HOUSE BILL NO. HB0014

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; and providing for effective dates.

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

Section 1. W.S. 26-55-101 through 26-55-112 and 26-55-114 are created to read:

CHAPTER 55

ENSURING TRANSPARENCY IN PRIOR AUTHORIZATION ACT

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-provider relationship is paramount and should not be subject to third party intrusion;

(ii) 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 or licensed health care provider. 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 as defined by W.S. 26-40-102(a)(iii);

(viii) "Medications for opioid use disorder" means the use of medications to provide a comprehensive approach to the treatment of opioid use disorder. United States 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 nonexpedited 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) "Step therapy protocol" means an evidence-based protocol or program that establishes the specific sequence in which prescription drugs for a specified medical condition are deemed medically appropriate for a particular patient and are covered by a health insurer or health benefit plan;

(xii) "Health care provider" means a person licensed, registered or certified under federal or state laws or regulations to provide health care services;

(xiii) "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 providers 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 affected 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) The department of insurance shall promulgate rules requiring health insurers or contracted utilization

review entities to make statistics available to the public and the department regarding prior authorizations and adverse determinations. At a minimum, the statistics shall include categories for:

(i) The health care provider 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 provider who has:

(i) Sufficient medical knowledge in an applicable 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) Knowledge of the applicable person's medical history and diagnosis.

26-55-106. Consultation after issuing an adverse determination.

After issuing an adverse determination, the health insurer or contracted utilization review entity shall provide the opportunity to the health care provider to discuss the medical necessity of the health care service with the person who has decision making authority and will be responsible for determining authorization of the health care service under review. The health insurer or contract utilization review entity shall attempt to schedule the discussion within five (5) business days after the health care provider's request.

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 provider who has:

(i) Sufficient medical knowledge in an applicable 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 nonurgent 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) calendar 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 have the following timelines:

(i) Outpatient service prior authorizations shall be valid for a period of not less than one (1) year;

(ii) Prescription drug authorization periods shall be effective for a period of not less than one (1) year including changes in dosage for a prescription drug prescribed by a health care provider, provided that the authorization period and dosage change are consistent with dosing and duration according to evidence-based guidelines for safety and efficacy;

(iii) Prior authorizations for inpatient services shall be valid for a length of time based on the patient's clinical condition. This period will be not less than one (1) day.

(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.

(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 ninety (90) 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.

(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.

(d) No enrollee shall be required to repeat a step therapy protocol if that enrollee, while under their current or a previous health benefit plan, used the prescription drug required by the step therapy protocol, or another prescription drug in the same pharmacologic class with a similar efficacy and side effect profile or with the same mechanism of action, and discontinued use due to lack of efficacy, effectiveness, an adverse event or contraindication. The enrollee's prescribing provider shall submit justification and clinical information, if requested, that demonstrates a clinically valid reason for why the covered prescribed drug is needed and documentation

of completion of previous step therapy protocols for the prescribed drug.

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

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

(b) This section does not limit the right of a health insurer or contracted utilization review entity to deny a claim when an appropriate prospective or retrospective review concludes that the health care services were not medically necessary.

Section 2. W.S. 26-55-113 is created to read:

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

(a) A health care provider, as identified by a unique national physician identifier, shall be granted a twelve (12) month or one (1) year exemption from completing a prior authorization request for a health care service, excluding the practice of pharmacy and prescription drugs, if:

(i) In the most recent twelve (12) month period, the health insurer or contracted utilization review entity has authorized not less than ninety percent (90%) of the prior authorization requests, rounded down to the nearest whole number, submitted by the health care provider for that health care service; and

(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.

(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. 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 ninety percent (90%), rounded down to the nearest whole number, authorization criteria based on a retrospective review of the claims for the particular service for which the exemption applies;

(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.

Section 3. The department of insurance shall promulgate all rules necessary to implement this act.

Section 4.

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

(b) Section 2 of this act is effective January 1, 2026.

(c) Sections 3 and 4 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)