ORIGINAL House
BILL NO. HB0057

ENROLLED ACT NO. 5, HOUSE OF REPRESENTATIVES

SIXTY-THIRD LEGISLATURE OF THE STATE OF WYOMING
2015 GENERAL SESSION

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), (iii), (f), (g)(ii)(A), (B), (j) and (k)(iv) 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;

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(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:

(iii) Provide internal review and external review procedures for all denied claims as required in this section and disclose all procedures, time lines and requirements for such review procedures in every ~~disability insurance policy~~ health insurance plan and as otherwise required in this section.

(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.

(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 ~~disability insurance policy~~ health insurance plan 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 ~~disability insurance policy~~ health insurance plan, but for the determination by the insurer that the services, procedures or supplies are not a medical necessity;

(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.

(k) In addition to the documents and information provided pursuant to this section, the independent review organization, to the extent the information is available and the independent review organization considers them appropriate, shall consider the following in reaching its decision:

(iv) The terms of coverage under the claimant's ~~disability insurance policy~~ health insurance plan;

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

(END)

_____ _____
Speaker of the House President of the Senate

_____
Governor

TIME APPROVED: _____

DATE APPROVED: _____

I hereby certify that this act originated in the House.

_____
Chief Clerk