

HOUSE BILL NO. HB0014

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; and providing for effective dates.

6

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

8

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

11

CHAPTER 55

12

ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION ACT

13

14

15 **26-55-101. Short title.**

1

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

4

5 **26-55-102. Legislative findings.**

6

7 (a) The legislature finds and declares that:

8

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

12

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

16

17 **26-55-103. Definitions.**

18

19 (a) As used in this act:

20

21 (i) "Adverse determination" means a decision by  
22 a health insurer or contracted utilization review entity to  
23 deny, reduce or terminate benefit coverage for health care

1 services furnished or proposed to be furnished because the  
2 services are not medically necessary or are experimental or  
3 investigational. A decision to deny, reduce or terminate  
4 health care services that are not covered for reasons other  
5 than their medical necessity or experimental or  
6 investigational nature is not an "adverse determination"  
7 for purposes of this act;

8

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

11

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

16

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

22

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

7

8           (vi) "Health insurer or contracted utilization  
9 review entity" means a person or entity that performs prior  
10 authorization for one (1) or more of the following  
11 entities:

12

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

17

18           (B) An insurer that writes health insurance  
19 policies;

20

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

23

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

3

4           (viii) "Medications for opioid use disorder"  
5 means the use of medications to provide a comprehensive  
6 approach to the treatment of opioid use disorder. United  
7 States food and drug administration approved medications  
8 used to treat opioid addiction include methadone,  
9 buprenorphine, alone or in combination with naloxone, and  
10 extended-release injectable naltrexone;

11

12           (ix) "Prior authorization" means the process by  
13 which health insurers or contracted utilization review  
14 entities determine the medical necessity or medical  
15 appropriateness of otherwise covered health care services  
16 prior to rendering such health care services. "Prior  
17 authorization" also includes any health insurer or  
18 contracted utilization review entity's requirement that an  
19 enrollee or health care provider notify the health insurer  
20 or contracted utilization review entity prior to providing  
21 a health care service;

22

1           (x) "Urgent health care service" means a health  
2 care service for which the application of the time periods  
3 for making a nonexpedited prior authorization decision  
4 could, in the opinion of a physician with knowledge of the  
5 enrollee's medical condition:

6

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

10

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

16

17           (xi) "This act" means W.S. 26-55-101 through  
18 26-55-114.

19

20           **26-55-104. Disclosure and review of prior**  
21 **authorization requirements.**

22

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

19

20           (b) Each health insurer or contracted utilization  
21 review entity shall not implement a new or amended prior  
22 authorization requirement or restriction unless its website

1 has been updated to reflect the new or amended prior  
2 authorization requirement or restriction.

3

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

12

13 (d) The department of insurance shall promulgate  
14 rules requiring health insurers or contracted utilization  
15 review entities to make statistics available to the public  
16 and the department regarding prior authorizations and  
17 adverse determinations. At a minimum, the statistics shall  
18 include categories for:

19

20 (i) The physician specialty;

21

22 (ii) The medication or diagnostic test or  
23 procedure;

1

2 (iii) The indication offered;

3

4 (iv) The reason for the adverse determination;

5

6 (v) Whether the adverse determination was  
7 appealed;

8

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

11

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

15

16 **26-55-105. Persons qualified to make adverse**  
17 **determinations.**

18

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

23

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

3

4           (ii) Knowledge of the coverage criteria;

5

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

10

11           **26-55-106. Consultation prior to issuing an adverse**  
12 **determination.**

13

14 If a health insurer or contracted utilization review entity  
15 is preparing to deny or considering rejecting the medical  
16 necessity of a health care service, the health insurer or  
17 contracted utilization review entity shall notify the  
18 enrollee's health care provider that medical necessity is  
19 being questioned. Before the health insurer or contracted  
20 utilization review entity issues an adverse determination,  
21 the enrollee's health care provider shall have the  
22 opportunity to discuss the medical necessity of the health  
23 care service with the person who will be responsible for

1 determining authorization of the health care service under  
2 review.

3

4 **26-55-107. Requirements applicable to persons**  
5 **reviewing appeals.**

6

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

11

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

14

15 (ii) Knowledge of the coverage criteria;

16

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

21

22 (iv) Not been employed by the health insurer or  
23 contracted utilization review entity or been under contract

1 with the health insurer or contracted utilization review  
2 entity other than to participate in one (1) or more of the  
3 health insurer or contracted utilization review entity's  
4 health care provider networks or to perform reviews of  
5 appeals, or otherwise have any financial interest in the  
6 outcome of the appeal;

7

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

10

11 (vi) Considered all known clinical aspects of  
12 the health care service under review, including but not  
13 limited to, a review of all pertinent medical records  
14 provided to the health insurer or contracted utilization  
15 review entity by the enrollee's health care provider, any  
16 relevant records provided to the health insurer or  
17 contracted utilization review entity by a health care  
18 facility, any pertinent material provided by the enrollee  
19 and any medical literature provided to the health insurer  
20 or contracted utilization review entity by the health care  
21 provider.

22

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

5

6           **26-55-108. Health insurer or contracted utilization**  
7 **review entities' obligations regarding prior authorization**  
8 **for nonurgent health care services**

9

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

18

19           **26-55-109. Health insurer or contracted utilization**  
20 **review entities' obligations with respect to prior**  
21 **authorizations for urgent health care services.**

22

1 Each health insurer or contracted utilization review entity  
2 shall make an authorization or adverse determination  
3 concerning urgent health care services and notify the  
4 enrollee and the enrollee's health care provider of that  
5 authorization or adverse determination not later than  
6 twenty-four (24) hours after receiving all necessary  
7 information to complete the review. The prior authorization  
8 request shall be considered authorized if the health  
9 insurer or contracted utilization review entity fails to  
10 notify the enrollee and the health care provider of a  
11 decision within twenty-four (24) hours of receiving all  
12 necessary information to complete the review. A health  
13 insurer or contracted utilization review entity shall  
14 provide an online portal for health care providers to have  
15 the option of submitting urgent prior authorization  
16 requests for urgent health care services.

17

18 **26-55-110. No prior authorization for medications for**  
19 **opioid use disorder.**

20

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

1

2           **26-55-111. Length of authorization generally;**  
3 **revocation of prior authorizations prohibited; length of**  
4 **authorization for chronic or long-term care conditions.**

5

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

13

14           (b) Each health insurer or contracted utilization  
15 review entity shall not revoke, limit, condition or  
16 restrict a previously approved authorization for health  
17 care services if the health care services are provided  
18 within forty-five (45) business days from the date the  
19 health care provider received the authorization approval  
20 for the specific service that was authorized.

21

22           (c) If a health insurer or contracted utilization  
23 review entity requires a prior authorization request for a

1 health care service for the treatment of a chronic or  
2 long-term care condition, the authorization shall remain  
3 valid for one (1) year. This section shall not apply to the  
4 prescription of benzodiazepines or schedule II narcotic  
5 drugs.

6

7 **26-55-112. Continuity of care for enrollees.**

8

9 (a) On receipt of all necessary information  
10 documenting an authorization from the enrollee, previous  
11 health insurer or the enrollee's health care provider, a  
12 health insurer or contracted utilization review entity  
13 shall honor an authorization granted to an enrollee from a  
14 previous health insurer or contracted utilization review  
15 entity for not less than ninety (90) days after an  
16 enrollee's coverage under a new health plan commences, if  
17 the health care service is a covered benefit under the new  
18 health insurance plan.

19

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

1

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

11

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

14

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

18

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

1

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

6

7           (b) A health insurer or contracted utilization review  
8 entity may evaluate whether a health care provider  
9 continues to qualify for exemptions as described in  
10 subsection (a) of this section not more than one (1) time  
11 every twelve (12) months. Nothing in this section shall  
12 require a health insurer or contracted utilization review  
13 entity to evaluate an existing exemption under subsection  
14 (a) of this section or prevent a health insurer or  
15 contracted utilization review entity from establishing a  
16 longer exemption period.

17

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

21

22           (d) A health care provider who does not receive an  
23 exemption under subsection (a) of this section may request

1 from the health insurer or contracted utilization review  
2 entity up to one (1) time per calendar year per service,  
3 evidence to support the health insurer or contracted  
4 utilization review entity's decision. A health care  
5 provider may appeal a health insurer or contracted  
6 utilization review entity's decision to deny an exemption.

7

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

12

13 (i) Makes a determination that the health care  
14 provider would not have met the eighty percent (80%)  
15 authorization criteria based on a retrospective review of  
16 the claims for the particular service for which the  
17 exemption applies for the previous three (3) months or for  
18 a longer period if needed to reach a minimum of five (5)  
19 claims for review;

20

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

1

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

4

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

12

13 (g) A determination to revoke or deny an exemption  
14 under subsection (a) of this section shall be made by a  
15 licensed health care provider that is of the same or  
16 similar specialty as the health care provider being  
17 considered for an exemption and has experience in providing  
18 the service for which the potential exemption applies.

19

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

1

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

5

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

8

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

11

12 (j) No health insurer or contracted utilization  
13 review entity shall deny or reduce payment for a health  
14 care service exempted from a prior authorization  
15 requirement under this section, including a health care  
16 service performed or supervised by another health care  
17 provider when the health care provider who ordered such  
18 service received a prior authorization exemption, unless  
19 the rendering health care provider:

20

21 (i) Knowingly and materially misrepresented the  
22 health care service in request for payment submitted to the  
23 health insurer or contracted utilization review entity with

1 the specific intent to deceive and obtain an unlawful  
2 payment from the health insurer or contracted utilization  
3 review entity; or

4

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

7

8 **26-55-114. Prior authorization for rehabilitative or**  
9 **habilitative services.**

10

11 (a) A health insurer or contracted utilization review  
12 entity shall not require prior authorization for  
13 rehabilitative or habilitative services including, but not  
14 limited to, physical therapy services or occupational  
15 therapy services for the first twelve (12) visits for each  
16 new episode of care. For purposes of this subsection, "new  
17 episode of care" means treatment for a new condition or  
18 treatment for a recurring condition that an enrollee has  
19 not been treated within the previous ninety (90) days.

20

21 (b) This section does not limit the right of a health  
22 insurer or contracted utilization review entity to deny a  
23 claim when an appropriate prospective or retrospective

