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: June 30, 1992

(2) Purpose:

Rule is designed to carry out the purposes of Chapter 70.47 RCW, the Health Care Access Act.

(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Repealed: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 92-09-157 on April 22, 1992 (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:

(6) Effective date of rule:

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

Emergency Rules
☐ Immediately
☐ Later (specify) _____

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

NAME (TYPE OR PRINT)
Gary L. Christenson

SIGNATURE

TITLE
Director

DATE
6/30/92

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED

JUN 30 1992

TIME 11:52 AM

WSR 92-14-088

AMENDATORY SECTION (Amending Order 89-002, filed 5/17/89)

WAC 55-01-010 DEFINITIONS. The following definitions apply throughout these rules.

(1) "Administrator" means the Washington basic health plan administrator.

(2) "Certificate of coverage" means a written document issued by the plan to a subscriber which describes the covered services, premiums, grievance procedures and other rights and responsibilities of enrollees. The certificate of coverage issued to a subscriber shall pertain to the subscriber and family dependents.

(3) "Copayment" means a payment indicated in the schedule of benefits which is made by an enrollee to a managed health care system or health care provider, or to the plan, when specifically instructed to do so by the plan, for covered services provided to the enrollee.

(4) "Covered services" means those services and benefits to which an enrollee is entitled, under the certificate of coverage issued by the plan to the enrollee (or to a subscriber on behalf of the enrollee), in exchange for payment of premium and applicable copayments.

(5) "Dependent child" means an individual's unmarried natural child, stepchild, or legally adopted child, who is either (a) younger than age nineteen, or (b) younger than age twenty-three and (i) is a full-time student at an educational organization which normally maintains a regular faculty and curriculum and normally has a regularly enrolled body of pupils or students in attendance at the place where its educational activities are regularly carried on, or (ii) is pursuing a full-time course of institutional on-farm training under the supervision of an educational organization described in WAC 55-01-010 (5)(b)(i).

(6) "Effective date of enrollment" means the first date, as established by the plan, on which an enrollee is entitled to receive covered services from the enrollee's respective participating managed health care system.

(7) "Enrollee" means a person who meets all eligibility requirements, who is enrolled in the plan, and for whom applicable premium payments have been made.

(8) "Family" means an individual or an individual and the individual's spouse, if not legally separated, and the individual's dependent children. For purposes of eligibility determination and enrollment in the plan, an individual cannot be a member of more than one family.

(9) "Family dependent" means a subscriber's legal spouse, if not legally separated, or the subscriber's dependent child, who meets all eligibility requirements, is enrolled in the plan, and for whom the applicable premium has been paid.

(10) "Grievance procedure" means the formal process for resolution of problems or concerns raised by enrollees which cannot be resolved in an informal manner to the enrollee's satisfaction. "Grievance" means a problem or concern presented for resolution through a grievance procedure.

(11) "Gross family income" means the total income of all members of an enrollee's family, regardless of whether those family members enroll in the plan. (a) For purposes of this definition, for applications for enrollment which are received by the plan on or before March 31, 1989, "income" includes but is not limited to wages and salaries, net income from rentals or self-employment, tips, interest income, dividends, royalties, public or private pensions, and Social Security benefits. (b) For purposes of this definition, for applications for enrollment which are received by the plan on or after April 1, 1989 and for premium payments which are made for coverage on or after June 1, 1989, "income" means total cash receipts before taxes from all sources, with the exceptions noted below. (i) Income includes money wages and salaries before any deductions; net receipts from nonfarm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses); 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); regular payments from Social Security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance (including aid to families with dependent children, supplemental security income, emergency assistance money payments, and non-federally-funded general assistance or general relief money payments), and training stipends; alimony, child support, and military family allotments or other regular support from an absent family member or someone not living in the household; private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments; college or university scholarships, grants, fellowships and assistantships, if received as or convertible by the recipient into cash; and dividends, interest, net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings. (ii) Income does not include the following types of money received: Capital gains; any assets drawn down as withdrawals from a bank, the sale of property, a house or a car; tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury (except workers' compensation). Also excluded are noncash benefits, 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, and such federal noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance. (c) "Income" shall not include income earned by dependent children, nor shall it include income of a family member who resides in another household when such income is not available to those family members seeking enrollment in the plan. (d) In the event that an item of income is received periodically, but less frequently than once per month, the latest amount received will be divided by the number of months in the period (i.e., between payments) in order to calculate an average amount per month. That monthly average will be combined with other monthly items of income to derive a monthly total, which will be used in the calculation of income as a percentage of federal poverty level. (For example, if an applicant receives quarterly interest payments in January, April, July, and October, and applies for coverage by the plan in September, the July payment will be divided by three to obtain a monthly income amount.)

(12) "Managed health care system" (or "MHCS") means any health care organization, including health care providers, insurers, health care service contractors, health maintenance organizations, or any combination thereof, that provides directly or by contract basic health care services, as defined by the administrator and rendered by duly licensed providers, on a prepaid capitated basis to a defined patient population enrolled in the plan and in the managed health care system.

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

(14) "Open enrollment" means a time period designated by the administrator during which enrollees may apply to transfer their membership from one participating managed health care system to another. There shall be at least one open enrollment period of at least twenty consecutive days, at least once annually, in each site served by the plan.

(15) "Participating," when referring to a managed health care system, means one that has entered into a contract with the plan to provide covered services to enrollees. When referring to a health care provider, "participating" means one who is employed by or has entered into a contract with a participating managed health care system to provide covered services to enrollees.

(16) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which a subscriber makes

to the plan on behalf of the subscriber and family dependents in consideration for enrollment in the plan.

(17) "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.

(18) "Rate" means the per capita amount, negotiated by the administrator with and paid to a participating managed health care system, that is based upon the enrollment of enrollees in the plan and in that MHCS.

(19) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which enrollees shall be entitled to receive from participating managed health care systems.

(20) "Service area" means the geographic area served by a participating managed health care system as defined in its contract with the plan.

(21) "Site" means a geographic area designated by the plan in which one or more participating managed health care systems are offered to enrollees for selection.

(22) "Subscriber" means an enrollee, or the parent or legal guardian of an enrolled dependent child, who has been designated by the plan as the individual to whom the plan and the managed health care system will issue all notices, information requests and premium bills on behalf of all enrolled family members. For purposes of chapter 55-01 WAC, notice to a subscriber shall be considered notice to all enrolled members of the subscriber's family as well.

(23) "Subsidy" means the difference between the rate paid by the administrator ~~((, from funds appropriated from the basic health plan trust account,))~~ to a managed health care system on behalf of an enrollee and the enrollee's premium responsibility.

(24) "Washington basic health plan" or "plan" means the system of enrollment and payment on a prepaid capitated basis for basic health care services, administered by the plan administrator through participating managed health care systems, created by chapter 70.47 RCW.

AMENDATORY SECTION (Amending Order 89-001, filed 2/16/89)

WAC 55-01-030 PREMIUMS AND COPAYMENTS. (1) Each subscriber shall be responsible for paying a monthly premium to the plan, on behalf of the subscriber and all family dependents, according to a premium schedule to be provided by the plan at the time the subscriber is enrolled by the plan. The amount of premium payable by any subscriber will be based upon the subscriber's gross family income and rates payable to participating managed health care systems, and may vary with the number and ages of individuals enrolled from a given family. A third party may, with the approval of the administrator and through a mechanism acceptable to the administrator, pay the premium on behalf of any enrollee. Premium amounts payable shall be a monthly dollar payment or a percentage of the total rate payable by the plan. ~~((A description of the premium schedule and an estimate of amounts due will accompany the benefits description and application for enrollment provided to applicants.))~~ A statement of the monthly amount due will be mailed to the subscriber upon determination of eligibility for the plan.

(2) Based on the information provided by an enrollee on the application for enrollment, and any other information obtained by the plan, the enrollee will be informed of the premium amount due. The plan will notify subscribers in writing of any revisions to the premium schedule or to the premium amounts payable to the plan, such notice to be mailed at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect, except that retroactive enrollment of a newborn or newly

adopted child (as provided in WAC 55-01-050(6)) may result in a corresponding retroactive increase in premium payable to the plan. For purposes of this provision, notice shall be deemed complete upon depositing the written revisions in the United States mail, first class postage paid, directed to the enrollee at the enrollee's last mailing address on file with the plan.

(3) Once the plan has determined that a subscriber and members of the subscriber's family (if any) are eligible for enrollment, the plan will bill the subscriber for the family's first month's premium. The subscriber and family members will not be eligible to receive covered services on the effective date of enrollment specified by the plan unless the premium bill is paid in full by the due date specified on the bill. Thereafter, the plan will bill each subscriber monthly, and the subscriber shall be responsible for payment of the billed amount in full by the date specified on the bill.

(4) Premium bills must be paid in full by the date specified on the bill. Payment may be made in person at the plan's administrative office in Olympia, Washington, or by mail to the address specified on the bill. If the plan does not receive payment in full of a premium bill by 5:00 p.m. on the date specified on the bill, the plan shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with the plan, requiring payment in full by a date not less than ten days from the date of the notice. If full payment is not received by the date specified in the delinquency notice, the subscriber and enrolled family members will be disenrolled effective the first day of the month following the last month for which full premium payment was received by the plan. Partial payment of premiums due will be regarded as nonpayment. The plan may disenroll a subscriber and enrolled family members in the event that the subscriber receives more than two delinquency notices in a twelve-month period.

(5) Enrollees shall be responsible for paying any required copayment directly to the provider of a covered service, unless the enrollee has been instructed by his or her managed health care system or the plan to make payment to another party. Copayments must be paid in full by the enrollee at the time of service. Failure to pay a required copayment in full at the time of service may result in the denial or rescheduling of that service by the managed health care system. Repeated failure to pay copayments in full on a timely basis may result in disenrollment, as provided in WAC 55-01-060(2).