SENATE FILE NO. SF0088

Health care reform.

Sponsored by: Senator(s) Rothfuss and Representative(s) Connolly

A BILL

for

1 AN ACT relating to health care; prohibiting specified practices relating to emergency care; requiring a private health benefit plan to cover certain adult children; generally prohibiting discrimination by a private health benefit plan based on health status; creating a multi-payer health claims database; requiring an insurer to provide specified health claims data to group purchasers of private health benefit plans; providing penalties and civil liability for misuse of specified health claims data; requiring the creation of an electronic prescribing system; specifying requirements relating to health care facility billing; creating a prescription drug importation program; creating a Medicaid buy-in program; creating a Medicaid prescription drug program for insurers; requiring the department of health to conduct outreach to specified
persons regarding contraceptive services and supplies; clarifying that all political subdivisions may make coverage through the state employees' and officials' group health insurance program available to their officers and employees; clarifying provisions relating to epinephrine auto-injectors in school districts; providing that specified interest rates relating to health care charges and debts are unlawful; requiring the submission of a waiver application relating to the Medicaid buy-in program; requiring specified actions relating to the expansion of Medicaid and the child health insurance program; requiring studies and reports; requiring specified actions relating to telemedicine; making conforming amendments; requiring the promulgation of rules; repealing provisions; and providing for effective dates.

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

Section 1. W.S. 9-3-219, 26-34-136, 26-43-301 through 26-43-305, 26-43-401 through 26-43-407, 33-24-159, 35-2-618, 35-7-2201, 42-4-122, 42-4-123 and 42-5-103 are created to read:
9-3-219. Applicability of specified provisions.

W.S. 26-43-301 through 26-43-407 apply to a health insurance plan issued under this act.


W.S. 26-43-301 through 26-43-407 apply to a health insurance plan issued by a health maintenance organization under this act.

ARTICLE 3

WYOMING HEALTH INSURANCE REFORM ACT

26-43-301. Short title.

This article may be cited as the "Wyoming Health Insurance Reform Act."


(a) As used in this article and W.S. 26-43-401 through 26-43-407:
(i) "Health care provider" means a person or facility which is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession;

(ii) "In-network" means an express or implied contract between an insurer, or its contractor or subcontractor, and a health care provider in which the provider has agreed to make specified health care drugs, devices and services available to a person covered by a private health benefit plan and to receive payment or reimbursement, other than any applicable copayment, coinsurance or other cost-sharing requirement, at a rate agreed upon by the insurer and provider;

(iii) "Insurer" means any entity defined in W.S. 26-1-102(a)(xvi) who provides health insurance coverage in this state, including a health maintenance organization, the state employees' and officials' group health insurance plan and any provider of a plan made available under W.S. 9-3-201;
(iv) "Private health benefit plan" means as defined in W.S. 26-1-102(a)(xxxiii), and includes a nonfully funded multiple employer welfare arrangement, the state employees' and officials' group health insurance plan and any plan made available under W.S. 9-3-201, but excludes any employee welfare benefit plan that is not subject to state regulation, as defined in 29 U.S.C. 1002.

26-43-303. Prohibition on balance billing, prior authorization and increased cost-sharing by insurers for emergency care; maximum threshold for emergency care made available by specified health care providers.

(a) Except as otherwise provided in this subsection, an insurer is solely liable for payment of all charges for medically necessary emergency care which is provided to a person covered by a private health benefit plan, whether or not the care was made available by an in-network health care provider. An insurer may impose the same copayment, coinsurance, deductible or other cost-sharing requirement which is specified in a private health benefit plan for medically necessary emergency care provided by an
in-network health care provider for care which is made
available by a provider who is not in-network. A person
covered by a private health benefit plan is not liable for
any differential between an insurer's in-network health
care provider rates or allowed costs for medically
necessary emergency care and any rates actually charged by
the health care provider for emergency care or any payments
or reimbursements actually made by an insurer. An insurer
shall not increase the premium, copayment, coinsurance,
deductible or other cost-sharing requirement of a person
covered by a private health benefit plan or reduce or limit
any benefit based on this subsection.

(b) A health care provider, excluding a person who
provides air ambulance evacuation, shall not charge a
person, or make a demand for payment or reimbursement to an
insurer, for medically necessary emergency care in an
amount greater than one hundred twenty-five percent (125%)
of the amount that would be allowable under the federal
Medicare program for the emergency care.

(c) An insurer shall not require prior authorization
for medically necessary emergency care.
(d) Coverage for medically necessary emergency care shall be made available to a person covered by a private health benefit plan whether or not the health care provider who makes emergency care available is in-network.

(e) This section shall not apply to medically necessary emergency care made available by a health care provider outside the United States.


(a) An insurer who issues a private health benefit plan which provides coverage for dependents shall make coverage available to an adult child of a policyholder until the child reaches twenty-six (26) years of age. Coverage provided to an adult child under this subsection must be identical to the coverage provided to the policyholder.
(b) An insurer shall not be required to make coverage available for the spouse or dependent of an adult child of a policyholder.

26-43-305. Prohibition against discrimination by an insurer based on health status.

(a) An insurer shall not fail to issue a private health benefit plan to any person based on the health status of the person or the spouse or dependent of the person. For the purposes of this section, health status includes:

(i) A preexisting medical condition of a person, including any physical or mental illness;

(ii) The claims history of a person, including any prior health care drugs, devices and services made available to the person;

(iii) Genetic information;
(iv) Any increased risk for illness, injury or any other medical condition, status or characteristic of a person.

(b) An insurer that issues a private health benefit plan shall not:

(i) Deny, limit or exclude a benefit based on the health status of a person covered by a private health benefit plan; or

(ii) Require any person covered by a private health benefit plan, as a condition of issuance or renewal, to pay a premium, deductible, copayment, coinsurance or other cost-sharing requirement based on the person's health status which is greater than any premium, deductible, copayment, coinsurance or other cost-sharing requirement charged to another person covered by a private health benefit plan who does not have a similar health status.

(c) An insurer that issues a private health benefit plan shall not adjust a premium, deductible, copayment coinsurance or other cost-sharing requirement for any
person covered by a private health benefit plan on the basis of genetic information.

ARTICLE 4

WYOMING HEALTH CARE PRICING TRANSPARENCY ACT


This article may be cited as the "Wyoming Health Care Pricing Transparency Act."


(a) As used in this article:

(i) "Department" means the department of health created pursuant to W.S. 9-2-101(a);

(ii) "Medical assistance" means as defined in W.S. 42-4-102(a)(ii).

(b) The definitions in W.S. 26-43-302(a) apply to this article.
26-43-403. Multi-payer health claims database; standards; civil penalty for failure to submit data.

(a) Notwithstanding any contract or provision of law which provides for the confidentiality of the information described in this section, an insurer which issues a private health benefit plan and persons administering medical assistance shall provide to the department at no charge, not less than on a quarterly basis, all claims data relating to medical diagnoses, procedures, prescription drugs, eligibility spans, demographics and other related categories which the department may require by rule.

(b) The department shall establish or join a multi-payer health claims database and deposit the data made available pursuant to subsection (a) of this section into the database on a quarterly basis. In determining whether to establish or join a multi-payer health claims database, the department shall consider all of the following:
(i) Cost-effectiveness to the state of Wyoming relating to establishing or joining a database;

(ii) Utility of the data which will be made available through establishing or joining a database, including medical assistance claims data;

(iii) Availability of qualified personnel to ensure the data is used effectively and in a secure manner;

(iv) Any other factor determined by the department to be relevant to its decision under this subsection.

(c) The department shall ensure that the data deposited in the multi-payer health claims database pursuant to subsection (b) of this section is used for:

(i) Public health research and investigations conducted by the state of Wyoming and its political subdivisions;
(ii) Comparison of the quality and pricing of health care by health care purchasers, including employers and consumers. The department shall make a subset or summary of the data required to be provided under subsection (a) of this section available for the purposes of this paragraph. The department shall ensure that the data required to be made available under this paragraph is provided to the public through an internet website;

(iii) Design and evaluation of alternative health care delivery and payment models conducted by the state of Wyoming, research institutions and institutions of higher education selected by the department.

(d) The data required to be provided under subsection (a) of this section shall be made available in the most detailed form which complies with federal law, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended.

(e) Data made available pursuant to subsection (a) of this section shall be used only for the purposes set forth in subsection (c) of this section and as otherwise required
by law. A violation of this subsection shall be punished as specified in W.S. 26-43-405. A person may file a complaint relating to a suspected violation of this subsection with the department in the manner prescribed by rule.

(f) An insurer which fails to make available the data required pursuant to subsection (a) of this section shall be subject to a civil penalty imposed by the department in the amount of ten thousand dollars ($10,000.00) per transaction or occurrence.

(g) An employee welfare benefit plan that is not subject to state regulation, as defined in 29 U.S.C. 1002, may make the data specified under subsection (a) of this section available to the multi-payer claims database by entering into a written agreement with the department.

26-43-404. Health claims data access for group purchasers of private health benefit plans; standards; civil penalty for failure to make data available.

(a) Notwithstanding any contract or provision of law which provides for the confidentiality of the information
described in this section, an insurer which provides coverage to a group purchaser of a private health benefit plan shall, at no charge and not more than twice per year, provide to the group purchaser upon written request:

(i) All claims data relating to benefits paid by the insurer on behalf of persons covered by the private health benefit plan, pursuant to a contract with the group purchaser, over the preceding six (6) months;

(ii) Sufficient data relating to the claims of persons covered by the private health benefit plan to allow the group purchaser of the plan to calculate the cost effectiveness of benefits provided by the insurer over the preceding six (6) months. This data shall include:

(A) Data necessary to calculate the insurer's actual rates or allowed costs relating to health care drugs, devices and services, organized by drug, device and service category or category of disease;

(B) Data relating to demographics, prescriptions, office visits with a health care provider,
inpatient services, outpatient services, diagnostic procedures and laboratory tests of persons covered by the private health benefit plan;

(C) Data necessary to make calculations which are required to comply with the risk adjustment, reinsurance and risk corridor requirements of 42 U.S.C. 18061 through 18063, as applicable;

(D) Data used to establish an experience rating for persons covered by the private health benefit plan, including coding relating to diagnostics and procedures, the total amount charged to any person, including a health care provider and the person covered by the private health benefit plan, for each drug, device or service made available to the person and all payments or reimbursements made to a health care provider, administrator, pharmaceutical company, pharmacy benefit manager or medical device manufacturer relating to a drug, device or service made available to the person covered by the private health benefit plan.
(b) In addition to the data required to be made available under subsection (a) of this section, an insurer shall also provide a summary report relating to the data, including sufficient detail to demonstrate the percentage of increase or decrease for each category of information, as applicable, over the preceding five (5) years or the date on which the insurer first entered into a contract with the group purchaser, whichever is later.

(c) An insurer shall provide the data required by subsection (a) of this section in:

(i) An electronic format which is easily searchable; and

(ii) The most detailed form which complies with federal law, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended.

(d) A group purchaser shall not disclose the data made available by an insurer under this section to any other person, except a person under contract with the group purchaser to assist the purchaser with analysis of the data.
and except as otherwise required by law. A person under contract with a group purchaser to analyze data shall not disclose the data made available under this section to any other person, except that the person under contract may provide a deidentified summary to a group purchaser relating to a data comparison with other group purchasers.

An insurer shall not require a group purchaser to contract with the insurer to analyze the data made available under this section and shall not impose any restrictions on analysis of the data which are not imposed by this section.

A violation of this subsection shall be punished as specified in W.S. 26-43-405. A person may file a complaint relating to a violation of this subsection with the department in the manner prescribed by rule.

(e) A group purchaser, and any person under contract with the group purchaser, shall have policies and procedures in place which are compliant with federal law, including the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191, as amended, to ensure the privacy and security of the data made available under this section.
(f) An insurer which fails to make available the data required pursuant to subsection (a) of this section shall be subject to a civil penalty imposed by the department in the amount of ten thousand dollars ($10,000.00) per transaction or occurrence.

(g) An employee welfare benefit plan that is not subject to state regulation, as defined in 29 U.S.C. 1002, may make the data specified under subsection (a) of this section available to group purchasers after entering into a written agreement with the department.

(h) As used in this section, "group purchaser" means:

(i) An employer with not less than fifty (50) employees enrolled in a private health benefit plan issued by an insurer;

(ii) A group of employers which cumulatively employ not less than fifty (50) employees as part of a nonfully funded multiple employer welfare arrangement;
(iii) The state employees' and officials' group health insurance plan; and

(iv) Any plan made available under W.S. 9-3-201.

26-43-405. Penalties for misuse of health claims data; applicability.

(a) A violation of W.S. 26-43-403(e) or 26-43-404(d) shall be punished as follows:

(i) For a violation committed by a person who did not have knowledge of the violation or failed to exercise reasonable care under the circumstances, the person shall be subject to a civil penalty imposed by the department of not less than one thousand dollars ($1,000.00) and not more than ten thousand dollars ($10,000.00);

(ii) Except as otherwise provided by paragraph (iii) of this subsection, for a knowing violation committed by a person or a violation based on willful neglect, the violation constitutes a high misdemeanor and shall be
punished by imprisonment for not more than one (1) year, a fine of not more than ten thousand dollars ($10,000.00), or both;

(iii) A knowing violation, or a violation based on willful neglect, committed by a person with the intent to use, or allow another person to use, the health claims data made available under this article for commercial advantage constitutes a felony and shall be punished by imprisonment for not more than five (5) years, a fine of not more than fifty thousand dollars ($50,000.00), or both.

(b) This section shall not apply to any violation based on health claims data which is publicly available at the time of the violation.

26-43-406. Civil liability for misuse of health claims data; applicability.

(a) A person injured by a knowing violation of W.S. 26-43-403(e) or 26-43-404(d), or a violation of either section based on willful neglect, with the intent to use, or allow another person to use, the health claims data made
available under those sections for commercial advantage, may maintain a civil action against the person who committed the violation, whether or not the person was convicted of any offense under W.S. 26-43-405, and recover actual and consequential damages, reasonable attorney's fees and court costs relating to the injury.

(b) Except as otherwise provided by the Wyoming Governmental Claims Act, W.S. 1-39-101 through 1-39-120, this section shall not apply to any action or inaction of an employee or officer of a governmental entity, as defined in W.S. 1-39-103(a)(i).

(c) This section shall not apply to any violation based on health claims data which is publicly available at the time of the violation.


The department, in consultation with the department of insurance, shall promulgate rules to implement this article.
33-24-159. Electronic prescribing system; standards; management by the department of health; promulgation of rules.

(a) There is created the Wyoming electronic prescribing system. Effective January 1, 2023, all private health benefit plans and health care providers in this state, including pharmacists, shall use the Wyoming electronic prescribing system for transmission of all prescriptions and prescription related data, consistent with applicable federal and state law. Notwithstanding any other provision of law, a prescription transmitted by the Wyoming electronic prescribing system pursuant to this section shall be treated as a valid prescription.

(b) A prescription transmitted by the Wyoming electronic prescribing system pursuant to subsection (a) of this section shall be accompanied by the following information:

(i) The validated electronic signature of the prescriber;
(ii) The prescriber’s contact information;

(iii) The date of the transmission;

(iv) The contact information of the pharmacy intended to receive the transmission;

(v) Other information required by rule of the department or which is required to be contained in a prescription or electronic prescribing system pursuant to federal or state law.

(c) Any transmission made under subsection (a) of this section shall be encrypted or transmitted by other technological means which is readily archivable and designed to protect the data and prevent access, alteration, manipulation or use by an unauthorized person.

(d) The department shall be responsible for the design, maintenance and operation of the Wyoming electronic prescribing system. If determined to be feasible, the department may adapt and expand the computerized program maintained by the board of pharmacy pursuant to W.S.
35-7-1060. The board shall cooperate with the department to carry out this section.

(e) The department shall ensure that the Wyoming electronic prescribing system complies with the requirements of W.S. 35-7-1060.

(f) The department may apply for and accept any gifts, grants or donations to assist in developing and maintaining the Wyoming electronic prescribing system.

(g) The department shall, in consultation with the board of pharmacy and the office of the attorney general, promulgate rules to implement this section, including establishing the technical and operational requirements of the Wyoming electronic prescribing system.

(h) As used in this section:

(i) "Department" means the department of health created pursuant to W.S. 9-2-101;
(ii) "Private health benefit plan" means as defined in W.S. 26-43-302(a)(iv).

35-2-618. Health care facility billing.

(a) Upon request, and not later than seven (7) business days after a patient's discharge from a health care facility, the facility shall provide to the patient, or the patient's representative or legal guardian, an itemized statement of charges and any procedural or diagnostic codes which relate to these charges. The bill shall contain a due date for the itemized charges, unit price data on rates charged by the facility and projected payments or reimbursements which may be made by an insurer for the charges. The statement shall also identify any facility charge or miscellaneous charges and explain their purpose.

(b) A health care facility shall ensure that all charges for drugs, devices and services made available by any health care provider during an episode of care at the facility are contained in a single bill which is provided to the patient, consistent with subsection (a) of this
section. As used in this subsection, "episode of care" means one (1) visit or admission to a health care facility.

(c) A health care facility shall make available to a patient a standard list of charges for drugs, devices and services at the facility and any facility charge or miscellaneous charges which may be imposed. The facility shall annually update this list and notify all patients in writing of the requirements of this subsection.

(d) The department shall promulgate rules to implement this section.

ARTICLE 22

PRESCRIPTION DRUG IMPORTATION PROGRAM

35-7-2201. Prescription drug importation program.

(a) There is created the prescription drug importation program. To the extent authorized by federal law and notwithstanding any other provision of state law, the department of health shall:
(i) Identify three (3) prescription drugs, excluding any schedule II controlled substances as defined in W.S. 35-7-1002(a)(iv), with the highest potential for consumer savings through importation from outside the United States; and

(ii) Conduct a limited prescription drug importation program relating to the prescription drugs identified in paragraph (i) of this subsection to benefit not more than five (5) counties within this state which face high prescription drug costs, as determined by the department.

(b) The department of health shall:

(i) Ensure that only drugs meeting United States food and drug administration safety and effectiveness standards are imported under subsection (a) of this section;

(ii) Consult with representatives of the pharmaceutical industry, patient advocates and any other
relevant persons or organizations before implementing this section;

(iii) Apply for any necessary federal permit, waiver, certification or other authorization necessary to carry out this section, which may include approval under 21 U.S.C. 384(l); 

(iv) If necessary, establish a process to ensure the purity, chemical composition and potency of imported prescription drugs; 

(v) Ensure that imported prescription drugs will not be distributed, dispensed or sold outside of Wyoming; and 

(vi) Comply with any applicable federal laws, including laws relating to patents and prescription drug security and tracing requirements.

(c) To cover any administrative expenses, the department of health may charge a fee to a distributor or a consumer who receives an imported prescription drug under
this section, unless doing so would not be cost effective for the consumer, based on the cost of the prescription drug in the United States. The department shall deposit fees collected under this section in the account created pursuant to subsection (d) of this section.

(d) There is created the prescription drug importation account. Funds remitted to the account pursuant to subsection (c) of this section shall be used by the department of health to implement this section. The account may be divided into subaccounts for purposes of administrative management. Funds in the account are continuously appropriated and shall not lapse at the end of any fiscal period. Interest accruing to this account shall be retained in the account and shall be expended for the purposes provided in this section.

(e) The department of health may enter into contracts to implement this section, including contracts with distributors and contracts with insurers to make coverage under a private health benefit plan available for imported prescription drugs under this section. As used in this
subsection, "insurer" and "private health benefit plan" mean as defined in W.S. 26-43-302(a).

(f) The provisions of W.S. 33-24-153, and any regulations adopted under that section, shall not apply to the department of health, or any person under contract with the department, while acting as an importer or distributor of imported prescription drugs under this section.

(g) The board of pharmacy, department of revenue and department of agriculture shall cooperate with the department of health to implement this section.

(h) The department of health may promulgate rules to implement this section.

42-4-122. Medical assistance buy-in program; standards; promulgation of rules.

(a) To the extent authorized by federal law, the department of health shall make coverage through medical assistance available for purchase to any person who is not otherwise eligible for medical assistance:
(i) Through an application made to the department in a manner established by rule;

(ii) If the secretary of the United States department of health and human services grants any necessary waiver, through the federal health benefits exchange established by the United States department of health and human services pursuant to the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

(b) The monthly premium charged to a person who purchases coverage through medical assistance shall be set by the department of health at an amount which ensures the program established pursuant to this section can fund all necessary expenses and is actuarially sound. The department may age rate the premium according to cost. The department shall maintain an appropriate reserve and may impose a limited copayment, coinsurance or other cost-sharing requirement to fund a reserve.
(c) A person who purchases coverage under this section shall receive the same benefits as those received by persons who are determined to be eligible for medical assistance pursuant to W.S. 42-4-106, the state plan for medical assistance and federal law.

(d) The purchase of coverage under this section shall only take place during an annual open enrollment period fixed by the department of health pursuant to rule.

(e) The department of health shall allow employers to make a contribution toward the premium established under subsection (b) of this section on behalf of an employee, if the employee chooses, in writing, to forgo enrollment in any private health benefit plan offered to the employee by the employer. If the secretary of the United States department of health and human services grants any necessary waiver and unless 26 U.S.C. 4980H or the imposition contained within that section is repealed, the department shall notify an employer subject to 26 U.S.C. 4980H who makes a substantial contribution under this subsection that the requirements of that section have been waived with respect to that employer.
(f) Except as authorized by federal law and any waiver granted by the United States department of health and human services and then only as appropriated by the legislature and available for expenditure, the department of health shall not use any federal funds to implement this section.

(g) If the standards of subsection (f) of this section are met, any federal savings obtained by the state of Wyoming from a federal waiver shall be used to implement this section.

(h) Notwithstanding any other provision of law, a person who purchases coverage through medical assistance under this section shall not be subject to the following provisions:

   (i) W.S. 42-2-401 through 42-2-405 and any other eligibility criteria relating to medical assistance which is not contained in this section or is not required by federal law; and
(ii) W.S. 42-4-106(b) and 42-4-201 through 42-4-208.

(j) A person shall not be eligible to purchase coverage through this section if the person is eligible for medical assistance under W.S. 42-2-401 through 42-2-405 or if the person is currently enrolled in a private health benefit plan for the period in which the person is seeking to purchase coverage under this section.

(k) The department of health shall promulgate rules to implement this section, including establishing the characteristics of a substantial contribution under subsection (e) of this section.

(m) As used in this subsection, "private health benefit plan" means as defined in W.S. 26-43-302(a)(iv).

42-4-123. Medical assistance prescription drug program for insurers; standards; promulgation of rules.

(a) The department of health shall make prescription drug services under medical assistance, which may include
the purchase of prescription drugs or services otherwise provided by a pharmacy benefit manager, available for a fee to any insurer which issues a private health benefit plan. As used in this subsection, "insurer" and "private health benefit plan" mean as defined in W.S. 26-43-302(a).

(b) The fee for services made available pursuant to subsection (a) of this section shall be set by the department of health at an amount not more than that which ensures the program established pursuant to this section can fund all necessary expenses, is actuarially sound and maintains an appropriate reserve.

(c) No federal funds shall be used to implement this section.

(d) The department of health shall promulgate rules to implement this section.

(e) As used in this section, "pharmacy benefit manager" means an entity that contracts with a pharmacy on behalf of an insurer or third party administrator to administer or manage prescription drug benefits.
42-5-103. Outreach to specified persons regarding contraceptive services and supplies.

(a) The department of health shall periodically conduct outreach to persons between thirteen (13) and eighteen (18) years of age who receive coverage through medical assistance pursuant to W.S. 42-4-101 through 42-4-121, or through the child health insurance program pursuant to W.S. 35-25-101 through 35-25-108, and the parents or legal guardians of these persons, regarding the availability of contraceptive services and supplies under those programs.

(b) The department of health shall promote the use of long acting reversible contraceptives to community health organizations and to persons who receive coverage through medical assistance and the child health insurance program, including as a component of the outreach conducted under subsection (a) of this section.

Section 2. W.S. 9-3-203(a)(iv), (xvi), by creating a new paragraph (xvii) and by amending and renumbering (xvii)
as (xviii), 9-3-210(e), 9-3-217, 21-4-316(e)(v), 26-18-106 by creating a new subsection (d), 26-18-306, 26-19-306(c)(iii), 26-22-202(a)(xv), 26-34-102(a)(xxix), 35-2-605(a)(xiv), 40-12-105 by creating a new subsection (b), 42-4-102(a)(iii), 42-4-106(b) and 42-4-110 are amended to read:

9-3-203. Definitions.

(a) As used in this act:

(iv) "Employee" means any employee of a participating school district or participating board of cooperative educational services whose salary is paid by funds of the district or board, or any official or employee of a political subdivision of the state of Wyoming or any official or employee of the state of Wyoming whose salary is paid by state funds, including employees and faculty members of the University of Wyoming and various community colleges in the state, except persons employed on intermittent, irregular, or less than halftime basis and any at-will contract employee who does not meet the requirements established under W.S. 9-2-1022(a)(xi)(F)(III)
or (IV). "Employee" shall not include employees of the agricultural extension service of the University of Wyoming who hold federal civil service appointments, are required to participate in federal civil service retirement and who elect to participate in the federal employees' health benefit program as authorized in W.S. 9-3-210(d);

(xvi) "Voluntary participating employer" includes a participating board of cooperative educational services, and a participating school district or any other political subdivision of the state of Wyoming;

(xvii) "Political subdivision" means a county, municipality, special district or other local government entity of the state of Wyoming;

(xvii)(xviii) "This act" means W.S. 9-3-202 through 9-3-218 9-3-219.

9-3-210. Amount of state's contribution; estimates submitted to state budget officer; specified employees participation in federal program; participating employer and resident contributions.
(e) A participating school district or other participating political subdivision shall pay to the department the monthly premium established by the department for coverage of each eligible employee or official of that district or subdivision electing to become covered by any portion of the group insurance plan. Monthly premiums shall be at minimum no less than rates assessed for coverage of other enrollees qualified under W.S. 9-3-203(a)(iv), and shall be based upon information reported by the participating district or political subdivision to the department, to be in a form and manner prescribed by the department.

9-3-217. Advisory panel; composition; compensation.

(a) The director of the department shall establish an advisory panel consisting of active plan participants employed by the state, participating school districts and political subdivisions, the University of Wyoming and Wyoming community colleges and of retired employees who are plan participants. The panel shall consist of no more than ten (10) members if there are less than five (5)
participating school districts or political subdivisions or no more than twelve (12) members if there are at least five (5) participating school districts or political subdivisions and, insofar as possible, shall proportionally represent the specified employee groups participating in the group health insurance plan. The advisory panel shall be consulted regarding plan benefits and costs. The director of the department shall, upon receiving notification from at least five (5) school districts or political subdivisions electing group insurance plan participation under W.S. 9-3-201(e), appoint two (2) additional advisory panel members to increase the advisory panel to twelve (12) members as provided in this section.

(b) State, participating school district, political subdivision and university and community college employee officers and employees who serve as members of the panel shall suffer no loss of wages for the time devoted to attending meetings of the panel called by the department. All members shall be provided per diem and travel expenses incurred for attending such meetings at the rates provided under W.S. 9-3-102 and 9-3-103.
21-4-316. Administration of stock epinephrine auto-injectors.

(e) As used in this section:

(v) "Stock epinephrine" or "epinephrine auto-injector" means injectable medications used for the treatment of severe, life-threatening allergies that schools or districts buy and keep on-site for emergency use, and may include any type or brand of injector, including a generic equivalent, which has been approved by the United States food and drug administration for epinephrine delivery.

26-18-106. Time limit on certain defenses; applicability.

(d) Subsections (b) and (c) of this section shall not apply to a private health benefit plan governed by W.S. 26-43-305.

(a) If the provisions of this article conflict with W.S. 26-43-301 through 26-43-305 or any other provision implementing those statutes, this article shall not control.

(b) If the provisions of this article conflict with any other provision of this code, the provisions of this article shall control.


(c) All health benefit plans covering small employers shall comply with the following provisions:

(iii) Late enrollees may be excluded from coverage for the greater of eighteen (18) months; or an eighteen (18) month preexisting condition exclusion, provided that if both a period of exclusion from coverage and a preexisting condition exclusion are applicable to a late enrollee, the combined period shall not exceed eighteen (18) months;
26-22-202. Issuance of a converted policy; conditions.

(a) Issuance of a converted policy is subject to the following conditions:

(xv) Maternity benefits may be included at the insured's option; and may be subject to the preexisting conditions limitations as discussed under paragraph (v) of this subsection;

26-34-102. Definitions.

(a) As used in this chapter:

(xxix) "This act" means W.S. 26-34-101 through 26-34-134 through 26-34-136.

35-2-605. Definitions.

(a) As used in this act, unless the context otherwise requires:
"This act" means W.S. 35-2-605 through 35-2-618.

40-12-105. Unlawful practices.

(b) It is unlawful for a health care provider or debt collector to impose an interest rate greater than the prime rate of interest plus three percent (3%) on any health care related charge or debt. As used in this subsection:

(i) "Debt collector" means a person employed or engaged by a collection agency to perform the collection of debts owed, due or asserted to be owed or due to another, including any owner or shareholder of the collection agency business who engages in the collection of debts;

(ii) "Prime rate of interest" means the interest rate listed in the first edition of the Wall Street Journal published in a calendar year, unless the prime rate is not listed in that edition of the Wall Street Journal, in which case any reasonable determination of the prime rate on the first day of the year may be used;
(iii) "Health care provider" means a person or facility who is licensed, certified or otherwise authorized or permitted by the laws of this state to administer health care in the ordinary course of business or practice of a profession, and includes a person who provides air ambulance evacuation.

42-4-102. Definitions.

(a) As used in this chapter:

(iii) "Qualified" means any categorically eligible individual satisfying eligibility criteria imposed by this chapter, the state plan for medical assistance and services and by rule and regulation of the department and shall include a person who purchases coverage through medical assistance pursuant to W.S. 42-4-122(a), to the extent necessary to implement that section;

42-4-106. Application for assistance; determination of eligibility; assignment of benefits; resources and income allowances defined for institutionalized spouse.
(b) Except as otherwise provided in W.S. 42-4-122(h)(ii), upon signing an application for medical assistance under this chapter, an applicant assigns to the department any right to medical support or payment for medical expenses from any other person on his behalf or on behalf of any relative for whom application is made. The assignment is effective upon a determination of eligibility. Application for medical assistance shall contain an explanation of the assignment provided under this subsection.

42-4-110. Charges for inpatient hospital services.

Except as otherwise provided in W.S. 42-4-122(b), a cost deduction, cost sharing or other similar charge shall not be imposed upon any recipient of medical assistance for inpatient hospital services provided on his behalf pursuant to this chapter.

Section 3. W.S. 35-7-1060(a) through (d) is amended to read:
35-7-1060. Wyoming electronic prescribing system-controlled substances.

(a) In addition to other duties and responsibilities as provided by this act, the board shall maintain a computerized program to track prescriptions for controlled substances for the purposes of assisting patients, practitioners and pharmacists to avoid inappropriate use of controlled substances and of assisting with the identification of illegal activity related to the dispensing of controlled substances. The tracking program and any data created thereby shall be administered by the board, and the board may charge reasonable fees to help defray the costs of operating the program. Any fee shall be included with and in addition to other registration fees established by the board as authorized in W.S. 35-7-1023.

(b) All prescriptions for schedule II, III and IV controlled substances dispensed by any retail pharmacy licensed by the board shall be filed with the board electronically or by other means required by the board.
close of business on the business day immediately following the day the controlled substance was dispensed. The board may require the filing of other prescriptions and may specify the manner in which the prescriptions are filed.

(c) The tracking program Wyoming electronic prescribing system shall not be used to infringe on the legal use of a controlled substance. Information obtained through the controlled substance prescription tracking program pursuant to this section is confidential and may not be released and is not admissible in any judicial or administrative proceeding, except as follows:

(i) The board department may release information to practitioners and practitioner appointed delegates and to pharmacists and pharmacist appointed delegates when the release of the information may be of assistance in preventing or avoiding inappropriate use of controlled substances;

(ii) The board department shall report any information that it reasonably suspects may relate to fraudulent or illegal activity to the appropriate law
enforcement agency and the relevant occupational licensing board;

(iii) The board department may release information to the patient to whom the information pertains or his agent or, if the patient is a minor, to his parents or guardian;

(iv) The board department may release information to a third party if the patient has signed a consent specifically for the release of his controlled substance prescription information to the specific third party;

(v) The board department may release information that does not identify individual patients, practitioners, pharmacists or pharmacies, for educational, research or public information purposes; and

(vi) Subject to the rules of evidence, information obtained from the program under this subsection is admissible in a criminal proceeding or an administrative proceeding involving professional licensing.
(d) Unless there is shown malice, gross negligence, recklessness or willful and wanton conduct in disclosing information collected under this act—section regarding controlled substance information, the board—department, any other state agency and any other person or entity in proper possession of information as provided by this section shall not be subject to any civil or criminal liability or action for legal or equitable relief.

Section 4. W.S. 26-19-107(a)(xi), (f), (g) and (m), 26-19-201(a)(ii), 26-19-302(a)(xix), 26-19-304(d)(iv), 26-19-306(c)(i), (ii) and (j), 26-22-202(a)(iii)(C), 35-7-1060(e) and 2013 Wyoming Session Laws, Chapter 116, Section 5 are repealed.

Section 5.

(a) The department of health shall apply to the secretary of the United States department of health and human services for any waiver necessary under 42 U.S.C. 1315 or 18052, as applicable, to implement W.S. 42-4-122, including to allow:
(i) Coverage under medical assistance to be made available for purchase on the federal health benefits exchange established by the United States department of health and human services pursuant to the Patient Protection and Affordable Care Act, P.L. 111-148, as amended, by a person who is not otherwise eligible for medical assistance;

(ii) A person who is determined eligible pursuant to 45 C.F.R. 155.305 for advance premium tax credits and cost-sharing reductions, if available, to use those credits and reductions to purchase coverage through medical assistance on the federal health benefits exchange in the manner set forth in W.S. 42-4-122, provided that, any cost-sharing reductions made available under this paragraph shall be provided to the state of Wyoming to make coverage available under W.S. 42-4-122;

(iii) An employer to make a contribution toward the premium established under W.S. 42-4-122(b) on behalf of an employee and for a substantial contribution to satisfy the requirements of 26 U.S.C. 4980H, provided that no
waiver relating to the satisfaction of 26 U.S.C. 4980H shall be sought if that section or the imposition contained within that section is repealed;

(iv) If applicable, the state of Wyoming to use any federal savings made available from the implementation of this waiver as pass through funds to administer W.S. 42-4-122.

Section 6.

(a) The governor, the director of the department of health and the insurance commissioner shall collaborate with the secretary of the United States department of health and human services and the centers for Medicare and Medicaid services to explore options for the expansion of:

(i) Medical assistance eligibility to one hundred thirty-three percent (133%) of the federal poverty level, plus any applicable income disregard, as authorized by 42 U.S.C. 1396a(a)(10)(A)(i)(VIII); and
(ii) Child health insurance program eligibility to three hundred percent (300%) of the federal poverty level, plus any applicable income disregard, as authorized by 42 U.S.C. 1397ee.

(b) If the collaboration required by subsection (a) of this section reveals viable and fiscally advantageous options for the expansion of medical assistance or child health insurance program eligibility in Wyoming, the department of health, with the approval of the governor, is authorized to pursue necessary and prudent state plan amendments and federal waivers for any expansion to take place.

(c) Prior to making an application to expand eligibility under any program pursuant to subsection (b) of this section, the director of the department of health shall provide written notice to the speaker of the house of representatives and the president of the senate. The director also shall provide a report to the joint labor, health and social services interim committee and the joint appropriations committee detailing the reasons for any proposed expansion, the means by which any proposed
expansion may be approved, any necessary funding and the reasons that any expansion is viable and fiscally advantageous for Wyoming. The notice and report required under this subsection shall be submitted in sufficient time to allow the legislature to have adequate notice to call a special session for the consideration of any expansion and prior to the effective date of any federal obligations which may be binding on the state.

(d) This section is repealed effective January 1, 2020, or on the date an amendment or repeal of 42 U.S.C. 1396a(a)(10)(A)(i)(VIII) is enacted into law, whichever is earlier.

Section 7.

(a) The department of health shall study the following topics and issue reports to the joint labor, health and social services interim committee by the dates specified:
(i) Not later than October 1, 2018, the current quality and availability of telemedicine in Wyoming and strategies for improving this service;

(ii) Not later than October 1, 2018, opportunities for pharmacists to provide limited primary care services, which may include vaccinations, treatments relating to the common cold and minor forms of influenza and testing for common maladies;

(iii) Not later than July 1, 2019, the department's decision to establish or join a multi-payer claims database, as required by W.S. 26-43-403; and

(iv) Not later than July 1 of each year from 2019 through 2028, an update on the implementation of W.S. 42-4-122 and 42-4-123.

(b) Not later than November 1, 2018, and pursuant to the requirements of W.S. 35-7-2201 as created by this act, the department of health shall study the manner in which to gain approval for the state of Wyoming to import prescription drugs from outside the United States for use
by Wyoming consumers and issue a report to the joint labor, health and social services interim committee. As a component of this study and report, the department shall:

(i) Determine how the state of Wyoming can become certified by the United States department of health and human services to operate a prescription drug importation program, including under 21 U.S.C. 384(l);

(ii) Determine how to ensure that only drugs meeting United States food and drug administration safety, effectiveness and other related standards are imported as part of this program;

(iii) Identify prescription drugs, excluding schedule II controlled substances as defined in W.S. 35-7-1002(a)(iv), with potential for consumer savings through importation from outside the United States;

(iv) Estimate potential consumer savings based on importation;
(v) Determine potential contractors who are capable of distributing imported drugs, if necessary;

(vi) Determine how to limit the distribution of imported drugs to Wyoming residents;

(vii) Consult with the department of agriculture, department of revenue, board of pharmacy, representatives of the pharmaceutical industry, patient advocates and any other relevant persons or organizations; and

(viii) Consult with the attorney general regarding the potential for pharmaceutical manufacturers to manipulate the pharmaceutical market in Wyoming or adversely affect consumer access to pharmaceuticals if prescription drugs were imported into Wyoming.

(c) The reports required by subsections (a) and (b) of this section shall also include, if necessary, any recommendations for legislative action.
Section 8. The department of health shall, if feasible, take any necessary steps to improve the quality and availability of telemedicine in Wyoming, including working with community health organizations to increase awareness and adjusting health care provider reimbursement rates under medical assistance. The department shall inform the joint labor, health and social services interim committee in writing of any actions taken pursuant to this section.

Section 9.

(a) Sections 1 and 2 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 only for the purposes of promulgating rules necessary to implement those sections, provided these rules shall not take effect until January 1, 2019.

(b) Section 3 of this act is effective January 1, 2023.
(c) Sections 5, 6, 7, 8 and 9 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.

(d) Except as otherwise provided by subsections (a), (b) and (c) of this section, this act is effective January 1, 2019.

(END)