

State of Washington

Washington Basic Health Plan
(agency name)

Administrative Order No. 88-001

(1) I, Thomas L. Kobler, director of Washington Basic Health Plan

do promulgate and adopt at Olympia, Washington (place)

the annexed rules relating to:

This notice proposes to establish a new chapter, 55-01 WAC, Washington Basic Health Plan (BHP), and several new sections within that chapter. These rules address the health care benefits to be made available to the public through the BHP, the basis upon which premium charges will be established, and the process whereby individuals may apply for enrollment. Eligibility for enrollment and reasons for disenrollment are also addressed. Procedures for the resolution of disputes are described, as are provisions whereby the administrator may contract with managed health care systems. An additional section defines terms to be used in the rules.

(2) ALTERNATIVE A. Use only for Adoption of Permanent Rules.

This action is taken pursuant to Notice No. WSR 88-21-116 filed with the code reviser on 10/19/88. These rules shall take effect: [X] thirty days after they are filed with the code reviser pursuant to RCW 34.04.040(2). [] at a later date, such date being

(2) ALTERNATIVE B. Use only for Adoption of Emergency Rules.

I, find that an emergency exists and that this order is necessary for the preservation of the public health, safety, or general welfare and that observance of the requirements of notice and opportunity to present views on the proposed action would be contrary to public interest. A statement of the facts constituting the emergency is:

These rules are therefore adopted as emergency rules to take effect upon filing with the code reviser.

(3) Pursuant to the requirements of RCW 34.04.026 that "every agency shall incorporate the most specific, but in no case omit all, of the following language alternatives when adopting or amending rules" fill in statement (a), (b), or (c) as appropriate:

[] (a) This rule is promulgated pursuant to RCW and is intended to administratively implement that statute.

[X] (b) This rule is promulgated pursuant to RCW 70.47.050 which directs that the

Washington Basic Health Plan (agency)

has authority to implement the provisions of Chapter 70.47 RCW (name of act or RCW citation)

[] (c) This rule is promulgated under the general rule-making authority of the (agency)

as authorized in RCW

(4) The undersigned hereby declares that the agency has complied with the provisions of the Open Public Meetings Act (chapter 42.30 RCW), the Administrative Procedure Act (chapter 34.04 RCW) and the State Register Act (chapter 34.08 RCW) in the adoption of these rules.

(5) This order, after being first recorded in the order register of this agency, is herewith transmitted to the Code Reviser for filing pursuant to chapter 34.04 RCW and chapter 1-12 WAC.

APPROVED AND ADOPTED December 1 1988

STATE OF WASHINGTON FILED

DEC 2 1988

By [Signature] Director Title

CODE REVISER'S OFFICE WSR 8824030

Chapter 55-01 WAC

WASHINGTON BASIC HEALTH PLAN

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| WAC | 55-01-001 | Authority. |
| | 55-01-010 | Definitions. |
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| | 55-01-050 | Enrollment in the plan. |
| | 55-01-060 | Disenrollment from the plan. |
| | 55-01-070 | Hearings and grievances. |
| | 55-01-080 | Contracts with managed health care systems. |

NEW SECTION

WAC 55-01-001 AUTHORITY. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

NEW SECTION

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

(8) "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.

(9) "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.

(10) "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. For purposes of this definition, "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. For purposes of this definition, "income" shall not include income of 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.

(11) "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.

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

(13) "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.

(14) "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.

(15) "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.

(16) "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.

(17) "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.

(18) "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.

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

(20) "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.

(21) "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.

(22) "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.

(23) "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.

NEW SECTION

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. 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.

NEW SECTION

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. 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.

(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. 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 coverage specified by the plan until 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 non-payment. 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).

NEW SECTION

WAC 55-01-040 ELIGIBILITY. (1) To be eligible for enrollment in the plan, an individual must:

- (a) Be under age sixty-five;
- (b) Not be eligible for medicare;
- (c) Reside within the service area of a participating managed health care system; and
- (d) Have a gross family income at the time of enrollment that does not exceed two hundred percent of the federal poverty level as adjusted for family size and determined annually by the Federal Department of Health and Human Services.

Persons not meeting all of these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by the plan, will not be enrolled. An enrollee who subsequently fails to meet all of the criteria will be disenrolled from the plan as provided in WAC 55-01-060--except that an enrollee whose gross family income exceeds twice the federal poverty level may continue as an enrollee for up to six months, provided all other criteria are met and provided that the enrollee pays a monthly premium

equal to the rate stated in the contract between the plan and the participating managed health care system selected by the enrollee.

(2) An individual otherwise eligible for enrollment in the plan may be denied enrollment if the administrator has determined that acceptance of additional enrollment in a given service area would exceed limits established by the legislature, would jeopardize the orderly development of the plan in that service area, or would result in an overexpenditure of plan funds. In the event that the administrator closes enrollment in a given service area, the plan will continue to accept applications for enrollment, but will not process those applications for determination of eligibility. The plan will place the names of applicants on a waiting list in the order in which applications are received, and will so notify the applicants. In the event that enrollment is reopened by the administrator, applicants whose names appear on the waiting list will be notified by the plan of the opportunity to enroll; provided that the plan may require new application forms and documentation from applicants on the waiting list, or may contact applicants to verify continued interest in applying, prior to determining their eligibility.

NEW SECTION

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 the date upon which they may begin receiving covered services from the plan.

(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 has also remitted full payment of the first premium bill to 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 thirty 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, which may include a request to complete a new application form and submit required documentation. 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 comply 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.

NEW SECTION

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. Re-enrollment 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) Bases for disenrollment of an enrollee by the plan may include, but shall not be limited to, the following: failure to meet the eligibility requirements set forth in WAC 55-

01-040; nonpayment of premium; repeated failure to pay copayments in full on a timely basis; fraud or abuse; 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 administrator that no professionally acceptable alternative exists, and the enrollee has been so advised. 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.

(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.

NEW SECTION

WAC 55-01-070 HEARINGS AND GRIEVANCES. The plan will develop procedures for the expeditious resolution of enrollees' grievances, and will require participating managed health care systems to do the same.

(1) If an enrollee has a grievance pertaining to a managed health care system, the enrollee shall exhaust the managed health care system's grievance procedure prior to requesting consideration of the grievance by the plan. The managed health care system's grievance procedure shall provide for expeditious resolution by managed health care system personnel with authority to require corrective action. There shall be a written reply from the managed health care system stating either the decision and its basis, or the reasons for failure to reach a decision, within thirty days of receipt of the written grievance. An enrollee has the right to request consideration of the grievance by the administrator if the final decision is adverse or if the written reply is not received within thirty days from the date the managed health care system received the written grievance.

(2) If an enrollee has a grievance pertaining to actions of the plan, the enrollee may submit the grievance to the plan for resolution by the plan's grievance procedure. A written description of the plan's grievance procedure will be provided to the enrollee upon enrollment, or at any time upon request. The plan's grievance procedure shall provide for resolution of the grievance within thirty days of receipt of complete information describing the grievance and its basis.

(3) An enrollee who is involuntarily disenrolled by the plan may contest the disenrollment by submitting a grievance to the plan, within ten days of the notice of disenrollment, for resolution by the plan's grievance procedure. The plan shall issue and mail a written decision within thirty days of receiving the grievance.

(4) An individual whose application for enrollment in the plan is denied may contest the denial of enrollment by submitting a grievance to the plan, within ten days of the notice by the plan of such denial, for resolution by the plan's grievance procedure. The plan shall issue and mail a written decision within thirty days of receiving the grievance.

(5) If the plan's decision resulting from its grievance procedure is adverse to an enrollee or applicant, he or she may, within fifteen days of receiving notice of the grievance decision, request a hearing under chapters 34.04 and 34.12 RCW in order to contest the plan's decision.

NEW SECTION

WAC 55-01-080 CONTRACTS WITH MANAGED HEALTH CARE SYSTEMS.

(1) The administrator may enter into a contract with any managed health care system which, in the opinion of the administrator, qualifies for participation in the plan. The administrator shall establish, and may from time to time revise, minimum standards to be satisfied by participating managed health care systems.

(2) No managed health care system may participate in the plan without entering into a written contract with the plan.

(3) The administrator shall develop procedures for the resolution of disputes between the plan and a managed health care system which will be set forth in the contract between the plan and the managed health care system.