted utilization review entity shall directly furnish those requirements and restrictions within twenty-four (24) hours after being requested by a health care provider. Requirements and restrictions provided or posted under this subsection shall be described in detail but also in easily understandable language. Content published by a third party and licensed for use by a health insurer or contracted utilization review entity may be made available through the health insurer or contracted utilization review entity's secure password-protected website, provided that the access requirements of the website do not unreasonably restrict

access to any current prior authorization requirements and restrictions.

(b) Each health insurer or contracted utilization review entity shall not implement a new or amended prior authorization requirement or restriction unless its website has been updated to reflect the new or amended prior authorization requirement or restriction.

(c) Each health insurer or contracted utilization review entity shall provide contracted health care providers and enrollees written notice of any new or amended prior authorization requirement or restriction implemented under the health insurer's medical policy or the health insurance contract not less than sixty (60) days before the new or amended prior authorization requirement or restriction is implemented.

(d) Health insurers or contracted utilization review entities shall make statistics available regarding prior authorizations and adverse determinations on their website in a readily accessible format. The statistics shall include categories for:

(i) The physician specialty;

(ii) The medication or diagnostic test or procedure;

(iii) The indication offered;

(iv) The reason for the adverse determination;

(v) Whether the adverse determination was appealed;

(vi) Whether the adverse determination was upheld or reversed on appeal;

(vii) The time between submission of the prior authorization request and the authorization or initial adverse determination.

26-55-105. Persons qualified to make adverse determinations.

(a) Each health insurer or contracted utilization review entity shall ensure that all adverse determinations are made by a physician or other appropriate licensed health care professional who has:

(i) Sufficient medical knowledge in a specific practice area or specialty;

(ii) Knowledge of the coverage criteria;

(iii) A current and unrestricted license to practice within the scope of their medical profession in a state, territory, commonwealth of the United States or the District of Columbia.

26-55-106. Consultation prior to issuing an adverse determination.

If a health insurer or contracted utilization review entity is preparing to deny or considering rejecting the medical necessity of a health care service, the health insurer or contracted utilization review entity shall notify the enrollee's health care provider that medical necessity is

being questioned. Before the health insurer or contracted utilization review entity issues an adverse determination, the enrollee's health care provider shall have the opportunity to discuss the medical necessity of the health care service with the person who will be responsible for determining authorization of the health care service under review.

26-55-107. Requirements applicable to persons reviewing appeals.

(a) Each health insurer or contracted utilization review entity shall ensure that all appeals of adverse determinations are reviewed by a physician or other appropriate licensed health care professional who has:

(i) Sufficient medical knowledge in a specific practice area or specialty;

(ii) Knowledge of the coverage criteria;

(iii) A current and unrestricted license to practice within the scope of their medical profession in a

state, territory, commonwealth of the United States or the District of Columbia;

(iv) Not been employed by the health insurer or contracted utilization review entity or been under contract with the health insurer or contracted utilization review entity other than to participate in one (1) or more of the health insurer or contracted utilization review entity's health care provider networks or to perform reviews of appeals, or otherwise have any financial interest in the outcome of the appeal;

(v) Not been directly involved in the initial adverse determination; and

(vi) Considered all known clinical aspects of the health care service under review, including but not limited to, a review of all pertinent medical records provided to the health insurer or contracted utilization review entity by the enrollee's health care provider, any relevant records provided to the health insurer or contracted utilization review entity by a health care facility, any pertinent material provided by the enrollee

and any medical literature provided to the health insurer or contracted utilization review entity by the health care provider.

(b) The enrollee's health care provider may request upon the initiation of an appeal that the appeal from an adverse determination be made by a physician or a specialist in the area of medicine under appeal.

26-55-108. Health insurer or contracted utilization review entities' obligations regarding prior authorization for non-urgent health care services

If a health insurer or contracted utilization review entity requires prior authorization of a health care service, the health insurer or contracted utilization review entity shall make an authorization or adverse determination and notify the enrollee and the enrollee's health care provider of the authorization or adverse determination within five (5) business days of obtaining all necessary information to complete the review.

26-55-109. Health insurer or contracted utilization review entities' obligations with respect to prior authorizations for urgent health care services.

Each health insurer or contracted utilization review entity shall make an authorization or adverse determination concerning urgent health care services and notify the enrollee and the enrollee's health care provider of that authorization or adverse determination not later than seventy-two (72) hours after receiving all necessary information to complete the review. The prior authorization request shall be considered authorized if the health insurer or contracted utilization review entity fails to notify the enrollee and the health care provider of a decision within seventy-two (72) hours of receiving all necessary information to complete the review. A health insurer or contracted utilization review entity shall provide an online portal for health care providers to have the option of submitting urgent prior authorization requests for urgent health care services.

26-55-110. No prior authorization for medications for opioid use disorder.

No health insurer or contracted utilization review entity shall require prior authorization for the provision of medications for opioid use disorder.

26-55-111. Length of authorization generally; revocation of prior authorizations prohibited; length of authorization for chronic or long-term care conditions.

(a) Each authorization shall be valid for one (1) year from the date the health care provider receives the authorization. The authorization period shall be effective regardless of any changes in dosage for a prescription drug prescribed by the health care provider, provided that the authorization period is consistent with evidence-based guidelines for safety and efficacy.

(b) Each health insurer or contracted utilization review entity shall not revoke, limit, condition or restrict a previously approved authorization for health care services if the health care services are provided within forty-five (45) business days from the date the

health care provider received the authorization approval for the specific service that was authorized.

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STAFF COMMENT

Subsection (b) above was originally placed under "retrospective denials" in its own statute, along with the language below. After speaking with the Department of Insurance, the Department thought it was best to consolidate retrospective denials with length of authorization and delete the below language so that it did not conflict with other statutes having to do with payment of insurance claims under Title 26, Chapter 40.

The deleted language is below:

(b) A health insurer or contracted utilization review entity shall pay a health care provider at the contracted payment rate for a health care service provided by the health care provider pursuant to an authorization unless:

(i) The health care provider knowingly and materially misrepresented the health care service in the prior authorization request with the specific intent to deceive and obtain an unlawful payment from the health insurer or contracted utilization review entity;

(ii) The health care service was no longer a covered benefit on the day it was provided;

(iii) The health care provider was no longer contracted with the patients' health insurance plan on the date the care was provided;

(iv) The health care provider failed to meet the health insurer or contracted utilization review entity's timely filing requirements for prior authorizations;

(v) The health insurer or contracted utilization review entity does not have liability for a claim; or

(vi) The patient was no longer eligible for health care coverage on the day the health care services were provided.

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(c) If a health insurer or contracted utilization review entity requires a prior authorization request for a health care service for the treatment of a chronic or long-term care condition, the authorization shall remain valid for one (1) year. This section shall not apply to the prescription of benzodiazepines or schedule II narcotic drugs.

26-55-112. Continuity of care for enrollees.

(a) On receipt of all necessary information documenting an authorization from the enrollee, previous health insurer or the enrollee's health care provider, a health insurer or contracted utilization review entity shall honor an authorization granted to an enrollee from a previous health insurer or contracted utilization review entity for not less than sixty (60) days after an enrollee's coverage under a new health plan commences, if

the health care service is a covered benefit under the new health insurance plan.

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STAFF COMMENT

The words "if the health care service is a covered benefit" were added to subsection (a) above because not all health care plans are universally the same. The enrollee's new health care plan may not cover all of the same health care benefits as the enrollee's previous health care plan.

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(b) During the time period described in subsection (a) of this section, a health insurer or contracted utilization review entity may perform its own review to grant a new authorization.

(c) If there is a change in coverage of, or a change in approval criteria for, a previously authorized health care service under the enrollee's current health care plan, the change in coverage or approval criteria shall not affect an enrollee who received authorization less than one (1) year before the effective date of the change. A health insurer or contracted utilization review entity may require

a new prior authorization request one (1) year after the enrollee's previous prior authorization was requested.

26-55-113. Provider exemptions from prior authorization requirements.

(a) A health care provider shall be granted an exemption from completing a prior authorization request for a health care service if:

(i) In the most recent twelve (12) month period, the health insurer or contracted utilization review entity has authorized not less than eighty percent (80%) of the prior authorization requests submitted by the health care provider for that health care service; and

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STAFF COMMENT

Paragraph (i) above originally read "In the most recent twelve (12) month period, the health insurer or contracted utilization review entity has authorized *or would have authorized* not less than eighty percent (80%) of the prior authorization requests submitted by the health care provider for that health care service; and". The highlighted words were removed because "would have authorized" is vague and confusing.

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(ii) The health care provider has made a prior authorization request for that health care service not less than five (5) times in the most recent twelve (12) month period.

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STAFF COMMENT

The Committee may wish to consider that proposed W.S. 26-55-113 may result in enrollees seeking out doctors that they know are receiving exemptions for certain procedures so that they do not have to go through the prior authorization process.

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(b) A health insurer or contracted utilization review entity may evaluate whether a health care provider continues to qualify for exemptions as described in subsection (a) of this section not more than one (1) time every twelve (12) months. Nothing in this section shall require a health insurer or contracted utilization review entity to evaluate an existing exemption under subsection (a) of this section or prevent a health insurer or

contracted utilization review entity from establishing a longer exemption period.

(c) A health care provider is not required to request an exemption in order to receive an exemption under subsection (a) of this section.

(d) A health care provider who does not receive an exemption under subsection (a) of this section may request from the health insurer or contracted utilization review entity up to one (1) time per calendar year per service, evidence to support the health insurer or contracted utilization review entity's decision. A health care provider may appeal a health insurer or contracted utilization review entity's decision to deny an exemption.

(e) A health insurer or contracted utilization review entity shall only revoke an exemption at the end of a twelve (12) month period if the health insurer or contracted utilization review entity:

(i) Makes a determination that the health care provider would not have met the eighty percent (80%)

authorization criteria based on a retrospective review of the claims for the particular service for which the exemption applies for the previous three (3) months or for a longer period if needed to reach a minimum of five (5) claims for review;

(ii) Provides the health care provider with the information it relied upon in making its determination to revoke the exemption; and

(iii) Provides the health care provider a plain language explanation of how to appeal the decision.

(f) An exemption under subsection (a) of this section shall remain in effect until the thirtieth day after the date the health insurer or contracted utilization review entity notifies the health care provider of its determination to revoke the exemption or, if the health care provider appeals the determination, the fifth day after the revocation is upheld on appeal.

(g) A determination to revoke or deny an exemption under subsection (a) of this section shall be made by a

licensed health care provider that is of the same or similar specialty as the health care provider being considered for an exemption and has experience in providing the service for which the potential exemption applies.

(h) A health insurer or contracted utilization review entity shall provide a health care provider that receives an exemption under subsection (a) of this section a notice that includes:

(i) A statement that the health care provider qualifies for an exemption from prior authorization requirements;

(ii) A list of services for which the exemption applies; and

(iii) A statement of the twelve (12) month duration of the exemption.

(j) No health insurer or contracted utilization review entity shall deny or reduce payment for a health care service exempted from a prior authorization

requirement under this section, including a health care service performed or supervised by another health care provider when the health care provider who ordered such service received a prior authorization exemption, unless the rendering health care provider:

(i) Knowingly and materially misrepresented the health care service in request for payment submitted to the health insurer or contracted utilization review entity with the specific intent to deceive and obtain an unlawful payment from the health insurer or contracted utilization review entity; or

(ii) Failed to substantially perform the health care service.

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STAFF COMMENT

The severability section of this bill draft has been omitted because severability is already taken into account under W.S. 8-1-103(a)(viii):

"If any provision of any act enacted by the Wyoming legislature or its application to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or

application, and to this end the provisions of any such act are severable;".

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Section 2. W.S. 26-40-102(c)(i) and (ii), (e)(ii) and (iii), (g)(ii)(A), (B) and (C), (m) and (n) is amended to read:

26-40-201. Payment of claims under medical necessity standard; review.

(c) When any claim for the ~~provision of or~~ payment for medical services, procedures or supplies is first denied as not being a medical necessity, or on another similar basis, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the settlement and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(i) A statement in the following, or substantially equivalent, language: "We have denied your request for ~~the provision of or~~ payment for a health care

service or course of treatment. You have the right to have our decision reviewed by following the procedures outlined in this notice;~~. You also may have the right to an expedited review under circumstances where a delayed review would adversely affect you.";~~ and

(ii) A statement describing a procedure for having the claim denial reviewed by the insurer, including all applicable time limits~~,~~ and requirements.~~ and a process for having a expedited review initiated as expeditiously as the claimant's medical condition or circumstances require, and in any event within seventy-two (72) hours, where:~~

(e) If a claim for the ~~provision of or~~ payment for medical services, procedures or supplies is denied on the basis that it is not a medical necessity, or on other similar basis, after having been reviewed by the insurer pursuant to subsection (c) or (d) of this section, the insurer shall provide to the claimant, in writing, a complete explanation of the basis for the decision and shall specify why the services, procedures or supplies requested are not medically necessary. Such explanation shall also include:

(ii) A statement in the following, or substantially equivalent, language: "We have denied your request for the ~~provision of or~~ payment for a health care service or course of treatment. You may have the right to have our decision reviewed by health care professionals who have no association with us and is not the attending physician or the physician's partner by following the procedures outlined in this notice;~~. You also may have the right to an expedited review under circumstances where a delayed review would adversely affect you.";~~ and

(iii) A statement describing the procedure for having the denied claim reviewed by an external review organization pursuant to regulations adopted by the commissioner. The statement shall include a description of all procedures, time limits and requirements~~, including those related to expedited reviews,~~ which the claimant must follow to obtain an external review and include a request for external review form and release of records form approved by the commissioner.

(g) Upon receiving a request for external review, the insurer shall:

(ii) Assign the request to an independent review organization that has been approved by the commissioner for a preliminary review. The insurer shall provide to the independent review organization all documents and information upon which the insurer relied in denying all claims under review. Failure to provide the documents and other information shall not delay the conduct of the external review. The independent review organization shall determine whether:

(A) The claimant is or was a covered person in the insurance policy at the time the ~~provision of or~~ payment for medical services, procedures or supplies was ~~requested or~~ provided;

(B) The ~~provision of or~~ payment for medical services, procedures or supplies requested by the claimant reasonably appears to be a covered service under the insurance policy, but for the determination by the insurer

that the services, procedures or supplies are not a medical necessity;

(C) The insurer has denied the claimant's request for the ~~provision of or~~ payment for medical services, procedures or supplies after having been given the opportunity to review the insurer's first denial one (1) or more times;

(m) Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice to the claimant, the insurer and the commissioner of its decision to uphold or reverse the decision of the insurer that the ~~provision of or~~ payment for medical services, procedures or supplies requested by the claimant are not medically necessary. Such written notice shall include:

(n) In the event the external review organization determines the claims should be allowed, the insurer shall approve the request for the ~~provision of or~~ payment for medical services, procedures or supplies that was the

subject of the review and notify the claimant of such approval within five (5) days.

Section 3. W.S. 26-40-102(c)(ii)(A) and (B) and (p) is repealed.

Section 4. The department of insurance shall promulgate all rules necessary to implement this act.

Section 5.

(a) Except as otherwise provided by subsection (b) of this section, this act is effective July 1, 2024.

(b) Sections 4 and 5 of this act are effective immediately upon completion of all acts necessary for a bill to become law as provided by Article 4, Section 8 of the Wyoming Constitution.

(END)