



# RULE-MAKING ORDER

## CR-103 (June 2004) (Implements RCW 34.05.360)

**Agency:** Health Care Authority  
Administrative Order # 08-02

- Permanent Rule  
 Emergency Rule

**Effective date of rule:**

**Permanent Rules**

- 31 days after filing.  
 Other (specify) \_\_\_\_\_ (If less than 31 days after filing, a specific finding under RCW 34.05.380(3) is required and should be stated below)

**Effective date of rule:**

**Emergency Rules**

- Immediately upon filing.  
 Later (specify) \_\_\_\_\_

**Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?**

- Yes  No If Yes, explain:

**Purpose:** These rules are necessary for the agency to implement the Health Insurance Partnership, as required by Chapter 70.47A RCW.

**Citation of existing rules affected by this order:**

Repealed:  
 Amended:  
 Suspended:

**Statutory authority for adoption:** RCW 70.47A.060

**Other authority :**

**PERMANENT RULE ONLY (Including Expedited Rule Making)**

Adopted under notice filed as WSR 08-19-065 on September 15, 2008.  
 Describe any changes other than editing from proposed to adopted version: None

If a preliminary cost-benefit analysis was prepared under RCW 34.05.328, a final cost-benefit analysis is available by contacting:

Name: \_\_\_\_\_ phone ( ) \_\_\_\_\_  
 Address: \_\_\_\_\_ fax ( ) \_\_\_\_\_  
 e-mail \_\_\_\_\_

**EMERGENCY RULE ONLY**

Under RCW 34.05.350 the agency for good cause finds:

- That immediate adoption, amendment, or repeal of a rule is necessary for the preservation of the public health, safety, or general welfare, and that observing the time requirements of notice and opportunity to comment upon adoption of a permanent rule would be contrary to the public interest.  
 That state or federal law or federal rule or a federal deadline for state receipt of federal funds requires immediate adoption of a rule.

Reasons for this finding:

**Date adopted:** October 31, 2008

**NAME (TYPE OR PRINT)**

Jason Siems

**SIGNATURE**

**TITLE**

HCA Rules Coordinator

**CODE REVISER USE ONLY**

OFFICE OF THE CODE REVISER  
 STATE OF WASHINGTON  
 FILED

DATE: October 31, 2008  
 TIME: 8:54 AM

**WSR 08-22-041**

**Note: If any category is left blank, it will be calculated as zero.  
No descriptive text.**

**Count by whole WAC sections only, from the WAC number through the history note.  
A section may be counted in more than one category.**

**The number of sections adopted in order to comply with:**

<b>Federal statute:</b>	New	_____	Amended	_____	Repealed	_____
<b>Federal rules or standards:</b>	New	_____	Amended	_____	Repealed	_____
<b>Recently enacted state statutes:</b>	New	<u>21</u>	Amended	_____	Repealed	_____

**The number of sections adopted at the request of a nongovernmental entity:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in the agency's own initiative:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted in order to clarify, streamline, or reform agency procedures:**

New	_____	Amended	_____	Repealed	_____
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**The number of sections adopted using:**

<b>Negotiated rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Pilot rule making:</b>	New	_____	Amended	_____	Repealed	_____
<b>Other alternative rule making:</b>	New	_____	Amended	_____	Repealed	_____

**Chapter 182-26 WAC**

**WASHINGTON HEALTH INSURANCE PARTNERSHIP (HIP) PROGRAM**

NEW SECTION

**WAC 182-26-010 Authority.** The administrator's authority to make rules is contained in RCW 70.47A.060.

NEW SECTION

**WAC 182-26-020 Definitions--Generally.** Unless the context clearly indicates otherwise, the definitions in Part 1 of this chapter apply throughout this chapter.

**PART 1  
DEFINITIONS**

NEW SECTION

**WAC 182-26-100 Definitions.** "Administrator" means the administrator of the Washington state health care authority established under chapter 41.05 RCW.

"Appeal" means a formal written request to the HIP or its designee for resolution of problems or concerns that cannot be resolved informally. For the purposes of this chapter, "appeal" applies only to HIP decisions regarding subsidy determinations and employer eligibility for the HIP.

"Applicant" means:

- An individual who applies for a premium subsidy through the HIP on behalf of the individual and his or her dependents; or

● A partnership participant who applies or reapplies for premium subsidy through the HIP on behalf of the partnership participant and his or her dependents during the annual subsidy application and renewal period as described in WAC 182-26-320.

"Application" means a form developed by the administrator that an applicant must sign, complete, and submit to the administrator to apply for a premium subsidy through the HIP. To be considered complete, the application must be accompanied by all supporting documents as required and determined by the administrator.

"Benchmark health benefit plan" or "benchmark plan" means a health benefit plan selected by the board and upon which the subsidy scale shall be determined and from which the administrator will calculate a partnership participant's premium subsidy.

"Board" or "HIP board" means the health insurance partnership board established under RCW 70.47A.100.

"Carrier" or "insurance carrier" means the same as defined in RCW 48.43.005.

"The department of social and health services" or "DSHS" means the department of social and health services as defined in RCW 43.20A.020.

"Dependent," for the purpose of determining subsidy eligibility, "dependent" means:

(1) A partnership participant's lawful spouse, not legally separated, who shares a home with the partnership participant; or

(2) The unmarried child of the partnership participant or participant's dependent spouse, whether by birth, adoption, legal guardianship, or placement pending adoption, and not given up for adoption, who is:

(a) Younger than age twenty-five; or

(b) Is of any age, is not able to take care of himself or herself due to disability, and is under legal guardianship of the partnership participant or the participant's dependent spouse.

(3) A dependent may be placed on only one HIP account at any given time.

"Designated health benefit plan" means a health benefit plan selected by the board as eligible for offer through the HIP.

"Disenroll" or "disenrollment" means the termination of a partnership participants' enrollment in the HIP program. Decisions regarding eligibility or enrollment status for insurance coverage will be made by the carrier.

"Eligible partnership participant" means a partnership participant who:

● Is a resident of the state of Washington;

● Has a family income that does not exceed two hundred percent of the federal poverty level, as determined annually by the federal Department of Health and Human Services; and

● Is a health plan eligible employee as defined in this section that is enrolled or is applying to enroll in the participating small employer's offered coverage.

"Employee" has the same meaning as defined in RCW 48.43.005.

"Employer agreement" means a form developed by the administrator that a small employer must complete, sign, and submit

to the administrator to request enrollment in the HIP.

"Health insurance partnership" or "HIP" means the health insurance partnership established in RCW 70.47A.030.

"Health plan eligible employee" means an individual who meets the participating small employer's enrollment criteria.

"HIP account" means an account maintained by the administrator for each partnership participant that includes but is not limited to:

- Demographic information for participants and dependents, if any;
- Subsidy status;
- Carrier and plan enrollment status; and
- Other information as required by the administrator.

"Income" or "family gross income" means total cash receipts, as defined in WAC 182-26-345, before taxes, for participants and all dependents.

"Individual health benefit plan selection." Reserved.

The "office of the insurance commissioner" or "OIC" means the insurance commissioner as defined in RCW 48.02.010.

"Open enrollment" means a designated time period during which partnership participants may enroll additional dependents or make other changes to their employer-sponsored health benefit plan coverage.

"Participating small employer" means a small employer who:

- Enters into a written agreement with the HIP to purchase a designated health benefit plan through the HIP;
- Attests at the date of the agreement that the employer does not currently offer coverage, including insurance purchased through the small group and association health plan markets, self-funded plans, and multiple employer welfare arrangements; and
- Attests at the date of the agreement that at least fifty percent of its employees are low-wage workers, as defined by the board.

"Partnership participant" means:

- A participating small employer as defined in this section;
- An employee of a participating small employer;
- A former employee of a participating small employer who chooses to continue coverage through the HIP following separation from employment, to the extent the employee is eligible for continuation of coverage under 29 U.S.C. Sec. 1161 et seq.; and
- A former employee of a participating small employer who chooses to continue coverage through HIP following separation from employment, to the extent determined by the board.

"Philanthropy" means a person, organization or other entity, approved by the administrator that is responsible for payment of all or part of the monthly premium obligation on behalf of a partnership participant.

"Premium" has the same meaning as described in RCW 48.43.005.

"Premium subsidy" or "subsidy" means payment to or reimbursement by the HIP on behalf of an eligible partnership participant toward the purchase of a designated health benefit plan.

"Qualifying change in family status" is defined in WAC 182-26-325.

"Section 125 plan" means a cafeteria plan compliant with section 125 of the federal Internal Revenue Code that enables employees to use pretax dollars to pay their share of their health benefit plan premium.

"Small employer" or "employer" as used in this chapter means an employer who meets the definition of "small employer" in RCW 48.43.005.

"Subsidy application and renewal period" means an annual period that lasts at least sixty days, during which:

- All partnership participants may apply for premium subsidies for themselves and their dependents; and

- All partnership participants receiving a subsidy are required to provide proof of their continuing eligibility for a premium subsidy.

The subsidy application and renewal period will begin ninety days before the employer-sponsored health benefit plan open enrollment period begins.

"Surcharge" means an amount, determined by the administrator, that may be added to a partnership participant's premium as provided for in WAC 182-26-500. The surcharge is not part of the premium and applies only to coverage purchased through the HIP.

"Washington state resident" means:

(a) A person who physically resides in and maintains a residence in the state of Washington.

(b) To be considered a Washington resident, individuals who are temporarily out of Washington state for any reason may be required to demonstrate their intent to return to Washington state.

(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 stays; or

(iii) Another person's home.

## PART 2 EMPLOYER ENROLLMENT

### NEW SECTION

**WAC 182-26-200 Employer eligibility for the HIP.** To enroll in the HIP, a small employer must:

- Meet the minimum contribution requirement under WAC 182-26-210;

- Meet the minimum participation requirement under WAC 182-26-220; and
- Agree to establish a section 125 plan under RCW 70.47A.030 (2) (a).

NEW SECTION

**WAC 182-26-210 Minimum employer contribution.**

- A small employer must contribute at least forty percent of each health plan eligible employee's total premium obligation.
- The minimum contribution requirement does not apply to a health plan eligible employee's dependent's premium.

NEW SECTION

**WAC 182-26-220 Minimum participation.**

- A participating small employer will determine the criteria for eligibility and enrollment in his or her designated health benefit plan.
- To participate in the HIP, the small employer must enroll at least seventy-five percent of the health plan eligible employees in the designated health benefit plan.
- When calculating the minimum participation percentage, employees who have similar existing coverage from another source and the health plan eligible employees' dependents will not be included.

**PART 3  
PREMIUM SUBSIDIES**

NEW SECTION

**WAC 182-26-300 Who can receive a premium subsidy?** An eligible partnership participant may receive a premium subsidy if there is sufficient funding available, as determined by the administrator.

NEW SECTION

**WAC 182-26-305 Applying for a HIP premium subsidy.** (1) To receive a HIP subsidy, an applicant must submit a complete application and all supporting documents as described in WAC 182-26-310 to the HIP.

(2) On a subsidy application, an applicant must list all eligible dependents up to age nineteen. The applicant must also provide other information and documents as required by the HIP.

(3) An applicant is not required to list dependents aged nineteen or over and under twenty-five on the application, but if they are listed on the application, the HIP will include the dependents' income for purposes of subsidy eligibility and calculation.

(4) An applicant is not required to apply for a subsidy for all of his or her dependents. However, any dependent that does not apply for a subsidy at the same time that the other family members apply must wait to apply as a dependent until the next subsidy application and renewal period.

NEW SECTION

**WAC 182-26-310 Application--Supporting documents.** (1) An application for a HIP subsidy must be accompanied by all of the following supporting documents:

- Proof of the family gross income as described in WAC 182-26-345.

- Proof of the applicant's Washington state residence, displaying the applicant's name and current address, such as a utility bill or rent receipt. The HIP may accept other documents if the applicant does not have a physical residence, for example, a signed statement from a person or other entity that is providing temporary shelter. The HIP will not accept a post office box or other mailing address as proof of residence.

- Other documents or information as requested by the HIP to establish or verify eligibility.

(2) The HIP may verify income of applicants for a HIP subsidy through comparison with other state and federal agency records or other third-party sources.

(3) Incomplete or inaccurate information may delay or prevent an applicant from receiving a premium subsidy. Intentionally submitting false information will, at a minimum, result in the loss of subsidy eligibility for an applicant or partnership participant

and all of his or her subsidized dependents.

NEW SECTION

**WAC 182-26-315 HIP application review.** (1) Except as provided in WAC 182-26-300, the HIP will review subsidy applications within thirty days of receipt. The HIP will send notification of an applicant's subsidy status upon completion of the review.

(2) Eligible applicants will be subsidized in the HIP in the order in which their completed applications have been received by the HIP, provided the administrator has determined there is subsidy funding available and the participating small employer also remits full payment of the first full month's premium to the HIP by the due date specified by the HIP.

NEW SECTION

**WAC 182-26-320 Annual subsidy application and renewal.** (1) The HIP will verify the continuing eligibility of eligible partnership participants at least annually, or upon renewal or a change of the employer-sponsored health benefit plan.

(2) Upon request of the HIP, subsidized eligible partnership participants must submit evidence satisfactory to the HIP that proves their continued eligibility for a premium subsidy and for the amount of subsidy they receive.

(3) The HIP may verify income of subsidized eligible partnership participants through comparison with other state and federal agency records or other third-party sources.

(4) If the eligible partnership participant's income on record with other agencies or third-party sources differs from the income the participant has reported to the HIP, or if questions arise concerning the documents submitted, the HIP may require updated documents from the participant to prove continued eligibility for the subsidy they receive. At that time, the HIP may also require updated proof of residence.

(5) Eligible partnership participants who have documented that they did not file a federal income tax return for previous years may not be required to provide additional verification of nonfiling, unless their circumstances appear to have changed or other information received by the HIP indicates they may have filed a federal income tax return.

(6) In addition to verification of income, eligible partnership participants must annually submit proof of Washington

state residence to the HIP.

(7) Partnership participants who fail to comply with an annual subsidy renewal request will be disenrolled from the HIP subsidy program and will no longer receive a premium subsidy from the HIP.

(8) If, as the result of an annual subsidy renewal review, the HIP determines that a partnership participant has not reported income accurately, the partnership participant will be subject to the provisions of WAC 182-26-335.

#### NEW SECTION

**WAC 182-26-325 Making changes to a HIP account.** (1) A partnership participant may add an eligible dependent to a HIP account:

(a) Annually, during the subsidy application and renewal period; or

(b) When there is a qualifying change in family status. In these cases, the partnership participant must notify the administrator on the required form within thirty calendar days of the change in family status. A "qualifying change in family status" means:

- The loss of other health care coverage for a dependent who has previously waived coverage in the partnership participant's employer-sponsored health benefit plan;

- The birth, adoption, or placement for adoption of a dependent child in the partnership participant's home;

- The partnership participant marries;

- The partnership participant or his or her spouse assumes custody or dependency of a child or adult dependent; or

- A dependent that was previously ineligible for the partnership participant's employer-sponsored health benefit plan coverage has become eligible.

(2) A partnership participant may remove dependents from a HIP account upon divorce, annulment, or legal separation, or upon the death of a dependent. In these cases, the partnership participant must notify the HIP within thirty calendar days of the change in family status.

(3) A partnership participant must notify the HIP of a change in his or her physical address within thirty calendar days of the change of address.

NEW SECTION

**WAC 182-26-330 Loss of subsidy eligibility.** A partnership participant may lose subsidy eligibility for himself or herself and his or her dependents when:

- The partnership participant's or dependent's coverage under his or her designated health benefit plan has been suspended or terminated;
- The partnership participant is no longer a Washington state resident;
- The partnership participant has not accurately reported his or her family gross income at the time of subsidy application or renewal; or
- The partnership participant's employer is disenrolled from the HIP program.

If the partnership participant loses subsidy eligibility, he or she will no longer receive a premium subsidy, beginning with the next coverage month following the determination of the change.

NEW SECTION

**WAC 182-26-335 Recoupment.** The HIP may recoup overpaid subsidy amounts from current and former partnership participants when the HIP determines that a subsidy overpayment occurred because the current or former partnership participant misrepresented or withheld information necessary to accurately determine their subsidy eligibility or subsidy amount.

NEW SECTION

**WAC 182-26-340 How does the HIP determine the premium subsidy amount?** (1) The HIP will apply a sliding scale subsidy schedule based on the partnership participant's family gross income and family size to determine the percentage of the employee's premium obligation the state will pay.

(2) The percentage in subsection (1) of this section will be applied to the health benefit plan employee premium share, including the amount due for dependents' coverage, remaining after deducting the employer contribution from the total premium amount for that participant.

(3) If a participating small employer chooses a health benefit plan with a higher premium than the benchmark plan, the subsidy will not exceed the amount applicable to the benchmark plan.

(4) In no case will the subsidy percentage exceed ninety

percent of the benchmark plan employee premium share.

(5) Once enrolled in the HIP, the subsidy percentage will not change until the next subsidy application and renewal period, even if the total premium share changes because of a qualifying change in family status.

#### NEW SECTION

**WAC 182-26-345 How does the HIP calculate income?** (1) The HIP will average applicants' or dependents' family gross income over a twelve-month period using the total income reported on the most recent tax year's federal income tax return.

(2) If the applicant or dependent cannot provide a copy or IRS transcript of the most recent tax year's federal income tax return, the applicant or dependent must submit a signed declaration of nonfiling and the HIP will calculate the income based on documents deemed acceptable to the administrator.

(3) If an applicant or his or her spouse is self-employed or receives rental income, the applicant or spouse may be required to submit a twelve-month history of receipts and expenses for proof of self-employment or rental income unless the applicant or spouse has not owned the business or rental for at least twelve months. In these cases, the applicant or spouse must send proof of all receipts and expenses for all months he or she has owned the business or rental.

(4) The HIP will deduct expenses an applicant or spouse pays for child or dependent care when calculating family income. The HIP will establish a maximum amount that can be deducted, consistent with IRS requirements. To qualify for this deduction:

(a) The care must be for a dependent on the account, as described under "dependent" as defined in WAC 182-26-100;

(b) The applicant and spouse, if any, listed on the account, must be employed, attend school, or be receiving Social Security disability benefits during the months the care was provided; and

(c) The person who was paid for the dependent's care cannot be the dependent's parent or stepparent or another of the applicant's or spouse's dependents.

(5) The HIP will deduct payments made for alimony when calculating family income.

NEW SECTION

**WAC 182-26-350 What does the HIP count as income?** Income includes all of the following, before any deductions (gross income):

Source	Received by the participant, spouse, child dependent aged nineteen or over and under twenty-five, or adult dependent	Received by a dependent child under age nineteen
Wages, tips, and salaries	Yes	No
Taxable interest	Yes	Yes
Ordinary dividends	Yes	Yes
Taxable refunds, credits, or offsets of state and local income taxes	Yes	Yes
Alimony received	Yes	N/A
Business income or loss	Yes	Yes
Capital gain or loss	Yes	Yes
Other gains or losses	Yes	Yes
IRA distributions	Yes	Yes
Pensions and annuities	Yes	N/A
Rental real estate, royalties, partnerships, S corporations	Yes	Yes
Farm income	Yes	Yes
Unemployment compensation	Yes	No
Social Security benefits	Yes	Yes
Other income	Yes	Yes

**PART 4  
ADMINISTRATIVE PROCEDURES**

NEW SECTION

**WAC 182-26-400 Appeals--Grounds.** (1) An employer may appeal a HIP decision regarding the employer group's eligibility or enrollment status in the HIP.

(2) A partnership participant or applicant may appeal a HIP decision regarding:

- Eligibility for a premium subsidy;
- Premium subsidy amounts;
- Premium subsidy adjustments or penalties.

NEW SECTION

**WAC 182-26-405 Appeals--Who may appeal a HIP decision?** The HIP will accept appeals from an appealing party. For the purposes of this chapter, "appealing party" means:

(1) A participating small employer or small employer who has been denied enrollment in the HIP;

(2) An eligible partnership participant or applicant; or

(3) A third party on the behalf of the person listed in subsection (1) or (2) of this section, as long as the HIP has authorization from the person appealing. The authorization must:

- Be in writing; and
- Verify that the third party represents the person appealing, and that the HIP can share the person's HIP account information with the third party.

NEW SECTION

**WAC 182-26-410 How to appeal a HIP decision.** (1) To appeal a HIP decision, submit a signed letter of appeal to the HIP. The HIP must receive the letter of appeal within thirty calendar days of the date of the decision. The letter of appeal should include:

(a) The appealing party's name, mailing address, and HIP account number if assigned;

(b) A copy of the notice of the decision being appealed or an explanation of the decision being appealed; and

(c) A statement explaining why the appealing party believes the decision was incorrect, outlining the facts surrounding the decision and including supporting documents.

(2) If an appealing party would like an opportunity to explain in person or by phone, the appealing party should include that in the letter of appeal.

(3) Within fifteen calendar days of the date the HIP receives

the letter of appeal, the HIP will send the appealing party written confirmation of receipt of the appeal. If requested by the appealing party, the HIP will schedule an opportunity for the appealing party to explain in person or by phone.

(4) Within sixty calendar days of the date the HIP receives the letter of appeal, the HIP will send the appealing party written notice of the HIP appeal decision. If the appeal is from a third party, the HIP will send a copy of the notice to the appealing party. The notice will include the reasons for the appeal decision and instructions for requesting a review of the appeal decision.

(5) The appeal decision becomes the final agency decision unless the HIP receives a valid request for an additional review from the appealing party. To be valid the request must:

- Be received by the HIP within thirty calendar days of the date of the appeal decision;
- Include a summary of the decision to be reviewed and explain why the appealing party believes the decision was incorrect; and
- Provide additional information or documents the appealing party would like the HIP to consider in the review.

(6) When a valid request for an additional review is received, HIP appeal decisions will be reviewed by a presiding officer according to the requirements of RCW 34.05.488 through 34.05.494. These review decisions will be based on the record and documents 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.

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

(8) If the appealing party disagrees with a review decision under subsection (5) of this section, he or she may request judicial review of the decision, as provided for in RCW 34.05.542.

**PART 5**  
**AGENCY OPERATIONS**

NEW SECTION

**WAC 182-26-500 Surcharge applicability.** (1) The HIP may apply the surcharge uniformly to each health benefit plan purchased through the HIP to reflect the HIP's administrative and operational expenses remaining after any legislative appropriation for this purpose during the year the surcharge is assessed.

(2) The surcharge may be added to the premium, but will not be considered a part of the small group community rate and applies only to coverage purchased through the HIP.

(3) The surcharge may not be used to pay any premium assistance payments.