RULE-MAKING ORDER
(RCW 34.05.360)

CR-103 (10/1/89)

Agency: Washington Basic Health Plan

☒ Permanent Rule
☐ Emergency Rule

(1) Date of adoption: 10-24-89

(2) Purpose: To change the requirement for submittal of documentation to verify income at recertification from six months worth to one months worth to make recertification consistent with the plan's application process.

(3) Citation of existing rules affected by this order:
Repealed:
Amended: 55-01
Suspended:

(4) Authority for adoption:
Statute: 70.47.050
Other Authority:

(5.1) **PERMANENT RULE ONLY**

Pursuant to notice filed as WSR ~~89-16-021~~ 89-19-018 on 9-11-89 (date).

Describe any changes other than editing from proposed to adopted version:

(5.2) **EMERGENCY RULE ONLY**

Pursuant to RCW 34.05.350 the agency for good cause finds:

☐ (a) 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.

☐ (b) 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:

(5.3) Any other findings required by other provisions of law as precondition to adoption or effectiveness of rule?
☐ Yes ☒ No If yes, explain:

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STATE OF WASHINGTON
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OCT 2 4 1989

(6) Effective date of rule:

Permanent Rules	Emergency Rules
☒ 31 days after filing	☐ Immediately
☐ Other (specify) _____ *	☐ Later (specify) _____

*(If less than 31 days after filing, specific finding in 5.3 under RCW 34.05.380(3) is required)

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STATE OF WASHINGTON
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OCT 24 1989

TIME: 11:21 AM PM
WSR 89-22-014

NAME (TYPE OR PRINT)
Thomas L. Kobler

SIGNATURE
Thomas L. Kobler

TITLE
Director

DATE 10-24-89

AMENDATORY SECTION (Amending Order 89-002, filed May 17, 1989)

WAC 55-01-050 ENROLLMENT IN THE PLAN. (1) Any individual applying for enrollment in the plan must complete and submit the plan's application for enrollment. Applications for enrollment of children under the age of eighteen must be signed by the child's parent or legal guardian, who shall also be held responsible by the plan for payment of premiums due on behalf of the child.

(2) Each applicant shall complete and sign the application for enrollment, listing family members to be enrolled and supplying such other information as required by the plan. (a) Documentation will be required, showing the amount and sources of applicants' income for the most recent complete calendar month as of the date of application. Applicants will also be required to submit a copy of their most recent federal income tax form. Income documentation shall be required for all income-earning family members, including those not applying for enrollment, except for family members who reside in another household and whose income is not available to the family seeking enrollment, and dependent children. (b) Documentation of residence shall also be required, displaying the applicant's name and address. (c) The plan may request additional information from applicants for purposes of establishing or verifying eligibility, premium responsibility or managed health care system selection. (d) Submission of incomplete or inaccurate information may delay or prevent an applicant's enrollment in the plan. Intentional submission of false information may result in disenrollment of the applicant and all enrolled family members, retroactive to the date upon which coverage began.

(3) Each family applying for enrollment must designate a participating managed health care system from which all enrolled family members will receive covered services. All applicants from the same family must receive covered services from the same managed health care system. No applicant will be enrolled for whom designation of a participating managed health care system has not been made as part of the application for enrollment. The administrator will establish procedures for the selection of managed health care systems, which will include conditions under which an enrollee may change from one managed health care system to another. Such procedures will allow enrollees to change from one managed health care system to another during open enrollment, or otherwise upon showing of good cause for the transfer.

(4) Except as provided in WAC 55-01-040(2), applications for enrollment will be reviewed by the plan 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.

(5) Eligible applicants will be enrolled in the plan in the order in which their completed applications, including all required documentation, have been received by the plan, provided that the applicant also remits full payment of the first premium bill to the plan by the due date specified by the plan.

(6) Not all family members are required to apply for enrollment in the plan; 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 dependent until the next open enrollment period available to that family member. Eligible newborn and newly adopted children may be enrolled effective from the date of birth or physical placement with the adoptive parents for adoption, provided that application for enrollment is submitted to the plan within sixty days of the date of birth or such placement for adoption. A newly acquired spouse of an enrollee may apply for enrollment within thirty days of the date of marriage and, if found eligible by the plan, will be enrolled on the first of a month following completion of the enrollment process by the plan, provided that the

addition of the spouse does not otherwise render the family ineligible for coverage by the plan.

(7) Any enrollee who disenrolls from the plan for reasons other than (a) ineligibility due to an increase in gross family income or (b) coverage by another health care benefits program may not re-enroll in the plan for a period of twelve months from the effective date of disenrollment. An enrollee who disenrolls because of ineligibility due to an increase in gross family income may re-enroll in the event that gross family income subsequently falls to a level which qualifies the enrollee for eligibility. An enrollee who disenrolls because of coverage by another health care benefits program may re-enroll in the event that the enrollee becomes ineligible for such other coverage, provided that the enrollee has been continuously covered since the date of disenrollment from the plan, and provides documentation of such continuous coverage to the plan. Before any person shall be re-enrolled in the plan, that person must complete a new application for enrollment and must be determined by the plan to be otherwise eligible for enrollment as of the date of application.

(8) Once every six months, the plan will request verification of information from enrollees ("recertification"), which may include a request to complete a new application form and submit required documentation. At recertification, enrollees will be required to report their ((~~monthly~~)) gross family income for the ((~~preceeding six~~)) most recent complete calendar month((s)) as of the recertification date specified by the plan, and to provide the same documentation of such income as required of applicants. The plan may request information more frequently from an enrollee for the purpose of verifying eligibility if the plan has good cause to believe that the enrollee's income, residence, family size or other eligibility criteria may have changed since the date on which information was last received by the plan. Enrollees shall be given at least twenty days from the date of any such information request to respond to the request. Failure to respond within the time designated in any information request shall result in a second request from the plan. Failure to respond within the time designated in any second request for information may result in disenrollment of the enrollee. Each enrollee is responsible for notifying the plan within thirty days of nay changes which could affect the enrollee's eligibility or premium responsibility.