Wyoming Insurance Department

Review Requirement Checklist

Health Maintenance Organization

Contact:
Wyoming Insurance Department
(307) 777-7401
(307) 777-2446(fax)

Updated 05/2015

Wyoming Insurance Department	Statutes	http://legisweb.state.wy.us
Wyoming Insurance Department	Rules and Regulations	http://soswy.state.wy.us
Wyoming Insurance Department	Memoranda/Dept. Position	
REVIEW REQUIREMENTS	**REFERENCE**	**COMMENTS**
General Requirements	W.S. §26-15-110	Filing Requirements
Transmittal Letter	Wyoming Uniform Filing Procedure	All filings shall:
		Contain the company's name, address, NAIC number and company phone number.
		Be sent in duplicate.
		Have a self-addressed, postage paid envelope.
		Have a "SUBJECT" line briefly describing the filing type.
		Contain an itemized listing of each policy form and endorsement, including form number.
		Contain the name of the individual responsible for the preparation of the filing.
		Contain a Certification of Compliance signed by an officer of the company, attorney or actuary.
Forms		No filing fee for rate or form filings.

Renewal or Extension	W.S.§26-15-121	The policy shall be renewable at the option of the insured except for: -nonpayment of premium; -fraud or misrepresentation by the insured; or -the insurer elects to non-renew.
Assignability	W.S. §26-15-122	The policy is assignable or not assignable as provided by its terms.
Proceeds Exempt From Creditors	W.S. §26-15-131	Except as otherwise provided by the policy or contract, the proceeds are exempt from claims of creditors.
Coverage Availability	W.S. §26-19-306	A small employer insurer is required to file its basic and standard plans for prior approval in the format prescribed by the Commissioner.
Preexisting Conditions	W.S. §26-19-306	The insurer shall use the HIPAA 6/12 preexisting condition language with portability credit for creditable coverage continuous to within ninety (90) days of the enrollment date.
Late Enrollee	W.S. §26-19-306	Late enrollees may be excluded from coverage for the greater of eighteen (18) months or an eighteen (18) months preexisting condition exclusion, provided that if both a coverage exclusion and a preexisting condition exclusion are applicable, the combined period shall not exceed (18) months.
Minimum Contribution and Participation Requirements	W.S. §26-19-306	The insurer shall apply these provisions uniformly among all small employer groups with the same number of eligible employees. Participation requirements may vary only by group size. In applying minimum participation requirements, the insurer shall not consider employees or dependents who are otherwise covered by a public or employment based health benefit plan in determining whether the applicable participation percentage is met.
Requirement to Insure All employees	W.S. §26-19-306	The insurer shall offer coverage to all eligible employees and dependents. Save for preexisting conditions and late enrollees, the insurer shall not modify a health benefit plan by rider, endorsement, restrict or exclude coverage or benefits for specified diseases, medical conditions or services otherwise covered by the plan.

HMO Affiliation Period	W.S. §26-19-306	The HMO may provide for an affiliation period only if: -no preexisting condition exclusion is imposed; -the affiliation period is applied uniformly without regard to any health status related factors; and -the affiliation period does not exceed two (2) months or three (3) months in the case of a late enrollee.
Exceptions to Coverage	W.S. §26-19-306	The insurer shall not be required to offer coverage in the case of the following: -where the employer is not physically located in the insurer's geographic service area; -when the employees do not work or reside within the geographic service area; -within an area where the insurer demonstrates a capacity limitation; -if accepting new applications would place the insurer in a financially impaired condition.
Claims Payment	W.S. §26-15-124	Claims shall be rejected or accepted and paid within forty-five (45) days after receipt of proofs of loss and supporting evidence.
Non-COBRA State Continuation	W.S. §26-19-113	The policy shall provide that employees and/or their covered dependents and association members, whose coverage under the group (2 to 19 employees) would otherwise terminate because of termination of employment or membership or eligibility for coverage, are entitled to continue their insurance under the group policy, still in effect, for themselves, their dependents or both, subject to all of the group policy's terms and conditions and as prescribed in this section.

Evidence of Coverage	W.S. §26-34-109	The HMO shall issue an evidence of coverage to include: name and address of the HMO; eligibility requirements; benefits and services within the service area; emergency care benefits and services; out-of-area benefits and services, if any; copayments, coinsurance, deductibles or other out-of-pocket expenses; limitations and exclusions, including an explanation of the use of a prescription drug formulary, if applicable; enrollee termination; enrollee reinstatement, if any; claims procedures; enrollee complaint procedures; continuation of coverage; conversion; extension of benefits, if any; coordination of benefits, if applicable; subrogation, if any; description of the geographic service area; entire contract provision; term of coverage; cancellation provisions of group or individual contract holder; renewal provisions; - reinstatement provisions of group or individual contract holder, if any; grace period of thirty-one (31) days during which the coverage shall remain in force; conformity with state law provision; and the details of any withholding agreement with a provider.
Free Look Period		The contract shall provide for a ten (10) day period to examine and return the contract and have the premium refunded.
Material Change		A material change shall be issued to the enrollee in a separate document.
Schedule of Premiums		Are to be pre-filed and approved by the Commissioner.

Notice of Change	W.S. §26-34-111	The HMO shall: -issue notice of any material change; -provide to the enrollee a list of providers upon enrollment and re-enrollment; -notify an enrollee, in writing, of the termination of a primary care provider (PCP), if applicable, and provide assistance to the enrollee in transferring to another PCP; -provide to the enrollee information on how services may be obtained, any additional information on access to services, and a toll-free telephone number.
Complaint System	W.S. §26-34-112	The HMO shall establish and maintain a complaint system which has been approved by the Commissioner. It shall be communicated to the enrollee in the contract.
Cancer Screening	W.S. §26-19-107	The policy shall provide benefits for screens of breast, cervical, colorectal and prostate cancer without application of a deductible with a $250 per year benefit. Policies with a deductible of $1000 or higher are exempt.
Adopted Children	W.S. §26-20-101	The policy must provide coverage for an adopted child from the earlier of the date the petition for adoption is filed or entry of the child in the adoptive home.
Newborns	W.S. §26-22-101	The policy must provide coverage on family contracts for a newborn for injury or sickness including congenital defects and birth abnormalities.
Diabetes Coverage	W.S. §26-20-201	The policy shall provide coverage for outpatient self-management and training.
Inherited Enzymatic Disorder Coverage	W.S. 26-40-401 et seq	Effective 07/01/2013, coverage must be included for equipment, supplies and outpatient self-management training and education, including medical nutrition therapy for inherited enzymatic disorders.

Prescription Eye Drop Refill Coverage	W.S. 26-20-501 et seq	Effective 07/01/2015, coverage for prescription eye drop refills must be dispensed as follows: (i) if a renewal is requested by the insured at least twenty-three (23) days for a thirty (30) day supply, or at least forty-five (45) days for a sixty (60) day supply, or at least sixty-eight (68) days for a ninety (90) day supply; and, (ii) one additional bottle of prescription eye drops if requested by the insured or the practitioner at the time the original prescription is filled, and the original prescription states that one (1) additional bottle is needed by the insured for use in a day care center or school. The benefits provided shall be subject to the same annual deductibles, copayments or coinsurance established for all other covered benefits within a given policy.
Oral Chemotherapy Parity with Injectable and Intravenous	W.S. 26-20-601 et seq	Effective July 01, 2015, coverage for oral chemotherapy must be covered in parity with injectable and intravenous therapy regardless of the formulation or benefit category determination by the policy or contract issuer; and, (b) No issuer of a health insurance policy or contract shall comply with this requirement by increasing the copayment, deductible or coinsurance amount required for covered injected or intravenous chemotherapy or by reclassifying benefits with respect to cancer treatment medications.