PROPOSED RULE MAKING

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

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FILED

DATE: October 31, 2023
TIME: 10:32 AM

WSR 23-22-106

Agency: Health Care Authority

☒ **Original Notice**

☐ **Supplemental Notice to WSR _____**

☐ **Continuance of WSR _____**

☒ **Preproposal Statement of Inquiry was filed as WSR** 23-07-109 **; 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) 182-558-0020 Definitions, 182-558-0030 Overview of eligibility, 182-558-0060, PPP for a client with a qualified employer-sponsored group health insurance plan, 182-558-0070 Program monitoring, 182-558-0080 Administrative hearings

Hearing location(s):

Date:	**Time:**	**Location:** (be specific)	**Comment:**
December 5, 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_3tyz-7OOQNW4WTLeVvp-jA 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: December 6, 2023 (Note: This is **NOT** the **effective** date)

Submit written comments to:	**Assistance for persons with disabilities:**
Name: HCA Rules Coordinator	Contact Johanna Larson
Address: PO Box 42716, Olympia WA 98504-2716	Phone: 360-725-1349
Email: arc@hca.wa.gov	Fax: 360-586-9727
Fax: 360-586-9727	TTY: Telecommunication Relay Services (TRS): 711
Other:	Email: Johanna.larson@hca.wa.gov
By (date) December 5, 2023, by 11:59 PM	Other:
	By (date) November 22, 2023

Purpose of the proposal and its anticipated effects, including any changes in existing rules: The agency is revising the Premium Payment Program (PPP) rules to: a) update eligibility requirements for clients enrolled in individual health plans; and b) clarify when and how the agency recovers overpayments from PPP clients.

The amended rules:

- Allow clients with individual health plans through the Washington Health Benefit Exchange (HBE) to enroll in the PPP.
- Require clients enrolled in an individual health plan purchased through the Washington Health Benefit Exchange (HBE) who are eligible for the PPP to undergo an eligibility telephone consultation within 30 days of submitting a completed application.
- Limit PPP enrollment to clients with employer-sponsored insurance (ESI) or individual health plans purchased through the Washington HBE; clients purchasing individual health plans outside of the Washington HBE are not eligible for PPP.

- Update and clarify exceptions to the comprehensive health insurance requirement for clients enrolled in the PPP if the client meets certain criteria.
- Describe the documentation required for payment of a comprehensive health insurance premium that is more than the average cost per user and describe the approval process.
- Clarify actions HCA may take if a PPP client has been identified as being encouraged into PPP enrollment for the purpose of maximizing revenue.
- Clarify situations in which the agency may adjust the premium reimbursement if the client's premiums or Medicaid eligibility have changed. The agency may also recover an overpayment for a retroactive disenrollment from a health plan.
- Remove language that would have grandfathered certain PPP clients.

Reasons supporting proposal: See purpose above

Statutory authority for adoption: RCW 41.05.021, 41.05.160

Statute being implemented: RCW 41.05.021, 41.05.160

Is rule necessary because of a:

Federal Law?	☐ Yes	☒ No
Federal Court Decision?	☐ Yes	☒ No
State Court Decision?	☐ Yes	☒ 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:	Melinda Froud	PO Box 42716, Olympia, WA 98504-2716	360-725-1408
Implementation:	Michaela Snook	PO Box 45518, Olympia, WA 98504-5518	360-725-1486
Enforcement:	Michaela Snook	PO Box 45518, Olympia, WA 98504-5518	360-725-1486

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)(c) (Incorporation by reference)
- ☐ RCW 34.05.310 (4)(d) (Correct or clarify language)
- ☐ RCW 34.05.310 (4)(e) (Dictated by statute)
- ☐ RCW 34.05.310 (4)(f) (Set or adjust fees)
- ☐ 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.*

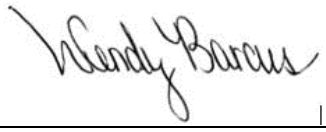
If any portion of the proposed rule is **not exempt**, does it impose more-than-minor costs (as defined by RCW 19.85.020(2)) on businesses?

☒ No Briefly summarize the agency's minor cost analysis and how the agency determined the proposed rule did not impose more-than-minor costs. This rule does not impose more than minor costs 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: October 31, 2023	**Signature:** 
Name: Wendy Barcus	
Title: HCA Rules Coordinator	

AMENDATORY SECTION (Amending WSR 19-11-129, filed 5/22/19, effective 6/22/19)

WAC 182-558-0020 Definitions. The following definitions, and those definitions found in chapter 182-500 WAC, apply to this chapter.

"Average cost per user" means the average medicaid expenditure for a person of the same age, sex, and eligibility type as the applicant, per fiscal year, as calculated by the agency.

"Comprehensive" means coverage comparable to the services offered under the agency's medicaid state plan that provides at least the following: Physician-related services, inpatient hospital services, outpatient hospital services, prescription drugs, immunizations, and laboratory and X-ray costs.

"Cost-effective" means it would cost less for the agency to pay premium assistance than not to pay premium assistance. The agency determines cost-effectiveness by comparing the anticipated cost of premiums, cost-sharing, and administrative costs to:

(a) The average cost per user; or

(b) The medicaid expenditures to be incurred if the client does not receive the premium assistance, based on the client's documented medical condition.

"Employer-sponsored group health insurance" means a comprehensive group health plan provided through an employer or other entity, for which the employer or entity pays some portion of the cost. Group health plans must cover all applicants whose employment qualifies them for coverage and cannot increase the cost for an applicant with a preexisting condition.

"Flexible health spending arrangement" means the portion of an employee's wages set aside in an account to pay for qualified expenses such as medical or child care costs.

"Health savings account" means a medical savings account available to employees enrolled in a high-deductible health insurance plan.

"High-deductible health insurance plan" means coverage that meets the definition in Section 223(c)(2) of the Internal Revenue Code.

"Individual health insurance plan" means any plan sold on the individual market, as defined by RCW 48.43.005.

"Overpayment" has the same definition for purposes of this chapter as that term is defined in RCW 41.05A.010.

"Premium tax credit" has the same definition for purposes of this chapter as defined in 26 C.F.R. 1.36B-1 through 1.36B-5.

"Qualified employer-sponsored group health insurance" means a comprehensive group health plan provided through an employer that is offered in a nondiscriminatory manner under 26 U.S.C. Sec. 105(h)(3), and for which the employer subsidizes at least forty percent of the cost of the premium.

AMENDATORY SECTION (Amending WSR 19-11-129, filed 5/22/19, effective 6/22/19)

WAC 182-558-0030 Overview of eligibility. (1) **Eligibility.** To be eligible for the premium payment program (PPP):

(a) A member of the client's medical assistance unit, as described in chapter 182-506 WAC, must be receiving benefits under the medicaid agency's:

(i) Alternative benefits plan coverage;

(ii) Categorically needy coverage; or

(iii) Medically needy coverage.

(b) The client must provide the medicaid agency with proof of:

(i) Enrollment in a comprehensive individual or comprehensive employer-sponsored health insurance plan;

(ii) A Social Security Number or tax identification number for the policy holder; and

(iii) Premium expenditures.

(c) A client enrolled in a qualified individual health insurance plan purchased through the Washington health benefit exchange must complete an eligibility telephone consultation with the medicaid agency within 30 calendar days of submitting a completed application.

(i) The telephone consultation must occur between the agency and the client, or the client's legal representative, or both.

(A) Within seven business days of receipt of the client's completed application, the agency attempts to schedule the consultation with the client by telephone. If the client is not reached within two business days from the first attempt, the agency attempts to reach the client in the manner in which the application was received (i.e., mail or email).

(B) The client must schedule their telephone consultation by responding to the agency by telephone or email within 10 business days of the agency's outreach.

(C) Upon completion of the telephone consultation, premium payment enrollment begins as outlined in subsection (7) of this section.

(ii) The agency may deny the client's application if the client fails to timely complete their telephone consultation.

(d) If the agency suspects that a client has been encouraged by any entity into enrollment in the premium payment program for the purpose of maximizing the revenue of a provider or a health plan, the agency immediately informs the client of their right to disenroll from the program. The agency may take other legal actions, as appropriate, which could result in the exclusion of a provider from the medicaid program under chapter 182-502 WAC.

(2) **Comprehensive health insurance plans.** A comprehensive health insurance plan includes:

(a) An individual health insurance plan purchased from the Washington health benefit exchange, also known as a qualified health plan (QHP);

(b) An employer-sponsored group health insurance plan; or

(c) A qualified employer-sponsored group health insurance plan.

(3) **Comprehensive health insurance plan exclusions.** A comprehensive health insurance plan does not include:

(a) A health savings account ((~~or~~)), flexible health spending arrangement, or other surcharge deductions (i.e., tobacco and spousal deductions);

(b) A high-deductible plan;

(c) A high-risk plan, including a Washington state health insurance pool (WSHIP) plan;

(d) A ((~~limited or supplemental plan, including a medicare supplemental plan~~)) medicare advantage or supplemental plan, including medicare Part C;

(e) ((~~A medicare advantage plan (medicare Part C);~~

~~(f) A qualified health plan (QHP)~~)) A QHP purchased through the Washington health benefit exchange with a premium tax credit; ((~~or~~

~~(g)~~)) (f) A plan that is the legal obligation of a noncustodial parent, or any other liable party under RCW 74.09.185; or

(g) Any individual health insurance plan that was not purchased through the Washington health benefit exchange.

(4) **Exceptions to comprehensive health insurance plan requirement:**

(a) The agency allows an exception to the comprehensive health insurance requirement for clients enrolled in the PPP based on a plan as described in subsection (3)((~~(c),~~)) (d)((~~,~~)) and (e) of this section when the client:

(i) Has been enrolled in the same plan continuously since January 1, 2012;

(ii) Was approved for and continuously enrolled in the PPP since January 1, 2012; and

(iii) Remained eligible for a medicaid program identified in subsection (1)(a) of this section continuously since January 1, 2012.

(b) If a client's medicaid eligibility for a program identified in subsection (1)(a) of this section or their enrollment in their health plan changes or terminates, the exception to the comprehensive health insurance requirement terminates.

(5) **Cost-effective comprehensive health insurance plan.** A comprehensive health insurance plan must be cost-effective as defined in WAC 182-558-0020.

(6) **Comprehensive health insurance premium above average cost.**

(a) If the agency determines that a client's comprehensive health insurance premium is more than the average cost per user, the ((~~client must provide the agency proof from the client's provider(s):~~

~~(a) Of an existing medical condition that requires or will be requiring extensive medical care; and~~

~~(b) That the cost of the medicaid expenditures would be greater if the agency does not pay premium assistance.~~)) agency pays a greater amount for a medicaid client on the health insurance plan if the following criteria are met:

(i) The client must provide the following completed information to the agency:

(A) A written request that the agency pay a greater amount than the average cost per user for a medicaid client on the health insurance plan.

(I) The client must currently have a medical condition or conditions requiring ongoing medical care.

(II) The request must include the cost of the premium for each member on the comprehensive health insurance.

(B) Written documentation from the client's provider of a medical condition or conditions that require ongoing medical care. (For example, a client's providers could submit treatment plans, medication or durable medical equipment lists, or other documentation.)

(ii) The agency reviews the submitted documentation and determines that the cost of the greater premium is less than the cost of covering the client under medicaid.

(A) The agency's clinical staff reviews the written documentation from the client's providers to determine if the client has a medical condition or conditions requiring ongoing medical care.

(B) The agency notifies the client within 60 days of the initial request if additional documentation is required.

(b) The agency notifies the client in writing of the approval or denial of the client's request within 90 calendar days from the date the agency received:

(i) All requested information from the client; or

(ii) The client's written request.

(c) The agency may deny the request if the client fails to submit all requested information in (a)(i) of this subsection within 90 calendar days of the client's request or fails to participate in consultation as required in subsection (1)(c) of this section.

(d) The agency determines the updated premium amount based on the client's portion of the total premium using the information submitted by the client under (a)(i) of this subsection.

(e) If approved, the effective date of the increased premium amount is the date the client submitted the written request to the agency.

(7) **Premium limit.** The agency pays no more than one premium per client, per month. PPP enrollment begins no sooner than the date on which:

(a) A client is approved for a medicaid program identified in subsection (1)(a) of this section;

(b) The agency receives and accepts the completed Application for HCA Premium Payment Program (HCA 13-705) form; ((~~and~~))

(c) A client's apple health managed care enrollment, if applicable, ends; and

(d) A client completes the telephone eligibility phone consultation, if applicable under subsection (1)(c) of this section.

(8) **Integrated managed care exemption.** A client enrolled in the PPP is exempt from ((~~mandatory~~)) integrated managed care under chapter 182-538 ((~~and 182-538A~~)) WAC.

(9) **Premium assistance subsidy.** The agency's premium assistance subsidy may not exceed the minimum amount required to maintain comprehensive health insurance for the medicaid-eligible client.

(10) **Proof of premium expenditures.** Proof of premium expenditures must be submitted to the agency by the client or the client's representative no later than the end of the third month following the last month of coverage.

(11) **Cost-sharing benefit limitations.** The agency's cost-sharing benefit for copays, coinsurance, and deductibles is limited to services covered under the medicaid state plan.

(12) **Proof of cost-sharing required.** Proof of cost-sharing must be submitted to the agency no later than the end of the sixth month following the date of service.

(13) **Client eligibility review.**

(a) The agency ((~~may~~)) reviews a client's eligibility annually for the PPP ((~~at any time including, but not limited to,~~)) or when the client's:

((~~(a)~~)) (i) Health insurance plan has an annual open enrollment;

((~~(b)~~)) (ii) Medicaid eligibility for a program identified in subsection (1)(a) of this section changes or ends;

((~~(c)~~)) (iii) Medical assistance unit changes;

((~~(d)~~)) (iv) Premium changes; or

((~~(e)~~)) (v) Private health insurance coverage changes or ends.

(b) If the agency finds that the client's premiums or medicaid eligibility have changed, the agency may adjust the premium reimbursement or terminate eligibility for the PPP. The agency notifies the client of any changes in PPP eligibility under this subsection.

AMENDATORY SECTION (Amending WSR 19-11-129, filed 5/22/19, effective 6/22/19)

WAC 182-558-0060 PPP for a client with a qualified employer-sponsored group health insurance plan. (1) **General rule.** Under section 1906A of the Social Security Act, the agency pays an eligible person's premium assistance subsidy and other cost-sharing obligations when the agency determines it is cost-effective as defined in WAC 182-558-0020.

(2) **Eligible persons.** An eligible person is:

(a) A client under age nineteen who is:

(i) Covered under a qualified employer-sponsored group health insurance plan as defined in WAC 182-558-0020;

(ii) Receiving benefits under:

(A) Alternative benefits plan coverage;

(B) Categorically needy coverage; or

(C) Medically needy coverage.

(b) The parent of the client in (a) of this subsection, if:

(i) Enrollment in the health plan depends on a parent's enrollment; and

(ii) The client is a dependent of the parents.

(3) **Cost-sharing benefit.** The premium payment ((~~plan~~)) program (PPP) may provide cost-sharing reimbursement to nonmedicaid-eligible parents for medicaid-covered services under this section.

AMENDATORY SECTION (Amending WSR 17-03-014, filed 1/5/17, effective 3/1/17)

WAC 182-558-0070 Program monitoring. (1) The agency monitors payments under the premium payment program.

(2) Under ((~~chapter 41.05A~~)) RCW 41.05A.110, the agency may recover any over-payment of a premium assistance subsidy or cost-sharing amount((~~, whether due to an~~)). Events that may cause an overpayment for purposes of this section include agency administrative error, ((~~or~~)) client error ((~~or~~)), misrepresentation, or retroactive disenrollment from a health plan.

AMENDATORY SECTION (Amending WSR 17-03-014, filed 1/5/17, effective 3/1/17)

WAC 182-558-0080 Administrative hearings. A client may request an administrative hearing under ((~~RCW 41.05A.110, 74.09.741, and~~)) chapter 182-526 WAC if the client does not agree with an agency decision regarding eligibility for the premium payment program, the amount of a premium assistance subsidy, or an overpayment of a premium assistance subsidy.