



# PROPOSED RULE MAKING

## CR-102 (June 2004)

(Implements RCW 34.05.320)

Do NOT use for expedited rule making

**Agency:** Administrative Order #10-03 - Health Care Authority – Basic Health Plan

<input checked="" type="checkbox"/> Preproposal Statement of Inquiry was filed as WSR 10-13-107 _____ ; or	<input checked="" type="checkbox"/> Original Notice
<input type="checkbox"/> Expedited Rule Making--Proposed notice was filed as WSR _____; or	<input type="checkbox"/> Supplemental Notice to WSR _____
<input type="checkbox"/> Proposal is exempt under RCW 34.05.310(4).	<input type="checkbox"/> Continuance of WSR _____

**Title of rule and other identifying information:** (Describe Subject)

Basic Health subsidized and nonsubsidized program rules contained in chapter 182-25 WAC.

**Hearing location(s):**

Health Care Authority  
676 Woodland Square Loop SE  
Olympia, WA  
The Sue Crystal Center Conference Room

Date: November 23<sup>rd</sup>, 2010 Time: 3:00 pm

**Submit written comments to:**

Name: Alyson Chase, Basic Health Communications Manager  
Address: PO Box 42683  
Olympia, WA 98504-2683  
e-mail [alyson.chase@hca.wa.gov](mailto:alyson.chase@hca.wa.gov)  
fax (360) 923-2765 by (date) November 23<sup>rd</sup>, 2010

**Assistance for persons with disabilities:** Contact

Nikki Johnson by November 5<sup>th</sup>, 2010  
TTY (888) 923-5622 or (360) 923-2805

**Date of intended adoption:** November 30<sup>th</sup>, 2010

(Note: This is NOT the effective date)

**Purpose of the proposal and its anticipated effects, including any changes in existing rules:**

Amending chapter 182-25 WAC to revise rules for the Basic Health Plan and to create new rules governing the Washington Health Program (nonsubsidized Basic Health).

**Reasons supporting proposal:**

The HCA intends to reorganize program rules, the Basic Health Plan rule, and provide clarification of the recertification process. The HCA will also add rules to administer the Washington Health Plan. Other changes and corrections may be incorporated as a result of the passage of federal or state legislation.

**Statutory authority for adoption:** RCW 70.47.050

**Statute being implemented:**

**Is rule necessary because of a:**

Federal Law?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
Federal Court Decision?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
State Court Decision?	<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

If yes, CITATION:

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
STATE OF WASHINGTON  
FILED

DATE: **October 18, 2010**

TIME: **4:29 PM**

WSR **10-21-077**

**DATE** **October 18, 2010**

**NAME** (type or print)

Jason Siems

**SIGNATURE**

**TITLE**

Rules Coordinator

**Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters:**

None

**Name of proponent:** (person or organization) Washington State Health Care Authority (HCA)

- Private
- Public
- Governmental

**Name of agency personnel responsible for:**

Name	Office Location	Phone
Drafting..... Preston W. Cody	676 Woodland Square Loop, Lacey, Washington	(360) 412-4361
Implementation.... Preston W. Cody	676 Woodland Square Loop, Lacey, Washington	(360) 412-4361
Enforcement..... Preston W. Cody	676 Woodland Square Loop, Lacey, Washington	(360) 412-4361

**Has a small business economic impact statement been prepared under chapter 19.85 RCW?**

Yes. Attach copy of small business economic impact statement.

A copy of the statement may be obtained by contacting:

Name:

Address:

phone ( ) \_\_\_\_\_

fax ( ) \_\_\_\_\_

e-mail \_\_\_\_\_

No. Explain why no statement was prepared.

The Joint Administrative Rules Review Committee has not requested the filing of a small business economic impact statement and there will be no costs to small businesses.

**Is a cost-benefit analysis required under RCW 34.05.328?**

Yes A preliminary cost-benefit analysis may be obtained by contacting:

Name:

Address:

phone ( ) \_\_\_\_\_

fax ( ) \_\_\_\_\_

e-mail \_\_\_\_\_

No: Please explain: RCW 34.05.328 does not apply to the Health Care Authority rules unless requested by the Joint Administrative Rules Committee or applied voluntarily.

## Chapter 182-22 WAC

### WASHINGTON HEALTH PLAN AND BASIC HEALTH PLAN ADMINISTRATION

#### PART 1--AUTHORITY AND DEFINITIONS

##### NEW SECTION

**WAC 182-22-100 Authority.** The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

##### NEW SECTION

**WAC 182-22-110 Definitions.** The definitions in this section apply throughout chapters 182-22, 182-23, 182-24, and 182-25 WAC.

"Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

"Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees or applicants which cannot be resolved in an informal manner to the appellant's satisfaction.

"Basic health plan" or "BHP" means the system of enrollment and payment for subsidized basic health care services administered by the HCA through managed health care systems.

"BHP Plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and BHP. Eligibility for BHP Plus is determined by the department of social and health services, based on medicaid eligibility criteria. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for medicare, and may be required to meet additional DSHS eligibility requirements.

"Copayment" means a payment indicated in the schedule of

benefits which is made by an enrollee to a health care provider or to the managed health care system.

"Covered services" means those services and benefits in the applicable BHP or WHP schedule of benefits (as outlined in the member handbook), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, coinsurance and deductible.

"Dependent," as it applies to BHP or WHP, means:

(a) The subscriber's lawful spouse, not legally separated, who resides with the subscriber; or

(b) The child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, who is younger than age twenty-six, and who has not been relinquished for adoption by the subscriber or the subscriber's dependent spouse; or

(c) A person of any age who is incapable of self-support due to disability, and who is the unmarried child of the subscriber or the subscriber's dependent spouse, whether by birth, adoption, or legal guardianship; or

(d) A child younger than age twenty-six who is residing with the subscriber under an informal guardianship agreement. For a child to be considered a dependent of the subscriber under this provision:

(i) The guardianship agreement must be signed by the child's parent;

(ii) The guardianship agreement must authorize the subscriber to obtain medical care for the child;

(iii) The subscriber must be providing at least fifty percent of the child's support; and

(iv) The child must be on the account for coverage.

"Disenrollment" means the termination of coverage for an enrollee.

"Effective date of enrollment" means the first date, as established by BHP or WHP, on which an enrollee is entitled to receive covered services from the enrollee's respective managed health care system.

"Eligible full-time employee" means an employee who meets all applicable eligibility requirements and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington state.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

"Eligible part-time employee" means an employee who meets all the criteria in definition "eligible full-time employee" of this

section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

"Employee" means one who is in the employment of an employer, as defined under RCW 50.04.080.

"Employer" means an enterprise licensed to do business in Washington state, as defined under RCW 50.04.080, with employees in addition to the employer, whose wages or salaries are paid by the employer.

"Enrollee" means a person who meets all applicable eligibility requirements, who is enrolled in BHP or WHP, and for whom applicable premium payments have been made.

"Family" means an individual or an individual and eligible spouse and dependents. For purposes of eligibility determination and enrollment, an individual cannot be a member of more than one family.

"Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

"Health care authority" or "HCA" means the Washington state health care authority.

"Home care agency" means a private or public agency or organization that administers or provides home care services directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the following DSHS programs: Chore, medicaid personal care, community options program entry system (COPES) or respite care (up to level three).

"Institution" means a federal, state, county, city or other government correctional or detention facility or government-funded facility where health care historically has been provided and funded through the budget of the operating agency, and includes, but is not limited to: Washington state department of corrections institutions; federal, county and municipal government jail and detention institutions; Washington state department of veterans affairs soldiers' and veterans' homes; department of social and health services state hospitals and facilities and juvenile rehabilitation institutions and group homes. An institution does not include: Educational institutions, government-funded acute health care or mental health facilities except as provided above, chemical dependency facilities, and nursing homes.

"Institutionalized" means to be confined, voluntarily or involuntarily, by court order or health status, in an institution, as defined in this section. This does not include persons on work release or who are residents of higher education institutions, acute health care facilities, alcohol and chemical dependency facilities, or nursing homes.

"Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

"Managed health care system" or "MHCS" means:

(a) Any health care organization (including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof) which has entered into a contract with the HCA to provide health care services; or

(b) A self-funded or self-insured method of providing insurance coverage to subsidized enrollees provided under RCW 41.05.140 and subject to the limitations under RCW 70.47.100(7).

"Maternity benefits through medical assistance," also known as S-Medical, means the coordinated program between BHP and DSHS for eligible pregnant women. This program includes all medicaid benefits, including maternity coverage. Eligible members must be at or below one hundred eighty-five percent of the federal poverty level. Eligibility for this program is determined by DSHS, based on medicaid eligibility criteria.

"Medicaid" means the Title XIX medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

"Medicare" means programs established by Title XVIII of Public Law 89-97, as amended, "Health Insurance for the Aged and Disabled."

"Open enrollment" means a time period designated by the administrator during which enrollees may enroll additional dependents or apply to transfer their enrollment from one managed health care system to another.

"Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage.

"Participating employer" means an employer who has been approved for enrollment as an employer group.

"Preexisting condition" means any illness, injury or condition for which, in the six months immediately preceding an enrollee's effective date of enrollment:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) Medication was prescribed or recommended for the enrollee; or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

"Premium" means a periodic payment, determined under RCW 70.47.060(2), which an individual, an employer, a financial sponsor, or other entity makes for enrollment in BHP or WHP.

"Program" means BHP, WHP, BHP Plus, maternity benefits through medical assistance, or other such category of enrollment specified within chapters 182-22 through 182-24 WAC.

"Provider" or "health care provider" means a health care professional or institution duly licensed and accredited to provide covered services in the state of Washington.

"Rate" means the amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.0201, negotiated by the administrator with and paid to a

managed health care system, to provide BHP or WHP health care benefits to enrollees.

"Schedule of benefits" means the health care services adopted and from time to time amended by the administrator for BHP or WHP, as applicable, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable copayments, as described in the member handbook.

"Service area" means the geographic area served by a managed health care system as defined in its contract with HCA.

"Subscriber" is a person who applies for coverage on his/her own behalf or on behalf of his/her dependents, if any, who is responsible for payment of premiums and to whom the administrator sends notices and communications. The subscriber may be an enrollee or the spouse, parent, or guardian of an enrolled dependent and may or may not be enrolled for coverage. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

"Washington health program" means the system of enrollment and payment for nonsubsidized basic health care services administered by the HCA through managed health care systems.

"Washington state resident" or "resident" means a person who physically resides and maintains a residence in the state of Washington.

(a) To be considered a Washington resident, enrollees who are temporarily out of Washington state for any reason:

(i) May be required to demonstrate their intent to return to Washington state; and

(ii) May not be out of Washington state for more than three consecutive calendar months.

(b) Dependent children who are attending school out-of-state may be considered to be residents if they are out-of-state during the school year, provided their primary residence is in Washington state and they return to Washington state during holidays and scheduled breaks. Dependent children attending school out-of-state may also be required to provide proof that they pay out-of-state tuition at an accredited secondary school, college, university, technical college, or school of nursing, vote in Washington state and file their federal income taxes using a Washington state address.

(c) "Residence" may include, but is not limited to:

(i) A home the person owns or is purchasing or renting;

(ii) A shelter or other physical location where the person is staying in lieu of a home; or

(iii) Another person's home.

## **PART 2--GROUP PARTICIPATION**

NEW SECTION

**WAC 182-22-210 Employer groups.** (1) BHP and WHP may accept applications for group enrollment from business owners, their spouses and eligible dependents, and on behalf of their eligible full-time and/or part-time employees, their spouses and eligible dependents.

(2) With the exception of home care agencies, the employer must enroll at least seventy-five percent of all eligible employees within a classification of employees, and the employer must not offer other health care coverage to the same classification of employees. For purposes of this section, a "classification of employees" means a subgroup of employees (for example, part-time employees, full-time employees or bargaining units). Employees who demonstrate in the application process that they have health care coverage from other sources, such as their spouse or a federal program, shall be excluded from the minimum participation calculation.

(3) BHP and WHP may require a minimum financial contribution from the employer for each enrolled employee.

(4) The employer will provide the employees the complete choice of managed health care systems available within the employee's county of residence.

(5) The employer will pay all or a designated portion of the premium, as determined by the administrator, on behalf of the enrollee. It is the employer's responsibility to collect the employee's portion of the premium and remit the entire payment to BHP or WHP, as applicable, and to notify BHP or WHP of any changes in the employee's account.

(6) In the event that an employer group will be disenrolled, all affected employee(s) will be notified prior to the disenrollment, and will be informed of the opportunity to convert their BHP or WHP group membership to individual account(s).

(7) Employees enrolling in BHP or WHP must meet all eligibility requirements.

NEW SECTION

**WAC 182-22-220 Home care agencies.** BHP and WHP will accept applications from home care agencies under contract with the department of social and health services (DSHS) for group enrollment, with premiums paid by the home care agency or DSHS or a designee, under the provisions for employer groups with the following exceptions or additions:

(1) To qualify for premium reimbursement through DSHS, home care agencies who enroll under the provisions of this section must be under current contract with DSHS as a home care agency, as defined by DSHS.

(2) Home care agencies need not enroll at least seventy-five percent of all eligible employees in BHP or WHP, and home care agencies may offer other coverage to the same classification of employees.

(3) Home care agencies need not make a minimum financial contribution for each enrolled employee.

(4) Home care agencies are not subject to WAC 182-22-210(5).

(5) Individual home care providers may enroll in BHP or WHP as individuals.

#### NEW SECTION

**WAC 182-22-230 Financial sponsors.** (1) A third party may, with the approval of the administrator, become a financial sponsor to BHP or WHP enrollees. Financial sponsors may not be a state agency or a managed health care system.

(2) BHP and WHP may require a minimum financial contribution from financial sponsors who are paid to deliver BHP or WHP services. Sponsors who meet the following criteria will be exempt from the minimum contribution:

(a) Organizations that are not paid to perform any function related to the delivery of BHP or WHP services, and do not receive contributions from other organizations paid to deliver BHP or WHP services;

(b) Charitable, fraternal or government organizations (other than state agencies) that are not paid to perform any function related to the delivery of BHP or WHP services, who receive contributions from other individuals or organizations who may be paid to deliver BHP or WHP services, if the organization can demonstrate all of the following:

(i) Organizational autonomy (the organization's governance is separate and distinct from any organization that is paid to deliver BHP services);

(ii) Financial autonomy and control over the funds contributed (contributors relinquish control of the donated funds);

(iii) Sponsored enrollees are selected by the sponsoring organization from all persons within the geographic boundaries established by the sponsor organization who meet the selection criteria agreed upon by the sponsor organization and the HCA; and

(iv) There is no direct financial gain to the sponsoring entity.

(c) Charitable, fraternal, or government organizations (other than state agencies) that are paid to perform a health care function related to the delivery of BHP services, if the organization can demonstrate all of the following:

(i) The organization's primary purpose is not the provision of health care or health care insurance, including activities as a third-party administrator or holding company;

(ii) There is organizational and financial autonomy (the

organization's governance and funding of sponsored enrollees is separate and distinct from the function that is paid to deliver BHP services);

(iii) The selection of sponsored enrollees is made by the organization separate and distinct from the function that is paid to deliver BHP services, and sponsored enrollees are selected from all eligible persons who meet the selection criteria agreed upon by the sponsor organization and the HCA, who live within the geographic boundaries established by the sponsor organization; and

(iv) There is no direct financial gain to the sponsoring entity.

(3) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; however, sponsored enrollees must meet all eligibility requirements.

(4) The financial sponsor will pay all or a designated portion of the premium on behalf of the sponsored enrollee. The financial sponsor must collect the enrollee's portion of the premium, if any, and remit the entire payment to BHP or WHP and to notify BHP or WHP of any changes in the sponsored enrollee's account.

(5) A financial sponsor must inform sponsored enrollees and BHP or WHP of the minimum time period for which they will act as sponsor. At least sixty days before the end of that time period, the financial sponsor must notify sponsored enrollees and BHP or WHP if the sponsorship will or will not be extended.

(6) A financial sponsor must not discriminate for or against potential group members based on health status, race, color, creed, political beliefs, national origin, religion, age, sex or disability.

(7) A financial sponsor must disclose to the sponsored enrollee all the managed health care systems within the enrollee's county of residence, the estimated premiums for each of them, and the BHP or WHP toll-free information number.

(8) BHP and WHP may periodically conduct a review of the financial sponsor group members to verify the eligibility of all enrollees.

### **PART 3--ADMINISTRATIVE PROCEDURES**

#### NEW SECTION

**WAC 182-22-310 Where to find instructions for filing an appeal.** (1) WAC 182-22-320 and 182-22-330 cover appeals submitted by or on behalf of BHP and WHP enrollees or applicants. To appeal a decision regarding a child enrolled in BHP Plus or a woman

receiving maternity benefits through medical assistance, subscribers must contact the Washington state department of social and health services (DSHS) to request a fair hearing under chapter 388-526 WAC.

(2) WAC 182-22-320 covers appeals of decisions made by the health care authority, such as decisions regarding eligibility, premium, premium adjustments or penalties, enrollment, suspension, disenrollment, or a member's selection of managed health care system (MHCS). Decisions which affect an entire group (for example, the disenrollment of an employer group) should be appealed for the entire group by the employer, home care agency, or financial sponsor, using these same rules.

(3) WAC 182-22-330 covers appeals of decisions made by the enrollee's managed health care system (MHCS), such as decisions regarding coverage disputes or benefits interpretation.

#### NEW SECTION

**WAC 182-22-320 How to appeal health care authority (HCA) decisions.** (1) HCA decisions regarding the following may be appealed under this section:

- (a) Eligibility;
- (b) Premiums;
- (c) Premium adjustments or penalties;
- (d) Enrollment;
- (e) Suspension;
- (f) Disenrollment; or
- (g) Selection of managed health care system (MHCS).

(2) To appeal an HCA decision, enrollees or applicants must send a letter of appeal to the HCA. The letter of appeal should be signed by the appealing party and must be received by the HCA within thirty calendar days of the date of the decision. The letter of appeal should include:

(a) The name, mailing address, and BHP or WHP account number of the subscriber or applicant;

(b) The name and address of the enrollee or applicant affected by the decision, if that person is not the subscriber on the account;

(c) A copy of the HCA notice of the decision that is being appealed or, if the notice is not available, a statement of the decision being appealed;

(d) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documentation; and

(e) If the appealing party is not an enrollee or the subscriber on the account, a signed agreement from the enrollee, authorizing the appealing party to act on his/her behalf.

(3) When an appeal is received, the HCA will send a notice to

the appealing party, confirming that the appeal has been received and indicating when a decision can be expected. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber.

(4) **Initial HCA decisions:** The HCA will conduct appeals according to RCW 34.05.485. The HCA appeals committee or a single presiding officer designated by the HCA will review and decide the appeal. The appealing party may request an opportunity to be present in person or by telephone to explain his or her view. If the appealing party does not request an opportunity to be present to explain, the HCA appeals committee or presiding officer will review and decide the appeal based on the information and documentation submitted.

(5) The HCA will give priority handling to appeals regarding a loss of coverage for an enrollee with an urgent medical need that could seriously jeopardize the enrollee's life, health, or ability to regain maximum function, provided:

(a) The appeal is received within ten business days of the effective date of the loss of coverage; and

(b) The enrollee has clearly stated in the letter of appeal or has otherwise notified the HCA that he or she has an urgent medical need.

(6) For all other appeals, the HCA will send the appealing party written notice of the initial HCA decision within sixty days of receiving the letter of appeal. If the appealing party is not an enrollee on the affected account, the notice will also be sent to the subscriber. The notice will include the reasons for the initial decision and instructions on further appeal rights.

(7) **Review of initial HCA decision:** The initial HCA decision becomes the final agency decision unless the HCA receives a valid request for a review from the appealing party.

(a) To be a valid request for review, the appealing party's request may be either verbal or in writing, but must:

(i) Be received within thirty days of the date of the initial HCA decision.

(ii) Include a summary of the initial HCA decision being appealed and state why the appealing party believes the decision was incorrect; and

(iii) Provide any additional information or documentation that the appealing party would like considered in the review.

(b) Requests for review of an initial HCA decision regarding a disenrollment for nonpayment will be reviewed by the office of administrative hearings through a hearing conducted under chapter 34.12 RCW and RCW 34.05.488 through 34.05.494.

(c) All other requests for review of an initial HCA decision will be reviewed by a presiding officer designated by the HCA according to the requirements of RCW 34.05.488 through 34.05.494, with the following exception: These review decisions will be based on the record and documentation submitted, unless the presiding officer decides that an in-person or telephone hearing is needed. If an in-person or telephone hearing is needed, the presiding officer will decide whether to conduct the hearing as an informal

hearing or formal adjudicative proceeding.

(d) The presiding officer will issue a written notice of the review decision, giving reasons for the decision, within twenty-one days of receiving the request for review, unless the presiding officer finds that additional time is needed for the decision.

(8) Enrollees who appeal a disenrollment decision that was based on eligibility issues and not related to premium payments may remain enrolled during the appeal process, provided:

(a) The appeal was submitted according to the requirements of this section; and

(b) The enrollee:

(i) Remains otherwise eligible;

(ii) Continues to make all premium payments when due; and

(iii) Has not demonstrated a danger or threat to the safety or property of the MHCS or health care authority or their staff, providers, patients or visitors.

(9) Enrollees who appeal a disenrollment decision related to nonpayment of premium or any issue other than eligibility will remain disenrolled during the appeal process.

(10) If the appealing party disagrees with a review decision under subsection (6) of this section, the appealing party may request judicial review of the decision, as provided for in RCW 34.05.542. Request for judicial review must be filed with the court within thirty days of service of the final agency decision.

#### NEW SECTION

#### **WAC 182-22-330 How to appeal a managed health care system (MHCS) decision.**

(1) Enrollees who are appealing an MHCS decision, including decisions related to coverage disputes; denial of claims; benefits interpretation; or resolution of complaints must follow their MHCS's complaint/appeals process.

(2) Each MHCS must maintain a complaint/appeals process for enrollees and must provide enrollees with instructions for filing a complaint and/or appeal. This complaint/appeals process must comply with the requirements of chapters 48.43 RCW and 284-43 WAC.

(3) On the request of the enrollee, the HCA may assist an enrollee by:

(a) Attempting to informally resolve complaints against the enrollee's MHCS;

(b) Investigating and resolving MHCS contractual issues; and

(c) Providing information and assistance to facilitate review of the decision by an independent review organization.

## PART 4--AGENCY OPERATIONS

### NEW SECTION

**WAC 182-22-410 Producers.** If specific funding has been appropriated for that purpose, insurance brokers or agents who have met all statutory and regulatory requirements of the office of the insurance commissioner, are currently licensed through the office of the insurance commissioner, and who have completed HCA's training program, will be paid a commission for assisting eligible applicants to enroll.

(1) Individual policy commission: Subject to availability of funds, and as a pilot program, HCA will pay a one-time fee to any currently licensed insurance broker or agent who sells BHP or WHP to an eligible individual applicant if that applicant has not been a BHP or WHP member within the previous five years.

(2) Group policy commission: Subject to availability of funds, and as a pilot program, fees paid for the sale of coverage to an eligible employer will be based on the number of employees in the group for the first and second months of the group's enrollment.

(3) Insurance brokers or agents must provide the prospective applicant with the BHP or WHP toll-free information number and inform them of BHP or WHP benefits, limitations, exclusions, waiting periods, cost sharing, all MHCSs available to the applicant within his/her county of residence and the estimated premium for each of them.

(4) All statutes and regulations of the office of the insurance commissioner will apply to brokers or agents who sell BHP or WHP, except they will not be required to be appointed by the MHCS.

(5) HCA will not pay renewal commissions.

### NEW SECTION

**WAC 182-22-420 Application processing.** Except as otherwise provided, applications for enrollment will be reviewed by HCA within thirty days of receipt and those applicants satisfying the eligibility criteria and who have provided all required information, documentation and premium payments will be notified of their effective date of enrollment.

NEW SECTION

**WAC 182-22-430 Open enrollment.** An open enrollment period of at least twenty consecutive days will be held annually. During this open enrollment period, enrollees may apply to enroll additional family members or to transfer their enrollment to a different MHCS, provided the MHCS selected is accepting new enrollment for the enrollee's program in the geographic area where the enrollee lives.

**PART 5--MHCS DUTIES**

NEW SECTION

**WAC 182-22-450 MHCS duties.** When an MHCS assists applicants in the enrollment process, it must provide them with the toll-free number for BHP or WHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

**Chapter 182-23 WAC**

**WASHINGTON HEALTH PLAN**

NEW SECTION

**WAC 182-23-010 Definitions.** "Standard health questionnaire" or "SHQ" has the same meaning as described in RCW 48.43.018.

"WHP enrollee" or "nonsubsidized enrollee" means an individual who enrolls in WHP, as the subscriber or dependent, and who pays or on whose behalf is paid the full costs for participation in WHP, without subsidy from the HCA.

NEW SECTION

**WAC 182-23-020 Eligibility.** (1) To be eligible for enrollment in WHP, an individual may have any income level and must:

- (a) Not be eligible for free or purchased medicare;
- (b) Not be receiving medical assistance from the department of social and health services (DSHS);
- (c) Not be enrolled in BHP;
- (d) Not be confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;
- (e) Be accepted for enrollment by the administrator as provided in RCW 48.43.018, either because the potential enrollee cannot be required to complete the standard health questionnaire or SHQ under RCW 48.43.018, or, based upon the results of the SHQ, the potential enrollee would not qualify for coverage under the Washington state health insurance pool;
- (f) Reside in an area of the state served by a managed health care system participating in the plan;
- (g) Choose to obtain coverage from a particular managed health care system; and
- (h) Pay or have paid on their behalf the full costs for participation in the plan, including the cost of administration, without any subsidy from HCA.

(2) Persons not meeting these criteria, as evidenced by

information submitted on the application for enrollment or otherwise obtained by WHP, will not be enrolled. An enrollee who is no longer a Washington resident or who is later determined to have failed to meet WHP's eligibility criteria at the time of enrollment, will be disenrolled.

#### NEW SECTION

**WAC 182-23-040 Washington health benefits.** (1) The administrator shall design and from time to time may revise WHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. WHP benefits may include copayments, waiting periods, limitations and exclusions that the administrator determines are appropriate and consistent with the goals and objectives of the plan. WHP benefits will be subject to a nine-month waiting period for preexisting conditions. Exceptions (for example, children up to age nineteen, maternity, prescription drugs, services for a newborn or newly adopted child) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of application for coverage under WHP. Similar coverage includes BHP; all DSHS programs administered by the medical assistance administration which have the medicaid scope of benefits; the DSHS program for the medically indigent; Indian health services; most coverages offered by health carriers; and most self-insured health plans. A list of WHP benefits, including copayments, waiting periods, limitations and exclusions, will be provided to the subscriber.

(2) In designing and revising WHP benefits, the administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary health care services, as well as the cost to the enrollees and to the state, and also will consider generally accepted practices of the health insurance and managed health care industries.

(3) Before enrolling, WHP will provide each applicant with a written description of covered benefits. This includes a description of all copayments, waiting periods, limitations and exclusions. WHP will advise individuals how to access information on the services, providers, facilities, hours of operation, and information about the managed health care system(s) available to enrollees in a given service area.

(4) WHP will send to all subscribers written notice of any

changes in the scope of benefits provided under WHP, or program changes that will affect premiums and member cost sharing at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. The administrator may make available a separate schedule of benefits for children, eighteen years of age and younger, for those dependent children in the plan.

NEW SECTION

**WAC 182-23-050 Premiums and cost sharing.** (1) Subscribers or their employer or financial sponsor shall be responsible for paying the full monthly premium to WHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule.

(2) Once WHP has determined that an applicant and his/her dependents (if any) are eligible for enrollment, the applicant or employer or financial sponsor will be informed of the amount of the first month's premium for the applicant and his/her enrolled dependents. New enrollees will not be eligible to receive covered services on the effective date of enrollment specified by WHP unless the premium has been paid by the due date given. Thereafter, WHP will bill each subscriber or employer or financial sponsor monthly.

(3) Full payment for premiums due must be received by WHP by the date specified on the premium statement. If WHP does not receive full payment of a premium by the date specified on the premium statement, WHP shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with WHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be suspended from coverage for one month. If payment is not received by the due date on the notice of suspension, the subscriber and enrolled family members will be disenrolled effective the date of the initial suspension. If an enrollee's coverage is suspended more than two times in a twelve-month period, the enrollee will be disenrolled for nonpayment as set forth herein. Partial payment of premiums due, payment which for any reason cannot be applied to the correct WHP enrollee's account, or payment by check which is not signed, cannot be processed, or is returned due to nonsufficient funds will be regarded as nonpayment.

(4) Enrollees shall be responsible for paying any required copayment, coinsurance, or deductible directly to the provider of a covered service or directly to the MHCS.

NEW SECTION

**WAC 182-23-060 Enrollment in the plan.** (1) Any individual applying for enrollment in WHP must submit a signed, completed WHP application and SHQ. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or guardian, who shall also be held responsible for payment of premiums due on behalf of the child and for completion of the SHQ. If an applicant is accepted for enrollment, the applicant's signature acknowledges the applicant's obligation to pay the monthly premium in accordance with the terms and conditions identified in the member handbook.

(a) Applicants for enrollment must provide evidence of Washington state residence, for example, a valid Washington state driver's license number, a copy of a current utility bill or rent receipt. Other documentation may be accepted if the applicant does not have a physical residence, for example, a signed statement from a person or other entity who is providing temporary shelter.

(b) WHP may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility, or MHCS selection.

(c) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment. Intentional submission of false information may result in disenrollment of the subscriber and all enrolled dependents.

(2) Each member may be enrolled in only one WHP account. Each family applying for enrollment must designate an MHCS from which the applicant and all enrolled dependents will receive covered services. All applicants from the same family who are covered under the same account must receive covered services from the same MHCS (with the exception of cases in which a subscriber who is paying for WHP coverage for his/her dependent who lives in a different service area). No applicant will be enrolled for whom designation of an MHCS has not been made as part of the application for enrollment. Procedures for the selection of MHCS are set forth in the WHP member handbook.

(3) Generally, enrollees may change from one MHCS to another only during open enrollment.

(a) If an enrollee moves to a new location in Washington state and their current MHCS is no longer available, they must choose an MHCS in their new service area (county). Until the family is enrolled in a new MHCS, only emergency services are covered in their new location.

(b) Enrollees meeting the requirements of (a) of this subsection are not required to reapply or complete the SHQ so long as there is not a gap in coverage longer than one month.

(4) Enrollees may change between the maximum benefit limits, but only when the subscriber completes a new application and SHQ. All individuals on an account are required to have the same maximum benefit limit.

(5)(a) Not all family members are required to apply for enrollment in WHP; however, any family member for whom application for enrollment is not made at the same time that other family

members may apply at any time provided they complete and pass the SHQ, and are otherwise eligible.

(b) Addition of an eligible newborn child or a child newly placed for adoption provided WHP receives the child's application for enrollment within sixty days of the date of birth or placement for adoption. These children may be enrolled effective from the date of birth or placement for adoption.

(6) Subscribers must notify WHP within thirty days of any changes that could affect their eligibility or their dependents' eligibility.

(7) Enrollees must annually submit documentation satisfactory to WHP. This process is called recertification and includes the following:

(a) Washington state residence;

(b) Medicare ineligibility for enrollees age sixty-five or over and enrollees who have been receiving Social Security disability benefits for twenty-four consecutive months or more;

(c) Enrollees who fail to comply with a recertification request will be disenrolled.

#### NEW SECTION

**WAC 182-23-070 Disenrollment from WHP.** (1) An enrollee or employer group may disenroll effective the first day of any month by giving WHP at least ten days prior notice of the intention to disenroll.

(2) WHP may disenroll any enrollee or group from WHP for good cause, which includes:

(a) Failure to meet the WHP eligibility requirements;

(b) Nonpayment of premium;

(c) Changes in MHCS or program availability when the enrollee's MHCS will no longer be available to him or her and no other MHCS in the area where the enrollee lives is accepting new enrollment in the enrollee's program;

(d) Fraud, intentional misrepresentation of information or withholding information that the enrollee knew or should have known was material or necessary to accurately determine their eligibility or premium responsibility, failure to provide requested verification of eligibility, or knowingly providing false information;

(e) Abuse or intentional misconduct;

(f) Danger or threat to the safety or property of the MHCS or the health care authority or their staff, providers, patients or visitors; and

(g) Refusal to accept or follow procedures or treatment determined by an MHCS to be essential to the health of the enrollee, when the MHCS has advised the enrollee and demonstrated to the satisfaction of WHP that no professionally acceptable alternative form of treatment is available from the MHCS.

(3) In addition to being disenrolled, any enrollee who knowingly provides false information to WHP or to a participating managed health care system may be held financially responsible for any covered services fraudulently obtained through WHP.

(4) At least ten days prior to the effective date of disenrollment, WHP will send enrollees written notice of disenrollment.

(a) The notice of disenrollment will:

(i) State the reason for the disenrollment;

(ii) State the effective date of the disenrollment;

(iii) Describe the procedures for disenrollment; and

(iv) Inform the enrollee of his or her right to appeal the disenrollment decision as set forth in chapter 182-22 WAC.

(b) A notice of disenrollment will be sent to both the employer or sponsor and to all members of an employer group, home care agency group or financial sponsor group that is disenrolled under these provisions. Enrollees affected by the disenrollment of a group account will be offered coverage under individual accounts. Coverage under individual accounts will not begin unless the premium for individual coverage is paid by the due date for the coverage month. A one-month break in coverage may occur for enrollees who choose to transfer to individual accounts.

(5) Enrollees who are notified that they will be disenrolled due to incomplete recertification documents shall not be disenrolled if they submit complete documents within thirty days after the disenrollment letter is mailed.

(6) Under the provisions of this subsection, WHP will suspend or disenroll enrollees and groups who do not pay their premiums when due. Partial payment or payment by check which cannot be processed or is returned due to nonsufficient funds will be regarded as nonpayment.

(a) At least ten days before coverage will lapse, WHP will send a delinquency notice to each subscriber whose premium payment has not been received by the due date. The delinquency notice will include a final due date and a notice that WHP coverage will lapse unless payment is received by the final due date.

(b) Except as provided in (c) of this subsection, coverage will be suspended for onemonth if an enrollee's premium payment is not received by the final due date, as shown on the delinquency notice. WHP will send written notice of suspension to the subscriber, which will include:

(i) The effective date of the suspension;

(ii) The due date by which payment must be received to restore coverage after the one-month suspension;

(iii) Notification that the subscriber and any enrolled dependents will be disenrolled if payment is not received by the final due date; and

(iv) Instructions for filing an appeal as provided in chapter 182-22 WAC.

(c) Enrollees whose premium payment has not been received by the delinquency due date, and who have been suspended twice within the previous twelve months will be disenrolled for nonpayment as of the effective date of the third suspension.

(d) Enrollees who are suspended and do not pay the premium for the next coverage month by the due date on the notice of suspension will be immediately disenrolled and issued a notice of disenrollment, which will include:

(i) The effective date of the disenrollment; and

(ii) Instructions for filing an appeal as provided in WAC 182-22-310.

(7)(a) Unless otherwise specified, enrollees who voluntarily disenroll or are disenrolled from WHP may not reenroll for a period of twelve months from the date their coverage ended and until all other requirements for enrollment have been satisfied. An exception to the twelve-month wait period will be made for:

(i) Enrollees who left WHP for other health insurance, who are able to provide proof of continuous coverage from the date of disenrollment, and who apply to reenroll in WHP within thirty days of losing the other coverage;

(ii) Enrollees who left WHP because they lost eligibility and who subsequently become eligible to reenroll;

(iii) Enrollees who were disenrolled by WHP because no MHCS was contracted to serve the program in which they were enrolled in the geographic area where they live. These enrollees may reenroll, provided all enrollment requirements are met, if an MHCS begins accepting enrollment for their program in their area or if they become eligible and apply for another HCA program; and

(iv) Enrollees who were disenrolled for failing to provide requested documentation of eligibility for recertification or as otherwise requested by WHP, who provide all required documentation within six months of disenrollment and are eligible to reenroll. Reenrollment in the plan will not be retroactive and shall take place within forty-five days of WHP receiving complete reenrollment documents that verify eligibility.

(b) An enrollee who is required to wait twelve months for reenrollment under (a) of this subsection may not reenroll prior to the end of the required twelve-month wait.

## Chapter 182-24 WAC

### BASIC HEALTH PLAN

#### NEW SECTION

**WAC 182-24-010 Definitions.** The following definitions apply throughout this chapter.

"BHP enrollee," "subsidized enrollee," or "reduced premium enrollee" means an individual who is not a full-time student who has received a temporary visa to study in the United States and who otherwise meets the criteria in (a), (b), or (c) of this subsection.

(a) An individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(b) An individual who enrolls in BHP, either as the subscriber or an eligible dependent, and who is a foster parent licensed under chapter 74.15 RCW and whose current gross family income does not exceed three hundred percent of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(c) To the extent that state funds are specifically appropriated for this purpose, with a corresponding federal match, "subsidized enrollee" also means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income is more than two hundred percent, but less than two hundred fifty-one percent, of the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

"Subsidy" means the difference between the amount of periodic payment the HCA makes to a managed health care system on behalf of a subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

NEW SECTION

**WAC 182-24-020 Eligibility.** (1) To be eligible for enrollment in BHP, unless otherwise specified elsewhere in this chapter, an individual must be a Washington state resident who:

- (a) Is not eligible for free or purchased medicare;
- (b) Is not receiving medical assistance from the department of social and health services (DSHS);
- (c) Is not enrolled in WHP;
- (d) Is not confined or residing in a government-operated institution, unless he or she meets eligibility criteria adopted by the administrator;
- (e) Is not a full-time student who has received a temporary visa to study in the United States;
- (f) Resides in an area of the state served by a managed health care system participating in the plan;
- (g) Chooses to obtain coverage from a particular managed health care system;
- (h) Pays or has paid on their behalf their portion of the costs for participation in the plan; and
- (i) Whose gross family income at the time of enrollment meets the definition of a subsidized enrollee.

(2) Persons not meeting these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by BHP, will not be enrolled. An enrollee who is no longer a Washington resident or who is later determined to have failed to meet BHP's eligibility criteria at the time of enrollment, will be disenrolled.

(3) Eligibility for BHP Plus and maternity benefits through medical assistance is determined by DSHS, based on medicaid eligibility criteria.

(4)(a) An individual otherwise eligible for enrollment in BHP may be denied enrollment if the administrator has determined that acceptance of additional enrollment would exceed limits established by the legislature, would jeopardize the orderly development of BHP, or would result in an overexpenditure of BHP funds. An individual otherwise eligible for enrollment in BHP also may be denied enrollment if no managed health care system(s) is accepting new enrollment in that program or from the geographic area where the applicant lives.

(b) If the administrator closes or limits enrollment, to the extent funding is available, BHP will continue to accept and process applications for enrollment from:

- (i) Children eligible for BHP, who were referred to DSHS for BHP Plus coverage, but were found ineligible for BHP Plus for reasons other than noncompliance;
- (ii) Employees of a home care agency group enrolled or applying for coverage under WAC 182-22-220;
- (iii) Eligible individual home care providers;
- (iv) Licensed foster care workers;
- (v) Persons who disenrolled from BHP in order to enroll in medicaid, and subsequently became ineligible for medicaid;
- (vi) Limited enrollment of new employer groups;

(vii) Members of the Washington National Guard and Reserves who served in Operation Enduring Freedom, Operation Iraqi Freedom, or Operation Noble Eagle, and their spouses and dependents; and

(viii) Subject to availability of funding, additional space for enrollment may be reserved for other applicants as determined by the administrator, in order to ensure continuous coverage and service for current individual and group accounts. (For example: Within established guidelines, processing routine income changes that may affect subsidy eligibility for current enrollees; adding new family members to an existing account; transferring enrollees between group and individual accounts; restoring coverage for enrollees who are otherwise eligible for continued enrollment under WAC 182-24-070 (7)(b) after a limited suspension of coverage due to late payment or other health care coverage; adding newly hired employees to an existing employer group; or adding new or returning members of federally recognized Native American tribes to that tribe's currently approved financial sponsor group.)

(c) If the administrator has closed or limited enrollment, applicants for BHP who are not in any of the categories in (b) of this subsection may reserve space on a waiting list to be processed according to the date the waiting list request or application is received by BHP. When enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by BHP of the opportunity to enroll. BHP may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, before determining their eligibility.

#### NEW SECTION

**WAC 182-24-025 How is income calculated?** "Gross family income" means total cash receipts, as defined in subsection (1) of this section, before taxes, from all sources, for subscriber and dependents regardless of whether they are enrolled in BHP, with the exceptions noted in subsection (2) of this section. An average of documented income received over a period of several months will be used for purposes of eligibility determination, unless documentation submitted confirms a change in circumstances so that an average would not be an accurate reflection of current income. A twelve-month average will be used when calculating gambling income, lump-sum payments, and income from capital gains. A twelve-month history of receipts and expenses will be required for calculating self-employment or rental income unless the applicant or enrollee has not owned the business for at least twelve months.

(1) Income includes:

(a) Wages, tips, and salaries before any deductions;

(b) Net receipts from nonfarm self-employment (receipts from a person's own business, professional enterprise, or partnership, after deductions for business expenses). A net loss from self-

employment will not be used to offset other income sources. In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, except that:

(i) A deduction for business use of the home may be allowed in cases where the enrollee has documented that more than fifty percent of their home is used for the business for the majority of the year; or

(ii) A deduction for business use of the home may be allowed in cases where the enrollee has documented that they maintain a separate building located on the same property as their home that is used exclusively for the business;

(c) Net receipts from farm self-employment (receipts from a farm which one operates as an owner, renter, or sharecropper, after deductions for farm operating expenses). In calculating net self-employment income, deductions will not be allowed for noncash-flow items such as depreciation, amortization, or business use of home, and a net loss from self-employment will not be used to offset other income sources;

(d) Periodic payments from Social Security, railroad retirement, military pension or retirement pay, military disability pensions, military disability payments, government employee pensions, private pensions, unemployment compensation, workers' compensation, and strike benefits from union funds;

(e) Payments for punitive damages;

(f) Public assistance, alimony, child support, and military family allotments;

(g) Work study, assistantships, or training stipends;

(h) Dividends and interest accessible to the enrollee without a penalty for early withdrawal;

(i) Net rental income, net royalties, and net gambling or lottery winnings;

(j) Lump sum inheritances and periodic receipts from estates or trusts; and

(k) Short-term capital gains, such as from the sale of stock or real estate.

(2) Income does not include the following types of money received:

(a) Any assets drawn down as withdrawals from a bank, the sale of property, a house, or a car;

(b) Tax refunds, gifts, loans, one-time insurance payments, other than for punitive damages, and one-time payments or winnings received more than one month prior to application;

(c) Noncash receipts, such as the employer-paid or union-paid portion of health insurance or other employee fringe benefits, food or housing received in lieu of wages, the value of food and fuel produced and consumed on farms, the imputed value of rent from owner-occupied nonfarm or farm housing, goods or services received due to payments a trust makes to a third party, and such noncash benefit programs as medicare, medicaid, food stamps, school lunches, state supplementary payment income that is specifically dedicated to reimburse for services received, and housing assistance;

(d) Income earned by dependent children with the exception of distributions from a corporation, partnership, or business;

(e) Income of a family member who resides in another household when such income is not available to the subscriber or dependents seeking enrollment in BHP;

(f) College or university scholarships, grants, and fellowships;

(g) Payments from the department of social and health services adoption support program authorized under RCW 26.33.320 and 74.13A.005 through 74.13A.080;

(h) Long-term capital gains;

(i) Crime victims' compensation;

(j) Documented child care expenses for the care of a dependent child of a subscriber may be deducted (at a rate set by the administrator and consistent with Internal Revenue Service requirements) when calculating gross family income. To qualify for this deduction:

(i) The subscriber and the spouse listed as a dependent on the account, if any, must be employed or attending school during the time the child care expenses were paid; and

(ii) Payment may not be paid to a parent or stepparent of the child or to a dependent child of the subscriber or his/her spouse.

#### NEW SECTION

**WAC 182-24-030 Failure to report correct income.** (1) If BHP determines that the enrollee has received a subsidy overpayment due to failure to report income correctly, BHP may:

(a) Bill the enrollee for the amount of subsidy overpaid by the state; or

(b) If the overpayment was due to fraud, intentional misrepresentation of information, or withholding information that the enrollee knew or should have known was material or necessary to accurately determine the premium, impose civil penalties of up to two hundred percent of the subsidy overpayment.

(2) Any BHP determination under subsection (1) of this section is subject to the enrollee appeal provisions in chapter 182-22 WAC.

(3) When a decision under subsection (1)(a) of this section is final, BHP may establish a payment schedule and, for enrollees who remain enrolled in BHP, will collect the amount owed through future premium statements. Enrollees who disenroll prior to paying the full amount of the subsidy overpayment may continue the payment plan previously approved by BHP or may be billed for the entire amount due. BHP may charge interest for the amount past due, at the rate specified under RCW 43.17.230 and rules promulgated under that section. The payment schedule will be for a period of no more than six months, unless BHP approves an alternative payment schedule requested by the enrollee. When a payment schedule is established, BHP will send the enrollee advance written notice of

the schedule and the total amount due. The total amount due each month will include the regular monthly premium plus charges for subsidy overpayment. If an enrollee does not pay the amount due, including charges for subsidy overpayment, the enrollee and all family members enrolled on the account will be disenrolled for nonpayment under WAC 182-24-070 (2)(b).

(4) When a final decision is made under subsection (1)(b) of this section, BHP will send the enrollee notice that payment of the civil penalty is due in full within thirty days after the decision becomes final, unless BHP approves a different due date at the enrollee's request. If the enrollee does not pay the civil penalty by the due date, the enrollee and all family members on the account will be disenrolled for nonpayment under WAC 182-24-070 (2)(b).

(5) Individuals who are disenrolled from BHP may not reenroll until charges for subsidy overpayments or civil penalties imposed under subsection (1) of this section have been paid or BHP has approved a payment schedule and all other requirements for enrollment have been met.

(6) BHP will take all necessary and appropriate administrative and legal actions to collect the unpaid amount of any subsidy overpayment or civil penalty, including recovery from the enrollee's estate.

(7) Enrollees under employer group or financial sponsor group coverage who do not follow the income reporting procedures established by BHP and their employer or financial sponsor may be billed directly by BHP for subsidy overpayments or civil penalties assessed under subsection (1) of this section. Enrollees who do not pay the amount due will be disenrolled under WAC 182-24-070 (2)(b) or (c). Enrollees who are disenrolled for nonpayment of a subsidy overpayment or civil penalties will be excluded from the minimum participation calculation for employer groups under WAC 182-22-210(2).

#### NEW SECTION

**WAC 182-24-040 BHP benefits.** (1) The administrator shall design and from time to time may revise BHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. The medicaid scope of benefits may be provided by BHP as the BHP Plus program through coordination with DSHS for children under the age of nineteen, who are found to be medicaid eligible. BHP benefits may include copayments, waiting periods, and limitations and exclusions which the administrator determines are appropriate and consistent with the goals and

objectives of the plan. BHP benefits will be subject to a nine-month waiting period for preexisting conditions. Exceptions (for example, maternity, prescription drugs, services for a newborn or newly adopted child, dependent children up to age nineteen) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of reservation or application for coverage under BHP. Similar coverage includes BHP, WHP, all DSHS programs administered by the medical assistance administration which have the medicaid scope of benefits, the DSHS program for the medically indigent, Indian health services, most coverages offered by health carriers, and most self-insured health plans. A list of BHP benefits, including copayments, waiting periods, and limitations and exclusions will be provided to the subscriber.

(2) In designing and revising BHP benefits, the administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary health care services, as well as the cost to the enrollees and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

(3) Prior to enrolling in BHP, each applicant will be given a written description of covered benefits, including all copayments, waiting periods, limitations and exclusions, and be advised how to access information on the services, providers, facilities, hours of operation, and other information descriptive of the managed health care system(s) available to enrollees in a given service area.

(4) BHP will provide to all subscribers written notice of any changes in the scope of benefits provided under BHP, or program changes that will affect premiums and copayments at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. This subsection does not apply to premium changes that are the result of changes in income or family size. The administrator may make available a separate schedule of benefits for children, eighteen years of age and younger, for those dependent children in the plan.

#### NEW SECTION

**WAC 182-24-050 Premiums and copayments.** (1) Subscribers or their employer or financial sponsor are responsible for paying the full monthly premium to BHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule. A third party may, with the approval of the administrator, become a financial sponsor and pay all or a designated portion of the premium on behalf of a subscriber and dependents, if any.

(2) The amount of premium due from or on behalf of a

subsidized enrollee will be based upon the subscriber's gross family income, the managed health care system selected by the subscriber, rates payable to managed health care systems, and the number and ages of individuals in the subscriber's family.

(3) Once BHP has determined that an applicant and his/her dependents (if any) are eligible for enrollment, the applicant or employer or financial sponsor will be informed of the amount of the first month's premium for the applicant and his/her enrolled dependents. New enrollees will not be eligible to receive covered services on the effective date of enrollment specified by BHP unless the premium has been paid by the due date given. Thereafter, BHP will bill each subscriber or employer or financial sponsor monthly.

(4) Full payment for premiums due must be received by BHP by the date specified on the premium statement. If BHP does not receive full payment of a premium by the date specified on the premium statement, BHP shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with BHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be suspended from coverage for one month. If payment is not received by the due date on the notice of suspension, the subscriber and enrolled family members will be disenrolled effective the date of the initial suspension. If an enrollee's coverage is suspended more than two times in a twelve-month period, the subscriber and enrolled family members will be disenrolled for nonpayment under the provisions of WAC 182-24-060(2). Partial payment of premiums due, payment which for any reason cannot be applied to the correct BHP enrollee's account, or payment by check which is not signed, cannot be processed, or is returned due to nonsufficient funds, will be regarded as nonpayment.

(5) Enrollees shall be responsible for paying any required copayment, coinsurance, or deductible directly to the provider of a covered service or directly to the MHCS.

(6) Monthly premiums due for foster parents with gross family income up to two hundred percent of the federal poverty level will be set at the minimum premium amount charged to enrollees with income below sixty-five percent of the federal poverty level. Monthly premiums due for foster parents with gross family income between two hundred percent and three hundred percent of the federal poverty level will not exceed one hundred dollars per month.

NEW SECTION

**WAC 182-24-060 Enrollment in the plan.** (1) Any individual applying for enrollment must submit a signed, completed application for enrollment. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or guardian, who shall also be held responsible for payment of premiums due on behalf of the child. If an applicant is accepted for enrollment, the applicant's signature acknowledges the applicant's obligation to pay the monthly premium in accordance with the terms and conditions identified in the member handbook. Applications for BHP Plus enrollment on behalf of children under the age of nineteen will be referred to the department of social and health services for medicaid eligibility determination.

(2) Each BHP or BHP Plus applicant must list all eligible dependents, regardless of whether the dependents will be enrolled, and must supply other information and documentation as required and where applicable by BHP and DSHS medical assistance.

(a) Applicants for BHP enrollment must provide documentation showing the amount and sources of their gross family income. Income documentation must include a copy of the applicant's most recently filed federal income tax form or verification of nonfiling status, and copies of pay stubs or other documents showing income for the most recent thirty days or complete calendar month as of the date of application. Applicants who were not required to file a federal income tax return may be required to provide other documentation showing year-to-date income. As described in WAC 182-22-210(5), BHP may use an average of documented income when determining eligibility.

(b) Applicants for BHP enrollment must provide documentation of Washington state residence, displaying the applicant's name and current address, for example, a copy of a current utility bill or rent receipt. Other documentation may be accepted if the applicant does not have a physical residence, for example, a signed statement from a person or other entity who is providing temporary shelter.

(c) BHP may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility, or MHCS selection.

(d) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment in BHP. Intentional submission of false information will result in disenrollment of the subscriber and all enrolled dependents.

(3) Each member may be enrolled in only one BHP account. Each family applying for enrollment must designate an MHCS from which the applicant and all enrolled dependents will receive covered services. All applicants from the same family who are covered under the same account must receive covered services from the same MHCS (with the exception of cases in which a subscriber who is paying for BHP coverage for his/her dependent who lives in a different service area). No applicant will be enrolled for whom designation of an MHCS has not been made as part of the application for enrollment. Procedures for the selection of MHCS are set forth in the BHP member handbook. Generally, enrollees may change from

one MHCS to another only during open enrollment or if they are able to show good cause for the transfer, for example, when enrollees move to an area served by a different MHCS or where they would be billed a higher premium for their current MHCS.

(4) When an MHCS assists BHP applicants in the enrollment process, it must provide them with the toll-free number for BHP and information on all MHCS available within the applicant's county of residence and the estimated premiums for each available MHCS.

(5) Except as otherwise provided in this chapter, applications for enrollment will be reviewed by BHP within thirty business days of receipt and those applicants satisfying the eligibility criteria and who have provided all required information, documentation and premium payments will be notified of their effective date of enrollment.

(6)(a) Eligible applicants will be enrolled in BHP in the order in which their completed applications, including all required documentation, have been received by BHP, provided that:

(i) At least one MHCS is accepting new enrollment in the program for which the applicant is applying and from the geographic area where the applicant lives; and

(ii) The applicant also remits full payment of the first premium bill to BHP by the due date specified by BHP.

(b) In the event a waiting list is implemented, eligible applicants will be enrolled in accordance with WAC 182-24-020.

(7) An open enrollment period of at least twenty consecutive days will be held annually. During this open enrollment period, enrollees may apply to enroll additional family members or to transfer their enrollment to a different MHCS, provided the MHCS selected is accepting new enrollment for the enrollee's program in the geographic area where the enrollee lives.

(8) Not all family members are required to apply for enrollment in BHP; however, any family member for whom application for enrollment is not made at the same time that other family members apply, may not subsequently enroll as a family member until the next open enrollment period, unless the subscriber has experienced a "qualifying change in family status." "Qualifying changes in family status" include:

(a) The loss of other health care coverage, for a family member who has previously waived coverage, provided BHP receives the family member's application within thirty days of the loss of other coverage, along with proof of the family member's continuous medical coverage from the date the subscriber enrolled in BHP;

(b) Marriage or assuming custody or dependency of a child or adult dependent (other than newborn or newly adopted children), provided BHP receives the new family member's application within thirty days of the change in family status;

(c) Addition of an eligible newborn child or a child newly placed for adoption provided BHP receives the child's application for enrollment within sixty days of the date of birth or placement for adoption. These children may be enrolled effective from the date of birth or placement for adoption; or

(d) Addition of a family member who was not previously eligible for coverage, and who has become eligible.

(9) Subscribers must notify BHP of any changes that could affect their eligibility or subsidy or their dependents' eligibility or subsidy:

(a) Within thirty days of the end of the first month of receiving an increased income; or

(b) Within thirty days of a change other than an income change (for example, a change in family size or address).

(10) BHP will verify the continuing eligibility of BHP enrollees through the recertification process at least once every twelve months. The twelve-month period begins upon completion of the previous recertification process. Upon request of BHP, subsidized enrollees must submit evidence satisfactory to BHP, proving their continued eligibility for enrollment and for the premium subsidy they are receiving.

(a) BHP will verify enrollees' income through comparison with other state and federal agency records or other third-party sources.

(b) If the enrollee's income on record with other agencies or third-party source differs from the income the enrollee has reported to BHP, or if questions arise concerning the documentation submitted, BHP will require updated documentation from the enrollee to prove continued eligibility for the subsidy they are receiving. At that time, BHP may also require updated documentation of residence to complete the recertification process.

(c) Enrollees who have been enrolled in BHP six months or more and have not provided updated income documentation for at least six months will be required to submit new income documentation if their wage or salary income cannot be compared to an independent source for verification. The six-month period begins upon completion of the previous recertification process.

(d) Enrollees who have documented that they are not required to file a federal income tax return for previous years will not be required to provide additional verification of nonfiling unless their circumstances appear to have changed or other information received indicates they have filed a federal income tax return.

(11) In addition to verification of income, BHP enrollees must annually submit documentation satisfactory to BHP of the following:

(a) Washington state residence;

(b) Full-time student status for dependent students age nineteen through twenty-five attending school out-of-state; and

(c) Medicare ineligibility for enrollees age sixty-five or over and for enrollees who have been receiving Social Security disability benefits for twenty-four consecutive months or more.

(12) When determining eligibility for BHP enrollment, noncitizens may be required to provide proof of immigration status, to verify whether they are here on a temporary visa to study in the United States.

(13) For good cause such as, but not limited to, when information received indicates a change in income or a source of income the enrollee has not reported, BHP may require enrollees to provide verification required in subsections (10) and (11) of this section more frequently, regardless of the length of time since their last recertification.

(14) Enrollees who fail to comply with a recertification request will be disenrolled, according to the provisions of WAC 182-24-070 (2)(d).

(15) If, as a result of recertification, BHP determines that an enrollee has not reported income or income changes accurately, the enrollee will be subject to the provisions of WAC 182-24-030.

#### NEW SECTION

**WAC 182-24-070 Disenrollment from BHP.** (1) An enrollee or employer group may disenroll effective the first day of any month by giving BHP at least ten days prior notice of the intention to disenroll.

(2) BHP may disenroll any enrollee or group from BHP for good cause, which includes:

(a) Failure to meet the BHP eligibility requirements;

(b) Nonpayment of premium under the provisions of subsection (7) of this section;

(c) Changes in MHCS or program availability when the enrollee's MHCS will no longer be available to him or her and no other MHCS in the area where the enrollee lives is accepting new enrollment in the enrollee's program;

(d) Fraud, intentional misrepresentation of information, or withholding information that the enrollee knew or should have known was material or necessary to accurately determine their eligibility or premium responsibility, failure to provide requested verification of eligibility or income, or knowingly providing false information;

(e) Abuse or intentional misconduct;

(f) Danger or threat to the safety or property of the MHCS or the health care authority or their staff, providers, patients or visitors; and

(g) Refusal to accept or follow procedures or treatment determined by an MHCS to be essential to the health of the enrollee, when the MHCS has advised the enrollee and demonstrated to the satisfaction of BHP that no professionally acceptable alternative form of treatment is available from the MHCS.

(3) In addition to being disenrolled, any enrollee who knowingly provides false information to BHP or to a participating managed health care system may be held financially responsible for any covered services fraudulently obtained through BHP.

(4) At least ten days before the effective date of disenrollment under subsection (2)(a) and (c) through (g) of this section, BHP will send the enrollee written notice of disenrollment.

(a) The notice of disenrollment will:

(i) State the reason for the disenrollment;

(ii) State the effective date of the disenrollment;

(iii) Describe the procedures for disenrollment; and

(iv) Inform the enrollee of his or her right to appeal the disenrollment decision as set forth in chapter 182-22 WAC.

(b) The notice of disenrollment will be sent to both the employer or sponsor and to all members of an employer group, home care agency group or financial sponsor group that is disenrolled under these provisions. Enrollees affected by the disenrollment of a group account will be offered coverage under individual accounts. Coverage under individual accounts will not begin unless the premium for individual coverage is paid by the due date for the coverage month. A one-month break in coverage may occur for enrollees who choose to transfer to individual accounts.

(5) Enrollees covered under BHP Plus or receiving maternity benefits through medical assistance will not be disenrolled from those programs when other family members lose BHP coverage, as long as they remain eligible for those programs.

(6) Enrollees who are notified that they will be disenrolled due to incomplete recertification documents shall not be disenrolled if they submit complete documents within thirty days after the disenrollment letter is mailed.

(7) Under the provisions of this subsection, BHP will suspend or disenroll enrollees and groups who do not pay their premiums when due, including amounts owed for subsidy overpayment, if any. Partial payment or payment by check which cannot be processed or is returned due to nonsufficient funds will be regarded as nonpayment.

(a) At least ten days before coverage will lapse, BHP will send a delinquency notice to each subscriber whose premium payment has not been received by the due date. The delinquency notice will include a final due date and a notice that BHP coverage will lapse unless payment is received by the final due date.

(b) Except as provided in (c) of this subsection, coverage will be suspended for one month if an enrollee's premium payment is not received by the final due date, as shown on the delinquency notice. BHP will send written notice of suspension to the subscriber, which will include:

(i) The effective date of the suspension;

(ii) The due date by which payment must be received to restore coverage after the one-month suspension;

(iii) Notification that the subscriber and any enrolled dependents will be disenrolled if payment is not received by the final due date; and

(iv) Instructions for filing an appeal under WAC 182-22-310.

(c) Enrollees whose premium payment has not been received by the delinquency due date, and who have been suspended twice within the previous twelve months will be disenrolled for nonpayment as of the effective date of the third suspension.

(d) Enrollees who are suspended and do not pay the premium for the next coverage month by the due date on the notice of suspension will be immediately disenrolled and issued a notice of disenrollment, which will include:

(i) The effective date of the disenrollment; and

(ii) Instructions for filing an appeal under WAC 182-22-310.

(8)(a) Unless otherwise specified in this chapter, and subject to the provisions of WAC 182-22-430, enrollees who voluntarily

disenroll or are disenrolled from BHP may not reenroll for a period of twelve months from the date their coverage ended and until all other requirements for enrollment have been satisfied. An exception to this provision may be made for:

(i) Enrollees who left BHP for other health insurance, who are able to provide proof of continuous coverage from the date of disenrollment, and who apply to reenroll in BHP within thirty days of losing the other coverage;

(ii) Enrollees who left BHP because they lost eligibility and who subsequently become eligible to reenroll;

(iii) Persons enrolling in BHP, who had enrolled and subsequently disenrolled from WHP under subsection (1) or (2)(b) of this section while on a waiting list for BHP, if otherwise eligible;

(iv) Enrollees who were disenrolled by BHP because no MHCS was contracted to serve the program in which they were enrolled in the geographic area where they live; these enrollees may reenroll, provided all enrollment requirements are met, if an MHCS begins accepting enrollment for their program in their area or if they become eligible and apply for another HCA program; and

(v) Enrollees who were disenrolled for failing to provide requested documentation of income or eligibility for recertification or as otherwise requested by BHP, who provide all required documentation within six months of disenrollment and are eligible to reenroll. Reenrollment in the plan will not be retroactive and shall take place within forty-five days of BHP receiving complete reenrollment documents that verify eligibility; subject to the provisions of WAC 182-24-050.

(b) An enrollee who is required to wait twelve months for reenrollment under (a) of this subsection may not reenroll before the end of the required twelve-month wait. If an enrollee satisfies the required twelve-month wait after applying for BHP and while waiting to be offered coverage, enrollment will not be completed until funding is available to enroll him or her.

AMENDATORY SECTION (Amending Order 04-03, filed 11/5/04, effective 1/1/05)

**WAC 182-25-120 Basic health plan coverage for health coverage tax credit eligible enrollees.** (1) "Health coverage tax credit eligible enrollee" or "HCTC enrollee" means an individual or qualified dependent determined by the federal Department of the Treasury to be eligible for a tax credit, as defined under RCW 70.47.020 (3) and (4). In the event that the federal health coverage tax credit program is no longer available, HCTC enrollment in BHP will end.

(2) Eligibility for HCTC enrollment, as subscriber or dependent, is determined by the federal Health Coverage Tax Credit program. HCTC enrollees must provide proof of eligibility for HCTC enrollment, but are not required to also meet the eligibility criteria in WAC (~~(182-25-030)~~) 182-23-020 or 182-24-020.

(3) Unless the enrollee has applied for, is eligible, and has enrolled as a (~~(subsidized)~~) BHP enrollee, the monthly premium due from or on behalf of an HCTC enrollee will be the full cost charged by the MHCS for coverage, plus the administrative cost of providing BHP coverage and the premium tax under RCW 48.14.0201.

(4) HCTC enrollees may pay the full premium for coverage to BHP or, if they are claiming the HCTC advance tax credit, may pay their portion of the premium to the federal HCTC program of the Internal Revenue Service (IRS) by the date required by the IRS.

(5) With the exception of subsections (3) and (7) of this section, (~~(subsidized)~~) BHP enrollees who are HCTC eligible will be subject to the rules for (~~(subsidized)~~) BHP enrollees.

(6) Notice of disenrollment will be sent to the HCTC enrollees for whom the premium has not been paid. This notice will be sent (~~(prior to)~~) before the month of coverage, but will not be subject to the notification requirements in WAC (~~(182-25-090(6))~~) 182-24-070(7). If payment is received no later than the first day of the month of coverage, the enrollee's coverage for that month will be reinstated.

(7) The nine-month waiting period for treatment of preexisting conditions will be waived for HCTC enrollees who have had three months or more of creditable coverage, as defined under Public Law 104-191, without a break in coverage of more than sixty-two consecutive days at the time of application. Subsidized enrollees who are HCTC eligible, who provide proof of that eligibility to their MHCS, will be treated as HCTC enrollees for purposes of determining whether the preexisting condition waiting period can be waived.

(8) HCTC enrollees who disenroll may return to HCTC enrollment without being subject to the provisions of WAC (~~(182-25-090(7))~~) 182-24-070(8).

(9) Because eligibility for the HCTC program is determined by the federal HCTC program at the Internal Revenue Service, BHP will not review appeals of eligibility for the HCTC program. Instructions on appealing an HCTC eligibility determination are available through the HCTC customer contact center.

#### REPEALER

The following sections of the Washington Administrative Code are repealed:

WAC 182-25-001	Authority.
WAC 182-25-010	Definitions.
WAC 182-25-020	BHP benefits.
WAC 182-25-030	Eligibility.
WAC 182-25-040	Enrollment in the plan.
WAC 182-25-050	Employer groups.
WAC 182-25-060	Home care agencies.
WAC 182-25-070	Financial sponsors.
WAC 182-25-080	Premiums and copayments.
WAC 182-25-085	Enrollees' failure to report correct income.
WAC 182-25-090	Disenrollment from BHP.
WAC 182-25-100	Where to find instructions for filing an appeal.
WAC 182-25-105	How to appeal health care authority (HCA) decisions.
WAC 182-25-110	How to appeal a managed health care system (MHCS) decision.