WSR 06-19-026
WITHDRAWAL OF EXPEDITED RULE MAKING
DEPARTMENT OF LABOR AND INDUSTRIES
(By the Code Reviser's Office)
[Filed September 12, 2006, 8:48 a.m.]

WAC 296-818-20020, proposed by the department of labor and industries in WSR 06-06-063 appearing in issue 06-06 of the State Register, which was distributed on March 15, 2006, is withdrawn by the code reviser's office under RCW 34.05.335(3), since the proposal was not adopted within the one hundred eighty day period allowed by the statute.

Kerry S. Radcliff, Editor
Washington State Register

WSR 06-19-035
EXPEDITED RULES
DEPARTMENT OF SOCIAL AND HEALTH SERVICES
(Management Services Administration)
[Filed September 13, 2006, 4:21 p.m.]

Title of Rule and Other Identifying Information: Amending WAC 388-02-0650 How do you serve your petition for judicial review?

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Department of Social and Health Services, P.O. Box 45850, Olympia, WA 98504-5850, or deliver to Blake Office Park East, 4500 10th Avenue S.E., Lacey, WA 98503, e-mail fernaax@dshs.wa.gov, fax (360) 664-6185, AND RECEIVED BY 5:00 p.m., November 20, 2006.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposal updates the address for the attorney general's office in this rule.

Expedited rule-making is appropriate for rules that "correct typographical errors, make address or name changes, or clarify language of a rule without changing its effect," under RCW 34.05.353 (1)(c).

Reasons Supporting Proposal: Updating this address gives the public more accurate information.

Statutory Authority for Adoption: RCW 34.05.220.

Statute Being Implemented: Chapter 34.05 RCW, Parts IV and V.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of social and health services, governmental.

Name of Agency Personnel Responsible for Drafting: Andy Fernando, 4500 10th Avenue S.E., Lacey, WA 98503, P.O. Box 45850, Olympia, WA 98504-5850, (360) 664-6094.

September 13, 2006

Andy Fernando, Manager

Rules and Policies Assistance Unit

AMENDATORY SECTION (Amending WSR 02-21-061, filed 10/15/02, effective 11/15/02)

WAC 388-02-0650 How do you serve your petition for judicial review? (1) You must file and serve the petition for judicial review of a final order within thirty days after the date it was mailed. You must file your petition for judicial review with the court. You must serve copies of your petition on DSHS, the office of the attorney general, and all other parties.

(2) To serve DSHS, you must deliver a copy of the petition to the secretary of DSHS or to BOA. You may hand deliver the petition or send it by mail that gives proof of receipt. The physical location of the secretary is:

DSHS Office of the Secretary
OB-2, 4th Floor
Mail Stop 45010
14th and Jefferson
Olympia, WA 98504-5010

The mailing address of the secretary is:

DSHS Office of the Secretary
P.O. Box 45010
Olympia, WA 98504-5010

The physical and mailing addresses for BOA are in WAC 388-02-0030.

(3) To serve the office of the attorney general and other parties, you may send a copy of the petition for judicial review by regular mail. You may send a petition to the address for the attorney of record to serve a party. You may serve the office of the attorney general by hand delivery to:

Office of the Attorney General
((~~670 Woodland Square Loop S.E.~~))
7141 Clearwater Drive S.W.
((~~Lacey, WA 98503~~))
Olympia, Washington 98504-0124

The mailing address of the attorney general is:

Office of the Attorney General
P.O. Box 40124
Olympia WA 98504-0124

WSR 06-19-084
EXPEDITED RULES
HEALTH CARE AUTHORITY
(Public Employees' Benefits Board)
[Order 06-09—Filed September 19, 2006, 12:22 p.m.]

Title of Rule and Other Identifying Information: PEBB retiree and surviving dependent enrollment rules in chapter 182-12 WAC and the PEBB plan change rule in chapter 182-08 WAC.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Barbara Scott, Health Care Authority, P.O. Box 42684, Olympia, WA 98504-2684, e-mail barbara.scott@hca.wa.gov, AND RECEIVED BY November 21, 2006.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: Proposed amendments to WAC 182-12-205 and 182-12-265 will allow retirees and their dependents that are full-benefit "dual eligible" for Medicare and Medicaid to retain their PEBB eligibility through deferred enrollment. Proposed amendments to WAC 182-12-205 will also allow dependents of retirees who are not full-benefit "dual eligible" for Medicare and Medicaid the ability to continue enrollment in PEBB health plan coverage while the retiree is in a deferred status. Proposed amendments to WAC 182-08-198 will allow retirees and their dependents that become eligible for Medicare Part A, Part B, or Part D outside the PEBB annual open enrollment period to make a plan change consistent with their Medicare enrollment period.

Reasons Supporting Proposal: Implementation of the Medicare Modernization Act of 2003 and subsequent changes in state law requires PEBB to manage the enrollment of certain beneficiaries in such a way that PEBB can collect the federal retiree drug subsidy and enrollees can retain their PEBB coverage. This mandate applies to those who are (a) enrolled by Medicare into a prescription drug plan or (b) elect to enroll in a prescription drug plan. Proposed amendments will optimize the collection of the subsidy and maintain the enrollment privileges of (1) full-benefit dual eligible members in a way that is consistent with existing PEBB rules related to deferral rights and (2) other PEBB members in a way that allows the best possible access to PEBB plans, based on enrollment decisions related to Medicare benefits through Part D. Amendments to PEBB rules during the implementation of RCW 41.05.068 did not provide adequate options for these retirees or their dependents.

Statutory Authority for Adoption: RCW 41.05.160.

Statute Being Implemented: RCW 41.05.068.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Health care authority, governmental.

Name of Agency Personnel Responsible for Drafting: Barbara Scott, Health Care Authority, (360) 923-2642; Implementation and Enforcement: Mary Fliss, Health Care Authority, (360) 923-2640.

September 19, 2006
Beth Dupre
Rules Coordinator

AMENDATORY SECTION (Amending WSR 04-18-039, filed 8/26/04, effective 1/1/05)

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

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

"Board" means the public employees' benefits board established under provisions of RCW 41.05.055.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in PEBB sponsored medical insurance by a retiree or surviving dependent.

"Dependent" means a person who meets eligibility requirements set forth in WAC 182-12-260.

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

"Effective date of enrollment" means the first date on which an enrollee is entitled to receive covered benefits.

"Extended dependent" means a dependent child who is not the child of an enrollee through birth, adoption, marriage, or a qualified same sex domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild or a niece or nephew for whom the enrollee is the legal guardian or the enrollee has legal custody.

"Health carrier" has the meaning set forth at RCW 48.43.005(18) for purposes of administering this Title 182 WAC only, it includes the uniform medical plan and uniform dental plan.

"Health plan" or "plan" means medical and dental coverage.

"Insurance coverage" means any health plan, life or long-term disability insurance plan administered as a PEBB benefit.

"LTD insurance" includes basic long-term disability insurance paid for by the employer and long-term disability insurance offered to employees on an optional basis.

"Life insurance" includes basic life insurance paid for by the employer and life insurance offered to employees on an optional basis.

"Open enrollment" means a time period designated by the administrator during which enrollees may apply to transfer their enrollment from one health carrier to another, enroll

in medical coverage if the enrollee had previously waived such coverage, or add dependents.

"PEBB plan" or "PEBB benefits" means one or more insurance coverages approved by the public employees' benefits board for eligible enrollees and their dependents.

"Subscriber" or "insured" means the employee, retiree, COBRA beneficiary or surviving dependent who has been designated by the HCA as the individual to whom the HCA and the health carrier will issue all notices, information, requests and premium bills on behalf of enrolled dependents.

"Waive" means to interrupt enrollment or postpone enrollment in a PEBB sponsored health plan by an employee (as defined in WAC 182-12-115) or a dependent who meets eligibility requirements set forth in WAC 182-12-260.

AMENDATORY SECTION (Amending Order 05-01, filed 7/27/05, effective 8/27/05)

WAC 182-08-198 When may an enrollee change health plans? (1) Enrollees may change health plans during the annual open enrollment. The enrollee must request the health plan change no later than the end of the open enrollment period. The new health plan's coverage will begin the first day of January after open enrollment.

(2) Enrollees may change health plans outside of the annual open enrollment period ((~~if one of the following events occur, provided the request to change~~)) under some circumstances. To make a health plan((~~s is made~~)) change, the enrollee must send a completed enrollment form (and a completed disenrollment form, if required) to the PEBB program no later than sixty days after the event occurs. The new health plan's coverage will begin the first day of the month after the PEBB program receives the form(s). These are the circumstances:

(a) ((~~The~~)) Enrollees may change health plans if they move((~~s~~)) and ((~~the~~)) their current health plan ((~~they are enrolled in~~)) is not available in their new location. If the enrollee ((~~fails to~~)) does not select a new health plan ((~~they~~)), the PEBB program will ((~~be~~)) automatically ((~~defaulted to~~)) enroll them in the Uniform Medical Plan or Uniform Dental Plan.

(b) ((~~The~~)) Enrollees may change health plans if they move((~~s~~)) and a health plan that was not available to them before is available to them in the new location. The enrollee may only choose ((~~to enroll in the~~)) a newly available health plan.

(c) Enrollees may change health plans if a court order requires the enrollee to provide coverage for an eligible spouse, same-sex domestic partner, or child and the enrollee adds the dependent to ((~~the~~)) their coverage.

(d) ((~~The enrollee is a~~)) Seasonal employees ((~~who is~~)) whose off-season is during the annual open enrollment period((~~. In this case the enrollee~~)) may select a new health plan upon their return to work.

(e) ((~~The employee retires.~~)) Employees may change health plans ((~~at the time that~~)) when they ((~~apply for~~)) enroll in PEBB((~~-sponsored~~)) retiree coverage.

(f) ((~~The~~)) Enrollee((~~'~~))s may change health plans when they become entitled to Medicare or enroll in a Medicare Part D plan.

(g) Enrollees may not change their health plan if their physician stops participation with the enrollee's health plan ((~~and it is determined by~~)) unless the PEBB appeals manager determines that a continuity of care issue exists. The PEBB appeals manager ((~~shall~~)) will use ((~~the following~~)) criteria that include but are not limited to the following in determining if a continuity of care issue((~~s~~)) exists:

(i) Active cancer treatment((~~, (i.e., chemotherapy and/or radiation)~~)); or

(ii) Recent transplant (within the last twelve months); or

(iii) Scheduled surgery within the next sixty days; or

(iv) Major surgery within the previous sixty days; or

(v) Third trimester of pregnancy((~~.~~

~~(g) It is determined by the PEBB appeals manager that there is a~~)); or

(vi) Language barrier ((~~issue (e.g., a Vietnamese speaking provider discontinues participation in a plan and no other Vietnamese speaking provider is available within the subscriber's area that is contracting with that plan and/or within the travel range of the subscriber)~~)).

(h) ((~~The~~)) Enrollees ((~~reaches~~)) may change health plans if they reach their medical plan's lifetime maximum.

(((~~(3) For enrollees making a health plan change during the annual open enrollment, the plan change must be made no later than the last day of the open enrollment period and the plan change is effective the first day of January following the open enrollment.~~

~~(4) For enrollees making a health plan change outside of open enrollment, the health plan change must be made no later than sixty days after the triggering event and the plan change is effective the first day of the month following the date the change request is received by the PEBB program.~~))

AMENDATORY SECTION (Amending WSR 04-18-039, filed 8/26/04, effective 1/1/05)

WAC 182-12-109 Definitions. The following definitions apply throughout this chapter unless the context clearly indicates another meaning:

"Administrator" means the administrator of the HCA or designee.

"Board" means the public employees' benefits board established under provisions of RCW 41.05.055.

"Creditable coverage" means coverage that meets the definition of "creditable coverage" under RCW 48.66.020 (13)(a) and includes payment of medical and hospital benefits.

"Defer" means to postpone enrollment or interrupt enrollment in PEBB sponsored medical coverage by a retiree or surviving dependent.

"Dependent" means a person who meets eligibility requirements set forth in WAC 182-12-260.

"Effective date of enrollment" means the first date on which an enrollee is entitled to receive covered benefits.

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

"Extended dependent" means a dependent child who is not the child of an enrollee through birth, adoption, marriage,

or a qualified same sex domestic partnership. Some examples of extended dependents include, but are not limited to, a grandchild or a niece or nephew for whom the enrollee is the legal guardian or the enrollee has legal custody.

"Health carrier" has the meaning set forth at RCW 43.43.005(18) for purposes of administering this Title 182 WAC only, it includes the uniform medical plan and the uniform dental plan.

"Health plan" or "plan" means medical and dental coverages.

"Insurance coverage" means any health plan, life, or long-term disability insurance plan administered as a PEBB benefit.

"LTD insurance" includes basic long-term disability insurance paid for by the employer and long-term disability insurance offered to employees on an optional basis.

"Life insurance" includes basic life insurance paid for by the employer and life insurance offered to employees on an optional basis.

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

"PEBB plan" or "PEBB benefits" means one or more insurance coverages approved by the public employees' benefits board for eligible enrollees and their dependents.

"Subscriber" or "insured" means the employee, retiree, COBRA beneficiary or surviving dependent who has been designated by the HCA as the individual to whom the HCA and the health carrier will issue all notices, information, requests and premium bills on behalf of enrolled dependents.

"Waive" means to interrupt enrollment or postpone enrollment in a PEBB sponsored health plan by an employee (as set forth in WAC 182-12-115) or a dependent who meets eligibility requirements set forth in WAC 182-12-260.

AMENDATORY SECTION (Amending Order 05-01, filed 7/27/05, effective 8/27/05)

WAC 182-12-205 Retirees may defer enrollment in PEBB health plan coverage at or ((~~following~~)) after retirement. Except as stated in subsection (1)(c) of this section, if a retiree defers enrollment in PEBB health plan coverage, PEBB also waives coverage for all eligible dependents. Retirees may not defer their retiree term life insurance, even if they have other coverage.

(1) ((~~Beginning January 1, 2001,~~)) Retirees may defer enrollment in PEBB health plan coverage at or ((~~following~~)) after retirement if ((~~they are~~)) continuously ((~~covered under~~)) enrolled in other medical coverage as stated below:

(a) Beginning January 1, 2001, retirees may defer their PEBB health plan coverage if enrolled in comprehensive employer-sponsored medical coverage as an employee or ((~~as~~)) the spouse or same-sex domestic partner of an employee((~~; or~~)).

(b) Beginning January 1, 2001, retirees may defer their PEBB health plan coverage if enrolled in medical coverage as a retiree or ((~~as~~)) the spouse or ((~~as the~~)) same-sex domestic partner of a retiree((~~'s retirement insurance from~~)) enrolled in a federal retiree plan.

(c) Beginning January 1, 2006, retirees may defer their PEBB health plan coverage if enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage as defined in this chapter. The retiree's dependents may continue their PEBB coverage if they meet PEBB eligibility criteria and are not eligible for creditable coverage under a Medicaid program.

(2) ((~~If a retiree defers enrollment in PEBB health plan coverage, coverage is automatically waived for all eligible dependents.~~

~~(3) Election of retiree term life insurance coverage may not be deferred during periods of other coverage or otherwise.~~

~~(4) In order~~)) To defer health plan coverage, ((~~a~~)) the retiree must ((~~submit the appropriate~~)) send a completed enrollment form to the PEBB program requesting ((~~deferment of~~)) to defer coverage. The ((~~notice of deferral must be received by~~)) PEBB ((~~benefit services prior to the date~~)) program must receive the form before coverage is deferred or ((~~within~~)) no later than sixty days after the date the retiree ((~~is~~)) becomes eligible to apply for PEBB ((~~sponsored~~)) retiree benefits.

(((~~(5)~~))) (3) Retirees who defer PEBB coverage may ((~~reenroll~~)) enroll in PEBB coverage ((~~following the end of a deferral period under conditions listed below.~~)) as follows:

(a) Retirees who defer PEBB health plan coverage while enrolled in employer-sponsored medical coverage((~~,~~)) may ((~~reenroll~~)) enroll in PEBB health plan coverage by ((~~submitting the appropriate~~)) sending a completed enrollment form(((~~s~~))) and ((~~satisfactory evidence~~)) proof of continuous enrollment in comprehensive employer-sponsored coverage to the PEBB program:

(i) During an annual open enrollment period (PEBB coverage will begin the first day of January after the open enrollment period); or

(ii) No later than sixty days after ((~~the last day of the~~)) their employer-sponsored coverage ends. (PEBB coverage will begin the first day of the month after the employer-sponsored coverage ends.)

(b) Retirees who defer PEBB health plan coverage while enrolled as a retiree or dependent of a retiree in a federal retiree plan will have a one-time opportunity to reenroll in PEBB health plan coverage by ((~~submitting the appropriate~~)) sending a completed enrollment form(((~~s~~))) and ((~~satisfactory evidence~~)) proof of continuous enrollment in a federal retiree medical plan to the PEBB program:

(i) During an annual open enrollment period (PEBB coverage will begin the first day of January after the open enrollment period); or

(ii) No later than sixty days after the ((~~date their~~)) federal retiree coverage ends. (PEBB coverage will begin the first day of the month after the federal retiree coverage ends.)

(c) Retirees who defer PEBB health plan ((~~enrollment will be effective the first day of the month following the date employer sponsored~~)) coverage ((~~or coverage under a federal retiree plan ended, except that reenrollment in PEBB insurance~~)) while enrolled in Medicare Parts A and B and Medicaid may enroll in PEBB health plan coverage by sending a

completed enrollment form and proof of continuous enrollment in creditable coverage to the PEBB program:

(i) During the annual open enrollment period (PEBB coverage will ((~~become effective~~)) begin the first day of January ((~~following~~)) after the open enrollment period); or

(ii) No later than sixty days after their Medicaid coverage ends (PEBB coverage will begin the first day of the month after the Medicaid coverage ends); or

(iii) No later than the end of the calendar year during which their Medicaid coverage ends if the retiree was also determined eligible under 42 USC §1395w-114 and subsequently enrolled in a Medicare Part D plan. (PEBB coverage will begin the first day of January following the end of the calendar year during which the Medicaid coverage ends.)

AMENDATORY SECTION (Amending Order 05-01, filed 7/27/05, effective 8/27/05)

WAC 182-12-265 What options for continuing health plan coverage are available to widows, widowers and dependent children if the employee or retiree dies? The surviving dependent of an eligible employee or retiree who meets the eligibility criteria in subsection (1), (2), or (3) of this section is eligible to enroll in public employees' benefits board (PEBB) retiree coverage as a surviving dependent. An eligible surviving dependent must enroll in or defer PEBB health plan coverage no later than sixty days after the date of the employee's or retiree's death.

(1) Dependents that lose eligibility due to the death of an eligible employee may continue health plan coverage under a retiree plan provided they immediately begin receiving a monthly retirement benefit from any state of Washington sponsored retirement system.

(a) The employee's spouse or qualified same sex domestic partner may continue coverage until death.

(b) Other dependents may continue coverage until they lose eligibility under PEBB rules.

(c) If a surviving dependent of an eligible employee is not eligible for a monthly retirement benefit (or a lump-sum payment because the monthly pension payment would be less than the minimum amount established by the department of retirement systems((,))) the dependent is not eligible to participate in PEBB retiree coverage. However, the dependent may continue health plan coverage under provisions of the federal Consolidated Omnibus Budget Reconciliation Act (COBRA) or WAC 182-12-270.

(d) The two federal retirement systems, Civil Service Retirement System and Federal Employees Retirement System, shall be considered a Washington sponsored retirement system for Washington State University extension service employees who were covered under PEBB insurance coverage at the time of death.

(2) Dependents that lose eligibility due to the death of a PEBB eligible retiree may continue health plan coverage under a retiree plan.

(a) The retiree's spouse or qualified same sex domestic partner may continue coverage until death.

(b) Other dependents may continue coverage until they lose eligibility under PEBB rules.

(c) Dependents that are waiving PEBB health plan coverage at the time of the retiree's death are eligible to enroll or defer PEBB retiree coverage. A form to enroll or defer PEBB health plan coverage must be hand-delivered or mailed to the PEBB ((~~benefit services~~)) program no later than sixty days after the retiree's death. To enroll in PEBB health plan coverage, the dependent must provide satisfactory evidence that enrollment in other health plan coverage was continuous from the most recent open enrollment period for which PEBB coverage was waived.

(3) Surviving spouses or eligible dependent children of a deceased school district or educational service district employee who were not enrolled in PEBB insurance coverage at the time of the subscriber's death may enroll in PEBB sponsored health plan 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, 41.35 or 41.40 RCW.

(a) The employee's spouse or qualified same-sex domestic partner may continue health plan coverage until death.

(b) Other dependents may continue coverage until they lose eligibility under PEBB rules.

(4) ((~~Application for~~)) Surviving dependents must notify the PEBB program of their decision to enroll or defer PEBB health plan coverage ((~~must be made in writing on an election form approved by PEBB~~)) no later than sixty days after the date of death of the employee or retiree. ((~~Coverage is retroactive~~)) If PEBB coverage ended due to the ((~~date~~)) death of the employee or retiree ((~~insurance~~)), PEBB will reinstate health plan coverage ((~~terminated~~)) without a gap subject to ((~~the~~)) payment of premium. In order to avoid duplication of group medical coverage, surviving dependents may defer enrollment in PEBB health plan coverage ((~~for each full calendar month in which they maintain coverage~~)) under ((~~other employer sponsored comprehensive medical coverage~~)) WAC 182-12-200 and 182-12-205. ((~~Notice~~)) To notify the PEBB program of their intent to enroll or defer PEBB health plan coverage the surviving dependent must ((~~be sent in writing~~)) send a completed enrollment form to the PEBB ((~~benefit services~~)) program no later than sixty days after the date of death of the ((~~subscriber~~)) employee or retiree.

((~~(5) Surviving dependents that defer coverage while enrolled in an employer sponsored comprehensive medical plan must submit an application to reenroll in PEBB coverage no later than sixty days after the last day of coverage under the employer sponsored medical plan. Satisfactory evidence of continuous enrollment in an employer sponsored comprehensive medical coverage will be required by the PEBB program prior to reenrollment in a PEBB health plan.~~))

WSR 06-19-086

EXPEDITED RULES

DEPARTMENT OF SOCIAL AND HEALTH SERVICES

(Aging and Disability Services Administration)

[Filed September 19, 2006, 12:27 p.m.]

Title of Rule and Other Identifying Information: WAC 388-78A-2480 Tuberculosis (TB) tests.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Rules Coordinator, Department of Social and Health Services, P.O. Box 45850, Olympia, WA 98504-5850, or deliver to Blake Office Park East, 4500 10th Avenue S.E., Lacey, WA 98503, e-mail fernaax@dshs.wa.gov, fax (360) 664-6185, AND RECEIVED BY 5:00 p.m. on November 20, 2006.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: The proposed amendment will eliminate a numbering/typographical error that exists in the current rule. Presently, there are two subsections (1)(d). The proposed amendment will renumber the second subsection (1)(d) and correctly identify it as subsection (1)(e).

Persons affected by this proposed amendment are boarding home licensees, boarding home residents, boarding home staff, and other persons who have an interest in the operation of boarding homes.

RCW 34.05.353 (1)(c) allows the use of expedited rule making to correct typographical errors that do not change the effect of the rule.

Reasons Supporting Proposal: Amending the rule will eliminate confusion regarding which subsection of WAC 388-78A-2480 is being referenced.

Statutory Authority for Adoption: RCW 18.20.090.

Statute Being Implemented: Chapter 18.20 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Department of social and health services, governmental.

Name of Agency Personnel Responsible for Drafting: Denny McKee, 4500 10th Avenue S.E., Lacey, WA 98503, (360) 725-2590, mckeedd@dshs.wa.gov; Implementation and Enforcement: Joyce Pashley Stockwell, 4500 10th Avenue S.E., Lacey, WA 98503, (360) 725-2401.

September 13, 2006

Andy Fernando, Manager

Rules and Policies Assistance Unit

AMENDATORY SECTION (Amending WSR 06-01-047, filed 12/15/05, effective 1/15/06)

WAC 388-78A-2480 TB tests. (1) The boarding home must ensure each staff person, except for volunteers and contactors, is screened for tuberculosis, as follows:

(a) Except when a staff person provided the boarding home with documentation of a previous positive Mantoux skin test, a staff person hired before September 1, 2004 must have had:

(i) A tuberculin skin test by the Mantoux method within six months preceding the date of employment in the boarding home; and

(ii) A second tuberculin skin test within one to three weeks after a negative Mantoux test if the staff person was thirty-five years of age or older at the time of hiring.

(b) A staff person hired on or after September 1, 2004 must have a baseline two-step skin test initiated within three days of being hired unless the staff person meets the requirements in (c) or (d) of this subsection. The skin tests must be:

(i) Given no less than one and no more than three weeks apart;

(ii) By intradermal (Mantoux) administration of purified protein derivative (PPD);

(iii) Read between forty-eight and seventy-two hours following administration, by trained personnel; and

(iv) Recorded in millimeters of induration.

(c) A staff person needs to have only a one-step skin test within three days of being hired if:

(i) There is documented history of a negative result from previous two-step testing; or

(ii) There was a documented negative result from one-step skin testing in the previous twelve months.

(d) A staff person does not need to be skin tested for tuberculosis if he/she has:

(i) Documented history of a previous positive skin test consisting of ten or more millimeters of induration; or

(ii) Documented evidence of adequate therapy for active disease; or

(iii) Documented evidence of adequate preventive therapy for infection.

((~~(d)~~)) (e) If a skin test results in a positive reaction, the boarding home must:

(i) Ensure that the staff person has a chest X ray within seven days;

(ii) Report positive chest X rays to the appropriate public health authority; and

(iii) Follow precautions ordered by a physician or public health authority.

(2) The boarding home must:

(a) Keep in the boarding home for the duration of the staff person's employment, and at least two years following termination of employment, records of:

(i) Tuberculin test results;

(ii) Reports of X-ray findings; and

(iii) Physician or public health official orders.

(b) Provide staff persons with a copy of the records specified in (a) of this subsection:

(i) During the time the staff person is employed in the boarding home, limited to one copy per report; and

(ii) When requested by the staff person.

(3) The boarding home must ensure that caregivers caring for a resident with suspected tuberculosis comply with the WISHA standard for respiratory protection.

WSR 06-19-103
EXPEDITED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2006-08—Filed September 20, 2006, 9:24 a.m.]

Title of Rule and Other Identifying Information: Technical correction to WAC 284-20A-050.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Kacy Scott, Insurance Commissioner's Office, P.O. Box 40255, Olympia, WA 98504-0255, e-mail Kacys@oic.wa.gov, fax (360) 586-3109, AND RECEIVED BY November 21, 2006.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: After adoption of WAC 284-20A-050 (Insurance Commissioner Matter No. R 2006-01) a possible ambiguity was discovered. The intent of WAC 284-20A-050 is to exempt insurers from medical malpractice cancellation and nonrenewal laws if they provide only incidental medical malpractice coverage. It does not benefit consumers, nor is it customary practice to send cancellation and nonrenewal notices when incidental coverages are cancelled. This proposed amendment would eliminate any possible misunderstanding or ambiguity in this section.

Reasons Supporting Proposal: This proposed amendment would eliminate any possible misunderstanding or ambiguity.

Statutory Authority for Adoption: RCW 48.02.060 and 48.18.547.

Statute Being Implemented: RCW 48.18.547.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Lisa Smego, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7134; Implementation: John Hamje, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7262; and Enforcement: Carol Sureau, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7050.

September 20, 2006
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2006-01, filed 8/10/06, effective 9/10/06)

WAC 284-20A-050 What constitutes a medical malpractice insurance policy for the purposes of RCW 48.18.290 (1)(b) and 48.18.2901 (1)(a)(ii)? A medical malpractice insurance policy means an insurance policy written with the principal intent to provide medical malpractice insurance. For the purposes of this section, a policy does not include medical malpractice insurance written as ancillary coverage to a general liability or package policy if the principal exposure insured is not medical malpractice.

WSR 06-19-104
EXPEDITED RULES
OFFICE OF THE INSURANCE COMMISSIONER

[Insurance Commissioner Matter No. R 2006-09—Filed September 20, 2006, 9:26 a.m.]

Title of Rule and Other Identifying Information: State of Washington United States Longshore and Harbor Workers' Compensation Act (USL&H) assigned risk plan. This proposed amendment is the result of a petition (P.36) from the administrator of the USL&H assigned risk plan.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Kacy Scott, Insurance Commissioner's Office, P.O. Box 40255, Olympia, WA 98504-0255, e-mail Kacys@oic.wa.gov, fax (360) 586-3109, AND RECEIVED BY November 21, 2006.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: In WAC 284-22-050(2), an applicant must obtain two denials of coverage in order to apply for coverage under the Washington USL&H assigned risk plan. Currently, there are only five active USL&H insurers authorized in Washington and all have high minimum premium requirements, below which the insurers will not even consider applications for coverage. When this assigned risk plan was created in 1992, it was understood that this plan would provide a market of last resort. Because the assigned risk plan maintains rates high enough to avoid competing with the voluntary market, that goal can be achieved without the two-denials requirement. The two-denial requirement in the definition of "applicant" is an unnecessary, burdensome, and inappropriate eligibility requirement and should be eliminated.

Reasons Supporting Proposal: The current definition requires small-premium employers to "shop" for denials from insurers knowing they will be turned down without consider-

ation. It is estimated by the administrator of the USL&H assigned risk plan that 85% of the plan employer-participants cannot meet the minimum premium requirements of any insurer in the voluntary market. For these applicants, the two-denial requirement is a meaningless exercise that needlessly wastes time and resources. Thus, this requirement should be eliminated.

Statutory Authority for Adoption: RCW 48.02.060 and 48.22.070.

Statute Being Implemented: RCW 48.22.070.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Mike Kreidler, insurance commissioner, governmental.

Name of Agency Personnel Responsible for Drafting: Melodie Bankers, P.O. Box 40258, Olympia, WA 98504-0258, (360) 725-7039; Implementation: Jim Odiorne, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7214; and Enforcement: Carol Sureau, P.O. Box 40255, Olympia, WA 98504-0255, (360) 725-7050.

September 20, 2006
Mike Kreidler
Insurance Commissioner

AMENDATORY SECTION (Amending Matter No. R 2001-10, filed 1/13/03, effective 2/13/03)

WAC 284-22-050 Definitions. (1) "Administrator" means any organization designated by the assigned risk plan and approved by the commissioner to provide administrative support for the plan. Such support shall be defined by the governing committee in its operating plan. It may include, but is not limited to, acceptance, processing, and distribution of incoming applications to the servicing carrier(s), collection of and accounting for premium income, determination of assigned risk plan reserves, investment of assigned risk plan assets, collection of statistical data, actuarial assistance for rate making, development of policy contracts, and auditing the activities of servicing carrier(s) to ensure that the assigned risk plan's rules are being applied properly.

(2) "Applicant" means an employer, seeking coverage from the assigned risk plan, who has, in good faith, ((~~sought~~)) been unable to purchase United States Longshore and Harbor Workers' Compensation Act coverage from ((~~at least two of the~~)) authorized insurers writing such coverage in Washington ((~~and has been declined such coverage by all insurers from which it has sought coverage~~)). "Applicant" does not include employers seeking coverage through the plan solely because of the lack of availability of maritime employers' liability coverage.

(3) "Authorized insurer" means any insurance company licensed to write workers' compensation insurance on a direct basis in this state.

(4) "Commissioner" means the commissioner of insurance of the state of Washington.

(5) "Governing committee" means the committee responsible for administering the assigned risk plan. It shall consist of thirteen members, who shall be appointed by the commissioner. The director of the department of labor and industries shall be one member. The remaining members shall be selected to insure equal representation of each of the following interest groups; authorized insurers writing primary or excess workers' compensation insurance, insurance producers, organized labor, and maritime employers.

(6) "Maritime employers' liability" means that liability imposed by 46 U.S.C. 688 (the Jones Act) and general maritime law for bodily injury including death of a master or member of the crew of any vessel.

(7) "Servicing carrier" means any authorized insurer designated by the assigned risk plan and approved by the commissioner and the United States Department of Labor to issue workers' compensation policies. It shall issue policies on behalf of the assigned risk plan, provide safety engineering, handle claims incurred by those covered by the assigned risk plan, provide premium audits, perform underwriting functions, and perform other duties as defined by the governing committee in its operating procedures.

(8) "State industrial insurance fund" means that entity defined in RCW 51.08.175 which provides primary workers' compensation insurance on a direct basis in this state.

(9) "United States longshore and harbor workers' compensation coverage" means that workers' compensation coverage required of employers by the United States Longshore and Harbor Workers' Compensation Act, 33 U.S.C. Secs. 901 through 950. It is hereinafter referred to as USL&H coverage.

(10) "Written premium" means gross direct premiums (excluding premiums on risks written ceded to the assigned risk plan), within the state of Washington, charged during the first preceding calendar year with respect to United States Longshore and Harbor Workers' insurance, less return premiums, dividends paid or credited to policyholders, or the unused or unabsorbed portions of premium deposits.

WSR 06-19-110
EXPEDITED RULES
WASHINGTON STATE UNIVERSITY
[Filed September 20, 2006, 9:55 a.m.]

Title of Rule and Other Identifying Information: Repealing WAC 504-36-010 Smoking regulations for campus buildings.

NOTICE

THIS RULE IS BEING PROPOSED UNDER AN EXPEDITED RULE-MAKING PROCESS THAT WILL ELIMINATE THE NEED FOR THE AGENCY TO HOLD PUBLIC HEARINGS, PREPARE A SMALL BUSINESS ECONOMIC IMPACT STATEMENT, OR PROVIDE RESPONSES TO THE CRITERIA FOR A SIGNIFICANT LEGISLATIVE RULE. IF YOU OBJECT TO THIS USE OF THE EXPEDITED RULE-MAKING PROCESS, YOU MUST EXPRESS YOUR OBJECTIONS IN WRITING AND THEY MUST BE SENT TO Ralph T. Jenks, University Rules Coordinator, Washington State University, Office of Procedures, Records and Forms, P.O. Box 641225, Pullman, WA 99164-1225, AND RECEIVED BY November 20, 2006.

Purpose of the Proposal and Its Anticipated Effects, Including Any Changes in Existing Rules: This proposal

repeals outdated smoking regulations. New regulations are not required because smoking requirements are explicitly and specifically dictated by chapter 70.160 RCW.

Reasons Supporting Proposal: A rule on this topic is no longer necessary because smoking requirements are explicitly and specifically dictated by chapter 70.160 RCW.

Statutory Authority for Adoption: RCW 34.05.353.

Statute Being Implemented: Chapter 70.160 RCW.

Rule is not necessitated by federal law, federal or state court decision.

Name of Proponent: Washington State University, public.

Name of Agency Personnel Responsible for Drafting: Ralph T. Jenks, Office of Procedures, Records and Forms, (509) 335-2004; Implementation: Dwight Hagihara, Environmental Health and Safety, (509) 335-3051; and Enforcement: Steven Hansen, Public Safety, (509) 335-8548.

September 15, 2006
Ralph T. Jenks, Director
Office of Procedures, Records, and Forms
and University Rules Coordinator

REPEALER

The following section of the Washington Administrative Code is repealed:

WAC 504-36-010	Smoking regulations for campus buildings.