

**DRAFT ONLY
NOT APPROVED FOR
INTRODUCTION**

HOUSE BILL NO.

Prior authorization regulations.

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

A BILL

for

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

7

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

9

10 **Section 1.** W.S. 26-55-101 through 26-55-114 are
11 created to read:

12

1 CHAPTER 55 - ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION

2 ACT

3

4 *****

5 *****

6 STAFF COMMENT

7

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

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17 26-55-101. Short title.

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

21

22 26-55-102. Legislative findings.

23

24 (a) The legislature finds and declares that:

25

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

29

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

4

5 **26-55-103. Definitions.**

6

7 (a) As used in this act:

8

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

19

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

22

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

5

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

11

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

18

19 (vi) "Health insurer or contracted utilization
20 review entity" means a person or entity that performs prior
21 authorization for one (1) or more of the following
22 entities:

23

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

5
6 (B) An insurer that writes health insurance
7 policies;

8
9 (C) A preferred provider organization or
10 health maintenance organization.

11
12 (vii) "Medically necessary health care services"
13 means as defined by W.S. 26-40-102(a)(iii);

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17 STAFF COMMENT

18
19 For the Committee's information, this definition reads:

20
21 (iii) "Medical necessity" means:

22
23 (A) A medical service, procedure or supply provided
24 for the purpose of preventing, diagnosing or treating an
25 illness, injury, disease or symptom and is a service,
26 procedure or supply that:

27
28 (I) Is medically appropriate for the symptoms,
29 diagnosis or treatment of the condition, illness, disease
30 or injury;

31

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

4
5 (III) Is in accordance with professional,
6 evidence based medicine and recognized standards of good
7 medical practice and care; and

8
9 (IV) Is not primarily for the convenience of the
10 patient, physician or other health care provider.

11
12 (B) A medical service, procedure or supply shall not
13 be excluded from being a medical necessity under this
14 section solely because the service, procedure or supply is
15 not in common use if the safety and effectiveness of the
16 service, procedure or supply is supported by:

17
18 (I) Peer reviewed medical literature, including
19 literature relating to therapies reviewed and approved by a
20 qualified institutional review board, biomedical compendia
21 and other medical literature that meet the criteria of the
22 National Institutes of Health's Library of Medicine for
23 indexing in Index Medicus (Medline) and Elsevier Science
24 Ltd. for indexing in Excerpta Medicus (EMBASE); or

25
26 (II) Medical journals recognized by the
27 Secretary of Health and Human Services under Section
28 1861(t)(2) of the federal Social Security Act.

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33 (viii) "Medications for opioid use disorder"
34 means the use of medications to provide a comprehensive
35 approach to the treatment of opioid use disorder. Food and
36 drug administration-approved medications used to treat
37 opioid addiction include methadone, buprenorphine, alone or

1 in combination with naloxone, and extended-release
2 injectable naltrexone;

3

4 (ix) "Prior authorization" means the process by
5 which health insurers or contracted utilization review
6 entities determine the medical necessity or medical
7 appropriateness of otherwise covered health care services
8 prior to rendering such health care services. "Prior
9 authorization" also includes any health insurer or
10 contracted utilization review entity's requirement that an
11 enrollee or health care provider notify the health insurer
12 or contracted utilization review entity prior to providing
13 a health care service;

14

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

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

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(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 26-55-114.

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

1 understandable language. Content published by a third party
2 and licensed for use by a health insurer or contracted
3 utilization review entity may be made available through the
4 health insurer or contracted utilization review entity's
5 secure password-protected website, provided that the access
6 requirements of the website do not unreasonably restrict
7 access to any current prior authorization requirements and
8 restrictions.

9

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

15

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

1

2 (d) The department of insurance shall promulgate
3 rules requiring health insurers or contracted utilization
4 review entities to make statistics available to the public
5 and the department regarding prior authorizations and
6 adverse determinations. At a minimum, the statistics shall
7 include categories for:

8

9 (i) The physician specialty;

10

11 (ii) The medication or diagnostic test or
12 procedure;

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14 (iii) The indication offered;

15

16 (iv) The reason for the adverse determination;

17

18 (v) Whether the adverse determination was
19 appealed;

20

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

23

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

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5 **26-55-105. Persons qualified to make adverse**
6 **determinations.**

7

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

12

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

15

16 (ii) Knowledge of the coverage criteria;

17

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

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1 **26-55-106. Consultation prior to issuing an adverse**
2 **determination.**

3

4 If a health insurer or contracted utilization review entity
5 is preparing to deny or considering rejecting the medical
6 necessity of a health care service, the health insurer or
7 contracted utilization review entity shall notify the
8 enrollee's health care provider that medical necessity is
9 being questioned. Before the health insurer or contracted
10 utilization review entity issues an adverse determination,
11 the enrollee's health care provider shall have the
12 opportunity to discuss the medical necessity of the health
13 care service with the person who will be responsible for
14 determining authorization of the health care service under
15 review.

16

17 **26-55-107. Requirements applicable to persons**
18 **reviewing appeals.**

19

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

1

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

4

5 (ii) Knowledge of the coverage criteria;

6

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

11

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

20

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

23

1 (vi) Considered all known clinical aspects of
2 the health care service under review, including but not
3 limited to, a review of all pertinent medical records
4 provided to the health insurer or contracted utilization
5 review entity by the enrollee's health care provider, any
6 relevant records provided to the health insurer or
7 contracted utilization review entity by a health care
8 facility, any pertinent material provided by the enrollee
9 and any medical literature provided to the health insurer
10 or contracted utilization review entity by the health care
11 provider.

12

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

17

18 **26-55-108. Health insurer or contracted utilization**
19 **review entities' obligations regarding prior authorization**
20 **for non-urgent health care services**

21

22 If a health insurer or contracted utilization review entity
23 requires prior authorization of a health care service, the

1 health insurer or contracted utilization review entity
2 shall make an authorization or adverse determination and
3 notify the enrollee and the enrollee's health care provider
4 of the authorization or adverse determination within five
5 (5) business days of obtaining all necessary information to
6 complete the review.

7

8 **26-55-109. Health insurer or contracted utilization**
9 **review entities' obligations with respect to prior**
10 **authorizations for urgent health care services.**

11

12 Each health insurer or contracted utilization review entity
13 shall make an authorization or adverse determination
14 concerning urgent health care services and notify the
15 enrollee and the enrollee's health care provider of that
16 authorization or adverse determination not later than
17 twenty-four (24) hours after receiving all necessary
18 information to complete the review. The prior authorization
19 request shall be considered authorized if the health
20 insurer or contracted utilization review entity fails to
21 notify the enrollee and the health care provider of a
22 decision within twenty-four (24) hours of receiving all
23 necessary information to complete the review. A health

1 insurer or contracted utilization review entity shall
2 provide an online portal for health care providers to have
3 the option of submitting urgent prior authorization
4 requests for urgent health care services.

5

6 **26-55-110. No prior authorization for medications for**
7 **opioid use disorder.**

8

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

12

13 **26-55-111. Length of authorization generally;**
14 **revocation of prior authorizations prohibited; length of**
15 **authorization for chronic or long-term care conditions.**

16

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

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(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.

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;

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

3

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

7

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

11

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

14

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

18

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21 *****
22

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

30

31 26-55-112. Continuity of care for enrollees.

32

1 (a) On receipt of all necessary information
 2 documenting an authorization from the enrollee, previous
 3 health insurer or the enrollee's health care provider, a
 4 health insurer or contracted utilization review entity
 5 shall honor an authorization granted to an enrollee from a
 6 previous health insurer or contracted utilization review
 7 entity for not less than ninety (90) days after an
 8 enrollee's coverage under a new health plan commences, if
 9 the health care service is a covered benefit under the new
 10 health insurance plan.

11

12 *****
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STAFF COMMENT

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15
 16 **The words "if the health care service is a covered benefit"**
 17 **were added to subsection (a) above because not all health**
 18 **care plans are universally the same. The enrollee's new**
 19 **health care plan may not cover all of the same health care**
 20 **benefits as the enrollee's previous health care plan.**

21

22 *****
 23 *****

24

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

29

1 (c) If there is a change in coverage of, or a change
2 in approval criteria for, a previously authorized health
3 care service under the enrollee's current health care plan,
4 the change in coverage or approval criteria shall not
5 affect an enrollee who received authorization less than one
6 (1) year before the effective date of the change. A health
7 insurer or contracted utilization review entity may require
8 a new prior authorization request one (1) year after the
9 enrollee's previous prior authorization was requested.

10

11 **26-55-113. Provider exemptions from prior**
12 **authorization requirements.**

13

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

17

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

23

1 *****
 2 *****
 3 STAFF COMMENT
 4

5 Paragraph (i) above originally read "In the most
 6 recent twelve (12) month period, the health insurer or
 7 contracted utilization review entity has authorized **or**
 8 **would have authorized** not less than eighty percent (80%) of
 9 the prior authorization requests submitted by the health
 10 care provider for that health care service; and". The
 11 highlighted words were removed because "would have
 12 authorized" is vague and confusing.
 13

14 *****
 15 *****
 16

17 (ii) The health care provider has made a prior
 18 authorization request for that health care service not less
 19 than five (5) times in the most recent twelve (12) month
 20 period.
 21

22 *****
 23 *****
 24 STAFF COMMENT
 25

26 The Committee may wish to consider that proposed W.S. 26-
 27 55-113 may result in enrollees seeking out doctors that
 28 they know are receiving exemptions for certain procedures
 29 so that they do not have to go through the prior
 30 authorization process.
 31

32 *****
 33 *****
 34

35 (b) A health insurer or contracted utilization review
 36 entity may evaluate whether a health care provider

1 continues to qualify for exemptions as described in
2 subsection (a) of this section not more than one (1) time
3 every twelve (12) months. Nothing in this section shall
4 require a health insurer or contracted utilization review
5 entity to evaluate an existing exemption under subsection
6 (a) of this section or prevent a health insurer or
7 contracted utilization review entity from establishing a
8 longer exemption period.

9

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

13

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

22

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

5

6 (i) Makes a determination that the health care
7 provider would not have met the eighty percent (80%)
8 authorization criteria based on a retrospective review of
9 the claims for the particular service for which the
10 exemption applies for the previous three (3) months or for
11 a longer period if needed to reach a minimum of five (5)
12 claims for review;

13

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

17

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

20

21 (f) An exemption under subsection (a) of this section
22 shall remain in effect until the thirtieth day after the
23 date the health insurer or contracted utilization review

1 entity notifies the health care provider of its
2 determination to revoke the exemption or, if the health
3 care provider appeals the determination, the fifth day
4 after the revocation is upheld on appeal.

5

6 (g) A determination to revoke or deny an exemption
7 under subsection (a) of this section shall be made by a
8 licensed health care provider that is of the same or
9 similar specialty as the health care provider being
10 considered for an exemption and has experience in providing
11 the service for which the potential exemption applies.

12

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

17

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

21

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

1

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

4

5 (j) No health insurer or contracted utilization
6 review entity shall deny or reduce payment for a health
7 care service exempted from a prior authorization
8 requirement under this section, including a health care
9 service performed or supervised by another health care
10 provider when the health care provider who ordered such
11 service received a prior authorization exemption, unless
12 the rendering health care provider:

13

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

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

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"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;".

Section 2. The department of insurance shall promulgate all rules necessary to implement this act.

Section 3.

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

(b) Sections 2 and 3 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)