HOUSE BILL NO. HB0057

Health insurance-medical necessity reviews.

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

A BILL

for

AN ACT relating to health insurance plans; amending requirements for review of an insurer's determination that a claimed service, procedure or supply is not medically necessary; providing a definition of health insurance plan; and providing for an effective date.

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

Section 1. W.S. 26-40-201(a), (b)(intro), (f) and (j) is amended to read:

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

(a) As used in this section:

(i) "Health insurance plan" means:

(A) A disability insurance policy as defined by W.S. 26-5-103;

(B) A private health benefit plan as defined by W.S. 26-1-102(a)(xxxiii);

(C) Accident only insurance;

(D) Accidental death or dismemberment insurance;

(E) Dental or vision care insurance;

(F) Disability income or a combination of accident only and disability income insurance;

(G) Specified disease insurance;

(H) Hospital confinement indemnity insurance; or

(J) Limited benefit insurance that is offered and marketed as supplemental health insurance and not as a substitute for hospital or medical insurance or major medical expense insurance.

(ii) "Medical necessity or other similar basis" includes, but is not limited to, "medically necessary," "medically necessary care" and "medically necessary and appropriate," as defined in W.S. 26-40-102(a)(iii).

(b) If any ~~disability insurance policy, as defined by W.S. 26-5-103,~~ health insurance plan provides for settlement of a claim for payment of medical services, procedures or supplies provided by a health care provider using a medical necessity or other similar basis the insurer shall:

(f) Within ~~sixty (60) days~~ one hundred twenty (120) days of receiving the written explanation required by subsection (e) of this section, a claimant may request an external review of the decision which is the subject of the explanation by filing a written request for such review.

The request shall be submitted to the insurer on a form approved by the commissioner, unless such form was not provided to the claimant as required by subsection (e) of this section, in which event any written request for an external review shall be sufficient.

(j) ~~All documentation or other information provided to the independent review organization by the insurer or claimant shall also be immediately provided to the adverse party by the independent review organization~~ The independent review organization shall, within one (1) business day of its receipt, forward all documentation and information it receives from an insurer or claimant to the opposing insurer or claimant. The insurer may use any documentation or other information provided by the claimant to reconsider its settlement of the claims. If the insurer chooses to reverse its prior decision, it shall immediately provide written notice to the claimant, the independent review organization and the commissioner, at which time the review shall be terminated.

Section 2. This act is effective July 1, 2015.

(END)