



PROPOSED RULE MAKING

CR-102 (July 2022) (Implements RCW 34.05.320) Do NOT use for expedited rule making

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STATE OF WASHINGTON
FILED

DATE: May 02, 2023

TIME: 2:36 PM

WSR 23-10-075

Agency: Health Care Authority, PEBB Admin #2023-02.01

☒ Original Notice

☐ Supplemental Notice to WSR _____

☐ Continuance of WSR _____

☒ Preproposal Statement of Inquiry was filed as WSR 23-04-075 ; or

☐ Expedited Rule Making--Proposed notice was filed as WSR _____; or

☐ Proposal is exempt under RCW 34.05.310(4) or 34.05.330(1); or

☐ Proposal is exempt under RCW _____.

Title of rule and other identifying information: (describe subject)

The following sections in chapter 182-08 WAC are revised:

WAC 182-08-196 What happens if my health plan becomes unavailable due to a change in contracted service area or eligibility for Medicare?

WAC 182-08-198 When may a subscriber change health plans?

Hearing location(s):

Date:	Time:	Location: (be specific)	Comment:
June 6, 2023	10:00 AM	The Health Care Authority holds public hearings virtually without a physical meeting place.	To attend the virtual public hearing, you must register in advance: https://us02web.zoom.us/webinar/register/WN_78lrW6mRRYWRuW7SIXs5IQ If the link above opens with an error message, please try using a different browser. After registering, you will receive a confirmation email containing information about joining the public hearing.

Date of intended adoption: Not sooner than June 7, 2023 (Note: This is **NOT** the effective date)

Submit written comments to:

Name: HCA Rules Coordinator

Address: PO Box 42716, Olympia, WA 98504-2716

Email: arc@hca.wa.gov

Fax: (360) 586-9727

Other:

By (date) June 6, 2023 by 11:59 PM

Assistance for persons with disabilities:

Contact Johanna Larson

Phone: ((360)-725-1495

Fax: (360)-586-9727

TTY: Telecommunication Relay services (TRS): 711

Email: Johanna.larson@hca.wa.gov

Other:

By (date) May 19, 2023

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The purpose of this proposal is to amend existing rules to support the Public Employees Benefits Board (PEBB) Program:

1. Implement Public Employees Benefits (PEB) Board Policy Resolutions:

- Amended WAC 182-08-196 and 182-08-198 to implement Resolutions PEBB 2023-01 when a subscriber has a change in residence that affects medical plan availability and PEBB 2023-02 when a subscriber is involuntarily terminated by a Medicare Advantage (MA) or Medicare Advantage-Prescription Drug (MA-PD) plan.

2. Make other technical amendments:

- Amended WAC 182-08-196 to update the title, add when the required forms electing a MA-PD plan must be received by the PEBB Program, add an exception for MA or MA-PD plan's enrollment effective date, and update subsections' references within the section.
- Amended WAC 182-08-198 to move a note up to the beginning of subsection (2), add an exception for a MA or MA-PD plan's enrollment effective date, clarify when a subscriber may select a dental plan when there is a change in residence, and add a new special enrollment event when the PEBB Program that there is a substantial decrease in the providers available under a PEBB medical plan.

Reasons supporting proposal: See purpose statement**Statutory authority for adoption:** RCW 41.05.021 and 41.05.160, Policy Resolutions PEBB 2023-01 and PEBB 2023-02.**Statute being implemented:** RCW 41.05.021 and 41.05.160**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:

Agency comments or recommendations, if any, as to statutory language, implementation, enforcement, and fiscal matters: N/A**Type of proponent:** ☐ Private ☐ Public ☒ Governmental**Name of proponent:** (person or organization) Health Care Authority**Name of agency personnel responsible for:**

	Name	Office Location	Phone
Drafting:	Stella Ng	PO Box 42716, Olympia WA 98504-2716	360-725-0883
Implementation:	Cade Walker	PO Box 42716, Olympia WA 98504-2716	360-643-7900
Enforcement:	Jean Bui	PO Box 42716, Olympia WA 98504-2716	360-725-1858

Is a school district fiscal impact statement required under [RCW 28A.305.135](#)?☐ Yes ☒ No

If yes, insert statement here:

The public may obtain a copy of the school district fiscal impact statement by contacting:

Name:
Address:
Phone:
Fax:
TTY:
Email:
Other:

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:
TTY:
Email:
Other:

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

Regulatory Fairness Act and Small Business Economic Impact Statement

Note: The [Governor's Office for Regulatory Innovation and Assistance \(ORIA\)](#) provides support in completing this part.

(1) Identification of exemptions:

This rule proposal, or portions of the proposal, **may be exempt** from requirements of the Regulatory Fairness Act (see [chapter 19.85 RCW](#)). For additional information on exemptions, consult the [exemption guide published by ORIA](#). Please check the box for any applicable exemption(s):

☐ This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.061](#) because this rule making is being adopted solely to conform and/or comply with federal statute or regulations. Please cite the specific federal statute or regulation this rule is being adopted to conform or comply with, and describe the consequences to the state if the rule is not adopted.

Citation and description:

☐ This rule proposal, or portions of the proposal, is exempt because the agency has completed the pilot rule process defined by [RCW 34.05.313](#) before filing the notice of this proposed rule.

☐ This rule proposal, or portions of the proposal, is exempt under the provisions of [RCW 15.65.570](#)(2) because it was adopted by a referendum.

☐ This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.025](#)(3). Check all that apply:

☐ [RCW 34.05.310](#) (4)(b)
(Internal government operations)

☐ [RCW 34.05.310](#) (4)(e)
(Dictated by statute)

☐ [RCW 34.05.310](#) (4)(c)
(Incorporation by reference)

☐ [RCW 34.05.310](#) (4)(f)
(Set or adjust fees)

☐ [RCW 34.05.310](#) (4)(d)
(Correct or clarify language)

☐ [RCW 34.05.310](#) (4)(g)
((i) Relating to agency hearings; or (ii) process requirements for applying to an agency for a license or permit)

☒ This rule proposal, or portions of the proposal, is exempt under [RCW 19.85.025](#)(4) (does not affect small businesses).

☐ This rule proposal, or portions of the proposal, is exempt under RCW _____.

Explanation of how the above exemption(s) applies to the proposed rule:

(2) Scope of exemptions: *Check one.*

☒ The rule proposal is fully exempt (*skip section 3*). Exemptions identified above apply to all portions of the rule proposal.

☐ The rule proposal is partially exempt (*complete section 3*). The exemptions identified above apply to portions of the rule proposal, but less than the entire rule proposal. Provide details here (consider using [this template from ORIA](#)):

☐ The rule proposal is not exempt (*complete section 3*). No exemptions were identified above.

(3) Small business economic impact statement: *Complete this section if any portion is not exempt.*

If any portion of the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor costs. These rules do not apply to small businesses.

☐ Yes Calculations show the rule proposal likely imposes more-than-minor cost to businesses and a small business economic impact statement is required. Insert the required small business economic impact statement here:

The public may obtain a copy of the small business economic impact statement or the detailed cost calculations by contacting:

Name:

Address:


Phone:

Fax:

TTY:

Email:

Other:

Date: May 2, 2023	Signature: 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

WAC 182-08-196 What happens if my health plan becomes unavailable ~~((due to a change in contracted service area or eligibility for medicare))~~? (1) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to a change in contracting service area as described below:

(a) When a health plan becomes unavailable during the plan year, a subscriber must elect a new health plan no later than ~~((sixty))~~ 60 days after the date their previously selected health plan becomes unavailable.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day.

(b) When a health plan becomes unavailable at the beginning of the next plan year, a subscriber must elect a new health plan no later than the last day of the public employees benefits board (PEBB) annual open enrollment.

(i) An employee must submit the required forms to their employing agency electing their new health plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

(iii) The effective date of the change in health plan will be January 1st of the following year.

(c) A subscriber who fails to elect a new health plan within the required time period as required in (a) or (b) of this subsection will be enrolled in a health plan designated by the director or designee.

(2) A subscriber must elect a new health plan when their previously selected health plan becomes unavailable due to the subscriber or subscriber's dependent ceasing to be eligible for their current health plan because of enrollment in medicare as described below:

(a) The required forms electing a new health plan must be received no later than ~~((sixty))~~ 60 days after the date their previously selected health plan becomes unavailable.

Exception: The required forms electing a new medicare advantage (MA) or medicare advantage-prescription drug (MA-PD) plan must be received no later than two months after the date their previously selected health plan becomes unavailable.

~~((b))~~ (i) An employee must submit the required forms to their employing agency electing their new health plan.

~~((e))~~ (ii) Any other subscriber must submit the required forms to the PEBB program electing their new health plan.

~~((d))~~ (iii) The effective date of the change in health plan will be the first day of the month following the later of the date the health plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in health plan begins on that day except for a MA or MA-PD plan which will begin the first day of the month following the date the form is received.

~~((e))~~ (b) A subscriber who is enrolled in a ~~((high deductible))~~ consumer directed health plan ~~((HDHP))~~ CDHP with a health savings account (HSA), and fails to elect a new health plan within the re-

quired time period as required in this subsection, will not be eligible to receive contributions to the HSA. A subscriber will be liable for any tax penalties resulting from contributions made when they are no longer eligible.

(3) A subscriber must elect a new medical plan when their previously selected medical plan becomes unavailable due to a change in their residence as described below.

(a) When a subscriber's medical plan becomes unavailable during the plan year, a subscriber must elect a new medical plan no later than 60 days after the date their previously selected medical plan becomes unavailable as described in WAC 182-08-198 (2) (e).

(i) An employee must submit the required forms to their employing agency electing their new medical plan.

(ii) Any other subscriber must submit the required forms to the PEBB program electing their new medical plan.

(iii) The effective date of the change in medical plan will be the first day of the month following the later of the date the medical plan becomes unavailable or the date the form is received. If that day is the first of the month, the change in medical plan begins on that day except for a MA or MA-PD plan which will begin the first day of the month following the date the form is received.

(b) A subscriber who fails to elect a new medical plan within the required time period as required in (a) of this subsection will be enrolled in a public employees benefits board medical plan designated by the director or designee.

(4) When a subscriber or their dependent must be disenrolled by a MA or MA-PD plan as required by federal law, the subscriber and their enrolled dependents will be enrolled in a PEBB medical plan as designated by the director or designee. The new medical plan coverage will begin the first day of the month following the date the MA or MA-PD plan is terminated.

(5) A subscriber enrolled in a health plan as described in subsection (1) (c) (~~(or (2) (e))~~), (2) (b), (3) (b), or (4) of this section may not change health plans except as allowed in WAC 182-08-198.

AMENDATORY SECTION (Amending WSR 22-13-158, filed 6/21/22, effective 1/1/23)

WAC 182-08-198 When may a subscriber change health plans? A subscriber may change health plans at the following times:

(1) **During the annual open enrollment:** A subscriber may change health plans during the public employees benefits board (PEBB) annual open enrollment period. A subscriber must submit the required enrollment forms to change their health plan. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. The required enrollment forms must be received no later than the last day of the annual open enrollment. Enrollment in the new health plan will begin January 1st of the following year.

(2) **During a special open enrollment:** A subscriber may revoke their health plan election and make a new election outside of the annual open enrollment if a special open enrollment event occurs. A special open enrollment event must be an event other than an employee gaining initial eligibility for PEBB benefits as described in WAC

182-12-114 or regaining eligibility for PEBB benefits as described in WAC 182-08-197. The change in enrollment must be allowable under Internal Revenue Code and Treasury regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, the subscriber's dependent, or both.

A subscriber may not change their health plan during a special open enrollment if their state registered domestic partner or state registered domestic partner's child is not a tax dependent. A subscriber may change their health plan as described in subsection (1) of this section.

To disenroll from a medicare advantage (MA) plan or medicare advantage-prescription drug (MA-PD) plan, the change in enrollment must be allowable under 42 C.F.R. Secs. 422.62(b) and 423.38(c). To make a health plan change, a subscriber must submit the required enrollment forms (and a completed disenrollment form, if required). The forms must be received no later than 60 days after the event occurs, except as described in (i) of this subsection. An employee submits the enrollment forms to their employing agency. Any other subscriber submits the enrollment forms to the PEBB program. In addition to the required forms, a subscriber must provide evidence of the event that created the special open enrollment. New health plan coverage will begin the first day of the month following the later of the event date or the date the form is received. If that day is the first of the month, the change in enrollment begins on that day except for a MA or MA-PD plan which will begin the first day of the month following the date the form is received.

Exception: When a subscriber or their dependent is enrolled in a (~~medicare advantage or medicare advantage-prescription drug~~) MA or MA-PD plan, they may disenroll during a special enrollment period as allowed under 42 C.F.R. Secs. 422.62(b) and 423.38(c). The new medical plan coverage will begin the first day of the month following the date the medicare advantage plan disenrollment form is received.

If the special open enrollment is due to the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption of a child, health plan coverage will begin the month in which the birth, adoption, or assumption of legal obligation for total or partial support in anticipation of adoption occurs. If the special open enrollment is due to the enrollment of an extended dependent or a dependent with a disability, the change in health plan coverage will begin the first day of the month following the later of the event date or eligibility certification. Any one of the following events may create a special open enrollment:

(a) Subscriber acquires a new dependent due to:

(i) Marriage or registering a state registered domestic partnership;

(ii) Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or

(iii) A child becoming eligible as an extended dependent through legal custody or legal guardianship.

((Note: ~~A subscriber may not change their health plan if their state registered domestic partner or state registered domestic partner's child is not a tax dependent.~~))

(b) Subscriber or a subscriber's dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);

(c) Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;

(d) The subscriber's dependent has a change in their own employment status that affects their eligibility or their dependent's eligibility for the employer contribution under their employer-based group health plan;

Note: As used in (d) of this subsection, "employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R. 54.9801-6.

(e) Subscriber or a subscriber's dependent has a change in residence that affects health plan availability.

(i) If the subscriber ((moves)) has a change in residence and the subscriber's current ((health)) medical plan is ((not)) no longer available ((in the new location)), the subscriber must select a new ((health)) medical plan((, otherwise there will be limited accessibility to network providers and covered services)) as described in WAC 182-08-196(3);

(ii) If the subscriber or the subscriber's dependent has a change in residence and the subscriber's current dental plan does not have available providers within 50 miles of the subscriber or the subscriber's dependent's new residence, the subscriber may select a new dental plan;

(Exception: A dental plan is considered available if a provider is located within 50 miles of the subscriber's new residence.))

(f) A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state registered domestic partner is not an eligible dependent);

(g) Subscriber or a subscriber's dependent enrolls in coverage under medicaid or a state children's health insurance program (CHIP), or the subscriber or a subscriber's dependent loses eligibility for coverage under medicaid or CHIP;

(h) Subscriber or a subscriber's dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from medicaid or CHIP;

(i) Subscriber or a subscriber's dependent enrolls in coverage under medicare, or the subscriber or a subscriber's dependent loses eligibility for coverage under medicare, or enrolls in or terminates enrollment in a medicare advantage-prescription drug or a Part D plan. If the subscriber's current medical plan becomes unavailable due to the subscriber's or a subscriber's dependent's enrollment in medicare, the subscriber must select a new medical plan as described in WAC 182-08-196(2).

(i) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has six months from the date of their or their dependent's enrollment in medicare Part B to enroll in a PEBB medicare supplement plan for which they or their dependent is eligible. The forms must be received by the PEBB program no later than six months after the enrollment in medicare Part B for either the subscriber or the subscriber's dependent;

(ii) A subscriber enrolled in PEBB retiree insurance coverage or an eligible subscriber enrolled in Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage has seven months to enroll in a medicare advantage or medicare advantage-prescription drug plan that begins three months before they or their dependent first enrolled in both medicare Part A and Part B and ends three months after the month of medicare eligibility. A subscriber may also enroll themselves or their dependent in a medicare advantage or medicare advantage-prescription drug plan before their last day of the medicare Part B ini-

tial enrollment period. The forms must be received by the PEBB program no later than the last day of the month prior to the month the subscriber or the subscriber's dependent enrolls in the medicare advantage or medicare advantage-prescription drug plan.

(j) Subscriber or a subscriber's dependent's current medical plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA). The authority may require evidence that the subscriber or subscriber's dependent is no longer eligible for an HSA;

(k) Subscriber or a subscriber's dependent experiences a disruption of care for active and ongoing treatment, that could function as a reduction in benefits for the subscriber or the subscriber's dependent. A subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB program determines that a continuity of care issue exists. The PEBB program will consider but not limit its consideration to the following:

(i) Active cancer treatment such as chemotherapy or radiation therapy;

(ii) Treatment following a recent organ transplant;

(iii) A scheduled surgery;

(iv) Recent major surgery still within the postoperative period;

or

(v) Treatment for a high-risk pregnancy;

(1) The PEBB program determines that there has been a substantial decrease in the providers available under a PEBB medical plan.

(3) If the employee is having premiums taken from payroll on a pretax basis, a medical plan change will not be approved if it would conflict with provisions of the salary reduction plan authorized under RCW 41.05.300.