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, 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 medicare advantage or supplemental plan, including medicare Part C;

(e) A QHP purchased through the Washington health benefit exchange with a premium tax credit;

(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) (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 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;

(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 integrated managed care under chapter 182-538 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 reviews a client's eligibility annually for the PPP or when the client's:

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

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

(iii) Medical assistance unit changes;

(iv) Premium changes; or

(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.

[Statutory Authority: RCW 41.05.021 and 41.05.160. WSR 24-02-019, § 182-558-0030, filed 12/21/23, effective 3/1/24; WSR 19-11-129, § 182-558-0030, filed 5/22/19, effective 6/22/19; WSR 17-03-014, § 182-558-0030, filed 1/5/17, effective 3/1/17.]