Title 182 WAC
HEALTH CARE AUTHORITY

Chapters

Chapter 182-04 WAC
PUBLIC RECORDS

WAC

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-04-030 Public records officer. [Order 01-77, § 182-04-030, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-04-065 Communication with the board. [Order 01-77, § 182-04-065, filed 8/26/77.] Repealed by 97-21-125, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

WAC 182-04-010 Purpose. The purpose of this chapter shall be to insure compliance by the Washington state health care authority (HCA) with the provisions of chapter 42.17 RCW dealing with public records.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-010, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-010, filed 8/26/77.]

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

(1) "HCA" means the Washington state health care authority, created pursuant to chapter 41.05 RCW.

(2) "Public record" includes any writing containing information relating to the conduct of government or the performance of any governmental agency or the performance of any governmental or proprietary information.

(3) "Writing" means all means of recording any form of communication or representation as defined in RCW 42.17.020(28).

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-015, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-015, filed 8/26/77.]

WAC 182-04-025 Public records. (1) All public records of the HCA as defined in WAC 182-04-015(2) shall be made available upon public request for inspection and copying pursuant to these rules, except however as provided by law.

(2) The public disclosure officer, or designee, shall respond promptly to requests for disclosure. Within five business days, the public disclosure officer, or designee shall respond by:

(a) Providing the record;

(b) Acknowledging the request and providing a reasonable estimate of the time it will take to respond to the request; or

(c) Denying the public record request.

(3) In acknowledging receipt of a public record request that is unclear, the public disclosure officer may ask the requestor to clarify what information the requestor is seeking. If the requestor fails to clarify the request, the public disclosure officer need not respond to it.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-025, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-025, filed 8/26/77.]

WAC 182-04-030 Repealed. See Disposition Table at beginning of this chapter.

WAC 182-04-035 Office hours. Public records shall be made available upon request only during working hours of the HCA. For the purpose of this chapter, the working hours shall be from 9:00 a.m. until noon, and from 1:00 p.m. until 4:00 p.m., Monday through Friday, excluding legal holidays.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-035, filed 10/21/97, effective 11/21/97; 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 invasion 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 the public, upon compliance with the following procedures:

(1) A request shall be made in writing or upon the form prescribed in WAC 182-04-070, which shall be available at the HCA. The form shall be presented to the public disclosure officer; or to any member of the agency's staff, if the public disclosure officer is not available, at the office of the agency during customary office hours. A request need merely identify with reasonable certainty the record sought to be disclosed. If the matter requested is referred to within the current index maintained by the public disclosure officer, a reference to the requested record as it is described in such current index is desirable.

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

(3) When the law makes a record disclosable to a specific person, a requestor may be required to provide personal identification.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-040, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-040, filed 8/26/77.]

WAC 182-04-041 Preserving requested records. If a public record request is made at a time when such record exists but is scheduled for destruction in the near future, the public disclosure officer shall retain possession of the record, and may not destroy or erase the record until the request is resolved.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-041, filed 10/21/97, effective 11/21/97.]

WAC 182-04-045 Copying. (1) No fee shall be charged for the inspection of public records.

(2) The agency shall collect the following fees to reimburse the agency for its actual costs incident to providing copies of public records:

(a) Fifteen cents per page for black and white photocopies, plus sales tax; and

(b) The cost of postage, if any.

(3) The public disclosure officer is authorized to waive the foregoing costs. Factors considered in deciding whether to waive costs include, but are not limited to: Providing the copy will facilitate administering the program, and/or the expense of processing the payment exceeds the copying and postage cost.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-045, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-045, filed 8/26/77.]

WAC 182-04-050 Exemptions. (1) The HCA reserves the right to determine whether a public record requested in accordance with the procedures outlined in WAC 182-04-040 is exempted under statutory provisions.

(2) Pursuant to RCW 42.17.260, the HCA 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 or vital governmental interest protected by chapter 42.17 RCW. The public disclosure officer will fully justify such deletion in writing in such a way so that the nature of the deleted information is made known.

(3) If disclosure is denied, the requestor is entitled to a written explanation of the denial which cites the relevant exemption and an explanation of how it applies to the record being denied.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-050, filed 10/21/97, effective 11/21/97; 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 disclosure 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 disclosure officer shall immediately consider the matter and either affirm or reverse such denial. Such review shall be deemed completed at the end of the second business day following the receipt by the disclosure officer of the request for review. This shall constitute final agency action for the purposes of judicial review, pursuant to RCW 42.17.320.

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-055, filed 10/21/97, effective 11/21/97; 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 an HCA employee;

(2) No public record shall be removed from the main office without the approval of the public disclosure officer or his/her designee;

(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 an HCA employee;

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

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-060, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-060, filed 8/26/77.]

WAC 182-04-065 Repealed. See Disposition Table at beginning of this chapter.

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

The information requested in Blocks 1 through 6 is not mandatory, however, the completion of these blocks will enable this office to expedite your request and contact you should the record you seek not be immediately available.

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1. Name — 4. Phone Number

2. Address — 5. Representing (if applicable)

3. Zip Code — 6. If urgent - date needed

Below please state what record(s) you wish to inspect and be as specific as possible. If you are uncertain as to the type or identification of specific record or records we will assist you.

I certify that the information requested from the above record(s) will not be part of a list of individuals to be used for commercial purposes.

(Signed) . . . . . .

Date . . . . . .

[Statutory Authority: RCW 41.05.160. 97-21-125, § 182-04-070, filed 10/21/97, effective 11/21/97; Order 01-77, § 182-04-070, filed 8/26/77.]

Chapter 182-08 WAC
PROCEDURES

WAC

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. The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or within 60 days of birth, adoption or placement for adoption.

(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. The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or within 60 days of birth, adoption or placement for adoption.

(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. The employee and dependents may have an additional opportunity to enroll in the event of acquisition of a new dependent as a result of marriage, birth, adoption, or placement for adoption, provided that enrollment is requested within 31 days of marriage or within 60 days of birth, adoption or placement for adoption.

[Statutory Authority: RCW 41.05.160. 97-21-126, § 182-08-095, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-042, § 182-08-095, filed 3/29/96, effective 4/29/96.]

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 eligibili-

ty 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 182-08-175.

(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: RCW 41.05.160. 97-21-126, § 182-08-160, filed 10/21/97, effective 11/21/97. 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 182-08-175 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 and may self-pay their optional life and long-term disability. 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: RCW 41.05.160. 97-21-126, § 182-08-175, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 93-23-065, § 182-08-175, filed 11/16/93, effective 12/17/93.]

Chapter 182-12 WAC
ELIGIBLE AND NONELIGIBLE EMPLOYEES

WAC

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: RCW 41.05.160. 97-21-127, § 182-12-111, filed 10/21/97, effective 11/21/97. 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.]

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 or have taken a lump-sum payment because their benefit would be less than fifty dollars under chapter 41.32 or 41.40 RCW. Individuals in teachers' retirement system, TRS III, not receiving a monthly retirement allowance (defined benefit) must be at least age fifty-five with at least ten years of service at the time of separation. 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: RCW 41.05.160. 97-21-127, § 182-12-117, filed 10/21/97, effective 11/21/97. 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, 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 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) Dependents of retirees covered under a PEBB plan at the time of the retiree's death are eligible to continue PEBB retiree coverage.

(iv) 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: RCW 41.05.160. 97-21-127, § 182-12-119, filed 10/21/97, effective 11/21/97. Statutory Authority: Chapter 41.05 RCW. 96-08-043, § 182-12-119, filed 3/29/96, effective 4/29/96.]

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 Washington state 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: RCW 41.05.160. 97-21-127, § 182-12-132, filed 10/21/97, effective 11/21/97. 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 182-12-200 Retirees may change enrollment in approved PEBB health plans. A retiree, whose spouse is enrolled as an eligible employee in a PEBB or Washington state 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: RCW 41.05.160. 97-21-127, § 182-12-200, filed 10/21/97, effective 11/21/97. 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.]

Chapter 182-16 WAC
PRACTICE AND PROCEDURE

WAC

WAC 182-16-030 Appeals from agency decisions—Applicability. Any enrollee of the health care authority's administered insurance plans (the self-insured plans) 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 health care authority's appeals committee. 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 41.05.160. 97-21-128, § 182-16-030, filed 10/21/97, effective 11/21/97. 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 health care authority's appeals committee. 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 specific portion of the decision being appealed making it clear what it is that is believed to be unlawful or unjust;

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

(6) Any and all information or documentation that the aggrieved person would like considered and feels substantiates why the claim or request for coverage should be covered (information or documentation submitted at a later date, unless specifically requested by the appeals committee, may not be considered in the appeal decision);

(7) A copy of the plan's response to the issue the appellant has raised;

(8) The type of relief sought;

(9) 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;

(10) The appealing party shall file, personally or by mail, with the health care authority the original 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;

(11) 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.

(12) The appeals committee will render a written decision within sixty days of receipt of the appeal.

[Statutory Authority: RCW 41.05.160. 97-21-128, § 182-16-040, filed 10/21/97, effective 11/21/97. 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 the health care authority's appeals committee upholds the original denial, the enrollee may request a hearing by writing to the health care authority's appeals manager. The health care authority must receive the written request for a hearing within fifteen days of the date the appeals committee's decision was mailed to the appellant.

(2) 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) Within ninety days 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 41.05.160. 97-21-128, § 182-16-050, filed 10/21/97, effective 11/21/97. 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

DISPOSITION OF SECTIONS FORMERLY CODIFIED IN THIS CHAPTER

182-18-005 Purpose. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-005, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-010 Transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-010, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-020 New programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-020, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-030 Pediatric programs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-030, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-040 Transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-040, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-050 Multiple organ transplants. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-050, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-060 Institutional commitment. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-060, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-070 Patient management. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-070, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-080 General recipient selection criteria for all organs. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-080, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-090 Liver transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-090, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-100 Liver transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-100, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-110 Kidney transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-110, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-120 Kidney transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-120, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-130 Pancreas transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-130, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-140 Pancreas transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-140, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-150 Heart and/or heart-lung transplant program. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-150, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

182-18-160 Heart and/or heart-lung transplant team training and experience. [Statutory Authority: Chapter 41.05 RCW. 91-17-043, § 182-18-160, filed 8/20/91, effective 9/20/91.] Repealed by 97-21-129, filed 10/21/97, effective 11/21/97. Statutory Authority: RCW 41.05.160.

WAC 182-18-005 through 182-18-160 Repealed. See Disposition Table at beginning of this chapter.

Chapter 182-25 WAC
WASHINGTON BASIC HEALTH PLAN

WAC

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

(vii) 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) College or university scholarships, grants, fellowships and assistantships;

(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. 97-15-003, § 182-25-010, filed 7/3/97, effective 8/3/97; 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 reservation or 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. 97-15-003, § 182-25-020, filed 7/3/97, effective 8/3/97; 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 or limits enrollment and to the extent funding is available, BHP will continue to accept and process applications for enrollment from:

(a) Applicants who will pay the full premium;

(b) Children eligible for BHP Plus;

(c) Pregnant women who, prior to April 1, 1997, apply to BHP, are referred and qualify for maternity benefits through DSHS;

(d) Children eligible for subsidized BHP, who were referred to DSHS for BHP Plus coverage, but were found ineligible for BHP Plus;

(e) Employees of a home care agency group enrolled or applying for coverage under WAC 182-25-060;

(f) Eligible individual home care providers;

(g) Licensed foster care workers;

(h) Limited enrollment of new employer groups; and

(i) Subject to availability of funding, additional space for enrollment may be reserved for other applicants as determined by the administrator, in order to ensure continuous coverage and service for current individual and group accounts. (For example: Within established guidelines, processing routine income changes that may affect subsidy eligibility for current enrollees; adding new family members to an existing account; transferring enrollees between group and individual accounts; restoring coverage for enrollees who are otherwise eligible for continued enrollment under WAC 182-25-090 after a limited suspension of coverage due to late payment or other health care coverage; adding newly hired employees to an existing employer group; or adding new or returning members of federally recognized native American tribes to that tribe's currently approved financial sponsor group.)

Applicants for subsidized BHP who are not in any of these categories may reserve space on a reservation list to be processed according to the date the reservation or application is received by BHP. In the event that enrollment is re-opened by the administrator, applicants whose names appear on the reservation list will be notified by BHP of the opportunity to enroll. BHP may require new application forms and documentation from applicants on the reservation list, or may contact applicants to verify continued interest in applying, prior to determining their eligibility.

[Statutory Authority: RCW 70.47.050. 97-15-003, § 182-25-030, filed 7/3/97, effective 8/3/97; 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 member may be enrolled in only one BHP account. 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 who are covered under the same account 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. In the event a reservation list is implemented, eligible applicants will be enrolled in accordance with WAC 182-25-030(4).

(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 enrollment in 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 enrollment in other health care coverage, he/she may reenroll in BHP, subject to enrollment limits and portability and preexisting condition policies as referenced in WAC 182-25-020(1) and 182-25-030(4) 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. Enrollees who are not under group coverage, may not reenroll for a minimum of twelve months from the effective date of their last suspension if they are disenrolled from BHP for nonpayment under WAC 182-25-090 (2)(b) because:

(a) They failed to pay the premium within the billing cycle for the next coverage month following a suspension of coverage; or

(b) They have been suspended from coverage more than two times in a twelve-month period for failure to pay their premium by the due date.

If a reservation list has been implemented, an enrollee who was disenrolled in accordance with WAC 182-25-090(2) and is eligible to enroll from the reservation list prior to the end of the required twelve-month wait for reenrollment, will not be reenrolled until the end of the twelve-month period. If an enrollee who was disenrolled in accordance with WAC 182-25-090(2) satisfies the required twelve-month wait for reenrollment while on the reservation list, enrollment will not be completed until funding is available to enroll him or her from the reservation list.

(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 converted to nonsubsidized enrollment for at least one month, until new income documentation has been submitted and processed. 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. 97-15-003, § 182-25-040, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-040, 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;

(f) Risk to the safety or property of MHCS staff, providers, patients or visitors; and

(g) 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. Enrollees who are not under group coverage, who fail to pay their premium by the due date will be suspended from coverage for one month. If payment is not received within the billing cycle for the next coverage month, the enrollee will be disenrolled from BHP for nonpayment, under (b) of this subsection. If an enrollee's coverage is suspended more than two times in a twelve-month period, the enrollee will be disenrolled for nonpayment under (b) of this subsection. Enrollees who are disenrolled for nonpayment under (b) of this subsection may not reenroll for a minimum of twelve months from the effective date of the last suspension. If a reservation list has been implemented, an enrollee who was disenrolled in accordance with WAC 182-25-090(2) and is eligible to enroll from the reservation list prior to the end of the required twelve-month wait for reenrollment, will not be reenrolled until the end of the twelve-month period. If an enrollee who was disenrolled in accordance with WAC 182-25-090(2) satisfies the required twelve-month wait for reenrollment while on the reservation list, enrollment will not

be completed until funding is available to enroll him or her from the reservation list.

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. 97-15-003, § 182-25-090, filed 7/3/97, effective 8/3/97; 96-15-024, § 182-25-090, filed 7/9/96, effective 8/9/96.]

Title 197 WAC
ECOLOGY, DEPARTMENT OF (COUNCIL ON ENVIRONMENTAL POLICY)

Chapters

Chapter 197-11 WAC
SEPA RULES

WAC

WAC 197-11-055 Timing of the SEPA process. (1) **Integrating SEPA and agency activities.** The SEPA process shall be integrated with agency activities at the earliest possible time to ensure that planning and decisions reflect environmental values, to avoid delays later in the process, and to seek to resolve potential problems.

(2) **Timing of review of proposals.** The lead agency shall prepare its threshold determination and environmental impact statement (EIS), if required, at the earliest possible point in the planning and decision-making process, when the principal features of a proposal and its environmental impacts can be reasonably identified.

(a) A proposal exists when an agency is presented with an application or has a goal and is actively preparing to make a decision on one or more alternative means of accomplishing that goal *and* the environmental effects can be meaningfully evaluated.

(i) The fact that proposals may require future agency approvals or environmental review shall not preclude current consideration, as long as proposed future activities are specific enough to allow some evaluation of their probable environmental impacts.

(ii) Preliminary steps or decisions are sometimes needed before an action is sufficiently definite to allow meaningful environmental analysis.

(b) Agencies shall identify the times at which the environmental review shall be conducted either in their procedures or on a case-by-case basis. Agencies may also organize environmental review in phases, as specified in WAC 197-11-060(5).

(c) Appropriate consideration of environmental information shall be completed before an agency commits to a particular course of action (WAC 197-11-070).

(d) A GMA county/city is subject to additional timing requirements (see WAC 197-11-310).