RULE-MAKING ORDER
(RCW 34.05.360)

CR-103 (10/1/89)

☒ Permanent Rule
☐ Emergency Rule

Agency: Washington Basic Health Plan

(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Repealed: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: 55-01-020, 55-01-050, and 55-01-060
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	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)

NAME (TYPE OR PRINT)
Gary L. Christenson

SIGNATURE
Gary L. Christenson

TITLE
Director

DATE
6/30/92

CODE REVISER USE ONLY

CODE REVISER'S OFFICE
STATE OF WASHINGTON
FILED

JUN 30 1992

TIME 3:41 AM PM

WSR 92-14-097

AMENDATORY SECTION (Amending Order 88-001, filed 12/2/88)

WAC 55-01-020 SCHEDULE OF BENEFITS. (1) The administrator shall design and from time to time may revise a schedule of benefits which shall include such physician services, inpatient and outpatient hospital services, proven preventive and primary care services, all services necessary for prenatal, postnatal and well-child care, and other services as determined by the administrator to be necessary for basic health care and which enrollees shall receive in return for premium payments to the plan and payment of required copayments. However, for the period beginning July 1, 1992, and ending June 30, 1993, the schedule of benefits shall not include prenatal or postnatal services for enrollees who are eligible for coverage under the medical assistance program under chapter 74.09 RCW, except to the extent that such services are necessary over not more than a one-month period in order to maintain continuity of care after diagnosis of pregnancy by the managed care provider, or except to provide any such services associated with pregnancies diagnosed by the managed care provider before July 1, 1992. The schedule of benefits may include copayments, limitations and exclusions which the administrator determines are appropriate and consistent with the goals and objectives of the plan.

(2) In designing and revising the schedule of benefits, the administrator will consider the effects of particular benefits, copayments, limitations and exclusions on access to necessary basic health care services, as well as the cost to the enrollees and to the state, and will also consider generally accepted practices of the health insurance and managed health care industries.

(3) Prior to enrolling in the plan, each applicant will be given a complete written description of covered benefits, including all copayments, limitations and exclusions. Enrollees will also be given information on the services, providers, facilities, hours of operation, and other information descriptive of the managed health care system(s) available to enrollees in a given site.

(4) Subscribers will be given written notice by the plan of any planned revisions to the benefit package and the accompanying premiums, 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. 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. The administrator will make available a separate schedule of benefits for children, eighteen years of age and younger, for those who choose to enroll only their dependent children in the plan.

AMENDATORY SECTION (Amending WSR 89-22-014, filed 10/24/89, effective 11/24/89)

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 reenroll 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 reenroll 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 reenroll 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 reenrolled 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) The plan may require any enrollee or applicant for enrollment in the plan who appears to meet eligibility requirements for medical care under chapter 74.09 RCW to complete the eligibility determination

process under chapter 74.09 RCW prior to enrollment or continued participation in the plan.

(9) 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 gross family income for the most recent complete calendar month 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 any changes which could affect the enrollee's eligibility or premium responsibility.

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

WAC 55-01-060 DISENROLLMENT FROM THE PLAN. (1) An enrollee may disenroll effective the first day of any month by giving the plan at least ten days prior written notice of the intention to disenroll. Reenrollment in the plan shall be subject to the provisions of WAC 55-01-050(7). The administrator shall also establish procedures for notice by an enrollee of a disenrollment decision, including the date upon which disenrollment shall become effective. Nonpayment of premium by an enrollee shall be considered an indication of the enrollee's intention to disenroll from the plan.

(2) The plan may disenroll any enrollee from the plan for good cause, which shall include: Failure to meet the eligibility requirements set forth in WAC 55-01-040; loss of eligibility; nonpayment of premium; repeated failure to pay copayments in full on a timely basis; failure to provide eligibility information necessary to determine whether the enrollee may be eligible for medical care under chapter 74.09 RCW within thirty days of the date of request by the plan; failure to apply when such application is required by the plan to the department of social and health services for determination of eligibility for medical care under chapter 74.09 RCW within thirty days of the date of request by the plan; fraud or abuse (including but not limited to serious misconduct); intentional misconduct; and refusal to accept or follow procedures or treatment determined by a participating provider to be essential to the health of the enrollee, where the managed health care system demonstrates to the satisfaction of the plan that no professionally acceptable alternative form of treatment is available from the managed health care system, and the enrollee has been so advised by the managed health care system. The plan shall provide the enrollee with advance written notice of its intent to disenroll the enrollee. Such notice shall specify an effective date of disenrollment, which shall be at least ten days from the date of the notice, and shall describe the procedures for disenrollment, including the enrollee's right to appeal the disenrollment decision as set forth in WAC 55-01-070. Prior to the effective date specified, if the enrollee submits a grievance to the plan contesting the disenrollment decision, as provided in WAC 55-01-070(3), disenrollment shall not become effective until the date, if any, established as a result of the plan's grievance procedure, provided that the enrollee otherwise remains eligible and continues to make all premium payments when

due; and further provided that the enrollee does not pose a threat of nonconsensual violent, aggressive or sexually aggressive behavior, assault or battery or purposeful damage to or theft of managed health care system property, or the property of staff or providers, patients or visitors while on the property of the managed health care system or one of its participating providers.

(3) Any applicant for enrollment in the plan who knowingly provides false information to the plan or to a participating managed health care system may be disenrolled by the plan and may be held financially responsible for any covered services obtained from the plan. The administrator may apply other available remedies as well.