WSR 24-02-019
PERMANENT RULES
HEALTH CARE AUTHORITY

[Filed December 21, 2023, 1:44 p.m., effective March 1, 2024]

Effective Date of Rule: March 1, 2024.

Purpose: The health care authority (agency) revised the premium payment program (PPP) rules to: (a) Update eligibility requirements for clients enrolled in a qualified health plan; and (b) clarify when and how the agency recovers overpayments from PPP clients.

The amended rules:

- Allow clients with individual health plans through Washington health benefit exchange (HBE) to enroll in the PPP.
- Require clients enrolled in an individual health plan purchased through Washington 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 Washington HBE; clients purchasing individual health plans outside of 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 the agency 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.

Citation of Rules Affected by this Order: Amending WAC 182-558-0020, 182-558-0030, 182-558-0060, 182-558-0070, and 182-558-0080.

Statutory Authority for Adoption: RCW 41.05.021, 41.05.160.

Adopted under notice filed as WSR 23-22-106 on October 31, 2023.

Number of Sections Adopted in Order to Comply with Federal Statute: New 0, Amended 0, Repealed 0; Federal Rules or Standards: New 0, Amended 0, Repealed 0; or Recently Enacted State Statutes: New 0, Amended 0, Repealed 0.

Number of Sections Adopted at the Request of a Nongovernmental Entity: New 0, Amended 0, Repealed 0.

Number of Sections Adopted on the Agency's own Initiative: New 0, Amended 0, Repealed 0.

Number of Sections Adopted in Order to Clarify, Streamline, or Reform Agency Procedures: New 0, Amended 5, Repealed 0.

Number of Sections Adopted using Negotiated Rule Making: New 0, Amended 0, Repealed 0; Pilot Rule Making: New 0, Amended 0, Repealed 0; or Other Alternative Rule Making: New 0, Amended 5, Repealed 0.

Date Adopted: December 21, 2023.

Wendy Barcus

OTS-4701.3

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.