Title 182 WAC
HEALTH CARE AUTHORITY

Chapters

Chapter 182-04 WAC
PUBLIC RECORDS

WAC

WAC 182-04-010 Purpose. The purpose of this chapter shall be to insure compliance by the Washington state employee insurance board with the provisions of chapter 42.17 RCW dealing with public records.

[Order 01-77, § 182-04-010, filed 8/26/77.]

WAC 182-04-015 Definitions. The following definitions shall apply:

(1) "Public record" includes any writing containing information relating to the conduct of government or the performance of any governmental agency or local agency regardless of form or characteristics.

(2) "Writing" means handwriting, typewriting, printing, photostating and every other means of recording any form of communication or representation, including letters, words, pictures, sounds symbols, or combinations thereof, and all papers, maps, magnetic or paper tapes, photographic films and prints, magnetic or punched cards, discs, drums and other documents.

(3) The Washington state employee insurance board, created pursuant to chapter 41.05 RCW. The state employee insurance board shall hereinafter be referred to as the board. For the purposes of WAC 182-04-015 through 182-04-070 inclusive, the term "board" shall also refer to the staff and employees of the Washington state employee insurance board.

[Order 01-77, § 182-04-015, filed 8/26/77.]

WAC 182-04-025 Public records. All public records of the board as defined in WAC 182-04-015(1) shall be made available upon public request for inspection and copying pursuant to these rules, except however as provided by RCW 42.17.310.

[Order 01-77, § 182-04-025, filed 8/26/77.]

WAC 182-04-030 Public records officer. The public records officer for the board shall be the insurance benefits supervisor or his designee. He shall be responsible for implementing the rules adopted by the board regarding release of public records in compliance with chapter 42.17 RCW.

[Order 01-77, § 182-04-030, filed 8/26/77.]

WAC 182-04-035 Office hours. Public records shall be made available upon request only during working hours of the board. For the purpose of this chapter, the working hours shall be from 8:00 a.m. until noon, and from 1:00 p.m. until 5:00 p.m., Monday through Friday, excluding legal holidays.

[Order 01-77, § 182-04-035, filed 8/26/77.]

WAC 182-04-040 Request for public records. In accordance with the requirements of chapter 42.17 RCW that agencies prevent unreasonable invasions of privacy, and to protect public records from damage or disorganization, and to prevent excessive interference with essential functions of the agency, public records may be inspected or copied, or copies of such records, may be obtained by members of the public, upon compliance with the following procedures:

(1) A request shall be made in writing upon a form prescribed by the agency which shall be available at its office. The form shall be presented to the public records officer; or to any member of the agency's staff, if the public records officer is not available, at the office of the agency during customary office hours. The request shall include the following information:

(a) The name, address, and organization represented, if any, of the person requesting the record;

(b) The time of day and calendar date on which the request was made;

(c) The nature of the request;

(d) If the matter requested is referred to within the current index maintained by the records officer, a reference to the requested record as it is described in such current index;

(e) If the requested matter is not identifiable by reference to the agency's current index, an appropriate description of the record requested.

(2) In all cases in which a member of the public is making a request, it shall be the obligation of the public records officer or staff member to assist the member of the public in appropriately identifying the public record requested.

[Order 01-77, § 182-04-040, filed 8/26/77.]

WAC 182-04-045 Copying. No fee shall be charged for the inspection of public records. The agency shall charge a reasonable fee for providing copies of public records and for use of the agency's copy equipment. This charge is the amount necessary to reimburse the agency for its actual costs incident to such copying.

[Order 01-77, § 182-04-045, filed 8/26/77.]

WAC 182-04-050 Exemptions. (1) The board reserves the right to determine that a public record requested in accordance with the procedures outlined in WAC 182-04-040 is exempted under the provisions of RCW 42.17.310.

(2) Pursuant to RCW 42.17.260, the board reserves the right to delete identifying details when it makes available or publishes any public record, in any case where there is reason to believe that disclosure of such details would be an invasion of personal privacy protected by chapter 42.17 RCW. The public records officer will fully justify such deletion in writing.

(3) All denials of requests for public records shall be accompanied by a written statement specifying the reason for the denial.

[Order 01-77, § 182-040-050, filed 8/26/77.]

WAC 182-04-055 Review of denials of public records request. (1) Any person who objects to the denial of request for public record may petition for prompt review of such decision by tendering a written request for review. The written request shall specifically refer to the written statement by the public records officer or other staff member which constituted or accompanied the denial.

(2) Following receipt of a written request for review of a decision denying a public record, the records officer shall immediately consider the matter and either affirm or reverse such denial. The request shall be returned with a final decision within two business days following the receipt of such request.

[Order 01-77, § 182-04-055, filed 8/26/77.]

WAC 182-04-060 Protection of public records. Following are guidelines which shall be adhered to by any person inspecting such public records:

(1) Inspection of any public records shall be conducted only during working hours as specified in WAC 182-04-035 with the presence of SEIB employees;

(2) No public record shall be removed from the main office without the approval of the insurance benefit supervisor or without the authorization of the SEIB;

(3) Public records shall not be marked, torn, or otherwise damaged;

(4) Public records must be maintained as they are in file or in a chronological order, and shall not be dismantled except for purposes of copying and then only by SEIB employees or others authorized by the insurance benefit supervisor;

(5) Access to file cabinets and other places where public records are kept is restricted, and shall be used by the board.

[Order 01-77, § 182-04-060, filed 8/26/77.]

WAC 182-04-065 Communication with the board. All communications with the board pertaining to the administration or the enforcement of chapter 42.17 RCW and these rules shall be addressed as follows: Insurance Benefits Supervisor, Department of Personnel, State of Washington, 600 South Franklin, Olympia, Washington 98504.

[Order 01-77, § 182-04-065, filed 8/26/77.]

WAC 182-04-070 Adoption of form. The board hereby adopts for use by all persons requesting inspection and/or copying or copies of its records, the form set out below, entitled "Request for public records."

State Employees Insurance Board
Department of Personnel
State of Washington
600 South Franklin
Olympia, Washington 98504

We have received your request for copies of our public records. We would appreciate it if you complete the form on the right and return with the amount required. We will forward the requested copies as soon as we receive this form.

Thank You.

Return to:

Insurance Benefits Supervisor
Department of Personnel
600 South Franklin
Olympia, Washington 98504

Request for Public Records

DATE . . . . . TIME . . . . . .

NAME . . . . . .

ADDRESS . . . . . .

. . . . . .

PURPOSE OF REQUEST

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. . . . . .

. . . . . .

I certify that the information obtained through this request for public records will be used only for the reasons stated and will not be used for commercial purposes.

. . . . . .

Signature

No. of copies . . . . . .

No. of pages . . . . . .

Per page charge $. . . . . .

Total charge $. . . . . .

[Order 01-77, § 182-04-070, filed 8/26/77.]

Chapter 182-08 WAC
PROCEDURES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-08-030 Scope and construction of terms. [Order 7228, § 182-08-030, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-040 Definitions. [Order 7228, § 182-08-040, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-060 Approval of health maintenance organization plans. [Statutory Authority: RCW 41.05.010 and 41.05.025. 87-21-069 (Resolution No. 87-6), § 182-08-060, filed 10/19/87; Order 7228, § 182-08-060, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-080 Employee to elect option. [Order 7228, § 182-08-080, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.

182-08-090 Transferred employee. [Order 3-77, § 182-08-090, filed 11/17/77; Order 7228, § 182-08-090, filed 12/8/76.] Repealed by 79-11-064 (Order 2-79), filed 10/18/79. Statutory Authority: Chapter 41.05 RCW.

182-08-110 Open enrollments. [Order 7228, § 182-08-110, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-111 Medical plan options between open enrollments. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-111, filed 1/9/81; 79-11-064 (Order 2-79), § 182-08-111, filed 10/18/79.] Repealed by 91-20-163, filed 10/2/91, effective 11/2/91. Statutory Authority: Chapter 41.05 RCW.

182-08-130 New dependents' medical coverage after enrollment. [Order 7228, § 182-08-130, filed 12/8/76.] Repealed by Order 3-77, filed 11/17/77.

182-08-140 New dependents' life coverage after enrollment. [Order 7228, § 182-08-140, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.

182-08-150 Reduction or cancellation of optional insurance coverages. [Order 3-77, § 182-08-150, filed 11/17/77; Order 7228, § 182-08-150, filed 12/8/76.] Repealed by 84-09-043 (Resolution No. 2-84), filed 4/16/84. Statutory Authority: Chapter 41.05 RCW.

182-08-170 Insurance status for a reverted employee. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-08-170, filed 8/5/86; 78-02-015 (Order 2-78), § 182-08-170, filed 1/10/78; Order 7228, § 182-08-170, filed 12/8/76.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-195 Retroactive employer and employee contributions restricted. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-08-195, filed 4/16/84.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-08-300 Criteria for selection of insurance company for automobile and homeowners insurance. [Statutory Authority: Chapter 41.05 RCW. 81-03-014 (Order 1-81), § 182-08-300, filed 1/9/81.] Repealed by 96-08-042, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

WAC 182-08-010 Declaration of purpose. The general purpose of this chapter is to establish a set of rules used by the Public Employees Benefits Board (PEBB) for designing employee and retiree eligibility and insurance benefits and for administration of these insurance plans by the Washington State Health Care Authority (HCA).

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-010, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-010, filed 12/8/76.]

WAC 182-08-015 Definitions. The following definitions apply throughout these rules unless the context clearly indicates other meaning:

(1) "Administrator" means the administrator of the HCA or designee.

(2) "Public employees benefits board" (PEBB). Established under provisions of chapter 41.05 RCW. The PEBB is created within the HCA and the administrator of the HCA shall serve as the chair of the board.

(3) "Open enrollment" means a time period designated by the administrator during which enrollees may apply to transfer their enrollment from one health plan to another, enroll in a medical plan if the enrollee had previously waived coverage or add dependents.

(4) "Enrollee" means a person who meets all eligibility requirements defined in chapter 182-12 WAC, who is enrolled in a PEBB plan, and for whom applicable premium payments have been made.

(5) "Subscriber" means the enrollee who has been designated by the HCA as the individual to whom the HCA and the health plan will issue all notices, information, requests and premium bills on behalf of all enrolled family members.

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

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-015, filed 3/29/96, effective 4/29/96.]

WAC 182-08-020 Duties and responsibilities. (1) The HCA's duties include, but are not limited to, the following:

(a) To promulgate and adopt rules consistent with RCW 41.05.021 and 41.04.160;

(b) Administer insurance benefits as designed by the PEBB and authorized under RCW 41.05.065;

(c) To analyze state-purchased health care programs and to explore options for cost containment and delivery alternatives for those programs that are consistent with the purposes of those programs;

(d) To analyze areas of public and private health care interaction;

(e) To provide information and technical administrative assistance to the PEBB;

(f) To review and approve or deny applications from counties, municipalities, eligible nonemployees, and other political subdivisions and to set the premium contribution for approved groups;

(g) To establish a competitive insurance contract bidding and evaluation process;

(h) To provide benefit plans designed by the PEBB through contracts with insurance entities or self-insurance;

(i) To appoint a health care policy technical advisory committee; and

(j) To establish billing procedures and collect funds from subscriber.

(2) The following shall be the duties and responsibilities of the PEBB:

(a) To promulgate and adopt rules for the conduct of its business;

(b) To study all matters connected with the provision of health care coverage, life insurance, liability insurance, accidental death and dismemberment insurance and disability income insurance on the best basis possible with relation to the welfare of the employees and the state. Liability insurance shall not be made available to dependents;

(c) To review and approve property and/or casualty insurance for state employees through payroll deduction. Any approved carriers must be financially sound, licensed in the state of Washington and have at least a B+ Best rating;

(d) To design and approve benefit plans and determine the terms and conditions of employee participation and coverage, including establishment of eligibility criteria;

(e) To authorize premium contributions for an employee and the employee's dependents.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-020, filed 3/29/96, effective 4/29/96; Order 7228, § 182-08-020, filed 12/8/76.]

WAC 182-08-095 Waiver of coverage. (1) State employees: Employees eligible for PEBB health care coverage have the option of waiving medical coverage for themselves and any or all dependents if they are covered by another medical plan. In order to waive medical coverage, the employee must complete an enrollment form that identifies the individuals for whom coverage is being waived. If an employee waives medical coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive medical coverage for any or all dependents.

Employees and dependents whose medical coverage is waived will remain enrolled in a PEBB dental plan. Employees will also remain enrolled in PEBB life and long term disability coverage.

If PEBB medical coverage is waived, an otherwise eligible person may not enroll in a PEBB plan until the next open enrollment period, or within 31 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) Coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 31 days or less.

(2) K-12 employees: Employees eligible for PEBB health care coverage have the option of waiving medical coverage for themselves and any or all dependents. In order to waive medical coverage, the employee must complete an enrollment form that identifies the individuals for whom coverage is being waived. If an employee waives medical coverage for him/herself, coverage is automatically waived for all eligible dependents. An employee may choose to enroll only him/herself, and waive medical coverage for any or all dependents.

Employees and dependents whose medical coverage is waived will remain enrolled in a PEBB dental plan if the district/unit participates in the dental plan. Employees will also remain enrolled in life and long term disability coverage if the district/unit participates in those plans.

If PEBB medical coverage is waived, an otherwise eligible person may not enroll in a PEBB plan until the next school district renegotiation period, or upon approval of the participating school district and the HCA. Approval of the HCA will require proof of other medical coverage to demonstrate that: 1) Coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 31 days or less.

(3) Political subdivision employees: Political subdivision employees may not waive PEBB medical coverage for themselves, but may waive medical coverage for their dependents if the dependents are covered by another medical plan. In order to waive medical coverage for dependents, the employee must complete an enrollment form that identifies the individuals for whom coverage is being waived.

Dependents whose medical coverage is waived will remain enrolled in their PEBB dental plan.

If PEBB medical coverage is waived, an otherwise eligible dependent may not enroll in a PEBB medical plan until the next open enrollment period, or within 31 days of loss of other medical coverage. Proof of other medical coverage is required to demonstrate that: 1) Coverage was continuous from the date PEBB coverage was waived; and 2) the period between loss of coverage and application for PEBB coverage is 31 days or less.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.]

WAC 182-08-120 Employer contribution. The PEBB has utilized the employers' contribution to provide coverage for the basic life insurance benefit, a basic long term disability benefit, medical coverage, and dental coverage, and to establish a reserve for any remaining balance. There is no employer contribution available for any other insurance coverages.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-120, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-08-120, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-120, filed 10/28/83; Order 3-77, § 182-08-120, filed 11/17/77; Order 7228, § 182-08-120, filed 12/8/76.]

WAC 182-08-160 Group coverage when not in pay status. Employees covered by a PEBB health plan have options for providing continued coverage for themselves and their dependents during temporary or permanent loss of eligibility. With the exception of approved family and medical leave, employees not in pay status for at least 8 hours per month are ineligible to receive the employer premium contribution:

(1) When an employee loses eligibility as an active employee, PEBB group coverage, except long-term disability, may be continued at the group premium rate by self-paying premiums for medical coverage only, or for medical and dental combined, or for dental only, and on life insurance for a maximum of 29 months. With respect to medical and dental coverage, the maximum time shall be reduced by the number of months of self-pay allowed under COBRA and the number of employer-paid months allowed under family and medical leave. Part-time faculty may self-pay for group coverage between periods of active employee eligibility for a maximum of 18 months. If an employee is temporarily not in pay status for any of the following reasons, he or she may continue PEBB group coverage by self-paying the premium:

(a) The employee is on authorized leave without pay,

(b) The employee is laid off because of a reduction in force (RIF)

(c) The employee is receiving time-loss benefits under workers' compensation

(d) The employee is awaiting hearing for a dismissal action

(e) The employee is applying for disability retirement

(2) The federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) gives enrollees the right to continue group coverage for a period of 18 to 36 months.

(3) The Family and Medical Leave Act of 1993 gives the enrollee the opportunity to extend eligibility with employer contribution toward premium for up to 12 weeks, see WAC 182-08-080.

(4) Enrollees have the right to convert to individual medical coverage when continuation of group medical coverage is no longer possible.

(5) The dependents of employees also have options for continuing coverage for themselves following loss of eligibility.

(6) Employees who revert to a previously held position and do not regain pay status during the last month in which their employer contribution is made may continue their PEBB-sponsored health and life coverage, by self-paying premium for up to 18 months (and in some cases up to 29 months).

(7) If a dependent(s) loses eligibility due to the death of the employee, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system. The employee's spouse may continue coverage indefinitely; other dependents may continue coverage until they lose eligibility under PEBB rules. Application for surviving dependent coverage must be made within 60 days from the death of the employee. If a dependent is not eligible for a monthly retirement income benefit, or a lump-sum payment because the monthly pension payment would be less than $50, the dependent may be eligible for continued coverage under COBRA.

(8) An employee may retain long-term disability coverage by self-payment of premium up to twenty-four months during an authorized leave without pay, but only if such leave is an approved educational leave.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-160, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-160, filed 11/16/93, effective 12/17/93; 86-16-061 (Resolution No. 86-3), § 182-08-160, filed 8/5/86; 83-22-042 (Resolution No. 6-83), § 182-08-160, filed 10/28/83; 80-01-082 (Order 5-79), § 182-08-160, filed 12/27/79; 78-03-021 (Order 3-78), § 182-08-160, filed 2/14/78; Order 7228, § 182-08-160, filed 12/8/76.]

WAC 182-08-165 Other group coverage option. The following shall apply to employees during any period of approved educational leave. In order to avoid duplication of group medical coverage, such employees who obtain coverage under another group medical plan may interrupt continuance of their PEBB self-pay medical/dental coverage for each full calendar month in which they maintain coverage under the other group medical plan, with the right to reinstate PEBB self-pay medical/dental coverage in the month following termination of the other group medical coverage. Provided, that the furnishing of evidence of such other group medical coverage may be required by the Washington state health care authority. Provided further, that the option to continue self-pay dental coverage shall be suspended for the same period that PEBB self-pay medical is suspended.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-165, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.065. 89-05-013 (Resolution No. 89-1), § 182-08-165, filed 2/9/89.]

WAC 182-08-175 Group coverage while on family and medical leave. Employees on leave under the federal Family and Medical Leave Act of 1993, and regulations implementing that act, shall continue to receive up to twelve weeks of employer-paid group medical, dental, basic life, and basic long-term disability insurance while on family and medical leave. If an employee fails to return to work after expiration of family and medical leave for a reason other than the continuation, recurrence, or onset of a serious health condition or other circumstance beyond the control of the employee, the employer may recover the premiums paid to maintain the employee's insurance coverage from the employee.

[Statutory Authority: Chapter 41.05 RCW. 93-23-065, § 182-08-175, filed 11/16/93, effective 12/17/93.]

WAC 182-08-180 Reimbursement payment of miscalculated premiums. Premiums miscalculated will be adjusted by returning the excess charged premium to the employer or subscriber. Errors producing an underpayment will be reimbursed by the employer or subscriber. The HCA will develop a repayment plan that will not create undue hardship on the employer or subscriber.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-180, filed 3/29/96, effective 4/29/96; Order 01-77, § 182-08-180, filed 8/26/77.]

WAC 182-08-190 Employer contribution. Every department, division, or agency of state government, and such county, municipal or other political subdivisions as are covered under the PEBB plans, shall provide premium contributions to the HCA for insurance benefits for its employees and their dependents. State employer contributions shall be set by the HCA and are subject to the approval of the governor. Employer contributions shall include an amount determined by the HCA to pay administrative costs to administer the plans for employees of these groups. Each eligible state employee in pay status for eight or more hours during a calendar month or for each eligible employee on family and medical leave shall be eligible for the employer contribution.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-190, filed 3/29/96, effective 4/29/96; 93-23-065, § 182-08-190, filed 11/16/93, effective 12/17/93; 78-02-015 (Order 2-78), § 182-08-190, filed 1/10/78; Order 3-77, § 182-08-190, filed 11/17/77.]

WAC 182-08-200 Payment of the employer contribution for eligible employees changing agency employment. When an eligible employee's employment ceases with an agency at any time prior to the end of the month for which a premium contribution is due and transfers to another agency, the losing agency is responsible for the payment of the contribution for that employee for that month. The receiving agency would not be liable for any employer contribution for that eligible employee until the month following the transfer.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-200, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-200, filed 11/17/77.]

WAC 182-08-210 Termination of employer paid insurance benefit programs. Coverage for a terminated employee, spouse and dependent children under the PEBB coverage medical, dental, and life insurance ceases at 12:00 midnight, the last day of the month in which the employee is in pay status. Long term disability ceases at 12:00 midnight the date your employment terminates.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-210, filed 3/29/96, effective 4/29/96; Order 3-77, § 182-08-210, filed 11/17/77.]

WAC 182-08-220 Advertising or promotion of PEBB sponsored benefit plans. In order to assure equal and unbiased representation of PEBB sponsored or approved benefit plans, any promotion of these plans shall comply with the following:

(1) All materials describing PEBB plan benefits are to be prepared by or approved by the HCA.

(2) Distribution or mailing of all plan benefit descriptions is to be performed by or under the direction of the HCA.

(3) All media announcements or advertising by a carrier which include any mention of the "Public Employees Benefits Board," "health care authority" or any reference to coverage for "state employees or retirees" or any group of employees covered by PEBB plans, must receive the advance written approval of the HCA.

Failure to comply with these requirements by a PEBB contracted plan or plan subcontractor may result in contract termination by the HCA and/or HCA refusal to consider continued or renewed contracting with the noncomplying party.

[Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-220, filed 3/29/96, effective 4/29/96; 91-20-163, § 182-08-220, filed 10/2/91, effective 11/2/91; 86-16-061 (Resolution No. 86-3), § 182-08-220, filed 8/5/86.]

Chapter 182-12 WAC
ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-12-120 Noneligible employees. [Order 5646, § 182-12-120, filed 2/9/76.] Repealed by 88-12-034 (Resolution No. 88-1), filed 5/26/88, effective 7/1/88. Statutory Authority: RCW 41.05.010.

182-12-122 Surviving dependents eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-122, filed 8/5/86; 80-05-016 (Order 2-80), § 182-12-122, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-122, filed 7/26/78.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-12-125 Employee or dependents become ineligible for state group coverage. [Statutory Authority: Chapter 41.05 RCW. 84-09-043 (Resolution No. 2-84), § 182-12-125, filed 4/16/84; Order 5646, § 182-12-125, filed 2/9/76.] Repealed by 84-14-058 (Order 5-84), filed 6/29/84. Statutory Authority: Chapter 41.05 RCW.

182-12-126 Extension of retiree dependents' eligibility. [Statutory Authority: Chapter 41.05 RCW. 86-16-061 (Resolution No. 86-3), § 182-12-126, filed 8/5/86.] Repealed by 87-21-069 (Resolution No. 87-6), filed 10/19/87. Statutory Authority: RCW 41.05.010 and 41.05.025.

182-12-127 Extension of retiree dependents' eligibility. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-127, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-127, filed 9/19/88. Statutory Authority: RCW 41.05.010 and 41.05.025. 87-21-069 (Resolution No. 87-6), § 182-12-127, filed 10/19/87.] Repealed by 91-11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.

182-12-130 Retirees eligible for Medicare. [Statutory Authority: Chapter 41.05 RCW. 91-14-084, § 182-12-130, filed 7/1/91, effective 7/1/91; 80-05-016 (Order 2-80), § 182-12-130, filed 4/10/80; Order 4-77, § 182-12-130, filed 11/17/77; Order 5646, § 182-12-130, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-12-135 Eligibility for employees on leave without pay. [Order 4-77, § 182-12-135, filed 11/17/77; Order 5646, § 182-12-

135, filed 2/9/76.] Repealed by 80-05-016 (Order 2-80), filed 4/10/80. Statutory Authority: Chapter 41.05 RCW.

182-12-140 New eligible employees. [Order 4-77, § 182-12-140, filed 11/17/77; Order 5646, § 182-12-140, filed 2/9/76.] Repealed by 89-05-013 (Resolution No. 89-1), filed 2/9/89. Statutory Authority: RCW 41.05.065.

182-12-150 Husband and wife are eligible employees. [Order 5646, § 182-12-150, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.

182-12-151 Dependent life insurance. [Order 01-77, § 182-12-151, filed 8/26/77.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-12-155 Classified employee eligible for employer contribution. [Order 5646, § 182-12-155, filed 2/9/76.] Repealed by Order 4-77, filed 11/17/77.

182-12-160 Elected officials. [Statutory Authority: Chapter 41.05 RCW. 86-06-003 (Resolution No. 86-1), § 182-12-160, filed 2/20/86; Order 5646, § 182-12-160, filed 2/9/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-12-165 State contribution for permanent employees appointed to instructional year or seasonal positions. [Statutory Authority: RCW 41.05.010. 88-12-034 (Resolution No. 88-1), § 182-12-165, filed 5/26/88, effective 7/1/88; Order 7228, § 182-12-165, filed 12/8/76.] Repealed by 96-08-043, filed 3/29/96, effective 4/29/96. Statutory Authority: Chapter 41.05 RCW.

182-12-170 State contributions for Medicare for actively employed. [Order 7228, § 182-12-170, filed 12/8/76.] Repealed by 83-22-042 (Resolution No. 6-83), filed 10/28/83. Statutory Authority: Chapter 41.05 RCW.

182-12-210 Extended self-pay medical and dental coverage. [Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-210, filed 6/2/89. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-210, filed 9/19/88. Statutory Authority: Chapter 41.05 RCW. 87-07-034 (Resolution No. 87-2), § 182-12-210, filed 3/13/87; 86-16-061 (Resolution No. 86-3), § 182-12-210, filed 8/5/86.] Repealed by 91-11-010, filed 5/3/91, effective 6/3/91. Statutory Authority: RCW 41.05.010 and 41.05.025.

WAC 182-12-110 Purpose. The purpose of this chapter is to establish criteria of employee eligibility for and effective date of enrollment in the public employees benefits board (PEBB) approved plans.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-110, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-110, filed 2/9/76.]

WAC 182-12-111 Eligible entities and individuals. The following entities and individuals shall be eligible to participate in PEBB insurance plans subject to the terms and conditions set forth below[.][:]

(1) State agencies. Every department, division, or separate agency of state government, including all state higher education institutions, including the higher education coordinating board, and the state board for community and technical colleges is eligible and required to participate in all PEBB approved plans. Insurance and health care contributions for ferry employees shall be governed by RCW 47.64.270.

Employees of technical colleges previously enrolled in a benefits trust may terminate PEBB coverage by January 1, 1996, or the expiration of the current collective bargaining agreements, whichever is later. Employees electing to terminate PEBB coverage have a one-time re-enrollment option after a five year wait. Employees of a bargaining unit may terminate only as an entire bargaining unit. All administrative or managerial employees may terminate only as an entire unit.

Technical colleges with employees enrolled in a benefits trust shall remit to the HCA a retiree remittance as specified in the omnibus appropriations act, for each full-time employee equivalent. The remittance may be prorated for employees receiving a prorated portion of benefits.

(2) Employees of employee organizations representing state civil service employees, at the option of each employee organization, and, effective October 1, 1995, employees of employee organizations currently pooled with employees of school districts for the purpose of purchasing insurance benefits, at the option of such employee organization.

(3) Employees of a county, municipality or other political subdivision of the state may participate in PEBB insurance programs provided:

(a) All eligible employees of the entity transfer to PEBB plan coverage as a unit. Bargaining units with other group coverage mandated by their collective bargaining agreement will be permitted to waive PEBB coverage as an entire unit, with the approval of the HCA.

(b) The legislative authority or the board of directors obligates itself to participate in all PEBB insurance plans. The PEBB medical and dental plans must be the only employer sponsored medical and dental plans available to all eligible employees.

(c) The legislative authority of the entity or the board of directors submits an application together with employee census data and, if available, prior claims experience of the entity to the HCA.

(d) The legislative authority or the board of directors agrees to maintain its PEBB plan participation for a minimum of one full year, and then through the end of the plan year.

(e) The legislative authority or the board of directors shall provide the HCA written notice of its intent to terminate PEBB plan participation no later than thirty days prior to the effective date of termination. If a county, municipality, or political subdivision, or employees of employee organizations as defined in WAC 182-12-111(2) terminates coverage in PEBB insurance plans, retired and disabled employees who began participating after September 15, 1991, will no longer be eligible to participate in PEBB insurance plans beyond the mandatory extension requirements specified in WAC 182-12-215.

(f) The HCA administrator approves the entity's application.

(4) School districts and educational service districts. Bargaining units and nonrepresented employees of school districts and educational service districts of the state may participate in PEBB insurance programs provided:

(a) The PEBB plans must be the only medical and dental plans made available to the members of the bargaining unit through their employment by the school district or educational service district.

(b) All eligible employees of the bargaining unit transfer as a unit and all nonrepresented employees transfer as a unit.

(c) The terms and conditions for the payment of insurance premiums shall be set forth in the provisions of the bargaining agreement and shall comply with the employer contribution requirements specified in RCW 28A.400.280. These provisions of the collective bargaining agreement,

including eligibility, shall be subject to review and approval by the PEBB at the time of application for participation.

(d) The application to participate in the PEBB plans is subject to the approval of the HCA.

(e) The eligibility requirements for dependents of school district and educational service district employees shall be the same as the requirements for dependents of the state employees and retirees as defined in WAC 182-12-115(10).

(f) The bargaining unit or unit of nonrepresented employees must agree to maintain its PEBB plan participation for a minimum of one full year, and then through the end of the school year.

(5) Eligible nonemployees: (a) Dislocated forest products workers enrolled in the employment and career orientation program pursuant to chapter 50.70 RCW shall be eligible for PEBB medical and dental plan coverage while enrolled in that program.

(b) School board members or students eligible to participate under RCW 28A.400.350.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-111, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.04.205, 41.05.065, 41.05.011, 41.05.080 and chapter 41.05 RCW. 92-03-040, § 182-12-111, filed 1/10/92, effective 1/10/92. Statutory Authority: Chapter 41.05 RCW. 78-02-015 (Order 2-78), § 182-12-111, filed 1/10/78.]

Reviser's note: RCW 34.05.395 requires the use of underlining and deletion marks to indicate amendments to existing rules, and deems ineffectual changes not filed by the agency in this manner. The bracketed material in the above section does not appear to conform to the statutory requirement.

WAC 182-12-115 Eligible employees. The following employees of state government, higher education, K-12 school districts, educational service districts, political subdivisions and employee organizations representing state civil service workers are eligible to apply for coverage by PEBB plans. For purposes of defining eligible employees of school districts, and educational service districts, the collective bargaining agreement will supersede all definitions provided under this rule if approved by the PEBB and/or the HCA.

(1) "Permanent employees." Those who work at least half-time per month and are expected to be employed for more than six months. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment.

(2) "Nonpermanent employees." Those who work at least half-time and are expected to be employed for no more than six months. Coverage begins on the first day of the seventh month following the date of employment.

(3) "Seasonal employees." Those who work at least half-time per month during a designated season for a minimum of three months but less than nine months per year and who have an understanding of continued employment season after season. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of a month, coverage begins on the date of employment. However, seasonal employees are not eligible for the employer contribution during the break between seasons of employment but may be eligible to continue coverage by self-paying premiums.

(4) "Career seasonal/instructional employees" Employees who work half-time or more on an instructional year (school year) or equivalent nine-month seasonal basis. Coverage begins on the first day of the month following the date of employment. If the date of employment is the first working day of the month, coverage begins on the date of employment. These employees are eligible to receive the employer contribution for insurance during the off-season following each period of seasonal employment.

(5) "Part-time faculty." Faculty who are employed on a quarter/semester to quarter/semester basis become eligible to apply for coverage beginning with the second consecutive quarter/semester of half-time or more employment at one or more state institutions of higher education. Coverage begins on the first day of the month following the beginning of the second quarter/semester of half-time or more employment. If the first day of the second consecutive quarter/semester is the first working day of the month, coverage begins at the beginning of the second consecutive quarter/semester.

Employers of part-time faculty must:

(a) Consider spring and fall as consecutive quarters/semesters when determining eligibility; and

(b) Determine "halftime or more employment" based on each institution's definition of "full-time"; and

(c) At the beginning of each quarter/semester notify, in writing, all current and newly hired part-time faculty of their potential right to benefits under this section. The employee shall have the responsibility, each quarter, to notify the employers, in writing, of the employee's multiple employment. In no case will there be a requirement for retroactive coverage or employer contribution if a part-time faculty member fails to inform all of his/her employing institutions about employment at all institutions within the current quarter; and

(d) Where concurrent employment at more than one state higher education institution is used to determine total part-time faculty employment of half-time or more, the employing institutions will arrange to prorate the cost of the employer insurance contribution based on the employment at each institution. However, if the part-time faculty member would be eligible by virtue of employment at one institution, that institution will pay the entire cost of the employer contribution regardless of other higher education employment. In cases where the cost of the contribution is prorated between institutions, one institution will forward the entire contribution monthly to HCA; and

(e) Once enrolled, if a part-time faculty member does not work at least a total of half-time in one or more state institutions of higher education, eligibility for the employer contribution ceases.

(6) "Appointed and elected officials." Legislators are eligible to apply for coverage on the date their term begins. All other elected and full-time appointed officials of the legislative and executive branches of state government are eligible to apply for coverage on the date their term begins or they take the oath of office, whichever occurs first. Coverage for legislators begins on the first day of the month following the date their term begins. If the term begins on the first working day of the month, coverage begins on the first day of their term. Coverage begins for all other elected and full-time appointed officials of the legislative and executive branches of state government on the first day of the month following the date their term begins, or the first day of the month following the date they take the oath of

office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of the month, coverage begins on the date the term begins, or the oath of office is taken.

(7) "Judges." Justices of the supreme court and judges of the court of appeals and the superior courts become eligible to apply for coverage on the date they take the oath of office. Coverage begins on the first day of the month following the date their term begins, or the first day of the month following the date they take oath of office, whichever occurs first. If the term begins, or oath of office is taken, on the first working day of a month, coverage begins on the date the term begins, or the oath of office is taken.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-115, filed 3/29/96, effective 4/29/96; 92-08-003, § 182-12-115, filed 3/18/92, effective 3/18/92; 91-14-084, § 182-12-115, filed 7/1/91, effective 7/1/91. Statutory Authority: RCW 41.05.065(3). 90-12-037, § 182-12-115, filed 5/31/90, effective 7/1/90. Statutory Authority: RCW 41.05.065. 89-12-045 (Resolution No. 89-2), § 182-12-115, filed 6/2/89; 89-01-053 (Resolution No. 88-6), § 182-12-115, filed 12/15/88. Statutory Authority: RCW 41.05.010. 88-19-078 (Resolution No. 88-4), § 182-12-115, filed 9/19/88; 88-12-034 (Resolution No. 88-1), § 182-12-115, filed 5/26/88, effective 7/1/88. Statutory Authority: Chapter 41.05 RCW. 86-21-042 (Resolution No. 86-6), § 182-12-115, filed 10/10/86; 83-12-007 (Order 2-83), § 182-12-115, filed 5/20/83; 80-05-016 (Order 2-80), § 182-12-115, filed 4/10/80; 78-08-071 (Order 5-78), § 182-12-115, filed 7/26/78; Order 5646, § 182-12-115, filed 2/9/76.]

WAC 182-12-117 Eligible retirees. (1) "Retirees and disabled employees." Eligible employees who terminate state service after becoming vested in a Washington state sponsored retirement system are eligible for retiree medical, dental and life coverages provided the person:

(a) Elects Medicare Parts A and B if the retiree, or covered dependents of a retiree, retired after July 1, 1991 and is eligible for Medicare; and

(b) Immediately begins receiving a monthly retirement income benefit from such retirement system; or

(c) If not retiring under the public employees retirement system (PERS), would have been eligible for a monthly retirement income benefit because of age and years of service had the person been employed under the provisions of PERS I or PERS II for the same period of employment; or

(d) Is an elected official as defined under 182-12-115(6) who has voluntarily or involuntarily left a public office, whether or not they receive a benefit from a state retirement system; or

(e) Must have taken a lump sum retirement benefit payment because their monthly benefit would have been under fifty dollars.

Employees who are permanently and totally disabled and eligible for a deferred monthly retirement income benefit are likewise eligible, provided they apply for retiree coverage before their PEBB active employee coverage ends. Persons retiring who do not have waiver of premium coverage from any PEBB life insurance plan are eligible for retiree life insurance, subject to the same qualifications as for retiree medical coverage. With the exception of the Washington State Patrol, retirees and disabled employees are not eligible for an employer premium contribution. The Federal Civil Service Retirement System shall be considered a Washington state sponsored retirement system for Washington State University cooperative extension service employees who hold a federal civil service appointment and who are covered under the PEBB program at the time of retirement or disability.

(2) Retired and disabled school district and educational service district employees. The following persons are eligible to participate in PEBB medical and dental plans only, provided they meet the enrollment criteria stated below and if eligible for Medicare, be enrolled in Medicare Parts A and B:

(a) Persons receiving a retirement allowance under chapter 41.32 or 41.40 RCW as of September 30, 1993, and who enroll in PEBB plans not later than the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995;

(b) Persons who separate from employment with a school district or educational service district on or after October 1, 1993, and immediately upon separation begin to receive a retirement allowance under chapter 41.32 or 41.40 RCW. Such persons who retire on or after October 1, 1993, must elect PEBB coverage not later than the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995, or sixty days following retirement whichever is later;

(c) Persons who separate from employment with a school district or educational service district due to a total and permanent disability, and are eligible to receive a deferred retirement allowance under chapter 41.32 or 41.40 RCW. Such persons must enroll in PEBB plans not later than the end of the open enrollment period established by the authority for the plan year beginning January 1, 1995, or sixty days following retirement, whichever is later.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-117, filed 3/29/96, effective 4/29/96.]

WAC 182-12-119 Eligible dependents. "Eligible dependents." The following are eligible as dependents under the PEBB eligibility rules:

(1) Lawful spouse.

(2) Dependent children through age nineteen. The term "children" includes the subscriber's natural children, stepchildren, legally adopted children, children for whom the subscriber has assumed a legal obligation for total or partial support of a child in anticipation of adoption of the child, or children specified in a court order or divorce decree. Married children who qualify as dependents of the subscriber under the Internal Revenue Code, and foster children approved by the HCA are included. To qualify for HCA approval, a foster child must:

(a) Be living with the subscriber in a parent-child relationship;

(b) Be dependent upon the subscriber for financial support;

(c) Not be eligible for coverage under Medicare, Medicaid, or similar government entitlement programs; and

(d) Not be a foster child for whom support payments are made to the subscriber through the state department of social and health services (DSHS) foster care program.

(3) Dependent children age twenty through age twenty-three who are dependent upon the employee/retiree for maintenance and support, and who are registered students in full-time attendance at an accredited secondary school,

college, university, vocational school, or school of nursing. Dependent student eligibility continues year-round for those who attend three of the four school quarters or two semesters and for the quarter following graduation provided the employee/retiree is covered at the same time; the dependent limiting age has not been exceeded; and the dependent meets all other eligibility requirements.

(4) Dependent children of any age who are incapable of self-support due to developmental or physical disability, provided such condition occurs prior to age twenty or during the time the dependent was covered under a PEBB plan as a full-time student. Proof of such disability and dependency must be furnished prior to the dependent's attainment of age twenty or loss of eligibility for student coverage, and as periodically requested thereafter.

(5) Dependent parents. Dependent parents covered under a PEBB medical plan before July 1, 1990, may continue enrollment on a self-pay basis as long as:

(a) The parent maintains continuous coverage in a PEBB-sponsored medical plan;

(b) The parent continues to qualify under the Internal Revenue Code as a dependent of an eligible subscriber;

(c) The subscriber who claimed the parent as a dependent continues enrollment in a PEBB program; and

(d) The parent is not covered by any other group medical insurance. Dependent parents may be enrolled in a different PEBB plan than that selected by the eligible subscriber; however, dependent parents may not add additional family members to their coverage.

(6) Surviving dependents.

(a) The following surviving dependents may continue their medical and dental coverages on a self-pay basis:

(i) If a dependent loses eligibility under a PEBB plan due to the death of the employee or retiree, the dependent(s) may continue coverage under a retiree plan provided the dependent(s) will immediately begin receiving a monthly benefit from any state of Washington-sponsored retirement system (the Federal Civil Service Retirement System shall be considered a Washington sponsored retirement system for Washington State University cooperative extension service employees who held a federal civil service appointment and who were covered under the PEBB program at the time of death).

(ii) If a surviving dependent of a PEBB employee or retiree is not eligible for a monthly retirement income benefit, or lump-sum payment because the monthly pension payment would be less than $50, the dependent may be eligible for continued coverage under COBRA.

(iii) Surviving spouses and/or eligible dependent children of a deceased school district or educational service district employee who were not enrolled in a PEBB plan at the time of death may continue coverage provided the employee died on or after October 1, 1993 and the dependent(s) immediately began receiving a retirement benefit allowance under chapter 41.32 or 41.40 RCW.

(b) Application for surviving dependent(s) coverage must be made in writing on the enrollment form approved by the health care authority within sixty days from the date of death of the employee or retiree. Coverage is retroactive to the date the employee or retiree coverage terminated subject to the payment of the premium. The employee's or retiree's spouse may continue coverage indefinitely; other dependents may continue coverage until they lose eligibility under PEBB rules.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-119, filed 3/29/96, effective 4/29/96.]

WAC 182-12-121 Change in eligibility status. Employees who voluntarily move from an eligible to an otherwise noneligible position shall retain their eligibility for the employer contribution each month in which they are in pay status eight hours or more, provided, (1) the new position is one in which the employee is scheduled to work half time or more, and (2) the employee did not terminate state service before taking the new position. Layoff because of reduction in force is not considered termination of state service. Proviso (1) above does not apply to employees who are on reduction in force status.

[Statutory Authority: Chapter 41.05 RCW. 80-01-082 (Order 5-79), § 182-12-121, filed 12/27/79.]

WAC 182-12-132 Retirees returning to state employment. If a retiree returns to work and is again eligible for employer contributions towards their PEBB or school district sponsored benefits the retiree may cancel their retirement deduction for health coverage as soon as eligibility is established and the retiree is enrolled as an active employee. The retiree must maintain retiree term life coverage during active employment in order to retain it at retirement. When the retiree again ceases active employment, the retiree must reenroll in a PEBB retiree plan within 60 days.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-132, filed 3/29/96, effective 4/29/96; 80-05-016 (Order 2-80), § 182-12-132, filed 4/10/80.]

WAC 182-12-145 Insurance eligibility for higher education. For the purpose of insurance eligibility, the PEBB considers the higher education personnel board, the council for post secondary education, and the state board for community colleges to be higher education agencies.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-145, filed 3/29/96, effective 4/29/96; Order 5646, § 182-12-145, filed 2/9/76.]

WAC 182-12-190 Retirees changing medical plans at retirement. Retirees eligible to continue their medical coverage after retirement may elect to change medical plans at the time of retirement.

[Statutory Authority: Chapter 41.05 RCW. 80-05-016 (Order 2-80), § 182-12-190, filed 4/10/80; Order 4-77, § 182-12-190, filed 11/17/77.]

WAC 182-12-200 Retirees may change enrollment in approved PEBB health plans. A retiree, whose spouse is enrolled as an eligible employee in a PEBB or school district-sponsored health plan, may defer enrollment in PEBB retiree medical and dental plans and enroll in the spouse's PEBB or school district-sponsored health plan. If a retiree defers enrollment in a PEBB retiree medical plan, enrollment must also be deferred for dental coverage. The retiree and eligible dependents may subsequently enroll in a PEBB retiree medical, or medical and dental, plan(s) if the retiree was continuously enrolled under the spouse's PEBB

or school district-sponsored health coverage from the date the retiree was initially eligible for retiree coverage:

(1) During any open enrollment period determined by the HCA; or

(2) Within 31 days of the date the spouse ceases to be enrolled in a PEBB or school district-sponsored health plan as an eligible employee; or

(3) Within 31 days of the date of the retiree's loss of eligibility as a dependent under the spouse's PEBB or school district-sponsored health plan.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-200, filed 3/29/96, effective 4/29/96; Order 4-77, § 182-12-200, filed 11/17/77.]

WAC 182-12-215 Continued PEBB medical/dental coverage under COBRA. Enrollees and eligible dependents who become ineligible for PEBB medical/dental coverage and who qualify for continued coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA), including any amendments hereinafter enacted, may continue their PEBB plan coverage by self-payment of plan premiums in accordance with COBRA statutes and regulations.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-215, filed 3/29/96, effective 4/29/96. Statutory Authority: RCW 41.05.010 and 41.05.025. 91-11-010, § 182-12-215, filed 5/3/91, effective 6/3/91.]

WAC 182-12-220 Eligibility during appeal of dismissal. Employees awaiting hearing of a dismissal action before the personnel appeals board, higher education personnel board or court may continue their PEBB coverages by self-payment of premium on the same terms as an employee who is granted leave without pay. If the hearing board or court upholds the dismissal, coverages shall terminate at the end of the month in which the board or court's decision is made. If the hearing board or court sustains the employee in the appeal and directs reinstatement of employer paid coverages retroactively, the employer must forward to the HCA the full employer contribution for the period directed by the hearing board or court. PEBB will refund to the employee any premiums the employee paid for coverages provided by the employer contribution. All optional life and long term disability insurance which was in force at the time of dismissal shall be reinstated retroactively, provided the employee makes retroactive payment of premium for any such optional coverage which was not continued by self-payment during the appeal process. If the employee chooses not to pay the retroactive premium, evidence of insurability will be required to obtain such optional coverage.

[Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-220, filed 3/29/96, effective 4/29/96; 86-16-061 (Resolution No. 86-3), § 182-12-220, filed 8/5/86.]

Chapter 182-13 WAC
STATE RESIDENT—MEDICARE SUPPLEMENT

WAC

WAC 182-13-010 Purpose. The purpose of this chapter is to establish criteria for state residents for participation in Medicare supplement coverage available through the HCA.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-010, filed 3/3/95, effective 4/3/95.]

WAC 182-13-020 Definitions. Unless otherwise specifically provided, the definitions contained in this section apply throughout this chapter.

(1) "HCA" means the Washington state health care authority.

(2) "Health plan," or "plan" means any individual or group: Policy, agreement, or other contract providing coverage for medical, surgical, hospital, or emergency care services, whether issued, or issued for delivery, in Washington or any other state. "Health Plan" or "plan" also includes self-insured coverage governed by the federal Employee Retirement Income Security Act, coverage through the Health Insurance Access Act as described in chapter 48.41 RCW, coverage through the Basic Health Plan as described in chapter 70.47 RCW, and coverage through the Medicaid program as described in Title 74 RCW. "Health plan" or "plan" does not mean or include: Hospital confinement indemnity coverage as described in WAC 284-50-345; disability income protection coverage as described in WAC 284-50-355; accident only coverage as described in WAC 284-50-360; specified disease and specified accident coverage as described in WAC 284-50-365; limited benefit health insurance coverage as described in WAC 284-50-370; long-term care benefits as described in chapter 48.84 RCW; or limited health care coverage such as dental only, vision only, or chiropractic only.

(3) "Lapse in coverage" means a period of time greater than ninety continuous days without coverage by a health plan.

(4) "Resident" means a person who demonstrates that he/she lives in the state of Washington at the time of application for, and issuance of coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-020, filed 3/3/95, effective 4/3/95.]

WAC 182-13-030 Eligibility. Residents are eligible to apply for Medicare supplement coverage arranged by the HCA when they are:

(1) Eligible for Parts A and B of Medicare, and

(2) Actually enrolled in both Parts A and B of Medicare not later than the effective date of Medicare supplement coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-030, filed 3/3/95, effective 4/3/95.]

WAC 182-13-040 Application for Medicare supplement coverage. Residents meeting eligibility requirements may apply for Medicare supplement coverage arranged by the HCA:

(1) During the initial open enrollment period of January 1 through June 30, 1995, or

(2) Within sixty days after becoming a resident, or

(3) In the thirty day period before the resident becomes eligible for Medicare, or

(4) Within sixty days of retirement, or

(5) During any open enrollment period established by federal or state law, or

(6) During any open enrollment period established by the HCA subsequent to the initial open enrollment period provided that the applicant is replacing a health plan with no lapse in coverage.

[Statutory Authority: RCW 41.05.197. 95-07-011, § 182-13-040, filed 3/3/95, effective 4/3/95.]

Chapter 182-16 WAC
PRACTICE AND PROCEDURE

WAC

WAC 182-16-010 Adoption of model rules of procedure. The model rules of procedure adopted by the chief administrative law judge pursuant to RCW 34.05.250, as now or hereafter amended, are hereby adopted for use by this agency. Those rules may be found in chapter 10-08 WAC. Other procedural rules adopted in this title are supplementary to the model rules of procedure. In the case of a conflict between the model rules of procedure and the procedural rules adopted in this title, the procedural rules adopted in this title shall govern.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-010, filed 6/25/91, effective 7/26/91.]

WAC 182-16-020 Definitions. As used in this chapter the term:

(1) "Administrator" shall mean the administrator of the health care authority;

(2) "Agency" shall mean the health care authority;

(3) "Agent" shall mean a person, association, or corporation acting on behalf of the health care authority pursuant to a contract between the health care authority and the person, association, or corporation.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-020, filed 6/25/91, effective 7/26/91.]

WAC 182-16-030 Appeals from agency decisions—Applicability. Any enrollee of a health care authority-administered insurance plan aggrieved by a decision of the agency or its agent concerning any matter related to scope of coverage, denials of claims, determinations of eligibility, or cancellations or nonrenewals of coverage may obtain administrative review of such decision by filing a notice of appeal with the administrator of the health care authority. Review of decisions made by HMOs or similar health care contractors will be pursuant to the grievance/arbitration provisions of those plans and are not subject to these rules. Except that decisions concerning eligibility determinations are reviewable only by the health care authority.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-030, filed 6/25/91, effective 7/26/91.]

WAC 182-16-040 Appeals—Notice of appeal contents. Any person aggrieved by a decision of the health care authority may appeal that decision by filing a notice of appeal with the administrator. The notice of appeal must contain:

(1) The name and mailing address of the enrollee;

(2) The name and mailing address of the appealing party;

(3) The name and mailing address of the appealing party's representative, if any;

(4) A statement identifying the decision appealed from and that portion of the decision considered unjust or unlawful;

(5) A clear and concise statement of facts in support of appealing party's position;

(6) A statement indicating whether the aggrieved person desires a hearing;

(7) The type of relief sought;

(8) A statement that the appealing party has read the notice of appeal and believes the contents to be true, followed by his/her signature and the signature of his/her representative, if any;

(9) The appealing party shall file, personally or by mail, with the health care authority the original and two copies of the notice of appeal. The notice of appeal must be received by the health care authority within sixty days after the decision of the agency staff was mailed to the appealing party. The agency shall acknowledge receipt of the copies filed with the agency and the agency's stamp placed upon such copies shall be prima facie evidence of the date of receipt;

(10) Within thirty days after receipt of notice of appeal, the agency shall notify the appellant of any obvious errors or omissions, and request any additional information.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-040, filed 6/25/91, effective 7/26/91.]

WAC 182-16-050 Appeals—Hearings. (1) If, in his/her notice of appeal, the person aggrieved does not request a hearing on the matter, the administrator or his/her designee shall consider all information submitted by the parties and render a decision which shall be deemed the final decision of the agency. A copy of that decision accompanied by a written statement of the reasons for the decision shall be served upon the enrollee or person aggrieved and the agency staff or agent who rendered the decision appealed from.

(2) If, in his/her notice of appeal the person aggrieved requests a hearing, the agency shall set the time and place of the hearing and give not less than seven days notice to all parties and persons who have filed written petitions to intervene.

(3) The administrator or his/her designee shall preside at all hearings resulting from the filings of appeals.

(4) All hearings shall be conducted in compliance with these rules, chapter 34.05 RCW and chapter 10-08 WAC as applicable.

(5) Following completion of the hearing, the administrator or his/her designee shall render a decision which shall be the final decision of the agency. A copy of that decision accompanied by a written statement of the reasons for the

decision shall be served on all parties and persons who have intervened.

[Statutory Authority: RCW 41.05.010 and 34.05.250. 91-14-025, § 182-16-050, filed 6/25/91, effective 7/26/91.]

Chapter 182-18 WAC
GENERAL REQUIREMENTS FOR ALL ORGAN TRANSPLANT PROGRAMS

WAC

WAC 182-18-005 Purpose. The purpose of this chapter is to establish general requirements for all organ transplant programs and specific requirements for liver, kidney, pancreas, heart and heart-lung transplant programs. Organ transplant programs must at a minimum meet the criteria outlined in the following sections to be eligible to receive payment for services which are provided to persons covered by the state's uniform medical plan.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-005, filed 8/20/91, effective 9/20/91.]

WAC 182-18-010 Transplant program. (1) The transplant program must be a current member of the United Network for Organ Sharing (UNOS).

(2) The program must have a transplant surgeon and a transplant physician on site who meet both the certification requirements and the specific training and experience requirements for the applicable organ.

(3) The program must have two or more years of experience with transplantation of the applicable organ and must meet the organ-specific volume and outcome requirements.

(4) For patients transplanted from 1985 and after the program must demonstrate actual one-year and two-year patient survival rates that exceed the national averages[1]. If the program's survival rates fall below the national averages, the program must demonstrate that this is related to patient severity (resulting from transplantation of unusually high-risk patients or similar factors). In lieu of actual survival rates, programs may provide actuarial one-year and two-year patient survival rates using the Kaplan-Meier technique.

[1] For liver transplants, the program must demonstrate one-year and two-year patient survival rates that exceed the national averages for patients transplanted from October 1987 and after.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-010, filed 8/20/91, effective 9/20/91.]

WAC 182-18-020 New programs. The "new program" requirement will only apply to abdominal transplant programs, i.e., kidney, liver, and pancreas. Heart and heart-lung programs will not be considered for "new program" status. In addition, thoracic transplant experience (e.g., heart and heart-lung) will not be recognized as adequate experience for establishing a "new program" for abdominal organs.

(1) If the program has less than two years experience with the applicable organ it must meet the following requirements to be considered a "new program":

(a) The program must have two or more years of transplant experience with another organ.

(b) The program must have performed fifty or more transplants of the other organ, i.e., fifty kidney transplants, fifty liver transplants, or fifty pancreas transplants, but not a combination. At least ten of the fifty transplants must have been performed in the past year.

(c) For patients transplanted from 1985 and after the program must demonstrate actual one-year and two-year patient survival rates that exceed the national averages[1]. If the program's survival rates fall below the national averages, the program must demonstrate that this is related to patient severity (resulting from transplantation of unusually high-risk patients or similar factors). In lieu of actual survival rates, programs may provide actuarial one-year and two-year patient survival rates using the Kaplan-Meier technique.

(d) The program must have a transplant surgeon and a transplant physician on site who meet the specific training and experience requirements for the applicable organ.

(e) The program must have performed four transplants of the applicable organ within a two-month period, with acceptable outcomes.

(2) A program that meets these requirements will be considered a "new program."

[1] For liver transplants, the program must demonstrate one-year and two-year patient survival rates that exceed the national averages for patients transplanted from October 1987 and after.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-020, filed 8/20/91, effective 9/20/91.]

WAC 182-18-030 Pediatric programs. (1) Pediatric programs that fail to meet the organ-specific volume requirements, but meet all other requirements, will be considered on a provisional basis, provided they meet the following criteria:

(a) The pediatric program is closely affiliated with an adult program.

(b) The pediatric program shares its primary transplant surgeon with the affiliated adult program.

(c) The program has performed a minimum volume of pediatric transplants with acceptable outcomes. The organ-specific minimum volumes will be at least: Three pediatric heart or heart-lung transplants; four pediatric liver transplants; two pediatric kidney transplants; and two pediatric pancreas transplants.

(2) Pediatric programs that meet these requirements may combine their volumes and outcomes with their affiliated adult program.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-030, filed 8/20/91, effective 9/20/91.]

WAC 182-18-040 Transplant team training and experience. (1) The primary transplant surgeon(s) must be certified by the American Board of Surgery or the American Board of Urology or its equivalent.

(2) The primary transplant physician(s) must be certified by the American Board of Internal Medicine or its equivalent.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-040, filed 8/20/91, effective 9/20/91.]

WAC 182-18-050 Multiple organ transplants. Coverage for multiple organ transplants other than heart-lung transplants will be carefully evaluated on a case-by-case basis by the health care authority and its medical advisors.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-050, filed 8/20/91, effective 9/20/91.]

WAC 182-18-060 Institutional commitment. (1) The hospital or medical center must allocate adequate resources to the transplant program including, but not limited to, the following: Funding; surgical beds; operating and recovery room resources; and intensive care resources.

(2) The hospital or medical center must provide an adequate level of collaborative support from physicians and ancillary health professionals in the fields of: Anesthesiology; hematology; immunology; infectious diseases; nursing; organ procurement; oncology; pathology; pediatrics (if appropriate); physical medicine and rehabilitation; pulmonary medicine and respiratory support; radiology; social services and tissue typing.

(3) The program must have a nursing team that is trained in managing the special problems of immunosuppressed patients.

(4) The program must have an anesthesia team that is available at all times.

(5) Adequate blood bank services must be available to provide large quantities of blood on short notice.

(6) The program must have adequate plans for organ procurement.

(7) The program must have adequate malpractice and liability insurance.

(8) The program must conduct regular quality assurance evaluations.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-060, filed 8/20/91, effective 9/20/91.]

WAC 182-18-070 Patient management. (1) The program must have patient assessment and management protocols that address the following phases of treatment: Waiting; hospitalization; post-discharge; and long-term management.

(2) The program must have established plans or procedures for managing patient complications and must demonstrate their capacity to respond immediately to patient emergencies.

(3) The program must have plans for maintaining adequate communication with referring physicians.

(4) The program must have plans for communicating with and educating the patient and family during the following phases of treatment: Waiting; hospitalization; post-discharge; and long-term management.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-070, filed 8/20/91, effective 9/20/91.]

WAC 182-18-080 General recipient selection criteria for all organs. (1) The transplant program must have established selection procedures and written criteria for determining the suitability of patients for transplantation. The procedures and criteria must ensure that candidates are selected in a fair manner.

(2) The transplant program's selection criteria must include generally accepted indications and contraindications that are specific to the applicable organ.

(3) The program's selection criteria must include the following, or similar, considerations:

(a) The candidate must be selected based on critical medical need and maximum likelihood of a successful outcome.

(b) The candidate must be emotionally stable with a realistic attitude demonstrated to the past and current illness. The patient must be capable of following a complex medical regimen for the rest of his/her life, after transplantation.

(c) The candidate must have the social and/or family support needed for him/her to adhere to the complex post-operative treatment program.

(4) When persons covered by the Washington state uniform medical plan are considered for candidacy, the program must submit completed patient evaluations to the Washington state health care authority.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-080, filed 8/20/91, effective 9/20/91.]

LIVER TRANSPLANT PROGRAMS SPECIFIC REQUIREMENTS

WAC 182-18-090 Liver transplant program. (1) The program must have performed a minimum of twenty liver transplants. At least ten of the twenty operations must have been performed in the past year.

(2) The hospital or medical center must provide an adequate level of collaborative support from physicians and ancillary health professionals in the field of hepatology.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-090, filed 8/20/91, effective 9/20/91.]

WAC 182-18-100 Liver transplant team training and experience. (1) The primary transplant surgeon must have at least one year of formal training and one year of

experience in performing liver transplants at a program that meets UNOS training requirements for livers. Training must have followed the residency or fellowship for the appropriate board certification. Experience must include preoperative assessment, post-operative management and operation as a primary surgeon for an optimum of twelve or more and a minimum of six liver transplants.

(2) In lieu of the above, the primary transplant surgeon must have three or more years of experience which include preoperative assessment, post-operative management and operation as a primary surgeon for an optimum of thirty-six or more and a minimum of eighteen liver transplants. Experience must have been acquired in a program that meets UNOS membership criteria.

(3) The primary transplant physician must have one year of formal training in transplantation medicine in a program that meets UNOS membership criteria. Training must have followed the residency or fellowship for the appropriate board certification. Training must include preoperative and post-operative patient care for an optimum of twelve or more and a minimum of six liver transplants.

(4) In lieu of the above, the primary transplant physician must have a minimum of two years of experience in transplantation medicine in a program that meets UNOS membership criteria. Experience must include patient care responsibility during the preoperative and post-operative period for an optimum of twenty-four or more and a minimum of twelve liver transplants.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-100, filed 8/20/91, effective 9/20/91.]

KIDNEY TRANSPLANT PROGRAMS SPECIFIC REQUIREMENTS

WAC 182-18-110 Kidney transplant program. (1) The program must have performed a minimum of thirty kidney transplants. At least ten of the thirty operations must have been performed in the past year.

(2) The hospital or medical center must provide an adequate level of collaborative support from physicians and ancillary health professionals in the field of nephrology.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-110, filed 8/20/91, effective 9/20/91.]

WAC 182-18-120 Kidney transplant team training and experience. (1) The primary transplant surgeon must have at least one year of formal training and one year of experience in performing kidney transplants at a program that meets UNOS training requirements for kidney transplants. Training must have followed the residency or fellowship for the appropriate board certification. Experience must include preoperative assessment, post-operative management and operation as a primary surgeon for an optimum of twenty or more and a minimum of ten kidney transplants.

(2) In lieu of the above, the primary transplant surgeon must have three or more years of experience which include preoperative assessment, post-operative management and operation as a primary surgeon for an optimum of sixty or more and a minimum of thirty kidney transplants. Experience must have been acquired in a program that meets UNOS membership criteria.

(3) The primary transplant physician must have one year of formal training in transplantation medicine in a program that meets UNOS membership criteria. Training must have followed the residency or fellowship for the appropriate board certification. Training must include preoperative and post-operative patient care for an optimum of twenty or more and a minimum of ten kidney transplants.

(4) In lieu of the above, the primary transplant physician must have a minimum of two years of experience in transplantation medicine in a program that meets UNOS membership criteria. Experience must include patient care responsibility during the preoperative and post-operative period for an optimum of forty or more and a minimum of twenty kidney transplants.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-120, filed 8/20/91, effective 9/20/91.]

PANCREAS TRANSPLANT PROGRAMS SPECIFIC REQUIREMENTS

WAC 182-18-130 Pancreas transplant program. (1) The program must have performed a minimum of fifteen pancreas transplants. At least ten of the fifteen operations must have been performed in the past year.

(2) The hospital or medical center must provide an adequate level of collaborative support from physicians and ancillary health professionals in the field of endocrinology.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-130, filed 8/20/91, effective 9/20/91.]

WAC 182-18-140 Pancreas transplant team training and experience. (1) The primary transplant surgeon must have at least one year of formal training and one year of experience in performing pancreas transplants at a program that meets UNOS training requirements for pancreas transplants. Training must have followed the residency or fellowship for the appropriate board certification. Experience must include preoperative assessment, post-operative management and operation as a primary surgeon for an optimum of ten or more and a minimum of five pancreas transplants.

(2) In lieu of the above, the primary transplant surgeon must have three or more years of experience which include preoperative assessment, post-operative management and operation as a primary surgeon for an optimum of thirty or more and a minimum of fifteen pancreas transplants. Experience must have been acquired in a program that meets UNOS membership criteria.

(3) The primary transplant physician must have one year of formal training in transplantation medicine in a program that meets UNOS membership criteria. Training must have followed the residency or fellowship for the appropriate board certification. Training must include preoperative and post-operative patient care for an optimum of ten or more and a minimum of five pancreas transplants.

(4) In lieu of the above, the primary transplant physician must have a minimum of two years of experience in transplantation medicine in a program that meets UNOS membership criteria. Experience must include patient care responsi-

bility during the preoperative and post-operative period for an optimum of twenty or more and a minimum of ten pancreas transplants.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-140, filed 8/20/91, effective 9/20/91.]

HEART AND/OR HEART-LUNG TRANSPLANT PROGRAMS SPECIFIC REQUIREMENTS

WAC 182-18-150 Heart and/or heart-lung transplant program. (1) The program must be approved by Medicare and must have performed a minimum of thirty-six heart and/or heart-lung transplants. At least twelve operations must have been performed in each of the past two years.

(2) The hospital or medical center must provide an adequate level of collaborative support from physicians and ancillary health professionals in the fields of cardiology, pulmonary medicine, and cardiovascular surgery.

(3) The hospital or medical center must have an active cardiovascular medical and surgical program. General indicators of this type of program would be a minimum of five hundred cardiac catheterizations and coronary arteriograms annually, with the ability and willingness to do these procedures on an emergency basis and a surgical group that has demonstrated low mortality rates in an active open heart surgical program involving at least two hundred fifty procedures a year.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-150, filed 8/20/91, effective 9/20/91.]

WAC 182-18-160 Heart and/or heart-lung transplant team training and experience. Training and experience requirements for the primary heart or heart-lung transplant surgeon can be met as follows:

(1) The primary transplant surgeon must be certified by the American Board of Thoracic Surgery or its equivalent.

(2) Training and experience during the applicant's cardiothoracic residency:

(a) The individual performed as primary surgeon twenty or more heart or heart-lung transplant procedures (application should be supported by operative notes) during his/her cardiothoracic fellowship.

(b) The individual has been involved in all levels of heart transplantation and patient care including donor selection, organ procurement, recipient selection, post-operative hemodynamic care, post-operative immunosuppressive therapy, and outpatient follow-up.

(c) The individual has a letter from the director of the training program verifying that the fellow has met the above requirements and that the fellow is qualified to direct a cardiac transplant program.

(d) The above training was at a medical center with a cardiothoracic training program that is approved by the American Board of Thoracic Surgery or, in the case of foreign training, by the UNOS Membership and Professional Standards Committee.

(3) When the training and experience requirements for the transplant surgeon have not been met during one's cardiothoracic residency, they can be met during a subsequent twelve-month cardiac transplant fellowship if all the following conditions are met:

(a) The fellow performed as primary surgeon twenty or more heart or heart-lung transplant procedures (application must be supported by operative notes) during his/her cardiac transplant fellowship.

(b) The fellow has been involved in all levels of heart transplantation and patient care including donor selection, organ procurement, recipient selection, post-operative hemodynamic care, post-operative immunosuppressive therapy, and outpatient follow-up.

(c) The fellow has a letter from the director of the training program verifying that the fellow has met the above requirements, and that the fellow is qualified to direct a cardiac transplant program.

(d) The above training was at a medical center with a cardiothoracic training program that is approved by the American Board of Thoracic Surgery and/or the UNOS Membership and Professional Standards Committee, or in the case of a foreign transplant center, one that has been reviewed by UNOS to assure that the program's overall training experience is acceptable.

(4) If the transplant surgeon requirements have not been met, as outlined above, in a cardiothoracic residency or heart transplant fellowship, they can be met by experience if the following conditions are met:

(a) The surgeon performed as primary surgeon, over a minimum of two or a maximum of three years, twenty or more heart or heart-lung transplant procedures at a UNOS member heart transplant program or its foreign equivalent (application should be supported by operative notes; transplants performed during board qualifying surgical residency do not count).

(b) The surgeon has been involved in all levels of heart transplantation and patient care including donor selection, organ procurement, recipient selection, post-operative hemodynamic care, post-operative immunosuppressive therapy, and outpatient follow-up.

(c) The surgeon has a letter from the director of this UNOS transplant program verifying that the surgeon has met the above requirements, and is qualified to direct a cardiac transplant program.

(5) The primary transplant physician must have one year of formal training in transplantation medicine in a program that meets UNOS membership criteria. Training must have followed the residency or fellowship for the appropriate board certification. Training must include preoperative and post-operative patient care for an optimum of fifteen or more and a minimum of seven heart and/or heart-lung transplants.

(6) In lieu of the above, the primary transplant physician must have a minimum of two years of experience in transplantation medicine in a program that meets UNOS membership criteria. Experience must include patient care responsibility during the preoperative and post-operative period for an optimum of thirty or more and a minimum of fourteen heart and/or heart-lung transplants.

[Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-160, filed 8/20/91, effective 9/20/91.]

Chapter 182-20 WAC
STANDARDS FOR COMMUNITY HEALTH CLINICS

WAC

WAC 182-20-001 Purpose. The purpose of this chapter is to establish procedures for determining eligibility and distribution of funds for medical, dental, and migrant services to community health clinics under section 214(3), chapter 19, Laws of 1989 1st ex. sess., including other state general fund appropriations for medical, dental, and migrant services in community health clinics since 1985.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-001, filed 5/26/95, effective 6/26/95.]

WAC 182-20-010 Definitions. For the purposes of these rules, the following words and phrases shall have these meanings unless the context clearly indicates otherwise.

(1) "Community health clinic" means a public or private nonprofit tax exempt corporation with the mission of providing primary health care to low income individuals at a charge based upon ability to pay.

(2) "Authority" means the Washington state health care authority.

(3) "Encounter" means a face-to-face contact between a patient and a health care provider exercising independent judgment, providing primary health care, and documenting the care in the individual's health record.

(4) "Health care provider" means any person having direct or supervisory responsibility for the delivery of health care including:

(a) Physicians under chapters 18.57 and 18.71 RCW;

(b) Dentists under chapter 18.32 RCW;

(c) Advanced registered nurse practitioner under chapter 18.88 RCW;

(d) Physician's assistant under chapters 18.71A and 18.57A RCW;

(e) Dental hygienist under chapter 18.29 RCW;

(f) Licensed midwife under chapter 18.50 RCW;

(g) Federal uniformed service personnel lawfully providing health care within Washington state.

(5) "Low-income individual" means a person with income at or below two hundred percent of federal poverty level. The poverty level has been established by Public Law 97-35 § 652 (codified at 42 USC 9847), § 673(2) (codified at 42 USC 9902 (2)) as amended; and the *Poverty Income Guideline* updated annually in the *Federal Register*.

(6) "Primary health care" means a basic level of preventive and therapeutic medical and/or dental care, usually delivered in an outpatient setting, and focused on improving and maintaining the individual's general health.

(7) "Relative value unit" means a standard measure of performance based upon time to complete a clinical procedure. The formula is one unit equals ten minutes. A table is available from the authority stating the actual values.

(8) "Administrator" means the administrator of the health care authority or the administrator's designee.

(9) "User" means an individual having one or more primary health care encounters and counted only once during a calendar year.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-010, filed 5/26/95, effective 6/26/95.]

WAC 182-20-100 Administration. The authority shall contract with community health clinics to provide primary health care in the state of Washington by:

(1) Developing criteria for the selection of community health clinics to receive funding;

(2) Establishing statewide standards governing the granting of awards and assistance to community health clinics;

(3) Disbursing funds appropriated for community health clinics only to those clinics meeting the criteria in WAC 182-20-160;

(4) Distributing available state funds to community health clinics according to the following priority in the order listed:

(a) First, to community health clinics that are private, nonprofit corporations classified exempt under Internal Revenue Service Rule 501 (c)(3) when governed by a board of directors including representatives from the populations served;

(b) Second, to local health jurisdictions with an organized primary health clinic or division;

(c) Third, to private nonprofit or public hospitals with an organized primary health clinic or department.

(5) Reviewing records and conducting on-site visits of contractors as necessary to assure compliance with these rules; and

(6) Withholding funding from a contractor until such time as satisfactory evidence of corrective action is received and approved by the authority, if the authority determines:

(a) Noncompliance with applicable state law or rule; or

(b) Noncompliance with the contract; or

(c) Failure to provide such records and data required by the authority to establish compliance with section 214(3), chapter 19, Laws of 1989 1st ex. sess., this chapter, and the contract; or

(d) The contractor or applicant provided inaccurate information in the application.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-100, filed 5/26/95, effective 6/26/95.]

WAC 182-20-130 Application for funds. (1) The authority shall, upon request, supply a prospective applicant with an application kit for a contract requesting information as follows:

(a) Include in the application a request for information as follows:

(i) The applicant's name, address, and telephone number;

(ii) A description of the primary health care provided;

(iii) A brief statement of intent to apply for funds;

(iv) The signature of the agency's authorized representative;

(v) Description of the nature and scope of services provided or planned;

(vi) Evidence of a current financial audit establishing financial accountability; and

(vii) A description of how the applicant meets eligibility requirements under WAC 182-20-160;

(b) Notify existing contractors at least ninety days in advance of the date a new contract application is due to the authority;

(c) Review completed application kits for evidence of compliance with this section;

(d) Develop procedures for:

(i) Awarding of funds for new contractors, special projects, and emergency needs of existing contractors; and

(ii) Notifying existing and prospective contractors of procedures and application process.

(2) The applicant shall:

(a) Complete the application on standard forms provided or approved by the authority; and

(b) Return the completed application kit to the authority by the specified due date.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-130, filed 5/26/95, effective 6/26/95.]

WAC 182-20-160 Eligibility. Applicants shall:

(1) Demonstrate private, nonprofit, tax exempt status incorporated in Washington state or public agency status under the jurisdiction of a local or county government;

(2) Receive other funds from at least one of the following sources:

(a) Section 329 of the Public Health Services Act;

(b) Section 330 of the Public Health Services Act;

(c) Community development block grant funds;

(d) Title V Urban Indian Health Service funds; or

(e) Other public or private funds providing the clinic demonstrates:

(i) Fifty-one percent of total clinic population are low income;

(ii) Fifty-one percent or greater of funds come from sources other than programs under WAC 182-20-160;

(3) Operate as a community health clinic providing primary health care for at least eighteen months prior to applying for funding;

(4) Provide primary health care services with:

(a) Twenty-four-hour coverage of the clinic including provision or arrangement for medical and/or dental services after clinic hours;

(b) Direct clinical services provided by one or more of the following:

(i) Physician licensed under chapters 18.57 and 18.71 RCW;

(ii) Physician's assistant licensed under chapters 18.71A and 18.57A RCW;

(iii) Advanced registered nurse practitioner under chapter 18.88 RCW;

(iv) Dentist under chapter 18.32 RCW;

(c) Provision or arrangement for services as follows:

(i) Preventive health services on-site or elsewhere including:

(A) Eye and ear examinations for children;

(B) Perinatal services;

(C) Well-child services; and

(D) Family planning services;

(ii) Diagnostic and treatment services of physicians and where feasible a physician's assistant and/or advanced registered nurse practitioner, on-site;

(iii) Services of a dental professional licensed under Title 18 RCW on-site or elsewhere;

(iv) Diagnostic laboratory and radiological services on-site or elsewhere;

(v) Emergency medical services on-site or elsewhere;

(vi) Arrangements for transportation services;

(vii) Preventive dental services on-site or elsewhere; and

(viii) Pharmaceutical services, as appropriate, on-site or elsewhere;

(5) Demonstrate eligibility to receive and receipt of reimbursement from:

(a) Public insurance programs; and

(b) Public assistant programs, where feasible and possible;

(6) Have established a sliding scale fee schedule for adjustment of charges, based upon the individual's ability to pay for low-income individuals;

(7) Provide health care regardless of the individual's ability to pay; and

(8) Establish policies and procedures reflecting sensitivity to cultural and linguistic differences of individuals served and provide sufficient staff with the ability to communicate with the individuals.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-160, filed 5/26/95, effective 6/26/95.]

WAC 182-20-200 Allocation of state funds. The authority shall allocate available funds to medical, dental and migrant contractors providing primary health care based on the following criteria:

(1) **Medical.**

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by April 1 of each year;

(B) Prorated according to the percentage of total medical contract funds distributed to each contractor;

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "medical base." The medical base means the total amount of money appropriated by the legislature for the medical program minus the amounts specified in (a)(i) and (ii) of this subsection. The medical base is distributed to medical contractors based upon the following formulas:

(i) The medical base is distributed to medical contractors based upon the following formula until June 30, 1995:

(A) Forty percent of the medical base is distributed equally among all medical contractors;

(B) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical users divided by the total medical sliding fee users

of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's medical users}}{\text{total of all contractors' medical users}} \times 30\% \text{ medical base}$$

(C) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical encounters by the total number of medical encounters reported by all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's medical encounters}}{\text{total of all contractors' medical encounters}} \times 30\% \text{ medical base}$$

(ii) Starting July 1, 1995, the medical base is distributed to medical contractors based upon the following formula:

(A) Forty percent of the medical base is distributed equally among all medical contractors;

(B) Sixty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee users divided by the total medical sliding fee users of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's medical sliding fee users}}{\text{total of all contractors' medical sliding fee users}} \times 60\% \text{ medical base}$$

(iii) Starting July 1, 1996, the medical base is distributed to medical contractors based upon the following formula:

(A) Forty percent of the medical base is distributed equally among all medical contractors;

(B) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee users divided by the total medical users of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's medical sliding fee users}}{\text{total of all contractors' medical sliding fee users}} \times 30\% \text{ medical base}$$

(C) Thirty percent of the medical base is distributed by the ratio of the contractor's primary health care (PHC) medical sliding fee encounters by the total number of medical sliding fee encounters reported by all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's medical sliding fee encounters}}{\text{total of all contractors' medical sliding fee encounters}} \times 30\% \text{ medical base}$$

(2) **Dental.**

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent of appropriated funds to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by April 1 of each year;

(B) Prorated according to the percentage of total dental contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the funds is referred to as the dental base. The dental base means the total amounts appropriated by the legislature for dental programs minus the amounts specified in (a)(i) and (ii) of this subsection and as follows:

(i) The dental base is distributed to dental contractors based upon the following formula until June 30, 1995:

(A) Forty percent of the dental base distributed equally among all dental contractors;

(B) Thirty percent of the dental base distributed by the ratio of contractor primary health care (PHC) medical users divided by the total medical users of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's medical users}}{\text{total of all contractors' users}} \times 30\% \text{ dental base}$$

(C) Thirty percent of the dental base is distributed by the ratio of the contractor's relative value units (RVU) divided by the total relative value units of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's RVU}}{\text{total of all contractors' RVU}} \times 30\% \text{ dental base}$$

(ii) Starting July 1, 1995, the dental base is distributed to dental contractors based upon the following formula:

(A) Forty percent of the dental base is distributed equally among all dental contractors;

(B) Sixty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee users divided by the total dental sliding fee users of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's dental sliding fee users}}{\text{total of all contractors' dental sliding fee users}} \times 60\% \text{ dental base}$$

(iii) Starting July 1, 1996, the dental base is distributed to dental contractors based upon the following formula:

(A) Forty percent of the dental base is distributed equally among all dental contractors;

(B) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee users divided by the total dental sliding fee users of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's dental sliding fee users}}{\text{total of all contractors' dental sliding fee users}} \times 30\% \text{ dental base}$$

(C) Thirty percent of the dental base is distributed by the ratio of the contractor's primary health care (PHC) dental sliding fee relative value units (RVU) divided by the total number of dental sliding fee relative value units (RVU) reported by all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's dental sliding fee RVUs}}{\text{total of all contractors' dental sliding fee RVUs}} \times 30\% \text{ dental base}$$

(3) **Migrant.**

(a) The authority may withhold appropriated funds as follows:

(i) As specified under law or up to ten percent to provide funding for new contractors, special projects, and emergency needs:

(A) With distribution of any remaining portion of this ten percent among contractors by April 1 of each year;

(B) Prorated according to the percentage of total migrant contract funds distributed to each contractor.

(ii) Up to ten percent for administration.

(b) The remainder of the appropriated funds is referred to as the "migrant base." The migrant base means the total amount of money appropriated by the legislature for the migrant program minus the amounts specified in (a)(i) and (ii) of this subsection. The migrant base is distributed to migrant contractors based upon the following formula:

The migrant base is distributed to migrant contractors based upon the following formula starting July 1, 1995: One hundred percent of the migrant base is distributed by the ratio of the contractor's primary health care (PHC) migrant users divided by the total migrant users of all contractors as reported in the prior calendar year annual reports.

$$\frac{\text{individual contractor's migrant users}}{\text{total of all contractors' migrant users}} \times 100\% \text{ migrant base}$$

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-200, filed 5/26/95, effective 6/26/95.]

WAC 182-20-300 Dispute resolution procedures. The authority shall define dispute resolution procedures in the contract which shall be the exclusive remedy and shall be binding and final to all parties.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-300, filed 5/26/95, effective 6/26/95.]

WAC 182-20-320 Audit review. Contractors shall:

(1) Maintain books, records, documents, and other materials relevant to the provision of goods or services adequate to document the scope and nature of the goods or services provided;

(2) Make the materials in subsection (1) of this section available at all reasonable times with prior notice for inspection by the authority;

(3) Retain these materials for at least three years after the initial contract with the authority;

(4) Provide access to the facilities at all reasonable times with prior notice for on-site inspection by the authority; and

(5) Submit annual reports consistent with the instructions of the authority.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-320, filed 5/26/95, effective 6/26/95.]

WAC 182-20-400 Limitations on awards. Specific to the medical, dental, and migrant base as referenced in WAC 182-20-200 (1)(b), (2)(b), and (3)(b):

(1) Until June 30, 1995:

(a) Any approved contractor shall initially receive no more than one hundred ten percent of that contractor's previous year's initial allotment.

(b) Any approved contractor shall initially receive no less than ninety percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide ninety percent, criteria shall be established to equitably allocate the available funds.

(c) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

(2) Between July 1, 1995, and June 30, 1996:

(a) Any approved contractor shall initially receive no more than one hundred twenty-five percent of that contractor's previous year's initial allotment.

(b) Any approved contractor shall initially receive no less than eighty-five percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide eighty-five percent, criteria shall be established to equitably allocate the available funds.

(c) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

(3) Between July 1, 1996, and June 30, 1997:

(a) Any approved contractor shall initially receive no more than one hundred twenty-five percent of that contractor's previous year's initial allotment.

(b) Any approved contractor shall initially receive no less than eighty percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide eighty percent, criteria shall be established to equitably allocate the available funds.

(c) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

(4) Starting July 1, 1997:

(a) Any approved contractor shall initially receive no more than one hundred twenty-five percent of that contractor's previous year's initial allotment.

(b) Any approved contractor shall initially receive no less than seventy-five percent of that contractor's previous year's initial allotment. In the event that funding is inadequate to provide seventy-five percent, criteria shall be established to equitably allocate the available funds.

(c) Funds in excess of the initial allocation shall be distributed in a supplemental allotment pursuant to WAC 182-20-200.

[Statutory Authority: RCW 43.70.040. 95-12-010, § 182-20-400, filed 5/26/95, effective 6/26/95.]

Chapter 182-25 WAC
WASHINGTON BASIC HEALTH PLAN

WAC

WAC 182-25-001 Authority. The administrator's authority to promulgate and adopt rules is contained in RCW 70.47.050.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-001, filed 7/9/96, effective 8/9/96.]

WAC 182-25-010 Definitions. The following definitions apply throughout these rules.

(1) "Administrator" means the administrator of the Washington state health care authority (HCA) or designee.

(2) "Appeal procedure" means a formal written procedure for resolution of problems or concerns raised by enrollees which cannot be resolved in an informal manner to the enrollee's satisfaction.

(3) "Basic health plan" (or BHP) means the system of enrollment and payment on a prepaid capitated basis for basic health care services administered by the administrator through managed health care systems.

(4) "BHP plus" means the program of expanded benefits available to children through coordination between the department of social and health services (DSHS) and basic health plan. To be eligible for the program children must be under age nineteen, with a family income at or below two hundred percent of federal poverty level, as defined by the United States Department of Health and Human Services. They must be Washington state residents, not eligible for Medicare, and may be required to meet additional DSHS eligibility requirements.

(5) "Co-payment" means a payment indicated in the schedule of benefits which is made by an enrollee to a health care provider or to the MHCS.

(6) "Covered services" means those services and benefits in the BHP schedule of benefits (as outlined in the member handbook issued to the enrollee, or to a subscriber on behalf of the enrollee), which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments.

(7) "Disenrollment" means the termination of covered services in BHP for a subscriber and dependents, if any.

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

(9) "Dependent." The following are eligible as dependents under BHP:

(a) Lawful spouse of the subscriber, if not legally separated, who resides in the same residence.

(b) Dependent child who is an unmarried child and who is:

(i) Younger than age nineteen and is one of the following: A natural child, stepchild or legally adopted child of a subscriber; or a child who has been placed with a subscriber pending adoption or is under legal guardianship of a subscriber.

(ii) Younger than age twenty-three and is a registered student in full-time attendance at an accredited secondary school, college, university, technical college or school of nursing. Dependent student eligibility continues year-round, including the quarter or semester following graduation, for those who attend full time (except for school holidays and scheduled spring and summer breaks) provided the subscriber is covered at the same time; the dependent limiting age has not been exceeded; and the dependent meets all other eligibility requirements.

(c) Legal dependent of any age who is incapable of self-support due to disability.

(10) "Eligible full-time employee" means an employee who meets all eligibility requirements in WAC 182-25-030 and who is regularly scheduled to work thirty or more hours per week for an employer. The term includes a self-employed individual (including a sole proprietor or a partner of a partnership, and may include an independent contractor) if the individual:

(a) Is regularly scheduled to work thirty hours or more per week; and

(b) Derives at least seventy-five percent of his or her income from a trade or business that is licensed to do business in Washington.

Persons covered under a health benefit plan pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1986 shall not be considered eligible employees for purposes of minimum participation requirements.

(11) "Eligible part-time employee" means an employee who meets all the criteria in subsection (10) of this section, but who is regularly scheduled to work fewer than thirty hours per week for an employer.

(12) "Employee" means one who is in the employment of an employer, as defined by RCW 50.04.080.

(13) "Employer" means an enterprise licensed to do business in Washington state, as defined by RCW 50.04.080.

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

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

(16) "Financial sponsor" means a person, organization or other entity, approved by the administrator, that is responsible for payment of all or a designated portion of the monthly premiums on behalf of a subscriber and any dependents.

(17) "Gross family income" means total cash receipts, as defined in (a) of this subsection, before taxes, from all sources, for subscriber and dependents whether or not they are enrolled in BHP, with the exceptions noted in (b) of this subsection.

(a) Income includes:

(i) Money wages, tips and salaries before any deductions;

(ii) Net receipts from nonfarm self-employment (receipts from a person's own unincorporated business, professional enterprise, or partnership, after deductions for business expenses);

(iii) 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);

(iv) Regular payments from Social Security, railroad retirement, unemployment compensation, strike benefits from union funds, workers' compensation, veterans' payments, public assistance, alimony, child support, military family allotments, private pensions, government employee pensions (including military retirement pay), and regular insurance or annuity payments;

(v) Work study or training stipends;

(vi) College or university scholarships, grants, fellowships and assistantships, if received as or convertible by the recipient into cash;

(vii) Dividends and interest accessible to the enrollee without a penalty;

(viii) Net rental income, net royalties, periodic receipts from estates or trusts, and net gambling or lottery winnings.

(b) Income does not include the following types of money received:

(i) Capital gains;

(ii) Any assets drawn down as withdrawals from a bank, the sale of property, a house or a car;

(iii) Tax refunds, gifts, loans, lump-sum inheritances, one-time insurance payments, or compensation for injury (except workers' compensation);

(iv) 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 noncash benefit programs as Medicare, Medicaid, food stamps, school lunches, and housing assistance;

(v) Income earned by dependent children;

(vi) Income of a family member who resides in another household when such income is not available to the subscriber or dependents seeking enrollment in BHP;

(vii) University scholarships, grants, fellowships and assistantships if not convertible to cash;

(viii) Documented child care expenses for the care of a dependent child of a subscriber may be deducted (at a rate set by the administrator and consistent with Internal Revenue Service requirements) when calculating gross family income. To qualify for this deduction, the subscriber must be employed during the time the child care expenses were paid, and payment may not be paid to a parent or step parent of the child or to a dependent child of the subscriber or his/her spouse.

(18) "Home care agency" means a private or public agency or organization that administers or provides home care services directly or through a contract arrangement to ill, disabled, or infirm persons in places of temporary or permanent residence, and is licensed by the department of social and health services (DSHS) as a home care agency. In order to qualify, the agency must be under contract with one of the following DSHS programs: Chore, Medicaid Personal Care, Community Options Program Entry System (COPES) or Respite Care (up to level three).

(19) "Insurance broker" or "agent" means a person who is currently licensed as a disability insurance broker or agent, according to the laws administered by the office of the insurance commissioner under chapter 48.17 RCW.

(20) "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) which has entered into a contract with the HCA to provide basic health care services.

(21) "Medicaid" means the Title XIX Medicaid program administered by the department of social and health services, and includes the medical care programs provided to the "categorically needy" and the "medically needy" as defined in chapter 388-503 WAC.

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

(23) "Nonsubsidized enrollee" or "full premium enrollee" means an individual who enrolls in BHP, as the subscriber or dependent, and who pays or on whose behalf is paid the full costs for participation in BHP, without subsidy from the HCA.

(24) "Open enrollment" means a time period designated by the administrator during which enrollees may enroll additional dependents or apply to transfer their enrollment from one managed health care system to another. There shall be at least one annual open enrollment period of at least twenty consecutive days.

(25) "Participating employee" means an employee of a participating employer or home care agency who has met all the eligibility requirements and has been enrolled for coverage under BHP.

(26) "Participating employer" means an employer who has been approved for enrollment in BHP as an employer group.

(27) "Preexisting condition" means any illness, injury or condition for which, in the three months immediately preceding an enrollee's effective date of enrollment in BHP:

(a) Treatment, consultation or a diagnostic test was recommended for or received by the enrollee; or

(b) The enrollee was prescribed or recommended medication; or

(c) Symptoms existed which would ordinarily cause a reasonably prudent individual to seek medical diagnosis, care or treatment.

(28) "Premium" means a periodic payment, based upon gross family income and determined under RCW 70.47.060(2), which an individual, their employer or a financial sponsor makes to BHP for subsidized or nonsubsidized enrollment in BHP.

(29) "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.

(30) "Rate" means the per capita amount, including administrative charges and any applicable premium and prepayment tax imposed under RCW 48.14.020, negotiated by the administrator with and paid to a managed health care system, to provide BHP health care benefits to enrollees.

(31) "Schedule of benefits" means the basic health care services adopted and from time to time amended by the administrator, which an enrollee shall be entitled to receive from a managed health care system in exchange for payment of premium and applicable co-payments, as described in the member handbook.

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

(33) "Subscriber" is a person who applies to BHP on his/her own behalf and/or on behalf of his/her dependents, if any, who meets all applicable eligibility requirements, is enrolled in BHP, and for whom the monthly premium has been paid. Notices to a subscriber and, if applicable, a financial sponsor or employer shall be considered notice to the subscriber and his/her enrolled dependents.

(34) "Subsidized enrollee" or "reduced premium enrollee" means an individual who enrolls in BHP, either as the subscriber or an eligible dependent, whose current gross family income does not exceed twice the federal poverty level as adjusted for family size and determined annually by the federal Department of Health and Human Services, and who receives a premium subsidy from the HCA.

(35) "Subsidy" means the difference between the amount of periodic payment the HCA makes to a managed health care system on behalf of a subsidized enrollee, and the amount determined to be the subsidized enrollee's responsibility under RCW 70.47.060(2).

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-010, filed 7/9/96, effective 8/9/96.]

WAC 182-25-020 BHP benefits. (1) The administrator shall design and from time to time may revise BHP benefits, according to the requirements of chapter 70.47 RCW, as amended. These benefits will include physician services, prescription drugs and medications, and inpatient and outpatient hospital services, limited mental health care services, limited chemical dependency services, limited organ transplant services, and all services necessary for prenatal, postnatal and well-child care, and will emphasize proven preventive and primary care services. The Medicaid scope of benefits may be provided by BHP as the BHP plus program through coordination with DSHS for children under the age of nineteen, who are found to be Medicaid eligible. BHP benefits may include co-payments, waiting periods, limitations and exclusions which the administrator determines are appropriate and consistent with the goals and objectives of the plan. BHP benefits will be subject to a three-month waiting period for preexisting conditions. Exceptions (for example, maternity, prescription drugs, services for a newborn or newly adopted child) are outlined in the schedule of benefits. Credit toward the waiting period will be given for any continuous period of time for which an enrollee was covered under similar health coverage if that coverage was in effect at any time during the three-month period immediately preceding the date of application for coverage under BHP. A list of BHP benefits, including co-payments, waiting periods, limitations and exclusions, will be provided to the subscriber.

(2) In designing and revising BHP benefits, the administrator will consider the effects of particular benefits, co-payments, limitations and exclusions on access to necessary 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 BHP, each applicant will be given a written description of covered benefits, including all co-payments, waiting periods, limitations and exclusions, and be advised how to access 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 service area.

(4) BHP will mail to all subscribers written notice of any changes in the amount and scope of benefits provided under BHP, or policy changes regarding premiums and co-payments at least thirty days prior to the due date of the premium payment for the month in which such revisions are to take effect. The administrator may make available a separate schedule of benefits for children, eighteen years of age and younger, for those dependent children in the plan.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-020, filed 7/9/96, effective 8/9/96.]

WAC 182-25-030 Eligibility. (1) To be eligible for enrollment in BHP, an individual must:

(a) Not be eligible for Medicare; and

(b) Reside within the state of Washington.

Persons not meeting these criteria, as evidenced by information submitted on the application for enrollment or otherwise obtained by BHP, will not be enrolled. An enrollee who subsequently fails to meet these criteria, or who is later determined to have failed to meet the criteria at the time of enrollment, will be disenrolled from the plan as provided in WAC 182-25-090.

(2) To be eligible for subsidized enrollment in BHP, an individual must have a gross family income that does not exceed two hundred percent of federal poverty level as adjusted for family size and determined annually by the U.S. Department of Health and Human Services, and must pay, or have paid on their behalf, the monthly BHP premium.

(3) To be eligible for nonsubsidized enrollment in BHP, an individual may have any income level and must pay, or have paid on their behalf, the full costs for participation in BHP, including the cost of administration, without subsidy from the HCA.

(4) An individual otherwise eligible for enrollment in BHP may be denied enrollment if the administrator has determined that acceptance of additional enrollment would exceed limits established by the legislature, would jeopardize the orderly development of BHP or would result in an overexpenditure of BHP funds. In the event that the administrator closes enrollment, BHP will continue to accept applications for enrollment, but will not process those applications for determination of eligibility. BHP 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 BHP of the opportunity to enroll. BHP 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.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-030, filed 7/9/96, effective 8/9/96.]

WAC 182-25-040 Enrollment in the plan. (1) Any individual applying for enrollment in BHP must submit a signed, completed BHP 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 for payment of premiums due on behalf of the child. If an applicant is accepted for enrollment, the applicant's signature acknowledges the applicant's obligation to pay the monthly premium in accordance with the terms and conditions identified in the member handbook. Applications for subsidized enrollment

on behalf of children under the age of nineteen shall be referred to the department of social and health services for Medicaid eligibility determination, unless the family chooses not to access this option.

(2) Each applicant shall list all eligible dependents to be enrolled and supply other information and documentation as required by BHP and, where applicable, DSHS medical assistance.

(a) Documentation will be required, showing the amount and sources of the applicant's gross family income. Acceptable documentation will include a copy of the applicant's most recently filed federal income tax form, and/or other documentation that shows year-to-date income, or income for the most recent thirty days or complete calendar month as of the date of application. An average of documented income received over a period of several months may be used for purposes of eligibility determination. Income documentation shall be required for the subscriber and dependents, with the exceptions listed under WAC 182-25-010 (17)(b).

(b) Documentation of Washington state residency shall also be required, displaying the applicant's name and address. Other documentation may be accepted if the applicant does not have a physical residence.

(c) BHP 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 BHP. Intentional submission of false information may result in disenrollment of the subscriber and all enrolled dependents.

(3) Each family applying for enrollment must designate a managed health care system from which the applicant and all enrolled dependents will receive covered services. All applicants from the same family must receive covered services from the same managed health care system (with the exception of cases in which a subscriber who is paying child support for his/her dependents lives in a different service area). No applicant will be enrolled for whom designation of a 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) Managed health care systems may assist BHP applicants in the enrollment process, but must provide them with the toll-free number for BHP, information on all MHCS available within the applicant's county of residence and an estimate of the premium the applicant would pay for each available MHCS.

(5) Insurance brokers or agents who have met all statutory and regulatory requirements of the office of the insurance commissioner, are currently licensed through the office of the insurance commissioner, and who have completed BHP's training program, will be paid a commission for assisting eligible applicants to enroll in BHP.

(a) Individual policy commission: Subject to availability of funds, and as a pilot program, BHP will pay a one-time fee to any currently licensed insurance broker or agent who sells BHP to an eligible individual applicant if that applicant has never been a BHP member in the past.

(b) Group policy commission: Subject to availability of funds, and as a pilot program, fees paid for the sale of BHP group coverage to an eligible employer will be based on the number of employees in the group for the first and second months of the group's enrollment.

(c) Insurance brokers or agents must provide the prospective applicant with the BHP toll-free information number and inform them of BHP benefits, limitations, exclusions, waiting periods, co-payments, all managed health care systems available to the applicant within his/her county of residence and the estimated premium for each of them.

(d) All statutes and regulations of the office of the insurance commissioner will apply to brokers or agents who sell BHP, except they will not be required to be appointed by the MHCS.

(e) BHP will not pay renewal commissions.

(6) Except as provided in WAC 182-25-030(4), applications for enrollment will be reviewed by BHP 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.

(7) Eligible applicants will be enrolled in BHP in the order in which their completed applications, including all required documentation, have been received by BHP, provided that the applicant also remits full payment of the first premium bill to BHP by the due date specified by BHP.

(8) Not all family members are required to apply for enrollment in BHP; 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 member until the next open enrollment period, unless the subscriber has experienced a qualifying change in family status:

(a) The loss of other continuous health care coverage, for family members who have previously waived coverage, upon proof of continuous medical coverage from the date the subscriber enrolled;

(b) Marriage; or

(c) Birth, adoption or change in dependency or custody of a child or adult dependent. Eligible newborn or newly adopted children may be enrolled effective from the date of birth or physical placement for adoption provided that application for enrollment is submitted to BHP within sixty days of the date of birth or such placement for adoption.

(9) Any enrollee who voluntarily disenrolls from BHP for reasons other than ineligibility or other health care coverage may not reenroll for a period of twelve months from the effective date of disenrollment. After the twelve-month period, or if the enrollee disenrolled for reasons of ineligibility or other health care coverage, he/she may reenroll in BHP, subject to portability and preexisting condition policies as referenced in WAC 182-25-020(1) and specified in the member handbook, provided he/she is determined by BHP to be otherwise eligible for enrollment as of the date of application. With the exception of enrollees under group coverage, enrollees who are disenrolled from BHP for nonpayment, in accordance with WAC 182-25-090(2), more than twice in a twelve-month period, and who

have a lapse in coverage of one month or more, may not reenroll for a period of twelve months from the effective date of the third disenrollment.

(10) On a schedule approved by the administrator, BHP will request verification of information from all or a subset of enrollees ("recertification"), requiring new documentation of income if the enrollee has had a change in income that would result in a different subsidy level. For good cause, BHP may require recertification on a more widespread or more frequent basis. Enrollees who fail to comply with a recertification request will be disenrolled from BHP. Each enrollee is responsible for notifying BHP within thirty days of any changes which could affect the enrollee's eligibility or premium responsibility. If, as a result of recertification, BHP determines that a subsidized enrollee's income exceeds twice the poverty level according to the federal income guidelines, and that the enrollee knowingly failed to inform BHP of such increase in income, BHP may bill the enrollee for the subsidy paid on the enrollee's behalf during the period of time that the enrollee's income exceeded twice the poverty level.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-040, filed 7/9/96, effective 8/9/96.]

WAC 182-25-050 Employer groups. (1) BHP will accept applications for group enrollment in BHP from business owners, their spouses and eligible dependents, and on behalf of their eligible full-time and/or part-time employees, their spouses and eligible dependents.

(2) With the exception of home care agencies (see WAC 182-25-060(2)), the employer must enroll at least seventy-five percent of all eligible employees within a classification of employees in the basic health plan, and the employer must not offer other health care coverage to the same classification of employees. For purposes of this section, a "classification of employees" will be defined as a subgroup of employees (for example, part-time employees, full-time employees or bargaining units). Employees who demonstrate in the application process that they have health care coverage from other sources, such as their spouse or a federal program, shall be excluded from the minimum participation calculation.

(3) BHP may require a minimum financial contribution from the employer for each enrolled employee.

(4) The employer will provide the employees the complete choice of BHP managed health care systems available within the employee's county of residence.

(5) The employer will pay all or a designated portion of the premium, as determined by the administrator, on behalf of the enrollee. It is the employer's responsibility to collect the employee's portion of the premium and remit the entire payment to BHP and to notify BHP of any changes in the employee's account.

(6) In the event that an employer group will be disenrolled, all affected employee(s) will be notified prior to the disenrollment, and will be informed of the opportunity to convert their BHP group membership to individual account(s).

(7) Employees enrolling in BHP must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-050, filed 7/9/96, effective 8/9/96.]

WAC 182-25-060 Home care agencies. BHP will accept applications from home care agencies under contract with the department of social and health services (DSHS) for group enrollment in BHP, with premiums paid by the home care agency or DSHS or a designee, under the provisions for employer groups, WAC 182-25-050, with the following exceptions or additions:

(1) To qualify for premium reimbursement through DSHS, home care agencies who enroll under the provisions of this section must be under current contract with DSHS as a home care agency, as defined by DSHS.

(2) Home care agencies need not enroll at least seventy-five percent of all eligible employees in the basic health plan, and home care agencies may offer other coverage to the same classification of employees.

(3) Home care agencies need not make a minimum financial contribution for each enrolled employee.

(4) Home care agencies are not subject to WAC 182-25-050(5).

(5) Individual home care providers may enroll in BHP as individuals.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-060, filed 7/9/96, effective 8/9/96.]

WAC 182-25-070 Financial sponsors. (1) A third party may, with the approval of the administrator, become a financial sponsor to BHP enrollees. Financial sponsors may not be a state agency or a managed health care system.

(2) The financial sponsor will establish eligibility for participation in that particular financial sponsor group; however, sponsored enrollees must meet all BHP eligibility requirements as outlined in WAC 182-25-030.

(3) The financial sponsor will pay all or a designated portion of the premium on behalf of the sponsored enrollee. It is the financial sponsor's responsibility to collect the enrollee's portion of the premium, if any, and remit the entire payment to BHP and to notify BHP of any changes in the sponsored enrollee's account.

(4) A financial sponsor must inform sponsored enrollees and BHP of the minimum time period for which they will act as sponsor. At least sixty days before the end of that time period, it is the responsibility of the financial sponsor to notify sponsored enrollees and BHP if the sponsorship will or will not be extended.

(5) A financial sponsor must not discriminate for or against potential group members based on health status, race, color, creed, political beliefs, national origin, religion, age, sex or disability.

(6) A financial sponsor may choose the managed health care system available to sponsored enrollees who participate in that financial sponsor group; however, the sponsor must disclose to the sponsored enrollee all the managed health care systems within the enrollee's county of residence, the estimated premiums for each of them, and the BHP toll-free information number.

(7) BHP may periodically conduct a review of the financial sponsor group members to verify the eligibility of all enrollees.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-070, filed 7/9/96, effective 8/9/96.]

WAC 182-25-080 Premiums and co-payments. (1) Subscribers or their employer or financial sponsor shall be responsible for paying the full monthly premium to BHP, on behalf of the subscriber and all enrolled dependents, according to the most current premium schedule. A third party may, with the approval of the administrator, become a financial sponsor and pay all or a designated portion of the premium on behalf of a subscriber and dependents, if any.

(2) The amount of premium due from or on behalf of a subscriber will be based upon the subscriber's gross family income, the managed health care system selected by the subscriber, rates payable to managed health care systems, and the number and ages of individuals in the subscriber's family.

(3) Once BHP has determined that an applicant and his/her dependents (if any) are eligible for enrollment, the applicant or employer or financial sponsor will be informed of the amount of the first month's premium for the applicant and his/her enrolled dependents. New enrollees will not be eligible to receive covered services on the effective date of enrollment specified by BHP unless the premium has been paid. Thereafter, BHP will bill each subscriber or employer or financial sponsor monthly.

(4) Full payment for premiums due must be received by BHP by the date specified on the bill. If BHP does not receive full payment of a premium by the date specified on the bill, BHP shall issue a notice of delinquency to the subscriber, at the subscriber's last address on file with BHP or, in the case of group or financial sponsor coverage, to the employer or financial sponsor. 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, as provided in WAC 182-25-090(2). Partial payment of premiums due or payment by check which is returned due to nonsufficient funds will be regarded as nonpayment.

(5) Enrollees shall be responsible for paying any required co-payment directly to the provider of a covered service at the time of service or directly to the MHCS. Repeated failure to pay co-payments in full on a timely basis may result in disenrollment, as provided in WAC 182-25-090(2).

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-080, filed 7/9/96, effective 8/9/96.]

WAC 182-25-090 Disenrollment from BHP. (1) An enrollee or employer group may disenroll effective the first day of any month by giving BHP at least ten days prior written notice of the intention to disenroll. Reenrollment in BHP shall be subject to the provisions of WAC 182-25-040(9). 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 BHP.

(2) BHP may disenroll any enrollee or group from BHP for good cause, which shall include:

(a) Failure to meet the eligibility requirements set forth in WAC 182-25-030, 182-25-050, 182-25-060, and 182-25-070;

(b) Nonpayment of premium;

(c) Repeated failure to pay co-payments in full on a timely basis;

(d) Fraud or knowingly providing false information;

(e) Abuse or intentional misconduct; and

(f) Refusal to accept or follow procedures or treatment determined by a MHCS to be essential to the health of the enrollee, where the managed health care system demonstrates to the satisfaction of BHP 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.

In the event that an employer group, a home care agency group or a financial sponsor group is disenrolled under these provisions, the employer or sponsor and all members of that group will be notified of the disenrollment and the enrollees will be offered coverage under individual accounts. BHP will make every effort to transfer the enrollees to individual accounts without a break in coverage; however, the enrollee will be responsible for ensuring that payment is received by BHP prior to the final disenrollment date for that month.

Enrollees who are disenrolled from BHP in accordance with (c), (d), (e) or (f) of this subsection may not reenroll for a period of twelve months from the effective date of disenrollment. With the exception of enrollees under group coverage, enrollees who are disenrolled from BHP for nonpayment, in accordance with (b) of this subsection, more than twice in a twelve-month period, and who have a lapse in coverage of one month or more, may not reenroll for a period of twelve months from the effective date of the third disenrollment.

BHP shall provide the enrollee or the parent, legal guardian or sponsor of an enrolled dependent 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 182-25-100 and 182-25-105. Prior to the effective date specified, if the enrollee submits an appeal to BHP contesting the disenrollment decision, as provided in WAC 182-25-105, disenrollment shall not become effective until the date, if any, established as a result of BHP's appeal 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 create a risk of violent, aggressive or harassing 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 enrollee who knowingly provides false information to BHP or to a participating managed health care system may be disenrolled by BHP and may be held financially responsible for any covered services fraudulently obtained through BHP.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-090, filed 7/9/96, effective 8/9/96.]

WAC 182-25-100 Appeals and mediation of grievances. (1) HCA decisions regarding basic health plan eligibility, premium, enrollment, disenrollment or change of MHCS may be appealed pursuant to WAC 182-25-105.

(2) The HCA will not hear appeals of decisions regarding children covered under BHP plus. Those decisions must be appealed through the department of social and health services, according to the provisions of chapters 388-08 and 388-526 WAC, as amended.

(3) Decisions made by a MHCS, such as coverage disputes or benefits interpretation may be appealed pursuant to WAC 182-25-110.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-100, filed 7/9/96, effective 8/9/96.]

WAC 182-25-105 Appeals of HCA decisions regarding BHP. (1) If a subscriber or applicant wishes to appeal a HCA decision regarding BHP eligibility, premium, enrollment, disenrollment or change of MHCS, he/she must send a letter of appeal, signed by the appealing party, to the HCA appeals committee no more than thirty days after the date the HCA's decision was sent to the subscriber or applicant. The letter should include the name, address and BHP account number of the enrollee and subscriber or the applicant and a statement of:

(a) The decision being appealed;

(b) Why the enrollee considers the decision to be incorrect; and

(c) The facts upon which the appeal is based, including any supporting documents.

(2) When the letter of appeal is received, the HCA appeals coordinator will contact the subscriber to explain his/her appeal rights and the appeal procedure used by the HCA appeals committee to conduct a brief adjudicative proceeding pursuant to RCW 34.05.482 through 34.05.494, as amended. Generally, the appeal will be limited to a review of submitted documents, but may also include a telephone or in-person conference. The HCA appeals committee will send its written initial decision to the subscriber or applicant within sixty days of receipt of the subscriber's or applicant's letter of appeal. The written initial decision will include reasons for the decision and information and instructions on further appeal rights. The appeals committee may also elect to convert the brief adjudicative proceeding to a formal adjudicative proceeding when it is more appropriate to resolve issues affecting the participants, and refer the appeal to the hearing officer.

(3) If the HCA appeals committee decision results in disenrollment, the enrollee may request a review hearing by the office of administrative hearings, pursuant to chapter 34.12 RCW and RCW 34.05.488 through 34.05.494, as amended. An enrollee or applicant may request review of all other initial decisions of the HCA appeals committee by a HCA hearings officer, pursuant to RCW 34.05.488 through 34.05.494, as amended. A request for review of the initial decision must be made in writing within twenty-one days after service of the written statement as required by RCW 34.05.485(3), as amended. Otherwise, the HCA appeals committee decision will be the final agency decision.

(4) If the HCA receives a timely appeal of a disenrollment decision, disenrollment shall not become effective pending the resolution of the appeal, provided that:

(a) The enrollee otherwise remains eligible and continues to make all premium payments when due (if the premium amount is the subject of the dispute, the premium will be billed at the rate the subscriber was paying prior to the dispute);

(b) The enrollee does not create a risk of violent, aggressive or harassing behavior, assault or battery or purposeful damage to or theft of MHCS property, or the property of staff or providers, patients or visitors while on the property of the MHCS or one of its participating providers.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-105, filed 7/9/96, effective 8/9/96.]

WAC 182-25-110 Appeals of MHCS decisions. (1) Disputes arising between enrollees and the managed health care system in which they are enrolled, such as coverage disputes or benefits interpretation, are considered to be contractual disputes between those parties. Every MHCS is required to maintain a grievance/appeals process for enrollees, providing for resolution by MHCS personnel with authority to require corrective action, including but not limited to review by appropriate medical personnel of complaints regarding quality of care or access to urgently needed services. The MHCS will make available information on its grievance/appeals process through its customer service department.

(2) The enrollee must exhaust the grievance/appeals process through the MHCS.

(a) If an issue is not resolved through that process within a reasonable time, or if the MHCS has not replied in writing to the enrollee within thirty days of receiving his/her written grievance/appeal, the enrollee may send a letter of appeal to the HCA appeals committee, requesting the HCA to inquire as to the status of the grievance/appeal. The HCA may initiate informal dispute resolution aimed at achieving a resolution satisfactory to the MHCS and the enrollee. In the event informal dispute resolution is unable to resolve the issue, the grievance/appeal will be reviewed by the HCA appeals committee.

(b) If the MHCS decision is not satisfactory to the enrollee, and the enrollee has not previously requested HCA assistance with the issue, the enrollee may send a letter of appeal to the HCA appeals committee. The letter of appeal must be received by the HCA no more than thirty days after the MHCS written notice of the decision is sent.

(3) When the letter of appeal is received, the HCA appeals coordinator will contact the subscriber to explain his/her appeal rights and the appeal procedure used by the HCA appeals committee to conduct a brief adjudicative proceeding pursuant to RCW 34.05.482 through 34.05.494, as amended. Generally, the appeal will be limited to a review of submitted documents, but may also include a telephone or in-person conference. The HCA appeals committee will send its written initial decision to both parties in the appeal, including the reasons for the decision, within

sixty days of scheduling the appeal and, if the decision supports the MHCS position, will advise the enrollee of further appeal rights. The appeals committee may also elect to convert the brief adjudicative proceeding to a formal adjudicative proceeding when it is more appropriate to resolve issues affecting the participants, and refer the appeal to the hearing officer. A HCA appeals committee decision which differs from the MHCS decision shall prevail and the MHCS shall perform in accordance to the HCA appeals committee decision.

(4)(a) If the HCA appeals committee agrees with the MHCS decision, the enrollee may request review of the HCA appeals committee decision by the HCA hearings officer. This request for review of the decision must be received no more than twenty-one days after the date of the HCA appeals committee decision.

(b) If the decision of the HCA appeals committee disagrees with the MHCS decision, the MHCS may request a dispute hearing with the HCA administrator, according to the terms of the contract between the MHCS and the HCA.

[Statutory Authority: RCW 70.47.050. 96-15-024, § 182-25-110, filed 7/9/96, effective 8/9/96.]